IN THE MATTER OF	*	**BEFORE THE**
ORLANDO R. DAVIS, M.D.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF PHYSICIANS**
LICENSE NUMBER: D33967	*	**Case Numbers: 2011-0811** **2014-0621**

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CONSENT ORDER

On August 26, 2015, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") voted to charge Orlando R. Davis, M.D. (the "Respondent"), license number D33967, with violating the Maryland Medical Practice Act (the "Act") codified at Md. Code Ann., Health Occ. (Health Occ.) §§ 14-101 *et seq.* (2014 Repl. Vol. and 2015 Supp.).

Disciplinary Panel B further voted to charge Respondent with violating condition eight of the conditions of probation as stated in the Consent Order of November 16, 2012 which requires:

> 8. Respondent shall practice according to the Maryland Medical Practice Act in accordance with all applicable laws, statues, and regulations pertaining to the practice of medicine. Failure to do so shall constitute a violation of this Consent Order.

The pertinent provisions of the Act with which Respondent failed to comply, and under which the Board voted to charged, are Health Occ. § 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:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in the State;

(40) Fails to keep adequate medical records as determined by appropriate peer review[;].

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background

1. At all times relevant hereto, the Respondent was, and is, licensed to practice medicine in Maryland. The Respondent was originally licensed to practice medicine in Maryland on July 22, 1986. On or about September 2014, the Respondent last renewed his license, which will expire on September 30, 2016.

2. In October 1990, the Respondent was granted life-time board-certification by the American Board of Psychiatry and Neurology in psychiatry.

3. The Respondent maintains an office for the private practice of psychiatry in Baltimore City, having re-located his private office to various locations in Baltimore City on a number of occasions since 1990.

4. The Respondent has also practiced psychiatry at various private, for-profit health centers, and as an independent practitioner at mental health service facilities also in Baltimore City.

5. Since 2009, the Respondent has practiced psychiatry, three days a week, at a private not-for-profit community mental health clinic in Baltimore City which provides rehabilitation and support services to people who are disabled or disadvantaged.

II. Complaint and Investigation

6. On or about February 6, 2014, the Board received a complaint from an

investigator for the Drug Enforcement Administration ("DEA") reporting concerns about the Responder's prescribing of CDS (controlled dangerous substances) at a medical practice in Suitland, Maryland. According to the investigator, patients were coming from other states for medical care and gathering outside of the office. The DEA had also received complaints from area pharmacists about the Respondent's prescribing practices.

7. In March 2014, the Board issued several subpoenas to various major pharmacies requesting a computer-generated printout of all prescriptions for controlled substances written by the Respondent from December 1, 2012 to March 11, 2014.

8. On May 5, 2014, Board staff selected 12 patient names from the pharmacy printouts. The Board issued a subpoena to the Respondent for the medical records of the 12 named patients and provided the Respondent an opportunity to submit a written response to the complaint.

9. On September 12, 2014, the Respondent was interviewed under oath by Board staff. Respondent stated that:

a. He is the psychiatrist for a forensic services community treatment team which takes patients from incarceration and from State mental health hospitals and integrates them into the community;

b. In his private practice, he provides services to children and adults with mental health and drug addiction problems;

c. He was employed by the Suitland practice in approximately late August 2013 and left in early December 2013. He worked two days a week, often until 11:00 p.m. or 12:00 am, noting "it was a large volume of people they had me seeing there." All of his patients were there for pain and "they were from all around."

d. He took a course in December 2013 in prescribing controlled substances for pain management that was independent from the requirements of his

Consent Order. He learned how to best convert people from the short-acting medicine (opioids) to the longer-acting medicine.

e. After taking the course, he advised patients about the changes in his prescribing. If a patient did not agree to the change, he gave the patient their final prescription and referred them to other providers.

f. After terminating with each of his patients, there was "no further need" for him at the medical practice.

g. On December 23, 2013, after finishing work, he was going to his car and was approached by a person with a gun who took his physician's bag. There were no prescription pads in is bag. After the robbery, he stopped going to the medical practice.

h. In addition to himself the medical practice employed an anesthesiologist and OB-GYN. The patients were "recruited" by a nurse who had experience in pain management. Patient presented as stable chronic pain patients who were switching from on pain management provider, who was prescribing at a certain level, to another.

i. He continued the patients on their current prescriptions until he studied about the comparison of the longer acting and the shorter- acting medications and he began to make a change.

j. He is certified as a buprenorphine provider with a capacity of 100 patients.

k. At his other practice locations, Respondent only offers longer acting medication. If patients come to him already on short acting medication, they must be willing to convert to longer acting opioids.

10. On April 27, 2015, the Board sent the case to Permedion Inc., an independent peer review entity, for a peer review of the 12 patients. The Board included the complaint from DEA, a transcript of the interview of the Respondent, the drug surveys from three area pharmacies, the Respondent's summary of care provided, and medical records as provided by the Respondent.

11. Two Peer Reviewers, one board-certified by the American Board of Anesthesiology, in Pain Medicine; the other board-certified by the American Board of Physical Medicine and Rehabilitation, in Pain Medicine, concurred that the Respondent

failed to meet standards for quality medical care in 10 out of 12 cases and failed to keep adequate medical records in 11 out of 12 cases. Neither of the reviewers reviewed the twelfth case since in involved treatment of a pediatric patient with ADHD, which is outside the scope of the pain medicine.

12. On June 26, 2015, the Board received the reports of the two peer reviewers.

13. On June 29, 2015, the Board sent copies of the peer review reports to the Respondent with the names of the reviewers redacted requesting a Supplemental Response.

14. On August 6, 2014, the Board received Respondent's Supplemental Response, which was subsequently reviewed by the two peer reviewers, prior to the issuance of Charges.

15. Based on the completed investigatory information and reports, the Board voted to charge the Respondent with violations of §§ 14-404(a)(22) and (40) of the Act; and violation of condition eight of the Consent Order of November 16, 2012.

III. General Allegations Pertaining to the Patients

16. Ten cases revealed the following common themes in regard to failure to meet standards of quality care and 11 cases revealed the following common themes in regard failure to keep adequate medical records:

a. Continued patients on high doses of Oxycodone, a short acting opioid, without explaining the rationale for doing so;

b. Prescribed Oxycodone, a medication with high street value, to several patients from other states and or who live far away from the clinic, one of whom had no prescribed pain medication in his urine and had no signs of withdrawal and two who were cash paying patients;

c. Failed to gradually lower the doses of short acting pain medicine from his initial visit with the patients, while gradually increasing the long acting;

d. Failed to obtain frequent random urine drug screens on all of the patients;

e. Failed to refer four patients with lumbar disc herniation to a pain management specialist or neurosurgeon for treatment; and

f. Prescribed Oxycodone and Methadone to a patient who was also taking benzodiazepines and soma which potentially can cause respiratory depression.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that Respondent violated Health Occ. § 14-404(a)(22) (fails to meet standards of quality care) and § 14-404(a)(40) (inadequate medical records). Disciplinary Panel B further finds as a matter of law that Respondent violated condition 8 of the Consent Order of November 16, 2012.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, by a majority of a quorum of Disciplinary Panel B of the Board considering this case, it is hereby:

ORDERED, the conditions of probation of the Consent Order of November 16, 2012 are terminated based on Respondent's having met the conditions of taking a Board-approved course in medical record keeping and a Board-approved course in psychopharmacology;

ORDERED, effective the date of this Consent Order, Respondent is placed on **PROBATION** for a minimum of **one (1) year** and until he fully and satisfactorily complies with the following conditions of probation:

a. Respondent shall continue with monthly supervision with a Board-approved supervisor who is Board-certified in Psychiatry as required by

the Consent Order of November 16, 2012:

i. Respondent shall meet in person with the supervisor on a monthly basis who will review a random selection of Respondent's medical charts. The supervisor will assess and provide feedback to Respondent with regard to the quality of his medical care and whether the documentation is adequate and sufficiently legible;

ii. Respondent shall ensure that the supervisor submits written reports to the Board on a quarterly basis regarding his/her assessment of Respondent's compliance with appropriate standards of care and appropriate documentation;

iii. Respondent shall have sole responsibility for ensuring that the supervisor submits the required quarterly reports to the Board in a timely manner; and

b. Respondent shall notify the Board of all locations where he practices medicine and his leaving or termination from any practice location;

c. Respondent's practice, including his mental health, addiction, pediatric, and/or pain management cases, may be reviewed by an appropriate peer review entity, or a chart reviewed by a Board designee;

d. An unsatisfactory peer review by an appropriate peer review entity shall be deemed a violation of probation as described below;

e. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order;

f. Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine. Failure to do so shall constitute a violation of this Consent Order;

g. There shall be no early termination of probation; and be it further

ORDERED if Respondent violates any term or condition of probation or this Consent Order, Disciplinary Panel B, in its discretion, after notice and an opportunity for a show cause hearing before Disciplinary Panel B, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction

which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of the terms and conditions being proved by a preponderance of the evidence; and be it further

ORDERED that after a minimum of **one (1) year** from the effective date of this Consent Order, the Respondent may submit a written petition to Disciplinary Panel B requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Disciplinary Panel B. Disciplinary Panel B will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and be it further

ORDERED that the Consent Order is a public document pursuant to Md. Code Ann., Gen. Pro. §§ 4-101 *et seq.* (2014 and 2015 Supp).

01/05/2016
Date

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

CONSENT

I, Orlando R. Davis, M.D., License No. D33967, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, David J. McManus, Esquire, and knowingly and voluntarily elect to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 (2014 Repl. Vol. & 2015 Cum. Supp.) and Md. Code Ann., State Gov't §§ 10-201 *et seq.* (2014 Repl. Vol. & 2015 Cum. Supp.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have 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 am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

01/04/2016
Date

Orlando R. Davis, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF

I HEREBY CERTIFY that on this 4th day of January, ~~2015~~ 2016 before me, a Notary Public of the State and County aforesaid, personally appeared Orlando R. Davis, M.D, License number D33967, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Alicia Lyn Moskal
Notary Public
My commission expires:

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