IN THE MATTER OF	*	**BEFORE THE**
KOFI ETRUW SHAW-TAYLOR, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D26832	*	**Case Numbers: 2016-0684 B, 2016-0105 B, 2016-0271 B, 2016-0281 B**

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

ORDER OF SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Kofi Etruw Shaw-Taylor, M.D. (the "Respondent") to practice medicine in the State of Maryland, License Number D26832.

Panel B takes such action pursuant to its authority under Md. Code Ann., State Gov't II ("State Gov't") § 10-226(c)(2) (2014 Repl. Vol. and 2016 Supp.), concluding that the public health, safety or welfare imperatively requires emergency action. Panel B bases its conclusion on the following investigative findings after conducting an investigation.

INVESTIGATIVE FINDINGS

Following receipt of a complaint regarding Respondent's overprescribing of opioids,[1] Panel B obtained investigatory information that Respondent, who was trained as a surgeon, and specialized in urology for many years, but whose hospital privileges

[1] Opioids are a class of drugs that include the illegal drug heroin as well as powerful pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and fentanyl. Opioids act on the nervous system to relieve pain; however, continued use and abuse can lead to physical dependence and withdrawal symptoms.

were summarily suspended in 2015, is now practicing what he describes as "pain management." Pain medicine is a medical sub-specialty for which Respondent has no training, and an area of medicine in which opioids may be prescribed, but which Respondent widely prescribes, and which can be abused and diverted for non-medical purposes. Respondent has coupled his "pain management" practice, with his addiction medicine practice that involves a patient population who has a demonstrated issue with opioid drug habituation/addiction and possible prescription drug abuse and/or diversion of opioids.

According to independent expert review by two physicians who are board-certified in anesthesiology and pain medicine, Respondent does not follow standards for practicing pain management and is professionally incompetent in regard to his pain management practices, especially his prescribing of opioids in that Respondent:

1. Prescribes controlled dangerous substances ("CDS") out of his scope of practice and experience. Respondent claims he has gained experience of pain management "by extension of addiction medicine"; however, only through a brief three hour training course, once a year, which he did not attend this past year;

2. Prescribes excessively high doses of CDS, particularly opioids, without justification, creating a cycle of rapid tolerance and dependence;

3. Prescribes benzodiazepines[2] with opioids which places patients at an increased risk for respiratory depression;[3]

---

[2]Benzodiazepines are a class of medications which have sedative, hypnotic (sleep-inducing), anxiolytic (anti-anxiety), anticonvulsant, and muscle relaxant properties. High doses of shorter-acting benzodiazepines may also cause anterograde amnesia and dissociation. Benzodiazepines are used in treating anxiety, insomnia, agitation, seizures, muscle spasms, alcohol withdrawal and as a pre-medication for medical or dental procedures.

[3] Respiratory depression means unusually slow or shallow breathing, which can result in too much carbon dioxide and not enough oxygen in the blood. The condition can be life-threatening. The most common cause of respiratory depression is a drug overdose. Alcohol, barbiturates, opiates, GHB and sedatives, especially when used in combinations or large amounts, can result in respiratory depression. Usually, the person's heartbeat and blood pressure will also slow down to dangerous levels.

4. Prescribes buprenorphine[4] with opioids and benzodiazepines which not only places patients at risk for respiratory depression but is also counter-intuitive since buprenorphine is prescribed to treat opiate dependency;

5. Fails to order regular toxicology screens for patients for whom he has prescribed high doses of CDS;

6. Fails to address urine toxicology screening results that are inconsistent with prescribed medications, which are suggestive that the patients are either selling the prescribed CDS, or are taking unprescribed CDS;

7. Continues to prescribe opioids to patients after the urine toxicology screens are positive for cocaine, heroin, and/or methadone;

8. Predominately prescribes opioid pain medications and other CDS as his sole method of "pain management;"

9. Prescribes opioids prior to exhausting alternative therapeutic options such as injection therapy, physical therapy, chiropractic therapy, or surgery;

10. Fails to adequately describe the rationale for his prescribing;

11. Prescribes CDS without seeing the patients for an office visit;

12. Fails to act in the best interest of patients by denying patients the care they require by appropriately trained specialists who could provide interventional and non-interventional procedures to actually alleviate the pain rather than mask it with opiates; and

13. Fails to maintain a regular and predictable office schedule which causes patients to wait many hours to be seen or Respondent to pre-write prescriptions for patients without seeing them for an office visit, and leads to disorganization, poor charting, and inability to maintain consistent staffing.

Prior to Panel B receiving the complaint regarding Respondent's irresponsible prescribing of opioids, on August 19, 2015, Panel B received a Mandated 10-Day Report[5] (the "Report") from a hospital in Baltimore City ("Hospital A"),[6] stating that

[4] Buprenorphine, sold under the brand name of Suboxone is a prescription medication for people addicted to heroin or other opiates that acts by relieving the symptoms of opiate withdrawal such as agitation, nausea and insomnia. Subutex is intended for use at the beginning of treatment while Suboxone is intended for the maintenance treatment of opiate addiction.

Respondent's hospital privileges were summarily suspended on July 29, 2015, following several patient surgical complications and a concern regarding the accuracy of Respondent's medical records. Panel B has investigated the Report from Hospital A as well as the over-prescribing complaint and a subsequent complaint of unprofessional conduct.

Moreover, on April 24, 2017, Respondent was arrested and charged by the Medicaid Fraud Control Unit of the Attorney General's Office with "Defrauding State Health Care." Respondent's arraignment will be May 26, 2017.

Based on the investigatory information obtained by Panel B as summarized above, and the specific instances described below, Panel B makes the following investigative findings and concludes that Respondent's actions constitute a substantial likelihood of a risk of serious harm to the public health, safety, or welfare which imperatively requires emergency action.

I. Background of Licensee

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in the State of Maryland. Respondent was originally licensed to practice medicine in Maryland in 1981. In September 2015, Respondent's license renewal was "blocked" due to unpaid Maryland personal income taxes. Respondent's license was reinstated on October 22, 2015, and will expire on September 30, 2017.

2. Respondent completed two years of post graduate training in General

---

[5] Pursuant to Health Occ. II § 14-413(a), a hospital is required to report to the Board if a licensed physician who has privileges with the hospital has had staff privileges changed, if the change is for reasons that might be grounds for disciplinary action. The hospital shall submit the report within 10 days of the action.

[6] The names of specific institutions are not used in the Order of Summary Suspension. Respondent is aware of the name of the hospital.

Surgery, followed by a three year residency in Urology.

3. Respondent was initially board-certified in Urology by the American Board of Urology in 1987. Respondent was re-certified in 1997 but allowed his re-certification to expire in 2007. Respondent has not sought board re-certification in Urology. Respondent is not, and has not been, board-certified by the American Board of Medical Specialties in any other medical specialty.[7]

4. Since 1981, Respondent has practiced medicine, specializing in urology. Respondent has had various office locations in the greater Baltimore area, and has held hospital privileges at various hospitals in the greater Baltimore area.

5. Since approximately 1986, Respondent has served as the medical director for approximately five different methadone/drug abuse programs in Baltimore City.

6. Since 2001 or 2002, Respondent has been continuously certified by the Drug Enforcement Administration ("DEA") to provided Office-Based Buprenorphine Opioid Treatment ("OBOT").[8]

7. On July 28, 2015, Respondent's hospital privileges at Hospital A were summarily suspended based on complications following two urological surgical procedures. Since July 2015, Respondent has not held any hospital privileges.

8. Since approximately August 2015, Respondent's "pain management" practice has increased, requiring expansion into an adjacent office; and, Respondent

---

[7] Respondent informed the Board that he received American Society of Addiction Medicine certification in Addiction Medicine in February 2002 and American Board of Addiction Medicine certification in May 2009; however, neither of these certifications is active at this time.

[8] Office Based Opioid Agonist Treatment ("OBOT") refers to a model of opioid agonist treatment that seek to integrate the treatment of opioid addiction into the general medical and psychiatric care of the patient. The foundation of OBOT is the conceptualization of opioid addiction as a chronic medical condition with similarity to many other chronic conditions. An important feature of OBOT is that it allows primary care physicians to provide addiction treatment services in their usual clinical settings, thus expanding the availability of care.

continues to practice office-based urology, internal medicine,[9] addiction medicine, and treatment with buprenorphine.

9. In August 2016, Respondent applied to DEA for, and received, a waiver to increase the number of patients he was treating with buprenorphine from 100 patients, to the current maximum of 275 patients.

10. Respondent maintains an office, in two suites, on Falls Road in Baltimore City called "Westside Medical Group, P.A., Addiction Medicine Centers of Maryland" (the Falls Road office").

11. From January 2015 to March 2016, Respondent employed a physician ('Physician A"),[10] to see his buprenorphine patients, on Thursdays between 9:00 a.m. and 2:00 p.m.

12. In 2016, for a couple of months, Respondent employed a nurse practitioner, on Mondays and Wednesdays, who saw Respondent's pain management and primary care patients.

13. Respondent also has a "pain management clinic," known as "Star Life Wellness Center," in Glen Burnie, Maryland, where Respondent practices on Thursday mornings.

II. Summary of Six Complaints

A. Mandated 10-Day Report from Hospital A - Case No. 2016-0684 B

14. On August 19, 2015, the Board received a Report from Hospital A, stating, "[Respondent] was summarily suspended on July 29, 2015, following several patient

[9] Respondent has not had graduate training in internal medicine.
[10] The names of employees are not provided in the Order of Suspension. Respondent has been provided a Confidential Identification List with the names of all institutions and employees who are referenced in the Order of Summary Suspension.

complications and a concern regarding the accuracy of his medical records."

15. Previously, on July 28, 2015, Hospital A advised Respondent in writing that his clinical privileges had been summarily suspended and that he may no longer admit or treat any patients at Hospital A. The correspondence to Respondent stated:

> The grounds for this action are that your clinical practice creates a reasonable possibility of injury to patients. Specifically, there have been 3 recent cases when your clinical activities have presented an immediate threat to patient care.

16. Respondent did not request a review of the suspension by the Medical Executive Committee.

17. On April 29, 2015, Respondent submitted a resignation letter to Hospital A.

B. Complaint Regarding Prescribing of Oxycodone-Case No. 2016-0271 B

18. On September 30, 2015, the Board received a complaint from an employee of the Behavioral Health Administration (the "Employee") of the Department of Health and Mental Hygiene ("DHMH"), a board-certified psychiatrist, who oversaw the service delivery system for mental health care and addiction care in Maryland. The Employee forwarded to the Board copies of a packet of letters to Respondent, with attachments; and explained to Board staff that when she arrived to work at DHMH, she found the documents in her office. The documents had been slipped under her door, anonymously.

19. The documents consisted of:

a. Four letters to Respondent, dated May 22, 2015, from a retrospective drug utilization review program of Respondent's patients who are members of a health plan that provides coverage to patients in Maryland with Medicaid, regarding his "patients with issues of concern that require [his] attention."

b. Laboratory reports of three of Respondent's patients, all of whom were prescribed Suboxone.[11] The reports showed that two of the patients were

"negative" for buprenorphine; and two of the patients were "positive" for benzodiazepines and morphine, although Respondent had not prescribed either. Respondent had prescribed Hydromorphone for one of the patients, in addition to suboxone.

c. Copies of three prescriptions, one of which was for a benzodiazepine, written on May 5, 2015, after the date of the laboratory reports, for the patient who was positive for benzodiazepines, although Respondent had not previously prescribed benzodiazepines for this patient.

d. Four "Retrospective Drug Utilization Review Program" reports. One report shows that Respondent prescribed oxycodone[12] 15 mg, 90 tablets and oxycodone 30 mg, 120 tablets on the same day, which the patient filled at two different pharmacies; another report showed "high daily dose of opioids (exceeding 200 mg morphine equivalent dose/day), and another patient where "use of 4 or more pharmacies may indicate abuse potential or inappropriate use of opioids."

e. A handwritten list of names of approximately 28 individuals.

C. Patient Complaint Regarding Unprofessional Conduct – Case No. 2016-0281 B

20. On October 27, 2016, the Board received a complaint from a patient of Respondent ("Patient 11").[13] In the complaint, Patient 11 stated in pertinent part:

> I have been a patient with Dr. Kofi Shaw Taylor for approximately one year. Since that time I have only seen him two times and my appointments were 12:30 pm and 2:30 p.m. On both occasions I had not been seen until 1:00 a.m. in the morning and the second occasion was 11:30 p.m.

21. On November 3, 2016, Board staff obtained Patient 11's medical record during an unannounced visit to Respondent's Falls Road office.

22. On November 7, 2016, the Board notified Respondent about Patient 11's complaint that alleges unprofessional conduct and requested that Respondent respond

---

[11] Suboxone is a combination of buprenorphine, an opioid medication, and naloxone, which blocks the effects of opioid medication, including pain relief or feelings of well-being that can lead to opioid abuse.
[12] Oxycodone is an opioid pain medication. sometimes called a narcotic, which is used to treat moderate to severe pain.
[13] Patient names are confidential and are not used in the charging document. Respondent has been provided with a separate "Confidential Identification List" with the names of each of the patients referenced in the Order of Summary Suspension.

to the complaint.

23. Respondent failed to respond to Patient 11's complaint.

D. Anonymous Complaint

24. On November 16, 2016, the Board received by facsimile, a four page "typewritten" complaint, signed by "Concerned Citizens." The complaint, specifically addressed to the Board's investigator for this case, described the issues of Respondent not physically seeing his patients, prewriting prescriptions which he requires his staff to hand out, maintaining about 50 to 60 patients a day, prescribing high amounts of oxycodone, and seeing patients as late as 3:00 a.m. The complainants stated that Respondent had patients who pay $400 to $450 a visit, in cash. The complainants provided a list of approximately 162 patients about whom they had concerns.[14]

E. Complaint from a Pharmacist

25. On February 9, 2017, the Board received by facsimile, a complaint from a licensed pharmacist ("Pharmacist A"),[15] regarding Respondent's unavailability to confirm the legitimacy of a prescription. According to Pharmacist A:

> On 6 feb (sic) 17, the patient presented two prescriptions written by doctor (sic) Shaw-Taylor for Percocet and fentanyl. After searching the Crisp portal and finding that the patient paid cash for hydrocodone, I wanted to verify the new Prescriptions. I called office phone number about ten times and the recording stated that the office was open and to leave a message. The voice mail was full. I also tried the paging number on the voicemail and the physicians cell #, which the patient had and was unable to leave any messages. However, the patient went outside and claimed that she spoke directly with the physician.

---

[14] The complainants are clearly knowledgeable about Respondent's office practice since they were able to provide names of multiple patients of Respondent. Three of the patients on the list are on the list of patients who records were reviewed by the peer reviewers. Moreover, many of the concerns are substantiated by reports of other witnesses.

[15] The name of the pharmacist is not provided in the Order of Summary Suspension. Respondent has been provided with the identity of the pharmacist.

On 7 feb (sic), I attempted to call all three phone numbers multiple times.

On 8 feb (sic), patient returned with the prescriptions and stated that the physician spoke with the pharmacy. No pharmacist, to include the chief of Pharmacy, spoke with the physician.

This physician is supposedly an addiction specialist and urologist, Yet (sic) is writing Percocet and fetanyl for back pain.
The patient also stated that the physician was not in the office because he had back surgery.

As a pharmacist, I do not believe that these prescriptions were for a legitimate medical use. It is unacceptable that a physician and his office is (sic) unreachable during normal business hours for several days.

F. Complaint from Relative of a Patient

26. On May 1, 2017, Board staff received a telephone call from the adult son of a former patient of Respondent ("Patient 12"). The son reported that Respondent was treating his mother in 2016 for "pain management" and that Respondent prescribed Percocet 30 mg. #120 and Xanax. The son accompanied his mother to three or four of her appointments. The son reported that every time he went to Respondent's office, "there was a line out the door" and that they waited approximately 9 hours from 11:00 am to 8:00 p.m. to be seen by Respondent.

III. Investigation of Complaints

A. Investigation of Report from Hospital A

27. On August 19, 2015, the Board subpoenaed and received the Respondent's Quality Assurance/Risk Management ("QA/RM") file from Hospital A, which revealed concerns about surgical complications from Respondent's care in regard to three patients. In addition, there was concern that Respondent copied three progress notes from another provider into a fourth patient's medical record, as if Respondent was

to three patients. In addition, there was concern that Respondent copied three progress notes from another provider into a fourth patient's medical record, as if Respondent was the author of the notes.

28. On October 19, 2015, the Board subpoenaed the medical records of the four patients from Hospital A.

29. On December 2, 2015, the Board notified Respondent that it was investigating the Report and requested that Respondent provide a response to the allegations.[16] The Board subpoenaed the office medical records of the four patients from Respondent and requested that Respondent provide a summary of his care of the four patients.[17]

30. In December 2015, Board staff interviewed the three physicians on staff at Hospital A who had concerns about Respondent.

31. On March 28, 2016, the Board referred the case to an independent peer review agency, requesting independent peer review by two physicians, board-certified in Urology.

32. In October 2016, the Board received the peer reviewers' reports of their findings. The peer reviewers concurred that with regard to two[18] of the four patients reviewed, Respondent failed to meet the appropriate standards for the delivery of quality medical and surgical care. The reviewers concurred that Respondent failed to keep adequate medical records with regard to three[19] of the four patients.

---

[16] Respondent did not provide a response.
[17] Respondent did not produce an office record for one of the four patients, stating that he did not have a record for the patient. Respondent did not provide any summaries of his care of the four patients.
[18] The patients on which the reviewers concurred in regard to standard of care violations are Patients 1 and 4.
[19] The patients on which the reviewers concurred in regard to inadequacy of documentation were Patients 1, 2, and 4.

involving perforation of the urinary tract. It brings to question whether he has adequate urologic skills. In the first case (Patient 1) there was a delay in treating the complication that possibly contributed to the patient dying (and) the consultation note seemed to be a "cut and copy" of another doctors note.

34. The other peer reviewer stated:

My review of the QA/RM files and of these 4 cases also confirms an unacceptable failure to respond in a responsible and timely fashion to Urologic emergencies. Although brought to light in the past, this has persisted to the harm of several patients and likely contributing to the death of (Patient 1).

B. **Investigation of Over-prescribing and Prescribing for Non-compliant Patients**

35. While the Board was investigating the Report from Hospital A regarding Respondent's surgical errors, the Board received the complaint about Respondent's overprescribing of opioids and his continuing to prescribe to patients who were non-compliant, based on urine toxicology screening.

36. In October 2015, the Board sent subpoenas to three national chain pharmacies and one local independent pharmacy requesting "a computer printout of any and all controlled dangerous substances prescribed by [Respondent] from February 2015 to October 20, 2015."

37. On February 5, 2016, the Board sent correspondence to Respondent, notifying him that it had received a complaint alleging overprescribing of CDS and prescribing CDS despite negative drug screening. The Board requested that Respondent provide a written response to the allegations. In addition, the Board enclosed a subpoena, answerable in ten business days, to Respondent for the medical records of ten patients, whose names had been selected from the complaint from the DHMH Employee and from the computer printouts. The Board also requested that

Respondent provide a summary of care for each patient and a certification of completeness of medical records form.

38. On March 7, 2016, Respondent submitted summaries of care of seven of the ten patients and stated he had "recently moved into his present office location"[20] and would submit the additional three summaries by March 9, 2016.[21]

39. On March 9, 2016, Respondent submitted the three additional summaries of care but did not submit the ten medical records with certification of medical records forms.

40. On March 11, 2016, the Board resubmitted its request to Respondent for ten medical records and certification of medical records forms.

41. On April 4, 2016, the Board received five of the subpoenaed medical records but Respondent did not include a certification of medical records form for the five records.

42. On April 5, 2016, the Board sent correspondence to Respondent requesting the five additional medical records and certification of medical records forms.

43. On April 20, 2016, Board staff received three additional of the original ten subpoenaed medical records.

44. On April 22, 2016, Board staff conducted an unannounced visit to Respondent's office. (See paragraph 109 for a summary of the visit.)

45. On April 26, 2016, the Board received one additional patient medical record of the original ten subpoenaed records.

---

[20] Respondent moved to the Falls Road location in approximately December 2014 or January 2015.
[21] Respondent's cover letter stated he had submitted seven "audited charts" and he that he would submit the remaining three charts by March 9, 2016. In actuality, Respondent submitted summaries of care, not medical records or charts.

46. On August 19, 2016, Board staff interviewed Respondent under oath. Respondent arrived one hour and ten minutes late for the scheduled interview. Respondent explained:

> Food from my esophagus went into my trachea. I almost choked. I couldn't breathe, Patients die from aspiration. That's what happened to me this morning.

Respondent's eyes were closed for a majority of the interview. Respondent's "beeper/pager" went off multiple times during the interview.

47. On October 24, 2016, the Board received one additional patient record of the group of ten records that had been originally subpoenaed on February 5, 2016. Respondent did not fully comply with the Board's subpoena for the ten medical records until nearly nine months after being served with the subpoena.

III. Peer Review of Opioid Prescribing

48. On November 21, 2016, the Board referred the case to an independent peer review agency, requesting independent peer review by two physicians, board-certified in pain medicine.

49. On February 22, 2017, the Board received the peer reviewers' reports of their findings. The peer reviewers concurred that with regard to nine[22] of the ten patients reviewed Respondent does not meet quality standards for pain medicine.

Peer Review of Individual Patients 1 through 10

Patient 1

50. In April 2014, Respondent first saw Patient 1, then a 46 year old male, on referral from an area pain center. Patient 1's medical record contains an MRI of

[22] The patients on which the reviewers concurred in regard to standard of care violations are Patients 1, 2, and 4 through 10.

November 2013 which showed "lumbar disc herniation" and a computer print-out from a pharmacy which showed he had been prescribed oxycodone 30 mg and other medications since October 2013. Respondent requested, but did not receive records of prior care. Respondent assessed "Sciatic: lumbar radiculopathy secondary to lumbar disc herniation, hypertension, hypothyroidism, hyperlipidemia, GERD, hypogonadism, and phantom left 5th digit pain." Respondent prescribed oxycodone 30 mg qid[23] #120, as well as medications for blood pressure, acid reflux, and thyroid. Respondent saw Patient 1 for regular 4 week follow-ups and referred Patient 1 for an orthopedic consult.

51. Following lumbar decompression surgery in March 2015, Patient 1 returned to Respondent with significant post-operative pain. Although Patient 1's toxicology screen in July 2015 was positive for heroin and cocaine, on September 21, 2015 and March 3, 2016, Respondent prescribed Neurontin[24] 600 mg tid, oxycodone 30 mg tid, and MS Contin[25] 30 mg bid.[26] Respondent also prescribed medications for blood pressure, acid reflux, and thyroid. Respondent did not obtain any further toxicology screens.

52. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 1 for reasons including but not limited to that he:

a. Fails to follow-up and obtain records of prior treatment;

b. Prescribes medications for pain which is outside the scope of his training and experience;

---

[23] Qid is a Latin abbreviation for the phrase "four times a day." Also used in the document are the following abbreviations: bid, which means "twice a day;" tid, which means "three times a day," qd, which means "daily" and prn, which means "as needed."

[24] Neurotin is a brand name of gabapentin, an anti-epileptic medication, used to treat seizures and some types of pain.

[25] MS Contin is the brand name for an extended release formulation of morphine.

[26] Another health care provider in Respondent's office saw Patient 1, monthly, from October 19, 2015 to February 3, 2016.

c. Prescribes excessively high doses of opioid medication which Patient 1's diagnoses do not warrant;

d. Fails to refer Patient 1 for a spinal cord stimulator to treat the diagnosis of phantom left hand pain;

e. Fails to order an updated MRI;

f. Fails to order more frequent urine drug screens, obtaining only 5 screens over the course of two years and 22 office visits, especially after Patient 1 had positive urine screens for cocaine and a positive screen for metabolite of heroin in 2015; and

g. Continues to maintain Patient 1 on opiate medications while Patient 1 is abusing illicit substances.

Patient 2

53. In August 2013, Respondent first saw Patient 2, then a 46 year old female, for one visit, when Patient 2 presented with a deformity of her right ankle, hypertension, and depression and requested an opiate prescription. Respondent prescribed oxycodone 15 mg tid and medication for high blood pressure.

54. Patient 2 returned in June 2014, after having been incarcerated. Respondent has been treating Patient 2 monthly since then for hypertension, obesity, GERD (gastroesphogeal reflux disorder), Hepatitis C, chronic arthritis of right ankle, and depression. Respondent prescribed oxycodone 15 mg qid, later reduced to oxycodone 15 mg tid, Lexapro 20 mg, for depression, and medications to treat blood pressure and acid reflux.

55. In October 2014, Respondent increased Patient 2's oxycodone dosage to 15 mg to qid.

56. In September 2015, Respondent added alprazolam[27] 2 mg bid.

[27] Alprazolam (Xanax) is a potent, short-acting anxiolytic of the benzodiazepine class. It is commonly used for the treatment of anxiety disorders.

57. In December 2015, Patient 2 was again incarcerated.

58. The results of Patient 2's toxicology screens are as follows:

a. December 2014, negative for opiates and positive for methadone;

b. March 2015, negative for oxycodone and positive for methadone;

c. February 2015, negative for oxycodone and positive for methadone; and

d. April 2015, negative for oxycodone and positive for methadone.

59. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 2, for reasons including but not limited to that he:

a. Prescribes medications for pain and psychiatric conditions, which are outside the scope of his training and experience;

b. Fails to order more frequent urine drug screens, obtaining only 4 screens over the course of 22 office visits;

c. Fails to refer Patient 2 for physical therapy for her right ankle pain to possibly decrease her opioid use; and

d. Fails to properly address the results of toxicology screens by discontinuing prescribing opiate pain medication and referring Patient 2 for addiction treatment.

Patient 3[28]

Patient 4

60. On January 8, 2015, Respondent first saw Patient 4, then a 48 year old female. According to Patient 4, she had been involved in a motor vehicle accident in December 2014 and complained of headaches, low back and neck pain. Initially, Respondent prescribed Oxycontin[29] 10 mg bid and oxycodone 5mg q 6 hrs prn. Respondent also treated Patient 4 for hypertension, depression and anxiety. Respondent prescribed diazepam 10 mg, fluoxetine 20 mg (Prozac) (and later 40 mg),

[28] There are no allegations in regard to Patient 3.
[29] Oxycontin is the brand name of Oxycodone.

alprazolam 1 mg bid, and morphine sulfate ER[30] 30 mg bid.

61. After a month, Respondent began treating Patient 4 for "narcotic addiction" and placed Patient 4 on Suboxone 8 mg qd.

62. At some point, Respondent then resumed prescribing oxycodone, Oxycontin, alprazolam and/or morphine sulfate ER.

63. Respondent saw Patient 4 for monthly visits through November 2015, after which Patient 4 discontinued seeing Respondent.

64. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 4, for reasons including but not limited to that he:

a. Prescribes medications such as medications for pain which are outside the scope of his training and experience;

b. Prescribes Suboxone concurrently with benzodiazepines which increases the risk of respiratory depression;

c. Prescribes Suboxone and morphine sulphate, an opioid, which is medically contraindicated when taken together because it defeats the purpose of the Suboxone;

d. Fails to order frequent urine drug screens, obtaining only 4 screens over the course of 20 office visits, and none after March 25, 2015; and

e. Fails to refer Patient 4 for a neck brace and spinal cord stimulator for her neck pain to possibly decrease her opioid dependence; and

f. Fails to document Patient 4's participation in a counseling program as an adjunct to the Suboxone Program; or conversely failed to insist that Patient 4 participate as a condition of receiving Suboxone.

Patient 5

65. On May 25, 2011, another health care provider in Respondent's office first saw Patient 5, then a 63 year old male. Patient 5 presented with multiple medical problems, including diabetes mellitus II, high blood pressure, GERD, neuropathy,

[30] Morphine sulfate ER is the generic name of MS Contin.

severe rheumatoid arthritis or osteoarthritis, depression, and a history of cocaine, heroin and marijuana use. The health care provider practitioner prescribed oxycodone 10 mg, gabapentin 300 mg, and Etodolac[31] ER 400 mg.

66. In May 2012, Respondent began treating Patient 5 for left shoulder pain and knee pain, and his internal medicine conditions, prescribing both oxycodone 10 mg prn #90 and Percocet 10 mg tid, which he later discontinued.

67. On June 1, 2012, an x-ray of Patient 5's shoulder showed "mild to moderate osteoarthritis of the right acromioclavicular joint ... and right glenohumeral joint."

68. In October and November 2012, Patient 5's toxicology screens were negative for prescribed oxycodone. Respondent did not order another urine toxicology screen until April 2013, which was positive for prescribed oxycodone.

69. In June 2014, Respondent increased oxycodone 10 mg to qid.

70. In October 2014, Patient 5's toxicology screen was positive for marijuana.

71. In May 2015, Respondent increased oxycodone to 30 mg tid.

72. Through March 2016, Respondent has maintained Patient 5 on oxycodone 30 tid.

73. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 5, for reasons including but not limited to that he:

a. Fails to follow-up with imaging studies (MRI) that he has ordered on April 1, 2015 and still did not have results by October 5, 2015;

b. Escalates Patient 5 to a high dose of oxycodone 30 mg tid;

c. Fails to order frequent urine drug screens, obtaining only 12 screens over

[31] Etodolac is in a group of drugs called nonsteroidal anti-inflammatory drugs (NSAIDs). Etodolac is used to treat pain or inflammation caused by arthritis.

the course of 57 office visits;

d. Fails to refer Patient 5 for durable medical equipment, such as, a knee brace and or lower back brace, given Patient 5's complaints of knee and lower back pain, which would provide benefit and decrease the necessity for higher doses of opioid medication; and

e. Fails to obtain information from the Prescription Drug Monitoring Program ("PDMP") through CRISP[32] to ensure compliance with prescribed CDS.

Patient 6

74. On April 10, 2014, Respondent first saw Patient 6, then a 34 year old female. Respondent diagnosed chronic pain syndrome, chronic right sacro-iliac joint pain, chronic left foot/ankle pain, low back pain, obesity, hypertension, anemia and menorrhagia. Patient 6's previous primary care provider had treated Patient 6 with oxycodone 30 mg tid and oxycodone 15 mg q 6 hrs prn.

75. Throughout 2014, Respondent prescribed oxycodone 15 mg bid #56 and oxycodone 30 mg qid #112.

76. In 2015, Respondent increased oxycodone 15 mg bid to tid and continued oxycodone 30 mg qid, which he continued throughout 2015 and early 2016.

77. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 6, for reasons including but not limited to that he:

a. Prescribes excessively high doses of opioid medications which Patient 6's diagnoses do not warrant;

b. Fails to uses a long acting opioid to manage Patient 6's pain, instead of frequent dosing of a short acting opioid;

---

[32] CRISP (Chesapeake Regional Information System for our Patients) is a regional health information exchange serving Maryland and the District of Columbia. The CRISP Portal is a free tool available to participating health care providers through the internet and facilitates the sharing of patient data across institutional boundaries. Available clinical data includes information from the Prescription Drug Monitoring Program (PDMP).

c. Fails to follow-up with getting results of his imaging orders for MRI of lumbosacral spine, CT of the head, x-ray of lumbar spine, and x-ray of cervical spine; or encouraging Patient 6 to obtain the imaging;

d. Fails to order any drug screens or perform in-office drug testing of urine to ensure compliance with prescribed opioids; and

f. Failed to obtain information from the PDMP to ensure compliance with prescribed CDS.

Patient 7

78. On January 10, 2007, another health care provider in Respondent's office first saw Patient 7, then a 51 year old female, for right ankle osteoarthritis and general internal medicine conditions. Initially, the health care provider treated Patient 7's pain with Naprosyn and/or Ibuprophen.

79. In August 2012, Respondent began treating Patient 7. Respondent assessed hypertension, degenerative joint disease, hyperlipidemia, tobacco addiction, and obesity. For pain, Respondent prescribed Naprosyn and Tramadol 50 mg bid.

80. Subsequently, Patient 7 complained of low back pain and knee pain. Respondent saw Patient 7 for monthly visits.

81. On May 22, 2014, Respondent added oxycodone 10 mg bid. Respondent continued Naprosyn and Tramadol but did not offer any other treatment besides medication.

82. On August 25, 2014, Respondent escalated oxycodone 10 mg from bid to 2 tablets every 6 hrs prn. Respondent scheduled Patient 7's next appointment for 3 months later.

83. On November 25, 2014, Respondent escalated oxycodone to 10 mg 2 tablets qid. Respondent ordered a toxicology screen but there is no laboratory report in

the medical record. Respondent did not see Patient 7 again until 2 months later.

84. On March 30, 2015, Respondent's records contain the only toxicology screen in Patient 7's medical record, which showed results consistent with prescribed medications.

85. Respondent continued to see Patient 7 monthly and continued to prescribe oxycodone 10 mg 2 tablets qid until March 2016; although Respondent's medical record does not contain any notes of the visits after October 2015.

86. On February 10, 2016, Respondent prescribed Naloxone[33] as well as the "standard" dose of oxycodone 10 mg 2 tablets qid.

87. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 7, for reasons including but not limited to that he:

a. Fails to see Patient 7 for assessments every two weeks, due to her opioid dosage;

b. Fails to order frequent urine drug screens over the course of a 12 month period, in spite of documenting a plan to order a drug screen every three or four months, which still would be insufficient to confirm compliance, even if they had occurred; and

c. Solely offers opiate pain medications to Patient 7 and fails to place Patient 7 on short term pain medications while treating her condition with physical therapy, interventional treatment such as injections, surgery, weight loss, psychosocial treatment, and smoking cessation.

Patient 8[34]

88. On March 12, 2015, Respondent first saw Patient 8, a female in her mid 30's who resides in Salisbury, Maryland. Respondent noted that Patient 8 is transferring her care to Respondent so she can be seen with her husband (Patient 9) who has been receiving suboxone maintenance treatment from Respondent. Respondent documented

[33] Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing or loss of consciousness and is used to treat a narcotic overdose in an emergency situation.
[34] Patient 8 is the wife of Patient 9.

diagnoses from Patient 8's primary care provider as: morbid obesity, diabetes mellitus II, hypertension, hypercholesterolemia, generalized anxiety disorder, attention deficit disorder, chronic lower back pain, chronic left hip pain, hypothyroidism, osteoarthritis, and overactive bladder. Patient 8 also brought a list of multiple medications which her previous provider prescribed for Patient 8's internal medicine conditions, as well as oxycodone 15 mg qid, Tramadol 50 mg 1 qd, Xanax I mg bid, Adderall 20 mg tid.

89. Respondent continued prescribing the medications for the internal medicine conditions, including alprazolam and Adderall for the psychiatric conditions. Respondent added methadone 10 mg 2 tabs tid and doubled oxycodone from 15 mg qid to 30 mg qid.

90. On July 6, 2015, Respondent added Suboxone 8 mg film tid.

91. On July 23, 2015, Respondent prescribed oxycodone 30 mg qid #10, which he repeated for several months, and then continued to prescribe "just" oxycodone 30 mg 5 x qd #150.

92. Respondent's records of Patient 8 contain only one urine toxicology screen which was positive for prescribed medications and negative for illicit substances.

93. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 8, for reasons including but not limited to that he:

a. Prescribes an excessive amount of medications including medications to treat internal medicine conditions; as well medications for pain and psychiatric conditions such as oxycodone, methadone, Suboxone, alprazolam, and Adderall, for which life style changes such as diet and exercise could possibly eliminate some of the prescribed medications;

b. Fails to place Patient 8 on short term pain medication while treating Patient 8's condition with referrals for physical therapy to increase her mobility and strength and to titrate up her physical exertion, interventional treatment, and obesity counseling;

c. Fails to refer Patient 8 for a lumbar support back brace to increase support and pain relief in the lumbar spine;

d. Fails to document a clear plan of care; and

e. Prescribes Suboxone, methadone and oxycodone at the same time, which is not medically indicated.

Patient 9[35]

94. On June 10, 2014, Respondent first saw Patient 9, a male in his mid 30's, who resides in Salisbury, Maryland, for heroin and alcohol addiction. Respondent placed Patient 9 in a 12-step program and in a Suboxone maintenance program.

95. Respondent also assessed attention deficit disorder, generalized anxiety disorder, and depression.

96. Respondent prescribed Suboxone 8 mg film 32 mg daily, alprazolam 1 mg tid and Adderall 20 mg qd, in addition to medications for asthma and chronic bronchitis. Respondent added Prozac 20 mg bid.

97. Based on toxicology screening, Patient 9 continued to abuse heroin and alcohol and his level of buprenorphine was low.

98. Respondent started prescribing oxycodone 15 mg tid.

99. Respondent fails to meet standards for quality pain medicine in regard to his care and treatment of Patient 9, for reasons including but not limited to that he:

a. Prescribes Suboxone concurrently with a benzodiazepine, which increases the risk of respiratory depression;

b. Prescribes an excessively high dose of Suboxone;

c. Prescribes oxycodone to Patient 9 who is abusing heroin and alcohol and is on Suboxone treatment, which counteracts the efforts to treat his opiate addiction;

[35] Patient 9 is the husband of Patient 8.

d. Continues to prescribe CDS even though Patient 9's urine toxicology screens are regularly inconsistent with his addiction treatment program; and

e. Fails to refer Patient 9 for alcohol abuse treatment.

Patient 10

100. On September 3, 2013, Respondent first saw Patient 10, then a 49 year old male, for treatment of Patient 10's 20 year heroin addiction and cocaine abuse. Respondent also noted bi-polar disorder. Respondent prescribed Suboxone 8 mg film, 20 mg qd, which Respondent later increased to 24 mg qd, and twelve-step meetings and support group therapy.

101. On June 3, 2014, Respondent prescribed oxycodone 30 mg bid #60 for a diagnosis of kidney stones. Respondent ordered a UROCT (computed tomography urography) imaging the urinary tract to diagnose renal calculus.

102. On February 2, 2015, Patient 10 complained of pain in left flank secondary to renal cyst. Respondent prescribed oxycodone 30 mg bid #60.

103. On April 7, 2015, and again on June 2, 2015, Respondent prescribed oxycodone 30 mg 1 qd although Respondent documented on both dates, "no complaints."

104. Laboratory toxicology reports regarding Patient 10 regularly showed positive results for cocaine, heroin, marijuana, alprazolam, and/or alcohol. The toxicology reports often were negative or low for prescribed buphrenorphine.

105. On August 5, 2015, Respondent discharged Patient 10 for "noncompliance" based on negative urines.

106. Respondent fails to meet standards for quality pain medicine in regard to

his care and treatment of Patient 10, for reasons including but not limited to that he:

a. Prescribes oxycodone simultaneously with Suboxone, which exacerbates Patient 10's addiction issue;

b. Fails to impose any consequence over several years of treatment, such a closer follow-ups or discharge, for inconsistent urine drug screens, which included both negative screens for buprenorphine and low levels of a positive for buprenorphine, positive THC, benzodiazepine, opiates, alcohol, and cocaine; and

c. Fails to refer Patient 10 to an in-patient facility where he can be strictly monitored and receive intensive therapy for any underlying psychological conditions including his bipolar disorder.

IV. Summary of Individual Patients

107. Respondent's failure to meet standards for quality pain medicine in regard to his care and treatment of nine out of ten patients, in part, is the basis for Panel B's finding that the public health, safety, and welfare imperatively requires emergency action.

V. Additional Investigation of Overprescribing and Unprofessional Conduct

108. Previously, on April 21, 2016, Board staff interviewed an individual who had been Respondent's office manager ("Office Manager A") at the Falls Road office from February 22, 2016 through April 14, 2016.[36] Office Manager A stated under oath:

a. She has witnessed Respondent yelling at patients, "every day, all day;"

b. If the other doctor (Physician A) in the practice discharged a patient because the patient did not have prescribed suboxone in the urine, the patient would sit in the office all day to see Respondent because he "gives them their medicine like nothing happened;"

c. Respondent recently permitted a patient who had "pulled a knife" on the nurse practitioner, to return to the office;

d. Respondent "pre-writes" prescriptions, completely filling in the

[36] On April 20, 2016, Office Manager A approached a member of the Board's investigative staff on the Board's parking lot and stated she wanted to speak with the staff person about Respondent.

prescription, with his signature, and leaves the prescriptions in the charts. Patients are scheduled at 9:00 a.m. and every 15 minutes but Respondent often does not come in until 3:00 p.m. Respondent may "pre-write" the first 10 or 15 patients because he is going to be late. When the patient comes in the office, a staff person gives the patients the prescriptions, makes a copy for the chart, and schedules the next appointment. On Monday and Wednesday, the nurse practitioner is present at 9:00 a.m., so she sees the patients but it can be 50 to 60 patients;

e. She worked in Respondent's office from 8:30 a.m. to 10:00 p.m., 11:00 p.m., 12:00 a.m., or 1:45 a.m.;

f. On April 20, 2016, Respondent came to the office at 6:00 p.m. Sometimes he arrives at 2:00 p.m. or 4:00 p.m. There is no schedule for Respondent's arrival time;

g. Patients come four or five hours late because they know Respondent comes late, so then staff has to stay late. Patients want to wait for Respondent and not see the other doctor or the nurse practitioner because they know they are not going to be able to "talk them into" what they want;

h. Patients sit in the parking lot waiting for Respondent to come in so they can go in the office, even if they don't have appointments. At times Respondent will have 70 patients instead of 50 or 60;

i. Patients want Respondent to be their internal medicine physician but the insurance companies do not have him listed as an internal medicine doctor;

j. Suboxone clinic is on Tuesdays and Thursday. Pain management and urology are on Mondays and Wednesdays. Respondent sees approximately 50 to 60 patients a day;

k. Respondent sees patients on Fridays, Saturdays, and Sundays. If they call his cell phone and if he is in the office, he will see them; and

l. She left Respondent's employ because she was not willing to work until 10:00 or 11:00 p.m., or later.

109. On Friday, April 22, 2016, Board staff conducted an unannounced visit at Respondent's Falls Road office. There were two patients present; even though office staff had informed Board staff that Respondent does not see patients on Fridays. One patient asked where Respondent was. The patient said that he had just called

Respondent and Respondent has left something for him. The medical assistant checked the patient's chart and informed the patient that she had "nothing for him today."

110. On May 5, 2016, Board staff interviewed Physician A who stated under oath:

a. Physician A is board-certified in internal medicine and maintains an office for primary care. Physician A is certified to prescribe buprenorphine;

b. Physician A practiced at Respondent's Falls Road office from January 2015, where she provided OBOT until March 2016, when she resigned because of "lack of organization," a lot of staff turnover, low staff morale, and "chaotic atmosphere";

c. A major complaint of the staff was the long hours;

d. Physician A worked on Thursdays from 9:00 a.m. to 2:00 p.m. Some patients came in at noon for a 9:00 a.m. appointment but she could not stay to see patients who were late;

e. On average, Physician A saw 10 to 15 patients a day; those who were employed and could reliably be seen on time;

f. Respondent was never in the office seeing patients when Physician A was present;

g. On occasion, the office manager handed a prescription to a patient, when Respondent was not in the office; and

h. The patients complained because Respondent would be hours late for his appointments.

111. On July 19, 2016, Board staff interviewed another individual who had been a former office manager for Respondent ("Office Manager B") who testified under oath:

a. Office Manager B worked for Respondent beginning in October or November 2014, until Respondent fired her, sometime in 2015, after he moved to the Falls Road office;

b. Office Manager B had concerns that Respondent often wrote prescriptions for Suboxone maintenance the day before the patients came to the Suboxone clinic. Office staff would obtain the patients' blood pressure, document in the chart, make a copy of the prescriptions, give the patients

the prescriptions and schedule the follow-up appointment. Respondent did not see the patients; and

c. When Respondent was in the office, sometimes he saw patients until 10:30 p.m.

112. On August 17, 2016, Board staff interviewed an individual who has been employed by Respondent as a medical assistant who testified under oath:

a. She worked for Respondent from April or May 2014 through November 2014, when Respondent terminated her;

b. Respondent was "gracious" in giving opioids. Respondent prescribed oxycodone "a lot";

c. Respondent allowed Suboxone patients whose urines were "dirty" to stay on Suboxone;

d. Respondent prescribed opioids to patients who were on Suboxone;

e. Respondent gave patients their Suboxone prescriptions "early";

f. Ninety percent of the patients were coming for an opioid or Suboxone;

g. Respondent allowed patients behind the desk where he had patient charts;

h. Respondent allowed patients to come in the office to be seen even after office hours;

i. Patients would have appointments for 9:00 a.m. but Respondent did not get to the office until 12:00 noon. He would leave the office while patients were still there and be gone for four hours; and

j. Respondent frequently wrote out prescriptions the day before the patients' came in the office. If Respondent did not come to the office, Respondent asked staff to give the patients the prescription which he had left in the patients' charts. The charts would be "everywhere".

k. There was a high staff turnover.

113. On October 28, 2016, the Board staff interviewed Patient 11, who testified under oath:

a. Respondent is Patient 11's "mental health doctor and my primary care physician";

b. Patient 11's initial appointment was for 12:30 p.m. on September 28, or 29, 2015 at the Falls Road office. Patient 11 presented at 12:30 p.m. Respondent did not arrive until 2:00 or 2:30 p.m.; but then left the office "to go to lunch";

c. Patients were in the office, some still waiting to be seen for a 9:30 a.m. appointment;

d. Respondent started seeing patients at 4:00 p.m. Respondent told some patients who had waited nine or ten hours to be seen that he was not going to fill their prescriptions and arguments between Respondent and those patients ensued;

e. While waiting for his appointment, around 8:00 p.m., Patient 11 witnessed Respondent and a female patient in front of other patients in a loud verbal argument that included Respondent's threat of physical violence. Respondent used a racial epithet and told the patient to "get the f--k out of (his) building." Respondent "put his hands on" the female patient and Patient 11 and other patients had to "pull him back";

f. Around 1:00 a.m., Respondent stated that he was not going to see Patient 11 and another patient who had been waiting since 12:30 p.m. The receptionist spoke to Respondent and Respondent finally agreed to see Patient 11 at 1:00 a.m.;

g. Respondent prescribed Lamictal,[37] Flowmax,[38] and alprazolam;

h. Approximately one month later, Patient 11 returned for a 2:30 p.m. appointment. Respondent arrived around 3:00 pm but did not start seeing patients until 4:00 p.m. There were approximately 25 patients waiting to be seen;

i. Respondent saw Patient 11 at 11:00 p.m. and wrote his prescriptions for three months;

j. Thereafter, until June 2016, Patient 11 saw a nurse practitioner at Respondent's office; and

k. Since June 2016, after the nurse practitioner "quit," Patient 11 calls

---

[37] Lamictal (lamotrigine) is an anti-epileptic medication used to treat epileptic seizures. Lamotrigine is also used to delay mood episodes in adults with bipolar disorder.

[38] Flowmax is used to improve urination in men with benign prostatic hyperplasia.

the Respondent's office and then picks up his prescriptions from office staff.

114. On Thursday, November 3, 2016, at approximately 12 noon, Board staff conducted an unannounced office visit at Respondent's Falls Road office to serve a subpoena to Respondent for Patient 11's medical record. Respondent was not present. Board staff obtained Patient 11's record from office staff.

115. On Thursday, December 1, 2016, at 2:15 p.m., in follow-up of the anonymous complaint of November 16, 2016, Board staff conducted an unannounced visit of Respondent's Falls Road office. Respondent was not present. Office staff were unable to tell Board staff when and whether Respondent would arrive. Patients were present in the office, inquiring about Respondent. Eleven patients had signed the sign-in sheet, starting at 12 noon, although office staff would not disclose to Board staff a name of the healthcare provider who had seen or was going to see the patients.

VI. Summary of Individual Patients

116. Respondent's practicing pain medicine, a medical specialty for which he has had no training, his failure to maintain consistent, predicable office hours and to be available by telephone to pharmacists, the lack of organization in his practice and the level of chaos and near violence in the office, his lack of control over his patients, his rapidly increasing his "pain management" practice to levels that he could not adequately treat, and his lack of timely responses to the Board's investigative subpoenas, are unprofessional, and in part, are the basis for Panel B's finding that the public health, safety, and welfare imperatively requires emergency action.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, the Board concludes as a

matter of law that the public health, safety, or welfare imperatively requires emergency action, and that pursuant to Md. Code Ann., State Gov't II § 10-226(c)(2), Respondent's license must be immediately suspended.

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law;

It is by an affirmative vote of a majority of the quorum of Panel B;

ORDERED that pursuant to the authority vested in Panel B by Md. Code Ann., State Govt. II § 10-226(c)(2) (2014 Repl. Vol. and 2016 Supp.), Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED;** and it is further

ORDERED that a post-deprivation hearing on the summary suspension in accordance with Md. Code Regs. 10.32.02.08 B(7) will be held on **Wednesday, May 24, 2017 at 1:00 p.m.** at the Maryland Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland, 21215-0095; and it is further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing before Panel B, Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days, an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that on presentation of this Order, Respondent **SHALL SURRENDER** to Board staff the following items:

(1) Respondent's original Maryland license D26832; and

(2) Respondent's current license renewal certificate, and it is further

ORDERED that a copy of the Order of Suspension shall be filed with Panel B immediately in accordance with Health Occ. II § 14-407 (2014 Repl. Vol.); and it is further

ORDERED that this is an Order of Panel B, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen Prov. §§ 4-101 et *seq.*

05/09/2017
Date

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