IN THE MATTER OF	*	BEFORE THE
TERRANCE A. MCSWEEN	*	MARYLAND STATE
Respondent.	*	BOARD OF PHYSICIANS
License Number: R12235	*	Case Number: 2219-0205

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FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Terrance A. McSween is a radiographer, who was originally licensed by the Board to practice radiography in Maryland in 2018. On February 27, 2020, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Mr. McSween with unprofessional or immoral conduct in the practice of radiation therapy, radiography, nuclear medicine technology, or radiology assistance. *See* Md. Code Ann., Health Occ. § 14-5B-14(a)(3). The charges alleged that Mr. McSween committed numerous infractions, including tardiness, inaccurately saving a patient's x-ray, bringing a family member to the office without checking in, inquiring about nurses' relationship statuses, and searching for documents by reviewing the medical records of patients that he was not treating while searching for a requisition document, among other issues.

On January 6 and 7, 2021, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. On April 6, 2021, the ALJ issued a proposed decision concluding that Mr. McSween was not was guilty of immoral or unprofessional conduct in the practice of radiography and proposed that the Board dismiss the charge.

The State filed exceptions to the factual findings and to the ALJ's conclusion that Mr. McSween's conduct was not unprofessional. On June 9, 2021, both parties appeared before Disciplinary Panel A of the Board for an exceptions hearing.

FINDINGS OF FACT

Disciplinary Panel A finds the following facts proven by a preponderance of evidence:

Mr. McSween is a radiographer, originally licensed in Maryland, on May 8, 2018, as part of a consent order. In the May 8, 2018 Consent Order the Board found that Mr. McSween failed to disclose five convictions or guilty pleas in his application and thus found to have fraudulently or deceptively attempted to obtain a license, was guilty of unprofessional or immoral conduct in the practice of radiography, and to have willfully made or filed a false report. The Board licensed Mr. McSween with a reprimand. After receiving his license, Mr. McSween was employed at a mobile imaging services company "Provider C" where he worked five days per week, twelve to sixteen hours per day and on call overnight. Beginning on July 21, 2018, Mr. McSween was also employed at an urgent care facility, "Provider A."

On August 30, 2018, while working for Provider A, Mr. McSween made an error in recording a patient's x-ray studies using the C-arm machine. Mr. McSween had labeled two studies for different patients under the same patient. Mr. McSween's supervisor noticed the error on the records and brought it to his attention. Mr. McSween stated that he would fix the problem; however, he did not fix the problem before leaving for the day. The next day, on a day that Mr. McSween was not working, Mr. McSween's supervisor noticed the problem had not been fixed and also noticed there was a record that was missing from a patient that Mr. McSween had seen the previous day. The supervisor called Mr. McSween twice and sent him an email to make him aware of the error that could result in one patient lacking access to his images and another patient accessing a different patient's images. Mr. McSween did not reply. On September 4 the supervisor called Mr. McSween again and sent another email message about her concerns but he did not respond to either phone call or email. Mr. McSween claimed to be not

sufficiently trained on the software, not to have received the phone calls made on August 31 and August 4, and unable to access the emails. On September 6, 2018, Mr. McSween was counseled about his conduct.

On September 7, 2018, a physician at Provider A listed several complaints against Mr. McSween, including being unprofessional by interrupting the physician, not providing personal space, and being slow to respond to requests for discharging patients. Mr. McSween was not told of these concerns and denied being close to the physician except when he was receiving training from her when he might have been close to her to look over her shoulder to observe procedures.

Between August 15, 2018, and September 12, 2018, Mr. McSween was late to work at Provider A seven times and late more than ten minutes on three of those occasions. On September 12, Mr. McSween was late to Provider A by over an hour. On that instance, Mr. McSween had an emergency dental issue, and called the welcome desk to relay the message. Provider A's policy was that Mr. McSween should have contacted his supervisor directly if he was going to be late. Mr. McSween did not contact his supervisor and patient care was delayed.

On September 13, 2018, Mr. McSween was taking an abdominal x-ray of a patient evaluated for constipation. The patient was a transgender female patient.[1] Mr. McSween was not told about the patient being transgender and did not use a gonadal shield as he would for all patients with testicles. When discovering during the procedure that the patient was transgender and had male genitalia, he stated, "This is the shit I don't like."

Also, on September 13, 2018, Mr. McSween was asked to perform an x-ray on a patient. The patient's significant other was in the room and asked why Mr. McSween was asking about

[1] The patient was female but had testicles.

whether the patient was pregnant and the significance of the forms she was signing. Mr. McSween explained that these forms were to protect the doctor and the institution from liability. A nurse filed a complaint against Mr. McSween, claiming that Mr. McSween suggested to the significant other to sue the physician.

On September 14, 2018, Mr. McSween was off duty and brought his three-year-old daughter to Provider A because she had had lacerated her toe on a sprinkler. Mr. McSween talked to the person at the front desk and then talked to one of the physician assistants who told him to bring his daughter back to a trauma bay. Mr. McSween cleaned her wound, and the physician assistant who looked at it determined it was a surface wound, which did not need stitches. The physician assistant provided a Band-Aid, antibiotic cream, and advised to monitor the wound for swelling and infection. The physician assistant told Mr. McSween that he did not need to check in and that he should not worry about it. About 11 days later, the physician assistant wrote an email to Mr. McSween's supervisor, explaining that he treated Mr. McSween's daughter, but no chart was generated for the visit. Mr. McSween's supervisor claimed that Mr. McSween did not register his daughter at the front desk and proceeded to the trauma room without asking first.

On September 26, 2018, Mr. McSween was terminated from Provider A for unsatisfactory job performance, timekeeping problems, and other violations of company policy and/or procedure. The summary included his lateness, his failure to record and save x-ray studies compromising protected health information, complaints about his inability to follow directions, unprofessionalism and use of inappropriate language, and bringing his daughter in for treatment without checking her in and without entering information about the visit into her chart.

On October 22, 2018, Mr. McSween began work part-time at an urgent care facility "Provider B."

On October 29, 2018, Mr. McSween arrived at Provider C, and the nurses, nursing assistants, and geriatric nursing assistants were not present. Mr. McSween found a nursing assistant and together they went to a nurse's office to find the requisition order from the physician for Provider C. The nurse filed a complaint, complaining that the area he was looking through to find the papers had sensitive resident information.

Around the same time, Mr. McSween was seeing a patient-inmate at a detention center for Provider C. Mr. McSween was in a room with nursing staff and asked the nurses if they were married or had boyfriends. Mr. McSween later explained that it was not of a sexual nature but just general small talk. One of the nurses orally complained about his questions, and that complaint was recorded in Mr. McSween's employment file.

On November 27, 2018, Mr. McSween was terminated from Provider C based on his confrontational and argumentative behavior.

On December 14, 2018, Mr. McSween arrived at the Dundalk location for Provider B, when he was supposed to be at Provider B's Forest Hill center. Mr. McSween claimed that he arrived at the Dundalk location at 7:38 a.m. and then, after seeing another x-ray technician's car in the parking lot, spent 15 minutes trying to figure out where he was supposed to be. He then went inside, checked in, at 7:56 a.m., and then left to go to the Forest Hill location, informing his employer that he had arrived at 7:38 a.m., but at the wrong location. His employer checked the video camera surveillance and determined that he had entered the building at 7:52 a.m. This was Mr. McSween's second time that he was late. Provider B found that he inaccurately reported his

time to avoid attendance infractions and terminated Mr. McSween's employment immediately on December 14, 2018.

Mr. McSween was employed by an urgent care facility from January 2019 to April 2019 ("Provider D"). He resigned that position to take a position at a hospital ("Provider E"), starting April 2019. At Provider E, Mr. McSween was counselled several times, but not suspended, for lateness. Mr. McSween resigned that position in September 2020. He has been employed at a mobile radiologic service company ("Provider F"), since August 2019.

On March 11, 2019, Mr. McSween applied with the Board for a renewal of his license and, on his application, reported "Yes" to the question, "Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, or institution . . . been terminated for disciplinary reasons?" He stated, "I was terminated by my employer, however Maryland law deemed that I was not in violation of gross misconduct as per explanation given by Maryland Department of Labor and was issued unemployment benefits." As discussed above, Mr. McSween had been terminated by three employers. The Board conducted an investigation and, on February 27, 2020, charged Mr. McSween.

CONSIDERATION OF EXCEPTIONS

Unprofessional Conduct in the Practice of Radiography, Health Occ. § 14-5B-14 (b)(3)

The State filed exceptions regarding several of the incidents at issue. The State also excepted to the ALJ's credibility findings pertaining to Mr. McSween and to the ALJ's legal analysis.

Mr. McSween's Credibility

In its exceptions, the State argues that Mr. McSween is not credible, based on his answer on his application that he was terminated from his employment, because Mr. McSween did not

state that he was, in fact, terminated from three employers. Further, the State argues that the Panel should consider his prior consent order where Mr. McSween admitted to not reporting his prior criminal history on his licensure application. The State also argues that its evidence should be afforded additional weight because it contains reports from multiple disinterested individuals who made independent complaints.

Mr. McSween responds that he voluntarily and truthfully reported that he was terminated from his employment and, when asked for details about where he was terminated, voluntarily provided the names of the three employers that terminated him. Mr. McSween also argues that the State's evidence should not be given any special weight and that the State failed to meet its the burden to prove its case under Health Occ. § 14-405(b)(2). He notes that no witnesses were interviewed and, while the supervisors testified at OAH, the witnesses who directly observed the events, including nurses, physicians, and physician assistants, did not testify under oath.

The Panel considered the prior Consent Order that included Mr. McSween's false statements on his initial application for license as well as his statements on his application that he was terminated from one position without mentioning that he had, in fact, been terminated from three employers. The Panel, however, does not consider such evidence as dispositive on his credibility, as the State requests, and has thus weighed Mr. McSween's testimony against the evidence presented by the State to determine the facts.

Expert Testimony and Common Judgement of the Profession

The State argues in its exceptions that the ALJ found no violation by Mr. McSween because the State failed to produce an expert. The State notes that when the issue involves non-technical matters, the "common knowledge and experience of reasonable" people do not require the testimony of an expert. *Suburban Hospital Assoc. v. Hadary*, 22 Md. App. 186, 194-95

(1974). The State further notes that the Administrative Procedure Act permits the Board to apply its specialized knowledge to reach its conclusions. State Gov't § 10-213(i). The State argues that no technical aspects of radiography are needed to assess Mr. McSween's conduct.

Mr. McSween responds that the ALJ did not specifically state that an expert is needed, but rather found that there was no testimony or evidence explaining how Mr. McSween committed unprofessional conduct and the American Registry of Radiologic Technologist's standards of ethics do not describe or prohibit any of Mr. McSween's alleged conduct, such as lateness, inquiring as to non-subordinate co-workers' marital status, or looking for a document amongst purported patient records.

While contrasting the case with *Finucan* and its production of an expert, the ALJ did not state that an expert is required to find a violation. The ALJ cited the *Finucan* case explaining that the terms "unprofessional or immoral conduct" are not defined in the governing statute, but rather "determined by the 'common judgment' of the profession as found by the professional licensing board" and that unprofessional conduct "refers to 'conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession.'" *Finucan v. Maryland Bd. of Physician Quality Assur.*, 380 Md. 577, 593 (2004). The ALJ noted that the *Finucan* case did include expert testimony about what violated the rules of the profession.

The Panel finds that an expert was not required for the State to prove the allegations, because the issues are not so technical in nature that they are beyond the expertise of the Board. The Panel, composed of health care practitioners and consumer members, has sufficient expertise about professionalism in a health care facility using its "experience, technical competence, and specialized knowledge of professionalism in the medical arena." State Gov't 10-213(i).

Mr. McSween's Lateness

Mr. McSween was late seven times within a month at Provider A, three times by more than ten minutes. Mr. McSween was also late twice at Provider B, including the instance when his late entry was recorded on video camera. Provider C listed "tardiness" as one of the deficiencies leading to Mr. McSween's removal, and Mr. McSween reported that he has been late several times while working for a fourth employer (Provider E) and was warned without any formal disciplinary action taken against him by the employer. The ALJ conceded that "chronic lateness may be characterized as unprofessional in certain contexts" but concluded that there was not a basis for finding that his tardiness amounts to unprofessional conduct in the "common judgment" of the profession. The ALJ noted that as a mobile radiographer he was required to travel and that the circumstances leading to lateness, the standards of discipline for lateness, including the number and the magnitude of lateness varied with each employer. Because there were no details regarding the cause of Mr. McSween's lateness, the ALJ stated that there was no basis for finding his lateness to be unprofessional conduct rather than part of the nature of his work.

The Panel disagrees with the ALJ. Mr. McSween's lateness went beyond the occasional instance of tardiness and was clearly a chronic and significant problem. It was evident that his lateness was not just part of the nature of his work, as it was listed as part of the reasons for all three of his terminations. He was late 7 times in less than a month at Provider A. He was late twice in two months and terminated for a timekeeping violation at Provider B. There were indications that his timeliness was also a problem at Provider C, and he acknowledged his continued tardiness at Provider E. The factual basis for these instances of tardiness is

undisputed. While not the most dangerous or serious violation of professionalism, Mr. McSween's conduct demonstrates a chronic problem that, in conjunction with his other violations, constitutes unprofessional conduct in the practice of radiography.

Over an Hour Late at Provider A

The State argues in its exceptions that, on September 12, 2018, Mr. McSween was late by over an hour causing a delay in patient care. Mr. McSween testified that he had an emergency dental problem causing him to be late, and he called the office and informed the front desk person of his emergency and asked her to tell his supervisor. He also claimed that he shared a note from his dentist with a manager. Mr. McSween claims that there was no testimony or evidence that the procedures that he used were unprofessional. The State responds that his excuse was unverifiable and self-serving.

The Panel finds that even if Mr. McSween called the front desk to inform Provider A about his emergency dental issue, he did not follow the procedures that Provider A required of him by not directly contacting his supervisor by phone. The ALJ suggested that a single lapse in protocol was not unprofessional conduct; however, the procedures to contact his supervisor were in place so that the appropriate personnel could attempt to make alternate arrangements. Along with his chronic lateness, Mr. McSween's failure to follow his employer's procedure that resulted in delayed patient care constitutes unprofessional conduct in the practice of radiography.

Late Arrival at Provider B

On December 14, 2018, Mr. McSween arrived at the Dundalk office of his employer. Mr. McSween reported to someone at Provider B that he arrived at 7:38 a.m. but spent around 15 minutes in the parking lot because he realized that he might be in the wrong location before deciding to clock-in and then go to the correct location. Provider B checked the videotape and

noted that Mr. McSween did not enter the building until 7:52 a.m. concluded that he reported his arrival time to avoid attendance infractions. The State claims that the most reasonable inference, based on his history of late arrivals and his history of mispresenting facts unfavorable to him, is that he arrived late and lied about his arrival time, committing both unprofessional and immoral conduct. Mr. McSween responds that the State presented no witnesses and the termination report does not contradict his version of events.

The Panel finds it is inconclusive if Mr. McSween was at the parking lot on time, but even if Mr. McSween did arrive to the parking lot when he said he did, he still would have been late. Even accepting Mr. McSween's testimony that he was present in the parking lot, Mr. McSween entered the building and clocked in after he was supposed to arrive. The Panel includes this to finding that he was chronically late to work and guilty of unprofessional conduct, but finds that it is not sufficient evidence to find immoral conduct.

Error in patient records and failure to respond to emails and phone calls from Provider A

On August 30, 2018, Mr. McSween conducted two studies for two separate patients but labeled the studies incorrectly as being under the same patient. Mr. McSween's supervisor testified that she pointed out the error to Mr. McSween, who stated that he would correct the mistake. However, the next day, August 31, 2018, the supervisor checked and found that the error was not fixed. The supervisor called Mr. McSween about the error twice that day. When he did not respond, she emailed him about the error. He did not respond to either the calls or the email. On September 4, 2018, Mr. McSween's supervisor sent another email with her concern and called again. Mr. McSween did not respond to those messages either. Mr. McSween's supervisor testified that employees are asked to try and check their emails in case there is an emergency.

Mr. McSween recounts the events differently. He admits that he made some errors and claims that he noticed the error and was trying to fix the error when his supervisor told him to triage a patient and stated that she would look into the error. He claims that, when he returned, the supervisor told him everything looks fine. He claimed that he did not have access to e-mail off site and could not answer phone calls while he was on duty at his other job and "wasn't aware of any messages" from those phone calls. When he returned he claims that she acknowledged that he had told her of the error.

The Panel finds Mr. McSween's supervisor's testimony is more believable. It is undisputed that Mr. McSween made an error in recording the c-arm and that it resulted in the images being filed in the wrong patient chart. In other words, one patient who should have had access to records did not and a second patient had access to images for himself and another patient. The Panel also finds Mr. McSween's supervisor's explanation is more plausible. It simply is illogical and unlikely that the supervisor told Mr. McSween that the error was corrected when the error had not been corrected and that supervisor would send repeated emails and phone calls asking him to correct the error if she had told him that the error had been corrected.

The Panel finds by a preponderance of the evidence that the supervisor told Mr. McSween about the error and he failed to fix it before leaving for the day. The following day, the supervisor checked and found that the error had not been fixed. Mr. McSween did not respond to multiple phone calls and did not check his email even though employees are asked to check their emails. Here, Mr. McSween knew that there had been an error and did not answer phone calls or check his email, per company policy. His failure to immediately correct his mistake, along with his failure to respond to multiple messages, under these circumstances, amounts to unprofessional conduct in the practice of radiography.

Comment Regarding X-Ray of Transgender Patient

Following an x-ray of a transgender patient at Provider A, Mr. McSween told a nurse, "This is the shit I don't like." The State argues that the only reasonable inference from the statement is that Mr. McSween made unprofessional comments based on the patient's transgender status. The State further states that using profanity with a colleague when discussing a patient is unprofessional. Finally, the State contends this comment was disruptive. In response, Mr. McSween claims that the comment was not transphobic but an expression of his annoyance and frustration at not being told that the patient was transgender before the x-ray because it affects the procedure for shielding the patient's reproductive organs.

The Panel credits Mr. McSween's explanation of his statement. While the nurse appears to have jumped to a conclusion that his statement was directed toward the patient's transgender status, the likelier explanation is that Mr. McSween was frustrated that he could not properly perform his job because necessary information was withheld from him. Further, a single utterance of profanity in a moment of frustration under the circumstances does not reach the level of unprofessional conduct.

Comments about Nurses' Relationship Status

Sometime in October or November of 2018, Mr. McSween asked all the nurses who were staff members of Provider C about their marital/relationship statuses. There is scant information about the incident, as the single source of this incident was from a report by a supervisor who relayed the information by one of the nurses about a month after the occurrence. Mr. McSween described the incident as small talk in a casual environment. The State states that Mr. McSween harassed staff members and that the causal setting is irrelevant. Mr. McSween argues that his inquiry about their relationship statuses does not reach to the level of sexual harassment or

unprofessional conduct. The Panel finds insufficient evidence that Mr. McSween's statements were unprofessional conduct based on the lack of details and lack of a first-hand account of the incident. Mr. McSween, however, should be reticent in the future about engaging in discussions that concern co-workers relationships and concerning any topics that could make other employees uncomfortable.

Going through Documents at the Nurses Office

Mr. McSween was searching through papers on the charge nurse's desk to find the record of one of his assigned patients. The State argues that Mr. McSween was "going through papers on the desk [of the charge nurse] that had sensitive information regarding other residents." According to Mr. McSween, he was escorted to the office and, alongside a nursing assistant, searched in the requisition document that Mr. McSween needed to perform his tasks. Mr. McSween testified that often a nurse would let the radiographer sit at the desk to get paperwork and this was an accepted practice.

The complaint was lodged by the director at one of Provider C's facilities and relayed by a nurse. The only testimony against Mr. McSween was from his supervisor at Provider C, who had received the complaint. The Panel finds that his search, which may have involved Mr. McSween seeing the charts of other patients, was meant to facilitate patient care and conducted with the aid of a nursing assistant at the facility and did not rise under the circumstances to unprofessional conduct. Accordingly, there is insufficient information to find unprofessional conduct in the practice of radiography for this instance.

Other Miscellaneous Issues

While not discussed in the exceptions, there were several other issues that were discussed in the charges and at the hearing that the ALJ found to be without sufficient support. Several of

them were either non-specific or otherwise without sufficient evidence beyond the complaint itself. Several complaints concerned his interaction with clients including confrontations with employees at the facilities, a negative attitude, inability to follow direction and receive guidance, and negative work habits. For example, a physician at Provider A listed five complaints against Mr. McSween, including being unprofessional by interrupting the physician, not providing personal space, being slow to respond to request for discharging patients. In short, there was insufficient evidence to support a conclusion of unprofessional conduct related to these complaints.

Another instance was one that concerned whether Mr. McSween encouraged a patient's family to sue the doctor. Upon closer review, the Panel finds it is more likely that Mr. McSween was explaining the purpose of certain forms.

A third instance was Mr. McSween's bringing his three-year-old daughter to Provider A because she had a laceration on her toe. The complaint alleged that he had not correctly checked his daughter in and brought her to a trauma room without permission. Like several of the issues in this case, the only evidence is the complaint, which contains little detail. On the other hand, Mr. McSween's rebuttal contained significant detail in which he explained that he had followed the physician assistant's instructions. In each of these specific instances, there is insufficient evidence to find unprofessional conduct in the practice of radiography.

CONCLUSIONS OF LAW

Based on the foregoing findings, Disciplinary Panel A concludes as a matter of law that Mr. McSween is guilty of unprofessional conduct in the practice of radiography, in violation of § 14-5B-14(a)(3) of the Health Occupations Article.

SANCTION

As a sanction, the State recommended a reprimand, probation for three years, enrollment in the Maryland Professional Rehabilitation Program, a peer supervisor who would provide routine reports to the Board about Mr. McSween's professional performance, two remedial classes in professionalism and ethics, and a $2,500 fine. As aggravating factors, the State noted Mr. McSween's prior discipline and two discrete offenses adjudicated together. Mr. McSween recommends "no sanction or only a minimum sanction and fine." Mr. McSween cites mitigating factors including no potential harm to patients, isolated incidents unlikely to recur, lack of premeditation, and lack of prior disciplinary record, attempts to remediate or mitigate harm, and good faith efforts to rectify the consequences of the conduct.

Mr. McSween's conduct, while unprofessional, did not cause patient harm and Mr. McSween has exhibited rehabilitation and rehabilitative potential. The Vice President of Operations at Mr. McSween's employer since 2019 testified on his behalf regarding the last year-and-a-half. This employer testified that Mr. McSween performed especially well during the pandemic and has not exhibited any particular deficiencies related to his radiography skill and has not provoked any complaints regarding his behavior. Thus, while the Panel finds a violation, it considers a course on professionalism and reprimand to be a sufficient discipline based on the relatively minor violations and exhibited rehabilitation.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that Terrance A. McSween, is **REPRIMANDED**; it is further

ORDERED that within **SIX (6) MONTHS**, Mr. McSween is required to take and successfully complete a course in professionalism. The following terms apply:

(a) It is Mr. McSween's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;
(b) Mr. McSween must provide documentation to the disciplinary panel that Mr. McSween has successfully completed the course;
(c) The course may not be used to fulfill the continuing medical education credits required for license renewal;
(d) Mr. McSween is responsible for the cost of the course; and it is further

ORDERED that Mr. McSween is responsible for all costs incurred in fulfilling the terms and conditions of this Final Decision and Order; and it is further

ORDERED that, if Mr. McSween allegedly fails to comply with any term or condition imposed by this Final Decision and Order, Mr. McSween shall be given notice and an opportunity for a hearing. If Disciplinary Panel A determines there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel. If Disciplinary Panel A determines there is no genuine dispute as to a material fact, Mr. McSween shall be given a show cause hearing before Disciplinary Panel A; and it is further

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that Mr. McSween has failed to comply with any term or condition imposed by this Final Decision and Order, the disciplinary panel may reprimand Mr. McSween, place Mr. McSween on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke Mr. McSween's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on Mr. McSween; and it is further

ORDERED that the effective date of the Final Decision and Order is the date the Final Decision and Order is signed by the Executive Director of the Board. The Executive Director signs the Final Decision and Order on behalf of Disciplinary Panel A; and it is further

ORDERED that this Final Decision and Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

10/07/2021
Date

Signature on File

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-5B-14.1, Mr. McSween has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Mr. McSween files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201