IN THE MATTER OF	*	**BEFORE THE**
PETER J. DELENICK, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D80662	*	**Case Numbers: 2016-0741B**

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

CONSENT ORDER

PROCEDURAL BACKGROUND

On January 26, 2017, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **PETER J. DELENICK, M.D.** (the "Respondent"), License No. D80662, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.*

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

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of:
>
> . . .
>
> (ii) Unprofessional conduct in the practice of medicine[.]

On August 23, 2017, the Respondent appeared before Panel B, sitting as a Disciplinary Committee for Case Resolution. As a result of negotiations occurring before Panel B, the Respondent agreed to enter into the following Consent Order,

consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Panel B makes the following Findings of Fact:

I. BACKGROUND

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on November 13, 2015. His Maryland license is active through September 30, 2018.

2. The Respondent is also licensed to practice medicine in the Commonwealth of Virginia since November 1, 1985, in Pennsylvania since July 29, 1980 and in Arizona since April 21, 2011. All licenses are current and unrestricted.

3. The Respondent is board-certified in orthopedic surgery.

4. The Respondent does not currently hold any hospital privileges in Maryland.

5. On or about March 9, 2016, the Board received a complaint from the Respondent's former employer ("Practice A"[1]), in Rockville, Maryland, alleging that Practice A terminated the Respondent's employment for misconduct, disruptive behavior and creating a hostile work environment.

6. On March 23, 2016, Practice A sent a follow-up letter to the Board to provide additional information regarding the Respondent's termination. The letter stated that following the Respondent's termination, Practice A and Respondent disagreed about payment of the Respondent's malpractice coverage during his employment at Practice

[1] For confidentiality purposes, the names of any practice entities, patients or other individuals will not be used in this Consent Order. The Respondent is aware of the identity of entities, patients or individuals referenced herein.

A. As a result, the Respondent refused to return a laptop computer lent to him by Practice A and refused to complete and sign outstanding patient notes.[2]

7. Thereafter, the Board initiated an investigation.

8. The Board requested that the Respondent provide a written response to the complaint. In his response, the Respondent stated that he had never spoken to his employers regarding the allegations made against him. The Respondent further stated that the complaint is a retaliation for complaints that the Respondent made against Practice A and its owners.

II. EMPLOYER-SPECIFIC FINDINGS

9. In furtherance of the Board's investigation, the Board issued subpoena *duces tecum* for the personal files from each of the Respondent's then-current employers and previous five employers.

A. CLINIC A

10. Clinic A, an urgent care center in Bethesda, Maryland, employed the Respondent as a *locum tenens* physician from approximately April 2016 until July 2016. The Respondent worked two days per week during his employment at Clinic A.

11. On September 1, 2016, Board staff interviewed the owner of Clinic A ("Provider A"). According to Provider A, he received complaints from patients regarding the Respondent. Specifically, Provider A stated that the Respondent displayed a lack of patience, and was derogatory and rude towards patients, one of whom walked out without being seen after an interaction with the Respondent.

[2] To date, the Respondent has not signed off on patient notes, preventing Practice A from billing for the Respondent's services. Ultimately, the Respondent returned Practice A's laptop to local law enforcement.

12. Provider A stated that the Respondent was verbally abusive, raised his voice and made the medical assistants feel uncomfortable. As a result, Provider A held a staff meeting to address the issue.

13. Provider A further stated that he kept a close eye on the Respondent and as soon as he observed the Respondent getting upset, he removed the Respondent from the situation and took over patient care.

14. Provider A stated that in the four-month period of the Respondent's employment at Clinic A, Provider A held two meetings to address concerns regarding the Respondent's behavior at work.

15. According to Provider A, he terminated the Respondent's employment when he discovered that the Respondent stole multiple vials of antibiotics from Clinic A.

16. On September 2, 2016, the Board's staff interviewed Witness A, a former medical assistant at Clinic A.

17. Witness A stated that the Respondent acted in a manner that made her feel physically threatened and intimidated. Witness A stated that she felt intimidated by the Respondent because of his large stature (6'6") relative to her small stature.

18. Witness A stated that after this incident, the Respondent gave her a hard time and didn't want to work with her.

19. Witness A also recalled patients complaining about the Respondent's rudeness, cultural insensitivity, and inappropriate comments.

B. PRACTICE A

20. Practice A, a pain management practice in Rockville, Maryland, employed the Respondent from December 26, 2015 until his termination on February 18, 2016. The

Respondent worked part-time at Practice A performing patient examinations and giving injections under fluoroscopic guidance.

21. On May 12, 2016, Board staff interviewed the part-owner and CEO of Practice A, a licensed chiropractor ("Provider B").

22. According to Provider B, the Respondent was "extremely combative and disruptive and difficult to handle from an employee perspective." Provider B further stated that the Respondent behaved inappropriately with various staff members.

23. The Board's staff interviewed four staff members and one patient at Practice A. The staff members testified about the Respondent's refusal to enter notes in patient charts, due to the Respondent's lack of experience with electronic medical records. Practice A attempted to accommodate the Respondent by allowing him to hand-write his patient notes, but the Respondent had difficulty doing so.

24. Two of the staff members testified that they observed memory loss and forgetfulness when interacting with the Respondent.

25. In addition, the staff members testified that the Respondent was dismissive and condescending to staff members, belligerent regarding office policies and rules, and that the Respondent made culturally insensitive remarks.

26. The patient testified that the Respondent was disrespectful to her, as well as to the staff member who was present in the examination room. The patient specifically requested not to see the Respondent for future appointments.

C. CLINIC B

27. Clinic B, a multi-disciplinary pain clinic in Danville, Virginia, employed the Respondent for a six- or seven-week period in 2015, until Clinic B terminated his employment.

28. In furtherance of its investigation, the Board issued a subpoena for the Respondent's personnel file at Clinic B.

29. In summary, a review of the Respondent's personnel file revealed that the Respondent:

a. used profane language with patients;

b. aggressively accused patients of being drug seekers;

c. raised his voice with patients;

d. made repeated inappropriate sexual remarks to staff and patients;

e. told jokes that were sexual in nature in the presence of staff and patients;

f. called female staff members inappropriate nicknames despite being told not to do so;

g. hung up on a mid-level staff member when discussing a patient;

h. verbally abused staff members;

i. documented in a patient's chart that he used a medication that is not stocked by Clinic B; and

j. threatened to punch another provider in the face.

30. Furthermore, according to the Respondent's personnel file, many of the Respondent's chart notes are deficient, preventing Clinic B from submitting for reimbursement for services rendered by the Respondent.

31. During his employment at Clinic B, the Respondent supervised a nurse practitioner. According to the Respondent's personnel file, the Respondent was abusive toward the nurse practitioner, who ultimately resigned from Clinic B.

32. After his termination from Clinic B, the Respondent filed multiple complaints to various government agencies against Clinic B and its owner.

D. CLINIC C

33. Clinic C, a walk-in clinic in Falls Church, Virginia, employed the Respondent for approximately three months from August 2014 to November 2014. It is unclear from the personnel file why his employment at Clinic C ended.

34. A review of the Respondent's personnel file revealed two employee incident reports involving the Respondent.

35. The first employee incident report, dated October 20, 2014 at 2:00 p.m., documented an incident in which the Respondent displayed rudeness and discourteous behavior. The Respondent refused to sign the employee incident report.

36. The second employee incident report, dated October 20, 2014 at 5:45 p.m., referenced the need for the Respondent to have "respect for colleagues and not be rude because it hinders patient care." In addition, the employee incident report stated that the Respondent was advised to provide his signature for electronic medical records and in response, the Respondent began yelling that the use of his signature is a billing scam. Finally, the employee incident report described how the Respondent refused to complete documentation or provide care to waiting patients and left Clinic C.

E. DISCIPLINARY ACTIONS IN VIRGINIA AND PENNSYLVANIA

37. By an Order dated May 18, 2006 (the "2006 Virginia Order"), the Virginia Board of Medicine (the "Virginia Board") placed the Respondent's Virginia license to practice medicine on indefinite probation. The Respondent's probation was subject to terms and conditions, including but not limited to, a comprehensive assessment of the Respondent's ability to practice medicine and surgery safely and competently.

38. In addition to findings of fact regarding standard of care and documentation deficiencies, the Virginia Order included findings of fact demonstrating "a pattern of disruptive behavior that may be the result of mental incapacity or illness." This behavior occurred at various hospitals in Northern Virginia in the mid-to-late 1990s.

39. As a result of his disruptive behavior, the Respondent was evaluated on multiple occasions which resulted in recommendations for psychiatric treatment and counseling, the appointment of physician mentors and disciplinary actions against his privileges.

40. The Virginia Order required the Respondent to undergo a complete assessment of his ability to practice safely and competently.

41. On October 3, 2006, the Respondent entered into a participation contract with the Virginia Health Practitioner's Intervention Program and underwent inpatient treatment from November 20, 2006 until January 23, 2007. The Respondent was diagnosed with a major psychiatric illness.

42. On April 17, 2007, in a reciprocal action based upon the 2006 Virginia Order, the Pennsylvania State Board of Medicine (the "Pennsylvania Board") indefinitely

suspended the Respondent's Pennsylvania license to practice medicine until such time as the Respondent's Virginia license was reinstated.[3]

43. On May 18, 2007, the Virginia Board and the Respondent entered into a Consent Order ("2007 Virginia Order") which found the Respondent in violation of the 2006 Order. The 2007 Order placed the Respondent on indefinite probation because he failed to timely comply with the conditions of the 2006 Virginia Order, failed to notify patients of the closure of his practice or to provide copies of medical records upon request.

44. On September 28, 2008, the Virginia Board reinstated the Respondent's license to practice medicine without restriction.

45. On May 7, 2009, the Pennsylvania Board reinstated the Respondent's license without restriction.

E. ADDITIONAL INFORMATION

46. In furtherance of its investigation, the Board obtained releases from the Respondent to obtain his medical records.

47. Included in the Respondent's medical records, one provider ("Provider C") documented in an office note on December 8, 2014 that "staff feels that [the Respondent] has been difficult to deal with. He initially did not want to complete the paperwork stating that he was a physician and did not have to do so."

48. In addition, the office note stated that the Respondent was "upset about his handling from the time of the first phone call . . . [,] was not satisfied with the discussion by the technologist or [Provider C], and that he would be complaining to the Virginia Medical Board."

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[3] The Virginia Board issued a mandatory suspension of the Respondent's Virginia license based upon Pennsylvania's action. However, the documentation indicates that the suspension was immediately lifted.

49. The Board also obtained the Respondent's medical record from another provider ("Provider D") of the Respondent. In light of Provider D's minimal notes, Board staff spoke with Provider D on the telephone.

50. Provider D diagnosed the Respondent "many years ago" with a mental health disorder and continues to prescribe medication to treat the Respondent.

51. Provider D further stated that he speaks to the Respondent weekly on the telephone and that they meet frequently to lecture students at schools in Virginia.

52. The Respondent's conduct, as described above, constitutes a violation, in whole or in part, of Health Occ. II § 14-404(a)(3(ii) Unprofessional conduct in the practice of medicine.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel B concludes as a matter of law that the Respondent violated the following provision of the Act: Health Occ. II § 14-404(a)(3) Is guilty of: (ii) Unprofessional conduct in the practice of medicine.

ORDER

It is, on the affirmative vote of a majority of the quorum of Panel B, hereby:

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **THREE (3) YEARS**.[4] During the probationary period, the Respondent shall fully and satisfactorily comply with all of the following probationary terms and conditions:

1. The Respondent shall enroll in the Maryland Physician Rehabilitation Program ("MPRP"). Within **five (5) business days**, the Respondent shall contact MPRP to schedule an initial consultation for enrollment. Within

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

fifteen (15) business days, the Respondent shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP. The Respondent shall fully and timely cooperate and comply with all of MPRP's referrals, rules, and requirements, including but not limited to, the terms and conditions of the Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered into with MPRP, and shall fully participate and comply with all therapy, treatment, evaluations, and toxicology screenings as directed by MPRP;

2. The Respondent shall sign and updated the written release/consent forms requested by Board and MPRP. The Respondent shall sign the release/consent forms to authorize MPRP to make verbal and written disclosures to the Board, including disclosure of any and all MPRP records and files possessed by MPRP. The Respondent shall also sign any written release/consent forms to authorize MPRP to exchange with (*i.e.*, disclose to and receive from) outside entities (including all of the Respondent's current therapists and treatment providers) verbal and written information concerning the Respondent and to ensure that MPRP is authorized to receive the medical records of the Respondent, including but not limited to, mental health and drug or alcohol treatment records;

3. During the probationary period, the Respondent shall provide the name(s) of any hospitals at which he is privileged and any medical officers at which the Respondent practices medicine. He shall provide a copy of this Consent Order to all hospitals at which he is privileged and any medical offices at which the Respondent practices medicine;

4. During the probationary period, the Respondent shall cause his employer(s) to submit quarterly reports regarding his compliance with professionalism standards. An unsatisfactory report or the employer(s) failure to submit a quarterly report may be deemed a violation of the Consent Order; and

5. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II §§ 14-101 -- 14-702, and all laws, statutes and regulations governing the practice of medicine.

AND IT IS FURTHER ORDERED that after **three (3) years**, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel B. The Respondent may be required to appear before the Board or Panel B to discuss his petition for termination. The Board or Panel B will grant the

petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

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

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

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

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

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

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014).

08/30/2017
Date

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

CONSENT

I, Peter J. Delenick, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact, Conclusions of Law and Order.

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

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

terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

8/28/2017
Date

Peter J. Delenick, M.D.
Respondent

Read and approved:

Anne Marie McGinley, Esquire
Counsel for Dr. Delenick

NOTARY

STATE OF Maryland

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 28th day of August 2017, 2017, before me, a Notary Public of the foregoing State and City/County, did personally appear Peter J. Delenick, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 4/18/2020