

IN THE MATTER OF	*	BEFORE THE
BRYAN S. WILLIAMS, M.D.	*	MARYLAND STATE
Respondent.	*	BOARD OF PHYSICIANS
License Number: D66774	*	Case Numbers: 2015-0725B, 2016-0824B
		2016-0830B, 2016-0860B, 2016-0904B
* * * * *	*	* * * * *

FINAL DECISION AND ORDER

INTRODUCTION

On April 4, 2016, Disciplinary Panel B of the Maryland State Board of Physicians (“Panel B”) charged Bryan S. Williams, M.D. with immoral and unprofessional conduct in the practice of medicine, willfully making or filing a false report in the practice of medicine, and willfully making a false representation when seeking or making application for licensure. *See* Md. Code Ann., Health Occupations (“Health Occ.”) §§ 14-404(a)(3), (11), and (36). The charges also alleged that Dr. Williams violated the Board’s sexual misconduct regulations, COMAR 10.32.17.01-.03, by inappropriately touching three female patients when performing physical examinations.

After the charges were issued, the Board received complaints from additional patients who reported similar allegations regarding Dr. Williams’s conduct. On May 18, 2016, following the receipt of the additional complaints, Panel B summarily suspended Dr. Williams’s license to practice medicine. On May 25, 2016, Dr. Williams was provided with the opportunity to show cause as to why the summary suspension should not be continued. Following the hearing, Panel B concluded that Dr. Williams continued to present a substantial likelihood of a risk of serious harm to the public health, safety, or welfare and voted to affirm the summary suspension. Dr. Williams initially requested a full evidentiary hearing before an Administrative Law Judge (“ALJ”) at the Office of Administrative Hearings (“OAH”), but withdrew the request for a

hearing prior to the scheduled hearing date. Accordingly, the summary suspension remains in effect.

On May 27, 2016, Disciplinary Panel B issued amended charges, which added the allegations of four additional patients to the original charges, pursuant to the same disciplinary grounds. The amended charges were forwarded to OAH for an evidentiary hearing and a proposed decision. A six-day hearing was held before an ALJ at OAH. On February 13, 2017, the ALJ issued a proposed decision concluding that Dr. Williams was guilty of unprofessional and immoral conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3); willfully made or filed a false report in the practice of medicine, in violation of Health Occ. § 14-404(a)(11); and willfully made a false representation when seeking or making application for licensure or any other application related to the practice of medicine, in violation of Health Occ. § 14-404(a)(36). The ALJ proposed that the amended charges be upheld and recommended the permanent revocation of Dr. Williams's medical license.

On March 6, 2017, Dr. Williams filed exceptions to the ALJ's proposed decision, and the State filed a response to Dr. Williams's exceptions. On May 10, 2017, both parties appeared before Disciplinary Panel A ("Panel A" or "the Panel") of the Board for an exceptions hearing.

FINDINGS OF FACT

At all times relevant to this proceeding, Dr. Williams was a licensed physician in the State of Maryland, initially licensed on October 18, 2007. From November 2010 through October 2014, Dr. Williams was employed as an interventional pain management specialist at Facility A.¹ The charges in this case concerned Dr. Williams's inappropriate touching of seven

¹ The names of patients, other individuals, and facilities have been redacted for confidentiality reasons.

female patients.² Panel A adopts the findings of fact made by the ALJ for Patients 2-6 as well as the facts surrounding Dr. Williams's termination from Facility A, his employment with Facility B, and his application to Facility C. The ALJ's Proposed Findings of Fact 1 – 8, 44 – 171, and 193 – 206 are incorporated by reference into the body of this document as if set forth in full, except as otherwise provided herein.³ *See* attached ALJ Proposed Decision, Exhibit 1. The Findings of Fact were proven by the preponderance of the evidence.

EXCEPTIONS⁴

Dr. Williams filed five exceptions to the ALJ's proposed decision and, additionally, challenged the ALJ's factual and credibility findings related to the seven patients who made allegations against Dr. Williams. Each of Dr. Williams's exceptions will be discussed in turn.

I. Facility A Subpoena and Investigation (Exceptions 1 and 2)

On August 18, 2016, the ALJ conducted a scheduling conference at OAH and indicated to the parties that Dr. Williams could ask OAH to issue subpoenas to Facility A to produce its investigation notes pertaining to the in-house investigation conducted based on Patient 1's complaint. The ALJ stated, "[i]t is up to [Facility A] either to comply with or move to quash the subpoena." On September 19, 2016, the ALJ held a prehearing conference to address, in part, any dispute that might arise from Dr. Williams's subpoena for Facility A's investigative notes.

On September 26, 2016, OAH issued seven subpoenas requested by Dr. Williams, including one to Facility A. The subpoena issued to Facility A required a Facility A employee to appear at the hearing scheduled for November 14, 2016, and produce "[a]ny/all notes made by

² For purposes of confidentiality, the patients involved in this case will be identified as Patients 1-7.

³ Except as indicated in this Order, the Panel does not adopt the discussion section of the ALJ's Proposed Decision.

⁴ Dr. Williams does not take exception to the ALJ's proposed findings of fact and conclusions of law that he willfully filed a false report or record in the practice of medicine, in violation of Health Occ. § 14-404(a)(11), and willfully made a false representation when making application for licensure, in violation of Health Occ. § 14-404(a)(36). The Panel adopts the ALJ's findings of fact and conclusions of law with respect to these two charges.

[Patient 1], [Physician A], [Physician B], [Employee A] or Dr. Bryan Williams regarding the complaint made by [Patient 1] and investigated by [Facility A].” On November 4, 2016, Facility A filed a motion to quash the subpoena. On November 9, 2016, the ALJ issued a ruling on Facility A’s motion to quash, stating that he considered the matter closed based on the untimely filing of Facility A’s motion to quash and, therefore, did not rule on Facility A’s motion “one way or another.”⁵ The ALJ acknowledged at the hearing that the subpoenas were not quashed, but that he did “not consider the subpoena outstanding at this point[.]”

Dr. Williams argues that the ALJ erred by failing to enforce the subpoena that was issued to Facility A for the notes associated with the internal investigation Facility A conducted regarding the allegations made by Patient 1. Dr. Williams also argues that the ALJ erred by refusing to allow him to question witnesses from Facility A regarding the investigation. The State responded that the investigation conducted by Facility A was an independent investigation, which was not part of the Board’s investigation and, therefore, not relevant to the proceedings in the case.

The subpoena in question was issued by OAH on September 26, 2016. There is nothing in the record to suggest that the subpoena was improperly served. Facility A filed a motion to quash the subpoena on November 4, 2016, citing attorney-client and work product doctrine privileges. The ALJ did not rule on the motion one way or another, but considered the matter closed based on Facility A’s untimely filed motion to quash based on the deadline imposed by the ALJ. Because, however, the subpoena was not quashed, there remained an active subpoena that the ALJ failed to enforce. According to Dr. Williams, the subpoena, if enforced, could have provided evidence to disprove Patient 1’s allegations. The Panel agrees with Dr. Williams that

⁵ Following the prehearing conference, the ALJ issued an Order stating, in part: “If, however, no action occurs with regard to a subpoena request for [Facility A]’s patient interview notes by October 31, 2016, I shall consider the matter closed.”

the ALJ erred by refusing to rule on the motion to quash subpoena and failing to enforce an active subpoena. Dr. Williams's exceptions with respect to the enforcement of the subpoena and questioning related to Facility A's investigation, exceptions 1 and 2, are granted.⁶

II. Procedural Defects (Exception 3)

During the Board investigator's testimony, the State objected to Dr. Williams's questions pertaining to alleged defects in the Board's investigation, including questions regarding why certain witnesses were not interviewed and why certain documents were not obtained. Dr. Williams argued that the questions should be permitted to challenge the substantive basis for the charges that were developed as a result of the Board's investigation. The ALJ concluded that the questions relating to the Board's investigation and process by which the charges were formulated would not be permitted on the basis of Health Occ. 14-405(g), which prohibits the challenge of any procedural defects alleged to have occurred prior to the filing of charges. The ALJ did, however, permit Dr. Williams to proffer the testimony he believed he could have elicited if he was permitted to engage in the line of questioning that was prohibited. Dr. Williams made 29 proffers concerning purported failures or deficiencies in the Board's investigation. The ALJ heard the proffers and accepted them into the record.

Health Occ. § 14-405 provides, "[t]he hearing of charges may not be stayed or challenged by any procedural defects alleged to have occurred prior to the filing of charges." In analyzing the scope of Health Occ. § 14-405, the Court of Appeals explained:

To the extent that deficiencies or irregularities in the pre-charge proceedings actually compromise the accused's opportunity for a full and fair hearing on the charges, in conformance with applicable Constitutional, statutory, or other legal requirements, or suffice in some way to deprive the agency (or court) of true jurisdiction to proceed, the accused is necessarily entitled, and must be allowed,

⁶ The Facility A subpoena only pertained to documents relating to Patient 1. Rather than remanding this case back to the ALJ for further proceedings, the Panel will simply not find a violation against Dr. Williams with respect to Patient 1.

to raise those deficiencies or irregularities, notwithstanding the statute or rule. Beyond that, however, the statute means what it says and must be given effect.

Board of Physician Quality Assur. v. Levitsky, 353 Md. 188, 206 (1999).

Dr. Williams argues that the ALJ erred in refusing to allow him to cross examine the Board's investigator regarding alleged deficiencies in the Board's investigation. Dr. Williams contends that he should have been permitted to question the Board's investigator about facts and witnesses she had not developed to establish that there was potentially exculpatory information that was missing from the Board's investigation.

The Panel agrees with Dr. Williams that alleged deficiencies in the Board's investigation are not procedural defects and, therefore, Health Occ. § 14-405 is not applicable. The ALJ erred by disallowing questioning regarding the sufficiency of the Board's investigation on the basis of Health Occ. § 14-405. Dr. Williams's exception in that respect is granted.

The Panel, however, finds that Dr. Williams had the opportunity to subpoena witnesses who were not called or interviewed by the Board and to explore any evidence that he deemed was missing from the Board's investigation in his own case in chief. Any alleged deficiencies in the Board's investigation have no bearing on this Panel's ultimate determination regarding the sufficiency of the evidence to support the charges. The Panel bases its findings on the evidence contained in the record, not the lack thereof. Accordingly, Dr. Williams has suffered no prejudice from the lack of cross-examination of the Board's investigator on the line of questioning at issue, and, therefore, it is not necessary to remand for further proceedings.

III. Hearsay Statements (Exception 4)

During the testimony of the Board's investigator, the State sought to admit the complaint filed by Patient 7, medical records of Patient 7, and transcript of Patient 7's interview with the Board investigator. Dr. Williams objected because Patient 7 would not be testifying at the

hearing and, therefore, would not be available for cross-examination or for the ALJ to assess the witness's credibility. Dr. Williams did not subpoena Patient 7 or otherwise attempt to secure her presence at the hearing. The ALJ determined that the hearsay evidence was sufficiently reliable and admitted the documents pertaining to Patient 7 over Dr. Williams's objections. Dr. Williams argues that the ALJ erred in admitting the hearsay statements of Patient 7 and documents concerning Patient 7 through the Board's investigator because Patient 7 did not testify at the OAH hearing.

"[W]ithin the context of administrative proceedings, it is well-settled that administrative agencies are not bound by technical common law rules of evidence." *Para v. 1691 Ltd. P'ship*, 211 Md. App. 335, 379 (2013) (internal quotation marks omitted). The Administrative Procedure Act provides that "[e]vidence may not be excluded solely on the basis that it is hearsay." Md. Code Ann., State Gov't § 10-213(c). Further, "[a]lthough we recognize the basic tenet of fairness in administrative adjudications is the requirement of an opportunity for reasonable cross-examination, fairness also requires the complaining party to avail itself of the opportunity to cross-examine." *Para*, 211 Md. App. at 384 (internal citations and quotation marks omitted). "As a consequence, the complaining party must subpoena testimony or a witness of the production of any evidence when the administrative proceeding permits." *Id.* In this case, Dr. Williams did not subpoena Patient 7 to testify at the hearing or attempt to conduct a deposition or interview of the patient prior to the OAH hearing. Dr. Williams had the opportunity to cross-examine the Board investigator regarding Patient 7 and called other witnesses to discredit the testimony of Patient 7.

The Panel agrees with the ALJ that the transcript of Patient 7's interview was properly admitted, but gives the evidence little weight based on the inconsistencies in Patient 7's story and the inability for both parties to question Patient 7 about the inconsistencies at the OAH hearing.

As discussed below, however, the Panel does not find a violation with respect to Patient 7, therefore the admissibility of the transcript of Patient 7's interview is of no consequence to Dr. Williams. Dr. Williams's exception on this issue is denied.

IV. Amending of Charges (Exception 5)

During the hearing, the State sought to modify several statements in the amended charges to accurately reflect the testimony of the witnesses who had previously testified at the hearing. Dr. Williams objected and argued that the amending of the charges in the middle of the hearing precluded him from later arguing that the charges were not supported by the testimony from the witness stand and deprived him of adequate notice. The ALJ permitted the modifications and found, "[t]he amended charges were not altered in any significant way such that [Dr. Williams] could not defend against them." As a result, the ALJ also found that the amended charges, with or without the State's modifications, provided Dr. Williams with sufficient notice of the charges against him. In his exceptions, Dr. Williams argues that the ALJ erred by permitting the State to amend the factual allegations in the charges, claiming that it deprived him of the notice required for due process.

The Panel has reviewed the modifications made to the amended charges. All the modifications made during the hearing pertain to Patient 1. In light of the fact that the Panel did not find a violation as to Patient 1, the modifications made to the amended charges have no impact on the Panel's final decision and order in this case. As such, the modifications to the amended charges are irrelevant and the Panel need not address whether Dr. Williams was provided sufficient notice to comport with due process. Dr. Williams's exception is denied.

V. Factual Discrepancies

Dr. Williams argues that the ALJ ignored certain facts and data that demonstrated that the allegations of the seven patients were not credible. He contends that he performed appropriate standard low back examinations on each of the seven patients, which were documented in the medical records. The exceptions made with respect to Patient's 2-7 will be discussed below.⁷

Patient 2

Patient 2 was seen by Dr. Williams on August 18, 2014, for pain in her spine. Dr. Williams asked the patient to lie down on the examination table and palpated from the top of her spine to the bottom, asking the patient if she was in any pain at various points during the examination. Patient 2 indicated that she was not in pain except that it was a little uncomfortable in her waist area. Dr. Williams continued to go lower and asked the patient to unbutton her jeans. Dr. Williams grabbed her underwear and tried to pull them down. When he was not able to pull them down, he instructed Patient 2 to pull down her underwear so that her entire buttocks were exposed. Dr. Williams continued to palpate until he reached her anus. Dr. Williams put on a glove and started touching her inside her anus. Dr. Williams did not use any lubricant and no chaperone was present for the examination. Patient 2 pulled up her pants and sat on the examination table while Dr. Williams was taking notes. Dr. Williams then asked Patient 2 to unbutton her pants a second time and he helped her to pull her pants down and expose her entire buttocks again. This time, Dr. Williams put on gloves and stuck a quarter of his finger into the patient's anus, again, without using lubricant or having a chaperone present. Dr. Williams did not explain to the patient on either occasion why it was necessary for him to insert his finger into her anus.

⁷ As discussed above, the Panel did not find a violation as to Patient 1 due to procedural irregularities concerning the motion to quash and, therefore, the Panel need not address any alleged factual discrepancies related to the testimony of Patient 1.

Dr. Williams takes exception to the ALJ's finding that he committed a sexual violation against Patient 2 by putting his finger a quarter of the way inside her anus on August 18, 2014. Dr. Williams testified that he performed an exam on the sacroiliac joint and the coccyx and, in doing so, palpated at the very top of the gluteal cleft, but was adamant that he did not insert his finger into Patient 2's anus. Dr. Williams argues that there is no way he could have stuck a finger in her anus without her bending over given her large size. The ALJ found Dr. Williams's attacks on Patient 2's credibility to be "meritless." The ALJ noted that Patient 2 was emotional when testifying and exhibited "considerable distress." It was clear to the ALJ that Patient 2 did not wish to be at an administrative hearing testifying against Dr. Williams and the ALJ found that the tears Patient 2 shed while testifying were genuine. The Panel adopts the ALJ's credibility determinations regarding Patient 2. The record reflects that there was no documented medical reason for Dr. Williams to place his finger inside Patient 2's anus.

The Panel finds that Dr. Williams committed a sexual violation as to Patient 2 and, therefore, is guilty of immoral and unprofessional conduct in the practice of medicine, in violation of Health Occ. §14-404(a)(3). Dr. Williams's exceptions with respect to Patient 2 are denied.

Patient 3

Patient 3 has two medical conditions, Arnold-Chiria Type 2 malformation and degenerated cervical discs, which cause her to experience constant and severe back pain. The patient's pain is so severe that she requires an intrathecal pump implanted under the skin in her abdomen to supply pain medication to her 24 hours per day. On December 16, 2013, Patient 3 saw Dr. Williams for a regular follow-up visit to obtain a refill of her intrathecal pump. During that visit, Patient 3 informed Dr. Williams that she was in more pain than usual and that her pain

was not being controlled with the current medication in the pump. Dr. Williams indicated that he wished to conduct an examination and Patient 3 consented. Dr. Williams asked Patient 3 to lower her pants and underwear to the point where her entire buttocks was exposed. Dr. Williams pressed up and down Patient 3's spine and then when he got to her hips, he moved around towards the front of her body. When he got to the front of her body, he pressed on a soft spot and Patient 3 winced in pain. Dr. Williams stated that it was pelvic pain and began examining in between Patient 3's legs.

According to Patient 3, Dr. Williams started pushing up in between her legs on both sides and then placed two fingers inside her vagina and pushed on each side. Patient 3 said to Dr. Williams, "I don't like where you're at." Dr. Williams did not stop pressing in the vaginal area or explain to Patient 3 what he was doing or why he needed to examine that area. Dr. Williams then concluded the examination and left the room. After Patient 3 left the office, she told her husband and her primary care provider what had occurred and researched online whether it was appropriate for Dr. Williams to insert his fingers into her vagina as part of an examination for back pain. At her next appointment, she brought her husband with her and addressed her concerns with Dr. Williams. Dr. Williams said to Patient 3's husband, "You have a very smart wife" and then changed the subject to other issues concerning Patient 3's care and treatment.

Dr. Williams does not challenge any of the ALJ's factual findings with respect to Patient 3, but rather, argues that the investigation into Patient 3's allegations was incomplete, which deprived him of the opportunity to demonstrate inconsistencies in Patient 3's testimony. Dr. Williams argued that the Board should have interviewed the individuals that Patient 3 complained to about Dr. Williams's conduct.

As discussed above, Dr. Williams had the opportunity to call witnesses at the hearing before the ALJ to challenge the patient's testimony, but he declined to do so. He had the opportunity to subpoena witnesses that were not called or interviewed by the Board and explore any evidence that he deemed was missing from the Board's investigation in his own case in chief. Dr. Williams had the opportunity for a full and fair hearing on the charges. The State presented sufficient evidence to support the charges without any additional witnesses named by Dr. Williams. The Panel finds that Dr. Williams committed a sexual violation as to Patient 3, and, therefore, is guilty of immoral and unprofessional conduct in the practice of medicine, in violation of Health Occ. §14-404(a)(3). Dr. Williams's exception is denied.

Patient 4

Dr. Williams takes exception to the ALJ's finding that he committed a sexual violation by giving Patient 4 a caudal spinal steroid injection in her gluteal cleft without medical necessity. He contends that he performed an appropriate caudal epidural steroid injection on Patient 4 at the sacral hiatus.

The patient testified that, on May 8, 2014, she believed she was at Dr. Williams's office to receive a lumbar epidural steroid injection. She signed a consent form, which included consent for "Lumbar, sacral, caudal epidural steroid injection" and hip injection under ultrasound. Dr. Williams then asked the patient to lay face-down and lower her pants. She lowered her pants to midway on her buttocks, which she believed was appropriate based on the lumbar injections that she received in the past. Dr. Williams asked her to lower her pants farther down, which she did, and her entire buttocks were then exposed. Dr. Williams explained that he was doing the procedure using ultrasound and that he would first numb the area. Patient 4 explained:

When he got ready to, you know, start the procedure, he spreaded my butt cheeks. He was pushing with a finger, I don't know which finger, but it was a lot of poking down there.

And I said to him, "No doctor has ever done down this far before. I've had these injections done before and no doctor has ever gone down this far," and he said to me that he's trying to get it as close to the nerve as possible.

Patient 4 explained that the injection she received was different from the previous injections because this injection was "in between my buttocks."

Dr. Williams did not tell her that she was getting a different type of injection than she had previously received or explain to her the reason for the different type of injection. The medical record reflects that a caudal epidural steroid injection under ultrasound guidance was performed, which is different from the lumbar epidural steroid injection that she had received in the past. The patient testified on cross examination that she had never received a caudal injection before and that she now recognizes that this injection is done lower than the lumbar injections which she was used to receiving.

While Dr. Williams should have informed the patient that she would be getting a different type of injection than she had received in the past and explained the reasons for doing the caudal injection, in light of the apparent confusion about the type of injection being performed, the Panel finds that there is insufficient evidence to substantiate a finding of sexual misconduct as to Patient 4. Dr. Williams's exceptions to the ALJ's decision pertaining to Patient 4 are granted. The Panel does not adopt the ALJ's discussion for Patient 4.

Patient 5

Dr. Williams began treating Patient 5's back pain in 2013. On November 23, 2013, Dr. Williams saw Patient 5 for a follow-up examination without anyone else present in the examination room. Dr. Williams asked Patient 5 to lay face down on the examination table. The patient's pants were lowered to her thighs and her underwear was lowered just above the crack in

her buttocks. Dr. Williams asked about her pain and the previous procedures that she had undergone and then started squeezing her thigh and worked his way up her leg until he got about a tenth of an inch from her rectum and vagina. Patient 5 testified that the examination lasted approximately 4 minutes, which she felt was a long time considering Dr. Williams was already familiar with her history of pain. Patient 5 saw Dr. Williams on several occasions for injections and procedures related to the treatment of her back pain, but at the appointment in question, Patient 5 did not undergo a procedure. On the date in question, Patient 5 was certain that she was alone in the room with Dr. Williams and that no other staff were present.

Patient 5 felt very uncomfortable during and after the examination, but she dismissed her feelings at the time and continued seeing Dr. Williams because she continued to have pain. In April of 2016, Patient 5's daughter told Patient 5 that she saw a news story concerning sexual assault allegations against Dr. Williams, which prompted Patient 5 to file a complaint with the Board.

Dr. Williams argued that Patient 5 was not credible because she changed the date of the alleged incident, which she stated was March 27, 2014, in the complaint to November 27, 2013, at the OAH hearing and changed the location of the examination from Largo to Kensington. Patient 5 acknowledged in her testimony that she gave the wrong date in her complaint and in her interview with the Board investigator. She explained that, upon further review of her medical records, the date could not have been March 27, 2014, because there were nurses present at that appointment and the appointment that the inappropriate touching occurred happened when there was no one else besides Patient 5 and Dr. Williams in the room.

The ALJ considered the discrepancies in Patient 5's testimony pointed out by Dr. Williams and, nevertheless, found Patient 5 credible. The ALJ placed more weight on the details

that Patient 5 gave regarding the examination rather than on the accuracy of the dates and found that the changes in Patient 5's testimony did not undermine her credibility. On the other hand, the ALJ did not find Dr. Williams to be credible. The Panel adopts the ALJ's credibility determinations with respect to Patient 5 and Dr. Williams.

Patient 5 was steadfast in her testimony about what occurred at her November 23, 2013, office visit with Dr. Williams. She acknowledged the discrepancies in the dates she gave, yet remained unwavering in her testimony as to what occurred at the appointment. The details of the inappropriate touching remain consistent, and the ALJ who had the opportunity to make demeanor based credibility findings found Patient 5 credible. The Panel agrees with the ALJ's finding that Dr. Williams committed a sexual violation as to Patient 5 and, as a result, Dr. Williams is guilty of immoral and unprofessional conduct in the practice of medicine, in violation of Health Occ. §14-404(a)(3). Dr. Williams's exception as to Patient 5 is denied.

Patient 6

Patient 6 began seeing Dr. Williams for lower back pain in May of 2011. She was referred to Dr. Williams by another doctor because Dr. Williams performed epidural injections under sedation. On one occasion, during a low back examination, Dr. Williams asked Patient 6 to lower her jeans and he pressed on her spine until he got to her buttocks and then when he got down to her buttocks he took her buttocks in his hands and groped her buttocks. Patient 6 was clear that the "fatty part of [her] butt" was in Dr. Williams's hands. Patient 6 was shown a YouTube video of a lumbar spinal examination and she testified, "Dr. Williams did all of that, but then his hands came down further. And then as he was going down my spine, my buttocks was like in his hands, and that doctor [in the video] did not do that to the young lady." The Panel finds that Dr. Williams exceeded the boundaries of a medically indicated appropriate lower back

examination and abused the trust of the patient in engaging in inappropriate sexual touching of her buttocks.

Patient 6 returned to see Dr. Williams for subsequent appointments because he was the only doctor she knew who would perform spinal injections under sedation. During one appointment when Patient 6 was at the surgical center to get a spinal injection, Dr. Williams conducted an examination of her and his thumb brushed across her clitoris. Patient 6 was wearing a gown and was fully unclothed except for her underwear. On both occasions there was no chaperone present during the examination and Dr. Williams did not wear gloves. Patient 6 did not complain to anyone about Dr. Williams's conduct at the time because she trusted him and thought that maybe she misinterpreted his conduct. Patient 6 testified that she was uncomfortable with Dr. Williams's conduct, yet still believed he was a good doctor and was complimentary of his care. She did not want to believe that Dr. Williams would touch her inappropriately, but when she was informed of the news broadcast concerning allegations against Dr. Williams she reassessed whether her concerns were unfounded and she filed a complaint with the Board because she did not want anyone else to go through what she went through.

Dr. Williams argues that Patient 6 is not credible because she could not remember specific dates when the conduct occurred and she changed her testimony regarding whether Dr. Williams was standing or sitting on a stool during the examination where he brushed her clitoris. At the OAH hearing Patient 6 admitted that she was unsure about whether Dr. Williams was standing or sitting when he examined her, but she was unyielding in her testimony that the touching occurred. She explained, "I know what he did. I know his finger went across my clitoris. I'm sorry if I did not get everything correct when I went there. I know that's what he did to me."

The ALJ considered the discrepancies in Patient 6's testimony pointed out by Dr. Williams and, nevertheless, found Patient 6 credible despite the lack of precision in her testimony. The ALJ placed more weight on the details Patient 6 gave regarding Dr. Williams's conduct and did not find Dr. Williams credible. The Panel adopts the ALJ's credibility determinations with respect to Patient 6 and Dr. Williams. The Panel finds that Dr. Williams committed a sexual violation as to Patient 6 and, therefore, is guilty of immoral and unprofessional conduct in the practice of medicine, in violation of Health Occ. §14-404(a)(3). Dr. Williams's exception as to Patient 6 is denied.

Patient 7

As discussed above, Patient 7 did not testify at the OAH hearing. The State submitted the transcript of Patient 7's interview with the Board investigator, which was admitted into evidence. Patient 7 could not recall the date of the inappropriate exam, but estimated that it occurred during the summer of 2014. Patient 7's medical records, however, reflect that the date of the examination was May 23, 2013. On May 30, 2013, Patient 7 called the office and spoke with a physician assistant asking for an explanation of the exam Dr. Williams performed on her.

Dr. Williams argues that the ALJ had no ability to assess demeanor of Patient 7 because Patient 7 did not testify at the hearing and erroneously relied on the transcript of Patient 7's Board interview while ignoring the uncontroverted testimony of several witnesses who described Patient 7 as dishonest. Dr. Williams also points out several inconsistencies in Patient 7's interview. For example, Dr. Williams notes that Patient 7 stated in her email through the patient portal that Dr. Williams was wearing gloves during the examination, but in the complaint and in her Board interview that Dr. Williams was not wearing gloves. Patient 7 also stated that she had seen Dr. Williams for several years before the date of the alleged incident, but her medical

records indicate that May 23, 2013 was the first visit that Patient 7 saw Dr. Williams. Dr. Williams also points out that the Largo office location was not open as of the date when the examination was alleged to have taken place.

Patient 7's inconsistent statements were not able to be reconciled at the OAH hearing. Further, the ALJ was not able to make any demeanor based credibility findings with respect to Patient 7 because Patient 7 did not testify. While the transcript of her interview was properly admitted, after considering the significant inconsistencies in Patient 7's story, the lack of testimony to harmonize the inconsistencies, the character witnesses who described her as dishonest and drug-seeking, and the inability for the ALJ to make any demeanor based credibility findings with respect to Patient 7, the Panel finds that there is insufficient evidence to support a violation as to Patient 7. Dr. Williams's exception with respect to Patient 7 is granted.

CONCLUSIONS OF LAW

The Panel concludes that Dr. Williams is guilty of immoral and unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3), due to his violations of the Board's sexual misconduct regulations, COMAR 10.32.17, for Patients 2, 3, 5, and 6, willfully making or filing a false report in the practice of medicine, in violation of Health Occ. § 14-404(a)(11), and willfully making a false representation when seeking or making application for licensure or any other application related to the practice of medicine, in violation of Health Occ. § 14-404(a)(36). The Panel does not find a violation of Health Occ. § 14-404(a)(3) with respect to Patients 1, 4, and 7.

SANCTION

Dr. Williams takes exception to the ALJ's proposed sanction of a permanent revocation and argues that a period of suspension followed by a period of probation would be a more equitable sanction. The Panel found that Dr. Williams committed a sexual violation against four

patients. He abused his professional status and destroyed the trust his patients placed in him. The Panel determines that revocation is an appropriate sanction in this case.

ORDER

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

ORDERED that Dr. Williams's license to practice medicine in Maryland (License Number D66774) is **REVOKED**; and it is further

ORDERED that the May 18, 2017 order imposing a summary suspension is terminated as moot; and it is further

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

12/29/17
Date

Ellen Douglas Smith
Ellen Douglas Smith, Deputy Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408, Dr. Williams has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this Final Decision and Order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Williams files a Petition for Judicial Review, the Board is a party and should be served with the court's process at the following address:

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

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

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

EXHIBIT 1

MARYLAND STATE BOARD OF
PHYSICIANS

v.

BRYAN S. WILLIAMS, M.D.,
RESPONDENT

LICENSE No.: D66774

* BEFORE THOMAS G. WELSHKO,
* AN ADMINISTRATIVE LAW JUDGE
* OF THE MARYLAND OFFICE
* OF ADMINISTRATIVE HEARINGS
*
* OAH No.: DHMH-MBP-71-16-23230

* * * * *

PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
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STATEMENT OF THE CASE

On April 4, 2016, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Bryan S. Williams, M.D. (Respondent) for violating various provisions of the Maryland Medical Practice Act (Act), the law governing the practice of medicine in this State. Md. Code Ann., Health Occ. §§ 14-101 through 14-507, and 14-601 through 14-607 (2014 & Supp. 2016). The Board issued amended charges on May 27, 2016 (Amended Charges). The Amended Charges contain two categories of charges by the Board against the Respondent. The Board based its first category of charges on its investigatory findings that the Respondent had inappropriately touched seven female patients in such a way that it constituted sexual misconduct, subjecting him to sanction under sections 14-404(a)(3)(i) and (ii) of the Act and Code of Maryland Regulations (COMAR) 10.32.17. It based its second category of charges on

its investigatory findings that the Respondent willfully made or filed false reports in the practice of medicine and willfully made a false representation when seeking or making an application for licensure, subjecting him to sanction under sections 14-404(a)(11) and (36) of the Act. The disciplinary panel to which the complaint was assigned forwarded the Amended Charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of a Proposed Decision (i.e., Proposed Findings of Fact, Proposed Conclusions of Law and a Proposed Disposition). COMAR 10.32.02.03E(8); COMAR 10.32.02.04B(1).¹

I held a hearing on November 14–18, 2016 and November 21, 2016, at the OAH in Hunt Valley, Maryland. Health Occ. § 14-405(a) (2014); COMAR 10.32.02.04. Assistant Attorney General and Administrative Prosecutor Victoria H. Pepper represented the State of Maryland (State). Catherine W. Steiner and M. Natalie McSherry, Attorneys-at-Law, represented the Respondent, who was present.

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

ISSUES

1. Is the Respondent subject to sanction under section 14-404(a)(3)(i) and (ii) of the Act for being guilty of immoral and unprofessional conduct in the practice of medicine, based on acts of sexual misconduct that he committed with respect to seven female patients?

¹ On May 18, 2016, the Board summarily suspended the Respondent from the practice of medicine. (State's Exhibit No. 1.) It continued the Respondent's summary suspension by an order it issued on May 25, 2016, after conducting a show cause hearing on that date. (State's Exhibit Nos. 2 and 3.) That summary suspension remains in effect.

2. Is the Respondent subject to sanction under section 14-404(a)(11) and (36) of the Act for willfully making or filing false reports in the practice of medicine and/or willfully making a false representation when seeking or making an application for licensure?

3. If the Respondent is subject to sanction, what sanction is appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

The State pre-marked fifty-one exhibits, which it placed in binders in compliance with my September 23, 2016 Prehearing Order. I admitted all of those exhibits except State Exhibit Nos. 6, 23 and 40, which the State did not offer into evidence. The Respondent pre-marked thirty exhibits and offered two additional exhibits (Nos. 31 and 32) during the hearing. The Respondent also complied with my September 23, 2016 Prehearing Order by placing his exhibits in binders. I did not admit Respondent Exhibit Nos. 15, 19, 28, 29, 30 and 32, because I sustained objections to those exhibits raised by the State.² (I have attached a complete Exhibit List as an Appendix to this decision.)

Testimony

The following witnesses testified on behalf of the State:

- Patients 1-7;³
- Person 1, friend of Patient 1;
- Friend 1, friend of Patient 4;
- [REDACTED] Chief of Medical Services with the Respondent's former employer, [REDACTED] (an affiliate of [REDACTED] (by Skype);

² I placed those exhibits in a sealed envelope as required by the OAH's Rules of Procedure. COMAR 28.02.01.22C.

³ I am not reciting names of the patients or their friends to protect their confidentiality. Also, Patient 6 testified via Skype videoconferencing.

- [REDACTED] M.D., Chief Compliance Officer for [REDACTED] (by Skype); and
- Doreen Noppinger, Investigator for the Board.

The following witnesses testified on behalf of the Respondent:

- Neil Howard Blumberg, M.D., Forensic Psychiatrist, whom I accepted as an expert in Forensic Psychiatry;
- [REDACTED] M.D., the Respondent's Supervisor at [REDACTED]
- [REDACTED] Assistant to the Respondent at [REDACTED]
- [REDACTED] R.N., Operating Room Technician;
- [REDACTED] R.N., Operations Manager, [REDACTED]
- [REDACTED] M.D., [REDACTED]
- [REDACTED] Clinical Assistant [REDACTED]
- [REDACTED] R.N., [REDACTED]
- [REDACTED] R.N., [REDACTED] and
- [REDACTED] M.D., [REDACTED]

The Respondent also testified on his own behalf.

PROPOSED FINDINGS OF FACT

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

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on October 18, 2007. (Stip. Parties.⁴)

⁴ The parties agreed to several stipulations during the September 23, 2016 prehearing conference, which I have incorporated into this decision.

2. The Respondent's Maryland medical license is scheduled to expire on September 30, 2017. (Stip. Parties.)

3. The Respondent held active medical licenses in the District of Columbia and Virginia until those licenses were suspended based on the Maryland Board's summary suspension. The Respondent also holds inactive medical licenses in California, Illinois and Michigan. (Stip. Parties.)

4. The Respondent is board-certified in anesthesiology and the sub-specialty of pain management. (Stip. Parties.)

5. From November 2010 through October 2014, the Respondent was employed as an interventional pain management specialist at [REDACTED] with offices in Maryland. (Stip. Parties.)

6. On September 2, 2010, before beginning his employment with [REDACTED] the Respondent signed an Employment Agreement. The terms of that agreement allowed either the Respondent or [REDACTED] to terminate the Respondent's employment relationship with [REDACTED] without giving any reason for doing so. To exercise this voluntary separation clause, the terminating party had to give the other party to the agreement ninety days' prior written notice. The Employment Agreement also stipulated that [REDACTED] could terminate the Respondent's employment for cause immediately upon written notice to the Respondent. (State's Ex. 7 at 0040.)

7. Among the "for cause" bases for termination delineated in the Respondent's Employment Agreement with [REDACTED] is "Failure to comply with [REDACTED] rules, standards and policies, including but not limited to quality assurance, EEO, credentialing, harassment, utilization management or confidentiality policies as in effect at this time or as may be modified or adopted in the future." (State's Ex. 7 at 0041.)

8. At all times relevant, [REDACTED] employed a chaperone policy applicable to all of its physicians. That chaperone policy allowed all patients (as well as parents and guardians) to request a non-family member chaperone to be present during an examination or procedure, including, but not limited to: (1) any pelvic examination and (2) any genital, breast and/or anal examination. (Test. [REDACTED] Transcript (T.) at 623-24, 629; State's Ex. 31.)

Findings with Respect to Patient 1

9. Patient 1 is fifty-eight-year-old woman.⁵ The Respondent treated Patient 1 from November 21, 2012 through January 24, 2014 for complaints of lower back pain that is most prominent in her left buttock, hip and groin. (Test. Patient 1, T. at 198 and 200; State's Ex. 8 at 6, 10; State's Ex. 41 at 8-12.)

10. The lower back pain that Patient 1 was experiencing stemmed from an on-the-job accident that Patient 1 had in 2009. (Test. Patient 1, T. at 193.)

11. Patient 1, as a member of [REDACTED] a health maintenance organization (HMO), generally must seek medical treatment at [REDACTED] facilities. If a [REDACTED] patient does not have a health care practitioner who can treat his or her particular condition, he or she can seek a referral to a physician outside of the [REDACTED] system. (Test. Patient 1, T. at 195.)

12. Before becoming the Respondent's patient, Patient 1 had also sought relief from her lower back pain by getting transforaminal epidural steroid injections (TFESI) from a pain management physician at the [REDACTED] a medical provider outside the [REDACTED] system. After receiving at least six of these injections, Patient 1 was reluctant to have more of them because of their painfulness. (Test. Patient 1, T. at 194-95; State's Ex. 8 at 4.)

⁵ The age given for all patients is their age as of the date that they testified at hearing.

13. To eliminate the need for TFESIs, Patient 1 underwent a surgical fusion of her sacroiliac joint. That surgical fusion did not significantly reduce Patient 1's lower back pain. (Test. Patient 1, T. at 195; State's Ex. 8 at 6; State's Ex. 41 at 8.)

14. In November 2012, the Patient sought a referral from her primary care physician to a [REDACTED] pain management specialist, because of the poor experience she had when she received TFESI procedures from her out-of-system pain management specialist. (Test. Patient, T. at 196.)

15. Patient 1 learned through her primary care physician at [REDACTED] that the Respondent might be helpful in alleviating her lower back pain, because he did not oppose sedating patients while performing the TFESI procedure. Because the Respondent employed a sedation technique called "twilight," Patient 1 made an appointment to seek pain relief treatment from the Respondent. (Test. Patient, T. at 196-97; State Ex. 8 at 4.)

16. On November 21, 2012, Patient 1 visited the Respondent at [REDACTED], Maryland Medical Office Building. There, he performed a physical examination of Patient 1. No chaperone was present in the examination room while the Respondent examined her. (Test Patient 1, T. at 198-99; State's Ex. 41 at 11.)

17. When the Respondent physically examined Patient 1 on November 21, 2012, he started by manipulating Patient 1's legs while Patient 1 sat on an examination table. After completing the leg manipulation, the Respondent had Patient 1 stand up and pull up her shirt, so he could feel around her waist and hips. He then had her pull down her pants and underwear past her buttocks. The Respondent then took his bare, ungloved hands and examined Patient 1's lower waist and buttocks. Starting at Patient 1's hips, the Respondent went up and down Patient 1's

buttocks until, with both hands, he spread open Patient 1's buttocks' cheeks. To spread open Patient 1's buttocks cheeks, the Respondent grasped inside of Patient 1's gluteal cleft (buttocks' crack) with his fingers. Even though he separated Patient 1's buttocks' cheeks in this manner, he did not digitally penetrate Patient 1's anus. (Test. Patient 1, T. at 196-97, 200-01, 230, 245; State's Ex. 8 at 5, 13 and 15.) After he had examined Patient 1, the Respondent told Patient 1 that a nurse would call her to schedule a procedure (that is, a TFESI and/or lumbar facet joint (LFJ) injection) to alleviate her lower back pain. (Test. Patient 1, T. at 198; State Ex. 41 at 12.)

18. Patient 1 considered the Respondent's examination of her buttocks cheeks in the manner that the Respondent examined them unnecessary to diagnose and treat her lower back pain. Immediately after having her November 21, 2012 appointment with the Respondent, she believed that the Respondent might have touched her inappropriately. Even so, she made no complaints about the Respondent to anyone at that time. (Test. Patient 1, T. at 198.)

19. On December 14, 2012, the Respondent administered a TFESI and an LFJ injection to Patient 1's lower back in the Ambulatory Surgical Center (ASC) at [REDACTED] facility without incident. (State's Ex. 41 at 16-38.)

20. On January 26, 2013, the Patient had a follow-up appointment with the Respondent in [REDACTED]. She told the Respondent that the TFESI and LFJ injection resolved many of her pain complaints in her lower back and buttocks, but she was now having pain in her anterior hip area. (State's Ex. 41 at 40.)

21. On the afternoon of June 14, 2013, Patient 1 came to the ASC at [REDACTED] facility for another series of injections. (Test. Patient 1, T. at 203; State's Ex. 41 at 44, 48-69, 176-78.)

22. On June 14, 2013, in preparation for having a TFESI and an LFJ⁶ injection to her lower back region, the Respondent had Patient 1 disrobe completely and dress in a hospital gown. (Test. Patient 1, T. at 203; State's Ex. 8 at 17-18.)

23. Before he administered the two injections to Patient 1 on June 14, 2013, the Respondent examined her in a cubicle near the operating room at the ASC. The cubicle was open, with patient privacy protected only by two moveable blue curtains that hung from a ceiling track. That track allowed the curtains to be rolled into place in such a way that they met each other and surrounded the cubicle. (Test. Patient 1 at 203.)

24. Only Patient 1 and the Respondent were present in the cubicle at the [REDACTED] ASC on June 14, 2013, when the Respondent examined Patient 1. (Test. Patient 1, T. at 204.)

25. On the afternoon of June 14, 2013, the Respondent closed the cubicle's curtains and examined Patient 1 by having her stand while he sat on a stool. The Respondent was facing Patient 1's back. He moved his hands from the bottom of Patient 1's legs upward to her thighs. He then moved up to Patient 1's buttocks region, where placed his hands to the front of Patient 1's body toward her vagina, coming close to the vaginal opening.⁷ (State's Ex. 8 at 18.)

26. When the Respondent approached Patient 1's vagina with his hands, Patient 1 exclaimed, "Man, what are you doing?" The Respondent reacted to Patient 1's exclamation by saying, "It's all right. Don't worry. It's all right."⁸ (State's Ex. 8 at 18.)

⁶ The ASC Surgery Consent Form that Patient 1 signed on June 14, 2013 identifies the procedure as a "lumbar epidural steroid injection facet joint injection (left)," in other words, an LFJ injection. (State's Ex. 41 at 176.) TFESI is mentioned on Patient 1's Anesthetic Record for June 14, 2013. (State's Ex. 41 at 178.)

⁷ When she testified, Patient 1 melded her recollection of the June 2013 and January 2014 incidents. Although I find what she related as a whole credible, I consider what she said to Board Investigator Noppinger on July 8, 2015 more accurate than when she testified on November 14, 2016, because her Board interview occurred closer in time to when the incidents happened. (See T. at 205.)

⁸ Patient 1's recollection of what the Respondent said varied slightly between what she testified to and what she told Ms. Noppinger on July 8, 2015. At the hearing, Patient 1 stated that when the Respondent's hands came close to her vagina, she exclaimed, "What are you doing," and quoted the Respondent's reply as, "Don't worry. It will be all right." On July 8, 2015, Patient 1 told Ms. Noppinger that she exclaimed, "Man, what are you doing?" and quoted the Respondent's reply as, "It's all right. Don't worry. It's all right." The two versions are very similar, but I am accepting the July 8, 2015 version, again, because it was closer in time to the date of the incident.

27. Patient 1 had no further discussion with the Respondent about the way he examined her, because minutes later, an anesthesiologist administered an intravenous anesthetic to Patient 1, sedating her, so she could tolerate the TFESI and LFJ procedures. (State's Ex. 8 at 18.)

28. Patient 1 had other appointments with the Respondent between June 14, 2013 and January 24, 2014, including appointments on July 26, 2013 and September 27, 2013, when the Respondent administered injections to Patient 1's lower back. Nothing noteworthy occurred during those appointments. (Test. Patient 1, T. at 206; State's Ex. 41 at 74-139, 170-72.)

29. Because of her concern about the way the Respondent had examined her on June 14, 2013, Patient 1 thereafter invited family members to serve as chaperones while the Respondent examined her or performed procedures. (Test. Patient 1, T. at 208.)

30. On January 24, 2014, Patient 1 appeared at the ASC in [REDACTED] to receive a steroid injection/cooled radiofrequency ablation of lateral branch.⁹ She invited her boyfriend, Person 1, who was also her driver, to stay with her while the Respondent examined her. Patient 1 had previously disclosed her concerns about the Respondent's examination techniques to Person 1. (Test. Patient 1, T. at 208; Test. Resp. at 1189-90; State's Ex. 8 at 20-21; State's Ex. 41 at 166-68.)

31. On January 24, 2014, the Respondent had Patient 1 disrobe and put on a hospital gown to facilitate the procedure. (Test. Patient 1, T. at 209; State's Ex. 8 at 21-22.)

32. On January 24, 2014, the Respondent examined Patient 1 in a cubicle similar to the one where he examined her on June 14, 2013. There was a bed and a chair inside the cubicle. Just as on June 14, 2013, two movable curtains surrounded the cubicle. (Test. Patient 1, T. at 208.)

⁹ Patient 1 misidentified the location of where the Respondent gave her her injections. Patient 1's medical records reflect that on January 24, 2014, the injection procedures took place at the ASC in [REDACTED]. Patient 1 testified that she thought she was in [REDACTED] on that date. (Test. Patient 1, T. at 208.)

33. While the Respondent examined Patient 1 on January 24, 2014, Person 1 was seated in a chair to the left of the bed on the opposite side of the cubicle from where the Respondent was examining Patient 1. The Respondent closed the curtains. Person 1 was outside the curtains. (Test. Patient 1, T. at 209.)

34. On January 24, 2014, the Respondent began his examination of Patient 1 by having her stand with her arms spread out in front of her. With gloves on his hands, he sat on a movable stool and started palpating at the base of Patient 1's legs and continued to move his hands up her body until they reached underneath her hospital gown. He kept moving up until his hands touched Patient 1's vagina. Once there, the Respondent put his fingers inside Patient 1's vagina, and while doing so, his knuckles touched Patient 1's clitoris. (Test. Patient 1, T. at 209–10, 212.)

35. When Patient 1 felt the Respondent's fingers inside her vagina, she became annoyed. She asked the Respondent "Why are you doing this? You already determined there's nothing there triggering any pain. So, why you keep doing this?" The Respondent did not respond. He ignored her and continued to feel around Patient 1's vagina. (Test. Patient 1, T. at 209–11; Test. Person 1, T. at 288; State's Ex. 8 at 22.)

36. After completing his examination of Patient 1, the Respondent took off his gloves, sniffed them, rolled them up, and threw them in the trash. The Respondent sat on the stool for a little while, then exited to the hallway, throwing his arms in the air as he walked away from the examination cubicle. (Test. Person 1, T. at 289; State's Ex. 9 at 13.)

37. After the Respondent examined Patient 1, he took Patient 1 to the ASC and administered the steroid injection/cooled radiofrequency ablation of lateral branch to her in her lower back under sedation. (State's Ex. 41 at 140–68.)

38. Not long after January 24, 2014, Patient 1 had an appointment with her primary care physician, Dr. [REDACTED] who also was employed by [REDACTED]. During that visit, Patient 1 told Dr. [REDACTED] about how she believed the Respondent touched her inappropriately when he examined her on January 24, 2014, immediately before she received her injection. (Test. Patient 1, T. at 213, 246.)

39. Some time after Patient 1 visited her, Dr. [REDACTED] communicated Patient 1's concerns to the Respondent's supervisor, Dr. [REDACTED] (State's Ex. 19 at 5.)

40. After receiving Dr. [REDACTED] report, Dr. [REDACTED] conferred with Dr. [REDACTED] at [REDACTED]'s Human Resources Department. After his consultation with Dr. [REDACTED], Dr. [REDACTED] decided to place the Respondent on administrative leave with pay while he initiated an investigation. (Test. [REDACTED] T. at 546-47; State's Ex. 19 at 5.)

41. [REDACTED] conducted an investigation and completed it on February 13, 2014. That investigation determined that Patient 1's allegations against the Respondent were unsubstantiated.¹⁰ After conferring with Dr. [REDACTED] and other appropriate staff members, Dr. [REDACTED] decided to allow the Respondent to return to work, but on the condition that he ensure a non-family member chaperone was present whenever the Respondent examined or performed a procedure on any female patient and for all patients, male or female, where he might need to examine their breasts, buttocks or genitals. (Test. [REDACTED] T. at 547; State's Ex. 19 at 5-7.)

42. During a telephone call to the Respondent that occurred soon after his conference with Dr. [REDACTED] and other appropriate staff members, Dr. [REDACTED] informed the Respondent of the findings of the investigation and directed him to use non-family member chaperones for all female patients and all patients, male or female, where breasts, buttocks or

¹⁰ This is obviously not the conclusion that I made. I have added this finding of fact *solely* to provide a narrative of what occurred as it relates to why [REDACTED] returned the Respondent to work.

genitals might become involved. The Respondent indicated to Dr. [REDACTED] that he understood that he had to use chaperones in the future, and noted he had, "learned a valuable lesson" from the incident involving Patient 1. (Test. [REDACTED] T. at 547-48 and Test. [REDACTED] T. at 633-34; State's Ex. 19 at 7-8.)

43. On April 22, 2014, the Respondent attended an online Continuing Medical Education (CME) seminar presentation called, "Understanding Boundary Violations and Chaperone Use-Best Practices." He attended this seminar at the direction of Dr. [REDACTED]; Dr. [REDACTED] also directed the Respondent to attend this seminar as a condition of returning to his medical practice in February 2014. (Test. Resp., T. at 1243-47; State's Ex. 32; Resp. Ex. 21.)

Findings with Respect to Patient 2

44. Patient 2 is a forty-two-year-old woman who was a member of [REDACTED]. The Respondent treated Patient 2 in [REDACTED] Medical Office Building on August 18, 2014 for spine-related pain. Patient 2 visited the Respondent based on a recommendation from her primary care physician, Dr. [REDACTED] (Test. Patient 2, T. at 326-27; State's Ex. 10 at 3; State's Ex. 43 at 00041-00045.)

45. Although Patient 2 only visited the Respondent once, she sent e-mails to him or his staff until October 3, 2014. (Test. Patient 2, T. at 342; State's Ex. 42 at 00031.)

46. The Respondent had Patient 2 obtain x-rays of her back before seeing her for an examination.¹¹ (Test. Patient 2, T. at 341.)

47. The Respondent examined Patient 2 in a small examination room. That room had an examination table that was covered with paper, a sink, and a desk with a computer on it to

¹¹ When she testified at the hearing, Patient 2 did not mention anyone taking x-rays before she went into the examination room with the Respondent. It is only logical, however, that she had her x-rays taken before seeing him, because August 18, 2014 was the only time that the Respondent examined Patient 2. She mentioned the x-rays as an afterthought in response to the Administrative Prosecutor's questions concerning e-mails that she sent to the Respondent. (T. at 341-42.)

allow the examining physician to make electronic entries in patients' medical records. A rolling stool was also present for the physician's use during examinations. A door could be closed to ensure patient privacy during examinations. (Test. Patient 2, T. at 328-29; State's Ex. 10 at 4.)

48. After a nurse escorted Patient 2 to the examination room, the Respondent entered the room, closed the door and inquired about what he could do for Patient 2. (Test. Patient 2, T. at 328; State's Ex. 10 at 4.)

49. At the time of the examination, Patient 2 was wearing blue jeans and a white shirt. (Test. Patient 2, T. at 331; State's Ex. 10 at 13.)

50. No chaperone was present in the examination room when the Respondent examined Patient 2 on August 18, 2014. (Test. Patient 2, T. at 329.)

51. Patient 2 explained to the Respondent that she was having a lot of back problems, with pain present throughout her spine. (Test. Patient 2, T. at 329.)

52. Patient 2 further explained to the Respondent that in December 2013, she fell in the snow while playing with her son. She thought she might have broken her tailbone when she fell. She told the Respondent that since that accident, she had been having "really, really bad pain" that became more pronounced when she sat, coughed or sneezed. (Test. Patient 2, T. at 330.)

53. After Patient 2 explained her symptoms to the Respondent, the Respondent had Patient 2 lie down on the examination table so he could examine her. He started with leg exercises, asking Patient 2 whether she was experiencing any pain as she performed the exercises. (Test. Patient 2, T. at 330.)

54. After the Respondent had Patient 2 perform the leg exercises on the examination table, he directed her to stand up facing toward the door. The Respondent was behind Patient 2. The Respondent went on to palpate Patient 2's spine from her neck to her abdomen. As he pressed down Patient 2's spine, he asked Patient 2 if it hurt at each pressure point. Patient 2 indicated that it did not hurt substantially in the areas where he was pressing, except in the waist area. (Test. Patient 2, T. at 330.)

55. The Respondent continued pressing downward. When he got to the region where Patient 2's buttocks started, he asked Patient 2 to unbutton her blue jeans, so he could palpate further down Patient 2's spine. (Test. Patient 2, T. at 331.)

56. The Respondent grabbed Patient 2's panties and tried to pull them down. When he did not have success in doing this, he asked Patient 2 if she could pull them down to the point that she was exposing her whole buttocks, which would allow him to examine the end of her spine. Patient 2 complied with this request. (Test. Patient 2, T. at 331.)

57. The Respondent continued to palpate downward until he touched around Patient 2's anal area on the outside only. He was gentle, but he still made Patient 2 feel very uncomfortable.¹² The Respondent asked Patient 2 if his touching hurt, to which Patient 2 replied, "Not really." (Test. Patient 2, T. at 331.)

58. The Respondent reached for some gloves that were available on the sink, placed them on his hands, and began touching the inside of Patient 2's anus. He did so without using any cream or lubricant. (Test. Patient 2, T. at 331.)

59. Patient 2 continued to feel uncomfortable as the Respondent examined her around her anus, but she did not tell the Respondent about her discomfort. (Test. Patient 2, T. at 332.)

¹² When Patient 2 testified that she was "uncomfortable," I understood this to mean that she was uncomfortable because she was embarrassed by what the Respondent was doing to her.

60. After examining Patient 2's anus, the Respondent returned to his computer and began explaining to Patient 2 what her most recent Magnetic Resonance Imaging (MRI) study had shown. He showed an MRI image to Patient 2 and told her that there was no evidence that she had ever broken her tailbone. He did note that the MRI image showed there was a water sac forming around one of Patient 2's discs and noted that this water sac could have been the source of Patient 2's back pain. (Test. Patient 2, T. at 332.)

61. Patient 2 also complained to the Respondent that she was experiencing foot and ankle pain. The Respondent told Patient 2 that he could not treat those conditions, but he would refer her to a podiatrist who would be able to do so. (Test. Patient 2, T. at 332-33.)

62. Just as Patient 2's examination was concluding, a nurse knocked at the door of the examination room. The nurse communicated through the closed door to the Respondent that another physician needed him. The Respondent told the nurse that he would be able to see that doctor in five minutes. (Test. Patient 2, T. at 333.)

63. The Respondent never opened the door while he was speaking to the nurse. (Test. Patient 2, T. at 333.)

64. Patient 2 sat back down on the examination table while the Respondent was conversing with the nurse. After he spoke with the nurse, the Respondent rolled the examining stool over closer to Patient 2 and said, "Can you come over one more time?" (Test. Patient 2, T. at 333.)

65. The Respondent directed Patient 2 to stand again. He positioned her sideways, so she would be looking at the side of the wall. He then positioned his legs between Patient 2's legs and asked Patient 2 to unbutton her jeans one more time, because he wanted to "make sure of something." (Test. Patient 2, T. at 333.)

66. The Respondent assisted Patient 2 with pulling her jeans and panties down to the point where her full buttocks was exposed. He put on new gloves, and faced Patient 2. He placed about one quarter of a finger inside Patient 2's anus and asked Patient 2 whether it hurt. Patient 2 replied, "Not really." (Test. Patient 2, T. at 333-34.)

67. Once the Respondent examined Patient 2's anus, he ended the examination. He stood up, removed his gloves and washed his hands at the sink. Patient 2 buttoned her jeans and sat on the examination table. (Test. Patient 2, T. at 334.)

68. At no time during any part of his examination of Patient 2 did the Respondent explain what he was doing or why he was doing it. (Test. Patient 2, T. at 335.)

69. The Respondent ended his visit with Patient 2 by saying, "Okay, it has been a pleasure. If you have any questions, please contact me." Both he and Patient 2 left the examination room at this point. (Test. Patient 2, T. at 334.)

70. The Respondent prescribed prednisone to Patient 2 for the treatment of her back, based on the results of the August 18, 2014 examination. (Test. Patient 2, T. at 340-41; State's Ex. 42 at 00045.)

71. Patient 2 went directly to the Ladies' Room to clean herself with toilet paper, because she still had the sensation that the Respondent's finger was in her anus. (Test. Patient 2, T. at 334.)

72. Patient 2 left the Kaiser medical building, went to her car, and from there, she called her husband and told him that she thought she had been sexually abused by the Respondent, because he touched her in her anus and she did not know if he was supposed to have done that. (Test. Patient 2, T. at 335.)

73. Patient 2 continued to feel uncomfortable for the remainder of the day. (Test. Patient 2, T. at 335.)

74. Soon afterward, Patient 2 received a routine e-mail from the Respondent, which acknowledged her visit with him on August 18, 2014. (Test. Patient 2, T. at 339; State's Ex. 42 at 00045.)

75. On September 3, 2014, Patient 2 sent an e-mail to the Respondent. In her e-mail, Patient 2 explained to the Respondent that she believed that the prednisone that he had prescribed was causing her to develop a rash that had affected her entire body. She wanted him to prescribe a medication to her to treat the rash. (Test. Patient 2, T. at 340; State's Ex. 42 at 00021.)

76. The Respondent did not answer Patient 2's e-mail concerning her presumed prednisone-induced rash. (Test. Patient 2, T. at 340.)

77. On September 3, 2014, Patient 2 sent a second e-mail to the Respondent. In that e-mail, Patient 2 wanted to know some more about her spinal problems based on the x-ray studies he performed of her spine on August 18, 2014. (Test. Patient 2, T. at 341.)

78. The Respondent replied to Patient 2's second September 3, 2014 e-mail, but did not answer her questions. (Test. Patient 2, T. at 342; State's Ex. 42 at 00031.)

79. On October 3, 2014, at 11:29 a.m., Patient 2 sent another e-mail to the Respondent as a follow-up to her September 3, 2014 e-mail. The Respondent did not reply. (Test. Patient 2, T. at 342-43.)

80. On October 15, 2014, [REDACTED] R.N., sent a return e-mail to Patient 2, in answer to Patient 2's October 3, 2014 e-mail, indicating that she would forward Patient 2's message to the Respondent. (Test. Patient 2, T. at 342-43; State's Ex. 42 at 00031.)

81. As of October 15, 2014, Patient 2 was also seeking updated records from [REDACTED] concerning a disability claim that she was pursuing. (Test. Patient 2, T. at 360.)

82. On October 15, 2014 at 1:26 p.m., Patient 2 wrote to Dr. [REDACTED] in an effort to obtain updated medical records related to her disability claim. (State's Ex. 43 at 00002.)

83. On October 15, 2014, at 1:56 p.m., Dr. [REDACTED] sent a return e-mail to Patient 2, indicating that he was covering for Dr. [REDACTED] that day. He advised Patient 2 to e-mail Dr. [REDACTED] when he returned to the office the following Monday and to make an appointment with him to address her ongoing concerns. (State's Ex. 43 at 00002.)

84. On October 15, 2014, at 3:55 p.m., Patient 2 sent an e-mail to Dr. [REDACTED] in reply to Dr. [REDACTED] earlier e-mail. That e-mail stated the following:

Your service is getting worse and worse[.] I felt that I was sexually abused by one of your colleagues, has been hard to know what are my health issues and I [have] been asking to update my records since Nov 2013 but nobody has done anything[.] I e-mail another department and someone told me that it will take some weeks, after somebody else review it, this is unbelievable[.]

(Test. Patient 2, T. at 344; State's Ex. 43 at 0002.)

85. When Dr. [REDACTED] came back from vacation, he read Patient 2's e-mail, noting with particularity Patient 2's allegation of sexual abuse by the Respondent. That allegation prompted him to call Patient 2 to gather more information. Over the telephone, Patient 2 explained to Dr. [REDACTED] the method that the Respondent used to examine her. Dr. [REDACTED] was greatly displeased with what he heard and told Patient 2, "He wasn't supposed to touch you like that. Nobody is supposed to touch you like that and not even with a chaperone present." (Test. Patient 2, T. at 345.)

86. Before he ended the call, Dr. [REDACTED] told Patient 2 that he needed to report what Patient 2 told him to his supervisor. (Test. Patient 2; T. at 345.)

87. Not long after Patient 2 spoke with Dr. [REDACTED] on the telephone, Dr. [REDACTED] called Patient 2 back; an unnamed woman employed by [REDACTED] also participated in the conversation by conference call. Dr. [REDACTED] and the woman informed Patient 2 that the call was being recorded. They asked Patient 2 what occurred during her examination by the Respondent on August 18, 2014. Patient 2 related everything that happened with regard to the Respondent touching her in areas that she considered inappropriate. (Test. Patient's 2, T. at 345; State's Ex. 10 at 34-35.)

88. Later, Dr. [REDACTED] made another telephone call to Patient 2 and left a message. She called back later and apologized for not answering the telephone, and explained to Dr. [REDACTED] that she did not answer because she did not want to talk about the incident any further. (Test. Patient 2, T. at 345-46; State's Ex. 10 at 36.)

Findings Related to the Respondent's Termination from [REDACTED]

89. [REDACTED] communicated Patient 2's concerns about the Respondent inappropriately touching Patient 2 to his supervisor, Dr. [REDACTED] the Physician-in-Charge (PIC) of [REDACTED] office. [REDACTED] then transmitted a secure message delineating what Dr. [REDACTED] told to him to Dr. [REDACTED]. At the time, Dr. [REDACTED] was [REDACTED]'s Assistant Director of Personnel. (Test. [REDACTED] T. at 631, 642.)

90. Dr. [REDACTED]'s message prompted Dr. [REDACTED] to call Dr. [REDACTED] to set up a conference call to speak to Patient 2. (Test. [REDACTED] T. at 632.)

91. On October 23, 2014, Dr. [REDACTED] called Patient 2. She listened to Patient 2 describe how and where the Respondent had touched her. Dr. [REDACTED] had [REDACTED] [REDACTED] Regional Compliance Officer for the [REDACTED] Health Plan, take notes

with respect to that description. (Test. Patient 2, T. at 345 and [REDACTED] T. at 632; State's Exs. 35-36.)

92. After gathering information from Patient 2, Dr. [REDACTED] scheduled a meeting with the Respondent on October 24, 2014 at [REDACTED]'s [REDACTED] office. Dr. [REDACTED] also participated in that meeting. (Test. [REDACTED] T. at 550; State's Ex. 37.)

93. During the October 24, 2014 meeting, the Respondent denied performing an anal or rectal examination of Patient 2. When Dr. [REDACTED] asked the Respondent about whether he thought of asking for a chaperone, the Respondent avoided the question by replying, "I explain even more than I did in January. It was very difficult for me to examine people after the last incident. The nurses cannot leave until I leave at the end of the day whether or not male or female in case I need a chaperone." (Test. [REDACTED] T. at 550; State's Ex. 37 at 0002.)

94. During the October 24, 2014 meeting, the Respondent also noted that he did not believe a chaperone was necessary to be present during examinations as long as the patient was "not fully undressed." He explained that he only pulled Patient 2's pants down to the point of the gluteal fold. The Respondent also noted, with regard to Patient 2, "If I was going to do a rectal exam, I would have told her that I was going to do a rectal exam." (State's Ex. 37 at 0002.)

95. On October 28, 2014, Dr. [REDACTED] met with the Respondent at [REDACTED] Medical Office Building. [REDACTED] Physician Human Resource Consultant, participated as note taker during that meeting. (Test. [REDACTED] T. at 552; State's Ex. 50.)

96. During the October 28, 2014 meeting, Dr. [REDACTED] announced to the Respondent that [REDACTED] was terminating his employment. Dr. [REDACTED] noted that Patient 2's complaint was the second time in eight months that a female patient had alleged that the Respondent had inappropriately touched her. In this regard, Dr. [REDACTED] explained to the Respondent that the basis for his termination was his failure to use a chaperone during his

examination of Patient 2. He averred that, "It shows an incredible lack of judgment to proceed with an examination without a chaperone." (Test. [REDACTED] T. at 552; State's Ex. 50.)

97. During the October 28, 2014 meeting, Dr. [REDACTED] also asked if the Respondent recalled their earlier conversation about the need to use chaperones. The Respondent nodded in agreement. (Test. [REDACTED] T. at 552; State's Ex. 50.)

98. On November 7, 2014, the Senior Benefits Administrator for [REDACTED] sent a letter to the Respondent, verifying the Respondent's termination from his employment, effective October 28, 2014, and informing him of medical and dental benefits that might be available to him after his termination through the Consolidated Omnibus Budget Reconciliation Act (COBRA). (State's Ex. 7 at 071-076.)

99. Because he was terminated without ninety days advance notice, the Respondent knew or should have known that [REDACTED] had terminated him for cause. (State's Ex. 7 at 0040-0041.)

*Findings with Respect to Patient 3*¹³

100. Patient 3 is a forty-eight-year-old woman. She suffers from two medical conditions, Arnold-Chiria Type 2 malformation and degenerated cervical discs, which cause her to experience severe, chronic and constant back pain. (State's Ex. 44 at 00001.)

101. An Arnold-Chiria Type 2 malformation is a congenital condition that involves a malformity around the skull. (Test. Patient 3, T. at 28.)

102. Patient 3 had nuts and bolts implanted in her spine to address the degeneration of her cervical discs. (Test. Patient 3, T. at 28.)

¹³ Patients 3 through 7 experienced acts of inappropriate touching by the Respondent before [REDACTED] terminated the Respondent's employment. Because these acts of inappropriate touching only became known to the Board after the Respondent's termination, however, I decided to address them here rather than earlier in my Proposed Findings of Fact, even though they are chronologically out of sequence.

103. The severity of the pain in Patient 3's back required her to have an intrathecal pump implanted beneath the skin in her abdomen. An intrathecal pump supplies pain medication to a patient through a catheter inserted into his or her spine twenty-four hours a day. The medication comes from a reservoir within the pump. A patient with an intrathecal pump must obtain periodic refills of the prescription medication for the pump's reservoir from his or her physician. (Test. Patient 3, T. at 29-30.)

104. At all times relevant, Patient 3 was a member of [REDACTED] (Test. Patient 3, T. at 32.)

105. Before June 2011, Patient 3 had been having her back pain issues treated at [REDACTED] Pain Center, which included having her intrathecal pump prescription refills provided there. When the Respondent began providing pain management services through [REDACTED], [REDACTED] switched Patient 3 to the Respondent, because he was able to provide the same services as [REDACTED]⁴ (Test. Patient 3, T. at 32.)

106. From June 2011 through December 2013, the Respondent provided pain management services to Patient 3 without incident. (Test. Patient 3, T. at 35-36, 50.)

107. On December 16, 2013, Patient 3 had her regular appointment with the Respondent. The Respondent saw Patient 3 in a small examination room at [REDACTED] office. The room had a door, but no windows. At that time, the Respondent cleaned the area of Patient 3's abdomen where the intrathecal pump was inserted and replaced the pump. (Test. Patient 3, T. at 36, 48-49.)

108. There was no chaperone in the examination room when the Respondent was examining Patient 3 on December 16, 2013. Patient 3 did not request a chaperone because she did not believe the Respondent would be performing a kind of medical examination that would necessitate the presence of a chaperone. (Test. Patient 3, T. at 37, 49.)

⁴ The Respondent use the word "repatriate" to describe the process of returning patients to [REDACTED] who had been obtaining health care services from other providers once [REDACTED] began providing those same services. He noted that he was recruited primarily to facilitate the repatriation of pain management patients. (Test. Respondent, T. at 1022.)

109. During her December 16, 2013 examination, Patient 3 told the Respondent that her pain was not being controlled and, in fact, was increasing. She also reported numbness in her feet. The Respondent replied that he wanted to examine Patient 3, and Patient 3 agreed to the examination. (Test. Patient 3, T. at 36; State's Ex. 20 at 11.)

110. Patient 3 had been sitting on an examination table. The Respondent directed Patient 3 to get off the table and stand up. He stood behind Patient 3 and had her lower her pants below her buttocks and began pressing up and down her spine, toward the bones that protrude from each side of the spinal column. Patient 3's underwear was below the cheeks of her buttocks. (Test. Patient 3, T. at 36, 48; State's Ex. 20 at 20.)

111. The Respondent stood behind Patient 3 and began examining her hips. As he conducted that examination, he caused Patient 3 discomfort by pressing on a soft spot in her pelvic region. A discussion ensued between the Respondent and Patient 3 about whether Patient 3 was experiencing pelvic pain as opposed to hip pain. (Test. Patient 3, T. at 36.)

112. The Respondent then began examining Patient 3 between her legs. He started pushing up between her legs on both sides and up in between her legs. (Test. Patient 3, T. at 36-37.)

113. When Patient 3 realized the Respondent was about to put his fingers near her vagina, she told him, "I do not like where you're at." The Respondent did not stop pressing around Patient 3's vaginal region, nor did he say anything about what he was doing or why he was doing it. (Test. Patient 3, T. at 37.)

114. The Respondent pressed twice on one side of Patient 3's vagina and then pressed twice on the other side of it. (Test. Patient 3, T. at 37.)

115. The Respondent concluded Patient 3's examination and left the examination room. He went to another room. A [REDACTED] employee brought Patient 3 her paperwork, and Patient 3 left the building. (Test. Patient 3, T. at 38.)

116. After leaving the [REDACTED] facility on December 16, 2013, Patient 3 researched examination techniques for back pain using the Internet, and discovered that there was no need to touch the vaginal area during an examination where a female patient describes the kind of back pain that Patient 3 was experiencing on December 16, 2013. (Test. Patient 3, T. at 39-40; Resp. Ex. 6.)

117. On February 12, 2014, Patient 3 visited the Respondent at [REDACTED]'s [REDACTED] office so she could get a medication refill for her intrathecal pump and seek relief for continued lower back pain. She was also scheduled to get an MRI scan that day. She asked her husband to accompany her because of the bad experience she had with the Respondent during her December 16, 2013 examination. (Test. Patient 3, T. at 52; State's Ex. 20 at 41; State's Ex. 44 at 00048.)

118. On February 12, 2014, although the Respondent talked about measures to ease Patient 3's chronic back pain, Patient 3 also confronted the Respondent about the way he examined her on December 16, 2013. Patient 3's husband was in the examination room with Patient 3 when she confronted the Respondent about his examination techniques. Patient 3 showed the Respondent information from the Internet that demonstrated that the examination methods that he used on December 16, 2013 were inappropriate. (Test. Patient 3, T. at 40, 51-52; State's Ex. 20 at 32.)

119. On February 12, 2014, the Patient and the Respondent also engaged in a discussion about the propriety of having an MRI scan done that day. Patient 3 was fearful that the MRI equipment might empty the medication from her intrathecal pump's reservoir. Although the Respondent attempted to convince Patient 3 that having an MRI would not affect her pump,

she and the Respondent agreed to delay the MRI scan to allow her intrathecal pump to empty. Patient 3 ultimately had her MRI scan performed on February 24, 2014. (Test. Patient 3, T. at 70-71; State's Ex. 44 at 00048, 00055.)

120. The Respondent also examined Patient 3 on February 24, 2014. (State's Ex. 44 at 00073.)

121. After the February 24, 2014 visit, Patient 3 had additional medical visits with the Respondent on April 28, 2014, June 30, 2014 and September 3, 2014.¹⁵ (Test. Patient 3, T. at 75; State's Ex. 44 at 00147, 00170-00171, and 00199.)

122. A few months after the December 16, 2013 incident, Patient 3 spoke to her primary caregiver, Dr. [REDACTED] about the way the Respondent examined her on that date. Dr. [REDACTED] told Patient 3 that it "was between him and I [sic], and I should go back and talk to him." (Test. Patient 3, T. at 53.)

123. Later in 2014, after the Respondent's termination from [REDACTED], Patient 3 visited a [REDACTED] pain specialist, Dr. [REDACTED] in [REDACTED], [REDACTED]. She told Dr. [REDACTED] how the Respondent examined her on December 16, 2013, focusing on the Respondent's act of touching her vagina and surrounding region. In response to Patient 3's description of what the Respondent did on that date, Dr. [REDACTED] indicated that he did not believe the Respondent's examination techniques were appropriate.¹⁶ (Test. Patient 3, T. at 53-54.)

¹⁵ When the Respondent's counsel cross-examined Patient 3, she listed the February date as the 28th, not the 24th and the September date as the 9th, not the 3rd when she asked Patient 3 whether she had seen the Respondent on specific dates. Patient 3, in response to counsel's questioning, agreed that she had seen the Respondent on all of the dates that the Respondent's counsel had recited. Despite Patient 3's answer in the affirmative to two erroneous dates, Patient 3's medical records, found at State's Exhibit No. 44 and Respondent No. 23, show that February 24, 2014 and September 3, 2014 are the correct dates.

¹⁶ According to Patient 3, Dr. [REDACTED]'s specific reply was, "Well, no I don't know you that well." (Test. Patient 3, T. at 54.)

124. On May 13, 2015, Patient 3 notified the Virginia Department of Health Professions that the Respondent inappropriately touched her on December 16, 2013. Virginia subsequently referred Patient 3's case to the Board, because the Respondent's reported misconduct occurred in Maryland. (Test. Patient 3, T. at 55-56, State's Ex. 11 at 000005-000012.)

Findings with Respect to Patient 4

125. Patient 4 is a forty-four-year-old woman and a member of [REDACTED]. She was formerly employed by the [REDACTED] Metropolitan Police Department. She began experiencing back pain in 2004, after slipping on ice and injuring her lumbar spine. In 2010, Patient 4 had an accident at work; an elevator malfunctioned and dropped her to the basement.¹⁷ That accident aggravated Patient 4's lumbar spine injury from 2004 and caused an additional injury to Patient 4's cervical spine. (Test. Patient 4, T. at 404-05; State's Ex. 46 at 000925.)

126. Patient 4's back pain is chronic and severe. It affects both her lumbar and cervical spines, with pain radiating to Patient 4's left upper buttock, down her left leg and into the heel of her left foot, including her toes. It also radiates from Patient 4's neck to her left shoulder, the upper left part of her back and down her left arm into her left hand and fingers. (Test. Patient 4, T. at 405.)

127. From 2004 through 2014, Patient 4 received treatment for her spine injuries and back pain that included nerve blocks, epidural steroid injections in both the lumbar and cervical regions of the spine, acupuncture, three rounds of physical therapy and aquatherapy. (Test. Patient 4, T. at 406.)

¹⁷ Patient 4 testified that the elevator dropped her "below the basement." (Test. Patient 4, T. at 404.) "To the basement" is probably what she meant.

128. On April 1, 2014, Patient 4 visited the Respondent for the first time. Patient 4's primary care physician, Dr. [REDACTED] had referred Patient 4 to the Respondent because he deemed her in need of pain management services to address her chronic back pain. (Test. Patient 4, T. at 407; State's Ex. 12 at 14; State's Ex. 46 at 000925-000927.)

129. On April 1, 2014, the Respondent examined Patient 4 at [REDACTED] Medical Office Building. During the examination, the Respondent checked Patient 4's spine and the strength of her arms and legs. Patient 4 described to the Respondent all the treatment she had had up to the time of her appointment with him. (Test. Patient 4, T. at 408; State's Ex. 46 at 000926.)

130. During the April 1, 2014 examination, Patient 4 told the Respondent that she recently had an MRI scan of her cervical spine. The Respondent suggested that Patient 4 also have an MRI scan of her lumbar spine. Patient 4 and the Respondent also talked about lumbar and cervical injections. (Test. Patient 4, T. at 408; State's Ex. 46 at 000927.)

131. Patient 4 agreed to have a caudal¹⁸ epidural steroid injection of her lumbar spine. She scheduled that procedure for May 8, 2014, at [REDACTED] Medical Office Building. (Test. Patient 4 at 408; State's Ex. 46 at 001619.)

132. No chaperone was present in the examination room when the Respondent examined Patient 4 on April 1, 2014. (Test. Patient 4 at 408.)

133. On May 8, 2014, Patient 4 appeared at [REDACTED] facility for the caudal epidural steroid injection of her lumbar spine. She signed the informed consent form and prepared for the procedure immediately after arrival. (Patient 4, T. at 409.)

¹⁸ A "caudal injection" means an injection that goes into the epidural space to address pain that is radicular. The injection point is into the sacral hiatus and the cornu (i.e., the opening leading into the epidural space). (Test. [REDACTED] T. at 978.)

134. The Respondent performed the caudal epidural steroid injection¹⁹ of Patient 4's lumbar spine by having Patient 4 lie face down on the bed located in an examination room. He directed Patient 4 to lower the sweatpants and underwear that she was wearing such that she exposed her entire buttocks. (Test. Patient 4, T. at 408-09; State's Ex. 12 at 18-23.)

135. The Respondent explained to Patient 4 that he would use an ultrasound device to locate the injection site. He noted that he would numb that area first. Patient 4's main concern at this point was whether the injection would be painful. She asked the Respondent whether the injection would hurt. He replied, "You will feel a pinch." (Test. Patient 4, T. at 410.)

136. When the Respondent started the procedure, he spread the cheeks of Patient 4's buttocks and pushed and poked with his finger. As the Respondent manipulated Patient 4's buttocks, Patient 4 told the Respondent, "No doctor has ever gone this far before. I've had these injections done before no doctor has ever gone down this far." The Respondent replied that he was trying to get as close to the nerve as possible. (Test. Patient 4, T. at 410; State's Ex. 12 at 21-23.)

137. The Respondent gave Patient 4 the caudal epidural steroid injection in between her buttocks, inside the gluteal cleft, just above the anus. (Test. Patient 4, T. at 410-11; State's Ex. 12 at 24-25.)

138. On May 8, 2014, no chaperone or other staff members were present in the room when the Respondent injected Patient 4 in between her buttocks. (Test. Patient 4; T. at 412, 416.)

139. On May 8, 2014, and immediately afterwards, Patient 4 expressed unease and displeasure to her daughter and Friend 1 about how the Respondent chose a site in between her buttocks to perform the caudal epidural steroid injection. At that time, neither Patient 4's

¹⁹ The full formal name for this procedure is "caudal epidural steroid injection under ultrasound." (Test. Patient 4; State's Ex. 46 at 000957.)

daughter nor Friend 1 took Patient 4's complaints about the Respondent seriously. (Test. Patient 4 at 419; Test. Friend 1 at 472-74; State's Ex. 12 at 53-54.)

140. On July 24, 2014, Patient 4 returned to [REDACTED] facility to have the Respondent perform an epidural steroid injection in her cervical spine. Because of her prior experience with the Respondent, Patient 4 returned to the Respondent with some reluctance. She ultimately decided to allow him to give her an epidural steroid injection because she wanted relief from her back pain. (Test. Patient 4; T. at 415, 420; State's Ex. 46 at 001619.)

141. On July 24, 2014, a nurse assisted the Respondent when he performed the epidural steroid injection in Patient 4's cervical spine. That procedure went forward without incident. (Test. Patient 4; T. at 416, 422; State's Ex. 46 at 001002-001005.)

142. On or about April 12, 2016,²⁰ Friend 1 called Patient 4 to tell her that the Channel 9 news²¹ was reporting that the Respondent had been brought up on charges for molesting his patients. Patient 4 performed an Internet search using Google to verify that the Respondent was, in fact, the physician brought up on these charges. (Test. Patient 4, T. at 424-26, 433-34.)

143. Patient 4 located an article on the Internet that described the charges that the Board had filed against the Respondent up to that time; that article also provided the telephone number of Administrative Prosecutor Victoria Pepper. Remembering her experience from 2014 and believing that that the way the Respondent performed the caudal steroid injection in between her buttocks on May 8, 2014 constituted possible misconduct by him, Patient 4 left a message for Ms. Pepper. She left that message because it was after business hours and all State offices were closed. (Test. Patient 4, T. at 425-26.)

²⁰ According to Patient 4, her original attempt at submitting her complaint by facsimile failed, and Board Investigator Doreen Noppinger asked her to resubmit it by scanning it and then sending it. Ms. Noppinger was responding to the telephone message that Patient 4 left for Ms. Pepper. (Test. Patient 4, T. at 426.) Therefore, Patient 4 surmised that she most likely received the call from Friend 1 on April 12, 2016. (Test. Patient 4, T. at 433.)

²¹ Friend 1 identified Fox 5 as the television station that broadcast the news report about the Respondent's alleged misconduct. (Test. Friend 1, T. at 475.)

144. Patient 4 also went to the Board's website, printed out a complaint form, wrote a statement describing the Respondent's misconduct on May 8, 2014, and on April 13, 2016, she sent it by facsimile to the Board. That submission did not reach the Board, although a later, scanned version of her complaint form did. (Test. Patient 4, T at 425-26; State's Ex. 24.)

Findings with Respect to Patient 5

145. Patient 5 is a fifty-three-year-old woman, who is a member of [REDACTED]. She began visiting the Respondent for back-related pain management treatments in 2013. (Test. Patient 5, T. at 112; State's Ex. 47 at 001468.)

146. Patient 5 worked in a variety of capacities for a bank and an auto dealership. She then briefly worked as a cosmetologist at [REDACTED] Air Force Base. She had to stop working in 2008 when she became disabled. (Test. Patient 5, T. at 110.)

147. In 2008, Patient 5 was diagnosed with lumbar displacement. This condition resulted in Patient 5 experiencing severe back pain, which required her to receive treatments such as cortisone injections and nerve burning, to help ease that pain. Despite receiving those treatments, Patient 5 continued to experience chronic and severe back pain. (Test. Patient 5; T. at 110; State's Ex. 14 at 40.)

148. Patient 5 became familiar with the Respondent because he treated her husband to help him deal with pain in his clavicle. (Test. Patient 5; T. at 112.)

149. On November 27, 2013, Patient 5 saw the Respondent at [REDACTED] Medical Office Building as a follow-up visit. The visit occurred in an examination room. The visit began with Patient 5 and the Respondent conversing about whether treatments that the Respondent had prescribed for Patient 5 had been effective. (Test. Patient 5, T. at 115, 147, 155; State's Ex. 47 at 001512.)

150. After their conversation, the Respondent examined Patient 5. He directed Patient 5 to lie down on the examination table and pull down her pants and panties to the point just above the crack in her buttocks. (Test. Patient 5, T. at 116; State's Ex. 14 at 18-20.)

151. When he started examining Patient 5, Respondent began by squeezing Patient 5's legs hard, asking Patient 5 if it hurt as he squeezed or pressed down on certain parts of her legs. (Test. Patient 5, T. at 116.)

152. The Respondent continued squeezing Patient 5's legs moving upward toward her buttocks. He continued moving up until he reached an area close to Patient 5's rectal area (i.e., anus). He also got close to Patient 5's vagina. (Test. Patient 5, T. at 116.)

153. The Respondent also began squeezing Patient 5's thigh. (State's Ex. 14 at 4-5, 18.)

154. When the Respondent had finished examining Patient 5 on November 27, 2013, he asked Patient 5 whether she wanted to get another cortisone injection, and she told him, yes, she wanted one. (Test. Patient 5; T. at 117.)

155. Because the Respondent had examined her in her rectal/anal and vagina areas, Patient 5 felt weird and uncomfortable after the examination had concluded. Patient 5 did not expect the Respondent to examine her in those areas of her body. Additionally, the Respondent had never examined Patient 5 while she was lying on her stomach during previous visits. (Test. Patient 5; T. at 117-18.)

156. No chaperone was present in the examination room on November 27, 2013 when the Respondent examined Patient 5. Patient 5 did not request a chaperone on that occasion, because she did not believe one was necessary since she was not having a gynecological examination. (Test. Patient 5; T. at 118-19.)

157. The door to the examination room was closed at all times on November 27, 2013 when the Respondent examined Patient 5. (State's Ex. 14 at 28.)

158. Patient 5 continued to visit the Respondent after November 27, 2013, because she needed to receive treatment for her back pain, such as epidural steroid injections. (Test. Patient 5, T. at 119; State's Ex. 47 at 001528-001533, 001558-001566, 001597-001601, 001629-001637.)

159. On April 15, 2016, Patient 5 filed a written complaint with the Board, because her adult daughter had alerted her that she had seen a television news story about the Respondent's alleged misconduct involving inappropriate touching of female patients. Based on the Respondent's behavior on November 27, 2013, Patient 5 believed that the Respondent had inappropriately touched her on that date as well. (Test. Patient 5, T. at 119, 131.)

160. Patient 5 suffers from bipolar disorder and experienced a sexual assault as a young child. The realization that the Respondent had inappropriately touched her in the sexual regions of her body caused Patient 5 to experience severe anxiety and required her to seek sexual assault counseling on a weekly basis. (Test. Patient 5, T. at 131-32, 137-40; State's Ex. 47 at 001556.)

Findings with Respect to Patient 6

161. Patient 6 is a fifty-eight-year-old woman. She has been a phlebotomist since the 1980s. She began working for [REDACTED] in December 1993 as a phlebotomist, but sometime later, she began working in [REDACTED] Utilization Management Operation Center (UMOC) in an administrative capacity. She is a member of [REDACTED] (Test. Patient 6, T. at 487.)

162. Patient 6 began seeing the Respondent for pain management in May 2011. (Test. Patient 6, T. at 489-90.)

163. Patient 6 found the Respondent's approach to pain management attractive to her, because he was the only physician she knew of who sedated patients when performing epidural injections. (Test Patient 6, T. at 492.)

164. During an examination that occurred sometime between 2012 and 2014, Patient 6 visited the Respondent at one of [REDACTED]'s medical office buildings for treatment of lower left-side back pain. (Test. Patient 6; T. at 491.)

165. The Respondent examined Patient 6 during one visit in which Patient 6 was seeking treatment for lower left-side back pain. On that occasion, he directed Patient 6 to lower her jeans until part of her buttocks was exposed. After Patient 6 lowered her jeans, the Respondent started pressing in the middle of Patient 6's back and continued pressing down her spine until he reached Patient 6's buttocks. Once at Patient 6's buttocks, the Respondent began groping them. (Test. Patient 6, T. at 491-92.)

166. No chaperone was present during the examination in which the Respondent groped Patient 6's buttocks. (Test. Patient 6, T. at 492.)

167. On another occasion, Patient 6 also presented to the Respondent for the treatment of back pain. The Respondent examined Patient 6 in a manner similar to the previous visit, but during this examination, he brushed against Patient 6's clitoris with his thumb. (Test. Patient 6, T. at 492-94.)

168. The Respondent never wore gloves when he examined Patient 6. (Test. Patient 6, T. at 492.)

169. Patient 6 did not complain to anyone about the Respondent's conduct at the time that he groped her buttocks and brushed her clitoris with his thumb, because she trusted him and thought she was misinterpreting what he was doing, believing her fears unfounded. (Test. Patient 6, T. at 490, 492.)

170. Before she filed a complaint with the Board, Patient 6 had an overall favorable opinion of the Respondent, so much so that she invited him to her daughter's wedding in April 2014. (Test. Patient 6, T. at 497-98, 527; State's Ex. 33 at 00035.)

171. Patient 6 filed a complaint against the Respondent with the Board on April 25, 2016. (State's Ex. 26.)

Findings with Respect to Patient 7

172. Patient 7 is a forty-year-old woman. She suffers from lower back pain. As of May 2013, she had been seeing the Respondent for pain management treatments for approximately two years. She usually visited him once every three months.²² (State's Ex. 17 at 3, 5.)

173. On May 28, 2013, Patient 7, accompanied by her five-year-old daughter, went to a [REDACTED] facility²³ to get a hard copy of a prescription refill from the Respondent. She had her vital signs taken at that location, but was told that the Respondent had an emergency and was not there; he was at [REDACTED] Medical Office Building. (State's Ex. 17 at 4.)

174. Patient 7 went to [REDACTED] Medical Office Building to get the hard copy of the prescription refill from the Respondent. (State's Ex. 17 at 4.)

²² The State issued a subpoena for Patient 7 to testify at the hearing, but she failed to appear. According to Ms. McSherry, Patient 7 was incarcerated at the Charles County Detention Center on November 16, 2016, the date she was scheduled to appear. (T. at 746.) Although no one verified Patient 7's incarceration, the State's counsel, Ms. Pepper, did acknowledge that Patient 7 had been incarcerated previously. (T. at 746-47.) Consequently, I am relying on the information that Patient 7 provided during her Board interview with Ms. Noppinger on May 4, 2016 as the primary source for my findings of fact regarding the Respondent's interactions with Patient 7.

²³ When Patient 7 provided her statement to Ms. Noppinger, she identified the location where she originally arrived to see the Respondent as [REDACTED] Medical Office Building. The Respondent strongly disputes the truth of this testimony. When he testified, the Respondent noted that [REDACTED] facility had not expanded as a "hub" to provide enhanced medical services, such as urgent care or surgery, until July 8, 2013. Moreover, the Respondent maintains that he did not see any patients in [REDACTED] facility until it was a hub. (Test. Respondent, T. at 1024.) The Respondent also offered a press release to buttress his testimony. (Resp. Ex. 22.) That press release clearly establishes the opening of [REDACTED] Medical Office Building in [REDACTED] as a hub on July 8, 2013. The Respondent contends, therefore, that Patient 7's assertion that she went to see him in [REDACTED] on May 28, 2013 demonstrates that she was not telling the truth, because he would not have seen patients there until two months later. Because Patient 7 continued to seek treatment from the Respondent after the [REDACTED] facility opened, however, she could have been confused about where she visited him on the date in question. Consequently, I do not find her identification of the place where she went to see the Respondent as [REDACTED] so significant that it completely discredits her. Moreover, Patient 7's medical records, and e-mails contained within those records, verify May 28, 2013 as a date when the Respondent examined Patient 7 as well as Patient 7's concerns about the way the Respondent examined her on that date. (State's Ex. 49 at 00007-00011.)

175. When Patient 7 arrived at [REDACTED] Medical Office Building on May 28, 2013; a physician's assistant took her to the examination room, and the Respondent came to see her. The Respondent asked Patient 7 how she was doing, and Patient 7 told him she was still having pain in her lower back. She emphasized that she was actually having more pain on her right side. (State's Ex. 17 at 5.)

176. Patient 7 demonstrated to the Respondent where the pain in her lower back was located using her hand to point to the site of her pain. (State's Ex. 17 at 5.)

177. After Patient 7 described where her pain was, the Respondent sat in an ordinary chair and directed Patient 7 to stand up in front of him. He positioned Patient 7 so that she was facing her daughter, who was in the room with her. He then pulled Patient 7's underwear and pants down to a point just below Patient 7's buttocks. (State's Ex. 17 at 5.)

178. The Respondent began poking Patient 7's lower back, where she told him the pain started. She also noted that the pain shot down the back of her right leg. The Respondent then started poking at Patient 7's buttocks, and continued down Patient 7's right leg. (State's Ex. 17 at 5.)

179. As the examination continued, the Respondent asked Patient 7 whether she had any pain on her left side. Patient 7 gave no answer, but the Respondent proceeded to poke down Patient 7's left leg, starting with her buttocks, in the same way he did with her right leg. (State's Ex. 17 at 5.)

180. While he was examining Patient 7 in the area surrounding her buttocks, the Respondent poked around the side of Patient 7's buttocks, squeezing it, and asking if Patient 7 felt any pain there. The Respondent's thumbs were in an area close to Patient 7's vagina while squeezing Patient 7's buttocks. (State's Ex. 17 at 5-6.)

181. Patient 7 felt uncomfortable with the Respondent's examination of her buttocks, because his thumbs were so close to her vagina. (State's Ex. 17 at 6.)

182. After the Respondent finished examining Patient 7, he started to pull up Patient 7's underwear, but Patient 7 quickly pulled them up herself. (State's Ex. 17 at 6.)

183. The Respondent explained to Patient 7 that he would be scheduling an x-ray for her because he believed that her pain might be getting worse and he wanted to find out why. He left the examination room, returned with the hard copy of Patient 7's prescription refill, and exited the room. (State's Ex. 17 at 6.)

184. On May 28, 2013, there was no chaperone in the room with Patient 7 while the Respondent examined her. (State's Ex. 17 at 20.)

185. On the way home from her visit with the Respondent on May 28, 2013, Patient 7 called her husband and told him that she was uncomfortable with the way the Respondent examined her. She told him, "It just didn't feel right." (State's Ex. 17 at 6.)

186. On May 30, 2013, Patient 7 e-mailed and called [REDACTED] the physician's assistant who escorted her into the examination room the previous day. When she spoke with Ms. [REDACTED] over the telephone, Patient 7 told Ms. [REDACTED] that she wanted an explanation concerning the lumbar spine examination that the Respondent performed on her the previous day. Ms. [REDACTED] reviewed the examination notes with Patient 7 over the telephone and provided the name of the examination the Respondent performed, but Patient 7 indicated she was not satisfied with that review. She wanted to speak with the Respondent personally. Ms. [REDACTED] advised Patient 7 to message the Respondent, but Patient 7 indicated that she could not find his messaging information on [REDACTED]'s website. (State's Ex. 17 at 7-8; State's Ex. 49 at 00007.)

187. Based on the name of the examination that Ms. [REDACTED] supplied to her, Patient 7 went to YouTube to find out how that examination was supposed to be done. (State's Ex. 17 at 8-9.)

188. On June 3, 2013, having received no additional response from the Respondent through her communications with Ms. [REDACTED] Patient 7 found an e-mail address for the Respondent and sent him the following e-mail message with regard to the examination he performed on her on May 28, 2013:

I would like to have a list of the names of the exams that you performed during my visit. Specifically the last exam where you pull down my underwear, put on gloves and squeeze my buttocks. That exam was VERY uncomfortable [:] I have NEVER had a doctor performed that exam, and I would like to know the name of it AND the purpose.

(State's Ex. 49 at 00010.)

189. On June 4, 2013, the Respondent called Patient 7 to discuss her e-mail message. Patient 7 asked the Respondent what type of examination he performed, and he provided the same name of the examination that Ms. [REDACTED] had given her. Patient 7 told the Respondent she viewed the example of that kind of examination on YouTube, and that was not the kind of examination that the Respondent had performed. The Respondent did not address Patient 7's question and went on to discuss the x-ray referral that he made on May 28, 2013. (State's Ex. 17 at 9.)

190. The Respondent made no notes concerning his telephone conversation with Patient 7 on June 4, 2013 in Patient 7's medical record. (State's Ex. 49 at 00011.)

191. After June 2013, Patient 7 relied on the Respondent's physician's assistant to obtain prescription refills for her from the Respondent. [REDACTED] ultimately switched Patient 7 to another pain management physician after the Respondent's termination. (State's Ex. 17 at 10.)

192. On May 9, 2016, Patient 7 filed a complaint against the Respondent with the Board. (State's Ex. 28.)

General Finding

193. Patients 2, 3, 5 and 6 had been sexually abused as children. (Test. Patient 2, T. at 356; Patient 3, T. at 38; Patient 5, T. at 131-32; Patient 6, T. at 499.)

Findings Related to the Respondent's New Employment with [REDACTED]

194. In December 2014, the Respondent began working as a pain management physician for [REDACTED] (Test. [REDACTED] T. at 967; Resp. Ex. 9.)

195. [REDACTED] requires physicians to have a female chaperone known as a "scribe" to be present at all times when they are examining female patients. When a physician examines and/or treats a female patient at [REDACTED] the physician communicates with the scribe, and the scribes make entries in the patient's electronic medical record. (Test. [REDACTED] T. at 903-05, 911-12; Test. [REDACTED] 969-70.)

196. During his employment with [REDACTED] from December 2014 through May 2016, there were no alleged instances of the Respondent inappropriately touching any female patients when he examined them. (Test. [REDACTED] T. at 916-17; Test. Resp., T. at 1011; Resp. Exs. 10-11.)

Findings Related to the Respondent's Application for Reappointment to [REDACTED]

197. At all times relevant, the Respondent had privileges at [REDACTED] that were subject to periodic renewal through a reappointment process. [REDACTED] is a medical facility under the umbrella of [REDACTED] (State's Ex. 38.)

198. On July 29, 2015, the Respondent electronically submitted his application for reappointment to [REDACTED] application). (Test. Noppinger, T. at 680-81, 717-18; State's Ex. 38.)

199. The [REDACTED] Application required the Respondent to answer the following questions pertinent to whether he had been disciplined by any other healthcare organization:

Have any of the following ever been, or are currently in process, either on a voluntary or involuntary basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

6. Membership on any hospital/medical staff?

....

10. Participation in any other healthcare organization (surgicenter, managed care, PPO, PHO, MSO, etc.)

(State's Ex. 38 at 00011.)

200. The Respondent answered "no" to both question 6 and question 10 with regard to disciplinary actions by any healthcare organizations. (State's Ex. 38 at 00011.)

201. Based on terms of his contract with [REDACTED] the Respondent knew or should have known that his termination from [REDACTED] on October 28, 2014 was for cause and, therefore, for disciplinary reasons. (State's Ex. 7 at 0040-0041.)

Findings Related to the Respondent's Renewal Application Submitted to the Board

202. In Maryland, physicians' licenses are subject to renewal every two years. On August 10, 2015, the Respondent submitted his physicians license renewal application (Renewal Application) electronically to the Board. (State's Ex. 39.)

203. Under Question 6, related to "Character and Fitness," the Renewal Application required the Respondent to answer the following:

The following questions pertain to the period since July 1, 2013. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann., Health Occ. § 14-404?

- n. Has your employment by any hospital, HMO, related healthcare or other institution or military entity been terminated for any disciplinary reasons?

(State's Ex. 39 at 00001-00002.)

204. The Respondent answered "no" to both questions d and n under Question 6 of his Renewal Application. (State's Ex. 39 at 00001-00002.)

205. Based on his interview with Dr. [REDACTED] on October 24, 2014 and his meeting with Dr. [REDACTED] on October 28, 2014, the Respondent knew or should have known that the results of the investigation conducted by [REDACTED] concerning his interaction with Patient 2 yielded information that could have been grounds for action under H.O. section 14-404. (Test. [REDACTED] T. at 550-52; State's Ex. 37.)

206. Based on terms of his contract with [REDACTED], the Respondent knew or should have known that his termination from [REDACTED] on October 28, 2014 was for cause and, therefore, for disciplinary reasons. (State's Ex. 7 at 0040-0041.)

DISCUSSION

I. The Law and Introduction.

The State charged the Respondent with violating various provisions of the Act, Health Occ. §§ 14-101 through 14-416 (2014 & Supp. 2016), and associated Code of Maryland Regulations (COMAR) sections related to sexual misconduct by physicians, specifically, COMAR 10.32.17.01 through .03. In essence, the State charged the Respondent with violating provisions of the Act and COMAR by inappropriately touching seven female patients in such a way that it constituted sexual misconduct. It also charged the Respondent with violating the Act

by willfully making or filing false reports in the practice of medicine and willfully making a false representation when seeking or making an application for licensure. (State's Ex. 51.)

The State cited the following legal authority as the basis for its charges:

Health Occupations sections 14-404(a)(3)(i) and (ii), (11) and (36), which state:

(a) Subject to the hearing provisions of § 14-405 of this subtitle, [the Board], on the affirmative vote of a majority of the quorum . . . , may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

....

(3) Is guilty of:

(i) Immoral conduct in the practice of medicine;²⁴ or

(ii) Unprofessional conduct in the practice of medicine;²⁵

....

(11) Willfully makes or files a false report or record in the practice of medicine; [or]

....

(36) Willfully makes a false representation when seeking or making application for licensure or any other application related to the practice of medicine

Health Occ. § 14-404(a)(3)(i) and (ii), (11) and (36) (Supp. 2016).

COMAR 10.32.17.01-03

.01. Scope.

This chapter prohibits sexual misconduct against patients or key third parties by individuals licensed or certified under Health Occupations Article, Titles 14 and 15, Annotated Code of Maryland.

.02. Definitions.

A. In this chapter, the following terms have the meanings indicated.

²⁴ "The meaning of terms such as 'immoral conduct' . . . is determined by the 'common judgment' of the profession as found by the professional licensing board." *Finucan v. Md. Bd. of Physician Quality Assurance*, 380 Md. 577, 593 (2004).

²⁵ Unprofessional conduct "refers to 'conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession.'" *Id.* (citing *Shea v. Bd. of Med. Exam'rs*, 146 Cal. Rptr. 653, 660 (Cal. Dist. Ct. App. 1978)).

B. Terms Defined.

(2) Sexual Impropriety.

(a) "Sexual impropriety" means behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or a key third party regardless of whether the sexual impropriety occurs inside or outside of a professional setting.

(b) "Sexual impropriety" includes, but is not limited to:

- (i) Failure to provide privacy for disrobing;
- (ii) Performing a pelvic or rectal examination without the use of gloves;
- (iii) Using the health care practitioner-patient relationship to initiate or solicit a dating, romantic, or sexual relationship; and
- (iv) Initiation by the health care practitioner of conversation regarding the health care practitioner's sexual problems, sexual likes or dislikes, or fantasies.

(3) "Sexual misconduct" means a health care practitioner's behavior toward a patient, former patient, or key third party, which includes:

- (a) Sexual impropriety;
- (b) Sexual violation;

(4) Sexual Violation.

(a) "Sexual violation" means health care practitioner-patient or key third party sex, whether or not initiated by the patient or key third party, and engaging in any conduct with a patient or key third party that is sexual or may be reasonably interpreted as sexual, regardless of whether the sexual violation occurs inside or outside of a professional setting.

(b) "Sexual violation" includes, but is not limited to:

- (v) Touching the patient's breasts, genitals, or any sexualized body part;

.03. Sexual Misconduct.

A. Individuals licensed or certified under Health Occupations Article, Titles 14 and 15, Annotated Code of Maryland, may not engage in sexual misconduct.

B. Health Occupations Article, §§14-404(a)(3) and 15-314(3), Annotated Code of Maryland, includes, but is not limited to, sexual misconduct.

As the moving party, the State has the burden of proof by a preponderance of the evidence. Md. Code Ann., State Gov't § 10-217 (2014); *Comm'r of Labor & Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996).

After considering all of the evidence presented in light of the applicable legal authority, I conclude that the State has met its burden of proof on all charges. It demonstrated that the Respondent is subject to sanction under section 14-404(a)(3)(i) and (ii) of the Act, because he was guilty of immoral and unprofessional conduct in the practice of medicine. That immoral and unprofessional conduct involved his engaging in "sexual impropriety" as defined by COMAR 10.32.17.02B(2)(a) and (b)(ii), and "sexual violation(s)" as defined by 10.32.17.02B(4)(a) and (b)(v), both of which constitute "sexual misconduct," as defined by COMAR 10.32.17.02B(3), with regard to acts of sexualized touching that he committed while examining Patients 1 through 7. The State also demonstrated that the Respondent is subject to sanction under section 14-404(a)(11) of the Act for willfully failing to disclose his termination from [REDACTED] on his July 29, 2015 application for reappointment to [REDACTED]. It further demonstrated that the Respondent is subject to sanction under section 14-404(a)(36) of the Act for willfully failing to disclose his termination from [REDACTED] on his August 10, 2015 physicians renewal application. The evidence that the Respondent provided in his defense, including his own testimony, does not refute or even mitigate the seriousness of the charges brought against him by the Board.

I will address the following: (a) the Respondent's assertion that alleged deficiencies in the Board's investigation and charging document prejudiced him such that he was denied due process, which I have concluded is not the case; (b) the Respondent's conduct vis-à-vis each patient as it relates to section 14-404(a)(3)(i) and (ii) of the Act; and (c) the Respondent's false reports/misrepresentations as they relate to section 14-404(a)(11) and (36). After I conclude those discussions, I will turn to the sanction that I believe the Board should adopt.

II. *Alleged Deficiencies in the Board's Investigation and Charging Document.*

From the preliminary stages of this proceeding—and during the hearing itself—the Respondent steadfastly asserts that the Board conducted an inadequate and incomplete investigation. He maintains that the Board's deficient investigation prejudiced him and, thus, denied him due process. The Respondent further asserts that the State's amendment of the already "Amended Charges" during the hearing process also prejudiced him because he could not adequately defend himself against charges that continuously changed. The State counters that whatever took place during the investigatory phase of this proceeding could not have prejudiced the Respondent, because the law precludes any attack on what occurred during the investigatory process. (See below.) Moreover, the State avers that its corrections to the Amended Charges also could not have prejudiced the Respondent because, during the hearing, the State only withdrew certain charges or modified them to comport with the evidence. It did so when it discovered that witness testimony did not support the Board's charges as written. (The State did not add any charges.)

With regard to the Respondent's contention that the Board's inadequate or incomplete investigation prejudiced him, section 14-405(g) of the Act states, "The hearing of charges may not be stayed or challenged by any procedural defects alleged to have occurred prior to the filing of charges." Health Occ. § 14-405(g) (2014).

The Respondent, however, argues that flaws in the Board's investigation process, the process that formed the basis of the charges that the State pursued during the hearing, prejudiced him, so much so, that his ability to have a fair hearing was irreparably undermined. He maintains the Board's investigation was deficient in two fundamental ways:

- The allegations of the complainant/patients are not supported by any contemporaneous corroboration.
- The Board's investigation lacked impartiality.

The Respondent cites *Rosov v. Maryland Board of Dental Examiners*, 163 Md. App. 98 (2005), in support of his argument.²⁶ With regard to *Rosov*, the Respondent's counsel argues, "[T]here's information in that case that indicates that the investigation here was deficient and deficient in a way that does impact [the Respondent's] due process rights as he is sitting here today defending his livelihood and his ability to practice medicine in Maryland." (T. at 1457.) I cannot discern what information the Respondent is referring to in *Rosov*. In *Rosov*, the respondent-dentist's major complaint was that Maria Bartrem, the Dental Board's investigator, was not present at the hearing and, therefore, could not authenticate her report. Dr. Rosov noted that such an unauthenticated hearsay report would be inadmissible in a judicial trial. *Rosov*, 163 Md. App. at 115. The Court of Special Appeals agreed with that assertion, but noted that the respondent-dentist was participating in an administrative hearing, not a judicial trial. Therefore, the investigator's report was admissible under the relaxed rules of evidence that apply in administrative proceedings. *Id.*

The respondent-dentist in *Rosov* also contended, "[T]he report reveals Bartrem's biased viewpoint, and cites 'major defects in the manner of the investigation, including the participation of the State but not Dr. Rosov, the documentation of the investigation, the manner of how

²⁶ The Respondent also cited *MacKoul v. Maryland State Board of Physicians*, No. 2607, 2016 WL 281592 (Md. Ct. Spec. App. Jan. 20, 2016) (Unreported), for the proposition that a charged physician must show prejudice to establish a due process challenge.

conclusions were reached, etc.” *Id.* The court rejected the Respondent’s contention and stated the following in doing so:

“[Dr. Rosov] provides no support in the record for his allegation that the investigation was substantially defective. He presented no evidence that Bartrem’s manner of investigation was faulty, nor does the record support such a conclusion. Rosov rests his argument on the fact of Bartrem’s employment by the Board and interaction with the staff during the investigation. If that were that the standard, any such report, by any agency charged with the enforcement of professional standards, would be suspect.”

Id. at 115–16.

Here, Ms. Noppinger was present and testified about her findings. She related Patient 7’s testimony in lieu of Patient 7 testifying because, presumably, Patient 7 was incarcerated and unavailable to appear at the hearing. Yet, as the *Rosov* court emphasized, hearsay is admissible in administrative hearings. *Id.* at 116. Additionally, just as in *Rosov*, Ms. Noppinger prepared interim investigative reports summarizing her notes; she did not offer conclusions about whether she believed that the Respondent engaged in acts of misconduct. (Resp. Ex. 16.) For the most part, when she testified, Ms. Noppinger also related only what interviewees told her. She also identified (i.e., authenticated) the transcripts of the patient-interviews that she and her co-investigators conducted, which the State offered as evidence. Therefore, the Respondent argues that Ms. Noppinger’s investigative reports were deficient for essentially the same reasons that Dr. Rosov alleged that Ms. Bartrem’s investigative report was deficient in his case, and the Court of Special Appeals rejected Dr. Rosov’s arguments.

As I discuss in detail below, there admittedly were discrepancies between what many of the patients told Ms. Noppinger and what they testified to at the hearing. These kinds of discrepancies are to be expected given that some of the earliest instances of the Respondent’s misconduct took place in late 2012. Memories can become clouded and details lost with that clouding. The Respondent, as noted, complained about this time lag (lack of contemporaneous

corroboration), but that too was unavoidable under the circumstances of this proceeding. Most of the patients here were reluctant to complain about the Respondent's inappropriate touching, because they were unsure whether the Respondent was just performing a thorough examination or whether he had crossed the line into sexual impropriety. Despite the time lags present here, I found the patients' versions of what occurred essentially identical at the macro level. Discrepancies only appear at the micro level. Again, I will examine in detail how these micro variances did or did not affect each patient's credibility.

The Respondent has protested throughout all phases of this proceeding that he was unable to seek potentially exculpatory materials from his former employer [REDACTED]. I dealt with the subpoena that the Respondent sent to [REDACTED] for various patient interview records in my November 14, 2016 Order and on the first day of hearing. I will not revisit that ruling here. Suffice it to state, that in the instances of six out of seven patients, the Respondent had the opportunity to confront his accusers face-to-face. His attorneys engaged in rigorous cross-examination of those six patients. His attorneys had the opportunity to question Ms. Noppinger about Patient 7's interview. His attorneys also had the opportunity to object to the State's evidence. Additionally, I am not making my proposed decision based on [REDACTED]'s investigation; I am making it solely on the record before me.

The Respondent further asserts that the failure of Ms. Noppinger to inform the Board of discrepancies and inconsistencies between the statements of the complaining patients in the medical record and other objective facts, which he contends, might have avoided bringing of some or all the charges in the first place, was also a deficiency in the Board's investigation. The Respondent cited no legal authority that requires the investigator to inform the Board of any discrepancies and inconsistencies. As noted above, section 14-405(g) of the Act forecloses attacks on the investigative process.

In a similar vein, the Respondent argues that the failure of Ms. Noppinger to notify him when it altered the allegations of the patients to correspond to what she determined would be the correct dates or circumstances (based on medical records or other documents) was a deficiency that denied him due process. Again, the Respondent cited no legal authority establishing such a requirement, and, likewise, section 14-405(g) of the Act precludes an attack on the investigative process.

According to the Respondent, the Board also violated his due process rights by failing to obtain peer review information about how lower back examinations should be done. To the extent that peer review was necessary, the State's failure to pursue it would only inure to the benefit of the Respondent.²⁷ I agree with the State, however, that peer review was unnecessary here because this hearing did not involve standard of care issues. Health Occ. § 14-404(a)(22) (Supp. 2016); COMAR 10.32.02.03D(1)(a). The charges at issue concern inappropriate sexual touching by the Respondent, not whether the Respondent performed a proper lower back examination of the patients who accused him of sexual misconduct.

The Respondent further argues that the Administrative Prosecutor's amendment of the charges "on-the-fly" is not a call that an administrative prosecutor can make. Amendment authority is vested in the Board. The Respondent views any amendment of the charges as making him face a "moving target," which rendered him incapable of offering a cogent defense.

I disagree with the Respondent's assertions regarding the amendment of the Amended Charges. The Amended Charges were not altered in any significant way such that the Respondent could not defend against them. For example, Charge 13 was altered to eliminate the sentence, "The Respondent then reached around and came close to, but did not touch Patient 1's vagina." That is a charge that the State admitted that it could not prove. I cannot find prejudice to

²⁷ The Respondent could have offered his own peer review evidence in the form of an expert opinion, provided that he complied with the requirements of COMAR 10.32.02.04C(3)(a).

the Respondent by the *removal* of a charge. In another example, a sentence in Charge 18 was amended to change the words, "After the procedure," to "Before the procedure," and "post-surgical" to "pre-surgical." Again, with the remainder of Charge 18 intact, I cannot find any prejudice to the Respondent; he still had sufficient information to defend against the charge. In addition, it would be a tremendous waste of time for the Administrative Prosecutor to receive permission from the Board every time she wanted to make minor alterations in the charges, when they did not impair the fundamental aspects of the charges as a whole.

Furthermore, Footnote 3 of the Amended Charges, states the following:

The statements of the Respondent's conduct with respect to the patients identified herein are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial to be offered against the Respondent.

(State's Ex. 51 at 4.)

With this disclaimer, the Board is alerting the Respondent that it does not intend to prove each charge against him *verbatim*. Its charges serve as a guide to alert the Respondent about the nature of his alleged misconduct. As the State notes, the charging document only needs to provide the Respondent with the "gist of the charges." *Regan v. State Bd. of Chiropractic Exam'rs*, 355 Md. 397, 417-18 (1999). The Amended Charges document, with or without alterations, certainly does that. Similarly, the Court of Special Appeals, citing *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950), noted, "Due process requires 'notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.'" *Reese v. Dep't of Health & Mental Hygiene*, 177 Md. App. 102, 150 (2007). The Amended Charges document fulfills this requirement as well.

III. *Charges Under Section 14-404(a)(3)(i) and (ii) of the Act.*

A. *The Respondent.*

The Respondent was initially licensed to practice medicine in Maryland on October 18, 2007, after receiving his medical education in Michigan and Illinois and practicing medicine in Illinois before moving to Maryland in 2007. He is forty-three years old. The Respondent is board-certified in anesthesiology and the sub-specialty of pain medicine. From November 2010 through October 2014, [REDACTED] employed the Respondent as an interventional pain management specialist. While at [REDACTED] he saw patients in Maryland at [REDACTED]'s [REDACTED] Medical Office Buildings. As noted above, [REDACTED] terminated him from his employment in late October 2014. [REDACTED] reemployed the Respondent as a pain management physician in December 2014. He remained an actively practicing physician there until May 2016, when the Board summarily suspended his medical license.

Many of the patients the Respondent treated initially had favorable opinions of him, including some who testified against him. Patients 1 and 6, for example, emphasized that before they learned about the Respondent, they could not find another pain management physician who would anesthetize them before administering excruciatingly painful TFESIs and LJF injections. They had, in fact, avoided those kinds of injections for some time before becoming the Respondent's patients, despite the potential those injections had for relieving their back pain.

On June 24, 2013, Patient 6 was so satisfied with the care that the Respondent provided to her that she sent an e-mail message to [REDACTED] praising him. That complimentary e-mail stated the following:

Wow! What can I not say about a terrific doctor, what I would like to say is that I truly, truly, truly appreciate [the Respondent]. All the pain issues I've been going through all these years[—]he's been so attentive to understand what I've been going through. He's always prompt to respond in a timely fashion through kp.org or phone calls. Due to my pain situation, he has always fit me into his schedule to take care of my condition. I hope he never, never leaves. I want to thank him from the bottom of my heart for the person he is.

(Test. Patient 6, T. at 497; State's Ex. 33 at 00035.)

Nevertheless, the evidence offered by the State depicts a very different Respondent—not the caring physician that Patient 6 portrayed in her June 24, 2013 e-mail—but a sexual predator who engaged in a pattern of subtly groping his female patients, *including Patient 6*, while ostensibly examining them for back pain.²⁸

The Respondent engaged in a distinct pattern of abuse that can be readily discerned, beginning with Patient 1. Elements of that pattern can be seen in how he interacted with her, as well as the remaining six patients who are the subject of the Board's charges.

B. Patient 1.

Patient 1 began seeing the Respondent precisely because the Respondent used twilight sedation to administer otherwise painful spinal injections. Patient 1 testified that the Respondent first examined her on November 21, 2012, at [REDACTED] Medical Office Building. That examination took place in a cubicle surrounded by privacy curtains that could be rolled in and out of place.

According to Patient 1, during that November 21, 2012 examination, once the Respondent manipulated her legs, he had her pull down her pants and underwear past her buttocks. The Respondent then took his bare hands (i.e., he was not wearing gloves) and examined Patient 1's lower waist and buttocks. Patient 1 noted that the Respondent started at her hips and moved his hands up and down until he reached her buttocks. Once there, the

²⁸ Or, as the State characterized it, "[T]he Respondent inappropriately touched seven female patients in sexualized areas of their body, their vagina, buttocks and anus without medical necessity, without patient consent and under the guise of medical treatment." (T. at 1404.)

Respondent spread and opened Patient 1's buttocks cheeks, placing his fingers inside her gluteal cleft as he did so.²⁹

Patient 1 stated that she thought it was odd that the Respondent needed to examine her buttocks at all, let alone in the manner that he did. She asserted, "When I left, I had the notion in my head my doctor is nasty. He examined me with no gloves. But I did not view it as being anything wrong. I just viewed it as part of his examination and he was just careless." (Test. Patient 1, T. at 198.)

[REDACTED] had then and has now a chaperone policy. Dr. [REDACTED] testified that [REDACTED]'s chaperone policy allowed all patients (as well as parents and guardians) to request a non-family member chaperone to be present during an examination or procedure, including, but not limited to: (1) any pelvic examination and (2) any genital, breast and/or anal examination. Signs announcing this policy are posted in all of [REDACTED]'s examination rooms. Patient 1 reported, however, that no chaperone was present during the November 21, 2012 examination, or during any subsequent examinations of her that the Respondent performed. She, like the other patients mentioned here, found no need for a chaperone because the Respondent was examining her for issues related to spinal pain; she did not anticipate him examining her buttocks.

On December 14, 2012, the Respondent administered two injections to Patient 1, a TFESI and an LFJ. Patient 1 had an appointment with the Respondent on January 26, 2013, as a follow-up to receiving her injections. Patient 1 averred that these appointments took place without incident.

²⁹ On July 8, 2015, Patient 1 told Ms. Noppinger that the Respondent "felt inside her behind." (State's Ex. 8 at 5.) On November 14, 2016, she testified that he "felt inside my buttock." (T. at 201.) Based on Patient 1's two parallel accounts of what occurred and Patient 1's assertion that the Respondent did not penetrate her anus, I determined that on November 21, 2012, the Respondent used Patient 1's gluteal cleft or buttocks crack as the gripping point for his fingers when he spread Patient 1's buttocks' cheeks.

On June 14, 2013, in preparation for having another TFESI and LFJ injection series, the Respondent performed a preoperative examination of Patient 1 at [REDACTED] facility. Patient 1 testified that that examination similarly took place in a cubicle surrounded by privacy curtains. The cubicle was located near the ASC where the Respondent would be administering the injections to Patient 1's spine. Before he examined Patient 1, to facilitate the injection process, Patient 1 noted that the Respondent had her remove her street clothes and put on a hospital gown.

Patient 1 explained that when the Respondent examined her on June 14, 2013, he had her stand while he sat on a stool. He was facing her back. Patient 1 stated that the Respondent moved his hands from the bottom of her legs upward to her thighs. He then moved up to Patient 1's buttocks region, where he placed his hands to the front of Patient 1's body toward her vagina, coming close to the vaginal opening. Although her hearing testimony and her interview remarks to Board Investigator Doreen Noppinger varied slightly, it is certain that Patient 1 exclaimed something close to "Man, what are you doing?" when the Respondent's hands approached Patient 1's vagina. According to Patient 1, the Respondent reacted to Patient 1's exclamation by saying, "It's all right. Don't worry. It's all right." Patient 1 was sedated soon afterward to receive her injections.

Patient 1 had other visits with the Respondent after June 14, 2013 that were uneventful. On January 24, 2014, Patient 1, though, appeared at the ASC in [REDACTED] to receive a steroid injection/cooled radiofrequency ablation of lateral branch. She invited her boyfriend, Person 1, to remain in the room with her while the Respondent examined her. She testified that she wanted Person 1 there because she feared the Respondent might again touch her in inappropriate places. Patient 1 had, at this point, told Person 1 about what she believed were the Respondent's questionable examination techniques.

According to Patient 1, on January 24, 2014, the Respondent had her disrobe and put on a hospital gown. The Respondent then examined Patient 1 in a cubicle similar to the one that he examined her in on June 14, 2013. There was a bed and a chair inside the cubicle, and, just as on November 21, 2012 and June 14, 2013, the cubicle was surrounded by two movable curtains.

Patient 1 explained that the Respondent began his examination by having her stand with her arms spread out in front of her. He sat on a movable stool and, with gloved hands, he started palpating at the base of Patient 1's legs and continued to move his hands up her body until they reached underneath her hospital gown. Patient 1 asserted that he kept moving up her legs until his hands touched her vagina. Once there, Patient 1 described the Respondent putting his fingers inside her vagina, and while doing so, she maintained that his knuckles touched her clitoris.

According to Patient 1, when she felt the Respondent's fingers inside her vagina, she became distressed. She asked the Respondent "Why are you doing this? You already determined there's nothing there triggering any pain. So, why you keep doing this?" Patient 1 insisted that the Respondent did not respond to anything she said. He ignored her and continued to feel around her vagina.

After completing his examination, Patient 1 and Person 1, who, as noted, was in the examination room the entire time that the Respondent was examining Patient 1, both saw the Respondent take off his gloves, sniff them, roll them up, and discard them in the trash. They also noted that when he exited to the hallway, he threw his arms in the air as he walked away from the examination cubicle.

I find Patient 1's testimony credible. Patient 1's description of the Respondent's conduct was detailed, and it has remained consistent in all important respects for a long time. I agree with the Respondent that Patient 1's hearing testimony varied somewhat from what she told Board Investigator Doreen Noppinger on July 8, 2015. I will also acknowledge that Patient 1 had some

difficulty in recalling when certain events happened and where they happened. She confused some of the events that occurred in June 2013 with those that occurred in January 2014. She also misidentified the place where her January 2014 examination and injection procedure took place as [REDACTED] instead of [REDACTED].

The variations in what Patient 1 remembered actually bolster Patient 1's trustworthiness. If Patient 1 had concocted a tale of alleged sexual abuse by the Respondent, evidence of rehearsal would have been readily apparent. One would have expected identical tellings each time someone asked her to explain what happened. The variances that I described, therefore, suggest Patient 1 did not rehearse her testimony and relied solely on her memory to relate the Respondent's misconduct.

Patient 1 also became emotional while describing what the Respondent did to her. She developed shortness of breath when she began testifying about the events of January 24, 2014. (T. at 209.) She started crying when speaking about how the Respondent would not stop touching her vagina on that date despite her protests.³⁰ *Id.*

Person 1 was present during the January 24, 2014 in the cubicle during Patient 1's examination. To the extent that he could see what the Respondent was doing, he supported Patient 1's version of events. I realize that Person 1 is Patient 1's significant other, so he cannot be deemed an impartial witness. Yet, he exhibited a matter-of-fact demeanor when he testified. Therefore, I found him credible as well.

³⁰ I noticed that while Patient 1 was offering this emotionally-charged testimony, the Respondent was sitting at the hearing room table with his attorneys, unfazed, with his head down taking notes. Just a few minutes later, he raised his head and began staring at Patient 1 while she testified. When she noticed the Respondent staring at her, Patient 1 remarked, "He keep (sic) looking over here at me. It makes me very uncomfortable and he know (sic) it. He know (sic) what he did." (Test. Patient 1, T. at 212.) I interpret the Respondent's act of staring at Patient 1 while she was testifying to be an intimidation tactic, particularly since he also stared at Patient 2, and she called him on it as well. (Test. Patient 2, T. at 399.) These two acts of intimidation by the Respondent undermine his credibility.

The Respondent denied sexually abusing Patient 1 or touching her inappropriately in any way. He, in fact, made a blanket denial of abusing and/or inappropriately touching all seven of the patients who have accused him of wrongdoing. To amplify his blanket denial, he called Dr. Neil Howard Blumberg, whom I accepted as an expert in forensic psychiatry. The Respondent asked Dr. Blumberg to provide an opinion concerning whether he had the mental make-up of a sexual predator. Dr. Blumberg testified that he conducted two mental status examinations of the Respondent—the latest one done on October 24, 2016, within a month of the first day of the hearing. Based on those examinations, Dr. Blumberg expressed the opinion that the Respondent does not have the mental make-up to be a sexual predator. (Test. Blumberg, T. at 863–66.) Dr. Blumberg noted that he has been a practicing forensic psychiatrist for thirty-five years. During four of those years (from 2009 through 2013), he was Chief of Forensic Services at Spring Grove Hospital Center, a State-run inpatient psychiatric facility. Dr. Blumberg noted that he has seen many individuals who have been diagnosed as psychopathic sex offenders. In his view, the Respondent possesses none of the proclivities of a psychopathic sex offender. (T. at 866.) According to Dr. Blumberg, the Respondent does not have an elevated or grandiose mood state. He is neither impulsive nor hypersexual. The Respondent is not narcissistic, antisocial or manipulative. In short, Dr. Blumberg stated because the Respondent has none of the character traits one would expect to find in a psychopathic sex offender, chances are that the Respondent is not one. (*Id.*)

I have considered Dr. Blumberg's expert testimony, but do not find it compelling. It lacks persuasiveness because it does not address the situations that form the basis for the Board's charges. The Respondent is not charged with rape or any other criminal offense. Dr. Blumberg's assessment might be accurate insofar as it shows that the Respondent would be incapable of committing rape or aggravated sexual assault outside of the doctor-patient relationship. As

Patient 1's description of how the Respondent touched her in sexualized areas demonstrates, though, his sexual misconduct is not overt, but subtle. In reviewing the descriptions of how the Respondent sexually touched each of the seven patients, I found a distinct pattern. The Respondent always started his examination by squeezing or manipulating a non-sexualized part of Patient 1's body, her back or legs, for example. He would then work his way either up or down to a sexualized area, such as the buttocks or vagina. His *modus operandi* was so discreet that after her first examination by the Respondent, Patient 1 actually questioned herself about whether the Respondent had crossed any boundaries, even though she felt his exam was "nasty."³¹

The Respondent not only attempted to bolster his own credibility, but he went on to attack Patient 1's credibility (as well as all of the other patients who are the subject of this hearing). The Respondent focused on the many discrepancies in her testimony in an effort to discredit her. As I already noted, I find no merit in this approach. I will, however, for the sake of completeness, address his arguments in this regard.

The Respondent asserts that on November 21, 2012, contrary to what was in the Board's original charges, the Respondent did not come close to Patient 1's vagina when he examined Patient 1. During the hearing, as already discussed, the State had to withdraw that part of its original charge. The Respondent maintains that on November 21, 2012, he did a lumbosacral spinal exam on Patient 1 to treat her symptoms of sacroiliac joint dysfunction. He did not examine Patient 1's buttocks in any way. In short, the Respondent contends that he performed a proper examination of Patient 1's lumbar spine that in no way involved any sexual misconduct.

³¹ The State suggests that taking Dr. Blumberg's assessment to its logical conclusion, if a mental disorder did not compel the Respondent to commit the acts of sexual misconduct with his female patients, then he must have done them purely to seek his own sexual gratification. (T. at 1411-12.)

For the reasons I already provided in detail, I found Patient 1's testimony as a whole credible. I believe the Respondent went beyond performing a lumbosacral spinal examination on Patient 1 in November 21, 2012, when he ventured onto spreading her buttocks' cheeks. He was not wearing gloves. Under the definition of sexual impropriety contained in COMAR 10.32.17.02B(2)(b)(ii), a physician commits an act of sexual impropriety with a patient when he performs a pelvic or rectal examination without using gloves. Consequently, absent any other evidence of sexual misconduct, the Respondent committed an act of sexual impropriety on November 21, 2012, by simply performing an examination of Patient 1's buttocks without wearing gloves.

With regard to the June 14, 2013 incident, the Respondent attacks the "salacious language" in Charge 15 referring to the Respondent separating Patient 1's labia, moving his hands up and down alongside Patient 1's vagina walls, and having his knuckles touch Patient 1's clitoris. Patient 1 did not use any of these words when speaking to Ms. Noppinger, according to the Respondent. In fact, she told Ms. Noppinger and repeated at the hearing, that the Respondent only came close to her vagina that day. On cross-examination, Patient 1 asserted that she did use the word "clitoris" when discussing the events of June 14, 2013 with Ms. Noppinger, but what she said was probably not transcribed. The Respondent emphasized that Patient 1's interview with Ms. Noppinger was transcribed by a court reporter, who is paid not to forget to transcribe the words of an interviewee.

Whether the Respondent actually touched Patient 1's vaginal walls or clitoris on June 14, 2013 has no significance to the ultimate resolution of the charges here. The Respondent was supposed to be performing an examination of Patient 1's lower back. He was not supposed to be anywhere near Patient 1's vagina or buttocks.

Part of the problem I found was that Patient 1 confused what occurred on June 14, 2013 with what occurred on January 24, 2014. On the latter occasion, the Respondent touched Patient 1's vagina, and his knuckles grazed Patient 1's clitoris. To reiterate, given that three incidents occurring over fourteen months were involved here, one would expect Patient 1's memory to fade after two or three years. Yet, the essence of her account of what occurred remains intact.

The Respondent also attempted to impeach Patient 1's credibility by challenging her memory about where (i.e., the specific [REDACTED] facility) his examinations of her took place, the way she related what took place to her primary care physician, the kind of procedure she received and so on. I consider these attempts to discredit Patient 1 failures for the reasons already set forth.

Despite my finding Patient 1's testimony credible as a whole, I do not find sufficient credible evidence to support the Board's allegation in Charge 22 that the Respondent had an erection while he was examining Patient 1 on January 24, 2014. The Respondent indicated that he was wearing loose-fitting extra-large scrubs on that day that would have obscured any erection, even if he had one. The State suggests that the obscuring effect of the scrubs would be eliminated once the Respondent sat down, and Patient 1 indicated that on the date in question the Respondent was sitting down when he examined her. There are reasons that Patient 1 might have seen a bulge or ripple in the Respondent's scrubs on January 24, 2014, other than the Respondent having an erection. Therefore, without more support in the record, I find the evidence inconclusive that the Respondent had an erection on that date.

With regard to Patient 1, I conclude that the Respondent committed a sexual impropriety as defined by COMAR 10.32.17.02B(2)(b)(ii) when he spread the cheeks of Patient 1's buttocks on November 21, 2012 without using gloves. I further conclude that he committed a sexual violation as defined by COMAR 10.32.17.02B(4)(v) when he spread the cheeks of Patient 1's

buttocks without medical necessity on November 21, 2012, touched her buttocks and area surrounding her vagina without medical necessity on June 14, 2013 and placed his fingers inside Patient 1's vagina and brushed his knuckles over her clitoris without medical necessity on January 24, 2014. These acts, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02B(3)(a) and (b), in turn, constitute immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to disciplinary action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

C. Patient 2.

The Respondent's misconduct, as it related to his putting his fingers inside Patient 1's vagina, prompted Patient 1 to notify her primary care physician, Dr. [REDACTED] who, in turn, reported what Patient 1 told him to the Respondent's superiors. Dr. [REDACTED] the Respondent's supervising physician, ultimately became involved and placed the Respondent on approximately two weeks administrative leave while he had [REDACTED] conduct an investigation into Patient 1's allegations. On or about February 13, 2014, Dr. [REDACTED] called the Respondent, told him that [REDACTED] had found Patient 1's charges unsubstantiated, *but* he also directed the Respondent to (1) always use non-family member chaperones for all female patients and all patients, male or female, where breasts, buttocks or genitals might become involved and (2) attend an online seminar called, "Understanding Boundary Violations and Chaperone Use—Best Practices."³²

The Respondent believes that because Dr. [REDACTED] allowed him to return to work, he had been exonerated of engaging in sexualized conduct with regard to Patient 1. (He remembered Dr. [REDACTED] telling him, "That lady's crazy. I don't know what she's talking about." Test. Resp., T. at 1242.) Yet, I find it telling that Dr. [REDACTED] imposed a stricter version

³² The Respondent has a different recollection of his telephone conversation with Dr. [REDACTED] which I will discuss in more detail below, as that conversation is more relevant to my discussion of the Board's charges under section 14-404(a)(11) and (36) of the Act.

of [REDACTED]'s chaperone policy on the Respondent than was applicable to other physicians who were practicing under his supervision. I infer that Dr. [REDACTED] thought that the Respondent's examination methods were such that patients might have falsely believed they were of a sexual nature, when in fact they were not. When he testified, Dr. [REDACTED] explained that he imposed the strict chaperone policy on the Respondent because he wanted to make sure that when the Respondent performed "below-the-belt" physical examinations of female patients (those that might involve the buttocks, vagina, or rectum) those patients would not erroneously conclude that the Respondent's examination was sexual in nature. (Test. [REDACTED] T. at 547.) Nevertheless, when the Respondent examined Patient 2, six months later on August 24, 2014, he did not use a chaperone.

Patient 2 visited the Respondent at [REDACTED] office on August 18, 2014 for treatment of spine-related pain. Her primary care physician, Dr. [REDACTED] recommended the Respondent, because he knew he had been successful in treating patients with chronic back pain.

Patient 2 testified that after she had series of x-rays, a nurse escorted her into a small examination room, which allowed its door to be closed for patient privacy. Patient 2 was fully clothed, wearing blue jeans and a white shirt. She did not have to dress in a hospital gown. After Patient 2 explained the kinds of back problems she was having, the Respondent examined her. First, he had her perform the leg exercises on the examination table. Then he had her stand up facing toward the door. He was behind Patient 2. It is unclear at this point whether he was wearing gloves. He then palpated Patient 2's spine from her neck to her abdomen. He pressed down at various places on Patient 2's spine, asking her if it hurt at each pressure point. She only described pain when the Respondent started pressing in her waist area.

According to Patient 2, when the Respondent had reached her buttocks, he asked her to unbutton her blue jeans, so he could further palpate down her spine. At this point, she stated he grabbed her panties and tried to pull them down. When he could not get them down, he directed Patient 2 to do pull them down to the point that she was exposing her entire buttocks. The Respondent continued to palpate until he reached Patient 2's anus. Patient 2 testified that although the Respondent was gentle when he first touched her anus, she felt uncomfortable.

After examining a region around Patient 2's anus, the Respondent reached for some gloves that were sitting on the sink in the room, put them on, and began touching inside of Patient 2's rectum. Patient 2 reported that he did so without using any cream or lubricant. Patient 2 testified that she continued to feel uncomfortable, that is, uncomfortable because she felt violated and embarrassed by what the Respondent was doing.

After a nurse interrupted the Respondent's examination of Patient 2 by alerting him through the closed door that another doctor wanted to see him, Patient 2 stated that the Respondent directed her to stand up again. Patient 2 reported that the Respondent positioned her sideways and positioned his legs between her legs. He asked Patient 2 to unbutton her jeans one more time, because he "wanted to make sure of something."

Patient 2 testified that the Respondent once again had her pull her jeans and panties down to the point where her buttocks were fully exposed. She stated he put new gloves on, and faced her, placing about one quarter of a finger inside her anus, and he asked Patient 2 whether it hurt. According to Patient 2, she said, "Not really." Patient 2 was clear that the Respondent never explained to her why he needed to examine her anus.

Patient 2 noted that although she never saw the Respondent again, she attempted to contact him by e-mail, because she was still seeking his guidance regarding treatment of her back pain. On one occasion, he responded, but did not answer her questions. Other times, he did not

respond at all. In mid-October 2014, when she became frustrated about not receiving e-mail responses to her questions from the Respondent and others at [REDACTED] Patient 2 wrote an e-mail to her primary care physician, Dr. [REDACTED]. Among the complaints that she made in her e-mail to Dr. [REDACTED] was that the Respondent sexually abused her. This communication culminated in an investigation by Dr. [REDACTED] of [REDACTED]'s Human Resources Department.

Patient 2 testified that after the Respondent essentially violated her sexually by examining her anus for no medically-valid reason on August 18, 2014, she began having difficulty sleeping. She has been having unpleasant dreams about the Respondent touching her in her anus. She woke up screaming, having what she first perceived as convulsions. A neurologist diagnosed her with having night terrors. She also reports that she developed a body rash that she did not have before her encounter with the Respondent. Patient 2 noted that she had been sexually abused when she was a child growing up in Costa Rica. Patient 2 indicated that the August 18, 2014 incident involving the Respondent brought back bad memories of that prior incident of sexual abuse. (Test. Patient 2, T. at 355–57.)

The Respondent suggests that Patient 2 had ulterior motives for accusing him of sexually abusing her on August 18, 2014. He notes that Patient 2 admitted on cross-examination that she is pursuing a disability claim. (Test. Patient 2, T. at 360.) Although Patient 2 indicated that she is seeking eligibility for disability payments based on cervical spondylosis, she has been seeing a psychiatrist for three years. (Test. Patient 2, T. at 361.) Additionally, the Respondent points out that Patient 2 only started accusing him of sexual abuse when her e-mail requests to [REDACTED] medical providers for answers to her questions went unanswered. It was only at this point, when her expectations were unmet, that Patient 2 “lashed out.” (T. at 1442.)

According to the Respondent, Patient 2 also should not be believed because her testimony is uncorroborated. Patient 2 testified that she told her husband about how the Respondent touched her in her around her anus immediately after the event occurred on the evening of August 18, 2014. Yet, Ms. Noppinger never interviewed Patient 2's husband on behalf of the Board, nor did the State call Patient 2's husband to testify. When Dr. [REDACTED] interviewed Patient 2 over the telephone in October 2014, [REDACTED] Regional Compliance Officer for the [REDACTED] participated in that interview. Again, Ms. Noppinger never interviewed Ms. [REDACTED] nor did the State call Ms. [REDACTED] to testify. The Respondent noted that Ms. [REDACTED] served as a scribe; Patient 2's native language is Spanish, and she used the word "anals," not anus. He asserted that he only went as far as the very top of Patient 2's gluteal cleft when he examined her, which in anatomical terms, is far from the anus, "given [Patient 2's] body habitus."³³

I find the Respondent's attacks on Patient 2's credibility are meritless. As noted earlier, when Patient 2 testified, she did so emotionally, exhibiting considerable distress. She did not wish to be at an administrative hearing testifying against the Respondent. At the end of her testimony, she repeated twice, "I just want this over." (Test Patient 2, T. at 356.) Accordingly, I conclude that Patient 2 is not someone who would subject herself to the ordeal of testifying at a hearing simply to enhance a disability claim, which is primarily based on a physical, rather than a mental health-related issue. The lack of corroboration by Patient 2's husband and Ms. [REDACTED] of Patient 2's testimony has no significance. Patient 2's testimony is corroborated by her medical records, which show that she visited the Respondent on August 18, 2014, and by her October 15, 2014 e-mail to Dr. [REDACTED], in which she complained about the Respondent sexually abusing her, almost as an afterthought. Patient 2's focus at the time she wrote that e-

³³ Patient 2 has a wide girth.

mail was her effort to obtain medical records from [REDACTED] to support her disability claim, not to make a complaint against the Respondent. Furthermore, Patient 2 did not impress me as an individual who would be so calculating that she would falsely accuse a physician, endangering his livelihood for no valid reason, simply to enhance a disability claim. When Patient 2 testified on November 15, 2016 and started crying when reliving what the Respondent had done to her on August 18, 2014, I found her tears genuine.

With regard to Patient 2, I conclude that the Respondent committed a sexual violation, as defined by COMAR 10.32.17.02B(4)(v), by putting his finger a quarter of the way inside her anus on August 18, 2014, without medical necessity. This act, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02(B)(3)(b), in turn, constitutes immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to disciplinary action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

D. Patient 3.

Patient 3 suffers from an Arnold-Chiria Type 2 malformation of the skull and the degeneration of her cervical discs. These conditions have caused Patient 3 to have pain so severe that she had an intrathecal pump implanted in the skin in her abdomen to supply a twenty-four hour a day regimen of pain medication through a catheter inserted into her spine. Despite having this pump, Patient 3 still needed to seek treatment for back pain. She also needed to have a physician provide refills of her medication for her intrathecal pump.

Before becoming the Respondent's patient, Patient 3 received pain management treatment at [REDACTED]. As a [REDACTED] member, though, Patient 3 had to seek treatment from a [REDACTED] physician once [REDACTED] hired a staff member that could provide the same treatment that Patient 3 was obtaining from an outside medical provider. In June 2011, Patient 3

began seeing the Respondent for pain management services, because he could now provide those services in-house.

Patient 3 testified that from June 2011 through December 2013, the Respondent provided pain management services to her without incident. That changed on December 16, 2013. On that date, Patient 3 testified, the Respondent saw her in a small examination room at [REDACTED] office. After making some adjustments with respect to her intrathecal pump, the Respondent performed an examination of Patient 3's spine, because Patient 3 had indicated to the Respondent that her pain was increasing and that she was feeling some numbness in her feet.

According to Patient 3, the Respondent directed her to get off the table where she was sitting and stand up. She was dressed in street clothes, and the Respondent directed her to lower her pants below her buttocks. After she did so, he began pressing up and down her spine, toward the bones that protrude from each side of the spinal column. At this point, Patient 3's underwear was below her buttocks' cheeks.

After examining Patient 3's pelvic region, the Respondent began examining Patient 3 between her legs. He started pushing up between her legs on both sides and up in between her legs. He continued going up Patient 3's legs until he reached her vagina. When she testified, Patient 3 noted that the Respondent did not say anything about what he was doing or why he was doing it when he got to her vagina. Once at Patient 3's vagina, he pressed twice on one side of it and then twice on the other side of it. Patient 3 was disturbed by what the Respondent had done. She testified that she told him, "I do not like where you're at." Despite Patient 3's protests, the Respondent continued pressing in and around Patient 3's vaginal region.

Patient 3 explained that after she arrived home, she did some Internet research regarding examination techniques for back pain and saw considerable aberrations between the methods described in her Internet research and what the Respondent did vis-à-vis pressing on the sides of her vagina.

Patient 3 visited the Respondent again on February 12, 2014, at [REDACTED] office, so she could get a medication refill for her intrathecal pump and continue to obtain relief for her lower back pain. She also had an MRI scan scheduled that day. She stated that she asked her husband to accompany to her next appointment, because she was afraid the Respondent might grope her vagina again. She confronted the Respondent about what occurred on December 16, 2013, but the Respondent diverted the conversation to other subjects, according to Patient 3.

Patient 3 indicated that she continued to visit the Respondent through September 2014. Nevertheless, a few months after the Respondent engaged in the inappropriate touching of Patient 3's vagina, Patient 3 described the way the Respondent examined her to her primary care physician, Dr. [REDACTED]. Patient 3 testified that Dr. [REDACTED] told her that she needed to discuss the matter with the Respondent, because it was between her and him. Later in 2014, Patient 3 learned from her new pain specialist, Dr. [REDACTED] whom she saw in Tysons Corner, Virginia, that, indeed, the Respondent's examination techniques were inappropriate. In May 2015, Patient 3 attempted to report Patient 3's sexual misconduct to the Virginia Department of Health Professions, but because the incident took place in Maryland, Virginia referred the matter back to the Board.

Patient 3 was matter-of-fact when she testified. Unlike Patients 1 and 2, who were emotionally distraught over what the Respondent did to them, Patient 3 was angry. Her anger did not distract from her credibility, however. It only enhanced it.

The Respondent asserts that there are problems with Patient 3's allegations that he committed sexual misconduct while examining her. He noted that Patient 3 called herself a fighter, yet she also testified that she did not want to be a part of this proceeding, a seeming contradiction. Patient 3 also refused to be interviewed by the Virginia Board of Health Professions, and resisted being orally interviewed by the Board until November 30, 2015. The Respondent contends that Patient 3 said that she told her husband and her mother about the incident involving the Respondent contemporaneously with its occurrence. Yet, the Respondent notes that Ms. Noppinger never interviewed Patient 3's husband or Patient 3's mother. Ms. Noppinger also never interviewed Dr. [REDACTED]. When she was interviewed by Ms. Noppinger, Patient 3 alluded to writing something in her journal about the December 16, 2013 incident. (State's Ex. 20 at 32, 35-36.) Even so, Ms. Noppinger never asked Patient 3 to provide that journal for her review. Moreover, the Respondent emphasized that he told the Board, and repeated at the hearing, that he never touched Patient 3's vagina. He stressed that the conversation on February 12, 2014 with Patient 3 and her husband focused on the Respondent complimenting Patient 3 on taking an active role in her own treatment, particularly her recent research involving piriformis syndrome. The Respondent emphasizes that the YouTube video, from which he took still photographs (Respondent Exhibit No. 6), demonstrates that a physician examining for piriformis syndrome must press aggressively on the sciatic nerve to elicit any possible symptoms. That is what he contends that he did with regard to Patient 3.³⁴

I reject the Respondent's assaults on Patient 3's credibility. One can be a fighter and also be reluctant to come forward at the same time. Patient 3 ultimately did come forward. She appeared at the hearing and she testified, subjecting herself to not only to direct examination, but

³⁴ Throughout much of the hearing, the Respondent utilized an anatomical model of the human abdomen to demonstrate proper techniques for examining the spine. I found these demonstrations of little value. Of course, during those demonstrations, the Respondent would be showing how proper spinal examinations are performed. The question before me, however, is did the Respondent actually perform the spinal examinations of the seven patients in question in the ways that he demonstrated using the anatomical model?

intense cross-examination, as well. I do not find that the lack of corroborating evidence undermines Patient 3's credibility. Her demeanor was forthright during every minute that she testified. Her description of the way the Respondent took sexual liberties with her while he examined her also paralleled those of all the other patients. At this point of my discussion, I will emphasize that although Patient 1 knew Person 1, and Patient 4 knew Friend 1, none of the patients knew each other, nor did they compare notes with one another before testifying. While it might be true that the Respondent needed to examine Patient 3 in such a way so as to diagnose piriformis syndrome, his need to press on the sciatic nerve to diagnose that condition did not explain his need to press twice on each side of Patient 3's vagina, an area that is far from the sciatic nerve.

With regard to Patient 3, I conclude that the Respondent committed a sexual violation as defined by COMAR 10.32.17.02B(4)(v), by pressing twice on each side of Patient 3's vagina without medical necessity. This act, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02B(3)(b), in turn, constitutes immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

E. Patient 4.

Patient 4 is a forty-four-year-old woman. She began experiencing back pain in 2004 after slipping on ice and injuring her lumbar spine. In 2010, Patient 4 had an accident at work that re-aggravated her lumbar spine injury and caused an additional injury to Patient 4's cervical spine. Patient 4's back pain is chronic and severe in both her lumbar and cervical spines, with pain radiating to her extremities.

Patient 4 testified that from 2004 through 2014, she received treatment for her back pain that included nerve blocks, epidural steroid injections in both the lumbar and cervical spine, acupuncture, three rounds of physical therapy and aquatherapy. Patient 4 noted that on April 1, 2014, she visited the Respondent for the first time. She explained that her primary care physician, Dr. [REDACTED] had referred her to the Respondent, so she could access his pain management services.

Patient 4 explained that when she first saw the Respondent on April 1, 2014, everything went routinely. The Respondent examined her spine and took note of the strength of her arms and legs. Patient 4 also provided her medical history to the Respondent up until the time of her appointment with him. She also noted that she recently had an MRI scan of her cervical spine. The Respondent recommended that Patient 4 obtain an MRI scan of her lumbar spine, as well. They also talked about whether Patient 4 might be a candidate for lumbar and cervical pain medication injections. Based on those discussions, Patient 4 agreed to have a caudal epidural steroid injection of her lumbar spine. She scheduled that procedure for May 8, 2014, at [REDACTED] facility. Patient 4 acknowledged that no chaperone was present in the examination room when the Respondent examined her and spoke with her on April 1, 2014.

Patient 4 testified that on May 8, 2014, she appeared at [REDACTED] facility for the caudal injection of her lumbar spine. According to Patient 4, the Respondent had her lie face down on the bed located in the examination room. Patient 4 indicated that the Respondent did not require her to undress and wear a hospital gown. Her bottom attire consisted of sweat pants and underwear. In order to inject her lumbar spine, the Respondent directed Patient 4 to lower her sweatpants and underwear such that she exposed her buttocks.

Patient 4 stated that the Respondent explained to her that he would be using an ultrasound device to locate the injection site. He told her that he would numb the area first. According to

Patient 4, at this point, her major concern was how much the injection would hurt. She asked the Respondent about this, and he told her that she would feel a pinch.

Once the procedure started, Patient 4 explained that the Respondent spread the cheeks of her buttocks and pushed and poked with his finger. According to Patient 4, while the Respondent was pushing and poking her buttocks with his finger, she remarked to him that no doctor has ever gone this far before. The Respondent replied that he was trying to get as close to the nerve as possible.

Patient 4 explained that the Respondent gave her the caudal epidural steroid injection in between her buttocks inside her gluteal cleft (or colloquially, butt crack). Patient 4 noted that there was no chaperone or other medical personnel in the procedure room when she received her injection on May 8, 2014.

After leaving [REDACTED] facility, Patient 4 told both her daughter and Friend 1 about how the Respondent chose a site in between her buttocks in which to perform the caudal epidural steroid injection, and that she found what he did odd and disconcerting. She noted that neither her daughter nor her friend took her complaints about the Respondent seriously at that time. Patient 4 indicated that on July 24, 2014, she received another epidural steroid injection from the Respondent with some reluctance, because of her experience on May 8, 2014. She had this injection, this time in her cervical spine. A nurse assisted with the July 24, 2014 procedure, however, and there were no problems.

Patient 4 noted that it was only in April 2016 that she filed a complaint with the Board, because Friend 1 alerted her to television reports about the Respondent's alleged sexual abuse of his patients. After researching those news reports, Patient 4 stated that she realized that she might have been a victim of the Respondent's misconduct as well.

The Respondent maintains that Patient 4 would be the "very easiest" patient for me as the trier of fact to deal with, because at the hearing, Patient 4 admitted that she now understands that a caudal epidural steroid injection under ultrasound guidance means that the Respondent would be giving her that injection below the region where he would have given her a lumbar injection. Therefore, when the Respondent injected Patient 4 in the gluteal cleft on May 8, 2014, he did not inappropriately touch her.

I do not believe that Patient 4 made the admission that the Respondent contends she did. On cross-examination, Patient 4 did concede that before May 8, 2014, she did not know what a caudal injection was, that it would be different from a lumbar injection, and that she knows the difference between the two now. (Test. Patient 4, T. at 451-52, 468.) She did not concede, however, that the Respondent's conduct was appropriate as a result of her gaining this knowledge. I glean this from the response that Patient 4 gave on November 15, 2016, in response to Ms. McSherry's questioning about knowing the difference between the kinds of injections. I will reproduce part of their exchange below:

Q. But your feelings during the procedure, if I understand correctly, were based on the fact that he or something touched you lower on your backside than others have done in previous procedures. That's why you felt violated, as you put it?

A. I felt violated because I know where a lumbar injection should be on the lowest part of my back. I know that it shouldn't be in between my buttocks.

And when I said to him, "I've had these injections done before," you would think at that point he would've said, "I'm giving you a caudal injection." He did not say that. He said, "I'm trying to make sure I get the injection close to the nerve." That's what he said.

(Test. Patient 4, T. at 468-69.)

The dialogue between Patient 4 and Ms. McSherry continued, but all Patient 4 admitted to is that she now knows the difference between cervical, lumbar and caudal injections. She never said that she no longer felt "violated" now that she knew the difference.

Furthermore, the Respondent might have had some chance of placing the evidence in equipoise had Patient 4's case been heard in isolation. Here, however, as alluded to above, there is a pattern of conduct by the Respondent in which he has repeatedly touched areas of his female patients' bodies in sexualized areas without medical necessity. In the case of Patient 4, Patient 4 testified clearly that the Respondent did not explain to her that she was not getting a lumbar injection, but a caudal injection. There was no reason for the Respondent not to explain this to Patient 4. I infer that he did not want disclose that information, because he wanted to inject Patient 4 in a sexualized area without her knowledge. It is also significant that on May 8, 2014, when he was subject to the strict chaperone-use policy imposed on him by [REDACTED] as the result of his encounter with the Patient 1, there was no chaperone, nurse or assistant in the procedure room when the Respondent performed the caudal spinal steroid injection on Patient 4. He did not want anyone watching.

With regard to Patient 4, I conclude that the Respondent committed a sexual violation as defined by COMAR 10.32.17.02B(4)(v), by giving her a caudal spinal steroid injection in her gluteal cleft, a sexualized area of the body, without medical necessity. This act, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02B(3)(b), in turn, constitutes immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to disciplinary action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

F. Patient 5.

Patient 5 is a fifty-three-year-old woman, who no longer works because she is disabled. In 2008, Patient 5 was diagnosed with lumbar displacement. This condition caused Patient 5 to experience severe back pain. To help ease that pain, she has sought treatment such as cortisone

injections and nerve burning. Despite these treatments, Patient 5's back pain remains chronic and severe.

Patient 5 testified that she learned about the Respondent through her husband, whom the Respondent treated for clavicle pain. On November 27, 2013, Patient 5 was already an established patient of the Respondent's. On that date, she noted, she saw the Respondent at [REDACTED] location. That visit took place in the examination room, and, according to Patient 5, there was no chaperone or anyone else in the examination room when the Respondent examined her. At the beginning of the visit, Patient 5 conversed with the Respondent about the effectiveness of her pain treatments. Patient 5 testified that following that discussion, the Respondent examined her. He directed her to lie down on the examination table and pull down her pants and panties to the point just above the beginning of her gluteal cleft.

According to Patient 5, the Respondent began his examination by squeezing her legs hard and asking her if it hurt as he squeezed or pressed down on certain parts of her legs. He continued squeezing up Patient 5's legs until he reached her buttocks. He kept moving until he reached Patient 5's anus; he also got close to her vagina. He then began squeezing her thigh.

Patient 5 noted that the Respondent then asked if she wanted to get another cortisone injection, and she said, yes, she wanted one. Nevertheless, Patient 5 explained that after the Respondent had touched her near her anus, rectum and vagina and continued to squeeze her thigh, she felt weird and uncomfortable. She related that she did not expect the Respondent to examine those areas of her body. Furthermore, she added, the Respondent had never examined her while she was lying on her stomach during previous visits.

Patient 5 further testified that she continued to see the Respondent to receive back pain treatments after November 27, 2013, because she needed them. Ultimately, Patient 5 filed a complaint against the Respondent with the Board after her adult daughter alerted her about

seeing a television news story about allegations that the Respondent engaged in acts of sexual misconduct with his patients. She filed a written complaint with the Board on April 15, 2016.

The Respondent finds many problems with Patient 5's testimony. He attributes Patient 5's complaint to the power of suggestion stemming from the television news reports that aired in the spring of 2016 about his alleged misconduct. The Respondent emphasizes that Patient 5 is a very detailed-oriented person. She had worked in the car leasing business and for a bank.

Throughout the investigatory stage of this proceeding, she was steadfast that the date that the Respondent had touched areas near her anus, rectum and vagina was March 27, 2014, during a 1:30 p.m. appointment at [REDACTED] facility. It was only as a result of some other communications, which the Respondent asserted the State did not identify, that Patient 5 changed the date to November 27, 2013. This is when she remembered having a one-on-one visit with the Respondent.

The Respondent cautions, however, that the facts surrounding in November 27, 2013 appointment do not fit. He points out that Patient 5 described a certain number of procedures that she had had before this incident and that number does not match up to what her records show she had up to that date. It does match March 27, 2014, however. Patient 5 testified that she called back to get a refill of her Flexeril prescription three months later, which would be February 2014. She noted, though, that when she called, the Respondent was no longer there. In February 2014, the Respondent was still working for [REDACTED] and Patient 5's medical records show that he had not prescribed Flexeril at that point. (Test. Patient 5, T. at 180-83; State's Ex. 47 at 001532.) The Respondent also emphasized that during cross-examination, Patient 5 "did a very characteristic defensive move. She crossed her arms and sunk back in her chair. That demeanor is informative with regard to the truthfulness of her testimony with regard to that story." (T. at 1451.)

Despite the Respondent's contentions to the contrary, I found Patient 5 credible. Patient 5 was testifying on November 14, 2016 —just short of three years after the November 27, 2013 date and more than two and a half years after the March 27, 2014 date. In evaluating Patient 5's credibility, I am simply not looking for date matches between her testimony and medical records (although this can be an important factor) or what she might have told Ms. Noppinger during her investigation. Demeanor is important, but it is one of several factors in evaluating a witness's credibility.³⁵ In short, whether a witness is telling the truth is not just a game of "Gotcha!" In evaluating Patient 5's credibility, I scrutinized the detail that Patient 5 gave when she described how the Respondent examined her. That detail was striking. To my knowledge, Patient 5 did not have any contact with any of the other patient-witnesses or their friends. Yet, her description of how the Respondent began examining her legs and then working his way up to her buttocks and vagina, concluding with him squeezing her one of her thighs, fits perfectly into the pattern of sexual misconduct that the Respondent exhibited with all of the other patients who are the subject of this proceeding.³⁶

The Respondent also alluded to Patient 5 having admitted to being sexually abused as a child and having psychiatric issues before she became his patient. Nevertheless, the Respondent never explicitly suggested or argued with specificity that Patient 5's experience of childhood sexual abuse or need for psychiatric treatment influenced her testimony. Moreover, for reasons I

³⁵ Possibly, Patient 5 was frustrated that she could not remember the exact date that the Respondent examined her in a sexually provocative way.

³⁶ I will also reiterate that the standard of proof here is by a "preponderance of the evidence," and not by a higher standard, such as clear and convincing evidence. The Maryland Court of Appeals has defined "preponderance of the evidence" as follows:

"To prove by a preponderance of the evidence means to prove that something is more likely so than not so. In other words, a preponderance of the evidence means such evidence which, when considered and compared with the evidence opposed to it, has more convincing force and produces in your minds a belief that it is more likely true than not true."

have already discussed in detail, I do not find the Respondent credible, which makes it less likely that I would believe him over a complaining patient-witness who has no personal stake in the outcome of this case.

With regard to Patient 5, I conclude that the Respondent committed a sexual violation, as defined by COMAR 10.32.17.02B(4)(v), on or about November 27, 2013 by touching Patient 5's buttocks, anus and vagina and squeezing her thigh without medical necessity. This act, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02B(3), in turn, constitutes immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to disciplinary action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

G. Patient 6.

Patient 6 is a fifty-eight-year-old woman who has actually been a [REDACTED] employee since December 1993. She started at [REDACTED] as a phlebotomist, but now she works in an administrative capacity.

Patient 6 began seeing the Respondent to manage her back pain in May 2011. As mentioned at the beginning of this discussion, Patient 6 initially had an extremely favorable opinion of the Respondent, mainly because he was the only physician that she could find who would sedate her while she received painful epidural injections in her spine.

Patient 6 testified that during two examinations that the Respondent performed sometime between 2012 and 2014, which were necessary to assess and treat her lower left-side back pain, the Respondent groped her buttocks. As she remembers it, on the first occasion, the Respondent directed her to lower her jeans until part of her buttocks became exposed. Patient 6 did so, and according to Patient 6, the Respondent started pressing in the middle of her back and continued pressing down her spine until he reached her buttocks, which he then started groping. No

chaperone was present during this examination, nor was any medical staff. Patient 6 stated that on the second occasion, the Respondent examined her in a manner similar to the previous visit. On that occasion, as he examined her, the Respondent brushed against her clitoris. Patient 6 testified that the Respondent never wore gloves when he examined her.

Patient 6 explained that she did not complain to anyone about the Respondent's conduct at the time that he groped her buttocks and brushed her clitoris, because she trusted him. She thought she was misinterpreting what he was doing and believed that her fears were unfounded.

Patient 6 misses the Respondent, because, as stated above, the Respondent uses sedation while providing epidural spinal injections, something rare among pain management physicians. (Test. Patient 6, T. at 510-11.) Other pain management physicians insist on their patients being awake and enduring the pain of the needle, because they fear that if the patient moves while sedated, nerve damage could result. (Test. Patient 1, T. at 195.)

The Respondent challenges Patient 6's testimony because of its imprecision. The Respondent notes that there are no specific dates, times, locations or anything to identify when the two alleged incidents occurred. He adds that there could not be any specific dates, times, locations or anything to identify when his misconduct occurred, because there was no misconduct. He also questions how he could have brushed against Patient 6's clitoris with his thumb, when Patient 6 was wearing underwear. The Respondent emphasizes that Patient 6 had a wonderful relationship with him and only filed a complaint against him with the Board after hearing television news broadcasts that accused him of sexual misconduct with his patients.

As with the preceding patient-witnesses, I reject the Respondent's attacks on Patient 6's credibility. It is true that she does not remember the exact dates when the Respondent groped her buttocks and brushed against her clitoris with his thumb or the locations where these incidents took place. Despite her lack of precision, however, I find Patient 6 credible. She described in

detail and forthrightly how the Respondent engaged in acts of sexual misconduct while examining her. I will note that Patient 6 stated that the Respondent directed her to pull down her jeans, such that part of her buttocks was exposed. If part of her buttocks was exposed, then I infer that her clitoris could have been exposed too. It is not surprising that Patient 6 waited until reports of the Respondent's sexual misconduct involving his female patients were broadcast on television until she filed her complaint with the Board. In other respects, Patient 6 liked the Respondent and benefited from his pain management techniques, particularly his use of sedation while providing painful epidural spinal injections. I surmise that Patient 6 only came forward with great reluctance, because she was practically a friend of the Respondent's — in April 2014, she had invited him to her daughter's wedding. (Test. Patient 6, T. at 527.)

With regard to Patient 6, I conclude that the Respondent committed a sexual impropriety as defined by COMAR 10.32.17.02B(2)(b)(ii) when he examined Patient 6's buttocks on two occasions sometime between 2012 and 2014 without using gloves. I further conclude that he committed a sexual violation as defined by COMAR 10.32.17.02B(4)(v) on two occasions sometime between 2012 and 2014 by groping Patient 6's buttocks and allowing his thumb to brush against her clitoris without medical necessity. These acts, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02B(3)(a) and (b), in turn, constitute immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to disciplinary action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

H. Patient 7.

As noted earlier, Patient 7 did not testify. Reportedly, she was incarcerated when the State scheduled her to appear. As an alternative, though, the State offered Ms. Noppinger as a witness to summarize what Patient 7 told her when she interviewed Patient 7 on May 4, 2016.

Because Ms. Noppinger served as a secondhand reporter, I will summarize what Patient 7 told her by referring directly to the transcript of her interview. (State's Ex. 16.)

Patient 7 is a forty-year-old woman. She suffers from lower back pain. As of May 2013, she had been seeing the Respondent for pain management treatments for approximately two years. She usually visited him once every three months.

Patient 7 told Ms. Noppinger that on May 28, 2013, she and her five-year-old daughter went to [REDACTED] facility to get a hard copy of a prescription refill from the Respondent. (She thought it was [REDACTED] but if the May 28, 2013 date is correct, [REDACTED] was not yet open as "hub" center where the Respondent would be seeing patients.) She had her vital signs taken at that location; when she learned that the Respondent was at [REDACTED] facility, she went to [REDACTED] to see him.

Patient 7 explained during her interview that when she arrived in [REDACTED] a physician's assistant took her to the examination room, and the Respondent saw her there. No chaperone was present. Patient 7 told the Respondent that she was still having pain in her lower back. She emphasized to him that she was actually having more pain on her right side, and used her hand to demonstrate to the Respondent where the pain in her lower back was.

Patient 7 noted that once she described where her pain was, the Respondent sat in a kind of chair that doctors usually did not use to perform back examinations and directed Patient 7 to stand up in front of him. According to Patient 7, he positioned her so that she was facing her young daughter. He then pulled Patient 7's underwear and pants to a point just below Patient 7's buttocks.

Patient 7 told Ms. Noppinger that the Respondent began poking her lower back, where she told him the pain started. She also noted that the pain shot down the back of her right leg. Patient 7 noted that the Respondent started poking at her buttocks, then down her right leg.

As the examination proceeded, Patient 7 asserted that the Respondent asked her whether she had any pain on her left side. Patient 7 stated that she gave no answer, but the Respondent proceeded to poke down Patient 7's left leg, starting with her buttocks, in the same way he did with her right leg. While he was examining Patient 7 in the area surrounding her buttocks area, the Respondent poked around the side of Patient 7's buttocks, squeezing it, and asking if Patient 7 felt any pain there. The Respondent's thumbs were in an area close to Patient 7's vagina while squeezing Patient 7's buttocks. Patient 7 felt uncomfortable with the Respondent's examination of her buttocks, because his thumbs were so close to her vagina. (State's Ex. 17 at 6.) After the Respondent finished examining her, Patient 7 explained that he started to pull up her underwear, but she noted that she quickly pulled them up herself.

According to Patient 7, the Respondent explained to her that he would be scheduling an x-ray for her because he believed that her pain might be getting worse and he wanted to find out why. He left the examination room, returned with the hard copy of her prescription refill, and exited the room.

Patient 7 disclosed to Ms. Noppinger that on the way home from her visit with the Respondent on May 28, 2013, she called her husband and told him that she was uncomfortable with the way the Respondent examined her. She told him that, "It just didn't feel right."

The discomfort that Patient 7 felt prompted her to e-mail and call [REDACTED] the physician's assistant who escorted her into the examination room the previous day. When she spoke with [REDACTED] over the telephone, Patient 7 stated that she told [REDACTED] that she wanted an explanation concerning the lumbar spine examination that the Respondent performed on her the previous day. [REDACTED] reviewed the examination notes with Patient 7 over the telephone and provided the name of the examination of the Respondent performed, but Patient 7 indicated she was not satisfied with that review. She wanted to speak with the Respondent

personally. [REDACTED] advised Patient 7 to send a message to the Respondent, but Patient 7 indicated that she could not find his messaging information on [REDACTED] website. (Patient 7's medical record contains a summary of this telephone conversation.)

Based on the name of the examination that [REDACTED] supplied to her, Patient 7 stated that she went to YouTube to find out how that examination was supposed to be done. On June 3, 2013, having received no additional response from the Respondent through her communications with [REDACTED] Patient 7 indicated that she found e-mail information for the Respondent and sent him an e-mail message, which stated the following:

I would like to have a list of the names of the exams that you performed during my visit. Specifically the last exam where you pulled down my underwear, put on gloves and squeezed my buttocks. That exam was VERY uncomfortable [:] I have NEVER had a doctor performed that exam, and I would like to know the name of it AND the purpose.

(State's Ex. 49 at 00010.)

Patient 7 told Ms. Noppinger that on June 4, 2013, the Respondent returned her telephone call to discuss her e-mail message. During their conversation, Patient 7 asked the Respondent with type of examination he performed, and he responded by providing the same name of the examination that [REDACTED] had given her. Patient 7 stated that she told the Respondent she viewed a demonstration of that kind of examination on YouTube, and that was not the kind of examination that the Respondent had performed. The Respondent did not address Patient 7's question any further and went on to discuss his x-ray referral. Patient 7's medical record contains no notes about what transpired during the Respondent's June 4, 2013 conversation with Patient 7, but it *does reflect that a conversation took place.* (State's Ex. 49 at 00011.)

The Respondent denied all of Patient 7's allegations. He contended that I should not believe anything that Patient 7 told Ms. Noppinger. In support of his position, he called [REDACTED] who was a clinical assistant for [REDACTED] at the time the Respondent was

employed there. According to [REDACTED] Patient 7 is a "very angry woman and not truthful." (Test. [REDACTED] at 1128-29.) According to [REDACTED] Patient 7 was disruptive, always demanding prescriptions and registering frequent complaints with [REDACTED] Member Services when she did not get what she wanted. (*Id.* at 1128.) [REDACTED] indicated that Patient 7 also tried to manipulate the prescription refill process. Patient 7 would finish her prescriptions early, and then request a refill under a different name. (*Id.* at 1132.) "If she couldn't have one narcotic, she'd request another narcotic," [REDACTED] emphasized. (*Id.*) The Respondent also spoke about Patient 7's apparent addiction issues when he testified and described her as "trouble." (Test. Resp., T. at 1319-20.) [REDACTED] similarly confirmed Patient 7's reputation for using illicit means to obtain narcotics, including forging prescriptions. (Test. [REDACTED] T. at 1382-83.)

The Respondent also contends that Patient 7 cannot be believed because certain parts of her testimony are contradicted by objective facts. He noted her medical record verifies that he did not prescribe Flexeril for her until April 14, 2014, some eleven months after May 28, 2013, when she supposedly went to [REDACTED] to obtain a refill for that medication. Additionally, as I already touched on, the Respondent offered a press release that showed that [REDACTED] facility had not expanded to become a hub until July 2013. (Resp. Ex. 22.) He maintains that he would not have seen any patients at [REDACTED] facility before it became a hub.

It might be true that Patient 7 has addiction issues and that she has lied in an effort to obtain narcotics through surreptitious means. Nevertheless, I have very carefully analyzed what Patient 7 told Ms. Noppinger and conclude that Patient 7's description of the way the Respondent squeezed her buttocks is credible.

The May 28, 2013 date that Patient 7 provided coincides perfectly with information in her medical record. That record shows that the Respondent examined her in [REDACTED] on this date. There is also a record of Patient 7's e-mail correspondence, which I have quoted, in which

she questioned the kind of examination that the Respondent performed on her and registered her complaint about how it was very uncomfortable. The Respondent also logged a telephone call that he had with Patient 7 on June 4, 2013 in Patient 7's medical record, but curiously, he did not summarize what he and Patient 7 spoke about during that call. The record states, "No notes of this type exist for this encounter." (State's Ex. 49 at 00011.) After reviewing the medical records of the six other patients who are the subject of this proceeding, I have gleaned that it is the usual practice of [REDACTED] physicians to summarize the content of all patient contacts in each patient's medical record. The absence of a summary of what the Respondent and Patient 7 spoke about on June 4, 2013, therefore, is significant. Its absence suggests that the Respondent might not have wanted Patient 7's record to reflect what he and Patient 7 had discussed.

Moreover, the existence of Patient 7's medical record, containing her e-mail complaint of May 30, 2013, defeats any argument that Patient 7 only contacted the Board after learning about television news reports concerning the Respondent's abuse of other patients. Those news reports were aired in the spring of 2016. There is nothing in the record to suggest that someone altered Patient 7's 2013 medical record three years later to provide support for her 2016 complaint against the Respondent.

Patient's 7's description of the Respondent's buttocks-squeezing and vagina-grazing also parallels the experience of the other six patients. Patients 1 and 6's experiences, in particular, are remarkably similar. Nothing in the record suggests that Patient 7 colluded with the other patients or their friends to fabricate false charges against the Respondent.

With regard to Patient 7, I conclude that the Respondent committed a sexual violation as defined by COMAR 10.32.17.02B(4)(v) on May 28, 2013 by squeezing Patient 7's buttocks and placing his thumb close to her vagina without medical necessity. These acts, by falling within the purview of sexual misconduct by a physician, as defined by COMAR 10.32.17.02B(3)(b), in

turn, constitute immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to disciplinary action against his medical license under section 14-404(a)(3)(i) and (ii) of the Act.

I. The Respondent's Subsequent Practice and [REDACTED]

In December 2014, the Respondent began working for [REDACTED] Dr. [REDACTED] the principal owner of [REDACTED] testified that his practice is similar to the one that the Respondent left at [REDACTED] At [REDACTED] [REDACTED] however, [REDACTED] requires physicians who are examining female patients to have a female chaperone known as a "scribe" present at all times [REDACTED] explained that when a physician examines and/or treats a female patient at [REDACTED] the physician communicates with the scribe, and the scribes make entries in the patient's electronic medical record.

When he testified, [REDACTED] alluded to the difficulties he and the other physicians have with treating patients who need pain management services. He noted, "They have needs and demands and sometimes medical conditions and co-morbidities, not excluding psychiatric and behavioral problems." (Test [REDACTED] T. at 893-94.) He noted that personnel at his facility need to be trained to react to violent outbursts and assaults by these patients. (*Id.* at 894.) Having unruly patients removed by the police is a common occurrence, according to [REDACTED] (*Id.*)

Given that most pain management patients exhibit some degree of volatility, [REDACTED] averred that he is not surprised that they would engage in making false accusations against their treating physicians. He suggested that if such patients do not get what they want from their physicians, they will make waiting room deals to formulate ways of gaining retribution against them. (T. at 909.)

also indicated that during the Respondent's employment with [REDACTED] from December 2014 through May 2016, there were no instances of the Respondent inappropriately touching any female patients. [REDACTED] who performed duties as a scribe while the Respondent practiced at [REDACTED] echoed [REDACTED] testimony. [REDACTED] asserted that if the Board returned the Respondent to the practice of medicine, he would have no problem rehiring him at [REDACTED]

I find the lack of any misconduct by the Respondent at [REDACTED] inconclusive. [REDACTED] has a mandatory chaperone policy for all of its physicians that presumably, unlike at [REDACTED] is strictly enforced. Essentially, the Respondent could not have engaged in the kind of sexual touching at [REDACTED] with a scribe with the qualifications of [REDACTED] looking on. [REDACTED] noted that before immigrating to the United States in 2009, she had been a practicing physician in the Philippines. Because of that experience, I find that she would be better able to recognize improper spinal examination techniques than most physician's assistants.

IV. *Charges Under Section 14-404(a)(11) of the Act.*

On July 29, 2015, the Respondent electronically submitted his application for reappointment to [REDACTED]. To reiterate, the [REDACTED] application required the Respondent to answer the following questions pertinent to whether he had been disciplined by any other healthcare organization:

Have any of the following ever been, or are currently in process, either on a voluntary or involuntary basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

6. Membership on any hospital/medical staff?

....

10. Participation in any other healthcare organization (surgicenter, managed care, PPO, PHO, MSO, etc.)

The Respondent answered "no" to both question 6 and question 10 with regard to disciplinary actions by any healthcare organizations as noted above. (State's Ex. 38 at 00011.) Those answers were false.

As of July 29, 2015, the Respondent had already been terminated by [REDACTED]. When he testified [REDACTED] explained that he decided to terminate the Respondent for failure to adhere to the strict chaperone policy that he required the Respondent to follow after his return to work in February 2014. [REDACTED] general chaperone policy allowed patients to request the presence of a chaperone during an examination of the pelvic area or genitals, breast or anus. By contrast, the chaperone policy that [REDACTED] imposed on the Respondent required him to use a non-family member chaperone for all female patients and all patients, male or female, where breasts, buttocks or genitals might become involved.) On October 28, 2014, the Respondent was terminated immediately from his employment. Based on the terms of his contract with [REDACTED] the Respondent knew or should have known his termination was for disciplinary reasons.³⁷

When [REDACTED] hired the Respondent September 2, 2010, the Respondent signed a contract titled "Employment Agreement." Under the terms of that agreement, [REDACTED] or the Respondent could mutually terminate the Respondent's employment on a voluntary basis without the other party giving a reason for doing so, provided the party wishing to terminate the agreement gave ninety days' prior written notice. If [REDACTED] decided to terminate the

³⁷ The Respondent testified that he did not remember [REDACTED] requiring him to follow a strict chaperone policy when [REDACTED] talked to him on the telephone on February 13, 2014. (Test. Resp., T. at 1242-43.) His recollection was that [REDACTED] only warned him not to use significant others as chaperones. *Id.* Yet, during his October 24, 2014 meeting with [REDACTED] the Respondent tacitly admitted that he was subject to a strict chaperone policy, because he found adherence to that policy impractical. (Finding of Fact No. 94, State's Ex. 37 at 0002.) He also contended that [REDACTED] never mandated his participation in the "Understanding Boundary Violations and Chaperone Use-Best Practices" in April 2014. I do not believe the Respondent. Not only is the Respondent's credibility as a whole lacking, but [REDACTED] was clear about what took place on February 13, 2014, and contemporaneous notes of what the parties said during the October 28, 2014 in-person meeting exist in the record. (Test. [REDACTED] T. at 552-53; State's Ex. 19 at 7-8; State's Ex. 50.)

Respondent "for cause" (or, in other words, for disciplinary reasons), it could do so immediately upon written notice to the Respondent.³⁸

When [REDACTED] announced to the Respondent that he was terminating him [REDACTED] [REDACTED] did not give the Respondent ninety days to wrap up his practice. He ordered him to leave [REDACTED] immediately. Additionally, during the October 28, 2014 meeting that [REDACTED] [REDACTED] had with the Respondent [REDACTED] told the Respondent that he was specifically terminating him for violating the chaperone policy that he had imposed on the Respondent earlier that year. The Respondent knew, therefore, that his departure from [REDACTED] was not voluntary, but was for violating an organizational rule. He could not have been mistaken about this.

The Respondent asserts that he actually answered the two questions at issue on the [REDACTED] Application using the information that he had at the time. First, he contends that neither [REDACTED] nor [REDACTED] ever told him how he should complete any future applications vis-à-vis his October 28, 2014 dismissal from his employment with [REDACTED]. Furthermore, the Respondent notes that had [REDACTED] terminated him from his employment for sexual misconduct (i.e., unethical or unprofessional conduct in the practice of medicine), the Board's regulations at COMAR 10.32.22.03B(4) would have required [REDACTED] to report his termination to the Board within ten days of his dismissal from his employment. She did not make such a report. Additionally, the Respondent indicated that after October 28, 2014, while he was practicing at [REDACTED] he was still able to see [REDACTED] patients upon referral.

³⁸ Written notice of his termination followed on November 8, 2014. That notice informed the Respondent that his termination was effective on October 28, 2014.

I reject the Respondent's attempt to obfuscate with regard to these two simple questions. I agree with the State, that the Respondent tried to "parse with surgical precision the meaning of the words on the application" and "restrict, restrict, restrict" the meaning of the words so that he did not have to tell [REDACTED] Hospital (and as noted below, the Board) about his termination from [REDACTED] (T. at 1408, 1410.)

Furthermore, strictly speaking, [REDACTED] did not terminate the Respondent for any sexual misconduct vis-à-vis his patients. It terminated him specifically for violating an organizational policy. This limited basis for the Respondent's termination is why [REDACTED] still was able to refer some patients to him while he was practicing at [REDACTED]. Although [REDACTED] might have been remiss in not reporting what occurred with respect to Patient 1 and Patient 2 to the Board, given that [REDACTED] imposed the strict chaperone policy on the Respondent based on allegations that he committed acts of sexual misconduct, it remains true that the actual reason for the Respondent's termination only concerned a policy violation. The [REDACTED] Application required "yes" or "no" answers for Question 6 and 10. Those questions concerned whether the Respondent, as an applicant for the renewal of his privileges with [REDACTED] Hospital, had ever lost his ability to practice medicine with a medical provider for disciplinary reasons. It did not matter what those disciplinary reasons were. In this context, therefore, the correct answers obviously were "yes" to both questions.

I conclude that the Respondent willfully filed a false report or record in the practice of medicine because he falsely answered Question 6 and 10 the [REDACTED] Application, subjecting him to disciplinary action against his medical license under section 14-404(a)(11) of the Act.

V. *Charges Under Section 14-404(a)(36) of the Act.*

On August 10, 2015, the Respondent submitted his physicians' license renewal application (Renewal Application) electronically to the Board. Under Question 6, related to "Character and Fitness," the Renewal Application required the Respondent to answer the following:

The following questions pertain to the period since July 1, 2013. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann., Health Occ. § 14-404?

.....

n. Has your employment by any hospital, HMO, related healthcare or other institution or military entity been terminated for any disciplinary reasons?

(State's Ex. 39 at 00001-00002.)

The Respondent answered "no" to both questions d and n under Question 6 of his Renewal Application. As with the [REDACTED] Application, when the Respondent answered Questions 6d and 6n "no," he was not telling the truth and knew it. With regard to Question 6d, the Respondent knew or should have known that [REDACTED] had launched an investigation against him in response to Patient 2's complaint that he engaged in improper sexual touching. All that is needed for a "yes" response in the case of Question 6d is for an organization, such as [REDACTED] to initiate an investigation into a physician's possible misconduct that would be prohibited under section 14-404(a) of the Act. The outcome of that investigation is irrelevant to whether a "yes" answer is necessary. More obvious, though, is the Respondent's failure to report his termination from his employment with [REDACTED] for disciplinary reasons by answering "yes" to Question 6n. I have already discussed at length why the Respondent should have known [REDACTED] dismissed him for disciplinary reasons with respect to the Board's

charge against the Respondent under section 14-404(a)(11) of the Act, so I need not repeat that reasoning here.

Again, for the same reasons discussed above, I reject the Respondent's assertion that he answered these questions using the information that he had at the time. As the State noted, the Respondent's attempt to restrict the meaning of these questions is disingenuous, particularly since the Board, in requiring responses to its questions, "attempts to cast a wide net to have any applicant respond in a truthful and accurate way and this covers a lot of ground." (T. at 1409.)

I conclude that the Respondent willfully made a false representation when making application for licensure by answering Questions 6d and 6n in the negative on his Renewal Application, subjecting him to disciplinary action against his medical license under section 14-404(a)(36) of the Act.

VI. *Sanctions.*

In this case, the State is seeking the permanent revocation of the Respondent's license to practice medicine. *See* COMAR 10.32.02.09A-B; COMAR 10.32.02.10. It maintains that the Respondent's seven known instances of sexually abusing his female patients, his lack of insight into the sexual abuse that he committed and the adverse effects on his patients, to which he is seemingly oblivious, require this action. As indicated above, the acts of sexual abuse by the Respondent constitute immoral and unprofessional conduct in the practice of medicine, subjecting the Respondent to sanction under section 14-404(a)(3)(i) and (ii) of the Act. The State argues that for this misconduct alone, his continued practice of medicine would pose a danger to the health and welfare of Maryland patients. Yet, the State points out that the Respondent also willfully filed a false application for the renewal of his privileges with [REDACTED] Hospital, and he

submitted an application for re-licensure with the Board that contained willful misrepresentations, which subjects him to sanction under sections 14-404(a)(11) and (36), respectively. I agree with the State's recommendation to revoke the Respondent's medical license permanently.

COMAR 10.32.02.10 provides sanctioning guidelines for the Board's disciplinary panel, which also are instructive in my review of the Respondent's case. Those guidelines indicate that the maximum sanction for sexual misconduct (sexual impropriety and sexual violation) under section 14-404(a)(3)(i) and (ii) is revocation of the offending physician's license to practice medicine. Similarly, the maximum penalty for violations of sections 14-404(a)(11) and (36) of the Act, individually, is also revocation of the offending physician's license to practice medicine. COMAR 10.32.02.09B lists a series of aggravating and mitigating factors to weigh in determining what sanction is appropriate. Three significant aggravating factors here are the actual harm that the Respondent caused his patients (COMAR 10.32.02.09B(6)(c)); the Respondent's offenses were part of a pattern of detrimental conduct (COMAR 10.32.02.09B(6)(d)); and the patients that the Respondent harmed were vulnerable (COMAR 10.32.02.09B(6)(g)).

Here, Patient 1 and Patient 2, in particular, are still suffering from the aftereffects of the Respondent's sexual abuse of them. Patient 1 exhibited shortness of breath when she was testifying about what the Respondent had done to her. Patient 2 now suffers from night terrors and has sought psychiatric treatment to aid her in dealing with the lingering trauma caused by the Respondent when he groped her buttocks and anus. Patient 5 has sought sexual assault counseling. She still sees a counselor on a weekly basis.

The Respondent's pattern of sexual abuse of the seven patients that are the subject of this proceeding is extraordinary when viewed in summary. Here is an encapsulated version of the various acts of sexual misconduct that the Respondent committed, listed patient-by-patient:

Patient 1: (1) examining Patient 1's buttocks with ungloved hands, (2) placing his hands near Patient 1's vagina, and (3) placing his hands inside Patient 1's vagina, allowing his knuckles to touch her clitoris.

Patient 2: needlessly examining Patient 2's buttocks and placing his fingers inside Patient 2's anus and rectum.

Patient 3: pressing Patient 3's vagina, twice on the left side of it and twice on the right side.

Patient 4: examining Patient 4's buttocks and giving her an injection in her gluteal cleft without a medical basis for doing so.

Patient 5: examining Patient 5's buttocks and anus, getting close to Patient 5's vagina and squeezing her thigh.

Patient 6: (1) groping Patient 6's buttocks with ungloved hands and (2) brushing his fingers against Patient 6's clitoris.

Patient 7: squeezing Patient 7's buttocks and placing his thumbs close to her vagina.

The women that the Respondent sexually abused were all vulnerable, because they were seeking treatment from him to relieve excruciating back pain. He was the only pain management physician who used sedation to give the painful injections necessary to relieve their back pain.

The Respondent's near-monopoly on providing injections under sedation made his patients reluctant to seek similar treatment from other physicians, who would likely shun the use of sedation. Patients 2, 3, 5 and 6 had been sexually abused as children. The Respondent's additional sexual abuse of them, therefore, reopened existing emotional wounds.

The Respondent's filing of two applications containing willfully false information suggests that he is dishonest. As I noted several times already, I also found the Respondent entirely lacking in credibility. As the State noted during its closing argument, "His responses

were disingenuous and . . . designed to hide rather than reveal the truth.” (T. at 1411.) The Respondent, therefore, cannot be trusted. The Board must be able to trust its physician licensees to be truthful in their applications. This is of great importance, because as the State emphasized, the Board does not have the ability to verify the accuracy of all of the 13,000 applications that it receives annually from physicians for initial or renewed licensure. The State suggests that medical facilities, such as [REDACTED] also lack those resources, so they rely on physicians being truthful in their applications as well.

The Respondent offered a number of witnesses to testify or write references on his behalf. Many of those witnesses were [REDACTED] employees at the time that the Respondent was practicing there. They testified that they had not seen the Respondent engage in any sexual misconduct with respect to his patients. They also served as character witnesses or references. Other witnesses were from [REDACTED]. [REDACTED] the Respondent’s boss there, testified that he would have no reservations about working with the Respondent again. [REDACTED] also from [REDACTED] indicated that in the year and a half that she worked with the Respondent, she had never seen him touch any patient inappropriately.³⁹ (Test. [REDACTED] T. at 975.) I do not give the testimony of these witnesses great weight. Those who worked with the Respondent at [REDACTED] did not know what was going on behind the doors of the examination rooms or behind the curtains of the examination cubicles with respect to the patients who accused the Respondent of sexual misconduct. Moreover, as the State emphasized, it is admirable that [REDACTED] is willing to re-employ the Respondent as a physician, but if the Board reinstated the Respondent’s medical license, he could leave [REDACTED] and find work in some other medical facility or

³⁹ [REDACTED] also offered testimony that suggested that there are legitimate reasons why a pain management physician who specializes in treating back pain might need to examine areas such as the buttocks or give injections in the gluteal cleft. (Test. [REDACTED] T. at 969–80.) Yet, as I explained in detail, I did not find any legitimate reasons for the Respondent to be touching or injecting the seven patients at issue in these areas of their bodies.

institution. (T. at 1412.) To reiterate, [REDACTED] use of scribes as *de facto* chaperones blocked the Respondent from engaging in the kinds of sexual misconduct with his patients that he engaged in at [REDACTED] which had a generally good chaperone policy, but one that was not strict enough and certainly one that was not enforced. The State also noted that even if the Respondent remained at [REDACTED] the Board could not delegate its responsibility to protect the health and welfare of the public to that medical practice.

Any sexual misconduct occurring within the practice of medicine is intolerable and actionable. COMAR 10.32.17.03A. Even if the State had proven that the Respondent engaged in an act of sexual misconduct with only one patient, that misconduct alone, combined with the Respondent's misrepresentations in his [REDACTED] Application and Renewal Application, would still justify the permanent revocation of his medical license.

The law provides that, if found to have committed a violation, a licensee may be assessed a monetary penalty. Health Occ. § 14-405.1(a) (2014); COMAR 10.32.02.09C-D. Here, the State did not indicate that the Board was seeking a monetary penalty against the Respondent.

PROPOSED CONCLUSIONS OF LAW

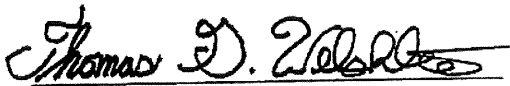
Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent is subject to sanction under the following provisions of the Act: sections 14-404(a)(3)(i) and (ii), (11) and (36). Md. Code Ann., Health Occ. § 14-404(a)(3)(i) and (ii), (11) and (36) (Supp. 2016). I further conclude as a matter of law that permanent revocation of the Respondent's license to practice medicine is an appropriate sanction for the Respondent's proven misconduct. *Id.*; COMAR 10.32.02.09A(3)(a)(iv), B(6)(c), (d) and (g).

PROPOSED DISPOSITION

I PROPOSE that the Amended Charges filed by the Board against the Respondent on May 27, 2016 be **UPHELD**; and

I PROPOSE that the Respondent be sanctioned by having his license to practice medicine in this State permanently **REVOKED**.

February 13, 2017
Date Decision Issued


Thomas G. Welshko
Administrative Law Judge

TGW/sw
#165571

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file written exceptions to this proposed decision with the disciplinary panel of the Board of Physicians and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216 (2014). Exceptions must be filed within fifteen (15) days from the date of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the disciplinary panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the opposing party will have fifteen (15) days from the filing of exceptions to file a written response. *Id.* The response must be addressed as above. *Id.* The Office of Administrative Hearings is not a party to any review process.

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MARYLAND STATE BOARD OF
PHYSICIANS

v.

BRYAN S. WILLIAMS, M.D.,
RESPONDENT

LICENSE No.: D66774

* BEFORE THOMAS G. WELSHKO,
* AN ADMINISTRATIVE LAW JUDGE
* OF THE MARYLAND OFFICE
* OF ADMINISTRATIVE HEARINGS
*
* OAH No.: DHMH-MBP-71-16-23230

* * * * *

FILE EXHIBIT LIST

State's Exhibits:

1. May 18, 2016 Order for Summary Suspension of the Respondent's License to Practice Medicine
2. May 25, 2016 Board of Physician Show Cause Hearing – transcript
3. May 25, 2016 Board Order continuing the Respondent's Summary Suspension
4. April 8, 2015 letter to Board from [REDACTED]
[REDACTED] with attached April 3, 2015 report made to Virginia Department of Health Professions
5. April 15, 2015 Subpoena *Duces Tecum* ("SOT") from Board to [REDACTED]
6. Not Offered and Not Admitted
7. [REDACTED] Personnel records for Respondent
8. July 8, 2015 Board interview transcript – Patient 1
9. July 8, 2015 Board interview transcript – Person 1
10. July 14, 2015 Board interview transcript – Patient 2
11. July 15, 2015 e-mail from Virginia Department of Health Professions and attachments regarding Patient 3
12. April 18, 2016 Board interview transcript – Patient 4
13. April 18, 2016 Board interview transcript – Friend 1
14. April 18, 2016 Board interview transcript – Patient 5
15. April 25, 2015 Board interview transcript – Patient 6

16. May 4, 2016 Board interview transcript – Patient 7
17. July 16, 2015 Board interview transcript – [REDACTED]
18. August 17, 2015 Board interview transcript – Respondent
19. August 27, 2015 Board interview transcript – [REDACTED]
20. November 30, 2015 Board interview transcript – Patient 3
21. July 20, 2015 Complaint to Board – Patient 2
22. August 4, 2015 letter to Board with attached Respondent's response to allegations of Patients 1, 2 and 3 and declarations by [REDACTED], and [REDACTED]
23. Not Offered and Not Admitted
24. April 13, 2016 Complaint to Board – Patient 4
25. April 15, 2016 Complaint to Board – Patient 5
26. April 25, 2016 Complaint to Board – Patient 6
27. April 28, 2016 letter from Catherine Steiner, Esquire, to Board with attached Respondent response to complaints of Patients 4, 5, and 6
28. May 9, 2016 Complaint to Board – Patient 7
29. May 16, 2016 letter from Catherine Steiner, Esquire, to Board with attached Respondent response to complaint of Patient 7
30. May 16, 2016 letter from Catherine Steiner, Esquire, to Board with declarations by two individuals
31. [REDACTED] Chaperone policy
32. [REDACTED] Continuing Medical Education power point presentation: "Understanding Boundary Violations and Chaperone Use – Best Practices"
33. April 15, 2015 SOT to [REDACTED] with attached relevant excerpts of response
34. September 14, 2015 SOT to Montgomery County Police Department regarding Patient 2's complaint with attached response
35. October 23, 2014 [REDACTED] written notes regarding conversation with Patient 2 and Patient 2's primary care physician
36. October 27, 2014 typed version of [REDACTED] written notes regarding conversation with Patient 2 and Patient 2's primary care physician
37. October 24, 2014 notes of [REDACTED] meeting with Respondent

-
38. September 10, 2015 SOT to [REDACTED] and attached response
– July 29, 2015 Respondent's Application for Reappointment - [REDACTED]
 39. August 10, 2015 Respondent's Application for Physician Licensure Renewal
 40. Not Offered and Not Admitted
 41. Patient 1 – Respondent medical records
 42. Patient 2 – Respondent medical records
 43. Patient 2 – primary care medical records
 44. Patient 3 – Respondent medical record (from 2013)
 45. Patient 3 – [REDACTED] medical records (excerpt)
 46. Patient 4 – Respondent medical records (excerpt from Patient 4's entire record)
 47. Patient 5 – Respondent medical records (excerpt from Patient 5's entire record)
 48. Patient 6 – listing of Respondent's procedures (excerpt from Patient 6's entire
record)
 49. Patient 7 – relevant records from Patient 7's entire record
 50. October 28, 2014 typed notes of meeting (with attached June 27, 2016 e-mail
transmitting the notes to Administrative Prosecutor)
 51. May 27, 2016 Amended Charges

Respondent's Exhibits:

1. Respondent – *Curriculum Vitae*
2. Practice Description – Respondent
3. Clinical Examination of the Lumbar Spine
4. Clinical Examination of the Hip and Buttock
5. Clinical Examination of the Sacroiliac Joint
6. Images from Video Clips – Lumbar Spine Examination Images from Video Clips
7. Images from Video Clips – Caudal Epidural Injection

8. [REDACTED] – CEO of [REDACTED] Curriculum Vitae,
and May 21, 2016 Letter to Maryland Board of Physicians

9. June 16, 2016 Letter from [REDACTED] Billing Manager of [REDACTED]
[REDACTED]

10. Letters to the Maryland Board of Physicians from [REDACTED] Patients:

- [REDACTED] May 20, 2016
- [REDACTED] May 20, 2016
- [REDACTED] May 20, 2016
- [REDACTED] May 23, 2016
- [REDACTED] May 25, 2016
- [REDACTED] May 27, 2016
- [REDACTED] - May 27, 2016
- [REDACTED] - May 27, 2016
- [REDACTED] May 27, 2016
- [REDACTED] May 27, 2016
- [REDACTED] May 27, 2016
- [REDACTED] - May 31, 2016
- [REDACTED] June 3, 2016
- [REDACTED] June 3, 2016
- [REDACTED] June 3, 2016
- [REDACTED] - June 13, 2016

11. E-mails/Letter of Support from Patients:

- [REDACTED] - May 14, 2016
- [REDACTED] - May 15, 2016
- [REDACTED] May 16, 2016
- [REDACTED] - May 20, 2016
- [REDACTED] June 28, 2016
- [REDACTED] - June 29, 2016

12. Declaration of [REDACTED] - May 27, 2015

13. [REDACTED]

- *Curriculum Vitae*
- Declaration - May 22, 2015
- Letter to the Maryland Board of Physicians - July 13, 2016

14. Additional Records Produced By [REDACTED] on May 5, 2015
(Supplement to State's Exhibit 33)

- Record 7
- Record 8
- Record 9
- Record 10
- Record 11
- Record 12
- Record 13

15. Not Admitted

16. Maryland Board of Physicians' Investigative Memoranda and Reports by Doreen Noppinger:

- July 20, 2015
- November 17, 2015
- November 23, 2015
- May 2, 2016
- May 23, 2016

17. Maryland Board of Physicians' July 28, 2015 Letter and Subpoena to the Respondent and August 4, 2015 Response to Complaints of Patients 1, 2 and 3

18. April 4, 2016 Charges under the Maryland Medical Practice Act

19. Not Admitted¹

20. Neil Blumberg, M.D. - Forensic Psychiatry Expert

- *Curriculum Vitae*
- June 21, 2016 Forensic Psychiatric Evaluation Report
- October 24, 2016 Supplemental Report

¹ I placed those exhibits in a sealed envelope as required by the OAH's Rules of Procedure at COMAR 28.02.01.22(c) for the purpose of review.

21. [REDACTED] Chaperone Policy:

- Exam Room Placard
- Chaperone Policy - Revised April 2014
- April 22, 2014: Understanding Boundary Violations and Chaperone Use
- Respondent's Cell Phone Log – April 22, 2014

22. Press Release: Expanded Wing of [REDACTED]
Now Open - July 8, 2013

23. Additional Medical Records: Patient 3 (Supplement to State's Exhibit 44), Bates nos.: 366–1320

24. Additional Medical Records: Patient 4 (Supplement to State's Exhibit 46), Bates nos.: 1321–1343

25. Additional Medical Records: Patient 5 (Supplement to State's Exhibit 47), Bates nos.: 1344–1518

26. Additional Medical Records: Patient 6 (Supplement to State's Exhibit 47), Bates nos.: 1519–2397

27. Additional Medical Records: Patient 5 (Supplement to State's Exhibit 47), Bates nos.: 2398–2664

28. Not Admitted

29. Not Admitted

30. Not Admitted

31. Drawing of an examination room done by the Respondent at the hearing

32. Not Admitted