

IN THE MATTER OF	*	BEFORE THE
CHARLES WILLIAM DAVIS, II, M.D.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: D66013	*	Case Number: 2016-0857A

\* \* \* \* \*

CONSENT ORDER

On May 2, 2017, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged **CHARLES WILLIAM DAVIS, II, M.D.**, (the "Respondent"), License Number D66013, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* (2014 Repl. Vol.).

Specifically, Disciplinary Panel A charged the Respondent with violating the following provisions of the Act under Health Occ. II § 14-404:

(a) *In general.* - Subject to the hearing provisions of §14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee is:

(3) Is guilty of:

...

(ii) Unprofessional conduct in the practice of medicine[.]

The pertinent provisions of Health Occ. II § 15-302 provide as follows:

(a) *In general.* - A physician may delegate medical acts to a physician assistant only after:

...

(2) Any advanced duties have been authorized as required under subsection (c) of this section.

(b) Contents. - The delegation agreement shall contain:

...

- (4) A description of the delegated medical acts that are within the primary or alternate supervising physician's scope of practice and require specialized education or training that is consistent with accepted medical practice[.]

The pertinent provisions of Md. Code Regs. ("COMAR") 10.32.03 provide as follows:

**.05 Delegation Agreements - Contents**

A. Before a physician may delegate medical acts and before a physician assistant may perform medical acts, the physician assistant and primary supervising physician shall file with the Board: (1) A delegation agreement on the Board-approved form [.]

B. The delegation agreement shall include the following information: (6) The delegated medical acts which the physician assistant will perform, including: (b) Any advanced duties[.]

**.07 Supervising Physicians.**

A. A primary supervising physician shall: (5) Obtain approval for the delegation of any advanced duties as specified in Regulation .06C, D, or E of this chapter;

**.11 Prohibited Conduct.**

C. Unprofessional conduct in the practice of medicine, Health Occupations Article, §14-404(a)(3), Annotated Code of Maryland, includes the failure of a physician to comply with the statute and regulations governing the physician's duty to supervise the physician assistant.

On September 13, 2017, a settlement conference was held before Disciplinary Panel A, serving as the Disciplinary Committee on Case Resolution ("DCCR"). As a resolution of this matter, the Respondent agreed to enter into this public Consent Order consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

## FINDINGS OF FACT

Disciplinary Panel A makes the following Findings of Fact:

### **I. BACKGROUND**

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on May 8, 2007. His Maryland license is active through September 30, 2018.
2. The Respondent also holds active licenses to practice medicine in Virginia and Florida.
3. The Respondent is board-certified in orthopedic surgery.
4. The Respondent maintained clinical privileges at a hospital ("Hospital A")<sup>1</sup> in Maryland until April 11, 2016. The Respondent also maintained clinical privileges at another Maryland hospital ("Hospital B") from 2009 until 2014.
5. The Respondent owns a private orthopedic surgery practice in Maryland and is the supervising physician for a physician assistant ("Physician Assistant A").
6. The Respondent has been Physician Assistant A's supervising physician since 2013. The Respondent and Physician Assistant A have never applied for advanced duties with the Board.
7. On April 21, 2016, the Board received a Mandated 10-Day Report (the "Report") from Hospital A stating that the Medical Executive Committee ("MEC") affirmed the summary suspension of the Respondent's clinical privileges, which was made effective on April 11, 2016. Hospital A summarily suspended the Respondent because the Respondent reportedly "directed, or otherwise permitted, his physician assistant ("PA") to perform irrigation and debridement of posterior thoracolumbar spine and removal of

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<sup>1</sup> In order to maintain confidentiality, names will not be used in these Charges.

hardware consisting of bilateral pedicle screws and spanning rods on March 31, 2016, which was determined to be outside the scope of the PA's Delegation Agreement."<sup>2</sup> Furthermore, the Report stated that the Respondent did not scrub into the case.

8. The MEC affirmed the summary suspension "in the context of [the Respondent's] prior history at Hospital A . . . as a precautionary measure pending further investigation."

9. Thereafter, the Board initiated an investigation.

## **II. Supervision of Physician Assistant A**

10. By letter dated May 2, 2016, the Board notified the Respondent of its investigation and requested a written response. The Board received the Respondent's written response on or about June 13, 2016.

11. In his written response, the Respondent acknowledged that he directed Physician Assistant A to perform the procedure on March 31, 2016, which consisted of removing ten (10) screws and an internal spanning rod. The Respondent also acknowledged that he was present in the operating room for the duration of the procedure but was not scrubbed in during the procedure.

12. On September 12, 2016, the Board interviewed Hospital A's Chief of Surgery ("Physician A"). Physician A stated that on or about May 14, 2015, he informally spoke with the Respondent and Physician Assistant A regarding the Respondent's allowing Physician Assistant A to perform acts outside the scope of her Delegation Agreement.

13. Physician A memorialized his conversation with the Respondent and Physician Assistant A in handwritten notes. Physician A documented the following:

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<sup>2</sup> Hospital A also summarily suspended Physician Assistant A's clinical privileges and reported the same to the Board (Companion Case Number: 2016-0858A). However, the MEC lifted Physician Assistant A's summary suspension after one day because it determined that Physician Assistant A was acting at the Respondent's direction.

After the meeting I spoke with [the Respondent] and [Physician Assistant A], his PA, about the about [sic] of work he is allowing her to do independently. I emphasized that she's acting outside the scope of practice and can lose her license if this is reported. I indicated to [the Respondent] that his continued participation in this practice may result in a suspension from the MEC and may jeopardize his medical license. After some bantering about it, he agreed to abide by this.

14. On October 11, 2016, the Board's staff interviewed Physician Assistant A under oath.

15. Physician Assistant A stated that "a few months prior" to the case on March 31, 2016, she and the Respondent had an "unofficial meeting" with Physician A, during which Physician A reminded the Respondent of his duty to scrub in for cases.

16. Physician Assistant A stated that she and the Respondent agreed that in the future the Respondent would scrub in on all cases with Physician Assistant A.

17. However, Physician Assistant A stated that the Respondent did not scrub in on the procedure on March 31, 2016 and that she performed the procedure on her own.

18. On February 2, 2017, the Board's staff interviewed the Respondent under oath.

19. The Respondent confirmed that he did not scrub in for the procedure on March 31, 2016.<sup>3</sup>

20. The Respondent stated that he never made the patient aware that he would not be scrubbing in or that Physician Assistant A would perform the procedure on her own.

21. During the Respondent's interview with Board staff, the Respondent stated that on a previous occasion, Physician A counseled him and Physician Assistant A regarding his failure to scrub in on procedures. The Respondent stated that Physician A only asked that "an attending," not necessarily the Respondent, scrub in on all

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<sup>3</sup> A plastic surgeon ("Physician B") was present for a portion of the case. On April 14, 2016, Physician Assistant A added Physician B as an alternate supervising physician on her Delegation Agreement.

procedures with Physician Assistant A. The Respondent reasoned that because Physician B had scrubbed in on the case, he did not have to scrub in as well.

22. The Respondent denied that Physician A previously counseled him about allowing Physician Assistant A to perform procedures outside the scope of her practice, and denied that Physician A explained the potential disciplinary consequences of this conduct.

23. The Respondent stated that he believed that Physician Assistant A was permitted to remove hardware under the section 18a of the Delegation Agreement, which states that the "Physician Assistant will practice only within the scope of practice of the primary supervising physician[.]"

24. Physician Assistant A's Delegation Agreement on file with the Board includes the following delegated medical acts: "Conduct histories and physical, interpret and evaluate patient data, interpret and evaluate imaging studies, first assist in surgery, hospital rounding." The Delegation Agreement does not include any advanced duties.

25. Hospital A provided a list of Physician Assistant A's approved advanced duties for the period of January 1, 2015 through December 31, 2016. The list does not include the removal of hardware from the spine.

26. By permitting Physician Assistant A to perform advanced duties that were outside the scope of Physician Assistant A's Delegation Agreement, the Respondent engaged in unprofessional conduct, in violation of Health Occ. II § 14-404(a)(3)(ii).

### **III. Unprofessional Conduct**

27. The Board's investigation revealed multiple instances of the Respondent's unprofessional conduct at Hospital A and Hospital B.

**A. Hospital A**

28. In furtherance of the Board's investigation, the Board issued a subpoena to Hospital A for the Respondent's Quality Assurance/Risk Management ("QA/RM") file.

29. The Respondent's QA/RM file contained a letter of formal reprimand ("Formal Reprimand"), dated April 16, 2016. The Formal Reprimand documented an incident that occurred on April 10, 2014, during which the Respondent "used foul and abusive language and an overtly physically intimidating manner" toward a radiology technician ("RT").

30. The Formal Reprimand also referenced other inappropriate conduct on April 10, 2014, including the Respondent's self-administering intravenous ("IV") saline because of dehydration due to alcohol consumption and risking patient safety by performing a surgical procedure while so dehydrated that he required an IV.

31. The Formal Reprimand referred the Respondent to the Maryland Physicians Health Program ("MPHP") for an evaluation regarding anger management and required him to follow all of MPHP's recommendations.

32. On February 14, 2017, the Board's staff interviewed the RT, who was employed at Hospital A for 30 years and worked directly with the Respondent in the operating room.

33. The RT stated that on April 10, 2014, she was preparing to take an x-ray during a procedure with the Respondent when another physician entered the operating room without a lead apron. The RT waited for the physician to either exit the operating room or put on a lead apron, causing the Respondent to yell, "Shoot the {expletive} {expletive}"

x-ray! What the {expletive} is wrong with you? I said shoot!" According to the RT, when she did not respond to the Respondent, he ordered her to "get the {expletive} out!"

34. The RT stated that she entered the substerile pod that was adjacent to the operating room to call the radiology department and request another technician. The RT stated that as she hung up the telephone, the Respondent entered the substerile pod, backed her against the wall, and "got in my face with his face," saying, "What the {expletive} is wrong with you, why don't you answer me?" The RT stated that she was "terrified" and "afraid to say anything" in response to the Respondent.

35. The RT stated that she reported the incident to her supervisor, the operating room manager and Hospital A human resources.

36. The Board's staff interviewed a certified registered nurse anesthetist (the "CRNA"), who was assigned to many of the Respondent's surgical cases. The CRNA also witnessed the incident involving the Respondent and the RT. The CRNA stated that the Respondent was "verbally abusive" toward the RT.

37. The CRNA remained in the operating room to provide care for the patient and stated that the Respondent left the operating room after the RT.

38. The CRNA further stated that in or around December 2015, he was involved in an incident with the Respondent, wherein the Respondent used expletives and said to the CRNA, "If you can't do what I {expletive} want, then get the {expletive} out of my room." As a result, the CRNA left the operating room and reported the incident to his attending anesthesiologist.

39. The CRNA further stated that he witnessed the Respondent in the operating room receiving IV saline in his arm prior to the start of a procedure. According to the



CRNA, another staff member started the IV on the Respondent, who was seated at a desk in the operating room.

40. The CRNA stated that prior to the procedure, the Respondent disclosed that he had attended a concert the night before and was dehydrated from drinking alcohol.

41. During this time, according to the CRNA, the patient was anesthetized in the operating room.

42. The RT also stated that she observed the Respondent with an IV line in his arm attached to a bag of saline IV fluid. She stated that she asked the Respondent what was wrong, and the Respondent stated that he was a little dehydrated from drinking alcohol the night before.

43. During his interview with the Board's staff, the CRNA further stated that Physician Assistant A typically started the Respondent's procedures and that the Respondent scrubbed in when it came time to put in hardware, then often left the operating room and allowed Physician Assistant A to "finish up and close."

44. In addition, both the RT and the CRNA stated that they witnessed the Respondent vaping<sup>4</sup> (or smoking e-cigarettes) in the operating room and surgeon's lounge.

45. The CRNA also stated that he witnessed the Respondent vaping before and after procedures in the operating room on at least three dozen occasions.

46. According to the CRNA, the Respondent sat at the nurse's desk in the operating room with the bottom half of his scrub mask untied to allow the e-cigarette to fit underneath his scrub mask.

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<sup>4</sup> Vaping is the act of inhaling and exhaling the water vapor produced by an electronic device called a vaporizer or e-cigarette.

47. The CRNA stated that he discussed with the Respondent the CRNA's concerns about the Respondent's use of e-cigarettes in the operating room, but the Respondent continued to vape.

48. The CRNA also reported the Respondent's use of e-cigarettes to Hospital A management.

49. The RT also stated that on four-to-five occasions, she observed the Respondent using e-cigarettes in the operating room, approximately six to eight feet from the patient.

50. On December 6, 2016, the Board's staff interviewed a surgical technician (the "surgical tech") at Hospital A. The surgical tech has been employed at Hospital A for over 20 years.

51. The surgical tech described an incident with the Respondent in which the surgical tech paged the Respondent, twice, to the front desk because he was being called to mark his patient for surgery. According to the surgical tech, the Respondent responded to the front desk yelling, "Who keeps calling me?" The surgical tech stated that she said, "Don't kill the messenger. It was me. They need you in the room to mark the patient."

52. The surgical tech stated that the Respondent leaned in and in a threatening manner said, "I'll kill the messenger if I want to kill the messenger."

53. According to the surgical tech, this incident was witnessed by at least one other Hospital A staff member, who advised the surgical tech to write up the incident.

54. The surgical tech also stated that on one occasion she observed the Respondent smoking an e-cigarette in the surgeon's lounge.

55. On December 6, 2016, the Board's staff interviewed the attending anesthesiologist ("Physician C"), who is also the Director of Quality Assurance for the Department of Anesthesia at Hospital A.

56. Physician C stated that on one occasion, toward the end of a procedure, he observed the Respondent vaping in the operating room. Physician C stated that the Respondent was seated at a desk approximately 10-15 feet away from the anesthesia equipment and operating table.

57. Physician C brought the Respondent's conduct to Hospital A's attention because Physician C perceived the use of an e-cigarette in the operating room as a safety risk.

58. Physician C also witnessed the Respondent vaping on a "handful" of occasions in the surgeon's lounge.

59. On one occasion, Physician C stated that as he walked out of the anesthesia office, "it almost smelled like someone was burning rubbish or burning leaves" in the operating room. Physician C then observed the Respondent, along with medical supply representatives,<sup>5</sup> vaping in the surgeon's lounge.

60. The Board staff also asked Physician A about the Respondent's alleged unprofessional conduct at Hospital A. Physician A stated that the Respondent has a reputation for "being a bully" and for being "rough and abusive."

61. Physician A confirmed that he spoke to the Respondent regarding the incident when the Respondent was observed with a saline IV in his arm before a procedure. Physician A stated that he told the Respondent that this practice was unacceptable and the Respondent stated that "he didn't know it was wrong and he did it all the time."

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<sup>5</sup> Several Hospital A employees noted that the Respondent was often accompanied in the operating room with medical or drug representatives.

62. Physician A stated that the Respondent was also counseled multiple times regarding his delinquent record keeping. The Respondent was frequently deficient, sometimes for weeks at a time, in completing and submitting his operative notes.

63. During the Respondent's interview, the Board's staff asked him about his conduct at Hospital A.

64. The Respondent acknowledged that he received an IV of saline prior to a procedure. However, the Respondent stated that he was feeling "under the weather" and another provider offered to give him an IV of saline. The Respondent denied telling operating room staff that he was dehydrated from drinking alcohol the night before, and denied that the patient was in the operating room.

65. The Respondent admitted to vaping in the operating room twice, approximately 10 feet from the patient. He could not recall whether the patient was in the room on either occasion. He further stated that Physician A counseled him for vaping in the operating room and that he was unaware of Hospital A's policy about vaping.

66. The Respondent stated that he began vaping only in the surgeon's lounge after Physician A counseled him about not vaping in the operating room.

67. The Respondent stated that he knew of "no literature to support" the argument that the use of e-cigarettes in the operating room poses a patient safety issue or fire hazard.

68. By verbally abusing Hospital A staff, using profanity, using threatening and intimidating behavior, smoking e-cigarettes in the operating room and surgeon's lounge, and self-administering a saline IV, the Respondent engaged in unprofessional conduct, in violation of Health Occ. II §14-404(a)(3)(ii).

**B. Hospital B**

69. In furtherance of the Board's investigation, the Board's staff issued a subpoena to Hospital B for the Respondent's QA/RM file.

70. The Respondent's Hospital B QA/RM file contains documentation of similar instances of unprofessional conduct, including:

- a. Allowing his physician assistant to perform cases without his supervision;
- b. Yelling, name-calling, and using threatening/intimidating behavior;
- c. Using extreme profanity; and
- d. Playing vulgar and offensive music at an "alarmingly" high volume in the operating room.

71. According to the Respondent's QA/RM file, in September 2010, a Hospital B employee reported an anonymous complaint to the Compliance Hotline, alleging that the Respondent played highly offensive and vulgar music in the operating room. Following that complaint, Hospital B interviewed seven staff members who substantiated the anonymous complaint.

72. Hospital B counseled the Respondent regarding his conduct.

73. The Respondent's Hospital B QA/RM file contained documentation of approximately four additional instances where the Respondent engaged in unprofessional conduct between December 2010 and December 2011.

74. For instance, in December 2010, a resident reported an incident in which the Respondent yelled "shut your mouth!" at the resident, tore up documentation in a patient's medical record and used profanity while speaking to the resident.

75. Hospital B counseled the Respondent regarding his conduct.

76. Further, on April 28, 2011, a Hospital B physician assistant ("Physician Assistant B") provided written documentation of her interactions with the Respondent. Physician Assistant B stated that because the Respondent and his physician assistant round on their own patients, she did not address a particular patient's slightly elevated white blood cell count. Physician Assistant B stated that the Respondent called her "god-damn lazy." Physician Assistant B also documented two additional incidents in which the Respondent acted unprofessionally toward her.

77. Two Hospital B staff members documented an incident in which the Respondent spoke rudely to Hospital B's Patient Care Manager, who was attempting to speak to the Respondent privately about issues that the nursing staff had with the Respondent. According to the Patient Care Manager and one witness, the Respondent spoke with an increasingly raised voice in front of patient family members and other staff.

78. As a result of multiple complaints of the Respondent's unprofessional conduct, on December 21, 2011, the Respondent entered into a Behavioral Improvement Plan ("the Plan") to address "ongoing concerns of [his] intolerable behavior." The Plan required the Respondent to seek professional behavior modification counseling and to provide monthly reports to Hospital B.

79. The Respondent's QA/RM file also contained documentation on an additional incident on or about September 19, 2013. Hospital B learned that the Respondent was observed in the surgeon's lounge after the documented start time of a surgical procedure for his patient. The documented incision time was 0908 and the Respondent entered the operating room at 0933.

80. The Respondent's QA/RM file contained documentation of a subsequent incident in March 2013 in which the Respondent was absent from the operating room for 45-60 minutes during a surgery. The surgery was taking longer than anticipated, prompting concern, which led to the discovery of a physician assistant and a medical student performing the surgery, including the insertion of screws.

81. Hospital B contacted the Respondent regarding his absence from the operating room during the procedure. The Respondent provided a written response, in which he explained his policy of allowing breaks during long procedures to allow operating room staff to rest and use the bathroom. He also stated that another patient met him at the hospital to view an MRI and due to difficulties with the computer, he was absent longer than expected.

82. The Respondent further stated that he has "at no time allowed a pedicle screw to be placed without my direct supervision and I believe that the individual that had reported that I had was in error[.]"

83. In September 2013, the Respondent formally released his reserved surgical time at Hospital B. In April 2014, the Respondent resigned his Hospital B clinical privileges.

84. On May 13, 2016, the Respondent requested that Hospital B reinstate his clinical privileges. However, Hospital B declined the Respondent's request, stating, "at this time, there is no interest in your return to [Hospital B]."

85. By verbally abusing Hospital B staff, using profanity, using threatening and intimidating behavior, the Respondent engaged in unprofessional conduct, in violation of Health Occ. II §14-404(a)(3)(ii).

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel A concludes as a matter of law that the Respondent violated Md. Code Ann., Health Occ. II § 14-404(a)(3)(ii) (unprofessional conduct in the practice of medicine); § 15-302(a)(2) and (b)(4) (requiring that advanced duties performed by physician assistants are authorized by the Board and consistent with accepted medical practice); and COMAR 10.32.03.05B(6)(b), COMAR 10.32.03.07A(5) and COMAR 10.32.03.11C (requiring a delegation agreement for the delegated medical acts that the physician assistant will perform, Board approval for advanced duties, and supervision of the Physician Assistant by a physician).

## ORDER

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

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

**ORDERED** that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS**.<sup>6</sup> During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1. Within 10 days, the Respondent shall enroll in the Maryland Professional Rehabilitation Program ("MPRP"). The Respondent shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP. The Respondent shall fully and timely cooperate and comply with all of MPRP's referrals, rules, and requirements, including but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered into with MPRP and shall fully participate and comply with all therapy, treatment, evaluations, and toxicology screening as directed by MPRP;

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<sup>6</sup> If the Respondent's license expires while the Respondent is on probation, the probationary period will be tolled.



2. The Respondent shall sign and update the written release/consent forms requested or required by the Board and MPRP. The Respondent shall sign the release/consent forms to authorize MPRP to make verbal and written disclosures to the Board, including disclosure of any and all MPRP records and files possessed by MPRP. The Respondent shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of the Respondent's current therapists and treatment providers) verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the medical records of the Respondent, including, but not limited to, mental health and drug or alcohol treatment records;
3. Respondent may not supervise any physician's assistants during the probationary period; and
4. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. § 14-101 – 14-702, and all laws and regulations governing the practice of medicine in Maryland.

**AND IT IS FURTHER ORDERED** that, after **TWO (2) YEARS**, the Respondent may submit a written petition to the Board requesting termination of probation. There shall be no early termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Disciplinary Panel A. The Respondent may be required to appear before the Board or Disciplinary Panel A to discuss his petition for termination. The Board or Disciplinary Panel A will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

**ORDERED** that within **ONE (1) YEAR** of the date of this Consent Order, the Respondent shall pay a civil fine in the amount of \$10,000.00 by money order or bank certified check made payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297, for deposit into the General Fund of Maryland; and it is further

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

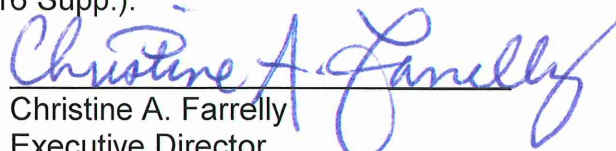
**ORDERED** that, after the appropriate hearing, if the Board or Disciplinary Panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Disciplinary Panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Disciplinary Panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

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

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

**ORDERED** that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 – 4-601 (2014 & 2016 Supp.).

10/30/2017  
Date

  
Christine A. Farrelly  
Executive Director  
Maryland State Board of Physicians

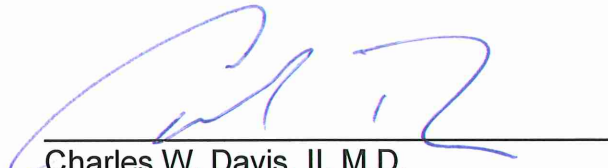
**CONSENT**

I, Charles W. Davis, II, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

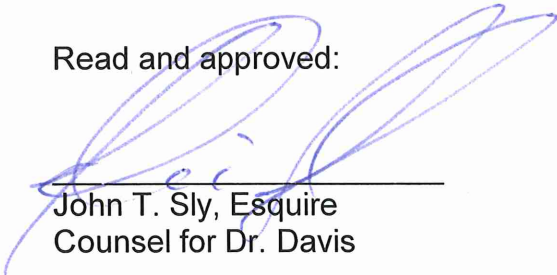
I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections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

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

10/26/17  
Date

  
Charles W. Davis, II, M.D.  
Respondent

Read and approved:

  
John T. Sly, Esquire  
Counsel for Dr. Davis

**NOTARY**

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 26<sup>TH</sup> day of October,  
2017, before me, a Notary Public of the foregoing State and City/County personally  
appear Charles W. Davis, II, M.D., and made oath in due form of law that signing the  
foregoing Consent Order was his voluntary act and deed.

**AS WITNESSETH** my hand and notary seal.

Alicia Lyn Moskal  
Notary Public

My commission expires:

ALICIA LYN MOSKAL  
NOTARY PUBLIC STATE OF MARYLAND  
My Commission Expires ~~October 5, 2017~~

10-05-2021