IN THE MATTER OF	*	BEFORE THE
RAVINDER K. RUSTAGI, M.D.	*	MARYLAND STATE
Respondent.	*	BOARD OF PHYSICIANS
License Number D24720	*	Case Number 2016-0933

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

FINAL DECISION AND ORDER

INTRODUCTION

On September 14, 2016, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") summarily suspended the license of Ravinder K. Rustagi, M.D., pursuant to Md. Code Ann., State Gov't § 10-226(c)(2)(i) (2014 Repl. Vol., 2017 Supp.) after concluding that the public health, safety or welfare imperatively required emergency action. On September 28, 2016, Panel B held a post-deprivation hearing for Dr. Rustagi to show cause why the summary suspension should not be continued. After the hearing, Panel B concluded that Dr. Rustagi's continued practice of medicine would present a substantial risk of serious harm to the public health, safety or welfare, and, therefore, affirmed the summary suspension imposed on September 14, 2016. Dr. Rustagi requested an evidentiary hearing on the merits of the summary suspension before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings ("OAH").

On September 30, 2016, Panel B charged Dr. Rustagi with unprofessional conduct in the practice of medicine, in violation of Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a)(3)(ii) (2014 Repl. Vol., 2017 Supp.). The summary suspension and the charges concerned Dr. Rustagi's disruptive conduct at two Maryland hospitals. Dr. Rustagi requested an evidentiary hearing on the charges. On October 17, 2016, the case was forwarded to OAH with

the instruction to consolidate the hearing on the charges with the hearing on the summary suspension.

On January 10, 2017, Panel B issued amended charges to include that Dr. Rustagi was professionally, physically, or mentally incompetent to practice medicine, in violation of Health Occ. § 14-404(a)(4).

A six-day hearing was held before an ALJ. Both parties offered testimony from witnesses at Hospital A and Hospital B as well as expert testimony concerning Dr. Rustagi's competency to practice medicine.[1] On July 3, 2017, the ALJ issued a proposed decision concluding that the summary suspension was properly imposed, that Dr. Rustagi was guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), and that Dr. Rustagi was professionally, physically, or mentally incompetent, in violation of Health Occ. § 14-404(a)(4). The ALJ recommended the revocation of Dr. Rustagi's license to practice medicine.

On July 21, 2017, Dr. Rustagi filed exceptions to the ALJ's proposed decision, and the State filed a response. On October 11, 2017, both parties appeared before Disciplinary Panel A ("Panel A") of the Board for an exceptions hearing.

FINDINGS OF FACT

Panel A adopts the ALJ's proposed findings of fact 1-68. *See* ALJ proposed decision, attached as **Exhibit 1**.[2] These facts are incorporated by reference into the body of this document as if set forth in full. The factual findings were proven by a preponderance of the evidence. The Panel also adopts the ALJ's discussion set forth on pages 29-41, which is also incorporated into this decision.

[1] The names of the hospitals have been redacted for privacy concerns.
[2] The ALJ proposed decision has been redacted to remove confidential information.

The facts of this case concern Dr. Rustagi's conduct at two Maryland hospitals, Hospital A and Hospital B. On May 13, 2016, the Board received a mandated 10-day report from Hospital A reporting that Dr. Rustagi was suspended from the hospital on May 6, 2016. The report stated:

> The Medical Staff of [Hospital A] received several complaints regarding Dr. Rustagi's behavior and professional conduct at [Hospital A] with respect to both patients and staff in the past month. Specifically, the Medical Staff received numerous complaints that Dr. Rustagi was berating staff and patients, disrupting orderly hospital operations, and inappropriately documenting personal complaints in patient medical records. One complaint of concern alleged that Dr. Rustagi inflicted pain on his patient by squeezing her wrist until she screamed, despite her prior objection that his actions caused pain to her wrist.
>
> Despite collegial efforts, Dr. Rustagi's behavior persisted. On the basis of this pattern of serious complaints against Dr. Rustagi, many of which have been corroborated, the Medical Staff and the Hospital believed that Dr. Rustagi currently presents an imminent danger to the health and safety of its patients and staff. Furthermore, Dr. Rustagi's actions interfered with the orderly operations at [Hospital A].
>
> When collegial efforts failed, the Vice President of Medical Affairs issued a formal warning to Dr. Rustagi that failure to curb the unprofessional actions would result in suspension. The warning went unheeded and the unprofessional actions persisted. Thus, pursuant to the Medical Staff Bylaws & Procedures, the Vice President of Medical Affairs, in consultation with Medical Staff and Hospital leadership, imposed a "Precautionary Suspension" for a period of 14 days – effective May 6, 2016 through May 19, 2016.

The Board opened an investigation based on the concerns raised in the 10-day report from Hospital A. During the Board's investigation, the Board learned that there were similar concerns regarding Dr. Rustagi's behavior and professional conduct at Hospital B. Based on Dr. Rustagi's conduct at Hospital A and Hospital B, Panel B summarily suspended Dr. Rustagi's license.

On November 14 and 15, 2016, Dr. Rustagi was evaluated by an out-of-State program. The assessment team was composed of medical doctors and licensed health professionals. The

report, submitted by the medical director of the program, concluded that Dr. Rustagi was no longer fit to practice medicine.

EXCEPTIONS

Dr. Rustagi takes exception to the ALJ's proposed findings of fact and conclusions of law that he was guilty of unprofessional conduct in the practice of medicine and mentally incompetent to practice medicine. He argues that the out-of-State report and the opinions of the medical director should be rejected because the other members of the assessment team did not testify at the hearing. Finally, he argues that the Panel should impose probation or suspension with conditions instead of following the ALJ's recommended sanction of revocation. Each of Dr. Rustagi's exceptions will be addressed, in turn.

I. Findings of Fact

Dr. Rustagi takes exception to many of the ALJ's proposed findings of fact. He disagrees with the version of facts presented by the hospital staff at both Hospital A and Hospital B and argues that the ALJ's findings of fact were not substantiated during the Board's investigation or at the hearing. He argues that the ALJ's findings of fact should be rejected but, in many cases, does not provide a reason for why Panel A should reject the ALJ's findings. Dr. Rustagi's conduct was well-documented in the quality assurance files of Hospitals A and B by multiple doctors, nurses, and staff members. Panel A has carefully reviewed the ALJ's proposed findings of fact and finds that each of the proposed findings of fact was established in the record and supported by a preponderance of the evidence. Dr. Rustagi's exceptions to the ALJ's findings of fact are denied.

II. Unprofessional Conduct

Dr. Rustagi takes exception to the ALJ's conclusion that he was guilty of unprofessional conduct in the practice of medicine. Dr. Rustagi does not dispute that his conduct occurred in the practice of medicine. He contends that his "dedication to his patients led to holding other health care providers accountable for the care they provided to his patients." In defending his conduct, he stated that "other health care providers attempted to interfere with, or obstruct, his plans of care, did not abide by his orders and instructions, and actively sought to inhibit his ability to provide quality care to his patients." The ALJ found that Dr. Rustagi's denials and rationalizations of his behavior were unpersuasive and that the statements he made during his testimony were contradictory and outweighed by the consistent testimony of the State's witnesses. Panel A agrees.

Unprofessional conduct is defined as "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 weight of the evidence supports the ALJ's finding that Dr. Rustagi is guilty of unprofessional conduct in the practice of medicine. Dr. Rustagi yelled at and berated staff members at both hospitals, threatened to stop caring for his patients if they did not follow his orders, and, in one instance, removed his hearing aids and put his fingers in his ears because he did not want to hear what a nurse was saying to him. Dr. Rustagi disrupted the working environment at both hospitals. *See e.g. Board of Physician Quality Assur. v. Banks*, 354 Md. 59, 75 (1999) (finding that Dr. Banks's "conduct was a threat to the teamwork approach of health care which requires participation from a variety of hospital personnel in order to deliver effective patient care."). Panel A finds that Dr. Rustagi's conduct was unbecoming of a member in good standing of the profession.

Dr. Rustagi's exception is denied.

III. Mental Incompetence

Between November of 2016 and February of 2017, Dr. Rustagi underwent three different evaluations to assess his competency to practice medicine. The first evaluation found that Dr. Rustagi was not competent to practice medicine. After receiving the results of the first evaluation, Dr. Rustagi and his treating physician requested an independent evaluation of Dr. Rustagi. The second evaluation concurred with the results of the first evaluation and determined that it would be unwise for Dr. Rustagi to be diagnosing and treating patients. Dr. Rustagi, at the direction of his attorney, then underwent a third evaluation. The third evaluation found, consistent with the first two evaluations, that Dr. Rustagi's results were below average for working physicians. The third evaluator, however, justified the low-test scores by Dr. Rustagi's communication and language difficulties, and opined that so long as Dr. Rustagi continues compliance with his care plan and his medical status is monitored on a regular basis, there are no absolute medical barriers to Dr. Rustagi's return to the practice of medicine.

Dr. Rustagi takes exception to the ALJ's finding that he was mentally incompetent to practice medicine. He argues that the first evaluation was not representative of his current condition and contends that his condition improved since the time of the evaluation. Dr. Rustagi also argues that the report of his expert and the opinions of his treating physician should be given more weight than the first and second evaluations.

The ALJ considered the reports from all three evaluations and concluded that Dr. Rustagi's condition did not improve between the first and third evaluations. The ALJ pointed out that the third evaluation was heavily qualified with caveats and that the evaluator could not definitively state that Dr. Rustagi had not experienced decline in his condition. Accordingly, the ALJ found that Dr. Rustagi was not competent to practice medicine. Panel A agrees with the

ALJ's thorough assessment of the evaluations and concurs with the first and second reports that Dr. Rustagi is incompetent to practice medicine.

Dr. Rustagi further contends that his procedural due process rights were violated because he was denied the ability to cross-examine all the health care providers who were part of the assessment team for the first evaluation. The report from the first evaluation contained the assessments of five different health professionals, all under the direction and supervision of the Program's medical director. Dr. Rustagi requested OAH to issue administrative subpoenas to the five members of the assessment team. The requested subpoenas were issued by OAH to the individuals at various out-of-State addresses. The individuals, except for the medical director who testified via Skype, did not appear at the OAH hearing. Dr. Rustagi called each member of the assessment team to testify and noted that they were not present in the hearing room or in the hallway. The State responded that the witnesses were located outside the State of Maryland, that OAH does not have out-of-State subpoena power, and that there was no evidence that Dr. Rustagi attempted to contact the witnesses or secure their presence other than by requesting the subpoenas to be issued.

Panel A concurs with the State that the "the subpoena powers of the State of Maryland stop at the state line[.]" *Attorney Grievance Comm'n of Maryland v. Mixter*, 441 Md. 416, 429 (2015). OAH issued the requested subpoenas and the other members of the assessment team failed to appear at the hearing. Because the witnesses were out-of-State residents and were not served with the subpoena in Maryland, OAH did not have jurisdiction over the witnesses and was unable to enforce the subpoena pursuant to Md. Code Ann., State Gov't § 9-1605(d)(2). *See In re Special Investigation No. 219*, 52 Md. App. 17, 24 (1982) ("[i]n the absence of a statute, a state court cannot require the attendance of a witness who is a nonresident of and is absent from

the state."). The fact that the other members of the assessment team subpoenaed by Dr. Rustagi were beyond the subpoena power of the State does not violate Dr. Rustagi's due process rights. *See Attorney Grievance Comm'n of Maryland v. Gallagher*, 371 Md. 673, 700 (2002) ("The fact that Mr. Lobo, and other witnesses subpoenaed by respondent, were beyond the subpoena power of this State does not violate respondent's due process rights."). The Panel finds that Dr. Rustagi received a full and fair hearing and had the opportunity to fully cross-examine the medical director regarding the opinions and recommendations rendered in the first evaluation report.

Dr. Rustagi argues that the medical director was not competent to testify regarding the portions of the report that were based on the opinions of his colleagues. At the hearing, the medical director explained the process involved in preparing the evaluation report. First, each member of the team met with Dr. Rustagi individually. Then, the team met and discussed their individual findings and used a collaborative approach to determine the agreed-upon diagnosis and recommendations. The medical director explained that the report represented a consensus of the opinions from the assessment team and that all the members of the team agreed with the findings and recommendations expressed in the report. When asked during direct and cross-examination, the medical director pointed out portions of the report that were written by his colleagues and testified that he agreed with the opinions. The record reflects that the medical director was heavily involved in the preparation of the report and, as the medical director and author of the report, agreed with the findings and recommendations articulated in the report. Accordingly, Panel A finds that the medical director was competent to testify regarding the entirety of the report.

Dr. Rustagi's exceptions are denied.

IV. Summary Suspension

Dr. Rustagi did not file exceptions to the ALJ's conclusion that the summary suspension of his license was proper because the public health, safety, or welfare imperatively required emergency action. In any event, Panel A agrees with the ALJ's conclusion that the summary suspension was proper.

CONCLUSIONS OF LAW

Panel A concludes that Dr. Rustagi is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), and that Dr. Rustagi is professionally, physically, or mentally incompetent, in violation of Health Occ. § 14-404(a)(4). The Panel also concludes that the summary suspension was proper because the public health, safety, or welfare imperatively required emergency action. State Gov't § 10-226(c)(2)(i).

SANCTION

Dr. Rustagi takes exception to the ALJ's proposed sanction of revocation and requests that the Panel either impose probation or a suspension with conditions. Pursuant to the Board's sanctioning guidelines, the minimum sanction for a violation of Health Occ. § 14-404(a)(4) is suspension until competence is established to the Board's satisfaction. COMAR 10.32.02.10B(4). The Panel agrees with the ALJ that it is unlikely that Dr. Rustagi's condition will improve. After careful consideration of all the evidence in the record, Panel A concludes that revocation is appropriate.

Dr. Rustagi's exception is denied.

ORDER

On an affirmative vote of a majority of a quorum of Disciplinary Panel A, it is hereby

ORDERED that Dr. Rustagi's license to practice medicine in Maryland (License Number D24720) is **REVOKED**; and it is further

ORDERED that the September 14, 2016, order imposing a summary suspension upon Dr. Rustagi's medical license is terminated as moot; and it is further

ORDERED that this is a public document pursuant to Md. Code Ann., Gen. Prov. § 4–101 *et seq.*

04/19/2018
Date

Christine A. Farrelly
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. § 14-408, Dr. Rustagi has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (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 Dr. Rustagi files a Petition for Judicial Review, the Board is a party and should be served with the court's process at the following address:

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

Notice of any Petition for Judicial Review should also be sent to the Board's counsel at the following address:

Stacey M. Darin, Assistant Attorney General
Office of the Attorney General
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Stacey M. Darin, Assistant Attorney General
Office of the Attorney General
Maryland Department of Health
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

Exhibit 1

MARYLAND STATE BOARD OF PHYSICIANS	*	BEFORE LORRAINE E. FRASER, AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
RAVINDER RUSTAGI,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH Nos.: DHMH[1]-MBP-71-16-30977
LICENSE No.: D24720	*	DHMH-MBP-72-16-30978[2]

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On September 14, 2016, a disciplinary panel of the Maryland State Board of Physicians (Board) issued an Order for Summary Suspension to Ravinder Rustagi, M.D. (Respondent), suspending his license to practice medicine in Maryland. On September 29, 2016, the disciplinary panel continued the summary suspension after a hearing before the panel. The Respondent was represented by Mervyn Schwedt, Esq. On September 30, 2016, the Board issued charges against the Respondent for unprofessional conduct in the practice of medicine, in violation of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-507 and 14-601 through 14-607 (2014 & Supp. 2016) (the Maryland

[1] On July 1, 2017, the Department of Health and Mental Hygiene (DHMH) became the Maryland Department of Health (MDH).
[2] Case number DHMH-MBP-71-16-30977 is the charges under Md. Code Ann., Health Occ. § 14-404 (Supp. 2016); DHMH-MBP-72-16-30978 is the summary suspension under Md. Code Ann., State Gov't § 10-226(c)(2)(2014).

Medical Practice Act or the Act). Specifically, the Respondent was charged with violating section 14-404(a)(3)(ii) of the Act. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2016); Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). On October 5, 2016, the Respondent requested a full evidentiary hearing. The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E, 10.32.02.04B(1). On October 17, 2016, the Board forwarded the matter to the OAH for a hearing and requested that the hearings for the summary suspension and the charges be combined.

The Board scheduled a Disciplinary Committee Case Resolution Conference for December 21, 2016, which was held but did not resolve the matter.

On January 10, 2017, the Board issued amended charges against the Respondent, adding the charge of professional, physical, or mental incompetence to the charge of unprofessional conduct in the practice of medicine. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (4) (Supp. 2016). The amended charges were based on the results of [redacted] evaluations of the Respondent conducted in November and December 2016. Sometime in January 2017, Mr. Schwedt ceased representing the Respondent.

I held a hearing on the following dates: March 20 and 21, and April 3, 4, 5, and 12, 2017. On March 20, and April 3 and 5, 2017, the hearing was held in Largo, Maryland. On March 21, and April 4 and 12, 2017, the hearing was held at the OAH in Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (2014); COMAR 10.32.02.04. Cory Silkman, Esquire, Tydings and Rosenberg, LLP, represented the Respondent, who was present. Dawn L. Rubin, Assistant Attorney General and administrative prosecutor, represented the State of Maryland (State).

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2016); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Was summary suspension of the Respondent's license proper because the public health, safety, or welfare imperatively required emergency action?
2. Is the Respondent guilty of unprofessional conduct in the practice of medicine?
3. Is the Respondent mentally incompetent to practice medicine?
4. If so, what sanction(s) are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence on behalf of the State, except as noted otherwise:

State Ex. 1	Order for Summary Suspension, 9/14/16
State Ex. 2	Transcript of post-deprivation hearing, 9/29/16
State Ex. 3	Letter to the Respondent from the Board, 9/29/16
State Ex. 4	Identification sheet listing the identities of Hospital A, Hospital B, Patient A, Patient B, Patient C, and Nurse A
State Ex. 5	Amended Charges Under the Maryland Medical Practice Act, 1/10/17
State Ex. 6	Initial application for licensure, 8/28/79, and supporting documents
State Ex. 7	Renewal application for licensure, 9/2/15
State Ex. 8	Mandated 10-Day Report, 5/6/16
State Ex. 9	Letter to the Respondent from the Board, 7/13/16
State Ex. 10	Letter to the Board from Mr. Schwedt, 7/27/16, with attachments
State Ex. 11	Letter to the Board from Mr. Schwedt, 8/2/16; Information Form; Authorization for Release of Information, 7/31/16
State Ex. 12	Letter to the Board from the Respondent, 8/5/16, with attachments
State Ex. 13	Medical Staff Conference Call to Discuss Complaints and Incidents Involving the Respondent, 4/22/16
State Ex. 14	Subpoena Duces Tecum, 5/17/16; excerpts from the Respondent's Quality Assurance file with Hospital A, received 6/13/16
State Ex. 15	Excerpts from the Respondent's Quality Assurance file with Hospital A, received 8/23/16

State Ex. 16	Subpoena Duces Tecum, 8/23/16; excerpts from the Respondent's Quality Assurance file with Hospital B, 1/1998-12/31/11, received 9/6/16
State Ex. 17	Excerpts from the Respondent's Quality Assurance file with Hospital B, 2010-2016 , received 8/2/16-8/11/16
State Ex. 18	Transcript of interview with Dr. [redacted], 9/13/16
State Ex. 19	Transcript of interview with [redacted], 9/13/16
State Ex. 20	Transcript of interview with [redacted], 9/13/16
State Ex. 21	Transcript of interview with [redacted], 9/13/16
State Ex. 22	Transcript of interview with [redacted], 8/18/16
State Ex. 23	Transcript of interview with [redacted], 9/29/16
State Ex. 24	[redacted] records 2010-2011
State Ex. 25	[redacted] records 2016
State Ex. 26	Maryland Board of Physicians Report of Investigation
State Ex. 27	[redacted] (not offered/admitted)
State Ex. 28	[redacted] (not offered/admitted)
State Ex. 29	[redacted] (not offered/admitted)
State Ex. 30	[redacted] Evaluation Report, 12/6/16
State Ex. 31	Letter to Dawn Rubin from the [redacted], 12/19/16
State Ex. 32	Curriculum Vitae of [redacted][3]
State Ex. 33	Report of [redacted], 12/17/16

I admitted the following exhibits into evidence on behalf of the Respondent, except as noted otherwise:

Respondent Ex. 1	Letter from [redacted], M.D., [redacted], 10/23/16
Respondent Ex. 2	Letter from [redacted], M.D., [redacted], 12/22/16
Respondent Ex. 3	Excerpts from Hospital A's peer review file, 2007-2014 (not offered/admitted)
Respondent Ex. 4	Privilege Application to Hospital B, 3/30/15, 6/30/15 (not offered/admitted)
Respondent Ex. 5	Reappraisal Evaluation Report and Recommendation, 6/30/15 (not offered/admitted)
Respondent Ex. 6	Curriculum Vitae of [redacted]
Respondent Ex. 7	Curriculum Vitae of [redacted] (not offered/admitted)
Respondent Ex. 8	Curriculum Vitae of [redacted] M.D. (not offered/admitted)
Respondent Ex. 9	Curriculum Vitae of the Respondent (not offered/admitted)
Respondent Ex. 10	[redacted] Evaluation Report [redacted], 3/1/17

[3] Master of Management in Health Care.
[4] American Board of Professional Psychology.

Testimony

The following witnesses testified on behalf of the State:

- [redacted], M.D., Chief Medical and Population Health Officer at Hospital B;
- [redacted], R.N. at Hospital B;
- [redacted], R.N. at Hospital A;
- [redacted] M.D., Chief Medical Officer at Hospital A;
- [redacted] Board Compliance Analyst;
- [redacted], R.N. at Hospital A; and
- [redacted], M.D., M.M.H.C., who was accepted as an expert in [redacted]

The Respondent testified in his own behalf, and presented the following witnesses:

- [redacted], R.N. at Hospital B;
- [redacted], M.D.;
- [redacted];
- [redacted];
- [redacted], R.N. at Hospital A;
- [redacted], R.N. at Hospital A;
- [redacted], M.D.; and
- [redacted], Ph.D, ABPP, who was accepted as an expert in [redacted] and [redacted] testing.

PROPOSED FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland. He was first licensed in Maryland in 1980. The Respondent is a cardiologist. He is not board certified.

2. The Respondent has been practicing cardiology in Maryland for over thirty years. He was educated in India, in English. He completed his medical residency in the United States.

3. At all times relevant to this proceeding, the Respondent had privileges to practice at Hospital A and Hospital B, except as described below.

4. The Respondent has a hearing impairment and uses hearing aids.

5. The Respondent has a history of [redacted], and continues to be [redacted]. In March 2014, the Respondent's [redacted] became worse and was [redacted]. The Respondent's [redacted] was related in part to [redacted]. During 2014 and 2015, the Respondent did not work consistently because of [redacted].

6. In April 2015, the Respondent saw [redacted], a [redacted], once for [redacted]. [redacted] recommended that the Respondent return in six months; however, the Respondent did not return to [redacted].

7. Sometime in January, February, or March of 2016,[5] the Respondent's treating [redacted], [redacted], prescribed [redacted] to the Respondent for [redacted]. The Respondent's [redacted] improved and he returned to work full-time.

[5] The evidence was vague as to the date [redacted] first prescribed [redacted].

Incidents at Hospital A

8. In 2009, a committee at Hospital A investigated complaints made against the Respondent alleging that he was assaultive and abrasive toward an operating room nurse and made inappropriate and stereotypical racial comments during rounds with residents. Based on the investigation, the Medical Executive Committee of Hospital A required the Respondent to send a letter of apology, withdraw as a faculty member of the teaching service, and seek an evaluation by the physician guidance service. The Respondent refused to comply with the three directives. On August 24, 2010, the Medical Executive Committee of Hospital A notified the Respondent that he would be suspended for twenty-eight days for failing to comply. The Respondent appealed. On November 4, 2010, the Medical Executive Committee of Hospital A and the Respondent agreed to resolve the matter as follows: the Respondent would cooperate with a complete evaluation by the [redacted] and submit to any treatment recommended, he would write a letter of apology to the complainant, and he would have the right to apply to be on the teaching service. On September 13, 2011, the Medical Executive Committee of Hospital A found that the Respondent had complied with all of the requirements of the November 4, 2010 agreement.

9. In the spring of 2015, the Respondent's behavior began to deteriorate again. He had difficulty adjusting when Hospital A instituted electronic medical records. Hospital A allowed the Respondent to use verbal orders, despite its policy requiring the use of electronic records, because of his difficulty. In addition, the Respondent wanted to manage his Critical Care Unit (CCU) patients himself from home and did not want CCU staff caring for his patients. Hospital A's policy provided that the hospitalists and intensivists on duty would care for CCU patients because critical care patients need decisions made about their care immediately.

10. Over the course of 2015 and 2016, the Respondent became increasingly demeaning and intimidating to staff. His behavior became increasingly vocal and aggressive, and often occurred in the presence of patients and their family members. Dr. [redacted], Chief Medical Officer, attempted to discuss his concerns regarding the Respondent's behavior with him on multiple occasions; however, the Respondent was dismissive of the complaints and Dr. [redacted]'s concerns.

11. On April 11, 2016, the Respondent repeatedly called Hospital A yelling that the registered nurses were not doing their duties and missing his orders. He demanded that an EKG result be faxed to him and was very upset when he was told it could not be faxed to him. Staff attempted to explain that no lab results or EKGs were to be faxed to him, but he became more agitated. The Respondent threatened the charge nurse, secretary, and all the nursing staff that he would report their incompetency to management.

12. On April 12, 2016, the Respondent shouted while on the telephone in the nursing station at Hospital A over a period of thirty minutes. He argued with and threatened a lab phlebotomist regarding blood work that was not completed on time. Later that evening, the Respondent shouted at the CCU resident on duty that night, complaining about the way the CCU resident on duty that day triaged a patient.

13. On April 13, 2016 at 08:00 hours, the Respondent entered an order for a cardiac ECHO[6] transthoracic for a patient instead of a 2D ECHO to rule out pericardial effusion. The Respondent entered the order incorrectly and as a result the order was not transmitted to the ECHO technicians. At 21:50 hours, the Respondent called the ECHO technician yelling that the study was not done. The technician attempted to explain to the Respondent that there was no order but the Respondent continued to yell and hung up on her. The Respondent called the

[6] Echocardiogram.

technician again and said that he wanted the study done immediately. The technician asked the Respondent if he would be there to read the results and he responded no. The Respondent called the technician five times until 23:14 hours, hanging up on her three times. The hospital operator then called the on-call technician, who attempted to get information regarding the patient from the Respondent, and who told the Respondent she would perform the study immediately if he would be there to read the results. The Respondent told her she had no right to ask him about the study and that she was just the technician and should come in and do the study. The Respondent called the on-call technician four times and hung up on her twice. The Respondent entered the order correctly at 22:50 hours but stated that he would not be in to read it. The study was performed at 07:15 hours on April 14, 2016. As of 15:20 hours on April 14, 2016, the Respondent had not read the study or examined the patient.

14. On April 14, 2016, the Respondent ordered urinalysis and urine culture for a patient. A CCU nurse told the Respondent that the patient was anuric and dialysis dependent. The Respondent replied by asking how long she had been a nurse and what kind of nurse was she in an aggressive and disrespectful manner. The Respondent loudly told the charge nurse in the presence of others that the nurse should be fired.

15. On April 14, 2016, a nurse was admitting a stroke patient when the Respondent pressured the nurse to abandon her patient and assist him with his patient, who was not in distress at the time. When the nurse explained that she had just received her patient, the Respondent yelled that the nurse was incompetent, her patient was not "coding," she should leave her patient and attend to his patient, and she should assist him with whatever he needed.

16. On April 14, 2016 at 19:00 hours, the Respondent asked a CCU nurse while in a patient's room if she had started a dopamine drip on the patient. The nurse told the Respondent that she had been told not to administer dopamine through a peripheral IV site, which is what the

patient had. The Respondent began to scream and yell at the nurse about following his orders and said that she was going to kill the patient. The Respondent and the nurse were five to ten feet from the patient, who was alert and orientated. The patient asked that they not argue and fight. Another doctor stepped in and the Respondent left the room.

17. On April 21, 2016, the Respondent met with a patient, her son, and her daughter regarding a note from case management that the patient was upset and wanted to return to the nursing home. The patient attempted to explain that was not exactly what she had said. The Respondent was loud and aggressive, demanding that the patient write a note that case management was incorrect, or he would fire her as a patient and she would have a new doctor and be sent to a floor where the nurses would be even more incompetent and unable to care for her safely. The patient agreed to write the note and her children and the nurse signed as witnesses. After everyone signed the statement, the Respondent wrote on the statement that the patient was not pressured in any way. The Respondent then explained the patient's spinal CT[7] results. The Respondent asked the patient if her wrist hurt. The patient responded yes (due to a chronic condition). The Respondent squeezed her wrist until she screamed and then attempted to explain how pressure can exacerbate pain. The patient and her family were visibly upset. Next, the Respondent told the patient that her hemoglobin and hematocrit and red blood cell count were declining and that if they were still low the next morning she would need a blood transfusion during hemodialysis. The Respondent did not give the patient any additional information or have her sign a consent form at that time. The next morning, a nurse called the Respondent with the lab results and the Respondent asked the nurse to take a phone order for the transfusion and have the patient sign a consent form. The nurse told the Respondent that he was uncomfortable writing the order for the transfusion and the Respondent replied that he would

[7] Computerized tomography.

write it later. The Respondent stated that he gave enough information to the patient the prior evening and that he did not need to discuss the transfusion further with the patient. However, the patient stated the day before that she did not want a transfusion and continued to be resistant that day. The patient also had questions about the transfusion. The nurse did not believe the patient was fully informed.

18. On April 22, 2016, [redacted], M.D., Medical Director, Clinical Innovation and Patient Safety, left a message for the Respondent regarding the patient, specifically why the Respondent had not discharged her to her nursing home. The Respondent called Dr. [redacted] stating that he did not want Dr. [redacted] or Dr. [redacted] to call him again. Rather, they could put their concerns in writing and he would respond at his convenience. Further, the Respondent said he was going to send Dr. [redacted] a bill for $400.00 for wasting his time. During the phone call the Respondent yelled, did not allow conversation, and did not allow Dr. [redacted] to speak. The Respondent said he did not care to whom Dr. [redacted] reported the incident.

19. On April 22, 2016, a conference call was held including [redacted], M.D., [redacted], M.D., [redacted], M.D., Dr. [redacted], [redacted], Esq., [redacted], Esq., and [redacted], Director of Medical Affairs. The purpose was to discuss the large number of complaints of inappropriate and unprofessional behavior against the Respondent in recent weeks. The concern was that the Respondent may have posed an imminent danger to the safety of the staff or patients and may have been interfering with the orderly operations of the hospital. The group concluded that the Respondent may be impaired and recommended that the Practitioner Health Committee investigate and make a recommendation. The group did not recommend suspension of the Respondent's clinical privileges at that time. Dr. [redacted] was to

call the Respondent and warn him that if there were one more incident of unprofessional behavior, he would be suspended immediately.

20. On April 22, 2016 at 10:00 hours, a nurse received a call from the Respondent demanding to speak to another nurse. The Respondent yelled, "Don't behave like you did the last time, I want you to ask the nurse to call me RIGHT NOW."[8] When told the nurse was off the unit helping with administrative activities, the Respondent yelled, "Does she work for the administration or does she work for the patient. I will give you time to contact the nurse and she should call in 10 minutes."[9]

21. On April 26, 2016 at 08:30 hours, the Practitioner Health Committee met to discuss staff complaints that the Respondent was yelling, screaming, demeaning, degrading, threatening, using abusive language, and being disrespectful. In addition, the committee discussed several instances where the Respondent wrote inappropriate comments in patient records, including that staff are stupid, that the hospital is legally and morally responsible, that he did not understand why the hospital had hired an inexperienced nurse, that nurses do not care about the patients, and that nurses ignore the doctor's orders purposefully. Also, the committee discussed the Respondent squeezing a patient's wrist causing her pain. The committee was to meet with the Respondent and make a final report within seven days.

22. On April 26, 2016, during the day shift, the Respondent called the CCU and asked a nurse why she had not placed patients of his from the Emergency Department into beds on the CCU. The nurse explained that it was not her decision as to which patients were placed on the CCU and that all of the CCU beds were assigned to patients. The Respondent said he was going to complain to the Administrator because he wanted a clear explanation as to why Intensive Care

[8] St. Ex. 14 p. 204.
[9] *Id.*

Unit (ICU) patients were being placed on the CCU instead of patients from the Emergency Department. The Respondent called the nurse several times asking about the CCU's census and how many transfers and admissions she had for the night. The Respondent called the nurse again and stated that he was coming to the CCU and that her census numbers had better be accurate or he was going to complain to the Administrator. The Respondent arrived and walked through the whole CCU and looked into each room. He then called the nurse a liar, saying there were four beds open. The nurse explained that two of the rooms were blocked and two were assigned to other patients. The Respondent pointed his finger in the nurse's face and stated that he was not talking to her, and then he did the same to the other CCU nurses. Dr. [redacted] was examining a patient on the CCU at that time and the Respondent walked Dr. [redacted] around showing him the empty rooms. Dr. [redacted] explained to the Respondent that the rooms were not available; however, the Respondent was adamant that the staff were lying and not placing his patients in CCU beds. He then yelled at staff members. Patients' family members were present and heard the Respondent yelling and asked if this happened all the time on the unit. Next the Respondent called the ICU nurse and demanded a report about the ICU patient who was being transferred to the CCU, a patient who was not the Respondent's. After receiving the information about the ICU patient, the Respondent stated that the patient was stable enough to be on a regular floor.

23. On April 26, 2016, at 21:45 hours, the Respondent again called the CCU and asked the nursing supervisor why she put an ICU patient in a CCU bed. The nursing supervisor explained that she had not assigned any ICU patients to the CCU. The Respondent insisted loudly that she had put an ICU patient on the CCU. The nursing supervisor then went to the Emergency Department to do rounds where she encountered the Respondent loudly discussing her on the phone in the patient care area with the CCU charge nurse. The nursing supervisor

introduced herself to the Respondent, and he continued to state that she had put an ICU patient in the CCU. The Respondent's voice continued to elevate and the nursing supervisor suggested they talk in a room, to which the Respondent replied that he was not going anywhere. At 22:20 hours, the Respondent told the charge nurse that he wanted the admission diagnosis for each patient on the CCU and that he was going to "write everyone up." The Respondent walked down the hall of the CCU loudly saying that there were two open rooms. As the nursing supervisor explained that there were not any open rooms, the Respondent interrupted her saying loudly that he was not talking to her and placed his finger over his lips indicating that she should be quiet. The charge nurse also attempted to explain to the Respondent that he could not use the rooms and he screamed at her that he was not talking to her.

24. On April 27, 2016, the Respondent went to the nurses' station on the PCRU[10] grumbling that his patients were still in the Emergency Department and not placed in the CCU. The charge nurse explained that room assignment was done by the Bed Control. The Respondent went to the CCU to check the rooms, yelling that he was being barred from bringing his patients to the CCU. He continued to yell and accuse the nurses of not favoring him. Patients complained to a nurse that the Respondent was so loud, including one patient who said that it seemed that the Respondent was high on drugs. Patients said the Respondent was making them feel stressed. The Respondent said he was going to "write up" all of the nurses on the CCU and PCRU.

25. On May 1, 2016, a nurse was in the process of administering pain medication to a patient when a clerk called her and said the Respondent wanted the nurse to come to the nurses' station. The nurse responded that she was in the middle of administering pain medication. After the nurse finished, she went to the nurses' station and approached the Respondent. The

[10] The CCU step down unit. The PCRU acronym was not specifically defined.

Respondent said "never mind I'm writing this up."[11] The supervisor arrived and the Respondent told her that the nurse said that she did not have time to talk to him, which was untrue. The Respondent wrote in the patient's progress notes that the nurse said that she did not have time to talk to him, made copies, and gave the copies to other staff members.

26. On May 3, 2016, the Respondent felt that his patient should have been admitted to the CCU instead of another patient. The Respondent wrote the name of the other patient in his patient's chart and wrote that he had informed the patient's family that Hospital A was responsible for "any increased morbidity or mortality."[12]

27. On May 4, 2016, the Practitioner Health Committee met with the Respondent and explained its concerns regarding his behavior. The Respondent did not take any responsibility for his actions, instead focusing on his complaints against other staff members. The committee agreed with the Respondent that some of his complaints were valid, and said they would be addressed, but emphasized that the purpose of the meeting was to address his behavior. During the meeting, the Respondent revealed that he was being treated by a [redacted] for [redacted] After the Respondent left the meeting, the committee decided to ask him for a letter from his treating [redacted] regarding his fitness to practice medicine.

28. On May 5, 2016, the Respondent called and accused a CCU nurse of trying to kill his patient, threatened her nursing license, and hung up on her. The nurse repeatedly called the Respondent to discuss the patient, specifically the prescribed vancomycin dose and the patient's blood sugar level. The Respondent refused to talk to the nurse and insisted that the nurse not care for the patient any longer. The Respondent also accused the nurse of being incompetent.

[11] St. Ex. 14 p. 208.
[12] St. Ex. 14 p. 208.

The Respondent called the patient's daughter and made comments about the nurse that made the daughter hesitant to let the nurse in the room to care for the patient.

29. On May 5, 2016, the Respondent made inappropriate comments in a patient's chart about a nurse.

30. On May 6, 2016, Hospital A imposed a precautionary suspension of all the Respondent's clinical privileges, effective immediately. Hospital A imposed the suspension because the medical staff believed he posed an immediate danger to the health and safety of patients and staff and his actions interfered with the orderly operation of the hospital. The written notice of the immediate suspension was sent via facsimile and Federal Express to the Respondent's home office, and mailed to his professional office. In addition, Dr. [redacted] called the Respondent and notified him of the suspension.

31. At the start of the night shift on May 6, 2016, the Respondent called the CCU asking that the nurse taking care of his patient call him with blood work results.

32. On May 6, 2016 at 20:42 hours, Dr. [redacted] called Hospital A staff notifying them that the Respondent's privileges were suspended. Dr. [redacted] stated that if the Respondent arrived at the hospital, staff should call security to have him escorted out.

33. On May 6, 2016 at 23:00 hours, the Respondent continually called nursing staff yelling and being verbally abusive on the phone. The Respondent yelled, "Did [the nurse] go into cardiac arrest because he has not called me yet?" The charge nurse told the Respondent to call Dr. [redacted] because they were not allowed to give out any information. The Respondent refused to call Dr. [redacted] and shouted that he was going to write up the charge nurse because she was not following his orders. The Respondent told the charge nurse to write in his patient's chart that Dr. [redacted] did not want the Respondent caring for the patient. The charge nurse refused to write the order. The Respondent said the charge nurse was working against him and

he wanted another nurse to write the order. The Respondent continued to call the charge nurse and she turned off her phone. When the charge nurse turned her phone back on two and a half hours later at 01:30 hours on May 7, 2016, there were twenty missed calls and fifteen messages from the Respondent.

34. On May 7, 2016 at 00:19 hours, the Respondent informed a CCU nurse that he was on his way to Hospital A to meet with a patient's daughters. The nursing supervisor notified security that the Respondent said he would be arriving at 01:30 hours. At 01:30 hours, the CCU charge nurse saw one of the patient's daughters waiting outside the patient's room and asked her why she was there. The patient's daughter said that the Respondent was meeting her there.

35. On May 7, 2016 at 02:11 hours, the Respondent arrived on the CCU and security, including county police, responded and notified him that he could not be on the property. The Respondent became belligerent, yelling and trying to enter the patient's room. The security officer prevented the Respondent from entering the patient's room by standing in the doorway. The Respondent tried to push the security officer out of the way and grabbed the officer's coat. The Respondent asked the police officer how to press charges against the security officer. The Respondent continued yelling and being hostile in the patient care area. The noise woke most of the patients and patients' family members were standing in the hallway watching the incident. The nursing supervisor attempted to speak to the Respondent, to which he replied that he did not want to talk to her, he was superior to her, and he had nothing to say to her. The nursing supervisor told the Respondent that Dr. [redacted] said that his privileges were suspended and he could not be on the property. The Respondent continued to elevate his voice and said he was not going anywhere. The nursing supervisor went into the patient's room and apologized for the Respondent's behavior. The patient's daughters stated that they would come back in the morning to arrange for their father's transfer to Hospital B. The patient's daughters attempted to

leave but the Respondent bullied them into staying by giving them an ultimatum, saying that if they did not stay with him until the morning he was not going to care for their father any longer. When the police officer said to the daughters that they did not have to follow the Respondent's ultimatum, the Respondent said that the fact that he is a doctor shows he is more educated and that the police officer should just stay in his place. At 02:30 hours, the nursing supervisor called Dr. [redacted] and told the Respondent she had Dr. [redacted] on the phone. The Respondent said that he did not want to speak to Dr. [redacted] and that Dr. [redacted] was a nobody. The Respondent refused to speak to Dr. [redacted] on the phone. The patient's daughters decided to come back in the morning to arrange for their father's transfer to Hospital B so that the Respondent could continue to be his doctor. At 03:00 hours, the Respondent informed the patient's daughters that because they would not stay the night he would no longer be caring for their father and he was leaving. Security escorted the Respondent out of the building. At 03:27 hours, a police officer called the nursing supervisor asking her to come to the Emergency Department. The Respondent signed into the Emergency Department as a patient complaining of bilateral knee pain, then left without being seen, saying that he was going to Hospital B.

36. On May 13, 2016, Hospital A reported to the Board that it had imposed a precautionary suspension of the Respondent's privileges, was continuing to investigate the complaints against the Respondent, and would determine if further action was necessary.

37. On May 17, 2016, Hospital A's Medical Executive Committee met and agreed that there was sufficient information that the Respondent was likely an impaired practioner. The committee agreed to offer the Respondent the opportunity to take a voluntary leave of absence and participate in the [redacted]. Upon successful completion of the program, the Respondent could request reinstatement. If the Respondent did not agree to the

offer, the committee recommended termination of the Respondent's membership and clinical privileges.

38. On May 19, 2016, Hospital A's Medical Executive Committee notified the Respondent of its decision and extended his precautionary suspension, giving him a deadline of June 3, 2016.

39. On May 24, 2016, the Respondent entered Hospital A intending to attend a general medical staff meeting. The Respondent was asked to leave the premises and he refused. Security was called and the Respondent was handcuffed and escorted to the Emergency Department for a [redacted] evaluation. Staff attempted to have the Respondent transferred to another facility for the evaluation but were unable to do so and the Respondent was released.

40. On May 27, 2016, a circuit court judge granted Hospital A a temporary restraining order against the Respondent, which prohibited him from entering the hospital's property and communicating with any hospital staff member regarding patient care or hospital operations.

41. On June 2, 2016, the Respondent accepted the Medical Executive Committee's offer, applied for a voluntary leave of absence, and agreed to participate in the [redacted].

42. On June 3, 2016, Hospital A and the Respondent entered into a consent order. The Respondent was prohibited from entering the hospital's property unless invited in writing by the president of the medical staff, the vice president of medical affairs, the hospital president, or the chief operating officer. The Respondent was prohibited from initiating any communication with hospital physicians or staff regarding patient care at the hospital or hospital operations. However, hospital physicians or staff could initiate communication with the Respondent regarding patients that were previously under his care. The Respondent was allowed to contact

and communicate with hospital physicians and staff on a personal basis outside of the hospital, but not regarding hospital affairs or patients. The consent order was to remain in effect unless and until Hospital A restored the Respondent's clinical privileges.

Incidents at Hospital B

43. On April 24, 2016, Patient A was admitted to Hospital B from the Emergency Department for a hematoma on his right hip. He had had surgery on his right hip two weeks earlier. He was under the care of the hospitalist. On April 26, 2016, Patient A requested that his care be assigned to the Respondent because the Respondent was his cardiologist and primary care physician.

44. On April 27, 2016, Dr. [redacted], a surgeon, examined Patient A and discussed with the Respondent operating on Patient A to incise, drain, and evacuate the hematoma. The Respondent advised against surgery because Patient A had been taking Coumadin and Lovenox.

45. On April 28, 2016 at 04:00 hours, the Respondent examined Patient A and ordered more lab work. At 08:30 hours, the operating room called the floor nurse and told her that Dr. [redacted] had scheduled Patient A for emergency incision, drainage, and evacuation of the hematoma. Patient A was taken to the operating room at 08:50 hours. The floor nurse attempted to call the Respondent but his phone rang and rang and did not go to voice mail. At 10:00 hours, the Respondent called the floor nurse, who gave him the lab results and told him Patient A had been taken to the operating room. The Respondent was very upset that Patient A was taken to the operating room without his permission. The floor nurse explained that she had been trying to reach him by phone but there was no response. The Respondent insisted that Patient A be returned to the unit immediately before surgery or anesthesia. The Respondent called the clinical coordinator and said, "I don't want my patient to have surgery today, get him back to the floor, call whoever you have to, VP of nursing or director of hospital, I will fire Dr.

[redacted] and get another surgeon, I am the physician."[13] While staff were discussing the matter, Patient A's ex-wife called and said that the Respondent called her and told her that Patient A could die if the surgery were performed because his blood was too thin. Patient A's ex-wife said if anything happened to Patient A, the hospital had been forewarned. At 11:00 hours, the Respondent called again asking if Patient A was back on the floor and demanded that the floor nurses get the patient back immediately. During this time, Dr. [redacted], Chief Medical Officer, spoke to the Respondent, Dr. [redacted], Dr. [redacted], the risk manager, the operating room director, and Patient A regarding the surgery and the Respondent's concerns about the thinness of the patient's blood and the type of anesthesia to be used. The Respondent wanted spinal anesthesia used. Patient A stated that he wanted to proceed with the surgery under general anesthesia. The decision was made to proceed with the surgery under general anesthesia. The Respondent was initially cordial but raised his voice and yelled and spoke over the others when they could not reach an agreement and then refused to be the attending physician of record. The Respondent told Patient A, "I've known you and treated you for twenty years and I care about you, the other doctor[s] don't care about you like that. I have saved your life several times, if you go ahead with this surgery today I will never see you or treat you again and you cannot call me again. If you have this surgery today, you will die."[14] At 11:28 hours, the Respondent called again and gave detailed verbal orders that he be removed from Patient A's care entirely, that he was not responsible for any complications, morbidity, or mortality if the surgery proceeded, and to call Dr. [redacted] with any problems. At 12:30 hours, the Respondent called and demanded that the order he had dictated at 11:30 hours be faxed to him. The floor director told the Respondent that he needed to enter the order in writing himself either in person

[13] St. Ex. 17 p. 51.
[14] St. Ex. 17 p. 58.

or electronically. The Respondent was very upset, insisted that his order was valid, and wanted it faxed to him. The floor director attempted to explain to the Respondent but he was not interested in listening and continued to insist that the nurse fax the order to him or fax a statement that the hospital was disregarding his valid order. He also requested copies of Patient A's CT scan and blood work be faxed to his office. The Respondent said that his philosophy was to blame others for problems and take all the credit for successes and that if there were problems from this, he would blame the floor director and clinical coordinator. The floor director spoke to Dr. [redacted] who said that the verbal order was not to be placed in the chart and that nothing was to be faxed to the Respondent. Dr. [redacted] stated that the Respondent knew the proper method of entering orders and changing physicians.

46. Based on the Respondent's behavior on April 28, 2016, Dr. [redacted] referred the incident to the peer review committee.

47. On June 6, 2016 at 16:12 hours, the Respondent called Dr. [redacted] and asked to be placed on the call schedule. Dr. [redacted] told the Respondent that based on his past on-call performance and recent unprofessional behavior, he would not be placed on the cardiology call schedule. The Respondent became belligerent, yelled, and threatened Dr. [redacted]. The Respondent made the following statements: "You are a dictator; I have never heard someone having so many meetings; you will see, you wait; you don't know who you are dealing with; I am going to complain about you and do other things."[15]

48. On June 11, 2016, a patient complained to a nurse that the Respondent had not visited her in the hospital the day before or that day. The patient said that the Respondent talked to her on the phone about being discharged that evening. The Respondent told her to get a ride to come to the hospital so that she could be discharged. The nurse called the Respondent to ask

[15] St. Ex. 17 p.103.

when he would come to the hospital to assess the patient and the Respondent said if the patient found a ride he would be there at 18:00 hours. The patient's ride was at the hospital but had to leave before 18:00 hours to attend to personal affairs. The patient and her family were upset because the Respondent had not seen the patient in two days and had inconvenienced friends of the family. At 19:00 hours, the Respondent wrote in the patient's chart that he would discharge the patient in the morning and that he had discussed the plan in depth with the patient. He also wrote that the patient preferred to leave in the morning and was unable to find a ride. The patient denied having a discussion with the Respondent about changing the discharge plan or seeing him that evening.

49. Hospital B has a policy requiring attending physicians to evaluate their patients every twenty-four hours and update the patient records with corresponding progress notes.

50. On July 28, 2016 at 19:00 hours, the Respondent arrived on the unit, pointed at the volunteer at the desk and told her, "You need to get me half and half."[16] When the volunteer did not understand, the Respondent said sarcastically, "You don't know what half and half is? You must be new."[17] The Respondent then told the volunteer to get coffee creamer. Next, the Respondent yelled at a nurse that a medication he had ordered had not been given to Patient C the day before. The nurse checked the electronic record and told the Respondent that the medication had been given; a second nurse verified this. The Respondent berated both nurses and said they were lying because the computer showed the order but did not say next to the order that it was given. The second nurse showed the Respondent that he was looking in the wrong location for the information. The Respondent blamed nursing for changing Patient C's Procrit order to every seven days. The nurse showed the Respondent that his order said for the Procrit to

[16] St. Ex. 17 p. 70.
[17] *Id.*

repeat every seven days. The Respondent complained that the lab had messed up his order for a serum electrophoresis and berated a lab technician over the phone and the phlebotomist in person. The phlebotomist was helping the Respondent to correct the problem and discovered that the Respondent was entering the order incorrectly the entire time.

51. On the morning of July 30, 2016, Patient B told her nurse that she wished to change her code status to do not resuscitate (DNR) but that the Respondent would not let her. A second nurse assessed Patient B's emotional status. Patient B said that she was tired of going through the issues related to her end-stage heart failure, that she "did not feel that her care was going anywhere,"[18] and that she was "ready to accept the end of her life."[19] At 19:00 hours, the Respondent spoke to Patient B in person. The Respondent was abrupt and coercive, stating loudly, "You are saying that you want to die, by you saying this and changing your status you are making me look bad as a doctor!"[20] He also told Patient B, "You don't understand what the word death means" and "I am going to cure you."[21] The Respondent included Patient B's son in the conversation, who told his mother that there would "be no more talk of this."[22] The Respondent said to Patient B, "Who will even take care of you? Your family will not do it."[23] Patient B's son was offended by that comment and said "Why wouldn't we take care of her."[24] The Respondent told Patient B, "I put you on antidepressants, and I will increase them now that you keep saying this."[25] The nurse observing the confrontation asked the Respondent to step into another room so that they could discuss the patient in private. The nurse told the Respondent of his (the nurse's) conversations with Patient B and that Patient B said she "felt pressured to keep

[18] St. Ex. 17 p. 78.
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*

going on even though it's not what she wanted."[26] The nurse told the Respondent that Patient B felt coerced by her family and the Respondent not to change her code status. The nurse said that Patient B did not want to end her life but wanted to go peacefully when it was to happen. The Respondent became agitated, saying "You people keep pushing for this change to kill this patient. I am not talking to you anymore. You are incompetent, and have no right to talk to me about this patient. I am the doctor not you."[27] The nurse replied that he was only advocating for the patient. The Respondent stormed away, said he was not talking to the nurse about this anymore, pulled his hearing aids out of his ears, and pushed his fingers in his ears.

52. In August 2016, Hospital B learned that the Board was investigating the Respondent's unprofessional behavior. At the time, Hospital B was in the midst of its own investigation of the Respondent's unprofessional behavior.

The [redacted] Evaluation

53. On November 14 and 15, 2016, the Respondent was evaluated by a multidisciplinary team at the [redacted] in response to a referral from the [redacted]. The team included: [redacted], M.D., [redacted]; [redacted], Ph.D, [redacted]; [redacted], Psy.D., ABPP, [redacted]; [redacted], LCSW, MAC; and [redacted], BSW, LADAC. The Respondent also had an [redacted] examination by [redacted] Au.D., CCC-A. The team reviewed records, interviewed the Respondent, and administered [redacted] tests.

[26] *Id.*
[27] *Id.* at pp.78-79.

54. At the time of the evaluation, the Respondent was taking the following prescribed [redacted] medications: [redacted]. He was also taking [redacted].

55. The evaluation revealed that the Respondent had mild [redacted] impairment and [redacted]. The Respondent had mild impairments in [redacted], [redacted], [redacted].

56. Based on the evaluation, Dr. [redacted] opined that the Respondent was no longer fit to practice medicine. He recommended that the Respondent be gradually withdrawn from [redacted] medication because chronic use is associated with diminished [redacted] functioning, and that the [redacted] be discontinued. He suggested re-evaluating the Respondent's [redacted] functioning if the medication changes produced improvement, although he believed it unlikely that the Respondent's [redacted] state would improve.

Dr. [redacted]'s Evaluation

57. On December 15, 2016, [redacted], Ph.D., [redacted], [redacted], conducted a [redacted] evaluation of the Respondent. The Respondent was referred to Dr. [redacted] by the Respondent's treating [redacted], [redacted], M.D.

58. At the time of the evaluation, the Respondent was taking the following prescribed [redacted] medications: [redacted]. The [redacted] was in the process of being tapered. He was also taking [redacted].

59. The evaluation revealed that the Respondent was functioning in the average range of general intellect. Dr. [redacted] strongly suspected that the Respondent had [redacted] declined

[28] The generic is [redacted]

from his prior level of functioning because it was statistically unusual for a physician to have an average I.Q. and the Respondent had practiced medicine in Maryland successfully for decades. The Respondent had lower than expected scores in general ability, word knowledge and rapid reading comprehension, learning, and memory. Dr. [redacted] noted that cultural and language biases of English-language, American-made tests could have impacted the Respondent's s cores; however, he thought [redacted] decline was more likely given the number of years the Respondent had been in the United States practicing medicine.

60. Dr. [redacted] noted that even in the absence of a [redacted], the Respondent's [redacted] disorder made it unwise for him to be diagnosing and treating patients. Dr. [redacted] recommended additional [redacted] tests, such as a [redacted],[29] that the Respondent be closely monitored by his primary care physician, and [redacted] re-evaluation in one year to determine any change in [redacted] functioning.

Dr. [redacted]'s Evaluation

61. On February 23 and 28, 2017, [redacted], Ph.D, ABPP, conducted a [redacted] evaluation of the Respondent. Testing was administered by [redacted], a master's level [redacted] associate. The Respondent was referred to Dr [redacted] by the Respondent's current attorney.

62. At the time of the evaluation, the Respondent was taking the following prescribed [redacted] medications: [redacted]. He had been weaned from [redacted]. He was also taking [redacted].[30]

63. During the interview and testing, the Respondent was extremely hard of hearing, requiring test instructions to be repeated and shouted at times. He was wearing his hearing aids

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[29] [redacted].

[30] Dr. [redacted]'s report does not mention whether the Respondent was taking [redacted].

during testing but forgot them on the day of the interview. On occasion, he searched for words and said that the Hindi word came to mind more easily than the English word.

64. The Respondent's intellectual functioning and academic achievement scores were in the average range but below levels expected in highly educated individuals such as physicians. In particular, he had difficulty with word finding. Dr. [redacted] attributed this to the Respondent's non-native proficiency in English.

65. The Respondent had borderline-to-mild inefficiencies in manual motor speed, dexterity, and persistence, which were more noticeable on his right side. Dr. [redacted] attributed this to the Respondent's history of [redacted] and subsequent [redacted] and [redacted].

66. The Respondent "failed a demanding auditory dual attention task that is sensitive to neuropsychological impairment."[31] Dr. [redacted] attributed this to the Respondent's hearing difficulties.

67. The Respondent showed equivocal deficits on a non-verbal card sorting task, an executive task which required him to efficiently establish, maintain, and shift mental set. Dr. [redacted] attributed this to the Respondent's hearing difficulties, i.e., not benefiting from auditory feedback during the test.

68. The evaluation showed the Respondent has [redacted] in remission and possible age-related changes in [redacted] efficiency, compounded by impairments in language proficiency, hearing, and peripheral motor functioning.

[31] Resp. Ex. 10.

Current Fitness to Practice Medicine

69. The Respondent is not currently fit to practice medicine based on his impairments in [redacted], English-language proficiency, hearing, and peripheral motor functioning. His [redacted] is asymptomatic and stable on his current medications.

DISCUSSION

Summary Suspension

Section 10-226(c)(2) of the State Government article provides for summary suspensions, as follows:

> (2) A unit may order summarily the suspension of a license if the unit:
> (i) finds that the public health, safety, or welfare imperatively requires emergency action; and
> (ii) promptly gives the licensee:
> 1. written notice of the suspension, the finding, and the reasons that support the finding; and
> 2. an opportunity to be heard.

Md. Code Ann., State Gov't § 10-226(c)(2)(2014).

On September 14, 2016, the disciplinary panel of the Board summarily suspended the Respondent's license to practice medicine on the grounds that the public health, safety, or welfare imperatively required emergency action. The Board based the suspension on the results of its investigation, namely the multiple complaints against the Respondent for unprofessional, inappropriate, and hostile behavior toward staff and patients at Hospitals A and B, as well as Hospital A's suspension of the Respondent's privileges, and the temporary restraining order Hospital A obtained against the Respondent. The disciplinary panel continued the suspension after the Respondent was unable to show cause why his license should not be summarily suspended at a hearing before the panel on September 28, 2016.

As detailed in the findings of fact above and discussed further below, the Respondent's behavior in April, May, June, and July, 2016, posed an imminent danger to the health, safety,

and welfare of staff and the patients in his care. His behavior was out of control and undeterred by the attempts of his colleagues and superiors to modify it. Notably, the Respondent made two attempts to enter Hospital A in May after his privileges were suspended and he was told not to enter the hospital. In addition, the Respondent's unprofessional and disruptive behaviors continued in June and July at Hospital B after his privileges were suspended by Hospital A in May. At the point the Board suspended the Respondent's license, he had not undergone any [redacted] evaluation. Thus, the Board acted properly, taking prompt action to protect patients and staff. Therefore, I conclude the Board's summary suspension was proper.

Charges Under § 14-404(a)(3)(ii), (4)

Section 14-404(a)(3)(ii), (4) of the Health Occupations article provides as follows:

> (a) 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:
>
> . . .
>
> (3) Is guilty of:
>
> . . .
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> (4) Is professionally, physically, or mentally incompetent.

Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (4) (Supp. 2016).

The Parties' Arguments

The State argued that the Respondent's behavior posed an imminent danger to patients and staff. The State maintained that his disruptive behavior continued after Hospital A suspended him on May 6, 2016, leading Hospital A to get a temporary restraining order against him. The State asserted that the Respondent's disruptive behavior undermined the culture of safety and intimidated staff. The State noted that none of the Respondent's witnesses were present during any of the incidents described in the findings of fact above. The State described

the Respondent as mentally incompetent based upon the findings of [redacted] impairment by Dr. [redacted]'s and Dr. [redacted]'s evaluations. The State noted that Dr. [redacted] acknowledged that he did not have access to the records detailing the complaints against the Respondent. The State maintained that Dr. [redacted]'s test results were similar to Dr. [redacted]'s and Dr. [redacted]'s evaluations. Rather, Dr. [redacted] interpreted his test results somewhat differently, attributing low scores to language difficulties and hearing problems. The State contended that the Respondent was educated in English and had been practicing medicine in the United States for over forty years, and testified that he could hear just fine during testing. The State maintained the Respondent's behavior continued through August 2016 and had the potential to harm patients. The State noted that intensivists were available to care for patients in the CCU twenty-four hours per day, seven days per week, but the Respondent was not. The State cited specific impacts to patients, such as the incident where a patient's discharge was delayed because the Respondent was not available. The State also cited the May 6, 2016 incident where the Respondent contacted the patient's family late at night to transfer the patient to Hospital B because his privileges were suspended at Hospital A.

The Respondent argued that he is mentally competent and fit to practice medicine. He alleged that the personal interactions in April and May were the result of a [redacted] induced by the [redacted] prescribed to him. He maintained his medication has been adjusted and his [redacted] has resolved. Also, he noted he stopped taking [redacted], which can impair [redacted] function. He claimed his most recent testing with Dr. [redacted] determined he was fit to practice medicine and not dangerous. He asserted that the test results were impacted by his hearing difficulties and because he is not a native English-language speaker. In addition, he asserted that his test results with Dr. [redacted] and Dr. [redacted] were impacted by the [redacted] that Dr. [redacted] had prescribed. He claimed that the State's witnesses did not identify an incident

where the Respondent harmed a patient. He argued there was no evidence he was unable to manage his patients and that the nurses testified that they did not have any difficulty reaching him. He maintained that he provided top-notch care to his patients. He claimed that when he went to Hospital A on May 6, 2016 to care for a patient, he had not received the letter from Dr. [redacted] suspending his privileges. He maintained the family wanted him to care for the patient. He asserted that he had two discussions with the family of Patient B regarding her code status. He alleged that his administrative privileges were not suspended when he went to Hospital A to attend a staff meeting. He argued that Dr. [redacted] was present when he allegedly yelled at a patient and that it did not happen.

Unprofessional Conduct in the Practice of Medicine

During April, May, June, and July, 2016, the Respondent repeatedly engaged in unprofessional conduct while practicing medicine at Hospitals A and B, as detailed in the findings of fact above. He did not communicate professionally with staff and patients. Rather, he yelled at and intimidated both patients and staff to follow his wishes. He refused to acknowledge other points of view. On more than one occasion, the Respondent threatened patients that he would no longer care for them if they did not follow his orders. He was extremely impatient with what he perceived to be mistakes made by others, when in some instances his actions had caused or contributed to the error. In particular, his difficulties using the electronic medical records system caused him to enter orders incorrectly or to misunderstand whether his orders had been executed. Whether the Respondent or other staff members made the errors, the Respondent's reactions were inappropriate, including yelling at staff, berating them, threatening to report them, and writing comments about them in patients' records. In one instance, the Respondent removed his hearing aids and put his fingers in his ears because he did not want to hear what a nurse was saying to him. His disruptive conduct continued despite the

concerns expressed to him by colleagues at both hospitals. Moreover, his disruptive conduct continued at Hospital B after he was suspended by Hospital A and after Hospital A obtained a restraining order against him.

During the Respondent's testimony, he minimized and rationalized his behavior. He admitted that his wife noticed that he was louder and anxious, and getting a little more angry at her. He explained this by saying that the [redacted] had caused him to become [redacted] and that he is loud because of his hearing problems. He stated that as Dr. [redacted] decreased his [redacted], his wife and son noticed he was calmer and not as loud. He denied that he caused a patient pain when he squeezed her wrist and said he was trying to explain stenosis to her. He maintained that he explained to the patient her need for a blood transfusion, said that he forgot to get her consent that evening but said that the nurse could have obtained the patient's consent because he had already explained it to her. He said that he had a very sick patient who remained in the Emergency Department too long, that he was told the patient would be moved to the CCU next, but then the patient was not moved, even though there were empty beds in the CCU. He said he discussed with Patient B and her family her wishes and that everyone was in agreement that they wanted "everything to be done," that Patient B wanted to remain "full code" and be resuscitated if necessary. He claimed the nurse kept insisting that Patient B had different wishes and that the nurse raised his voice but that he (the Respondent) did not raise his voice. He said he did not remember taking his hearing aids out but that he sometimes did because they hurt. He denied that his privileges were suspended until he received the notice in writing on May 9, 2016. He claimed that the family wanted him to care for the patient on May 6, 2016 and that was why he had the family meet him at the hospital to transfer the patient to Hospital B when Hospital A would not let him see the lab results or give orders. He said when he tried to enter the patient's room, the security guards pushed him back and he fell down, causing pain to his leg. He said

staff members were yelling at him and that he was not yelling. He stated that the suspension of his clinical privileges did not mean that he could not be in the hospital or attend medical staff meetings. He admitted that he was told it was not a good idea for him to attend the medical staff meeting but went anyway. He stated that he preferred to care for his patients on the ICU and CCU because he did not like his orders being changed every twelve hours, that the intensivists were there for backup, and that the nurses knew all his phone numbers. He denied ever raising his voice at nursing staff. He stated that Dr. [redacted]'s testimony was "all lies." He said he has not had a single complaint about him in thirty-three years. He said the complaints involving Patients A, B, and C were "all lies." He stated that Dr. [redacted] lied and did not call him on May 6, 2016, to tell him he was suspended. He also said it was not his "duty to talk to Dr. [redacted] in the middle of the night" when the nurse told him that Dr. [redacted] was on the phone.

The Respondent's denials and rationalizations of his behavior were unpersuasive and statements he made during his testimony were contradictory. For example, during direct examination regarding the events of May 6, 2016, the Respondent testified that the nurses were making mistakes with his orders and did not draw the patient's blood properly. He said the blood work was done again at 8:00 p.m. and that he was looking for the results on the EMR[32] but did not see the results. He said he called the nurse about the results and the nurse told him that his privileges were suspended. He said Ms. [redacted] (the charge nurse) told him that he could not give orders and that a new doctor had been assigned to the patient. He stated that he called the patient's daughter and asked her to meet him at Hospital A so that they could transfer the patient to Hospital B. However, on cross examination, the Respondent stated that Ms. [redacted] (a R.N.) only said that he could not see the patient or give orders or follow the patient. The Respondent testified, "I had no idea before I arrived at the hospital I was suspended." Then he said that Ms.

[32] Electronic medical record.

[redacted] at the hospital, was the first one who told him that he was suspended. He was asked whether Ms. [redacted] told him that Dr. [redacted] was on the phone but that he (the Respondent) refused to speak to him (Dr. [redacted]). His response was "It is not my duty to talk to him about my behavior in the middle of the night. I was concerned about my patient." The Respondent's actions and statements about the events of May 6, 2016 show that he was aware that his privileges were suspended prior to entering Hospital A. Further, his response to learning his privileges were suspended at Hospital A was to call the patient's daughter and ask her to meet him at the hospital at 1:30 a.m. in order to transfer the patient to Hospital B. This action was wholly inappropriate and completely unprofessional. Transferring the patient to Hospital B was a decision based on the Respondent's suspension by Hospital A, not by the patient's medical needs.

The Respondent's conflicting testimony is outweighed by the consistent testimony of the State's witnesses. The State presented the testimony of doctors and nurses from both Hospital A and Hospital B regarding the complaints against the Respondent, as well as the contemporaneous records of events as they occurred at both facilities. The State's witnesses had direct knowledge of the events they described and their testimony was consistent with the contemporaneous records. The witnesses called by the Respondent did not have direct knowledge of the incidents described in the findings of fact above, and in most instances the witnesses were unaware of the events. The Respondent's behavior during April, May, June, and July, 2016, was unacceptable in any setting but particularly in a hospital CCU where his behavior interfered with patient care, and had the potential for serious harm to patients. Therefore, I find the Respondent engaged in unprofessional conduct in the practice of medicine.

Professionally, Physically, or Mentally Incompetent

The cause of the Respondent's unprofessional behavior leads to the question of the Respondent's current mental competence to resume the practice of medicine. Dr. [redacted] testified that in his expert opinion, the Respondent is [redacted] impaired and not mentally competent to practice medicine. Dr. [redacted] recommended the Respondent discontinue taking [redacted] and [redacted] because [redacted] could impact his [redacted] and [redacted] could destabilize his [redacted]. Dr. [redacted] noted that the Respondent did not have any insight into his condition. Dr. [redacted] also recommended the Respondent have an [redacted] to see if there were [redacted]. Dr. [redacted] suggested the Respondent be re-evaluated if his function improved after the medications were discontinued, although he believed it unlikely that the Respondent's [redacted] would improve. Dr. [redacted] opined that the Respondent was a danger to others in the practice of medicine because he could forget things or misprescribe medication, in addition to the problematic behavior he had engaged in. At the time of Dr. [redacted]'s evaluation, the Respondent was in the process of being weaned off the [redacted]; he was still taking [redacted]. Dr. [redacted] opined that the Respondent had [redacted] declined based on his test scores. Dr. [redacted] acknowledged cultural and language biases could have impacted the Respondent's scores. However, Dr. [redacted] noted that the Respondent had successfully practiced medicine in Maryland for decades and concluded that [redacted] decline was more likely.

Dr. [redacted] opined that the Respondent's [redacted] is in remission and that he has possible age-related changes in [redacted] efficiency, which are compounded by the Respondent's impairments in language proficiency, hearing, and peripheral motor functioning. At the time of Dr. [redacted]'s evaluation, the Respondent was no longer taking [redacted] but was still taking [redacted]. Dr. [redacted]'s testimony focused on the Respondent's hearing difficulties and the fact that English is not his first language as possible causes of the Respondent's low scores on his

evaluation. However, Dr. [redacted] could not definitely state that the Respondent has not experienced [redacted] decline. Moreover, Dr. [redacted]'s opinion regarding the Respondent's competency to resume the practice of medicine was heavily qualified with caveats in both his testimony and his report. What follows is Dr. [redacted]s opinion in full in his report:

> **OPINIONS REGARDING REINSTATEMENT OF LICENSE AND RETURN TO WORK:** It would appear that the more seriously disruptive aspects of [the Respondent's] behavior have been controlled by his current regimen of [redacted] and [redacted] medication. I remain concerned that he is vulnerable to relapse should [redacted], and to this end I believe that he would benefit from [redacted], in conjunction with his ongoing [redacted] treatment, at [the] very least to monitor his behavior and serve as an "early warning system" should his [redacted] reappear or begin to blossom into something more severe.
>
> I would recommend repeat [redacted] evaluation every 2-3 years to assess any age-related changes in [the Respondent's] [redacted] functioning, behavior, and comportment.
>
> [The Respondent] can't hear as well as he needs to. He should seek more intensive audiologic evaluation than the screening recently performed at [redacted], should avail himself of better assistive hearing devices than he currently uses, and should be much more mindful of using his hearing aids than currently appears to be the case.
>
> **However, so long as he remains in treatment with Dr [redacted] and [redacted], so long as he is compliant with his medications, so long as his [redacted] status is monitored on a regular basis, and so long as he is helped to appreciate the degree to which external stressors, hearing integrity, and his [redacted] status potentially affect his professional functioning, I am of the opinion that there are no absolute [redacted] barriers to the reinstatement of [the Respondent's] license and his return to work as a licensed physician.**

Respondent Ex. 10 (emphasis in original).

On cross examination, Dr. [redacted] acknowledged that the Respondent had seen Dr. [redacted] once in April 2015 for [redacted], and that Dr. [redacted] had recommended that the Respondent return in six months, but that the Respondent did not do so. Dr. [redacted] also acknowledged that he was aware that the Respondent was educated in English, had been in the

United States for forty years, had done his residency in the United States, and had been practicing medicine in the United States since then. Dr. [redacted] agreed that the I.Q. scores he obtained were consistent with the I.Q. scores Dr. [redacted] obtained and that the scores were low and below the level expected of a physician. Dr. [redacted] noted that on one test the Respondent was shown a picture but could not identify it in English, although he reported coming up with the Hindi word. In response to my question, Dr. [redacted] agreed that this increased difficulty with the English word versus the Hindi word could be the result of [redacted] decline. Dr. [redacted] noted that this word retrieval difficulty was unlikely to be the result of the [redacted] effects of [redacted]. Dr. [redacted] stated that the Respondent's memory skills and motor skills had improved since the [redacted] was discontinued, that his [redacted] performance was average to above average, but that his performance on the language testing was dismal. Dr. [redacted] stressed the importance of the Respondent remaining under a doctor's care and repeat [redacted] testing every two years.

Dr. [redacted] testified as the Respondent's treating [redacted]; however, he was not qualified as an expert during the hearing. Dr. [redacted] stated that he had treated the Respondent in the past for three to four episodes of [redacted] that responded well to medication. Dr. [redacted] explained that the Respondent's [redacted] that began in 2014 was more severe and did not respond to medication. He said he prescribed [redacted] sometime in February or March 2016, gradually increasing the dosage, and that the Respondent returned to his normal self. However, he noted that in April and May 2016, the Respondent's wife contacted him stating that the Respondent was edgy and not listening to her. In response, Dr. [redacted] reduced the [redacted] dosage and added [redacted], and [redacted] at night. Dr. [redacted] stated that the Respondent was [redacted] in April and May but then returned to normal. Dr. [redacted] described the Respondent as somewhat remorseful about what happened at the hospital. Dr. [redacted] denied seeing any

irritability and said the Respondent's [redacted] and functioning were completely intact. Dr. [redacted] stated that he spoke to the Respondent every two weeks and saw him once per month. On cross examination, Dr [redacted] stated that the Respondent's wife told him that the Respondent had been suspended by Hospital A and that the Respondent told him he was suspended by the Board. However, he acknowledged that he had not seen the records from Hospital A or B, was not aware the Respondent had tried to enter Hospital A to see a patient after he was suspended, and was not aware that Hospital A had obtained a restraining order against the Respondent. Dr. [redacted] stated that the Respondent had mentioned seeing Dr. [redacted], but Dr. [redacted] did not know that Dr. [redacted] had recommended that the Respondent return in six months or that the Respondent did not do so.

Dr. [redacted]'s testimony is troubling in several respects. First and foremost, Dr. [redacted] only discussed treating the Respondent for [redacted] whereas Dr. [redacted] and Dr. [redacted] discussed the Respondent's [redacted]. In addition, Dr. [redacted] was not fully aware of all the Respondent's behaviors that caused the Board to suspend his license. Thus, it appears that the Respondent is not being completely forthcoming with Dr. [redacted]. Further, Dr. [redacted] testified that the Respondent was [redacted] in April and May 2016 and then returned to normal, when in fact the Respondent continued to engage in unprofessional behaviors in June and July 2016. Finally, Dr. [redacted]'s opinion that the Respondent can return to the practice of medicine relies heavily on the Respondent's continued treatment and monitoring by Dr. [redacted] and other professionals. However, Dr. [redacted] only sees the Respondent once per month. There was no evidence that the Respondent is being treated or monitored by any other medical professional.

During direct examination at the hearing, the Respondent was calm, spoke in a normal tone of voice, and did not indicate he was having any difficulty hearing. This was in direct contrast to Dr. [redacted]'s experience of having to yell at the Respondent to be understood during

his evaluation. However, during cross examination, the Respondent raised his voice. For example, he raised his voice while adamantly denying that any complaints had been made against him and insisting that he had not been provided with copies of any complaints. The Respondent made these assertions despite the fact that the documents were sitting in front of him, and that counsel for the State had given the documents to him during a recorded prehearing conference before me in January 2016, during which he also raised his voice. At no point during any of the Respondent's evaluations or at the hearing did the Respondent acknowledge that his behavior was unprofessional or inappropriate. The Respondent showed no remorse for his actions, instead focusing on his perceived misbehavior of others. The Respondent did not demonstrate any understanding or insight as to how his mental health impacted his professional functioning during April, May, June, and July, 2016, or his need for more intensive support and treatment.

While it is possible [redacted] impacted the Respondent's performance during the first two evaluations, the Respondent had ceased taking [redacted] by the time he was evaluated by Dr. [redacted], yet Dr. [redacted]'s evaluation still revealed deficits. Assuming for the sake of discussion that all of the Respondent's low test scores can be explained by hearing and language difficulties, that still raises serious concerns as to the Respondent's competency to practice medicine. In other words, if the Respondent's abilities to hear or function in English are that compromised, he is not competent to practice medicine in English in Maryland. However, based on all the evidence before me, I find it is more likely that an underlying disease process was the cause of the Respondent's unprofessional behavior and negatively impacted the Respondent's [redacted] performance during the evaluations. Therefore, I find that the Respondent is not competent to resume the practice of medicine.

One final note, I am sympathetic to the Respondent and his situation. It was obvious that he is very sincere and dedicated to his patients and the practice of medicine. I can appreciate the difficulty of facing one's health challenges, particularly when they negatively impact one's life so significantly.

Sanctions

The State recommends revoking the Respondent's license to practice medicine. *See* COMAR 10.32.02.09A, B and 10.32.02.10. The State argued that a mitigating factor in the Respondent's favor is that he does not have any prior disciplinary history. The State asserted that an aggravating factor against the Respondent is that his actions had the potential to harm patients. The State maintained that the Respondent has not acknowledged his conduct at all. The State contended that the Respondent is not able to safely practice medicine.

The Respondent argued that he is competent to practice medicine, the summary suspension should be lifted, his license should not be revoked, and his license should be reinstated.

As stated above, I find that the Respondent is not competent to practice medicine. The Respondent's evaluations show he is experiencing [redacted] difficulties that did not resolve with medication changes; thus, it is unlikely his [redacted] will improve. The Respondent's [redacted] difficulties pose a significant risk of harm to patients in his care. COMAR 10.32.02.09B. As such, the appropriate sanction is revocation of the Respondent's license to practice medicine. COMAR 10.32.02.10B(4)(b). However, at a minimum, the Respondent's license should remain suspended unless and until the Board finds he is mentally competent to resume the practice of medicine. *Id.*

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the summary suspension of the Respondent's license was proper because the public health, safety, or welfare imperatively required emergency action. Md. Code Ann., State Gov't § 10-226(c)(2) (2014).

I further conclude as a matter of law that the Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of section 14-404(a)(3)(ii) of the Act. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2016).

I further conclude as a matter of law that the Respondent is mentally incompetent to practice medicine, in violation of section 14-404(a)(4) of the Act. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (4) (Supp. 2016).

As a result, I conclude that the Board may sanction the Respondent for the cited violations. *Id.*; COMAR 10.32.02.09A, B and 10.32.02.10B(4)(b).

PROPOSED DISPOSITION

I **PROPOSE** that the summary suspension issued by the Board on September 14, 2016, be **UPHELD**;

I **PROPOSE** that charges filed by the Board against the Respondent on September 30, 2016, be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned by revocation of his license to practice medicine.

July 3, 2017
Date Decision Mailed

Lorraine E. Fraser (GRB)
Lorraine E. Fraser
Administrative Law Judge

LEF/sm
#168249

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Board of Physicians that delegated the captioned case, and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of this proposed order. COMAR 10.32.02.05B. The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2014); COMAR 10.32.02.05C. The Office of Administrative Hearings is not a party to any review process.

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