IN THE MATTER OF	*	BEFORE THE
NICOLA I. RILEY, M.D.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: D71213	*	Case Numbers: 2011-0118, 2011-0130 and 2011-0160

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

CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges Nicola I. Riley, M.D. (the "Respondent") (D.O.B. 03/27/65), License Number D71213, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Repl. Vol.).

The pertinent provisions of the Act under H.O. § 14-404 provide the following:

(a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another;

(3) Is guilty of: (ii) unprofessional conduct in the practice of medicine;

(18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine; [and/or]

(36) Willfully makes a false representation when seeking or making application for licensure or any other application related to the practice of medicine.

ALLEGATIONS OF FACT[1]

The Board bases its charges on the following facts that the Board has reason to believe are true:

BOARD INVESTIGATIVE ALLEGATIONS PERTAINING TO APPLICATION FOR INITIAL LICENSURE

Case Number 2011-0160

1. On or about June 15, 2010, the Respondent submitted an Application for Initial Medical Licensure (the "Application") to the Board.

2. The Application required that the Respondent answer "YES" or "NO" to a series of questions pertaining to her character and fitness. The Application requested that the Respondent provide a "list of all adverse actions taken against you and provide a complete explanation" for all "YES" responses.

3. The Respondent answered "YES" to Question 17(g), which states: Have you committed a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment?

4. The Respondent submitted a written explanation of her "YES" answer to Question 17(g) of the Application. In pertinent part, the Respondent stated,

> I, Nicola Riley, MD, have been convicted or pled no contest to a federal violation. The federal violation was an Article 132 United States Code of Military Justice: Conduct unbecoming an officer for fraternization with an enlisted soldier.
>
> This offense occurred while on active duty in the US Army in 1991. The records are sealed due to my top secret security

[1] The allegations set forth in this document are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.

> clearance at the time, but will appear during an extensive background check.

5. At the conclusion of the Application, the Respondent certified that she personally reviewed all of her responses on the Application and that the information she provided was true and accurate to the best of her knowledge.

6. By electronic mail message to the Respondent, dated June 25, 2010, a Board staff person requested that the Respondent provide additional information with respect to the circumstances surrounding her criminal conviction.

7. By letter dated June 27, 2010, the Respondent replied to this electronic mail message. In pertinent part, the Respondent stated,

> The conviction was a United Courts of Military Justice in July 1991, while stationed at Fort Carson, Colorado.
>
> This is consider (sic) a felony conviction and will show up on any routine background check.
>
> The charges were as follow: Article 132, Conduct unbecoming an officer with conspiracy to commit fraternization, credit card fraud and subsequent criminal impersonation, due to follow (sic) soldiers under my care using other peoples (sic) credit cards. I failed to report them in a timely manner and was held accountable for my lack of inaction (sic).
>
> I plead non (sic) contest and agreed to 30 months with a minimum of one year at Fort Leavenworth, Kansas a minimal security prison barracks, with subsequent parole at my home of record, New York City, New York.
>
> I served my one year at Fort Leavenworth and subsequent parole in New York without further incident. I did receive a dishonorable discharge and have no further obligation to the US Army after 1993.
>
> Unfortunately all my copies of the trial were destroyed in a storage fire in 1995.

8. The Board issued the Respondent a medical license, effective July 20, 2010, under License Number D71213.

9. The Board subsequently initiated an investigation of the Respondent's responses on her Application under Board Case Number 2011-0160.

10. As part of its investigation, the Board obtained a series of documents, including but not limited to the Respondent's military court-martial records and her 1996 medical school application.

11. The Respondent's criminal conviction involved the theft of property from jewelry stores in or around Colorado Springs, Colorado. While serving as a member of the United States Army, the Respondent obtained the names and social security numbers of other service members through her active duty work. The Respondent then falsely completed credit applications with those names and social security numbers at local jewelry stores, after which she charged jewelry and other items under the false identities she created. The Respondent unlawfully obtained this property on several occasions, either alone or while accompanying other participants in the scheme. The Respondent unlawfully obtained several thousands of dollars of property as a result of the scheme.

12. The Respondent made material misrepresentations and otherwise did not provide truthful responses in her Application and in subsequent communications with the Board. The Respondent failed to disclose the full extent and circumstances surrounding her criminal conviction in the State of Colorado in 1991. In her Application and in subsequent communications with the Board, the Respondent misrepresented the full extent of her criminal conduct.

13. The Respondent misrepresented that she was convicted of conduct unbecoming an officer due to fraternization with enlisted personnel or failure to report the misconduct of enlisted personnel under her command. In fact, on more than one occasion the Respondent herself obtained property by fraud from commercial retail establishments.

14. The Respondent's misrepresentations also include but are not limited to the following: The Respondent misrepresented that she pled "non (sic) contest" when in fact, she pleaded guilty during court martial proceedings in Colorado. The Respondent misrepresented that her military records were sealed due to her "top secret security clearance," whereas the United States Army documents the Board obtained do not identify that she had a "top secret" security clearance. The Respondent misrepresented that her conviction for conduct unbecoming an officer related to fraternization with an enlisted soldier, whereas United States Army documents do not identify "fraternization with an enlisted soldier." The Respondent misrepresented that her conviction was based on her failure to report enlisted personnel, when in fact the transcript of her plea hearing indicates that on more than one occasion she herself instigated and perpetrated acts of fraud. The Respondent misrepresented that she was convicted of Article 132 of the United States Code of Military Justice when in fact she was convicted of Article 133.

15. On November 12, 2010, the Respondent sent a facsimile transmission to the Board in which she provided additional documents about her court martial, including her discharge papers from the United States Army. In her typed facsimile transmission, the Respondent stated,

> Enclosed is the only information in my records reference (sic) my Article 132. Any further information will have to be

> requested by your office to Department of the Army. Also, enclosed is a copy of the correspondence sent to the Maryland board reference (sic) this issue when I applied for my license. FULL DISCLOSURE with no apparent (sic) scheming. (emphasis in original)

16. The Respondent also made material misrepresentations or omissions on her 1996 medical school application, despite certifying that the information she submitted in it was "current, complete, and accurate to the best of . . . [her] . . . knowledge."

17. For example, in the essay portion of the application, the Respondent misrepresented the full extent of her military career. The Respondent stated that at the completion of her tour of duty in 1992, she "left the military with numerous decorations, a multitude of experiences, and friends spanning the globe." The Respondent failed to disclose that she had been court-martialed in 1991 for conduct unbecoming an officer and had been incarcerated at Fort Leavenworth, Kansas for one year, after which she was dishonorably discharged from the military in or around 1992.

18. The Respondent also made material misrepresentations or omissions with respect to her post-secondary history, volunteer and employment history. In this portion of the application, the Respondent misrepresented that from 1987-1992, she was working in various positions as an officer in the United States Army when in fact, during a portion of that time she had been court-martialed and was incarcerated.

19. The Respondent's actions, as described above, constitute, in whole or in part, one or more of the following violations of the Act: fraudulently or deceptively obtained or attempted to obtain a license for the applicant or licensee or for another, in violation of H.O. § 14-404(a)(1); is guilty of unprofessional conduct in the practice of

medicine, in violation of H.O. § 14-404(a)(3)(ii); and/or willfully makes a false representation when seeking or making application for licensure or any other application related to the practice of medicine, in violation of H.O. § 14-404(a)(36).

BOARD INVESTIGATIVE ALLEGATIONS PERTAINING TO PREGNANCY TERMINATION IN ELKTON, MARYLAND

20. The Board re-alleges and incorporates by reference herein paragraphs one (1) through nineteen (19), *supra*.

21. The Respondent is board-certified in family medicine. The Respondent's primary practice location is: 1220 East 3900 South, Suite 4A, Salt Lake City, Utah 84124.

22. The Respondent has no hospital privileges in the State of Maryland.

23. Shortly after being granted licensure, Steven C. Brigham, M.D. ("Dr. Brigham") hired the Respondent to perform abortions at the Maryland offices of American Women's Services ("AWS"). Dr. Brigham owns and operates AWS, which provides abortion services at facilities in several states, including New Jersey, Pennsylvania, Virginia, and Maryland.

24. Dr. Brigham is licensed to practice medicine in New Jersey but is not and has never been licensed to practice medicine in Maryland. Dr. Brigham was formerly licensed to practice medicine in the State of New York. On November 30, 1994, Dr. Brigham's New York medical license was revoked for gross negligence and negligence on more than one occasion. On or about September 17, 2010, the New Jersey State Board of Medical Examiners summarily suspended Dr. Brigham's New Jersey medical license.

25. AWS's Maryland offices are located at the following addresses: 3506 N. Calvert Street, Suite 110, Baltimore, Maryland 21218; 6005 Landover Road, Suite 6, Cheverly Maryland 20785; 801 Toll House Avenue, Unit H-6, Frederick, Maryland 21701; 4700 Berwyn House Road, College Park, Maryland 20740; and 126 East High Street, Elkton, Maryland 21921.[2]

26. The Respondent reportedly began performing abortions at one or more of these facilities on or about July 30, 2010. The Respondent flew from her home in Utah every other week to Maryland to perform abortions, typically on Thursdays, Fridays and Saturdays.

27. At the time the Respondent accepted employment from Dr. Brigham, she was aware of the fact that Dr. Brigham was not licensed to practice medicine in the State of Maryland.

28. At the time the Respondent accepted employment from Dr. Brigham, she was aware of the fact that the initial intake for her abortion patients would take place in New Jersey, where they would undergo initial assessment, including but not limited to "laminaria[3] insertion, digoxin[4] injection and ultrasound." The Respondent was informed that the patients would then be sent to Maryland for completion of the abortion, and that Dr. Brigham would accompany the patients and bring their charts.

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[2] According to State Department of Assessments and Taxation records, since at least 2004, Dr. Brigham has established a series of corporate entities for these facilities, going by various trade names, such as Access Medical Care, P.C., Professional Medical Services, P.C., Advanced Professional Care, LLC, and American Women's Services.

[3] Laminaria is a product developed from seaweed that is used to dilate the cervix for various purposes, including abortions.

[4] Digoxin is widely used to treat various heart conditions, but can be used for purposes of causing fetal demise.

29. In mid-August 2010, the Board initiated an investigation of the Respondent after receiving two complaints about her. The first complaint was filed by representatives of the Elkton Police Department, which the Board docketed under Case Number 2011-0118. The second complaint was filed by a physician from a Baltimore-area hospital on August 18, 2010, which the Board docketed under Case Number 2011-0130.

30. After conducting an investigation into these complaints, the Board, on August 31, 2010, issued an Order for Summary Suspension pursuant to Md. State Gov't Code Ann. § 10-226(c)(2). The Respondent was served with the Board's Order on September 2, 2010. The Board summarily suspended the Respondent's medical license, concluding that the public health, safety or welfare imperatively required emergency action. In its Order, the Board stated the following:

> The Board concludes that the Respondent poses a threat to her patients' safety and wellbeing and thereby represents a danger to the public, her patients, and the profession of medicine. The Respondent . . . exercised poor medical judgment and otherwise exposed her patients to harm. The Respondent knowingly participated in a practice arrangement in which abortions were initiated in one state, after which the patients were instructed to drive across state lines to an undisclosed location for completion of the abortion. This arrangement potentially placed the patients at grave risk for harm or catastrophic outcomes. The Respondent practiced with an unlicensed individual, Dr. Brigham, or aided an unlicensed individual, Dr. Brigham, in the practice of medicine. With respect to the August 13, 2010, abortion, the Respondent knowingly participated in a surgical procedure that was initiated elsewhere. When the Respondent noted that she had ruptured Patient A's uterus, she exercised poor judgment or placed her patient in potential life-threatening danger by refusing to call for an ambulance or emergency medical services, and transporting her to a hospital by automobile. When the Respondent arrived at the hospital, she acted in a manner that delayed or otherwise impeded emergency staff from attending to Patient A, which endangered

Patient A's health and placed her at additional risk for life-threatening injury or death.

31. The Board convened a show cause hearing on the Order for Summary Suspension on October 27, 2010, after which the Board continued the summary suspension of the Respondent's Maryland medical license.

32. The Board's investigative findings are set forth *infra.*

Case Number 2011-0118

33. On or about August 16, 2010, a representative of the Elkton Police Department submitted a complaint to the Board with respect to the Respondent and Dr. Brigham. The complainant stated that on August 13, 2010, the Respondent and Dr. Brigham transported a critically injured patient (referred to *infra* as "Patient A")[5] in a private vehicle to the Emergency Department of a hospital ("Hospital A"), located in Elkton, Maryland, following a failed surgical abortion. The complaint stated that Patient A was subsequently transported to a Baltimore-area hospital ("Hospital B") for surgical intervention.

Case Number 2011-0130

34. On August 18, 2010, a physician ("Physician A") from Hospital B submitted a second complaint against the Respondent to the Board.

35. Physician A stated that on August 13, 2010, the Respondent performed an abortion on Patient A, during the course of which the Respondent noted a uterine perforation. The Respondent then transported Patient A in a personal vehicle to the emergency room at Hospital A, where it was determined that Patient A sustained a

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[5] To ensure confidentiality, patient names will not be disclosed in this charging document. The Respondent may obtain the identity of any individuals or entities referenced herein by contacting the assigned administrative prosecutor.

uterine perforation with evisceration of small bowel through the uterine perforation into the vagina. Due to the extent of Patient A's injuries, Patient A was transported to Hospital B, where Physician A and a general surgeon performed an exploratory laparotomy, repair of the hysterotomy, and small bowel resection in order to repair the injuries Patient A sustained during the failed abortion.

36. Physician A stated that she filed the complaint for the following reasons: (a) It was "unsafe" to transport a patient in Patient A's condition via personal vehicle to the emergency room, which "demonstrates poor clinical judgment" that placed Patient A "at risk"; and (b) "It is concerning that patients were being transported across state lines to complete medical care."

The August 13, 2010, Pregnancy Termination

37. On or about August 9, 2010, Patient A, then 18-years old, visited the Voorhees, New Jersey office of AWS to obtain an abortion after discovering that she was pregnant. While there, Patient A reportedly underwent a sonogram that determined that she was approximately 21 weeks pregnant. Patient A was instructed that she would have to return to the facility because the procedure would be performed over a two-day period.

38. Patient A returned to the Voorhees, New Jersey office of AWS on August 12, 2010, to begin the procedure. During this visit, Patient A met with Dr. Brigham, who initiated the abortion process by inserting/administering the laminaria. Patient A signed various forms on August 12, 2010, including a form entitled, "Consent for Laminaria Insertion." In part, this form states, "I understand that the insertion of laminaria into my cervix **COMMITS ME TO THE TERMINATION OF THE PREGNANCY**." (emphasis in

original). Patient A also signed a form entitled, "Consent for Use of Misprostol in Voluntary Surgical Abortion." In part, this form advised Patient A that she may be given the drug Cytotec, which is usually prescribed to prevent stomach ulcers, but may also increase the possibility of miscarriage by softening the cervix and causing expulsion of the pregnancy by causing contractions.

39. Within Patient A's chart is a form that she signed entitled, "Post-Laminaria Insertion Instructions." In part, this form states, "Remember that your abortion really begins when the laminaria is inserted into your cervix." At the bottom of the form, Patient A was instructed to return to the facility for completion of the procedure at 8:00 a.m. on August 13, 2010.

40. Patient A returned to the facility on August 13, 2010, whereupon AWS staff gave her two pills to take to induce contractions.

41. At least two other patients were also at the facility to complete abortion procedures. Patient A, who believed that she would be provided transportation to Philadelphia to complete the abortion, was advised that AWS would not provide transportation to the other facility. Instead, she was instructed to use her own personal vehicle. Dr. Brigham arrived at the facility and instructed Patient A and the other women who were scheduled to complete abortions to form a line of cars and follow the lead car to a location where the abortion would be performed.

42. Patient A, accompanied by her mother and boyfriend, followed the caravan of cars to the location, which turned out to be the Elkton office of AWS. Patient A arrived at the Elkton location and entered the facility. Patient A was instructed to wait

in the waiting room, during which time one of the other women who was undergoing an abortion was taken to a procedure room for that purpose.

43. After the first abortion was completed, Patient A was escorted into the procedure room, whereupon she saw Dr. Brigham, who introduced her to the Respondent. Patient A was then placed on the procedure table where the abortion was to be performed.

44. Patient A recalls that the Respondent began administering medications to her at Dr. Brigham's direction, which ultimately caused her to lose consciousness. Patient A next remembers regaining consciousness at Hospital A.

45. The Respondent reportedly administered several intravenous anesthetic medications, including Versed, Ketamine and Fentanyl. The Respondent also reported that she provided other contractile agents. The Respondent did not place an intravenous line for intravenous access prior to commencing the procedure. Thereafter, the Respondent commenced performing the abortion surgery, which she called a dilation and evacuation. During the surgery, the Respondent perforated Patient A's uterus and also suspected that she may have injured Patient A's bowel.

46. After encountering these complications, the Respondent came out of the procedure room and informed Patient A's mother and boyfriend that Patient A would have to be transported to the hospital. Patient A's mother and boyfriend requested that Patient A be taken to the hospital by ambulance.

47. The Respondent refused to call for an ambulance, however.

48. The Respondent originally contemplated taking Patient A by wheelchair to the hospital, which was about two blocks away, but ultimately decided to drive her there.

49. According to the Respondent, staff at the clinic dressed Patient A, who was still in a state of semi-unconsciousness.

50. The Respondent, with the assistance of Dr. Brigham and a staff member, placed Patient A in a wheelchair and wheeled her outside the facility to a rented Chevrolet Malibu. The Respondent placed Patient A in the back seat and reportedly sat there with her while Dr. Brigham drove them to Hospital A.

51. Upon their arrival at the emergency department at Hospital A, the Respondent moved Patient A out of the back seat of the automobile and placed her in a wheelchair, whereupon security and hospital personnel came up to them offering assistance. Hospital staff and security personnel stated that the Respondent and Dr. Brigham were circumspect about who they were, what had happened and from where they had come. Hospital staff stated that they attempted to take Patient A inside the emergency department for assessment, at which point the Respondent began insisting on getting their identities and demanded that an emergency room physician come outside to talk to her, causing a delay in Patient A's transport inside for care. During this time, Patient A was still in the wheelchair, slumped over, in a state of semi-unconsciousness.

52. Patient A was ultimately taken inside where her condition was assessed. The Respondent reported to the emergency room physician that she and Dr. Brigham attempted to perform an abortion on Patient A when they began having complications. Physicians at Hospital A determined that during the failed abortion, the Respondent ruptured Patient A's uterus and possibly perforated her bowel. They ordered imaging studies that demonstrated blood and retained fetal tissue in Patient A's abdomen.

53. Because of the complexity of Patient A's injuries and Patient A's critical status, physicians and hospital staff contacted Hospital B to transport Patient A there for emergency surgery.

54. The Respondent then left Hospital A and returned to the Elkton office of AWS to perform another abortion.

55. Patient A was transferred to Hospital B by helicopter where she was assessed by physicians there, including Physician A, the complainant in Case Number 2011-0130. Patient A was declared a level one case, requiring immediate transport to the operating room, where Physician A assessed her. Physician A confirmed that Patient A's uterus was ruptured and that maternal bowel had extended through the uterine perforation and into the uterus and vagina. Physician A also identified fetal components in Patient A's abdomen by imaging studies.

56. Physician A operated on Patient A with the assistance of a general surgeon. Physician A and the general surgeon performed an exploratory laparotomy, repair of the hysterotomy, and small bowel resection in order to repair the injuries Patient A sustained during the failed abortion. In addition, Physician A and the general surgeon removed the remaining fetal tissue from Patient A which, because of the perforation, had migrated into the abdominal cavity.

Additional Police Investigation

57. Officers of the Elkton Police Department returned to AWS's Elkton facility on August 18, 2010, to serve a search and seizure warrant for Patient A's medical record, which they were not able to find. Officers did locate a chest freezer in the

facility, which contained approximately 35 late term fetuses and fetal parts removed from Patient A.

58. Officers also found two sets of logs at the facility, entitled, "Daily Tissue and Regulated medical Waste log for NJ offices," and "Recovery Room Log." These logs show the date, weeks of pregnancy and the total sample weight, presumably relating to abortions that were performed at the facility. The latest fetal age is measured as being 36 weeks. The forms list other later term abortions involving fetal ages of 28, 20, 33 and 35 weeks. The logs also identify the following physician names: "Dr. Sheppard (sic), Dr. Woaker (sic), Dr. Rilley (sic)."[6]

59. On August 20, 2010, officers of the Elkton Police Department served a search and seizure warrant at Dr. Brigham's New Jersey office in order to obtain the medical records that correspond to the fetuses found in the chest freezer. Officers reportedly found only two medical records related to the fetuses found in the Elkton facility.

Cease and Desist Order, August 25, 2010

60. On August 25, 2010, the Board issued a Cease and Desist Order (the "Order") pursuant to Md. Health Occ. Code ("H.O.") § 14-206(e), in which it ordered Dr. Brigham to immediately cease and desist from practicing medicine in Maryland without a license. In its Order, the Board stated the following:

> Dr. Brigham is not and has never been licensed to practice medicine in Maryland.
>
> Dr. Brigham has performed surgical procedures in Elkton, Maryland on a regular basis, performing two to three procedures

[6] The logs note that on July 30, 2010, the Respondent performed an abortion that involved a 33 week old fetus. The other physician who was listed on the log was a Dr. Shepard.

on each visit during each of approximately two visits per week for at least several months prior to the date of this Order.

On August 13, 2010, Dr. Brigham initiated a procedure, which then had to be completed on an urgent basis. Dr. Brigham then followed the patient in an automobile as the patient, under his instructions, traveled to Elkton, Maryland for the completion of the procedure. In Elkton, Maryland, the patient was admitted, as planned, to a clinic owned by the Respondent for the completion of the procedure. Dr. Brigham directed the surgical procedure that took place at his clinic on that date.

As recently as Friday, August 20, 2010, Dr. Brigham arranged for and attempted to assist in surgical procedures in Elkton, Maryland.

Dr. Brigham has been observed performing surgical procedures on approximately 50 occasions in Maryland at the Elkton location since January 2010.

The health of Maryland patients is being endangered by Dr. Brigham's unlicensed practice of medicine in this State.

61. The Respondent's actions, as described above, constitute, in whole or in part, one or more of the following violations of the Act: is guilty of unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii); and/or practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine, in violation of H.O. § 14-404(a)(18), for reasons including but not limited to the following:

(a) The Respondent aided and abetted or otherwise assisted Dr. Brigham's circumvention of the abortion laws/regulations of the State of New Jersey;

(b) The Respondent practiced medicine with an unauthorized person, Dr. Brigham, or aided an unauthorized person, Dr. Brigham, in the practice of medicine;

(c) The Respondent knowingly participated in a practice arrangement in which abortions were initiated in one state, after which the patients were instructed to drive significant distances for completion of the abortion, which under the circumstances exposed the patients to additional and unnecessary medical risks;

(d) The Respondent infringed on Patient A's autonomy by participating in a practice arrangement in which Patient A was not provided with the details, locations, or providers that would be involved in her care;

(e) The Respondent exercised poor professional judgment and placed patients at risk by performing pregnancy terminations without previously having in place a contingency plan in case of surgical complications;

(f) The Respondent performed abortions in Elkton, Maryland, without having an arrangement with an accredited hospital for patients, in the event of surgical complications;

(g) The Respondent exercised poor clinical judgment and acted unprofessionally by failing to call for an ambulance or emergency medical services after encountering complications while performing an abortion on Patient A on August 13, 2010, and instead, transporting Patient A to Hospital A by private automobile; and

(h) The Respondent, after transporting Patient A to Hospital A by personal vehicle, acted in a manner that delayed or otherwise impeded emergency staff members from attending to Patient A, which endangered

Patient A's health and placed her at additional risk for life-threatening injury or death.

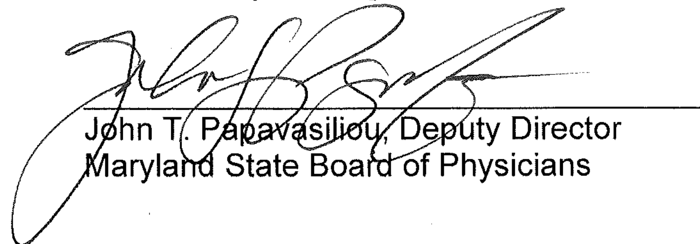
NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under Md. Health Occ. Code Ann. §§ 14-404(a)(1), (3)(ii), (18) and/or (36), the Board may impose disciplinary sanctions against the Respondent's license, including revocation, suspension, or reprimand, and may place the Respondent on probation, and/or may impose a monetary fine.

NOTICE OF CASE RESOLUTION CONFERENCE

A case resolution conference has been scheduled for **Wednesday, April 6, 2011, at 10:00 a.m.**, at the Board's Office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference is described in the attached letter to the Respondent. If this case is not resolved at the case resolution conference, a pre-hearing conference and evidentiary hearing will be scheduled.

1/19/11
Date



John T. Papavasiliou, Deputy Director
Maryland State Board of Physicians