IN THE MATTER OF	*	**BEFORE THE**
RASHEED A. ABASSI, M.D.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License Number D65329	*	**Case Nos. 2014-0595 & 2014-0743**

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

FINAL DECISION AND ORDER

On November 19, 2014, Rasheed A. Abassi, M.D. was charged under the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, with unprofessional conduct in the practice of medicine, *see* Health Occ. § 14-404(a)(3)(ii). The case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing and a proposed decision.

On July 21 and 22, 2015, an evidentiary hearing was held before an administrative law judge ("ALJ") at OAH. On October 19, 2015, the ALJ issued a proposed decision finding Dr. Abassi guilty of unprofessional conduct in the practice of medicine. As a sanction, the ALJ recommended a one-year suspension of Dr. Abassi's medical license followed by three years of probation, participation in the Maryland Professional Rehabilitation Program, an ethics course, and a $30,000 fine.

On February 10, 2016, an exceptions hearing was held before Disciplinary Panel A (the "Panel") of the Maryland State Board of Physicians (the "Board").

FINDINGS OF FACT

The following findings of fact were proven by the preponderance of evidence[1]:

[1] Unless otherwise specified in this final decision and order, the Panel adopts the ALJ's proposed findings of fact and discussion on pages 6-34 of the ALJ's Proposed Decision, which are

Dr. Abassi was initially licensed to practice medicine in Maryland in 2006 and has continuously renewed his license. He specializes in internal medicine. During the period at issue, he practiced as a hospitalist at a Hospital in Maryland (the "Hospital").

On October 24, 2013, the Hospital's Medical Executive Committee decided that a Focused Professional Practice Evaluation ("FPPE"), which would include a chart review, would be conducted to investigate complaints against Dr. Abassi, which mostly concerned standard of care concerns, such as a failure to perform evaluations in a timely manner.[2] One of the members of the Medical Executive Committee was Physician 1, a surgeon.

On November 21, 2013, after reviewing the FPPE findings, the Hospital's Medical Executive Committee recommended the continuation of the FPPE, a further chart review, a reduced caseload for Dr. Abassi, and other remedial measures.[3]

While the FPPE was being conducted, Dr. Abassi began accessing confidential medical files through the Hospital's computerized electronic records system of patients with whom Dr. Abassi had no involvement and whose records he had no legitimate reason for assessing. Believing that the FPPE was being used unfairly against him, Dr. Abassi was attempting to find cases of medical errors by others with which he planned to use to retaliate for the FPPE. One physician Dr. Abassi targeted was Physician 1.

One of the electronic patient files Dr. Abassi improperly accessed concerned Patient A. Physician 1 performed surgery on Patient A in 2011, from which Patient A suffered complications. The complications from the surgery were fully repaired in 2012, and Patient A

---

incorporated by reference into the body of this document. The ALJ's Proposed Decision is attached as **Exhibit 1.**

[2] The Hospital's Quality, Safety and Professional Affairs Committee also approved the FPPE.

[3] Neither the conclusion of law nor the sanction in this final decision and order is based upon any medical care or conduct that was investigated in the October/November 2013 FPPE.

did not need any further treatment related to the complications. On January 3, 2014, at 2:46 p.m., Dr. Abassi assessed Patient A's confidential electronic medical file. Immediately after accessing Patient A's file, Dr. Abassi called Patient A's home. At 4:10 p.m., that same day, January 3, 2014, Patient A's wife saw a missed phone call on her home telephone's Caller ID. She called the number back, and Dr. Abassi answered the phone. They briefly spoke, and Dr. Abassi asked Patient A's wife to have Patient A call him. Prior to this January 3, 2014, telephone conversation, neither Patient A nor his wife had any involvement or contact with Dr. Abassi, nor had they ever heard of him.

On January 6, 2014, Patient A returned Dr. Abassi's telephone call. Dr. Abassi falsely told Patient A that he was part of the Hospital's medical review board investigating Physician 1. Dr. Abassi asked about Patient A's surgery with Physician 1, and Patient A told him that he had developed a hernia as a result of the surgery. Dr. Abassi asked whether Patient A was aware that a major artery had been damaged during the surgery. Patient A said he was aware. Dr. Abassi made disparaging remarks about Physician 1 and recommended that Patient A pursue legal action against Physician 1. Dr. Abassi also told Patient A that he would call him back in a week and that he was going to send him paperwork to sign.

After the telephone call, Patient A became concerned about the conversation, and, on January 7, 2014, he called the Hospital. Patient A spoke with several Hospital executives and told them about his conversation with Dr. Abassi.

On January 8, 2014, as a result of his conversation with Patient A, the Hospital summarily suspended Dr. Abassi's clinical privileges. The Hospital also initiated an audit of Dr. Abassi's use of the hospital's computers to determine whether he had accessed the records of patients with whom he had no involvement. The audit found that, between November 1, 2013,

and January 8, 2014, Dr. Abassi accessed the electronic records of 53 patients with whom he had no involvement and whose records he had no legitimate justification for accessing.[4]

On January 22, 2014, Dr. Abassi called Patient A, and they spoke again. Dr. Abassi told Patient A that he knew Patient A notified the Hospital of their previous conversation, that the Hospital was trying to take away Dr. Abassi's license, and that the Hospital prohibited Dr. Abassi from returning to the Hospital. Dr. Abassi asked Patient A to tell the Hospital that either he (Patient A) or his wife had asked Dr. Abassi to become Patient A's primary care physician. Patient A told Dr. Abassi that he did not want to speak with him anymore and hung up.

Patient A had never asked Dr. Abassi to become his primary care physician nor did he ever seek any medical care from Dr. Abassi. Patient A and his wife were satisfied with their own primary care physician, who had been treating them for over 20 years. Further, by 2014, Patient A did not need any treatment for any condition or complication related to his surgery with Physician 1 in 2011.[5]

DR. ABSSI'S EXCEPTION

Dr. Abassi does not dispute that it is unprofessional conduct for a physician to access confidential medical records without a legitimate justification, nor does Dr. Abassi dispute that the conduct at issue in this case was "in the practice of medicine." Dr. Abassi only challenges the ALJ's credibility determinations.

---

[4] The Hospital's audit initially found that Dr. Abassi had illegitimately accessed 54 patient files, but the Hospital ultimately lowered that number by one to 53, because Dr. Abassi had previously treated one of the 54 patients (Patient B). Likewise, the Panel finds that Dr. Abassi accessed the 53 confidential patient files without a legitimate justification, with Patient B's file not being included in the 53 illegitimately accessed files.

[5] In his interview with the Board's investigator, Dr. Abassi said that Patient A told him that he was "looking for someone to help him fix an abdominal hernia."

At the OAH hearing, Dr. Abassi testified that (1) he did not initiate the contact with Patient A or his wife; (2) he did not access Patient A's electronic medical file (or, if he did, he did so unintentionally); and (3) his reasons for accessing the 52 other electronic patient files at issue were legitimate. The ALJ did not find Dr. Abassi credible, finding his testimony "inconsistent," "illogical," "implausible" and "incredible." Conversely, the ALJ found Patient A and his wife "very credible." The ALJ focused on the discrepancies between Dr. Abassi's versions of events and the hospital records and on the implausibility that Patient A would initiate contact with Dr. Abassi. Eight witnesses (patients and colleagues) vouched for Dr. Abassi's professionalism and integrity. The ALJ found they were sincere and well-intentioned but that their high regard for Dr. Abassi was insufficient to overcome the compelling evidence against him.

Dr. Abassi argues the ALJ erred in accepting the testimony of Patient A and Patient A's wife and by rejecting his (Dr. Abassi's) testimony. Dr. Abassi mainly relies upon the testimony of the eight character witnesses he presented.

The State argues that the Panel should accept the ALJ's credibility determinations, relying upon the fact that the ALJ observed the witnesses testify. The State also argues that Dr. Abassi's testimony was inconsistent, contradicted by the hospital's records, and implausible.

In order to assess the credibility of the witnesses, it is necessary to compare the testimony of the witnesses with the Hospital's records. The Hospital's computer system recorded that, on January 3, 2014, at "14:46:09" (2:46 p.m.), Dr. Abassi accessed Patient A's electronic file. (Joint Exhibits 10-18A and 10-18E.) According to Patient A's wife, on that same day, January 3, 2014, she returned home from work at approximately 4:10 p.m. Upon returning home, she saw that someone had called her home phone while she was out and that the caller's telephone number

was recorded on Caller ID. Patient A's wife immediately called that number. Dr. Abassi answered her call, and they spoke. Dr. Abassi requested that she ask Patient A to call him. Until this telephone conversation, neither Patient A nor his wife had ever spoken with Dr. Abassi, ever attempted to contact him, or knew who he was. There is no dispute that Dr. Abassi had never met nor had any contact with Patient A or his wife prior to January 3, 2014. The testimony of Patient A's wife is consistent with the Hospital's computer records.

Dr. Abassi's versions of events are inconsistent and belied by the Hospital's records. Dr. Abassi had repeatedly denied that he accessed Patient A's records. On February 28, 2014, Dr. Abassi wrote to the Board, "I did not access any of [Patient A's] records. I had no reason to access [Patient A's] records because he decided not to establish any relationship with my office." (Joint Exhibit 4, at 3.) Also, when Dr. Abassi testified before the hospital, he was asked whether he accessed Patient A's records and answered, "No, no, no. I was not accessing. I did not access. And even in my response to the state, I had mentioned I did not access [Patient A's] chart." (Joint Exhibit 10-30, Transcript, April 2, 2014, at 198.) And when Dr. Abassi testified before the ALJ, he was asked whether he recalled accessing the hospital's records associated with Patient A and testified, "No, Your Honor. No, I do not." (Transcript, July 22, 2015, at 346.) Later in his testimony before the ALJ, however, Dr. Abassi changed his position, stating that, on January 3, 2014, he *may have, or did, unintentionally* access Patient A's electronic record. (Transcript, July 22, 2015, at 395.)

The Panel finds that Dr. Abassi's testimony is not credible. The Hospital's computer system recorded that Dr. Abassi accessed Patient's electronic file. He accessed Patient A's electronic file approximately 85 minutes before Patient A's wife saw Dr. Abassi's telephone

number on Caller ID. There is no doubt that Dr. Abassi accessed Patient A's confidential electronic file, and there is no doubt that he did so intentionally.

Dr. Abassi's explanations for his accessing the remaining confidential medical records are also untenable. The Hospital reviewed Dr. Abassi's computer access from November 1, 2013, though January 8, 2014. The audit found that, during this period Dr. Abassi accessed records of 53 patients, which he had no legitimate basis viewing.

One of Dr. Abassi's explanations is that he accessed the medical records in order to comply with a request from an Emergency Room physician to complete a death certificate. He was, however, unable to identify the deceased individual. According to Dr. Abassi, he was asked to sign the death certificate during the holiday season in late December 2013. But, according to Dr. Abassi, he misplaced the name given to him and had to search through the patient files to find the correct patient. Dr. Abassi further testified that the Emergency Room death at issue occurred within 24 hours of the Emergency Room physician's request for him to complete the death certificate and that a death certificate must be signed within 72 hours of the death. The evidence shows, however, that the most recent Emergency Room death prior to late December 2013, was September 11, 2013, several months before Dr. Abassi claims he was asked to sign the death certificate. (Tr., 7/21/2015, at 179-80; Joint Ex. 10-29 at 3.)

In light of the specific and reliable evidence contradicting Dr. Abassi's testimony, the Panel does not accept Dr. Abassi's contention that the Panel should find him credible based upon the witnesses who testified in general about his professionalism and integrity. The Panel does not

accept Dr. Abassi's testimony.[6] Except as otherwise specifically noted, the Panel adopts the ALJ's credibility determinations. Dr. Abassi's exception is denied.

CONCLUSION OF LAW

Based upon the findings of fact, Board Disciplinary Panel A concludes that Dr. Abassi is guilty of unprofessional conduct in the practice of medicine, in violation of § 14-404(a)(3)(ii) of the Health Occupations Article.

SANCTION

The ALJ recommended a one-year suspension followed by three years of probation, enrollment in MPRP, a $30,000 fine, and an ethics course. Dr. Abassi did not take exception to the ALJ's recommended sanction, although, during the exceptions hearing before the Panel, Dr. Abassi's counsel did ask that Dr. Abassi's license not be suspended.

Protecting the confidentiality of patients' records is a responsibility the Panel takes extraordinarily seriously. Dr. Abassi showed no regard for patient confidentiality in this case. Even more disturbing, however, are Dr. Abassi's intentions and his use of the confidential information. The evidence indicates that Dr. Abassi accessed the records to try to uncover information to use in retaliation for the FPPE. Dr. Abassi used the improperly attained confidential information to contact a former patient of the Hospital, a patient with whom Dr. Abassi had no previous relationship. Dr. Abassi falsely told the patient that he was part of a hospital committee conducting a review of another physician at the Hospital. Dr. Abassi's false representation prompted the patient to provide Dr. Abassi with even more information about his

[6] In finding Dr. Abassi not credible, the ALJ partly relied upon Dr. Abassi's decision to not call the physician he claims asked him to complete the death certificate as a witness. (ALJ's Proposed Decision at 31, 39.) The Panel does not accept this reasoning by the ALJ. The Panel does not find credible Dr. Abassi's testimony concerning the alleged death certificate, but the panel does so without taking as a negative inference the fact that Dr. Abassi did not call a witness to corroborate his testimony.

medical condition. And, after the patient reported Dr. Abassi to the Hospital, Dr. Abassi again contacted the patient, this time asking the patient to give the Hospital false information.

The dishonesty and poor judgment Dr. Abassi has displayed warrants and necessitates the suspension of his medical license and his enrollment in the Maryland Professional Rehabilitation Program. The Panel adopts the sanction recommended by the ALJ. In order to allow Dr. Abassi time to make arrangements for his patients to be transferred to other physicians, the suspension will go into effect in 10 business days from the date of this final decision and order.

ORDER

Based upon the findings of fact and conclusion of law, it is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby

ORDERED that Rasheed A. Abassi, M.D.'s license to practice medicine in Maryland (License Number D65329) is **SUSPENDED** for **ONE YEAR.** The one-year suspension goes into effect in 10 business days; and it is further

ORDERED that within 10 business days, Dr. Abassi shall enroll in the Maryland Professional Rehabilitation Program ("MPRP"). Dr. Abassi shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP and 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, and evaluations as directed by MPRP; and it is further

ORDERED that Dr. Abassi shall sign and update the written release/consent forms requested or required by the Board and MPRP. Dr. Abassi 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. Dr. Abassi shall also sign any written release/consent forms to authorize MPRP to exchange information regarding Dr. Abassi with agents of MPRP (evaluators and treatment providers referred to by MPRP for Dr. Abassi); and it is further

ORDERED that, within one year, Dr. Abassi shall successfully complete a Board disciplinary panel-approved course in medical ethics. The course may not be used to fulfill the continuing medical education credits required for license renewal. Dr. Abassi must provide documentation to the Board that he successfully completed the course; and it is further

ORDERED that, upon the termination of the suspension, Dr. Abassi will be placed on **PROBATION** for a minimum period of **THREE YEARS**;[7] and it is further

ORDERED that, during the probationary period, Dr. Abassi shall comply with all of the following probationary terms and conditions:

1. Dr. Abassi shall continue participation in the Maryland Professional Rehabilitation Program ("MPRP"). Dr. Abassi shall continue his Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP. Dr. Abassi 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 screening as directed by MPRP;

[7] The suspension will not be terminated if Dr. Abassi fails to renew his license. If Dr. Abassi's license expires while the license is suspended, the suspension period will be tolled. If Dr. Abassi fails to renew his license while he is on probation, the probationary period and any conditions of probation will be tolled.

2. Dr. Abassi shall sign and update the written release/consent forms requested or required by the Board and MPRP. Dr. Abassi 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. Dr. Abassi shall also sign any written release/consent forms to authorize MPRP to exchange information regarding Dr. Abassi with agents of MPRP (evaluators and treatment providers referred to by MPRP for Dr. Abassi);

3. Prior to the completion of probation,[8] Dr. Abassi shall pay a civil fine in the amount of $30,000 by money order or bank certified check made payable to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297;

4. Dr. Abassi shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland;

5. After three years of probation, Dr. Abassi 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 A. Dr. Abassi may be required to appear before the Board or Panel A to discuss his petition for termination of probation. The Board or Panel A will grant the petition to terminate probation if Dr. Abassi 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 Board or Panel A determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or Panel A if

[8] Dr. Abassi may pay the fine in total or pay a portion of the fine during the suspension period. In either event, the fine must be paid in full before to the termination of probation.

there is no genuine dispute as to a material fact, that Dr. Abassi has failed to comply with any term or condition of the suspension, of probation, or of this order, the Board or Panel A may reprimand Dr. Abassi, place Dr. Abassi on probation with appropriate terms and conditions, impose a civil monetary fine upon Dr. Abassi, or revoke or further suspend Dr. Abassi's license to practice medicine in Maryland; and it is further

ORDERED that Dr. Abassi is responsible for all costs incurred in fulfilling the terms and conditions of this Final Decision and Order; and it is further

ORDERED that, unless stated otherwise in the order, any time period prescribed in this order begins when this Final Decision and Order goes into effect. The Final Decision and Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel A.

ORDERED that this Final Decision and Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

03/01/2016
Date

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to § 14-408(a) of the Health Occupations Article, Dr. Abassi has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order is mailed. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Abassi petitions for judicial review, the Board is a party and should be served with the court's process. In addition, Dr. Abassi should send a copy of his petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.

Exhibit 1

MARYLAND STATE BOARD OF	*	BEFORE LOUIS N. HURWITZ,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
RASHEED A. ABASSI, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: DHMH-MBP-71-15-10140
LICENSE No.: D65329	*	MBP Nos.: 2014-0595 & 2014-0743

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

PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On November 19, 2014, a disciplinary panel of the Maryland State Board of Physicians (Board or MBP) issued Charges against Rasheed A. Abassi, M.D., (Respondent) for alleged acts in violation of the Medical Practice Act (the Act). Md. Code Ann., Health Occ. §§ 14-101 through 14-507 and 14-601 through 14-608 (2014). Specifically, the Board alleges that the Respondent violated section 14-404(a)(3) of the Act. Md. Code Ann., Health Occ. § 14-404(a)(3) (2014). The Board forwarded the charges to the Health Occupations Prosecution and Litigation Division (HOPL), Office of the Attorney General, State of Maryland (State), for prosecution.

On March 30, 2015,[1] the matter was transmitted to the Office of Administrative Hearings (OAH) for a hearing. Md. Code Ann., Health Occ. § 14-405 (2014). On May 5, 2015, I conducted a Prehearing Conference at the OAH in Hunt Valley, Maryland. Robert J. Gilbert,

[1] This is the date the OAH received the case.

Deputy Counsel, HOPL, Administrative Prosecutor, represented the State, and John T. Harrington, Esquire, represented the Respondent. On May 13, 2015, I issued a Prehearing Conference Report and Scheduling Order.

On July 21 and 22, 2015, I held a hearing on the merits at the OAH. Md. Code Ann., Health Occ. § 14-405(a) (2014); Code of Maryland Regulations (COMAR) 10.32.02.04. Mr. Harrington represented the Respondent, who was present. Mr. Gilbert represented the State.

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

ISSUES

1. Did the Respondent engage in unprofessional conduct in the practice of medicine, in violation of the Act; and, if so,
2. What sanction(s) are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following documents into evidence as Joint exhibits:

Joint #1	Licensing Information, dated March 24, 2014
Joint #2	Application for Renewal of Licensure, dated July 15, 2014
Joint #3	Report of Disciplinary Action, [redacted] Hospital Center ([redacted]), received January 22, 2014
Joint #4	Respondent's response to complaint, dated February 28, 2014, with the following attached sub-exhibits:
Joint #4-1	Letter dated January 8, 2014 from Dr. [redacted] to the Respondent, re: immediate summary suspension
Joint #4-2	[redacted] Patient Chart, dated June 15, 2012

Joint #4-3	Letters from the Respondent to Dr. [redacted] dated November 13, 2013 and November 21, 2013
Joint #5	Complaint from Patient A, dated January 25, 2014
Joint #6	Transcribed interview of [redacted], dated May 2, 2014
Joint #7	Transcribed interview of Respondent, dated June 12, 2014
Joint #8	Transcribed interview of Louis E. [redacted], dated July 14, 2014
Joint #9	Transcribed interview of Deborah [redacted], dated July 14, 2014
Joint #10	Report of the [redacted] Ad Hoc Hearing Committee, dated May 13, 2014, with attached exhibit and Table of Contents
Joint #10-1	Medical Staff Code of Professional Conduct, signed by the Respondent, dated September 29, 2010
Joint #10-2	Maryland Hospital Credentialing Application signed by the Respondent, dated April 23, 2008
Joint #10-3	Notice of Privacy Practices for [redacted] Health, Inc., dated Sept. 23, 2013
Joint #10-4	Excerpts from Medical Staff Bylaws, [redacted], approved September 19, 2013
Joint #10-5	[redacted] ([redacted]) Policy and Procedure Manual excerpt, Medical Staff Focused and Ongoing Professional Practice Evaluation (FPPE/OPPE) and Peer Review, revised October 2012
Joint #10-6	Confidentiality Statements signed by the Respondent, dated July 15, 2010 and May 31, 2013
Joint #10-7	[redacted] Policy and Procedure Manual excerpt, Health Insurance Portability and Accountability Act (HIPAA) Policy: Notice of Privacy Practices, review date - January 2011
Joint #10-8	[redacted] Policy and Procedure Manual excerpt, Policy on Security and Safeguarding of Health/Hospital Information Against Loss, Destruction, Tampering & Unauthorized Access, reviewed August 2012, revised January 2009
Joint #10-9	Memorandum from Thomas [redacted], M.D., Medical Staff President, to the Medical Executive Committee, dated October 21, 2013
Joint #10-10	Medical Executive Committee Minutes, dated October 24, 2013

Joint #10-11	Minutes of Quality, Safety and Professional Affairs Committee, Board of Directors, dated October 24, 2013
Joint #10-12	Memorandum from Dr. [redacted] to Dr. [redacted], dated November 5, 2013
Joint #10-13	Letter from Dr. [redacted] and Dr. Stephen [redacted] to the Respondent, dated November 5, 2013
Joint #10-14	Letter from Scott M. [redacted] M.D., Quality Oversight Committee, to Dr. [redacted], dated November 20, 2013
Joint #10-15	Minutes of Medical Executive Committee Executive Session, dated November 21, 2013
Joint #10-16	Affidavit of Patient [redacted],[2] dated March 18, 2014.
Joint #10-17	Memorandum from Dr. [redacted] to Lou [redacted] dated January 8, 2014
Joint #10-18A-E	Audit Trail of access by the Respondent to Patient A's medical information, printed on March 10, 2014
Joint #10-19	Letter from Dr. [redacted] to the Respondent, dated January 8, 2014
Joint #10-20	Memo from Kate [redacted], Vice President of Quality, Safety & Accreditation, to Richard [redacted], dated January 15, 2014
Joint #10-21	Letter from Dr. [redacted] to the Respondent, dated January 21, 2014
Joint #10-22	Letter from Dr. [redacted] to the Respondent, dated January 23, 2014
Joint #10-23	Memorandum from Deborah [redacted], RN, Physician Quality Coordinator, to Dr. [redacted], dated January 23, 2014.
Joint #10-24	Memo to File from by [redacted], Medical Staff Office, dated January 23, 2014
Joint #10-25	Minutes from Medical Executive Committee Executive Session, dated January 23, 2014
Joint #10-26	Minutes from Quality, Safety and Professional Affairs Committee, dated January 24, 2014

[2] This witness was a patient of [redacted] and not of the Respondent. For confidentiality purposes and ease of redaction, he will be referred to as Patient A throughout the rest of the decision.

Joint #10-27	Letter from John T. Harrington, Esquire, to Dr. [redacted], dated February 4, 2014
Joint #10-28	Letter from Dr. [redacted] to the Respondent, dated February 28, 2014
Joint #10-29	Revised Summary of Access by the Respondent to Unauthorized Accounts (for the period from November 1, 2013 to January 9, 2014)
Joint #10-30	Transcript of April 2, 2014 Fair Hearing of the Respondent, with the following attachments: Respondent's Closing Memorandum and Closing Statement of Medical Executive Committee
Joint #11	Investigation Report, dated October 17, 2014
Joint #12	Charges Under the Maryland Medical Practice Act, dated November 19, 2014

I admitted the following exhibits into evidence on behalf of the State:

State #1	American Medical Association (AMA) Principles of Medical Ethics, undated
State #2	AMA Opinion 7.025 - Records of Physicians: Access by Non-Treating Medical Staff, undated

I admitted the following exhibit into evidence on behalf of the Respondent:

Resp. #1	Respondent's *Curriculum Vitae*

Testimony

The State presented the following witnesses:

[redacted][3] Patient A's spouse

Patient A

[redacted], M.D., [redacted] Vice President of Medical Affairs

Louis [redacted], Vice President of Information Technology (IT), [redacted] Hospital Center

Deborah [redacted] R.N., Clinical Systems Analyst, IT Department, [redacted]

[3] This witness will be referred to in the balance of this decision as Patient A's wife.

The Respondent testified in his own behalf and presented the following witnesses:[4]

[redacted] spouse of [redacted] a patient of the Respondent

[redacted] a patient of the Respondent.

[redacted] a patient of the Respondent

[redacted] M.D., a friend and colleague of the Respondent

[redacted] M.D., a gastroenterologist with privileges at [redacted]

[redacted] M.D., a nephrologist with privileges at [redacted]

[redacted] M.D., a former member of the Purple Team at [redacted]

[redacted] a patient of the Respondent

PROPOSED FINDINGS OF FACT

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

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland. The Respondent was initially licensed to practice medicine in Maryland on or about November 16, 2006, under License No. D65329. The Respondent's license is currently active and is due to expire on September 30, 2016.

2. The Respondent is engaged in the practice of internal medicine. He is not board certified in any area of practice.

3. Since 2007, the Respondent has been affiliated with [redacted] which became [redacted] in December 2012, when [redacted] acquired [redacted].

4. [redacted] has a contract with the Respondent for him to provide services as a hospitalist. A hospitalist is a physician whose primary responsibility is to care for

[4] I have listed the actual names of the Respondent's patients who voluntarily appeared at the hearing to testify for the Respondent.

patients who have been admitted to the hospital. Prior to the advent of hospitalists, physicians in private practice would take care of their patients in the hospital.

5. Starting in 2009, prior to the [redacted] acquisition o[redacted], the Respondent was one of three physicians who had a contract with [redacted] to provide hospitalist services as part of what was known as the Purple Team, which the Respondent helped form. The contract continued in force when [redacted] purchased [redacted]

6. On September 29, 2010 and July 15, 2013, the Respondent signed a statement acknowledging receipt of the [redacted] Medical Staff Code of Professional Conduct, which includes the requirement to "Not look up confidential data on patients unless the information is necessary for the care of that patient." (Joint Ex. # 10-6).

7. Since 2012, the Respondent began working in a private medical practice, known as the [redacted] Center, while also working at [redacted]

8. In February 2013, [redacted] implemented a paperless electronic medical records system, known as the McKesson Horizon View system. While the hospital was transitioning to the McKesson Horizon View system in 2013 and 2014, employees could also access old paper-based records from the McKesson Physician View system, which were scanned into the new system so they could be viewed on paper or electronically (on line).

9. All three physicians on the Purple Team had access to the hospital's entire medical records system as part of their membership on the medical staff and duties as a hospitalist.

10. For the period from July 2013 to January 2014, the Respondent was not on any [redacted] committees that were investigating quality assurance matters, adult or infant deaths, or negligent or substandard surgical outcomes.

11. In the fall of 2013, the Respondent came to the attention of Stephen [redacted] M.D., [redacted]'s Vice President of Medical Affairs, when several complaints and quality of care issues regarding the Respondent were brought to light.

12. In November 2013, the complaints and quality of care issues led [redacted]'s Medical Staff Office and the Medical Executive Committee to initiate an FPPE of the Respondent. A Quality Oversight Committee was also convened to address the issues.

13. As part of its review, [redacted] referred the matter for preliminary investigation, a chart peer review audit, and other tracking of complaints.

14. As part of the FPPE process, the Respondent had the opportunity to address the issues raised about his delivery of care.

15. On November 21, 2013, [redacted]'s Medical Executive Committee convened an Executive Session and recommended continuation of an FPPE, a chart review to include review of proper documentation, timely responses, appropriate care based on professionally accepted standards, and medical reconciliation. The committee found that the Respondent was carrying such a large caseload that it had led him to cut corners.

16. The committee also recommended a reduced workload for the Respondent, that he seek counseling, and that he attend live courses on ethics, team building/communications, and hospitalist medicine.

17. Among the non-administration members of [redacted] present at the Medical Executive Committee on November 21, 2013 was [redacted] M.D., a surgeon at [redacted]

18. The Respondent believed he had been treated unfairly in being subject to an FPPE and believed that the actions being reviewed, with respect to a patient for whom he

ordered a computed tomography (CT) scan, should have been reviewed by a panel of internists.

19. After [redacted] took disciplinary action against the Respondent, he began looking at patients' medical records, without justification, for his own purposes.

20. On January 3, 2014, the Respondent accessed Patient A's confidential medical record, which included information about the Patient's 2011 surgery, in which Dr. [redacted] was one of two surgeons involved.

21. On the same day, approximately one and one-half hours later, Patient A's wife arrived home and noticed a number on her caller ID and returned the call, thinking it may have been important. When she called the number, the person who answered the phone did so by asking if the caller was Patient A, using his first name. The person who answered the call identified himself as the Respondent and asked Patient A's wife to have Patient A call him back. The Respondent did not state the reason for wanting to speak with Patient A.

22. Over the course of the next two days, Patient A attempted to return the Respondent's call and left a message at his private medical practice.

23. On January 6, 2014, the Respondent contacted Patient A, a one-time patient at [redacted], representing that he was part of a [redacted] medical review board that was reviewing cases of Dr. [redacted] and, as part of that review, Patient A's surgical treatment at the hospital in 2011. The Respondent had accessed Patient A's medical record at [redacted] and obtained information about his scheduled gastric bypass surgery in 2011, which was not completed.

24. The Respondent had no clinical reason to access Patient A's medical record at [redacted] given that he and Patient A had never entered into a doctor/patient relationship,

nor did the Respondent or any member of the Purple Team treat Patient A. Neither was the Respondent called upon to consult regarding Patient A's care while at [redacted]. Similarly, Patient A did not give the Respondent permission to access his [redacted] medical record.

25. During the January 6, 2014 call, the Respondent asked Patient A if he was aware that Dr. [redacted] the surgeon who performed the unsuccessful 2011 operation, nicked one of Patient A's arteries during the surgery. Due to the artery being nicked, the [redacted] surgery was not performed.

26. During the Respondent's call to Patient A, the Respondent discussed the possibility of financial compensation for the surgical error and spoke disparagingly about Dr. [redacted]

27. The Respondent informed Patient A that he would like to pass the information on to a "legal team" and that Patient A would be receiving some legal papers in the mail to sign. The Respondent further noted that he would be calling back in about a week.

28. In response to questions from the Respondent about his health since the 2011 surgery, Patient A disclosed to the Respondent that he had surgery in late 2012 to repair an incisional hernia caused by the 2011 surgery. Patient A further disclosed that he has not had any problems with the hernia repair since it was repaired in 2012.

29. At the time of the Respondent's call to Patient A, Patient A had a primary care physician with whom he was satisfied and who has treated him for over twenty years. Patient A did not tell the Respondent he was seeking another physician for his primary care or the services of a surgeon.

30. After the telephone conversation with the Respondent, Patient A began considering that it was very odd for a doctor to be contacting him about being eligible for compensation as a result of a surgery that had not been performed successfully.

31. On January 7, 2014, Patient A contacted [redacted] and was referred to the Medical Affairs Office to inform them of the unusual call he received from the Respondent.

32. On January 8, 2014, Dr. [redacted], president of [redacted]s Medical Staff, suspended the Respondent's hospital privileges on an emergency basis, pending further investigation.

33. On or about January 10, 2014, [redacted] management staff assigned Deborah [redacted], R.N., then the Physician Quality Coordinator at [redacted][5] to perform an audit of the Respondent's access of electronic medical records which were on what is known as the McKeeson system. Ms. [redacted] was selected due to her experience reviewing medical records and because she is well-versed in the area of Information Technology.

34. As part of the audit, Ms. [redacted] reviewed medical records from the period of November 1, 2013 to January 8, 2014 in order to determine whether patient records accessed by physician members of the Purple Team were, in fact, patients of those physicians.

35. In reviewing the records accessed by the Respondent, Ms. [redacted] applied a methodology that excluded those situations where the Respondent was the attending or discharging physician, where he was assigned as the primary care physician in the Emergency Department, where he or another Purple Team member had been called in as a consultant on a patient's case by a doctor from the Emergency Department, where the Respondent or any of the Purple Team physicians had entered an order or progress note,

[5] As of the dates of the hearing, Ms. [redacted] was serving in a new position, as a Clinical Systems Analyst, Information Technology (IT) Department.

where any member of the Purple Team was referred to in the Miscellaneous section of the Emergency Department record for the patient, or where any Purple Team physician was on call for a patient's case. The exclusions were applied to eliminate those medical records that the Respondent may have had a legitimate reason to access.

36. The audit revealed that the Respondent was the only Purple Team physician who accessed medical records of patients who were not his. The audit also showed that the Respondent accessed the records of fifty-three patients for no legitimate reason. The Respondent accessed one other person's record, that of Patient B, who was later shown to have been the Respondent's private patient at some point.

37. Of the fifty-four patient records accessed, nineteen were of patients who had died in the Emergency Department (the date of the patients' deaths ranged from February 2, 2013 to September 11, 2013), and five were of patients who had died during their hospitalization, with dates ranging from February 23, 2013 to January 3, 2014.

38. On January 22, 2014, the Respondent telephoned Patient A and advised him that he was aware that Patient A had contacted the hospital about their earlier telephone conversation. The Respondent informed Patient A that [redacted] was trying to take away his medical license for violating Patient A's HIPAA rights. The Respondent explained that he was "just trying to stop Dr. [redacted] from doing so many bad surgeries." (Tr., p. 61).

39. On or about January 22, 2014, the Board received [redacted]'s Report of Disciplinary Action, informing them of the Respondent's summary suspension, effective January 8, 2014.

40. During their January 22, 2014 telephone conversation, the Respondent requested Patient A to have his wife tell [redacted] that she sought out the Respondent as a primary care physician for Patient A and that would be a justification for the Respondent to

access Patient A's medical record. The Respondent was persistent in repeating his request more than once, even after Patient A refused to agree to direct his wife to make such a misrepresentation to [redacted] Patient A eventually hung up on the Respondent. The Respondent unsuccessfully tried to call Patient A again several more times.

41. After leaving a message on January 22, 2014 at [redacted] about the call from the Respondent, Patient A was able to speak to Dr. [redacted], a [redacted] Vice President, on January 24, 2014 about the January 22, 2014 conversation with the Respondent.

42. On January 23, 2014, Dr. [redacted], [redacted]s President, wrote to the Respondent to inform him that the Medical Executive Committee (MEC) met and voted to continue the summary suspension of the Respondent's privileges at [redacted]

43. On January 25, 2014, Patient A provided a written statement to [redacted] describing the calls he received from the Respondent.

44. Patient A had subsequent conversations with Dr. [redacted], [redacted] Assistant Vice President of Medical Affairs, and Dr. Stephen [redacted] Vice President of Medical Affairs, and answered numerous questions [redacted] management had about Patient A's conversations with the Respondent.

45. On March 14, 2014, Patient A provided an Affidavit containing a description of his above-referenced telephone conversations with the Respondent.

46. The Respondent views the disciplinary suspension as retaliation by [redacted] for his expression of concern about patient care and the administration's misuse of the Emergency Department. The Respondent also denied violating the privacy and confidentiality of any patient.

47. On April 2, 2014, a [redacted] Ad Hoc Hearing Committee convened a hearing to address the Respondent's summary suspension. The Committee failed to find that the

Respondent's summary suspension lacked any substantial basis or that it was arbitrary, unreasonable or capricious.

48. In its report to the MEC, dated May 13, 2014, the Ad Hoc Hearing Committee stated that there is sufficient evidence that the Respondent accessed numerous patient records with no apparent legitimate reason.

49. At the present time, the Respondent holds a medical license in Maryland. He has no record of any prior disciplinary action taken against his license in Maryland.

50. The Respondent remains active in the private practice of medicine, working out of his medical office in [redacted], Maryland.

DISCUSSION

Applicable Law/Policies

The Board has charged the Respondent with violating section 14-404(a)(3)(ii) of the Act. The relevant grounds for reprimand or probation of a licensee, or the suspension or revocation of a license under the Act include the following:

> (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[.]

Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (2014).

While the Act fails to provide any standard for or definition of the phrase "unprofessional conduct," the Maryland Court of Appeals reasonably defined the term to include conduct that breaches rules or ethical codes of professional conduct or conduct unbecoming to a member in good standing in the profession. *Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577,

593, *cert. denied*, 543 U.S. 862 (2004). The Maryland Court of Appeals has consistently expanded the definition of "in the practice of medicine" to include conduct such as sexual misconduct by physicians with patients or hospital employees, false statements made by physicians during hospital peer review investigations, Board investigations and disciplinary proceedings, and false statements made on physician license renewal applications. The Court has considered whether the conduct "occurred while the physician was performing a task integral to his or her medical practice," *Maryland Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 74 (1991), and whether the conduct was "sufficiently intertwined with patient care." *Kim v. Maryland State Bd. Of Physicians*, 423 Md. 523 (2011).

The Board referred to the federal HIPAA[6] statute that provides for the privacy of health information. [redacted] is a "covered entity" under HIPAA. HIPAA requires [redacted] to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information. [redacted] maintains a policy to ensure compliance with HIPAA. [redacted]s Policy and Procedure Manual also provides mandatory HIPAA training at the time of hire and on an annual basis for all employees and independent contractors.

American Medical Association (AMA) Opinion 7.025-Records of Physicians: Access by Non-Treating Medical Staff provides:

> Physicians who use or receive information from medical records share in the responsibility for preserving patient confidentiality and should play an integral role in the designing of confidentiality safeguards in healthcare institutions. Physicians have a responsibility to be aware of the appropriate guidelines in their healthcare institution, as well as the applicable federal and state laws.
>
> Informal case consultations that involve the disclosure of detailed medical information are appropriate in the absence of consent only if the patient cannot be identified from the information.

[6] HIPAA is an acronym for the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2021 (codified as amended in scattered titles of the U.S.C.). It was enacted to safeguard the privacy of individually-identifiable health information.

Only physicians or other healthcare professionals who are involved in managing the patient, including providing consultation, therapeutic, or diagnostic services, may access the patient's confidential medical information. All others must obtain explicit consent to access the information. Monitoring user access to electronic or written medical information is an appropriate and desirable means for detecting breaches of confidentiality. Physicians should encourage the development and use of such monitoring systems.

This opinion focuses on the issue of access to medical records by medical staff not involved in the treatment or diagnosis of patients. It does not address the need to access medical records for clinical research, epidemiological research, quality assurance, or administrative purposes.

State's Exhibit #2

The AMA Principles of Medical Ethics provides, in pertinent part, as follows:

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional transactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

...

State's Exhibit #1

I. The State's Case

The State notes that the Board's disciplinary action is based upon its function and responsibility to ensure that physicians act in a professional manner in the practice of medicine. The State asserts that one of the highest obligations a physician has is protecting and maintaining patient confidentiality. In addition, it points out that the government has put in place rules and regulations to ensure patient confidentiality. Pursuant to the federal HIPAA statute, hospitals have promulgated their own bylaws and codes of conduct that require its physicians to maintain patient confidentiality. The conduct at issue here, however, deals with a physician's duty to protect the privacy of persons who were not his patients. The persons at issue here were patients of MedStar, just not the Respondent's patients.

At the heart of the State's case is the Respondent's alleged access to non-patients' private medical records, which it points out that physicians are prohibited from accessing when they do not have a professional relationship with that individual, a non-patient. The State alleges that the Respondent inappropriately accessed the records of numerous non-patients, thereby violating standards of professional ethics.

A. Patient A and his Spouse

The State presented the testimony of Patient A and his wife to describe the Respondent's unwanted intrusion into their lives. Prior to the Respondent contacting Patient A and his wife, neither of them had any prior relationship with him. They were never his patients nor had they ever contacted him to provide them with medical care.

Patient A's wife testified regarding a call she received on January 3, 2014 from a number she did not identify. When she responded to the call, the caller identified himself as the Respondent and informed her he was trying to reach "[Patient A]." In replying to the notion that the Patient's wife ever attempted to contact the Respondent because she was looking for a physician for the

Patient or that Patient A called the Respondent because he was looking for a surgeon, Patient A's wife found the concept ridiculous given that her husband was not in need of surgery and was satisfied with his primary care physician. The witness laughed at the absurdity of the suggestion that she initiated contact with the Respondent for the purpose he claimed.

Patient A testified about receiving the message from his wife about the Respondent's telephone call to their home and attempting to call the number that he found on his caller ID. Instead of reaching someone, Patient A received a fax machine-type tone. Patient A then looked up the Respondent on the internet and called his medical practice to find out why the Respondent had called. The office was closed. On January 6, 2014, Patient A was finally able to speak to a live person. He explained that he told the person that he was returning the Respondent's call. Patient A testified that at no time did he state to the person answering the phone or to the Respondent that he was looking for a surgeon or a primary care physician.

Patient A recalled that the Respondent returned his call about 5:00 p.m. on January 6, 2014, and introduced himself as a member of a review board at [redacted]. Patient A explained that the Respondent informed him that he had reviewed his medical record at [redacted] and seemed to know about his 2011 surgery in detail. During the conversation, the Respondent asked Patient A if he was aware of the fact that Dr. [redacted], the surgeon who operated on Patient A in 2011, nicked one of his arteries during surgery and further suggested that Patient A may be entitled to compensation for the surgeon's error. Patient A noted that, after further questioning by the Respondent about his health, he disclosed to the Respondent that he had an incisional hernia arising out of his 2011 surgery. He told the Respondent the hernia was subsequently repaired in a successful surgery in 2012. Patient A also emphasized that he never gave the Respondent, whom he did not know, permission to access his medical record.

Patient A said that, after the telephone conversation with the Respondent, he thought it highly irregular for a physician to contact him in that fashion, discuss his medical history, speak disparagingly about another doctor's work and further offer to refer his case to a "legal team" that would provide him with papers to sign. Patient A noted that he began feeling more and more uncomfortable about his exchange with the Respondent, which prompted Patient A to telephone [redacted] and inform someone there about the unsolicited call from the Respondent.

On January 7, 2014, upon speaking to someone in the [redacted] Medical Affairs Office, Patient A learned that the Respondent had been subject to recent disciplinary action at [redacted] and was not a member of any [redacted] review board. Patient A noted that he described the telephone conversation he had with the Respondent and answered numerous questions from [redacted] management.

Patient A went on to explain another disturbing telephone encounter he had with the Respondent, who telephoned him on January 22, 2014 and communicated that he was aware that Patient A had provided [redacted] information about their earlier conversation. The Respondent advised Patient A that the hospital was lying to Patient A. Patient A remembered the Respondent saying that he was being investigated. He noted that the Respondent also said that he was only trying to prevent Dr. [redacted] "from performing bad surgeries." The Respondent also requested the Patient to have his wife tell [redacted] that she sought him out as a primary care physician for Patient A and that would provide justification for the Respondent to have accessed the Patient's medical records. Patient A recalled that he refused the Respondent's persistent request and hung up on him. Patient A then reported the January 22, 2014 conversation to [redacted]

Patient A noted that the unsolicited and unauthorized attention from the Respondent has caused him stress, aggravation, concern about retaliation by the Respondent, and a serious concern about who has access to his medical records. He is concerned that a stranger has a lot of information

about him, including what is in his medical records, and the knowledge of where he lives. Patient A also explained that he has had to take time off from work as a result of this intrusion into his life.

B. [redacted] M.D.

Dr. [redacted], [redacted] Vice President of Medical Affairs, explained his role as a hospital administrator at [redacted] Dr. [redacted] described the Respondent's role at [redacted] as a hospitalist and one of three physicians who served on the Purple Team as independent contractors.

The witness verified that the Respondent has not, at least from July 2013 to January 2014, served on any MedStar committees that investigated quality assurance matters, adult or infant deaths, or negligent or substandard surgical outcomes. Dr. [redacted] went on to explain complaints and quality of care issues in 2013 that led to the initiation of an FPPE of the Respondent. [redacted] was in the process of implementing a recommendation that the Respondent's volume of patients be reduced when, in January 2014, Patient A provided information that led to the Respondent's summary suspension.

Speaking of Patient A's allegations from January 2014, Dr. [redacted] noted that "physicians are sworn to uphold the privacy of our patients' information." He further explained that if a physician has a reasonable reason to be in a chart, that is acceptable, but if there is no legitimate reason to be in a chart, a physician "has crossed the line of law and ethics."

Once Patient A's allegations were presented to [redacted] Dr. [redacted] noted, the hospital imposed a summary suspension of the Respondent, effective January 8, 2014, and directed the IT Department to complete a privacy audit of the Respondent's activities in the electronic medical records to determine if there existed any legitimate clinical reason for the Respondent to have accessed Patient A's medical chart. [redacted] was also concerned about the allegations regarding the Respondent calling Patient A, offering to assist him in obtaining legal representation, speaking

disparagingly about Dr. [redacted], and requesting Patient A to have his wife lie to [redacted] about the nature of her January 3, 2014 phone conversation with the Respondent.

Dr. [redacted] deferred to the witnesses from [redacted]'s IT Group for a thorough explanation of the audits' findings. He summarized the audit's findings by stating that [redacted] found that the Respondent accessed 54 records,[7] including Patient A's record, without any legitimate reason. Dr. [redacted] noted that the Respondent was provided a hearing on April 2, 2014, pursuant to [redacted]'s bylaws, during which he was able to contest [redacted]'s allegations, which were based on the privacy audit's findings. Dr. [redacted] noted that the Ad Hoc Committee's Report to the Medical Executive Committee upheld [redacted]'s earlier findings that the Respondent had violated patients' HIPAA rights.

Dr. [redacted] went on to explain that he understands that the Respondent believes that the instant charges against him are part of some retaliation against him by [redacted], but he emphasized that [redacted] pursued this action because of the Respondent's violation of patients' HIPAA rights.

In his testimony, Dr. [redacted] briefly addressed the implausibility of the Respondent's response to the charges related to unauthorized access of medical records and deferred to the IT professionals to explain that the Respondent could not have "accidently" accessed electronic medical records of patients whose names may have appeared in error on his patient list. Dr. [redacted] pointed out that the Respondent accessed the Physician View search function of the medical record indicating that there were no patients on his list at the time. With the type of access the Respondent had, it was not possible for those records to appear on his list without him affirmatively going in and searching for names.

Similarly, Dr. [redacted] found little credence in the Respondent's claim that patients whose records he accessed had sought office care from him, therefore he had a right to view their hospital

[7] Dr. [redacted] included Patient B in this total.

records. Dr. [redacted] noted that he has not seen such evidence of any doctor/patient relationships in the records accessed and, given the categories of patients whose records the Respondent had accessed, it would be hard to believe that they sought care from the Respondent's office. For example, the Respondent accessed numerous records of patients who arrived in the Emergency Department and died immediately or shortly thereafter and could not have sought care in his office. Dr. [redacted] pointed out that there were also several infants and children whose records were accessed and, therefore, could not have sought care in the Respondent's office, as the Respondent is not a pediatrician. As for the Respondent's assertion that he had accessed records of deceased patients because the Medical Examiner had called him about those patients, Dr. [redacted] found it extremely improbable that the Medical Examiner would be making such an inquiry for a patient who had died months before the Respondent accessed that person's electronic medical record.

C. Louis [redacted] and Deborah [redacted]

Mr. [redacted], Vice President of IT at [redacted] testified about the different forms of recordkeeping at MedStar, including paper records and the more recent electronic medical records. He explained that [redacted] went to a paperless system in February 2013 called the McKesson Horizon View System. Mr. [redacted] explained that, with the advent of HIPAA in 1996, the entire industry was required to secure the paper and electronic records. Rules and regulations regarding access were put in place, in addition to an audit trail to show who accessed each electronic file. Tracker systems are able to show which user had access to which patient records.

Mr. [redacted] noted that, in a memo dated January 8, 2014, Dr. [redacted], then Associate Vice President of Medical Affairs at [redacted], requested IT to produce a report showing all accounts where the Respondent accessed records, eliminating situations where a member of the Purple Team was not the attending physician of record. The witness said that one thing the audit revealed is that the Respondent accessed Patient A's medical record on January 3, 2014. The

medical record showed that the Respondent was not listed as the attending, admitting, referring or consulting physician for Patient A. The record further showed that the Respondent accessed the patient's demographic information. Mr. [redacted] also referred to Ms. [redacted]'s findings, which will be discussed below, that show the Respondent accessed medical records in a number of instances where the patients were not in his immediate care or in the care of the Purple Team.

To discuss the audit of [redacted] patients' records, the State presented the testimony of Deborah [redacted], R.N., who worked at [redacted] in early 2014 as the Physician Quality Control Coordinator. Ms. [redacted] is now employed in [redacted]'s IT Department as a Clinical Systems Analyst. In her former position, Ms. [redacted] testified that she produced reports regarding medical records, as they relate to the areas of core measures (reviewing open charts for sufficient documentation), finance, and physician and nursing compliance. Ms. [redacted] is intimately familiar with the details of [redacted]'s electronic medical records.

Ms. [redacted] noted that while she was serving in her former position in January 2014, [redacted] management asked her to review electronic medical records and determine when a member of the Purple Team accessed an electronic record and identify whether the record was accessed for that Team member's actual patient.

Ms. [redacted] explained the methodology she used in poring over 100 pages of reports generated by her audit inquiry for the period from November 1, 2013 to January 8, 2014. As Ms. [redacted] considered the Purple Team physicians who accessed records, her review revealed that the Respondent was the only Purple Team physician who had accessed charts not assigned to him.

In conducting the audit, Ms [redacted] described how she applied certain exclusion criteria to eliminate from consideration all medical records the Respondent could possibly have had a legitimate reason to access. Ms. [redacted] pointed out how she excluded from consideration records for a patient when any Purple Team physician was called or contacted or placed an order as a result

of a rapid response, wrote a progress note or there was documentation that the Purple Team physician was that patient's primary care physician. Next, Ms. [redacted] excluded records of patients where the Emergency Department practitioner attempted to or actually contacted a Purple Team physician. Ms. [redacted] went on to explain that patient records were also excluded from consideration when a physician placed an order in the Emergency Department for any Purple Team physician to consult on an Emergency Department patient's case, even if that consult was not performed by that Purple Team physician. The last exclusion applied to the audit was the situation where any Purple Team physician's name, phone number or office or clinic address was documented in the miscellaneous section of the Emergency Department record. The last exclusion was applied because a patient may have been referred to the Respondent and he would have had a legitimate reason to look at the record.

Ms. [redacted] referred to her audit report and testified that the audit revealed that the Respondent accessed fifty-four patient accounts during the period in question. Of the fifty-four patient accounts accessed, nineteen were those of patients who died in the Emergency Department, five who died during hospitalization and two records were for those of infants. Six of the records were accessed multiple times. There was no evidence the Respondent had been caring for any of the patients whose record he accessed, with the exception of Patient B. For the patients who had died during hospitalization, the Respondent was not a physician on the case and had not been consulted. As for the infant charts, Ms. [redacted] noted that the Respondent does not have privileges for pediatric care. Ms. [redacted] also pointed out, that on December 25 and 31, 2013 and January 1, 2014, the Respondent accessed records of the nineteen patients who died in the Emergency Department from February 2013 to September 2013. She found it odd that a physician would have a need to access medical records for patients who died up to ten months prior. In addition, in those death cases, Ms. [redacted] mentioned that the records do not show that the Respondent contacted the

Medical Examiner or that the Medical Examiner contacted the Respondent. During the audit, Ms. [redacted] also became aware of a separate Death Log that was kept in the Emergency Department without standard security provisions.

Based on the audit results, which show unauthorized patient access by the Respondent on fifty-three occasions, Ms. [redacted] ventured to speculate that the Respondent clicked into the various charts from a list. In summary, after Ms. [redacted] conducted a privacy audit of [redacted] electronic medical records from November 1, 2013 to January 8, 2014, applying exclusion criteria to eliminate any cases where the Respondent could have been said to have had a legitimate reason to access the records of [redacted] patients, she was clear in her conclusion that the Respondent accessed numerous patient records with no legitimate justification.

II. The Respondent's Case

The Respondent's position is that he did not do anything improper in accessing the medical records identified in these cases. He maintains that he is able to explain his access to the non-death records. He further recognizes that his testimony is irreconcilable with Patient A and his wife and only describes the chasm as "a fundamental disconnect." The Respondent spoke of his dedication to the field of medicine and his colleagues' and patients' high regard for his honesty, integrity, trustworthiness and professionalism. He argued that a suspension, which he maintains is unwarranted, would be the death knell for his career in medicine. In the alternative, if a sanction is in order, the Respondent offered that a reprimand and continuing education would be more appropriate.

A. The Respondent's Testimony

The Respondent testified about his origins in Nigeria and coming to this country in 1991 seeking political asylum, which the United States granted in 1994. He summarized his medical training and the path he took that led him to [redacted] The Respondent discussed [redacted]'s

transition from a small family-owned hospital to a corporate entity. He also explained how he was instrumental in forming the Purple Team at [redacted] and his role as a hospitalist there.

The Respondent noted that he has not encountered any problems while working at three other hospitals in the region. He made a point of stating that he understands the importance of patient confidentiality. He noted that in his private practice he maintains a separate room for patients' charts.

In explaining that [redacted] was in transition to an electronic medical records system during the period covered by the audit, November 1, 2013 through January 8, 2014, he was able to log into the old and the new systems. He pointed out that he saw some patients he did not recognize on a list of patients under his care. The Respondent pointed out that he needed to research those names in [redacted]'s electronic patient records.

Regarding the death records, the Respondent asserted that a Dr. Sandra [redacted] gave him the name of a patient who came to [redacted] dead-on-arrival (DOA) and that it was the Respondent's responsibility as the Purple Team Physician on call to sign the death certificate. He denied accessing any records associated with patient deaths in the emergency room or during hospitalization that he had no reason to access. The Respondent explained that the Death Log kept in the Emergency Department only has patient numbers and he had to access the electronic record to locate the decedent by name. At some point in the proceedings, the Respondent also indicated that he accessed the record of a deceased patient in response to a telephone inquiry from the Medical Examiner.

With respect to patients who were not DOA and who did not expire in the hospital, the Respondent went on to describe that sometimes a patient's name that he does not recognize will appear on his list of patients. In those cases, he will access the electronic record and discover only about fifty percent of the time that the patient is actually under his care. He noted that sometimes the patient will be connected to another colleague or is now under the care of another doctor.

In addressing the fifty-four patients whose electronic medical records he accessed, the Respondent indicated that [redacted] gave him the names of only two patients whose records he purportedly accessed, Patient A and Patient B. Patient B's medical record was one of the fifty-four [redacted] patient records the Respondent accessed. The Respondent provided documentation to [redacted] corroborating his assertion that Patient B had also been a private practice patient of his.

As far as Patient A is concerned, the Respondent acknowledged speaking with Patient A, stating that the patient contacted him by telephone, looking for a surgeon to repair his abdominal hernia. He recalled that the conversation was brief. The Respondent stated that he told Patient A that he is not a surgeon, but a primary care physician. The Respondent also denied ever telling Patient A that he was on a [redacted] review committee or that he reviewed his medical chart. He initially stated in his testimony at this hearing that he never reviewed Patient A's chart. On cross-examination, the Respondent acknowledged the possibility that he accessed Patient A's medical record.

The Respondent emphatically denies that he offered to arrange for legal representation for Patient A. He also denies that he ever called Patient A a second time (on January 22, 2014) and requested Patient A to have his wife falsely tell [redacted] staff that she had contacted him because she was seeking a primary care physician for Patient A.

The Respondent noted that he could not document that other patients whose records he may have accessed were in fact his patients because he was not given their names and he was denied access to [redacted] records once his privileges at [redacted] were summarily suspended on January 8, 2014.

The Respondent was asked about any issues he had with [redacted] management in 2013. He explained that he had raised issues about patient care and concerns about the Purple Team's contract with [redacted] The Respondent characterized his relationship with [redacted] as "turning sour".

around July or August 2013. Specifically, he recalled a situation where [redacted] called into question medical care he provided for an Emergency Department patient. [redacted] reviewed the Respondent's actions with respect to that patient and initiated an FPPE, a focused review, of his actions. The Respondent feels strongly that the review process was unfair and that his concerns were not addressed by [redacted] management. He also described a separate situation where Dr. [redacted] was yelling at him, making accusations, and referring to complaints from nurses. Overall, he categorized his working environment with Dr. [redacted] and Dr. [redacted] to be hostile towards the end of 2013.

On cross-examination, the Respondent agreed that a physician may not access a patient's confidential medical information unless he is either managing the patient or providing consultative, therapeutic or diagnostic services. He also agreed that if a physician accesses the record of a patient with whom he does not have a relationship, that it constitutes unprofessional conduct in the practice of medicine.

In clarification on cross-examination and on re-direct, the Respondent stated that he told the Board that he did not access Patient A's [redacted] medical records. In response to several questions about this, he also stated it is possible that he accessed the Patient's record. Reference was made in the record to the Respondent accessing Patient A's demographic record. The Respondent affirmed that demographic data is part of the Patient's confidential medical information. The demographic information includes information about the surgery the Patient underwent and that Dr. [redacted] was one of his surgeons.

B. Character Witnesses

Patients [redacted] (and his wife, [redacted]), [redacted] and [redacted] were presented as character witnesses. Similarly, physician colleagues [redacted], [redacted] and [redacted], some of whom are also the Respondent's friends, also

testified in support of the Respondent. The patients described the Respondent as caring, knowledgeable, trustworthy, professional and compassionate. Mr. [redacted] used the terms "great" and "phenomenal" in speaking about the Respondent. Mr. [redacted] referred to the Respondent as his teacher and mentor, calling him a caring person and an honorable man. He noted that the Respondent has traveled to medical missions in Africa and elsewhere to help others in need.

Dr. [redacted] spoke of the Respondent as a mentor who trains clinicians and interns and serves as a consultant to the Centers for Disease Control. He explained that the Respondent has adopted a leadership role in fighting the Ebola virus in Sierra Leone. Dr. [redacted] who has known the Respondent for about eight years, characterized him as a very competent physician who is "very good with patients," and knowledgeable, someone who stands out in his profession. Dr. [redacted] is a nephrologist to whom the Respondent refers cases. Dr. [redacted] spoke about accessing medical records. He testified that his name may not also appear in a patient's records when he is called upon for a consult, but he indicated that he would have documentation ready if anyone questioned whether he has a professional relationship with that patient.

Dr. [redacted] also a [redacted] physician and friend of the Respondent since 2007, testified about his role as one of the independent contractor physicians who served MedStar as a member of the Purple Team. He described the Respondent as being passionate, caring and hard-working. He noted that the Respondent was concerned about the [redacted] patient population not receiving excellent care. Dr. [redacted] stated that the Respondent "makes sacrifices for patients in [redacted] Maryland."

In speaking of the electronic medical record system at [redacted] Dr. [redacted] stated that, as a physician in private practice, he would have remote access to [redacted]'s McKesson system. He explained that he could remotely check [redacted]'s records of someone who came to see him in his

private practice. Dr. [redacted] also acknowledged that he would have a chart to prove that the patient was, in fact, his.

III. Did the Respondent Engage in Unprofessional Conduct in the Practice of Medicine?

The Respondent does not dispute that it is well established that a physician who accesses medical records which he has no justification to access is engaging in unprofessional conduct in the practice of medicine. The evidence clearly establishes that the Respondent, without justification, accessed a series of [redacted] patients' medical records from November 1, 2013 to January 8, 2014, resulting in [redacted] suspending his privileges there.

What serves as a backdrop for the relevant sequence of events is the Respondent's involvement in a patient's care in August 2013, which led to [redacted] subjecting the Respondent to an FPPE, a focused evaluation, in early November 2013. The Respondent believes the process of the review and corrective action taken against him were patently unfair. One of the members of the [redacted] review committee that recommended disciplinary action against the Respondent arising out of the August 2013 patient care incident was Dr. [redacted], a surgeon at [redacted] After the action was taken against the Respondent by [redacted] in November 2013, the Respondent began looking at medical records, without justification, for his own purposes.

Although there were a whole series of [redacted] patients for which the Respondent had no justification to access their medical records, it is helpful to look at two separate groups of records. One involves emergency room deaths and infants, and the other covers other patients.

The Respondent was unable to refute the State's evidence that he accessed the records of those in the "other" category because he claims he was denied access to those records and had no idea who those patients are. He argued that, if he could have learned the identity of the patients, he could have shown that he had a clinical/office relationship with those patients by producing his private medical office charts for those patients.

The State accurately pointed out that the Respondent could have subpoenaed [redacted] records for the patients at issue as part of his defense and then presented records from his medical office to show that he had a clinical relationship with them. The Respondent's defense that he had such a clinical relationship with the patients in the other category is unsupported by any evidence other than his word, which for reasons I will state below, is very questionable.

The other category of patient records the Respondent accessed is emergency room deaths and infants. His only explanation for combing through the records of patients who died in the emergency room is that a Dr. [redacted] had called him sometime during the Christmas week of 2013 and asked him to look up a death record of a patient who recently died in order to provide information for a death certificate. The Respondent did not present Dr. [redacted] as a witness to corroborate that claim. He was also unable to provide the name of the decedent. Looking at the listing of decedents from the emergency room, the most recent date of death was September 11, 2013, which rendered the Respondent's explanation contradictory and illogical. The Respondent also had no valid explanation for why he looked up the charts of the infants.

The Respondent knew from his work at [redacted] that he had no right to access non-patient's records and, according to Dr. [redacted], the Respondent had no right to access the records of his own patients without justification.

The testimony of Ms. [redacted], as discussed above, clearly sets out the methodology she utilized in identifying patient records the Respondent accessed without justification. Ms. [redacted] provided a detailed description of the exclusion criteria she utilized as part of the process of identifying those medical records that the Respondent accessed with justification. Not only did that analysis reveal that the Respondent accessed numerous medical records without justification, it also showed that he was the only Purple Team physician who did so. The audit, as explained by

Ms. [redacted] produced an electronic "fingerprint" of the Respondent as he accessed records without authorization.

One of the most troubling aspects of this case is the Respondent's unauthorized accessing of medical records, including those of Patient A, and the outrageous behavior the Respondent exhibited when he contacted him. The Respondent only admits that it is possible that he accessed Patient A's medical record at [redacted] but he denies that he contacted Patient A, other than to respond to Patient A's call to his medical office, during which Patient A was ostensibly inquiring about seeking a surgeon to repair his hernia. The Respondent's responses to Patient A's account of his interaction with the Respondent, who was a total stranger to Patient A before the Respondent telephoned Patient A's home, are illogical, implausible and incredible.

The Respondent's suggestion that a woman representing Patient A telephoned his office looking for a physician was absurd to Patient A and his wife because they have an internist they are satisfied with and who has been treating them for over twenty years. As part of her job, Patient A's wife is familiar with many of the physicians in the county. Even if she had been looking for a new physician, Patient's A's wife testified that she knows there are "plenty of really great doctors" in [redacted] County and she would not have to go outside of [redacted] County to find one.

It is no coincidence that the Respondent accessed Patient A's medical records on the afternoon of January 3, 2014, which preceded the attempted calls he made to Patient A's home. The Respondent clearly had been searching Patient A's medical records, most likely for the purpose of trying to gain information about hospital officials or hospital improprieties, likely in retaliation for the disciplinary action he faced in November 2013. I would have to believe that a miraculous coincidence occurred if I accepted the notion that Patient A's wife just happened to call the Respondent's office unsolicited on January 3, 2014, only about an hour and one-half

after the Respondent accessed her husband's record, the latter of which the Respondent only states *may* have happened. The audit of hospital records confirms that the Respondent accessed Patient A's confidential medical record.

I find the accounts of Patient A and his wife to be very credible. I found their laughter to be very telling and appropriate when testifying in response to the Respondent's claim that Patient A called his office because he was looking for a surgeon to repair his hernia. Both Patient A and his wife testified that Patient A's hernia had been successfully repaired in 2012 and he had no need for a surgeon in January 2014. It is inconceivable to me that Patient A and his wife would give much of their time in providing written statements, subjecting themselves to numerous interviews by [redacted] staff and the Board, missing work, and appearing at hearings in order to fabricate a story against a man who is a total stranger to them. The concept that they would do all of this is utterly ridiculous. Patient A and his wife have nothing to gain in making the allegations they have consistently and steadfastly asserted since bringing the Respondent's actions to [redacted]'s attention. On the other hand, I note that the Respondent's accounts of what occurred have been both inconsistent and illogical. I addressed the logic issue above. As far as the Respondent's inconsistency, he stated that he did not access Patient A's medical record, but subsequently at this hearing he acknowledged it is possible that he did.

The Respondent also denies that he represented that he was part of a [redacted] review committee, that he had a discussion with Patient A about assisting him in obtaining legal representation, or that he spoke disparagingly of Dr. [redacted]. Similarly, and not very credibly, the Respondent denied that he telephoned Patient A several times on January 22, 2014 in an aggressive attempt to encourage Patient A to have his wife misrepresent to inquiring [redacted] personnel that she initiated contact with the Respondent because she was assisting her husband in obtaining a

primary care physician. I find the Respondent's denial about making the January 22, 2014 call to Patient A beyond belief.

It was [redacted]'s audit of patient records that revealed the Respondent had accessed an additional fifty-two patient records without authorization. It is understandable, given the extent of the confidentiality breaches, that [redacted] did not initially provide the Respondent with the names, other than those of Patients A and B, corresponding to the records the Respondent accessed for no legitimate reason. However, I note that the Respondent, as part of this proceeding, was not denied a request for the names of the patients. There is no indication he subpoenaed or requested the information from the State in any way as this matter was pending before the OAH. His defense regarding the fifty-two other patients was that that he did not do anything improper in accessing the medical records identified in these cases. He presented no documentation to support that defense.

In summary, I find that the Respondent engaged in unprofessional conduct in the practice of medicine in violation of section 14-404(a)(3)(ii) of the Health Occupations Article by accessing medical records without authorization and by using information obtained to harass and intimidate a patient and his wife. He also violated [redacted] policy and the AMA guidelines noted above.

IV. Sanction

In this case, the State is seeking to impose a one-year suspension of the Respondent's medical license, and a requirement that he be referred by the Board for a general evaluation by the Maryland Professional Rehabilitation Program, which is administered through The Maryland State Medical Society (MedChi), and the Board. Such an order would include the requirement that the Respondent be mandated to attend and abide by all of the measures recommended. The State additionally requested that I recommend that after the Respondent's suspension, he remain on probation for three years, be supervised in order to determine whether his professional

behavior meets the standards of the profession, and be required to complete appropriate coursework in the area of medical ethics and that he should pay a fine of $30,000.00. COMAR 10.32.02.09 sets forth the general sanctioning guidelines for physicians, providing in pertinent part as follows:[8]

> **.09 Sanctioning and Imposition of Fines.**
>
> A. General Application of Sanctioning Guidelines.
>
> (1) Sections A and B of this regulation and Regulation .10 of this chapter do not apply to offenses for which a mandatory sanction is set by statute or regulation.
>
> (2) Except as provided in §B of this regulation, for violations of Health Article §§14-404(a) . . . Annotated Code of Maryland, the [Board's] disciplinary panel shall impose a sanction not less severe than the minimum listed in the sanctioning guidelines nor more severe than the maximum listed in the sanctioning guidelines for each offense.
>
> (3) Ranking of Sanctions.
>
> (a) For the purposes of this regulation, the severity of sanctions is ranked as follows, from the least severe to the most severe:
>
> (i) Reprimand;
>
> (ii) Probation;
>
> (iii) Suspension; and
>
> (iv) Revocation.
>
> (b) A stayed suspension in which the stay is conditioned on the completion of certain requirements is ranked as probation.
>
> (c) A stayed suspension not meeting the criteria for §A(3)(b) of this regulation is ranked as a reprimand.

[8] COMAR 10.32.02.10 provides a matrix for sanctions for various violations of the Act.

(d) A fine listed in the sanctioning guidelines may be imposed in addition to but not as a substitute for a sanction.

(e) The addition of a fine does not change the ranking of the severity of the sanction.

(4) The disciplinary panel may impose more than one sanction, provided that the most severe sanction neither exceeds the maximum nor is less than the minimum sanction permitted in the chart.

(5) Any sanction may be accompanied by conditions reasonably related to the offense or to the rehabilitation of the offender. The inclusion of conditions does not change the ranking of the sanction.

. . . .

(8) Depending on the facts and circumstances of each case, and to the extent that the facts and circumstances apply, the disciplinary panel may consider the aggravating and mitigating factors set out in §B(5) and (6) of this regulation and may in its discretion determine, based on those factors, that an exception should be made and that the sanction in a particular case should fall outside the range of sanctions listed in the sanctioning guidelines.

(9) If the disciplinary panel imposes a sanction that departs from the sanctioning guidelines set forth in Regulation .10 of this chapter, the disciplinary panel shall state its reasons for doing so in its final decision and order.

B. Aggravating and Mitigating Factors.

(1) Depending on the facts and circumstances of each case, and to the extent that the facts and circumstances apply, the disciplinary panel may consider the aggravating and mitigating factors set out in §B(5) and (6) of this regulation and may in its discretion determine, based on those factors, that an exception should be made and that the sanction in a particular case should fall outside the range of sanctions listed in the sanctioning guidelines.

(2) Nothing in this regulation requires the disciplinary panel or an administrative law judge to make findings of fact with respect to any of these factors.

(3) A departure from the sanctioning guidelines set forth in Regulation .10 of this chapter is not a ground for any hearing or appeal of a disciplinary panel action.

(4) The existence of one or more of these factors does not impose on the disciplinary panel or an administrative law judge any requirement to articulate its reasoning for not exercising its discretion to impose a sanction outside of the range of sanctions set out in the sanctioning guidelines.

(5) Mitigating factors may include, but are not limited to, the following:

(a) The absence of a prior disciplinary record;

(b) The offender self-reported the incident;

(c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;

(d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;

(e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;

(f) The offender has been rehabilitated or exhibits rehabilitative potential;

(g) The misconduct was not premeditated;

(h) There was no potential harm to patients or the public or other adverse impact; or

(i) The incident was isolated and is not likely to recur.

(6) Aggravating factors may include, but are not limited to, the following:

(a) The offender has a previous criminal or administrative disciplinary history;

(b) The offense was committed deliberately or with gross negligence or recklessness;

(c) The offense had the potential for or actually did cause patient harm;

(d) The offense was part of a pattern of detrimental conduct;

(e) The offender committed a combination of factually discrete offenses adjudicated in a single action;

(f) The offender pursued his or her financial gain over the patient's welfare;

(g) The patient was especially vulnerable;

(h) The offender attempted to hide the error or misconduct from patients or others;

(i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;

(j) The offender did not cooperate with the investigation; or

(k) Previous attempts to rehabilitate the offender were unsuccessful.

The Respondent has no disciplinary history. On the other hand, I find that there are several aggravating factors to be considered. I agree with the Board that the Respondent's offense was a series of deliberate actions on his part. Aside from the numerous privacy violations committed against the many patients revealed by an audit of the electronic medical records the Respondent accessed without authorization, his actions also caused Patient A and his wife much mental distress. Both Patient A and his wife explained their consternation at being contacted by a stranger who began discussing Patient A's medical history with him. The offense was part of a pattern of detrimental conduct that involved invading the privacy of a group of individuals. As Patient A realized that the initial unsolicited contact from the Respondent was highly irregular, he

contacted [redacted] management staff. It was after reporting the Respondent's actions that the Respondent contacted Patient A again, aggressively trying to obtain information from him while at the same time pressuring Patient A to encourage his wife to make a misrepresentation to [redacted] personnel in an attempt to cover-up his misdeed. Both Patient A and his wife have had to spend much time and energy as they have participated, as requested by [redacted] and the State, in this disciplinary process.

It is apparent that all through the process, the Respondent has made false statements and provided inconsistent information to [redacted] and the Board, in attempts to hide his conduct in accessing confidential medical records without authorization and in having inappropriate conversations with Patient A. The Respondent has clearly chosen the path of denying the allegations, in the face of strong evidence, repeating the denials and digging in his heels, even as inconsistencies and logical flaws in his position were brought to his attention. He has, for the most part, decided "to stonewall it," that is, to remain steadfast in his denials throughout the process, with the one exception of acknowledging now that he *may* have accessed Patient A's record. This is not a situation where a wrongdoer has acknowledged the error of his ways and shown remorse.

The Respondent asserted a defense, yet he did not offer the testimony of Dr. [redacted] or anyone else to corroborate his bald assertion that he was justified in accessing the records of those patients other than Patient A. The only patient whose record the Respondent may have had a legitimate purpose in accessing was that of Patient B, who was a private patient of his at some point.

As a physician who acknowledged in writing [redacted] policy regarding patient privacy on at least two occasions during his career there, he knew of the confidentiality requirements regarding hospital patients, including those with whom he had no physician/patient relationship.

I have considered the testimony of the Respondent's patients and colleagues, who spoke of his honesty, integrity and professionalism. I do not doubt the sincerity and good intentions of those witnesses who hold the Respondent in high regard. More significantly, however, I have focused on the volume of evidence that establishes that the Respondent accessed numerous medical records without authorization and his improper communication with Patient A and the impact of his actions on others.

The Respondent is still currently engaged in the clinical practice of medicine in his private medical practice, although [redacted] has suspended his medical privileges there.

The Regulations require me to consider all of this disparate information, including the facts of this case and all mitigating and aggravating factors, in order to recommend a fair and effective sanction. In this Proposed Decision, I have concluded that the State has proven by a preponderance of the evidence a pattern of privacy violations by the Respondent that constituted unprofessional conduct in the practice of medicine, in violation of the Act. The Respondent's explanations fly in the face of logic and of the considerable weight of the evidence.

I recommend that the Respondent be suspended from the practice of medicine for one year, followed by three years of probation, with a referral to the Maryland Professional Rehabilitation Program for a general evaluation, with any attendant recommendations, and a requirement to attend any applicable course in medical ethics the Board may impose. I further recommend that the Respondent be required to pay a fine of $30,000.00.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Proposed Findings of Fact and Discussion, I conclude as a matter of law that the Respondent engaged in unprofessional conduct in the practice of medicine, in violation of the Medical Practice Act. Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (2014); *Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577, *cert. denied* 543 U.S. 862

(2004); *Maryland Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 74 (1991); and *Kim v. Maryland State Bd. Of Physicians*, 423 Md. 523 (2011). As a result, I conclude that the Board may discipline the Respondent for the cited violations. Md. Code Ann., Health Occ. § 14-404(a); COMAR 10.32.02.09A and B.

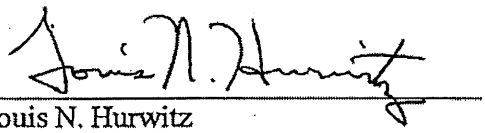
PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Board against the Respondent on November 19, 2014, be **UPHELD**, and

I **PROPOSE** that the Respondent be suspended for a period of one year, followed by a three-year period of probation.

I further **PROPOSE** that the Respondent be referred to the Maryland Professional Rehabilitation Program for a general evaluation, and be required to attend any applicable course in medical ethics the Board may impose.

I further **PROPOSE** that the Respondent be required to pay a fine of $30,000.00.



October 19, 2015
Date Decision Issued

Louis N. Hurwitz
Administrative Law Judge

LNH/dlm
#158496

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions to this proposed decision with the disciplinary panel of the Board of Physicians and request a hearing on the exceptions. The exceptions must be written and be filed within fifteen (15) working days from the date of the proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the disciplinary panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director, Compliance Administration.

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

Copies Mailed To:

Christine Farrelly, Executive Director
Compliance Administration
Maryland Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215

Robert J. Gilbert, AAG
Administrative Prosecutor
Health Occupations Prosecution & Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

Rosalind Spellman, Administrative Officer
Health Occupations Prosecution & Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

John T. Harrington, Esquire
The Employment Law Group, PC
888 17th Street, NW, 9th Floor
Washington, DC 20006

Rasheed Abassi, M.D.
11524 Cosca Park Place
Clinton, MD 20735

John Nugent, Principal Counsel
Health Occupations Prosecution & Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201