IN THE MATTER OF	*	**BEFORE THE**
WESTERN MARYLAND HEALTH SYSTEM, INC.	*	**MARYLAND STATE**
	*	**BOARD OF PHYSICIANS**
The Respondent	*	**Case Number: 2220-0241A**

* * * * * * * * * * * * *

CONSENT ORDER

On or about April 23, 2020, the Maryland State Board of Physicians (the "Board") notified Western Maryland Health System, Inc. (the "Respondent")[1] of its failure to comply with provisions of the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.) and the regulations adopted by the Board, Md. Code Regs. ("COMAR") 10.32.01 *et seq.*

The pertinent provisions of the Act and COMAR are as follows:

Health Occ. § 14-5B-15 Report.

(a) In general. -- Except as provided in subsections (b) and (d) of this section, hospitals, related institutions, alternative health systems as defined in Section 1-401 of this article, and employers shall file with the Board a report that the hospital, related institution, alternative health system, or employer limited, reduced, otherwise changed, or terminated any licensee for any reason that might be grounds for disciplinary action under Section 14-5B-14 of this subtitle.

....

(e) Time for filing report. -- The hospital, related institution, alternative health system, or employer shall submit the report within 10 days of any action described in this section.

....

[1] Effective approximately February 1, 2020, the Respondent merged with the University of Pittsburgh Medical System and is known as UPMC Western Maryland.

(g) Penalties. –

(1) The Board may impose a civil penalty of up to $ 1,000 for failure to report under this section.

The pertinent regulations adopted by the Board are as follows:

COMAR 10.32.22.03 Mandated Reports.

A. Subject to the limitations set out in §§ B, C and D of this regulation, the reporting entity shall report to the Board in writing any change made with respect to a health care provider:

(1) Whom the reporting entity employs;

(2) Who works with the reporting entity under contract; or

(3) To whom the reporting entity has granted privileges.

B. A reporting entity shall inform the Board of any change that has been made, in whole or in part, because the reporting entity had reason to believe that the health care provider:

....

(3) Disrupted the workplace;

(4) Committed unethical or unprofessional conduct;

....

(14) Repeatedly violated hospital bylaws, rules, policies, or procedures after warning; or

(15) Committed any other act or suffered from any other condition which the reporting entity had reason to believe may constitute a violation of the Acts.

COMAR 10.32.22.06 Enforcement.

....

M. It is not a defense to the allegation of a failure to report that:

(1) An employee of the reporting entity was not aware of:

(a) The change made by the reporting entity; or

(b) The obligation to report[.]

....

O. If the Board finds after a hearing that a reporting entity failed to file any report required by this chapter, the Board shall issue a final disposition with findings of fact, conclusions of law, and civil penalty. In its final disposition, the Board may impose a civil penalty as follows:

....

(2) With respect to reports concerning allied health providers:

(a) $500 for the first occurrence in a calendar year[.]

On or about September 9, 2020, Disciplinary Panel A of the Board ("Panel A")[2] and the Respondent participated in a settlement conference. Following the settlement conference, Panel A and the Respondent agreed to enter into this Consent Order to resolve the case as described below.

FINDINGS OF FACT

Panel A finds the following facts:

1. On or about April 30, 2019, the Board received a renewal application

[2] As of May 8, 2020, Health Occ. § 14-5B-15(g) authorizes a disciplinary panel of the Board to impose a civil penalty of up to $1,000 for a failure to report under Health Occ. § 14-5B-15. *See* SB 395, ch. 613, HB 560, ch. 612 (2020).

for a Maryland licensed radiographer (the "Radiographer").[3] In the renewal application, the Radiographer revealed that within the last two years, she had been terminated for disciplinary reasons, explaining in part: "I was wrongfully accused of falsifying a document."

2. Based on the information in the Radiographer's renewal application (the "Complaint"), the Board initiated an investigation.

3. In furtherance of the investigation, the Board's investigator obtained written responses from the Respondent and relevant personnel records. The records revealed the following.

4. Effective May 10, 2018, the Respondent, a Maryland hospital, terminated the Radiographer, who it had been employing since approximately 1991. The Respondent failed to report to the Board that it had terminated the Radiographer.

5. The Respondent terminated the Radiographer as a result of three instances in which the Radiographer violated the Respondent's bylaws, rules, policies, or procedures. The records show that as a result of each incident, the Radiographer received written warnings or disciplinary action, including a "written warning," a "final written warning," and, termination. These instances are described in more detail below.

[3] To ensure privacy, the names of certain individuals involved in this case are not disclosed in this document. The Respondent may obtain the identity of the referenced individuals or entities in this document by contacting the administrative prosecutor.

6. On or about July 11, 2017, according to an "Employee Disciplinary Record" contained in the Radiographer's personnel records, the Radiographer was issued a "written warning" based on a "service excellence" violation, specifically: "reports of [the Radiographer] displaying negativity in regards to the Diagnostic Imaging Management staff." The document states, "This type of behavior does not meet WMHS [the Respondent] Service Excellence expectations and is completely unacceptable." The document explicitly warned, "Should she [the Radiographer] display additional behavior that does not meet expectations, further disciplinary action, up to and including termination will occur."

7. Approximately three months later, on or about September 5, 2017, according to another "Employee Disciplinary Record" contained in the Radiographer's personnel records, the Radiographer was issued a "final written warning" based on a "policy violation" by the Radiographer, specifically accessing confidential information without authorization. The information the Radiographer accessed included patient diagnostic imaging studies and at least one report. In addition, the Radiographer accessed confidential information from the Respondent's computer records system relating to an "Event Study Log" and, without authorization, "gave it to her spouse's attorney."

8. The document states that the Radiographer's actions "are a breach in protocol. She failed to follow the established process for supplying data to an attorney. Additionally, she violated HIPAA regulations by accessing [patient] information [and] was less than truthful during the investigation by denying she had

accessed it." Again, the document explicitly warned of progressive discipline, stating that "If [the Radiographer] continues to display inappropriate behaviors then further disciplinary action, up to and including termination will occur."

9. Finally, on or about May 10, 2018, according to another "Employee Disciplinary Record" contained in the Radiographer's personnel records, the Radiographer was notified of her termination based on another "policy violation" by the Radiographer, specifically "falsification of documentation."

10. When asked to respond to the Board's concerns regarding its failure to report the Radiographer's termination to the Board, the Respondent stated in a letter dated November 20, 2019, that the Radiographer was terminated "because she failed to complete her job duties on a consistent basis."

11. The letter clarified that regarding the incident of May 10, 2018, the Radiographer had an internal checklist that she was required to complete on a daily basis. The internal checklist indicated that [the Radiographer] had completed her job tasks, when in some instances she had not." However, it was the Respondent's position that the Radiographer's termination was not a reportable change under the regulations adopted by the Board cited above.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent failed to report to the Board within 10 days that it had terminated its employee, the Radiographer, for reasons that might be grounds for disciplinary action under the following provisions of Health Occ. § 14-5B-14(a): (3) Is guilty of

unprofessional or immoral conduct in the practice of radiation therapy, radiography, nuclear medicine technology, or radiology assistance; (10) Willfully makes or files a false report or record in the practice of radiation therapy, radiography, nuclear medicine technology, or radiology assistance; and (12) Breaches patient confidentiality.

The Respondent's failure to report the termination of the Radiographer to the Board, as described above, constitutes a violation of Health Occ. § 14-5B-15.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by Panel A, hereby:

ORDERED that the Respondent shall pay to the Board a civil penalty of $500 (five hundred dollars), due within 30 (thirty) days of the effective date of this Consent Order; and it is further

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

Signature on File

10/13/2020
Date

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

CONSENT

I acknowledge that the Respondent has had the opportunity to consult with counsel at this and all stages of this matter. I understand that this Consent Order will resolve the Notice issued against Respondent in the above referenced cases. By this Consent and for

the sole purpose of resolving the issues raised by the Board, the Respondent agrees and accepts to be bound by the foregoing Consent Order. Respondent acknowledges that the Findings of Fact and the Conclusions of Law contained in this Consent Order will be treated as proven as if entered into after the conclusion of a formal evidentiary hearing in which the Respondent would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on its own behalf, and to all other substantive and procedural protections provided by the law. The Respondent agrees to forego its opportunity to challenge these Findings of Fact and Conclusions of Law. Respondent acknowledges the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. The Respondent affirms that it waives its right to any appeal in this matter. The Respondent affirms that it has asked and received satisfactory answers to its questions regarding the language, meaning, and terms of this Consent Order. On behalf of the Respondent, I sign this Consent Order, voluntarily and without reservation, and I fully understand and comprehend the language, meaning, and terms of this Consent Order.

10/7/2020
Date

Barry P. Ronan
Agent for the Respondent (printed name)

Signature on File

Agent for the Respondent (signature)

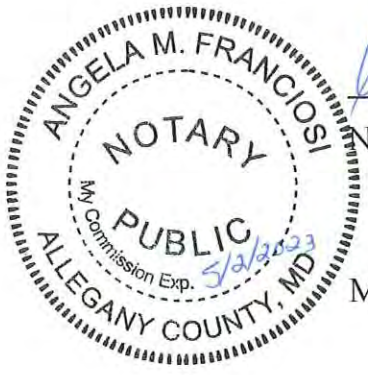
NOTARY

STATE OF Maryland

CITY/COUNTY OF Allegany

I HEREBY CERTIFY that on this 7 day of October, 2020, before me, a Notary Public of the foregoing State and City/County personally appeared Barry P. Roman [Agent for the Respondent], and made oath in due form of law that signing the foregoing Consent Order was his/her voluntary act and deed.

AS WITNESSETH my hand and notary seal.



Angela M. Franciosi
Notary Public

My commission expires: 5/2/2023