IN THE MATTER OF	BEFORE THE
KWASI A. DEBRA, M.D.,	MARYLAND STATE
	BOARD OF PHYSICIANS
Respondent	
License Number: D40683	Case Numbers: 2226-0114, 2226-0120 A

CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby charges **KWASI A. DEBRA, M.D.** ("the Respondent"), License Number D0040683, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occupations ("Health Occ.") §§ 14-101 *et seq.* (2021 Repl. Vol. & 2025 Supp.). The Respondent is charged under the following provision of the Act:

Health Occ. § 14-404. License denial, suspension, or revocation.

(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;

. . .

(33) Fails to cooperate with a lawful investigation conducted by the Board or a disciplinary panel[.]

ALLEGATIONS OF FACT[1]

Panel A bases its charges against the Respondent on the following facts that it has cause to believe are true:

I. BACKGROUND

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Board initially issued the Respondent a license to practice medicine in Maryland on October 1, 1990, under license number D0040683. His license is scheduled to expire on September 30, 2026, subject to renewal.

2. The Respondent previously held licenses to practice medicine in Washington, D.C.,[2] Virginia,[3] Nevada,[4] and Florida.[5]

3. The Respondent practices medicine at a private medical office (the "Office") in Prince George's County, Maryland.

II. PRIOR BOARD HISTORY

April 2012 Consent Order

4. The Board initiated an investigation of the Applicant after receiving a complaint about him from a national insurance company's investigator. The Board's

---

[1] The allegations set forth in this document are intended to provide the Respondent with reasonable notice of the Panel's 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 in connection with these charges.

[2] The Respondent was licensed in Washington, D.C. under license number MD20163, which expired on or about December 31, 2020.

[3] The Respondent was licensed in Virginia under license number 0101047582, which expired on or about November 30, 2010.

[4] The Respondent was licensed in Nevada under license number 10190, which expired on or about June 30, 2007. The status of his Nevada medical license is currently suspended.

[5] The Respondent was licensed in Florida under license number ME85824, which expired on or about January 31, 2005.

investigation revealed that the Applicant improperly signed another physician's name on patient summaries when that physician did not examine any of the patients involved. The Applicant provided those patient summaries to the national insurance company during its investigation of his practice. On or about April 9, 2012, the Applicant entered into a Consent Order with the Board in which he agreed that he was guilty of unprofessional conduct in the practice of medicine, filing false reports or records in the practice of medicine, and failing to keep adequate medical records. Pursuant to the Consent Order, the Applicant agreed to a sanction of suspension of his license for 30 days, followed by a minimum of three years of probation, a $25,000 fine, a requirement to complete a tutorial in medical ethics, and to undergo peer review of his charts.

5. On or about May 24, 2012, the Board terminated the Applicant's suspension and placed the Applicant on probation for a minimum of three years with terms and conditions.

6. On or about May 29, 2015, the Board terminated the Applicant's probation.

May 2017 Consent Order

7. On September 28, 2016, the Applicant signed an affirmation in his 2016 renewal application that he had obtained the required 50 Category 1 Continuing Medical Education ("CME") credit hours during a two-year period. However, the documentation of CME credits that the Applicant provided to the Board showed that he only completed 28.25 hours of the required 50 hours. On or about May 26, 2017, the Applicant entered into a Consent Order with the Board in which he agreed that his failure to provide documentation of the required 50 hours of Category 1 CME credit hours constituted a failure to comply

with the statute and regulations. The Applicant agreed to the following sanction: a civil penalty of $2,175.00 ($100 per missing CME credit hour), and the requirement to obtain 50 credit hours of Category 1 CME for the 2016 renewal *and* the outstanding 21.75 hours that he did not obtain for the 2016 renewal, for a total of 71.75 Category 1 CME credit hours in order for his license to be renewed in 2018.

8. On or about September 6, 2018, the Board determined that the Applicant satisfied the terms and conditions of the May 2017 Consent Order.

III. THE BOARD'S INVESTIGATION

The Patient

9. On or about July 18, 2025, the Board received a complaint (the "Complaint") from a patient (the "Patient") regarding the Respondent's treatment during an Office visit on June 11, 2025. The Patient alleged that she went to the Respondent to get Botox injections under her eyes, and the Respondent recommended she also get filler in her nose. The Respondent administered filler to her nose, which was "immediately painful and bleed [*sic*] profusely." She alleged that the Respondent advised that this was normal. The Patient returned to the Respondent's Office the next day with severe pain in her nose and jaw and blurry vision. The Respondent again advised that this was normal and advised her to put ice on it. The Patient had to find care for her nose from another medical provider (the "Provider").

10. After reviewing the Complaint, the Board opened an investigation of the Respondent and issued a subpoena *duces tecum* to the Office for a complete copy of the Patient's medical and billing record. On August 12, 2025, the Board received the Patient's

medical records from the Office, which showed that the Respondent administered dermal filler to the Patient's nose on June 11, 2025.

11. Pursuant to its investigation, the Board obtained the Patient's medical records from the Provider, which revealed the following in part:

a. The Respondent administered dermal filler to the Patient's nose on June 11, 2025. The Patient went back to the Respondent after she noticed discoloration. The Respondent told her it was bruising and advised her to ice the area. The Patient went back to the Respondent and received similar advice.

b. On or about June 13, 2025, the Patient was diagnosed with a "two day old right nasal vascular occlusion injury after receiving nasal filler to her nasal tip and right ala." The Patient was prescribed medications to dissolve the filler in her nose and improve blood flow to the soft tissue.

c. Through treatment, the Provider was "able to restore much of the blood supply but unfortunately [the Patient] had about 48hrs of ischemia from when the filler was first injected until she came to see us."

12. On or about March 16, 2026, Board staff conducted an under-oath interview with the Patient, during which she stated that she was still undergoing treatment from the Provider to repair her nose.

13. On or about April 22, 2026, Board staff conducted an under-oath with an administrator (the "Administrator") at the Provider. She stated that when the Patient walked in, "it was obvious we needed to treat [her] right away." The Administrator stated that the Patient had vascular occlusion on her nose, and her skin was clearly "necrosed. . . . basically rotting." The Patient was tearful because she was in pain, she could not open her mouth, and her vision was blurred. The Administrator stated that the surgeons at the Provider were

"shocked that somebody could do this and then tell [the Patient] for two days that it was a bruise, while she was . . . losing sensation in her face." The Administrator and a surgeon at the Provider called the Respondent to discuss the Patient. The Respondent "didn't seem to care[.]"

The Respondent's Failure to Cooperate with a Lawful Board Investigation

14. By letter dated July 21, 2025, Board staff informed the Respondent of the Complaint, provided him a copy of it, and requested that he provide a written response to the allegations within 10 business days of the date of the letter.

15. By emails dated August 8, 2025, Board staff resent the July 21, 2025 letter to the Respondent and to his Office with copies of the Complaint. In the emails, Board staff informed the Respondent that it had not yet received his written response to the Complaint and asked him to send his written response by August 15, 2025.

16. By email dated August 8, 2025, the Respondent informed Board staff that "[t]he document has been mailed express post" and the Board "should receive it by Monday."

17. By email dated August 25, 2025, Board staff informed the Respondent that the Board had still not received his written response to the Complaint. Board staff requested that the Respondent provide a tracking number for the document that he said he mailed to the Board in his earlier email.

18. Board staff contacted the Respondent by emails dated November 26, 2025 and December 5, 2025, requesting that he provide a copy of his written response.

19. By email dated December 18, 2025, the Board sent a subpoena *duces tecum* to the Respondent for his written response to the Complaint. The Respondent did not provide his written response to the Board in response to the subpoena.

20. On the morning of April 9, 2026, Board staff arrived at the Respondent's Office to conduct an inspection. The Respondent was not present. Board staff spoke to another physician who was there ("Physician A") and his receptionist (the "Receptionist"). The Receptionist told Board staff that the Respondent had not been in the Office since approximately December 2025 and that the property was foreclosed on around January 2026. The Respondent and Physician A previously shared the Office. Physician A said he used to pay rent to the Respondent, but he now pays rent to a different person after the property was sold at auction. Board staff inspected the Respondent's area of the Office and observed several examination rooms that were cluttered and had office furniture in them, including upholstered chairs placed upside down on exam tables. The exam rooms also had open cabinets containing various medical equipment and supplies, many of which were still in their packaging.

21. By letter and email dated April 17, 2026, Board staff informed the Respondent that the Board still had not received his written response. Board staff advised the Respondent that his written response to the Complaint, including a summary of care provided to the Patient, is due on May 6, 2026. Enclosed with the letter were: a subpoena *ad testificandum* requiring the Respondent to appear at the Board for an interview on May 1, 2026; a subpoena *duces tecum* requiring the Respondent to provide the Board with the Patient's complete medical and billing record and Certification of Medical Records Forms;

and the prior December 18, 2025 subpoena *duces tecum*. Board staff advised the Respondent that "failure to comply with Board subpoenas may result in a disciplinary panel of the Board issuing charges for failure to cooperate with a lawful investigation conducted by the Board[.]"

22. By email dated May 1, 2026, the Respondent informed Board staff that he was out of the country and that he will respond as soon as he returns from his emergency.

IV. GROUNDS FOR DISCIPLINE

The Respondent, as described above, is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii), and the Respondent has failed to cooperate with a lawful investigation conducted by the Board or a disciplinary panel, in violation of Health Occ. § 14-404(a)(33).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, a Disciplinary Panel of the Board finds that there are grounds for action under Health Occ. 14-404(a)(3)(ii) and/or (33), it may impose disciplinary sanctions against the Respondent's license in accordance with the Board's regulations under 10.32.02.09 and 10.32.02.10, including revocation, suspension, or reprimand and may place the Respondent on probation. The panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent.

NOTICE OF DISCIPLINARY COMMITTEE FOR CASE RESOLUTION CONFERENCE, PREHEARING CONFERENCE AND HEARING

A conference before the Disciplinary Committee for Case Resolution ("DCCR") in this matter is scheduled for **Wednesday, November 4, 2026, at 9:00 a.m.**, at the Board's

office, 4201 Patterson Avenue, Fourth Floor, Baltimore, Maryland 21215. The nature and purpose of the DCCR is described in the attached letter to the Respondent. The Respondent must confirm in writing his intention to attend the DCCR. The Respondent should send written confirmation of his intention to participate in the DCCR to:

Christine Farrelly
Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue
Fourth Floor
Baltimore, Maryland 21215

If the case cannot be resolved at the DCCR, a pre-hearing conference and a hearing in this matter will be scheduled at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031. The hearing will be conducted in accordance with Md. Code Ann., Health Occ. § 14-405, and Md. Code Ann., State Gov't §§ 10-201 *et seq.* (2021 Repl. Vol. & 2025 Supp.).

ANTHONY G. BROWN
ATTORNEY GENERAL

7/21/2026
Date



Blair E. Thompson
Assistant Attorney General
Deputy Principal Counsel
Office of the Attorney General
Health Occ. Prosecution &
Litigation Division
300 West Preston St., Suite 201
Baltimore, Maryland 21201
410-767-1889
blair.thompson@maryland.gov