IN THE MATTER OF	*	**BEFORE THE**
SWAMI A. NATHAN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D18414		**Case Number: 2217-0088B**

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

CONSENT ORDER

On September 24, 2018, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Swami A. Nathan, M.D., (the "Respondent"), License Number D18414, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2017 Supp.).

The Respondent was charged under the following provisions of Health Occ. § 14-404(a):

> **§ 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 of the Board, 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; and
>
> . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On February 27, 2019, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

I. FINDINGS OF FACT

Disciplinary Panel B finds:

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 4, 1975. His license is active and is scheduled to expire on September 30, 2019.

2. The Respondent currently practices as the sole practitioner at his independent practice in Frederick, Maryland, and holds hospital privileges at Hospital A. The Respondent is board-certified in Neurological Surgery.

3. On or about March 20, 2017, the Board received a complaint from a pharmacy manager ("Complainant") alleging that the Respondent allowed an employee ("Individual A") to call in Controlled Dangerous Substance ("CDS") prescriptions for herself for years.[1] The Complainant stated that he believes there is no physician-patient relationship between the Respondent and Individual A. He also stated that when he talked to the Respondent about his concerns related to

[1] The Complainant stated that he recognized Individual A as the person calling in the prescriptions because she had visited the pharmacy for ten years and had an identifiable "bubbly and airy" voice. He stated that Individual A called in prescriptions pretending to be Nurse A, a nurse at the Respondent's office.

Individual A calling in prescriptions for herself, the Respondent stated that "[Individual A] has been going through a rough time so he allows it."

4. The Board thereafter initiated an investigation of the Respondent's prescribing practices which included subpoenaing patient medical records for Individual A and nine other patients, requesting written responses from the Respondent, interviewing the Respondent, and referring the matter to two peer reviewers board-certified in Pain Management. The findings of the investigation and peer reviewers are summarized below.

RESPONDENT'S RESPONSE

5. On or about July 6, 2017, the Board notified the Respondent of the complaint filed, requested a written response, and transmitted a subpoena for ten patient records.

6. On or about July 26, 2017, the Respondent sent his written response to the Board. The Respondent stated that he was not aware Individual A was calling in prescriptions for herself and when he received a call from the Complainant, he told him not to fill the prescription because Individual A was an employee and not a patient. He also explained that after the incident, he initiated care with Individual A as a new patient so she would not go through withdrawal.

7. On or about July 27, 2017, the Board received the ten patient medical records from the Respondent, including Individual A's record.

8. On or about February 28, 2018, the Respondent sent his supplemental response to the Peer Review reports. He writes that "the issues identified by the peer reviewers

can be easily remedied" and that he "will make changes to [his] practice as it concerns medical management of patients with pain." The Respondent also stated that he is transferring all of his current chronic pain patients who are on long-term opioids to other physicians.[2] The Respondent stated he will "adopt safeguards consistent with the comments of the peer reviewers to ensure patient compliance with any narcotic therapy" and he is "willing to enroll in a medical records course."

PATIENT-RELATED ALLEGATIONS

9. The peer reviewers concurred that the Respondent violated the standard of quality medical care in ten of the ten patient records they reviewed and failed to maintain adequate medical records in nine of the ten patients they reviewed (identified in the peer review reports as Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10).

STANDARD OF CARE VIOLATIONS

PATIENT 1

10. Patient 1, identified as Individual A, was the Respondent's employee who called in prescriptions for herself. The Respondent initiated care with Patient 1 after the complaint was filed against him. The Respondent saw Patient 1 for two visits and prescribed medication to prevent withdraw symptoms.

11. With regard to Patient 1, the peer reviewers concurred that the Respondent failed to meet the standard of quality care by treating Patient 1 after he discovered that

[2] The Respondent stated that "of the ten patients whose charts the Board subpoenaed and submitted for peer review, eight have already been transferred to other providers for evaluation and treatment of pain."

she had been obtaining prescriptions for herself without his authorization or a physician/patient relationship.

PATIENTS 2-10

12. With regard to Patients 2-10, the peer reviewers found that the Respondent failed to meet the standard of quality care for reasons including, but not limited to, the items listed below. The Respondent:

    a. Failed to conduct a risk assessment prior to prescribing opioids – Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10;

    b. Failed to utilize a written opioid agreement– Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10;

    c. Failed to check patients' past and ongoing medication history with the Prescription Drug Monitoring Program ("PDMP") or Chesapeake Regional Information System ("CRISP") – Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10;

    d. Failed to document urine screens as part of routine treatment and monitoring, including to patients prescribed a high dosage of opioids who may be at a high risk of diversion or abuse – Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10;

    e. Failed to conduct continuing assessment of whether opioid prescriptions helped current pain level, and presence of any adverse effects from prescription – Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10.

13. The Respondent's conduct, in whole or in part, constitutes failure to meet standards of quality care, in violation of Health Occ. § 14-404(a)(22).

INADEQUATE MEDICAL RECORDKEEPING

14. The peer reviewers found that the Respondent failed to maintain adequate medical documentation for nine of the ten patients they reviewed for reasons including, but not limited to, the items listed below. The Respondent:

    a. Maintained limited documentation and many of his notes are handwritten, illegible, and lack appropriate detail – Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10; and

    b. Failed to document information related to patient monitoring including his treatment rationale for prescribing opioids, and the pain scores and functional status of the patients– Patients 2, 3, 4, 5, 6, 7, 8, 9, and 10.

15. The Respondent's conduct, in whole or in part, constitutes failure to maintain adequate medical records, in violation of Health Occ. § 14-404(a)(40).

II. CONCLUSIONS OF LAW

The Respondent failed to meet appropriate standards of care, in violation of § 14-404(a)(22), and failed to keep adequate medical records, in violation of § 14-404(a)(40).

III. ORDER

It is thus by Panel B, hereby:

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

ORDERED that the Respondent is placed on **PROBATION**[3] for a minimum period of **ONE (1) YEAR.** Within that one-year probationary period, the Respondent shall comply with the following terms and conditions:

(1) Within **five (5) business days** of the effective date of this Consent Order, the Respondent shall inform the Board in writing of his current employer or employers, the employer's or employers' address or addresses, and of all locations, including hospitals, at which the Respondent provides health care services. The Respondent shall keep the Board informed of any subsequent employment changes within **five (5) business days** of the change.

(2) Within **SIX (6) MONTHS** of the effective date of this Consent Order, the Respondent is required to take and successfully complete **TWO** panel-approved courses: (i) one course in Controlled Dangerous Substances ("CDS") prescribing, with an emphasis on patient monitoring; and (ii) a separate course

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

in professional ethics, with an emphasis on maintaining appropriate boundaries in the workplace. The following terms apply:

(a) It is the Respondent's responsibility to locate, enroll in, and obtain the disciplinary panel's approval of the courses before the courses begin;

(b) The disciplinary panel will not accept courses taken over the internet;

(c) The Respondent shall provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

(d) The courses may not be used to fulfill the continuing medical education credits required for license renewal;

(e) The Respondent is responsible for the cost of the courses.

(3) The Respondent is subject to a chart and/or peer review conducted by the disciplinary panel or its agents as follows:

(a) The Respondent shall cooperate with the peer review process;

(b) The disciplinary panel in its discretion may change the focus of the peer review if the Respondent changes the nature of his practice;

(c) If the disciplinary panel, upon consideration of the peer review and the Respondent's response, if any, determines that the Respondent is meeting the standard of quality care in his practice, the disciplinary panel shall consider the peer review condition of the Consent Order met;

(d) If the disciplinary panel, upon consideration of the peer review and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care in his practice or

cannot safely and competently practice, the disciplinary panel may charge the Respondent with a violation of probation and/or under the Medical Practice Act.

(4) The disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the respondent's Controlled Dangerous Substances ("CDS") prescriptions. The administrative subpoena will request the Respondent's CDS prescriptions from the beginning of each quarter.

(5) The Respondent shall not apply for early termination of probation.

(6) A violation of probation constitutes a violation of the Consent Order.

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

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

ORDERED that, after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent'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 upon the Respondent; and it is further

ORDERED that, after the Respondent has complied with all the terms and conditions of probation, and the minimum period of **ONE (1) YEAR** of probation imposed by the Consent Order has passed, the Respondent may submit a written petition to the panel requesting termination of probation. The Respondent may be required to appear before the panel to discuss his petition for termination. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The disciplinary panel may grant the petition to terminate the probation through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and if there are no pending complaints related to the charges; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order, and it is further

ORDERED that this Consent Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. §§ 4–333(b)(6) (2014 & Supp. 2017).

03/27/2019
Date

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

CONSENT

I, Swami A. Nathan, acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 et seq. concerning the pending charges. I waive these rights and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered 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 their behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understands the language and meaning of its terms.

3.22-19
Date

Signature on File

Swami A. Nathan, M.D.

STATE/ DISTRICT OF Maryland

CITY/COUNTY OF: Frederick

I HEREBY CERTIFY that on this 22nd day of March, 2019, before me, a Notary Public of the State/District and County aforesaid, personally appeared Swami A. Nathan, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Cassandra M. Raso

Notary Public

My Commission expires: 8/26/2021

CASSANDRA M. RASO NOTARY PUBLIC FREDERICK COUNTY, MD