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| **IN THE MATTER OF** | * | **BEFORE THE** |
| **ROGER THEODORE, M.D.** | * | **MARYLAND STATE** |
| **Respondent** | * | **BOARD OF PHYSICIANS** |
| **License Number: D14165** | | **Case Number: 2016-0875B** |

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**CONSENT ORDER**

On November 14, 2017, Disciplinary Panel B of the Maryland State Board of Physicians ("the Board") charged **ROGER THEODORE, M.D.,** (the "Respondent"), License Number D14165, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II §§ 14-101 *et seq.* (2014 Repl. Vol.).

The pertinent provisions of the Act under Health Occ. II § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> ...
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On February 28, 2018, a conference with regard to this matter was held before a panel of the Board's Disciplinary Committee for Case Resolution ("DCCR"). As a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

## FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 9, 1972. His license is scheduled to expire on September 30, 2019. The Respondent holds an inactive license in Pennsylvania.

2. The Respondent is board-certified in general surgery.

3. In 2008, the Respondent became employed by a group pain management practice ("the Practice") in Towson, Maryland.

4. In a statement to the Board, the Respondent advised that he "primarily received supervision and consultative care" from the medical director of the Practice for most of the Respondent's patient encounters.

### I. Prior Disciplinary History

5. On September 18, 2009, the Board charged the Respondent with failure to meet appropriate standards for the delivery of quality medical care (Health Occ. II § 14-404(a)(22)) and failure to keep adequate medical records (Health Occ. II § 14-404(a)(40)) with regard to his practice of surgery.

6. Effective January 27, 2010, the Respondent entered into a Consent Order under the terms of which he was reprimanded and placed on probation for two years. The Respondent was required to successfully complete an intensive course in medical recordkeeping.

7. The Board terminated the Respondent's probation on April 3, 2013.

## II. Current Allegations

8. The Board initiated an investigation of the Respondent after receiving a complaint dated April 27, 2016, from a family member of a patient (identified as Patient 1 herein) of the Respondent who reported concerns about the quantity of opioids the Respondent and the medical director of the Practice[1] were prescribing to the patient.

9. In furtherance of its investigation, the Board obtained ten patient records from the Respondent for review. The Board referred the patient charts and related materials to a peer review entity for review. The peer reviewers found deficiencies in the Respondent's prescribing practices and recordkeeping, which constituted violations of the Act.

10. The peer reviewers noted the following general deficiencies with regard to the Respondent's prescribing practices:

    a. The Respondent consistently prescribed excessively high dosages of highly addictive short-acting opioids and long-acting opioids over prolonged periods of time in the absence of clinical evidence to support the dosages prescribed;

    b. The Respondent prescribed high dosages of oxycodone that were in excess of the morphine equivalent recommended for chronic pain management;

    c. The Respondent maintained patients on excessively high levels of opioids for months and even years despite lack of improvement of functionality or pain control;

[1] Disciplinary Panel B has charged the medical director of the Practice with violations of the Act.

d. The Respondent failed to adequately monitor patients for the potential risk of diversion or addiction;

e. The Respondent failed to significantly modify his treatment plan when patients demonstrated aberrant behavior including inconsistent urine drug tests ("UDTs"). Inconsistent results include positive results for drugs not prescribed, or illicit drugs or negative tests for drugs that were prescribed, which would raise concern for diversion;

f. The Respondent failed to obtain updated imaging studies or other objective clinical indications of a patient's pain;

g. The Respondent consistently failed to check patients' past and ongoing medication history with the Chesapeake Regional Information System for our Patients ("CRISP") or the Maryland Prescription Drug Monitoring Program ("PDMP");

h. The Respondent failed to taper or wean patients from excessive dosages of opioids in spite of the lack of functional improvement or pain control over extended periods of time;

i. The Respondent failed to refer patients for appropriate consultations, including interventional pain management, for non-opioid-based treatment; and

j. The Respondent continued to maintain or escalate opioid doses in spite of patient behavior indicating opioid use disorder where an addiction consult would be more appropriate.

## PATIENT-SPECIFIC FINDINGS OF FACT

11. In addition to the general practice deficiencies, the peer reviewers found the patent-specific practice deficiencies that include those set forth below.

**Patient 1**

12. Patient 1, a male in his mid-50s, began seeing the Respondent in or around August 2015 for low back and bilateral knee pain. Patient 1 had been discharged by his previous pain management physician because of non-compliance, specifically, UDTs that were positive for non-prescribed oxycodone.

13. Patient 1 was identified as a "medium-high risk" patient when he sought treatment at the Practice.

14. The Respondent prescribed high dosages of short-acting and long-acting opioids: Dilaudid 4 mg (hydromorphone)[2] TID (three times a day) and Exalgo 12 mg (extended release hydromorphone) BID (twice a day). The Respondent maintained Patient 1 on these medications for months.

15. In December 2015, the Respondent documented, *inter alia,* "we will continue to monitor [Patient 1] for compliance to include UDTs, pill counts and pain logs."

16. Despite having been identified as a "medium-high risk" patient, the Respondent ordered only two UDTs" from August 2015 through June 2016, the course of treatment reviewed.

17. One of the UDTs was reported as inconsistent because no opioids were detected. The second UDT was reported as inconsistent because a non-prescribed drug, Tramadol, a Schedule IV CDS, was detected.

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[2] All medications are Schedule II Controlled Dangerous Substances ("CDS") unless otherwise indicated.

18. The Respondent failed to address with Patient 1 the inconsistent UDT results.

19. The Respondent failed to order pill counts.

20. In April 2016, the Respondent discontinued Exalgo and started MS Contin 30 mg (extended release morphine) BID. The Respondent failed to document his treatment rationale for changing Patient 1's regimen.

21. The Respondent failed to meet appropriate standards for the delivery of quality care and failed to maintain adequate medical records with respect to Patient 1. The Respondent prescribed high dosages of opioids for prolonged periods of time without appropriate justification. The Respondent failed to refer Patient 1 for a surgical consultation in spite of Patient 1's ongoing complaints of pain after a trial of injections and physical therapy. The Respondent failed to monitor Patient 1's compliance adequately and failed to address Patient 1's inconsistent UDTs. The Respondent failed to document his treatment rationale for changing Patient 1's medication regimen.

**Patient 2**

22. Patient 2, a male in his early 50s, was referred to the Practice in March 2014 for complaints of back pain. At that time, Patient 2's referring physician was prescribing Patient 2 oxycodone 15 mg five times a day.

23. On Patient 2's initial office visit, his UDT tested positive for Suboxone, a Schedule III CDS, which Patient 2 stated he had obtained from his brother, and metabolites of ethyl alcohol.

24. A physician at the Practice other than the Respondent documented that Patient 2 was advised "not to drink alcohol while on opiates."

25. After approximately three visits, the Respondent added methadone 10 mg to Patient 2's medication regimen.

26. At Patient 2's next visit, a physician other than the Respondent stopped methadone because Patient 2 had complained of shortness of breath, and started Opana 10 mg. (extended release oxymorphone) BID. The Respondent maintained Patient 2 on this regimen despite several UDTs that tested positive for alcohol and documentation that Patient 2 was at high risk of aberrancy because of his alcohol consumption.

27. Imaging conducted for Patient 2's spine did not reveal acute pathology.

28. In July 2105, the Respondent noted that he was considering "increasing long acting by 1 – 2 a day and decreasing short acting agent." The Respondent, however, did not make the change and continued to prescribe the same dosages oxycodone (six/day) and Opana (twice/day).

29. In May 2016, the Respondent increased Patient 2's Opana to three times a day. Patient 2 had not presented with new complaints or injuries and had noted on the office visit form that his condition was unchanged. The Respondent failed to document his treatment rationale for change.

30. In the Respondent's summary of care for Patient 2 dated June 26, 2016, that he transmitted to the Board, the Respondent documented that Patient 2 was being prescribed Opana twice a day, when, in fact, he had increased Patient 2's dosage to three times a day.

31. The Respondent failed to meet appropriate standards of care for the delivery of quality medical care with regard to Patient 2. The Respondent prescribed high

dosages of opioid pain medication for prolonged periods of time without appropriate justification or significant pathology and without indication that Patient 2 was functioning better at the higher dosages. The Respondent failed to taper Patient 2's opioids when Patient 2 continued to drink alcohol. The Respondent increased Patient 2's dosage of Opana in the absence of appropriate justification. The Respondent failed to monitor Patient 2's compliance adequately.

**Patient 3**

32. Patient 3, a female in her early 40s, began seeing the Respondent in December 2013 with complaints of "total body pain."

33. Patient 3's prior medication regimen included Fentanyl 75 mcg/hour, oxycodone 15 mg QID and a benzodiazepine, clonazepam 1mg TID.

34. One of Patient 3's prior pain management physicians had documented that Patient 3 has a "significant psych history." The physician further noted that Patient 3 was requesting an increase of opioids and that he was "leery." The physician started Patient 3 on a trial of Savella, a non-opioid medication approved for the treatment of fibromyalgia.

35. The Respondent failed to discontinue Patient 3's benzodiazepines. Instead, the Respondent increased Patient 3's benzodiazepine dosage despite prescribing her increasingly higher dosages of opioids.

36. During the review period, the Respondent doubled Patient 3's dosage of oxycodone and increased her Fentanyl dosage despite Patient 3's reports of feeling drowsy and falling on several occasions. The Respondent failed to document his treatment rationale for increasing Patient 3's opioid dosages.

37. Although he identified Patient 3 as a high risk patient, the Respondent failed to adequately monitor Patient 3's compliance. He ordered minimal UDTs and did not address her use of marijuana except for telling Patient 3 that it was illegal and to suggest that she "look into medical marijuana."

38. The Respondent failed to meet appropriate standards of care for the delivery of quality medical care with regard to Patient 3. The Respondent prescribed high dosages of opioid medication in conjunction with a benzodiazepine for prolonged periods of time. He failed to adequately monitor Patient 3's compliance.

**Patient 4**

39. Patient 4, a male in his late 30s, was initially seen in the Practice by the Respondent in July 2008 for chronic abdominal and low back pain after sustaining a gunshot wound in 2007.

40. Patient 4 had been maintained by his previous physician on methadone 40 mg a day and oxycodone 15 mg a day.

41. Patient 4 had been discharged by his previous physician because of his use of marijuana and a history of cocaine and heroin use.

42. During the review period, the Respondent increased Patient 4's dosage of methadone to 50 mg a day and his oxycodone to 75 mg a day. In 2010, the Respondent also started Xanax, a benzodiazepine, and ultimately prescribed three tablets a day.

43. The Respondent maintained Patient 4 on a regimen of high dosages of methadone, oxycodone and Xanax for years.

44. The Respondent failed to consistently and regularly monitor Patient 4's compliance. When the Respondent did order UDTs, Patient 4 often tested positive for marijuana, cocaine and on one occasion, heroin. The Respondent increased office visits for a short period of time subsequent to Patient 4's positive tests; but rarely even temporarily decreased his dosage of medications. The Respondent did not increase the frequency of Patient 4's UDTs after inconsistent test results.

45. The Respondent did not refer Patient 4 to an addiction specialist during the review period despite Patient 4's frequent violations of the Practice's Medication Contract and his ongoing use and history of illicit drug use.

46. In 2014, the Respondent wrote one prescription for Dilaudid #50, a short-acting opioid, noting that it was for "acute surgery pain – dressing change."

47. In letters to Patient 4's referring physician, the Respondent failed to mention Patient 4's continued usage of marijuana or use of other illicit drugs. In a couple of letters, the Respondent stated that a UDT was performed with consistent results; however, in both instances, the UDT was not documented and the results were not in Patient 4's record. This constitutes a failure to maintain adequate medical records.

48. The Respondent failed to meet appropriate standards of quality medical care with regard to Patient 4's treatment. The Respondent inappropriately prescribed high dosages of opioids to Patient 4 for prolonged periods of time in conjunction with benzodiazepines. The Respondent continued to prescribe and escalate Patient 4's opioid dosages without significant improvement in Patient 4's function or pain levels. The Respondent failed to significantly modify Patient 4's treatment plan

despite multiple inconsistent UDTs and failed to refer Patient 4 to an addiction specialist despite the inconsistent UDTs and Patient 4's ongoing use of illicit drugs.

**Patient 5**

49. Patient 5, a female in her late 40s, initially presented to the Practice in October 2013. Patient 5 was seen for chronic pain in both knees, mechanical low back pain, mechanical neck and shoulder pain, headache, anxiety, depression and deconditioning. She had a history of alcohol and drug abuse.

50. Patient 5's records do not contain notes of an initial assessment, informed consents or Medication Agreements.

51. Review of Patient 5's care indicates that nurse practitioners or physicians other than the Respondent saw Patient 5 for much of 2014.

52. Patient 5's medication regimen in 2013 included methadone 10 mg six times a day and a non-opioid medication for neuropathic pain. Clonazepam, a benzodiazepine, was added during this time by a practitioner other than the Respondent

53. In August 2014, a nurse practitioner started oxycodone 10 mg every four to six hours.

54. During the period during which the Respondent treated Patient 5, he continued a regimen that included methadone 10 mg three tablets a day, oxycodone 15 mg TID, clonazepam 0.5 mg TID, Lyrica and Trazodone.

55. Towards the end of the review period, Patient 5's functional level improved; she was participating in an addiction program and had stopped drinking. The

Respondent, however, continued to escalate her opioid dosages even though she appeared to be functioning well at lower levels.

56. The Respondent maintained Patient 5, a high-risk patient, on high dosages of opioids in conjunction with a benzodiazepine. The Respondent did not significantly modify Patient 5's treatment regimen despite numerous UDTs that were positive for non-prescribed medications and illicit drugs and Patient 5's admitted use of cocaine.

57. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient 5. The Respondent inappropriately prescribed high-dosage opioids in conjunction with a benzodiazepine to a high-risk patient and did not significantly modify Patient 5's treatment plan despite numerous inconsistent UDTs.

58. The Respondent failed to maintain adequate medical records. He notified Patient 5's referring physician in writing on at least two occasions that Patient 5 has regular EKGs to check QT intervals every six months and routine blood work to evaluate liver and kidney function; however, neither records of the tests or the results are in Patient 5's records. The Respondent failed to adequately document his treatment rationale.

**Patient 6**

59. Patient 6, a female in her late 30's, began seeing the Respondent in 2010. Patient 6's past medical history included chronic low back pain and bilateral knee pain. She had been seen by a previous pain specialist who declined to prescribe OxyContin when she requested it.

60. Patient 6 is a high-risk patient; she had a history of alcohol abuse, admitted to using cocaine and is a smoker.

61. During the review period, the Respondent prescribed escalating dosages of opioids including methadone (30 mg TID at the end of the review period), oxycodone (15 mg QID at the end of the review period) and Xanax 0.25 mg BID despite numerous inconsistent UDTs. Moreover, the Respondent prescribed escalating dosages of opioids despite Patient 6's admission that she continued to drink alcohol and had been admitted to a local hospital for alcohol withdrawal.

62. The Respondent failed to meet appropriate standards of quality care and maintain adequate medical records with respect to Patient 6. The Respondent inappropriately prescribed and continued to prescribe high dosages of opioids in conjunction with benzodiazepines to this high-risk patient. He did not significantly modify Patient 6's treatment plan despite repeated violations of her Medication Agreement and admitted use of cocaine and alcohol. The Respondent failed to document his treatment rationale in a clear manner.

**Patient 7**

63. Patient 7, a female then in her early 50s, began treatment at the Practice in 2006. Her past medical history includes mechanical neck, shoulder and low back pain, myofascial pain and history of a seizure disorder.

64. Patient 7 traveled from New Jersey to be seen at the Practice.

65. In 2014, an addiction specialist opined that Patient 7 needed to be monitored carefully with random urines and increased frequency of office visits because of her substance abuse history.

66. Patient 7 was treated by practitioners other than the Respondent until 2014. Prior to 2014, Patient 7 had been prescribed high dosages of OxyContin 20 mg or 40 mg and oxycodone 15 mg.

67. The Respondent continued Patient 7 on this regimen through the end of the review period, over two years. Although other practitioners had somewhat decreased Patient 7's opioid dosage prior to 2015, the Respondent increased Patient 7's dosages OxyContin 40 mg, variously prescribing from four to five tablets a day to nine tablets a day, and her oxycodone 15 ng from four tablets a day to five-six tablets a day.

68. The Respondent failed to consider opioid rotation despite Patient 7's identification as a high risk patient.

69. The Respondent failed to adequately document his treatment rationale and medical decision-making.

70. The Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to maintain adequate medical records with respect to Patient 7. He inappropriately prescribed high dosages of opioids for prolonged periods of time despite concerns regarding her substance abuse history. The Respondent failed to document his treatment rationale in a clear manner.

**Patient 8**

71. Patient 8, a male in his early 30s, began seeing the Respondent in July 2014, with complaints of back pain.

72. A physician other than the Respondent had initially seen Patient 8 in June 2014 and had documented that Patient 8 had taken some oxycodone 30 mg from a family member.

73. Throughout the review period, Patient 8 expressed his desire to be prescribed oxycodone 30 mg and protested when a practitioner other than the Respondent temporarily decreased his dosage. Practitioners other than the Respondent noted in Patient 8's record that he "seems unmotivated in any treatment other than medication" and that he wanted to "forget" about long-acting opioids.

74. Patient 8's imaging study revealed no significant pathology.

75. During the review period, the Respondent increased Patient 8's oxycodone dosage from 15 mg five/day to 30 mg TID at Patient 8's request.

76. In March 2015, the Respondent added OxyContin 40 mg 1/day to Patient 8's regimen when Patient 8 reported taking more oxycodone than prescribed because of neck pain resulting from his work schedule.

77. In July 2015, the Respondent stopped Patient 8's OxyContin because of insurance issues and replaced it with Opana ER 10 mg BID. The Respondent also increased Patient 8's oxycodone to 30 mg QID.

78. In August 2015, the Respondent increased Patient 8's Opana from 10 mg to 30 mg BID. The Respondent documented that Patient 8 had reported that Opana was not as effective as OxyContin and had wanted OxyContin 40 mg to be prescribed to him again.

79. The Respondent maintained Patient 8 through the end of the review period on a regimen of Opana 30 mg BID and oxycodone 30 mg QID.

80. On June 16, 2016, a medical assistant noted that opioid dose reduction strategies and treatment options, including Suboxone, had been discussed with Patient 8. [3]

81. On June 26, 2016, at the request of the Board, the Respondent documented a summary of his care of Patient 8. The Respondent reiterated that dosage reductions strategies and Suboxone treatment had been discussed with Patient 8.

82. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient 8. The Respondent prescribed high dosages of opioids for prolonged periods of time without appropriate justification and in the absence of pathology sufficient to justify the high dosages.

**Patient 9**

83. Patient 9, a male in his late 40s, was initially seen by another practitioner in the Practice in June 2013. Patient 9's complaints included chronic low back pain, work-related injury, neck pain and shoulder pain.

84. Patient 9 previously had been treated by two other pain management practices; he was discharged from one because he tested positive for cocaine.

85. Patient 9 was initially prescribed OxyContin 20 mg BID and oxycodone 15 mg TID.

86. After being maintained on that regimen for almost a year, the Respondent increased Patient 9's dosage of oxycodone 15 mg from TID to QID at the patient's request because he was working longer hours. Although the increase was to be for two months only, the Respondent continued the higher dosage until May 2015.

87. In May 2015, Patient 9 complained of pain "every time I want to do something...that's not quality of life." The Respondent increased Patient 9's

[3] On May 31, 2016, Board staff issued to the Respondent a subpoena for 10 patient records, including that of Patient 8.

dosage of OxyContin from 20 mg BID to 40 mg BID. He decreased Patient 9's oxycodone from QID to BID.

88. In August 2015, an MRI conducted on Patient 9's cervical spine revealed increased right disc herniation at C5 – 6 and C6 – 7. The Respondent failed to refer Patient 9 for a surgical or interventional consultation.

89. In September 2015, the Respondent documented in a letter to Patient 9's primary care physician that Patient 9's last urine screen (in August 2015) was consistent for medications prescribed. The Respondent failed to report that the urine screen was positive for alcohol.

90. The Respondent failed to meet appropriate standards for the delivery of quality medical services to Patient 9. Patient 9 was a high risk patient. The Respondent escalated Patient 9's opioid dosages despite inconsistent UDTs and Patient 9's improved functionality.

**Patient 10**

91. Patient 10, a male in his early 20s, presented to the Respondent in November 2013 with complaints of leg, jaw and abdominal pain resulting from multiple gunshot wounds. At the time he was referred to the Practice, his medication regimen included morphine sulfate extended release ("MSER") 15 mg BID, oxycodone 5 mg QID, Tramadol 50 mg QID and Gabapentin 300 mg TID.

92. Patient 10's initial UDT was negative for oxycodone. Thereafter, the Respondent failed to address Patient 10's consecutive UDTs that were negative for oxycodone. In one instance, the Respondent increased Patient 10's dosage of oxycodone to 5 mg five/day immediately following a UDT that was negative for oxycodone.

93. In March 2014, the Respondent increased Patient 10's dosage of MSER to three/day. The Respondent failed to document his treatment rationale except to note "chronic pain."

94. In January 2015, the Respondent increased Patient 10's dosage of oxycodone to 6/day at Patient 10's request. to three tablets a day after Patient 10 complained of increased jaw pain.

95. The Respondent continued to prescribe Patient 10 the increased dosage of MSER until August 2015 when Patient 10 requested a decrease because he had heard that morphine might cause eye problems.

96. Throughout the review period, the Respondent consistently prescribed oxycodone and tramadol, two short-acting opioids, to Patient 10.

97. The Respondent's June 2016 summary of care, which was written at the Board's request, inaccurately reports that he was prescribing Patient 10 oxycodone QID. The Respondent further failed to report that Patient 10's "current" treatment regimen included Tramadol; the Respondent reported only oxycodone and morphine sulfate.

98. The Respondent failed to meet appropriate standards of care for the delivery of quality medical services with respect to Patient 10. He failed to address Patient 10's inconsistent UDTs. During the review period, the Respondent increased Patient 10's morphine dosage by 33% and his oxycodone dosage by 50% and failed to reduce Patient 10's opioid dosage to reflect Patient 10's improved functionality. The Respondent did not consider Patient 10's high risk, as evidenced

by consecutive negative UDTs and consistently prescribed two short-acting opioids to Patient 10 for over three years.

## CONCLUSIONS OF LAW

Based on the foregoing findings of fact, Disciplinary Panel B concludes as a matter of law that the Respondent failed to meet standards of care for the delivery of quality medical or surgical care, in violation of H.O. § 14-404(a)(22) and failed to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

## ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby

**ORDERED** that the Respondent is **REPRIMANDED;** and it is further

**ORDERED** that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS** with the following conditions:[4]

1) The Respondent shall not be the supervising physician for any advanced practice provider;

2) The Panel will issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program ("PDMP") on a quarterly basis for all of the Respondent's CDS prescriptions. The administrative subpoenas will request a review of the Respondent's CDS prescriptions from the beginning of each quarter;

3) Within the first six (6) months of the probationary period, the Respondent shall successfully complete a Board disciplinary panel-approved course in medical documentation. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

[4] If the Respondent's license expires while the Respondent is on probation, the probationary period will be tolled.

4) Within the first six (6) months of the probationary period, the Respondent shall successfully complete a Board disciplinary panel-approved course in CDS prescribing. The Board disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

5) The Respondent is prohibited from prescribing CDS during the probationary period;

6) The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

**ORDERED** that the Respondent shall not apply for the early termination of probation; and it is further

**ORDERED** that, after a minimum of two years, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel B. The Respondent may be required to appear before the Board or Panel B to discuss his petition for termination. The Board or Panel B will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

**ORDERED** that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or Panel B; and it is further

**ORDERED** that if the Board or Panel B determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or Panel B if there is no genuine dispute as to a material fact, that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Panel B may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, impose a civil monetary fine upon the Respondent, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Panel B may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

**ORDERED** that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

**ORDERED** that, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and it is further.

**ORDERED** that this Consent Order is a public document pursuant to Md. Code Ann., General Provisions, §§ 4-101 *et seq.*

05/22/2018
Date

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

## CONSENT

I, Roger Theodore, M.D., acknowledge that I have been represented by counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by Disciplinary Panel B, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of Disciplinary Panel B to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of a disciplinary panel of the Board that I might have filed after any such hearing.

I sign this Consent Order voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

***Signature on File***

5-16-18
Date

Roger Theodore, M.D.
Respondent

**NOTARY**

**STATE OF MARYLAND**
**CITY/COUNTY OF** Anne Arundel

**I HEREBY CERTIFY** that on this 16th day of May 2018, before me, a Notary Public of the foregoing State and City/County, personally appeared Roger Theodore, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Notary Public

My commission expires: 8/16/18

MICHELLE LONGO Notary Public ANNE ARUNDEL COUNTY, MD