Joseph C. Randall, Jr., M.D.
[redacted]

July 13, 2016

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, Maryland 21215-2299

RE: Surrender of Medical License
License Number: D42752
Case Numbers: 2014-0604A & 2015-0344A

Dear Ms. Farrelly and Members of Disciplinary Panel A:

I have decided to **SURRENDER** my license to practice medicine in the State of Maryland, License Number D42752, effective immediately. I understand that upon surrender of my license, I may not give medical advice or treatment to any individual, with or without compensation, and cannot otherwise engage in the practice of medicine in the State of Maryland as it is defined in the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ."), §§ 14-101 *et seq.*, (2014 Repl. Vol.) and other applicable laws. In other words, as of the effective date of this Letter of Surrender, I understand that the surrender of my license means that I am in the same position as an unlicensed individual in the State of Maryland.

I understand that this Letter of Surrender is a **PUBLIC** document and on Disciplinary Panel A of the Maryland State Board of Physicians' (the "Board's") acceptance becomes a **FINAL ORDER** of Disciplinary Panel A.

I have decided to surrender my license to practice medicine in the State of Maryland to avoid further prosecution of the disciplinary charges now pending before Disciplinary Panel A. I acknowledge that the Board's investigation determined that following a formal peer review, I failed to meet the standard of quality care with regard to five patients constituting violations of Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a)(22) and my documentation was inadequate with regard to nine patients constituting violations of Health Occ. § 14-404(a)(40); and I acknowledge that the Board's investigation determined that I engaged in unprofessional conduct toward four pain management patients, including sexual misconduct with three of the patients, and unprofessional conduct toward two employees in my former practice site, constituting

violations of Health Occ. § 14-404(a)(3)(ii). Disciplinary Panel A's Charges are attached hereto and incorporated herein as **Attachment A**.

I wish to make it clear that I have voluntarily, knowingly, and freely chosen to submit this Letter of Surrender in lieu of Disciplinary Panel A proceeding with further investigation and to avoid prosecution of Disciplinary Panel A's Charges. If this case were to proceed to a hearing, I agree that the State would be able to prove the Charges, and for purposes related to medical licensure, these investigatory findings will be treated as if proven. I understand that by executing this letter of surrender, I am waiving any right to contest the Charges in a formal evidentiary hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf and all other substantive and procedural protections provided by law, including the right to appeal to circuit court.

I understand that Disciplinary Panel A will advise the Federation of State Medical Boards, the National Practitioner Data Bank, and the Healthcare Integrity and Protection Databank of this Letter of Surrender, and in any response to any inquiry, that I have surrendered my license in lieu of further disciplinary action. I also understand that in the event I apply for a license in any form in any other state or jurisdiction, this Letter of Surrender and the underlying investigative documents may be released or published by Disciplinary Panel A to the same extent as a final order that would result from disciplinary action, pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014), and that this Letter of Surrender is considered a disciplinary action by the Board.

I affirm that on or before the date of Disciplinary Panel A's acceptance of this Letter of Surrender, I will provide to Board staff my original Maryland medical license and my most recent renewal license issued by the Board. I also affirm that I will provide access to and copies of patient medical records in compliance with Title 4, subtitle 3 of the Health General article. I further recognize and agree that by submitting this Letter of Surrender, my license will remain surrendered for a minimum period of three (3) years, pursuant to Code Md. Regs. 10.32.02.06B(2)(b). In the event that I apply for reinstatement of my Maryland License, I understand that Panel A or its successor is not required to grant reinstatement; and, if it does grant reinstatement, may impose any terms and conditions the disciplinary panel considers appropriate for public safety and the protection of the integrity and reputation of the profession. I understand that when applying for reinstatement, I will approach Panel A or its successor in the same posture as one whose license has been revoked. I also understand that if I apply for reinstatement, I bear the burden of demonstrating my professional competence and fitness to practice medicine to the satisfaction of Panel A or its successor.

I acknowledge that I may not rescind this Letter of Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have consulted with an attorney before signing this Letter of Surrender. I understand both the nature of Panel A's actions and this Letter of Surrender fully. I acknowledge that I understand

and comprehend the language, meaning, and terms and effect of this Letter of Surrender. I make this decision knowingly and voluntarily.

Sincerely,

Joseph C. Randall, Jr., M.D.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Baltimore City

I HEREBY CERTIFY that on this 13th day of July 2016, before me, a Notary Public of the State and City/County aforesaid, personally appeared Joseph C. Randall, Jr., M.D. and declared and affirmed under the penalties of perjury that signing the foregoing Letter of Surrender was her voluntary act and deed.

AS WITNESS my hand and official seal.

Dana Mullis
Notary Public

My Commission expires: 9/5/17

ACCEPTANCE

On this 13th day of July, 2016, I, Christine A. Farrelly, Executive Director, on behalf of Disciplinary Panel A of the Maryland State Board of Physicians,

accept Joseph C. Randall, Jr., M.D.'s **PUBLIC SURRENDER** of his license to practice medicine in the State of Maryland.

Christine A. Farrelly

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

ATTACHMENT A

IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Joseph C. Randall, Jr., M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D42752	*	**Case Numbers: 2014-0604A & 2015-0344A**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") hereby charges Joseph C. Randall, Jr., M.D. (the "Respondent"), License Number D42752, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a) (2014 Repl. Vol.).

The pertinent provisions of the Act provide:

> (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:
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> ...
>
> (3) Is guilty of:
>
> (i) Immoral conduct in the practice of medicine; or
> (ii) Unprofessional conduct in the practice of medicine;
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> ...
>
> (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 location in this state;
>
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

The pertinent provisions of Md. Code Regs. 10.32.17 provide:

.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

...

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:

...

(iii) Using the health care practitioner-patient relationship to initiate or solicit a dating, romantic, or sexual relationship;

...

(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; or

(c) Engaging in a dating, romantic, or sexual relationship which violates the code of ethics of the American Medical Association, American Osteopathic Association, American Psychiatric Association, or other standard recognized professional code of ethics of the health care practitioner's discipline or specialty.

(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:

(i) Sexual intercourse, genital to genital contact;
(ii) Oral to genital contact;
...
(iv) 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) ... Annotated Code of Maryland, includes, but is not limited to, sexual misconduct.

ALLEGATIONS OF FACT[1]

I. BACKGROUND

Disciplinary Panel A of the Board bases its charges on the following facts that it has cause to believe are true:

1. The Respondent is board-certified in internal medicine. He has had no formal training in pain management.

2. During all times relevant to these charges, the Respondent practiced internal medicine at a primary care group practice ("Practice A") with eight locations in Maryland. The Respondent practiced at the Annapolis location.

[1] The allegations set forth in this document 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 in connection with these charges.

3. On or about January 27, 2014, the Board received a complaint from a family friend of a former patient of the Respondent ("Patient 1") who alleged that the Respondent had overprescribed controlled dangerous substances ("CDS") to Patient 1 despite the complainant having notified the Respondent of Patient A's drug addiction.

4. Following receipt of the January 27, 2014 complaint, the Board opened an investigation into the allegations.

5. On or about May 21, 2014, Board staff notified the Respondent of its investigation, requested a written response to the complainant's allegations, subpoenaed ten patient records and requested case summaries of patients whose records had been subpoenaed.

6. By letter dated June 26, 2014, the Respondent submitted a written response to the allegations cited in the complaint, acknowledging he had received information from Patient 1's family members that she had been engaging in opioid and other CDS abuse.

7. On or about August 28, 2014, Board staff conducted an interview of the Respondent under oath.

8. According to the Respondent, one in four of his patients at Practice A is a chronic pain patient.

9. By form letter dated September 2013, Practice A had notified patients in the practice that "recent trends and standards in medicine have now defined that the care for patients with chronic pain should be provided as a multi-disciplinary approach by Pain Management Specialty teams." Further, since the Respondent was expected to be

out of the office for a period of time, all of his patients will be referred to pain management specialty physicians.[2]

10. In furtherance of its investigation, on or about December 19, 2014, the Board transmitted records for formal peer review by two physicians board-certified in internal medicine ("peer reviewers"). The peer reviewers submitted reports to the Board as set forth in pertinent part below.

PATIENT-RELATED ALLEGATIONS

11. The peer reviewers concurred that the Respondent violated the standard of quality medical care in five of ten patient records they reviewed (identified in peer review reports as Patients 2, 3, 4, 6 and 10); and that he failed to maintain adequate medical records in nine of ten patient records they reviewed (identified in peer review reports as Patients 1, 2, 3, 4, 6, 7, 8, 9 and 10).

12. Specifically, the peer reviewers found that with regard to the following chronic pain management patients, the Respondent failed to meet the standard of quality medical care and failed to maintain adequate medical records for reasons including but not limited to the following:

A. The Respondent failed to adequately document appropriate physical examinations relating to areas treated for chronic pain-- Patients 1, 2, 3, 4, 6 and 8;

B. The Respondent failed to enforce or document adequate justification for failure to enforce the terms of the narcotics contract --- Patients 1, 3 and 10;

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[2] There is a letter from the Medical Director to the Respondent dated October 31 (illegible year) with an attached CDS report for October 2013 listing multiple CDS that had been prescribed by the Respondent for patients on October 18 through 31, 2013, and the Medical Director wrote: "Please note the attached report from the last two weeks. Hopefully, these are for the most part, bridge scripts to get these patients to pain management. I will run this report monthly."

C. The Respondent failed to adequately document justification for modification of CDS dosages -- Patients 1, 2, 3, 4, 6 and 8;

D. The Respondent failed to adequately document laboratory results for patients on long-term opioid therapy-- Patients 3, 8 and 10;

E. The Respondent failed to adequately document assessments and plans for specific diagnoses relating to chronic pain-- Patients 3, 4 and 10;

F. The Respondent had "copied" several patient visits from one visit to the next -- Patients 1, 2, 3, 4, 6, 7, 8, 9 and 10;

G. The Respondent failed to order adequate radiology studies relating to the evaluation of chronic pain complaints -- Patients 2, 6 and 10;

H. The Respondent failed to adequately or timely refer or order other methods of pain management such as physical therapy, pain management specialists,[3] behavioral health, neurosurgery --Patients 2, 3, 4, 6, and 10;

I. The Respondent's use of non-narcotic pain modalities for chronic pain patients was inadequate -- Patients 4 and 6;

J. The Respondent disregarded "red flags" signifying possible abuse or diversion of CDS and continued prescribing opioids and other CDS without adequate precautions --Patients 2, 4, and 10; and

K. The Respondent failed to adequately monitor patients on long-term CDS therapy with urine toxicology screening -- Patients 2, 3, 4, 6 and 8.

[3] As noted above in ¶ 9, in September 2013, Practice A notified the Respondent's patients that they would be required to obtain a pain management specialist for their chronic pain care. The Respondent, however, did not enforce this requirement with most of his patients.

13. On or about March 3, 2015, Board staff provided the Respondent with copies of the redacted peer review reports and provided him with an opportunity to provide a supplemental response.

14. On or about March 20, 2015, the Respondent filed a supplemental response with the Board acknowledging after he had reviewed the reports he had developed a better understanding of his deficiencies in providing care to the chronic pain population.

15. The Respondent's conduct, in whole or in part, constitutes failure to meet standards of quality care, in violation of Health Occ. § 14-404(a)(22), and failure to maintain adequate medical records, in violation of Health Occ. § 14-404(a)(40).

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16. On or about November 6, 2014, the Board received a complaint from a former patient of the Respondent (Patient A) alleging in part the Respondent made "sex offers" to her in order for her to receive pain prescriptions. She also alleged the Respondent told her he had a "fetish" and that he liked "older women."

17. Based on Patient A's allegations, the Board initiated an investigation. Board staff subpoenaed the Respondent's employment file from Practice A, relevant patient records, and interviewed the Respondent and several witnesses including staff and patients from Practice A.

18. During the course of its investigation, Board staff discovered additional allegations that the Respondent had engaged in inappropriate conduct with staff and patients at Practice A as set forth below.

19. Review of the Respondent's employment file revealed that in April 2012 a patient of Practice A (not the Respondent's patient), "Patient B," had filed a complaint with Practice A alleging that the Respondent had placed inappropriate telephone calls to her

and that he had obtained personal information about Patient B without her permission from her medical records.[4]

20. An interview of a phlebotomist who was employed by a laboratory in the same building as Practice A ("Employee A") revealed allegations that the Respondent had made inappropriate comments to her during work hours. Additionally, Employee A alleged that she had received information from friends who saw the Respondent as a family physician that the Respondent had engaged in unprofessional conduct with two of the family members.[5]

21. An interview of Patient C (one of the family members identified in ¶ 20), revealed that the Respondent had allegedly provided CDS prescriptions for sexual activity to her as well as to her family member ("Patient D").

22. Interviews of staff at Practice A revealed that the Respondent had been alleged to have conducted himself aggressively during work hours toward a medical assistant employed at Practice A, Employee B.

23. The allegations are set forth more specifically below.

PATIENT-RELATED ALLEGATIONS

PATIENT A

24. On or about January 8, 2015, Board staff interviewed Patient A under oath.

25. Additionally, Board staff subpoenaed Patient A's medical record from Practice A, received a written response from the Respondent and interviewed the Respondent[6] about the allegations cited in Patient A's complaint.

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[4] Subsequently, both Patient B and her husband filed written complaints with the Board alleging he had placed inappropriate unsolicited telephone calls to Patient B.
[5] Patients C and D set forth below, are two members of the family identified by Employee A.
[6] Board staff interviewed the Respondent on September 25, 2015.

26. In April 2010, after her husband's death, Patient A, a female in her 60s, began seeing the Respondent for medical care for multiple conditions including pain management. The Respondent prescribed CDS to Patient A including opioids (oxycodone) and benzodiazepines (Xanax).

27. Patient A saw the Respondent approximately monthly, to receive her prescriptions for pain medication through November 2013.

28. Sometime around May or June 2013, Patient A stated that the Respondent said:

> I want to ask you a question...I don't know how you are going to take it...If you do something for me...You know, you can have your pain medication.

29. Patient A stated in response to the Respondent's statement in ¶ 28, that she said,"...I don't care if you're the most handsome movie star in the world...I would never do anything with anyone under any conditions...."

30. Patient A stated in response to the statement in ¶ 29, that the Respondent told her to "think it over."

31. In June 2013, Patient A tested positive for methadone at Laboratory A, an opioid not being prescribed by the Respondent.

32. Patient A vehemently denied she had taken the methadone. According to Patient A, the Respondent stated, when he told her about the positive test result, "We have to think of something for you to stay here." When Patient A asked what the Respondent meant, he asked if she had heard of a "fetish." The Respondent told Patient A she was beautiful and asked her whether she wanted to continue seeing him as a provider she would be interested in "you and me getting together."

33. On the same date Patient A's urine had tested positive at Laboratory A, Patient A had her urine tested at Laboratory B. Her urine tested negative for methadone.

34. On or about October 23, 2013, Practice A discharged Patient A from the practice stating that she had not followed the directions of her provider as it relates to the chronic use of narcotic medications. After receiving the letter from Practice A, Patient A stated that she telephoned the Site Administrator and told her about the Respondent's "sexual harassment."

35. On October 26, 2013, Patient A documented that the Respondent had contacted her by telephone to ask whether there was any "consideration to what we were talking about. Keep in mind, only once."[7]

36. Patient A documented that the Respondent contacted her by telephone on October 27, 2013 stating he wanted to speak to her and on October 28, 2013, stating he wanted to see her in his office at 12:00 noon.

37. On November 13, 2013, Patient A's medical record reflects the Respondent issued a prescription to her for oxycodone 30 mg (60 tablets).

38. In addition to reporting the Respondent's conduct to the Site Administrator, Patient A confided in Employee A.

39. The Respondent's conduct in whole or in part with regard to Patient A constitutes evidence of unprofessional and/or immoral conduct in violation of Health Occ. § 14-404(a)(3)(i) and/or (ii), pursuant in whole or in part to Code Md. Regs. 10.10.32.17.01 *et seq*.

PATIENT B

40. On or about September 4, 2015, Board staff conducted an under oath interview of Patient B.

[7] Patient A independently documented her communications with the Respondent.

41. Additionally, Board staff subpoenaed Patient B's medical record from Practice A, a police report Patient B had filed regarding the incident,[8] and interviewed the Respondent about the allegations cited in Patient B's complaint.[9]

42. Patient B stated that on or about March 8, 2012, while waiting for an appointment at Practice A, Patient B was introduced to the Respondent by a medical assistant at the practice.[10] Patient B's appointment was with another provider.

43. Patient B stated that she had received medical care from Practice A since approximately June 2000. According to Patient B, she never saw the Respondent for medical care, and this was confirmed by the Respondent.

44. According to Patient B, sometime around April 11, 2012, the Respondent called Patient B on approximately three occasions on her cell phone. She was in a vehicle with her husband when the Respondent telephoned her.

45. On the first occasion, Patient B heard heavy breathing on the telephone.

46. On the second occasion, the same number appeared on Patient B's cell phone and the Respondent did not immediately introduce himself. He referred to himself as "Randall" and called Patient B by her first name. She described his tone as "creepy" and recalled the Respondent said, "I remember you, don't [you] remember me?" Patient B stated that the Respondent told her he had reviewed her file and knew she was being prescribed narcotics.[11] Patient B told the Respondent not to call her.

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[8] Patient B had reported the incident as set forth below to the Anne Arundel County Police Department on April 12, 2012.

[9] The interview took place on September 25, 2015.

[10] Patient B had asked the Medical Assistant whether the Respondent was a new physician at Practice A.

[11] The Respondent acknowledged during his interview that he had accessed Patient B's telephone number from her medical record. He also acknowledged that he contacted Patient B, but stated that he only placed one telephone call to her.

47. After Patient B hung up from the Respondent, he called her a few minutes later. Patient B's husband took the cell-phone from Patient B. Patient B's husband told the Respondent (with profanity) not to call Patient B.

48. On or about April 12, 2012, Patient B and her husband, very upset by the Respondent's calls, reported the unsolicited cell phone contact to the Anne Arundel County Police Department.

49. Patient B also reported the Respondent's telephone calls to Practice A. On April 11, 2012, Practice A's Medical Director documented a summary of her conversation with Patient B, and her subsequent discussion with the Respondent. The Medical Director "locked down" Patient B's medical record as Patient B had requested, limiting access to Patient B's primary care provider. Additionally, the Medical Director contacted Practice A's HIPAA compliance officer to arrange for the Respondent to review HIPAA compliance policies.

50. During the Respondent's interview with Board staff, he acknowledged that he had telephoned Patient B, but denied that he had spoken in an inappropriate manner. His rationale for contacting Patient B was that he was no longer taking any pain patients.[12]

51. The Respondent's conduct in whole or in part with regard to Patient B constitutes evidence of unprofessional conduct in violation of Health Occ. § 14-404(a)(3)(ii).

[12] It was undisputed however, that Patient B had another provider at Practice A, and had not contacted the Respondent about providing medical care to her. Additionally, Patient B had not told the Respondent she was being prescribed pain medication. That information was in her medical record, and she had not provided him with permission to access her medical record.

PATIENT C

52. On or about November 24, 2015, Board staff interviewed Patient C, a female in her 30s, who had begun seeing the Respondent for primary care in approximately 2009. The Respondent treated[13] her through approximately October 2014.

53. The Board subpoenaed prescriptions issued by the Respondent for Patient C, pharmacy surveys and Patient C's medical records. Patient C's medical records indicate she had a history of substance abuse.[14]

54. On January 7, 2016, Board staff interviewed the Respondent regarding his care and treatment of Patient C.

55. On or about April 14, 2009 the Respondent began treating Patient C with Percocet (120 tablets monthly) for "back pain."[15] Shortly thereafter, he began also treating her with Xanax for complaints of anxiety.

56. Initially, the Respondent saw Patient C in the office on approximately a monthly basis.

57. Patient C stated that the Respondent made flirtatious and perverted comments to her during the office visits.

58. Eventually, as the visits progressed (approximately six months after the initial visit), Patient C stated that the Respondent told her that if Patient C would not provide him with sex, he would not provide her with CDS prescriptions.

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[13] Treatment includes the Respondent's continued prescribing to Patient C after she was discharged from Practice A as set forth below.

[14] A notation in Patient C's medical record in June 2009 reflects that her mother contacted the Respondent to tell him that she was afraid her daughter would "OD" based on the prescriptions he was providing her.

[15] According to Patient C, the purpose of the visit was to undergo a physical examination. She had not been previously prescribed CDS for her complaints of back pain.

59. On or about June 20, 2011, the Respondent returned a telephone call from Hospital A informing him that Patient C had been an in-patient there approximately one month ago, and the staff had discovered seven empty Xanax bottles with the Respondent's name as prescriber. The Respondent documented that Patient C was "not trying to change" and that he would be requesting she be discharged from Practice A.

60. On or about July 5, 2011, the Respondent prescribed to Patient C 180 tablets of oxycodone 15 mg, as well as 180 tablets of oxycodone 30 mg. A few days before this, on June 28, 2011, the Respondent documented that he had prescribed oxycodone 15 mg (180 tablets) and oxycodone 30 mg (180 tablets) to start on June 28, 2011 and end on June 27, 2011. Additionally, the Respondent documented that Patient C admitted to him that she had snorted heroin for her pain. He documented that he informed Patient C that she would be dismissed from Practice A.

61. During Patient C's final office visit on or about July 8, 2011, Patient C's husband accompanied her. According to Patient C, while she was in the examination room with the Respondent he aggressively attempted to engage in sexual activity with her and she ran out of the examination room.

62. Patient C stated she reported the incident to the Site Administrator who called the Respondent into the office along with Patient C and her husband. The Respondent denied the allegations and he wrote a prescription for Patient C stating, "Will this shut you up?"[16] The Site Administrator according to Patient C told her to leave and she was not allowed back in the office.

[16] According to Patient C's record, the Respondent documented that he provided her with a "script" however, he did not specify for what medication.

63. By letter dated July 8, 2011, Practice A discharged Patient C from the practice based on the Respondent's following characterization of what occurred during the office visit:

> [Patient C] presented with what was revealed to be her husband...demanding medications reportedly post assault, this patient has multiple issues with medications being stolen, they refused to leave. Patient was given script and informed that I will no longer provide medication. She needs to be discharged from the practice.

64. On or about February 23, 2012, Practice A received notification from a pain management practice that Patient C had an appointment scheduled.

65. On or about June 20, 2012, a pain management specialist who evaluated Patient C, sent a copy of his consultative report to Practice A, in which he recommended non-opioid treatment. He stated that he was not recommending opioids for Patient C as she is "a very high risk patient due to her history of previous abuse and her young age."

66. Patient C stated during her interview that approximately four months after Practice A discharged her from the practice, the Respondent contacted Patient C by telephone, and told her that since she had not pressed charges with the police, he would talk with the Site Administrator about Patient C returning to Practice A. Until that time, the Respondent requested that Patient C come "after hours" to see him.

67. On November 3, 2012, Patient C left a message for the Respondent (through Practice A) stating she was recently seen by the Respondent and a script was given. She was requesting another prescription for oxycodone.

68. On or about June 13, 2013, there is a note in Patient C's record that she left a telephone message, "patient said you told her to call to speak with you..."

69. Pharmacy surveys, copies of original prescriptions and medication bottles obtained from Patient C reflect that over 40 CDS prescriptions were issued by the

Respondent to Patient C between October 2012 and October 2014 for medications including oxycodone, Xanax and Adderall.

70. Patient C stated that because of her addiction, she returned to see the Respondent for prescriptions on several occasions over the course of about one year.[17] According to Patient C, the Respondent contacted her by telephone monthly to tell Patient C what time to meet him after the office closed and the employees had left.

71. According to Patient C, she and the Respondent engaged in sexual intercourse or he performed oral sex on Patient C, in exchange for prescriptions for oxycodone, Xanax and other CDS.

72. According to the Respondent's interview, he stated that for approximately one year, he met with Patient C at the practice to provide her with prescriptions on Thursdays, sometimes when the office was still open, and sometimes when it had just closed. He was aware that Patient C was addicted but he continued to prescribe for her because he was afraid she would report him to the Board.[18]

73. The Respondent issued prescriptions to Patient C using both her maiden surname and her married surname.

74. Sometime around the end of 2013, according to Patient C, her family member (Patient D) saw the Respondent for care and Patient D told Patient C that the Respondent "came on to her and tried to have sex with her."[19]

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[17] Pharmacy surveys and prescriptions obtained by the Board during its investigation confirmed that the Respondent continued prescribing oxycodone, Adderall, Xanax and other CDS to Patient C through October 30, 2014. Moreover, during the Respondent's interview, he acknowledged that he continued to prescribe CDS for Patient C after she had been discharged from Practice A.

[18] He stated during the January 7, 2016 interview that Patient C threatened to report him to the Board "for sex, and for giving her medications when I knew she was doing things, which I didn't at the time."

[19] According to Patient D, she drove Patient C to a visit with the Respondent after hours on one occasion.

75. The Respondent's conduct in whole or in part with regard to Patient C constitutes evidence of unprofessional and/or immoral conduct in violation of Health Occ. § 14-404(a)(3)(i) and/or (ii), pursuant in whole or in part to Code Md. Regs. 10.10.32.17.01 *et seq.*

PATIENT D

76. On or about November 24, 2015, Board staff interviewed Patient D under oath.

77. Board staff subpoenaed Patient D's medical record from Practice A.

78. On January 7, 2016, Board staff interviewed the Respondent under oath with regard to his care and treatment of Patient D.

79. Patient D, a female in her 20s, saw the Respondent for medical care beginning on or about July 30, 2013. She saw the Respondent for care through September 2015.

80. According to Patient D, the purpose of her initial visit was for a physical examination.[20] Patient D stated the Respondent asked her if her back hurt, and prescribed oxycodone and Xanax (120 tablets each). Additionally, her medical record reflects that the Respondent prescribed Adderall.

81. Patient D saw the Respondent on approximately a monthly basis.

82. On approximately September 4, 2013, Practice A issued to Patient D a form letter stating that since the Respondent was expected to be out of the office, she would be referred to a pain management physician.

83. According to Patient D, a few months after Patient D began seeing the Respondent, during a scheduled visit, he requested that Patient D "lay down on the bed and take my pants off." She refused, and the Respondent subsequently refused to write her a prescription for oxycodone.

[20] According to Patient D, the Respondent was a family physician to several of her family members.

84. On September 30, 2013, the Respondent documented that Patient D had not yet seen a pain management referral, and therefore he would no longer refill her pain medication.

85. According to Patient D, after approximately three months of the Respondent refusing to issue oxycodone prescriptions to Patient D,[21] she stated that she agreed to provide oral sex to the Respondent in order to receive her prescriptions.[22]

86. On January 9, 2014, and June 24, 2014, the Respondent refilled Patient D's prescriptions for Adderall and Xanax. He documented, "she will need to see pain management."

87. Beginning on July 24, 2014, the Respondent began prescribing oxycodone 15 mg (120 tablets).

88. According to Patient D, she performed oral sex on the Respondent during her office visits on three occasions.

89. According to Patient D, during several office visits, the Respondent made inappropriate comments of a sexual nature to Patient D.

90. On several occasions, according to Patient D, the Respondent inappropriately touched Patient D on her buttocks or her breasts (under her brassiere).

91. According to Patient D, in August 2015, when the Respondent requested that Patient D engage in sexual relations with him, she refused.

92 By letter dated September 25, 2015, Practice A discharged Patient D from the practice for not following the "directions of your provider" as it relates to the chronic use of controlled medications.

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[21] Patient D stated that during this time, she was addicted to CDS and obtained medications on the street.
[22] Patient D's medical records reflect a visit on September 30, 2014, and then a gap until January 9, 2014.

93. The Respondent's conduct in whole or in part with regard to Employee A constitutes evidence of immoral and/or unprofessional conduct in violation of Health Occ. § 14-404(a)(3) (i) and/or (ii), pursuant in whole or in part to Code Md. Regs. 10.10.32.17.01 *et seq.*

EMPLOYEE-RELATED ALLEGATIONS

EMPLOYEE A

94. On or about May 7, 2015, Board staff interviewed Employee A under oath.

95. Employee A, a certified medical assistant and phlebotomist, was employed by Laboratory A which was located in the same building as Practice A. Employee A has worked for Laboratory A since June 2009. She is responsible for drawing blood and handling urine specimens for Practice A's patients.

96. Employee A recalled that the Respondent had made sexually inappropriate comments to her sometime around 2013 or 2014. She told the Respondent if he ever spoke to her that way again, she would tell his wife. The Respondent has not spoken inappropriately to Employee A since that instance.

97. Employee A stated that Patient A had confided in her that the Respondent had acted inappropriately toward her (Patient A).

98. Employee A recalled that Patient A told her the Respondent directed her to leave her cell phone in another room as he did not want her recording their conversation. Additionally, Employee A stated that Patient A told her that the Respondent had made inappropriate comments to her (Patient A) that included being propositioned for drugs. Patient A told Employee A that she was afraid no one would believe her because of her medication history.

99. The Respondent's conduct in whole or in part with regard to Patient D constitutes evidence of unprofessional conduct in violation of Health Occ. § 14-404(a)(3)(ii), pursuant in whole or in part to Code Md. Regs. 10.10.32.17.01 *et seq.*

EMPLOYEE B

100. On or about May 7, 2015, Board staff interviewed Employee B under oath.

101. Employee B, an office assistant at Practice A, has been employed at Practice A for 14 years.

102. Employee B has worked with the Respondent at Practice A for approximately five years.

103 Employee B stated that the Respondent has mistreated her, insulted her, used profanity and mocked her during work hours.

104. Employee B recalled one instance around 2008 or 2009 in which the Respondent became so angry with her that he almost struck her. The incident involved a patient who was late, and she told the Respondent the patient needed to be seen.[23]

105. Employee B stated that she is afraid of how the Respondent will react toward her if a patient is late.

106. Sometime in 2015, Employee B stated that she was returning from lunch, walked by the Respondent's office and he directed a statement, "pow, pow" to her.

107. On another occasion, Employee B stated that the Respondent called her a "dumb ass" because he didn't want to see a patient who was running late.[24]

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[23] The Site Administrator and Medical Director documented a February 25, 2009 incident involving the Respondent and Employee B. The Medical Director spoke with the Respondent about his conduct, and documented that he was aware he had "behaved badly."

[24] A February 25, 2014 email from Practice A's Site Administrator to the Medical Director references that the Respondent referred to Employee B as a "dumb ass" for adding a walk in patient to his schedule.

108. Employee B stated that she heard the Respondent on occasion use the "f- word" during office hours with patients within hearing distance.

109. Employee B stated that sometime around 2012 Employee A had confided in her that the Respondent had made sexually inappropriate comments and gestures toward her (Employee A).

110. Employee B stated that on a few occasions, approximately one year before the interview (in 2014), patients came to see the Respondent around noon who were not on the schedule. The patients were self-pay, and did not check in or out at the reception desk.

111. The Respondent's conduct in whole or in part with regard to Employee B constitutes evidence of unprofessional conduct in violation of Health Occ. § 14-404(a)(3)(ii).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under Md. Health Occ. § 14-404 (a)(3)(i) and/or (ii) and/or (22) and/or (40), the Board may impose disciplinary sanctions against Respondent's license, including revocation, suspension, reprimand and/or probation and/or may impose a fine.

NOTICE OF DISCIPLINARY COMMITTEE FOR CASE RESOLUTION

A Disciplinary Committee for Case Resolution ("DCCR") Conference in this matter is scheduled for **July 13, 2016, at 9:00 a.m.** at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the DCCR is described

in the attached letter to the Respondent. If this matter is not resolved on terms accepted by Disciplinary Panel B, an evidentiary hearing will be scheduled.

BRIAN E. FROSH
ATTORNEY GENERAL OF MARYLAND

5/16/2016
Date

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