IN THE MATTER OF	*	**BEFORE THE**
MICHAEL A. BASCO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D72935	*	**Case Number: 2014-0045**

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FINAL DECISION AND ORDER

On September 29, 2014, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Michael A. Basco, M.D., an obstetrician/gynecologist, with unprofessional conduct in the practice of medicine. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii). Disciplinary Panel B also charged Dr. Basco with sexual misconduct against patients or key third parties. *See* COMAR 10.32.17. The charges alleged that Dr. Basco touched two patients in a sexual manner and acted in an inappropriate manner toward three coworkers. The case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing and a proposed decision. Prior to Dr. Basco's evidentiary hearing, the Administrative Law Judge (the "ALJ") denied Dr. Basco's motion *in limine* to exclude State's exhibits 2 through 16, which concerned Dr. Basco's prior disciplinary history.

Following an eight-day hearing, the ALJ issued a proposed decision on July 23, 2015. The ALJ found that Dr. Basco was guilty of unprofessional conduct in the practice of medicine and sexual misconduct against Patient B by inappropriately handling her breasts, lowering her pants, and commenting on her appearance. The ALJ also found that Dr. Basco acted unprofessionally by placing ice down the pants of a co-worker, Employee A. The ALJ did not find that Dr. Basco committed unprofessional conduct or sexual misconduct against Patient A, nor did the ALJ find that Dr. Basco committed unprofessional conduct in his actions related to

Employee B or Employee C. The ALJ recommended: a (1) six-month suspension; (2) one-year probation; (3) evaluation as recommended by the Maryland Professional Rehabilitation Program; and (4) enrollment in an ethics course. Both the State and Dr. Basco filed exceptions. On October 14, 2015, Disciplinary Panel A of the Board ("the Panel") heard arguments on the parties' exceptions.

FINDINGS OF FACT

The Panel adopts the ALJ's Proposed Findings of Fact. The ALJ's Proposed Findings of Fact (pages 8-26) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. The Panel also adopts the ALJ's discussion set forth on pages 26-51, except as otherwise provided herein. The factual findings were proven by a preponderance of the evidence.

To summarize, at his first employer ("Physician A's office"), with respect to Employee A and Patient B, the ALJ found that Dr. Basco engaged in unprofessional conduct. The ALJ found that Dr. Basco placed ice down Employee A's pants (the "ice incident"). Concerning Patient B, Dr. Basco directed and assisted her in lifting her shirt and placed a stethoscope on her chest. While performing this examination, Dr. Basco handled Patient B's breasts while positioning the stethoscope. He lowered Patient B's pants, exposing her buttocks, felt her spine in several places, and, after pulling up her pants, told her "you look cute and everything is fine." The Panel adopts these findings.

The ALJ found that there was insufficient evidence to establish unprofessional conduct based upon the allegations of Patient A, which occurred at Dr. Basco's second employer's office. Because Patient A had been under the anesthetic Ketamine when alleged sexual contact

occurred, the ALJ found her perceptions unreliable. The Panel adopts the ALJ's findings that there was insufficient evidence to support allegations pertaining to Patient A.

The ALJ also found that there was insufficient evidence to establish unprofessional conduct based upon the pertaining to Employees B and C at Physician A's office. The ALJ found that Dr. Basco became agitated in the presence of Employee B and shook her desk and kicked the wall. The ALJ concluded that these actions did not rise to the level of unprofessional conduct. The Panel adopts the ALJ's conclusion. Dr. Basco was also charged based on allegations by Employee C that there was a list of patients who refused to see Dr. Basco and that he routinely saw patients without a chaperone. The ALJ found insufficient evidence to support these allegations and the Panel adopts the ALJ's finding that there was no unprofessional conduct with regard to Employee C as alleged in Paragraph 29 of the charging document.

UNDISPUTED ISSUES

Before addressing the exceptions filed by the parties, the Panel notes that Dr. Basco did not file any exceptions pertaining to the ice incident with Employee A. The ALJ found that placing ice down Employee A's pants was unprofessional behavior that degrades the atmosphere of professionals in the office, diminishes the safety of a medical environment, and reflects poorly on the medical profession. The Panel adopts the ALJ's undisputed findings of facts, conclusion of law, and discussion related to this incident.

The Panel also notes that the State did not file any exceptions to the ALJ's failure to find a violation related to Employee C's allegations of unprofessional conduct. The charges alleged that patients complained to Employee C about Dr. Basco's inappropriate comments, that the practice kept a list of patients who refused to see him, and that he routinely saw patients without a chaperone. The ALJ found the charges were not supported by the evidence. The Panel adopts

the ALJ's finding that the charges in paragraph 29 of the charging document related to Employee C were unsupported by the evidence.

Dr. Basco filed an exception ("exception 1") regarding the ALJ's failure to formally dismiss the charges related to Employee C. The State responded that the issue was moot. The Panel concludes that it cannot dismiss the charge of unprofessional conduct because the Panel finds Dr. Basco acted unprofessionally related to Patient B and Employee A. *See Geier v. State Bd. of Physicians*, 223 Md. App. 404, 440 (2015). The Panel does note, however, that its finding of unprofessional conduct is based solely on Dr. Basco's conduct related to Employee A and Patient B.

EXCEPTIONS

I. Prior discipline is admissible for sanctioning purposes - (Respondent Exception 5)

Dr. Basco filed an exception to the admission of State's Exhibits 2-16 at the hearing, which consisted of prior disciplinary actions against Dr. Basco. Dr. Basco argued in his exceptions that these exhibits had no probative value, were highly prejudicial, and were improperly admitted before a finding of culpability.

The Panel finds that the ALJ correctly admitted this evidence. Dr. Basco claims that the evidence was improperly admitted before a finding of culpability. The Office of Administrative Hearings, however, does not conduct bifurcated hearings separating culpability findings and sanctions. COMAR 28.02.01. To admit this evidence, the State was required to introduce it at the hearing. Under State Gov't § 10-213(a)(1), "[e]ach party in a contested case shall offer all of the evidence that the party wishes to have made part of the record."

The Panel finds that evidence of Dr. Basco's prior disciplinary history was probative for deciding a sanction. The Board's regulations specifically list prior disciplinary history as an

aggravating factor that should be considered by a Panel. COMAR 10.32.02.09B(6)(a) ("Aggravating factors may include[:] . . . [t]he offender has a previous . . . administrative disciplinary history[.]"). The Panel, therefore, rejects Dr. Basco's assertion that this evidence was not probative. Because the evidence of prior discipline was probative, the ALJ appropriately admitted the evidence. State Gov't § 10-213(b).

Dr. Basco argues that evidence of his prior disciplinary history was irrelevant to the charges and placed Dr. Basco in a bad light.[1] Here, the admission of prior disciplinary history did not prejudice the ALJ because the prior discipline was only considered for sanctioning purposes and not to prove the underlying claims. *See* ALJ's Proposed Decision at 47-48. The ALJ's proposed decision does not discuss, allude to, or consider the prior discipline for any reason other than determining the appropriate sanction.

Dr. Basco implies that the evidence is prejudicial because the ALJ would not be able to separate the prejudicial nature of the documents from the proper purpose of considering a sanction. But, "[i]t is well settled that a legally trained judge, unlike a lay jury, is capable of compartmentalizing his thinking and of preventing knowledge which might inflame a jury from influencing his own decisions." *Ehrlich v. State,* 42 Md. App. 730, 739–40 (1979) (citing *State v. Hutchinson*, 260 Md. 227 (1970)). "[I]t is clear that we have consistently reposed our confidence in a trial judge's ability to rule on questions of admissibility of evidence and to then assume the role of trier of fact without having carried over to his factual deliberations a prejudice on the matters contained in the evidence which he may have excluded." *Graves v. State*, 298 Md.

[1] Dr. Basco also challenges the ALJ's proposed decision because the ALJ failed to consider Dr. Basco's disciplinary history when evaluating whether he had similar allegations in the past. Panel A cannot reconcile Dr. Basco's objection to the Board admitting such information with his objection to failing to consider such information. The Panel only considered this discipline in ruling on whether to adopt the ALJ's proposed sanction.

542, 547 (1984) (quoting *State v. Hutchinson*, 260 Md. 227, 236 (1970)). Compartmentalization, that is, "I may know something for certain purposes, but I don't know it for other purposes," is considered "[m]other's milk" for judges, and "[w]e trust the judge to compartmentalize." *Polk v. State*, 183 Md. App. 299, 306-07 (2008). Both the ALJ and the Panel have the expertise to compartmentalize the determinations of underlying culpability and the sanction.

Dr. Basco also objected to the admission of the evidence of prior discipline because he claims it was repetitious. In other words, there were three underlying original cases that resulted in multiple reciprocal actions by other jurisdictions. The ALJ acknowledged the repetition, noting in her proposed decision that "[t]he majority of sanctions imposed upon the Respondent by various jurisdictions were due to reciprocity between jurisdictions, rather than a multiplicity of violations." ALJ Proposed Decision at 47. The Panel thus considers Dr. Basco's prior discipline with full awareness that exhibits 2-16 reflect three prior incidents that resulted in two disciplinary actions by the Board.

Dr. Basco also argues that the Panel should not consider prior consent orders because the orders "were settlement agreements and no party should be able to use settlements to prove liability for, or validity of, a charges in those actions." The Board's regulations do not limit consideration of prior discipline to non-consent orders, but instead includes all disciplinary actions. COMAR 10.32.02.09B(6)(a) ("Aggravating factors may include . . . [t]he offender has a previous criminal or administrative disciplinary history[.]"). Maryland courts have approved a health occupations board's consideration of prior consent orders as evidence of prior discipline in consideration of imposing incremental discipline when determining sanctions. *See Rosov v. Maryland State Bd. of Dental Examiners*, 163, Md. App. 98, 121 (2005). Dr. Basco's exception is denied.

II. Testimony Regarding the Use of a Chaperone - (Respondent Exception 2)

Dr. Basco claims that the ALJ ignored evidence that Dr. Basco consistently had a chaperone with him when examining patients. He cites seven witness statements to demonstrate that he consistently used a chaperone. Dr. Basco claims that the Panel should find that he used a chaperone and, therefore, was not alone in the room with Patient B, as she alleged.

Of Dr. Basco's seven witness statements, the majority do not support his claim that he used a chaperone. Two witness statements do not concern his use of a chaperone at all. Specifically, a former patient of Dr. Basco did not testify about Dr. Basco's use of a chaperone and the Acting Human Resources Director at his second employer, did not testify about Dr. Basco's use of a chaperone.

Physician A, Dr. Basco's former employer, discussed chaperones in his testimony, but did not verify that Dr. Basco used a chaperone. Rather, he testified that a team of people were *available* to Dr. Basco to serve as a chaperone.

Dr. Basco presented written statements from a medical assistant who worked with Dr. Basco at Physician A's office and a nurse co-worker at his second employer. The medical assistant stated that she never saw Dr. Basco enter a patient room without a chaperone. The nurse stated that she did not see Dr. Basco alone with a patient.

Two other witnesses who describe Dr. Basco's use of a chaperone were Employee C, a receptionist/assistant at the Physician A's office, and Employee D, a nurse midwife at Physician A's office. These witnesses also testified about the specific day at issue regarding Patient B. The ALJ deemed these witnesses' statements to be "questionable, if not overtly false." Employee D testified that she herself was the chaperone for Dr. Basco and Patient B on June 18, 2012. This testimony was untrue. Employee D's testimony was contradicted by rebuttal

witnesses, who presented convincing evidence that Employee D was out of the office on June 18, 2012. Accordingly, the Panel does not find Employee D's testimony regarding Dr. Basco's use of a chaperone credible. Employee C testified that Patient B was rushed and angry when she departed from the office. The ALJ deemed this to be unlikely and thus, the ALJ did not find her testimony credible. The Panel adopts the ALJ's credibility determination regarding Employee C.[2]

Patient B testified that Dr. Basco touched her breasts and back and lowered her pants to reveal her buttocks. The ALJ found Patient B's demeanor supported her testimony. The ALJ found that Patient B's testimony was sincere, specific, consistent, straightforward, and steady. The Panel accepts the ALJ's credibility determination of Patient B.

In contrast, the ALJ found that Dr. Basco's testimony describing their encounter was "embellished, exaggerated, and dramatized as to diminish his credibility." ALJ Proposed Decision at 42. The ALJ rejected Dr. Basco's suggestions about Patient B's motives for lying. The Panel also rejects this claim. In sum, the ALJ questioned Dr. Basco's interpretation of events and declared his version of events flimsy and rebutted. The Panel accepts this finding.

After considering the witness statements and testimony presented by Dr. Basco regarding his practice of using a chaperone and the direct testimony of Dr. Basco, Patient B, Employee C, and Employee D about the June 18, 2012 examination of Patient B, the Panel concludes that the ALJ correctly determined that Dr. Basco sexually touched Patient B.

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[2] Dr. Basco also argues that the ALJ should have considered Dr. Basco's prior disciplinary history as proof of his use of a chaperone. As mentioned previously, however, Dr. Basco had argued the opposite, that the ALJ should not have admitted Dr. Basco's prior discipline at all. The Panel agreed with the ALJ's use of the prior discipline in this case only for purposes of considering a sanction.

III. Investigator's and Physician A's Statements – (Respondent's Exception 3)

Dr. Basco argues that the ALJ erred by failing to consider testimony of Physician A or the investigator that he hired related to the investigation conducted regarding the allegations of Patient B. Physician A hired an attorney to investigate Patient B's complaint. The investigator reviewed Patient B's written complaint and interviewed Dr. Basco over the telephone. The investigator did not interview Patient B. The investigator did not attempt to locate or identify the chaperone that Dr. Basco claimed was present at the appointment, nor did he interview any chaperone. Physician A and the investigator concluded that Dr. Basco did not engage in the conduct alleged by Patient B. The investigator testified at the hearing before the ALJ about Dr. Basco's denial of Patient B's allegations. Dr. Basco asks the Panel to consider the conclusions of these witnesses and reject the conclusions of the ALJ. The Panel denies this request.

Dr. Basco suggests that the ALJ should have relied on the investigator's investigation and adopted his conclusion, and, by implication, discounted her own credibility determinations. In contrast to the investigator's phone interview with Dr. Basco, the testimony heard by the ALJ was in-person and under oath. The ALJ observed testimony from each of the persons who claimed to be present: Patient B, Dr. Basco, and the alleged chaperone, Employee D. The Panel rejects Dr. Basco's suggestion that the ALJ should have disregarded her own impressions of the live testimony and instead should have substituted the investigator's second-hand impressions.

In addition, Maryland law does not permit opinion testimony on the credibility of other witnesses. *Riggins v. State*, 155 Md. App. 181, 206 (2004). "It is the settled law of this State that a witness, expert or otherwise, may not give an opinion on whether he believes a witness is telling the truth. Testimony from a witness relating to the credibility of another witness is to be rejected as a matter of law." *Bohnert v. State*, 312 Md. 266, 278 (1988). "Whether a witness on

the stand personally believes or disbelieves testimony of a previous witness is irrelevant, and questions to that effect are improper, either on direct or cross-examination." *Id.* at 277. In his exceptions, Dr. Basco highlights in bold and underlines the sections of the investigator's testimony related to whether he believed Dr. Basco was telling the truth and the reasons for that belief. The Panel finds this evidence improper witness bolstering and gives it little weight.

Dr. Basco also asks the Panel to find that Physician A was correct when he concluded that there was no "concrete evidence" of sexual misconduct by Dr. Basco. According to State Gov't § 10-213(d), the Panel may exclude evidence that is incompetent, irrelevant or immaterial. Generally, opinions by lay witnesses are "limited to those opinions or inferences which are (1) rationally based on the perception of the witness and (2) helpful to a clear understanding of the witness's testimony or the determination of a fact in issue." Md. Rule 5-701. Crucially, the admissibility is premised on the fact that it is "derived from first-hand knowledge." *Robinson v. State*, 348 Md. 104, 118 (1997). Lay opinion based on information learned from third parties rather than first-hand knowledge is generally inadmissible. *Smith v. State*, 182 Md. App. 444, 491 (2008). In *Smith*, the Court of Special Appeals found that a detective was not permitted to offer an opinion based on the hearsay statements of the witnesses rather than first-hand knowledge. Physician A's opinion about sufficiency of the evidence against Dr. Basco was based on the investigator's oral report relaying his interview with Dr. Basco, not based on Physician A's first-hand knowledge. The Panel declines to give Physician A's opinion any weight and concludes that the ALJ properly decided not to adopt Physician A's opinion.

IV. Adequacy of the Charges – (Respondent's Exception 4)

Dr. Basco claims that the ALJ committed error because she failed to find that the Board's investigation was incomplete and inadequate to support the charges. The adequacy of the

investigation was not an issue before the ALJ and is not an issue before the Panel. The Panel, like the ALJ, makes its determination of factual findings and conclusions of law regarding Dr. Basco's alleged unprofessional conduct and sexual misconduct based on the testimony of witnesses and admission of exhibits at the OAH hearing.

V. State's Exceptions

The State argues that the Panel should reject the ALJ's conclusion that there was insufficient evidence to find that Dr. Basco sexually violated Patient A. The Panel declines to do so. The Panel adopts the ALJ's finding that there is insufficient evidence to prove sexual misconduct because Patient A was under the anesthetic Ketamine when the sexual abuse was alleged. The State also argues that Dr. Basco's outburst related to Employee B was unprofessional conduct. The Board adopts the ALJ's finding that this outburst was not unprofessional conduct in the practice of medicine.

CONCLUSIONS OF LAW

The Panel concludes that Dr. Basco is guilty of unprofessional conduct in the practice of medicine in violation of § 14-404(a)(3)(ii) of the Health Occupations Article based on his inappropriate sexual touching of Patient B and his putting ice down Employee A's pants. The Panel also concludes that Dr. Basco's conduct related to Patient B was sexual misconduct in violation of COMAR 10.32.17.03. The Panel concludes that Dr. Basco's conduct related to Patient A, Employee B, and Employee C does not constitute unprofessional conduct in the practice of medicine.

SANCTION

The Panel has considered Dr. Basco's current sexual violation committed against Patient B and the unprofessional conduct related to the ice incident with Employee A. The Panel also has considered Dr. Basco's prior Maryland disciplinary history including (1) a reciprocal action

based on a medical recordkeeping violation and (2) a nine month suspension followed by eighteen months probation with terms and conditions based on unprofessional conduct in the practice of medicine, failing to meet the standard of care, failing to keep adequate medical records, and practicing medicine with an unauthorized person. The Panel declines to assign any weight to Exhibits 2 and 3 because these disciplinary actions by other states occurred outside of Maryland, over 12 years ago, and prior to Dr. Basco's receiving his Maryland license. The Panel adopts the sanction recommended by the ALJ with modifications. The Panel will suspend Dr. Basco's license for six months followed by one year of probation. The Panel will also require Dr. Basco to be evaluated through the Maryland Professional Rehabilitation Program (the "MPRP"), and, if necessary to be enrolled in the MPRP for monitored treatment. In addition, the Panel will require that Dr. Basco take an ethics course focused on boundary issues.

ORDER

It is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that fifteen days after the date of this Order, the license of Michael A. Basco, M.D. is **SUSPENDED** for a minimum of **SIX MONTHS** and until Dr. Basco has fully satisfactorily complied with the following requirements:

1. Dr. Basco shall complete an ethics course pertaining to sexual boundary violations. Dr. Basco shall submit to the Board written documentation regarding the particular course he proposes to fulfill this condition. The Board reserves the right to require Dr. Basco to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of alternative proposals. The Board will approve a course only if it deems the curriculum and the duration of the course adequate to fulfill Dr. Basco's education needs. The course may not be used to fulfill continuing medical education credits required for license renewal. Dr. Basco shall be responsible for all costs incurred in fulfilling the course requirements and for submitting written documentation to the Board of his successful completion of the course;

2. Within fifteen days, Dr. Basco shall enroll in the Maryland Professional

Rehabilitation Program ("MPRP") for evaluation and, if necessary, treatment;

3. Once enrolled in the MPRP, Dr. Basco shall undergo an evaluation by the MPRP or its agents to determine whether Dr. Basco is able to appropriately manage his behavior with regard to his interactions staff and patients professionally, and what conditions, if any, are appropriate for his return to practice;

4. Dr. Basco shall fully cooperate in the evaluation and, if necessary, treatment, including complying with all of the MPRP's recommendations. Dr. Basco shall provide the MPRP with all records and information requested by the MPRP, and Dr. Basco shall sign any written release/consent forms to ensure that the MPRP is able to obtain all records and information including treatment information and mental health records and information, necessary for complete and thorough evaluation and treatment;

5. Should the MPRP recommend it, Dr. Basco may be required to enter into a Board-monitored Participant Rehabilitation Agreement. Dr. Basco shall fully and timely cooperate and comply with all the MPRP recommendations, referrals, rules, and requirements including, but not limited to, the terms and conditions of any Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered into with the MPRP, including any treatment and evaluations recommended by the MPRP;

6. Dr. Basco shall sign any written release/consent forms, and update them, as required by the Panel and the MPRP. Specifically, Dr. Basco shall sign any written release/consent forms required by the Panel to authorize the MPRP to make verbal and written disclosures to the Panel, including disclosure of any and all MPRP records and files.

IT IS FURTHER ORDERED that once the MPRP completes its evaluation, the Panel will review the evaluation and meet with Dr. Basco and the administrative prosecutor. The Panel will then determine whether to terminate the suspension based on whether Dr. Basco presents a risk to patient safety; and it is further

ORDERED that if the Panel declines to terminate the suspension, then Dr. Basco shall continue treatment with the MPRP until such time that the Panel determines that he is not a risk to patient safety; and it is further

ORDERED that if the Panel votes to terminate the suspension, the Panel will determine appropriate probationary terms and conditions, if any, to be imposed; and it is further;

ORDERED that when the Panel votes to terminate the suspension of Dr. Basco's license, Dr. Basco shall be placed on **PROBATION** for a minimum of one year from the date of the termination of the suspension and Dr. Basco shall fully, timely, and satisfactorily cooperate and comply with all terms and conditions imposed by the disciplinary panel upon termination of Dr. Basco's suspension; and it is further

ORDERED that if Dr. Basco fails to comply with any condition of the suspension, probation, or this Final Decision and Order, the Board or Disciplinary Panel, after notice and an opportunity to be heard, may impose any sanction which the Board or Panel may have imposed in this case under section 14-404(a) or 14-405.1 of the Health Occupations Article, including additional probation, a reprimand, suspension, revocation, or a civil monetary penalty; and it is further

ORDERED that after one year from the date of his commencement of his probation, Dr. Basco may submit a written petition to the Board requesting termination of the probation. After consideration of the petition, the probation may be terminated through an order of Disciplinary Panel A. Disciplinary Panel A will grant the termination if Dr. Basco has fully and satisfactorily complied with all of the terms of probation; and it is further

ORDERED that Dr. Basco is responsible for any costs incurred in fulfilling the terms of this Order; and it is further

ORDERED that this is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014).

12/30/15
Date

Ellen Douglas Smith, Deputy Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Basco has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Basco files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

MARYLAND STATE BOARD OF PHYSICIANS	*	BEFORE HARRIET C. HELFAND,
	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
MICHAEL A. BASCO, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: DHMH-MBP-71-15-04194
LICENSE No.: D72935	*	MBP No: 2014-0045

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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 September 29, 2014, a disciplinary panel of the Maryland State Board of Physicians (Board or MBP) issued Charges against Michael A. Basco, M.D., (Respondent) for alleged acts in violation of the Medical Practices Act (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 Prosecutions and Litigation Division (HOPL), Office of the Attorney General, State of Maryland (State) for prosecution.

On February 6, 2015, the matter was transmitted to the Office of Administrative Hearings (OAH) for a hearing. Md. Code Ann., Health Occ. § 14-405 (2014). On March 4, 2015, I conducted a Prehearing Conference at the OAH in Hunt Valley, Maryland. Robert J. Gilbert, Deputy Counsel, HOPL, Administrative Prosecutor, represented the State, and Thomas L. Doran,

Esquire, represented the Respondent. On March 9, 2015, I issued a Prehearing Conference Report and Scheduling Order.

On March 23, 2015, the Respondent filed a Motion *in Limine* (Motion), requesting that I exclude a number of items on the State's exhibit list, and any evidence regarding prior disciplinary actions against the Respondent. As a result of the filing of the Motion, I convened a telephone prehearing conference with counsel to discuss scheduling responses to the Motion and converting an upcoming hearing date initially planned for the merits to a hearing on the Motion. Following the discussion and scheduling changes, on April 13, 2015, the State filed an Opposition to the Respondent's Motion, and on April 20, 2015, the Respondent filed a Reply Memorandum in support of the Motion. On April 28, 2015, I conducted a hearing on the Motion at the OAH. On May 8, 2015, I issued a ruling on the Motion.

From June 1, 2015 through June 10, 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. Doran 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 exhibits into evidence on behalf of the State:

State #1	MBP Practitioner Profile System-Respondent's Licensing Information
State #2	Agreed Order, Texas State Board of Medical Examiners, dated August 15, 2003
State #3	Consent Agreement and Order, Commonwealth of Pennsylvania, State Board of Medicine, dated October 10, 2004
State #4	Agreed Order, Texas Medical Board, dated August 26, 2011
State #5	Final Order Adopting Hearing Examiner's Adjudication and Order, Commonwealth of Pennsylvania, State Board of Medicine, dated August 31, 2012
State #6	Consent Order, MBP, dated November 20, 2012
State #7	Order for Summary Suspension of License to Practice Medicine, MBP, dated May 29, 2013
State #8	Letter from MBP to Respondent, dated June 12, 2013
State #9	Notice of Out-of-State Suspension Order, Medical Board of California, dated June 20, 2013
State #10	Notice of Summary Action to Suspend License, District of Columbia Department of Health, Board of Medicine, dated July 10, 2013
State #11	Consent Order, MBP, dated February 28, 2014
State #12	Termination of Out-of-State Suspension Order, Medical Board of California, dated April 8, 2014
State #13	Agreed Order, Texas Medical Board, dated June 27, 2014
State #14	Decision and Order, Medical Board of California, dated August 27, 2014
State #15	Consent Order, District of Columbia Board of Medicine, dated July 10, 2014
State #16	Corrected Final Order Adopting Hearing Examiner's Adjudication and Order, dated November 14, 2014

State #17	Complaint Form, MBP, received April 18, 2013
State #18	Transcript, Telephonic Interview with [redacted] (Patient A), dated May 28, 2013
State #19	Cheverly Police Department, Incident Report, dated April 11, 2013
State #20	Interview with [redacted], dated August 20, 2013
State #21	Medical Records, Patient A, received May 23, 2013
State #22	Letter from Respondent to Dana Mullen, Compliance Analyst, MBP, dated May 22, 2013
State #23	Letter from [redacted] to Respondent, dated August 24, 2012
State #24	Medical Records- [redacted] (Patient B)[1]
State #25	Letter from [redacted], Esquire, to Dr. [redacted], dated October 31, 2012; letter To Whom it May Concern from Patient B, dated August 1, 2012; Statement from [redacted] dated August 15, 2012; Statement from [redacted] dated August 15, 2012[2]
State #26	Transcript of Interview with [redacted], dated December 19, 2013
State #27	Transcript of Interview with [redacted], dated December 19, 2013
State #28	Transcript of Interview with Patient B, dated December 20, 2013
State #29	Transcript of Interview with Dr. [redacted], dated January 16, 2014
State #30	Transcript of Interview with Respondent, dated March 18, 2014
State #31	Memorandum of Telephone Interview with [redacted] dated April 9, 2014
State #32	Letter from Dana Mullen, Compliance Analyst, MBP, to Donovan Dietrick, M.D., dated April 23, 2014, with attached Focus of Review, dated April 23, 2014
State #33	*Curriculum Vitae*, Donovan Dietrick, M.D.

[1] Patient B is also known as [redacted]

[2] A copy of these documents was accompanied by a fax sheet, dated November 6, 2013, from [redacted], of Dr, [redacted] office, to Dana Mullen, MBP investigator.

State #34	Letter from Donovan Dietrick, M.D., to Dana Mullen, Compliance Analyst, MBP, dated May 16, 2014 (parts redacted)
State #35	MBP Report of Investigation, undated
State #36	American Medical Association Opinion 9.045—Physicians with Disruptive Behavior, issued December 2000
State #37	The Joint Commission Sentinel Event Alert, Issue 40, July 9, 2008—Behaviors that undermine a culture of safety
State #38	Charges Under the Act, dated September 29, 2014
State #39	(not offered)[3]
State #40	Letter from [redacted] to Dr. [redacted], undated
State #41	(not offered)
State #42	Cease and Desist Order, MBP Case Nos: 2007-0448; 2010-0304; and 2011-0117
State #43	State of New Jersey, Department of Law & Public Safety, Division of Consumer Affairs, State Board of Medical Examiners—In the matter of the Suspension or Revocation of the License of: [redacted] M.D., Final Order, filed November 12, 2014
State #44	(not admitted)
State #45	Leave Request Form, dated June 1, 2012
State #46	Letter from [redacted] Esquire, to [redacted], CNM, dated October 31, 2012
State #47	Spread Sheet, Billing Information, June 13-20, 2012

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

Resp. #1	(not offered)[4]

[3] State #39 was not offered into evidence and was not included in the case materials; State #41 was not offered, but is included in the case file and so labeled; and State #44 was not admitted, but is included in the case file and so labeled.

[4] Resp. #1 was not offered into evidence, but was included in the case materials and is labeled as such; Resp. #8 was withdrawn from evidence and is not included in the case materials; Resp. ## 16, 18, and 19 were not offered and are not included in the case materials.

Resp. #2	Letter from [redacted] Acting Human Resources Manager, [redacted], to MBP, dated March 19, 2015
Resp. #3	Affidavit of [redacted] M.D., dated May 31, 2015, with attached statement, undated
Resp. #4	Statement of [redacted] undated
Resp. #5	Statement of [redacted] undated
Resp. #6	Statement of [redacted] dated January 6, 2014
Resp. #7	Letter from [redacted] to MBP, dated September 25, 2014; Statement of [redacted] faxed November 11, 2014
Resp. #8	(withdrawn)
Resp. #9	Letter from [redacted] To Whom It May Concern, dated April 15, 2015
Resp. #10	Letter from Steven J. Adashek, M.D., FACOG, To Whom It May Concern, dated April 16, 2015 (with redactions)
Resp. #11	*Curriculum Vitae*, Steven J. Adashek, M.D., FACOG
Resp. #12	Medical Records, Patient A
Resp. #13	Medical Records, Patient B
Resp. #14	Medical Records, Patient B
Resp. #15	Respondent's *Curriculum Vitae*
Resp. #16	(not offered)
Resp. #17	Medical Records, Patient B
Resp. #18	(not offered)
Resp. #19	(not offered)
Resp. # 20	Diagram

Testimony

The State presented the following witnesses:

Patient A

Dana Mullen, Compliance Analyst, MBP

[redacted][5]

[redacted][6]

[redacted] M.D.

Donovan Dietrick, M.D., who was accepted as an expert in Obstetrics and Gynecology (Ob/Gyn)

[redacted]

The Respondent testified in his own behalf, and presented the following witnesses:

[redacted][8]

[redacted] M.D.

Steven J. Adashek, M.D., who was accepted as an expert in Ob/Gyn.

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[5] Ms. [redacted] testified at OAH on June 2, 2015, and testified as a rebuttal witness by telephone on June 8, 2015.
[6] [redacted] testified at OAH on June 2, 2015, and testified as a rebuttal witness by telephone on June 8, 2015.
[7] Ms. [redacted] testified as a rebuttal witness by telephone.
[8] Ms. [redacted] Ms. [redacted] and Dr. [redacted] testified by telephone.

PROPOSED FINDINGS OF FACT

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

Background Information

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 August 11, 2011, under License No. D72935.

2. In addition to licensure in Maryland, the Respondent practiced medicine and/or was licensed to practice medicine in Texas, California, Pennsylvania, Virginia, and the District of Columbia.

3. The Respondent is board certified in Ob/Gyn.

4. Since October 2013, the Respondent has worked as a computer medical healthcare consultant and product manager in the field of Medical Informatics. In his current position, although he no longer engages in a clinical medical practice, the Respondent requires a medical license to take an exam to become board certified in Medical Informatics.

Respondent's Employment in Dr. [redacted]'s Office

5. Dr. [redacted] is a physician with an office in Waldorf, Maryland, specializing in Ob/Gyn. Dr. [redacted] is board eligible, but not board certified.

6. On or about December 15, 2011, the Respondent began working in Dr. [redacted]'s medical practice. Dr. [redacted] wanted to expand his practice and open an ambulatory surgery center. Both the Respondent and Dr. [redacted] had privileges at [redacted] to perform surgery and deliveries. Dr. [redacted] also

employed [redacted][9] as a Certified Nurse Midwife (CNM), but Ms. [redacted] was not eligible for privileges at [redacted] and was restricted to seeing patients in the office.

7. In addition to the Respondent and Ms. [redacted], Dr. [redacted] also employed office staff for administrative and medical support duties. [redacted], the office manager, performed scheduling and some billing functions, in addition to other office administrative work. A number of medical assistants also worked in the office to assist the physicians and Ms. [redacted] with patient care.

8. Dr. [redacted]'s office had an unwritten policy of requiring that a chaperone accompany a physician performing an examination of a patient. When the Respondent arrived at the practice, he instituted the assignment of certain medical assistants to accompany each physician. When a particular medical assistant was not available, a physician could recruit any other member of the office staff to chaperone an examination.

9. Office notes and records in the practice identify which provider saw a particular patient, but do not identify whether a chaperone was present, or who served as a chaperone.

10. Dr. [redacted]'s office contained a break room where employees could eat lunch and socialize. In the break room, employees frequently engaged in outlandish behavior, telling off-color jokes and performing lewd dances and movements. One employee in particular, [redacted], a medical assistant, was often at the forefront of the action.

11. Dr. [redacted]'s office was generally not run in a financially responsible manner and was not adept in the use of advanced electronic medical records. In some cases, bills for materials and tax obligations were left unpaid.

[9] Ms. [redacted] was also known as [redacted]

"Ice" Incident

12. On August 14, 2012, the Respondent was sitting in the break room, holding a cup of ice. Ms. [redacted] along with [redacted] and [redacted], other medical assistants, was also in the room with the Respondent. The employees had been joking.

13. At one point, Ms. [redacted] while speaking on a phone, bent over a refrigerator in the break room to store an item. Ms. [redacted]'s posterior was close to the Respondent, and the Respondent, who was leaning back in his chair and laughing, impulsively took a piece of ice from his mouth and, extending the waistband of Ms. [redacted]'s pants, placed the ice down her pants. Ms. [redacted] left the room.

14. Following the incident, Ms. [redacted] and Ms. [redacted] reported their observations to Ms. [redacted] who asked them to document the incident in writing. Ms. [redacted] also spoke to Ms. [redacted] about the matter.

"Desk" Incident

15. Sometime in 2012, the Respondent entered Ms. [redacted]'s office while she was speaking with Ms. [redacted].[10] The Respondent was extremely upset about an office matter. He shut the door and began to yell and curse, shook Ms. [redacted]'s desk loudly, and kicked the wall. The Respondent was not directing his anger directly towards either Ms. [redacted] or Ms. [redacted]

16. Ms. [redacted] was startled by the Respondent's behavior, and left the office for the day. The Respondent later apologized to Ms. [redacted] for his outburst. Ms. [redacted] accepted the Respondent's apology.

[10] None of the witnesses were able to provide an exact date for the "desk" incident.

Patient B

17. Patient B was a twenty-seven year old (date of birth: April 10, 1985) obstetrical patient at the office who primarily saw Ms. [redacted] as her medical practitioner.

18. On March 6, 2012, during Patient B's initial prenatal visit to Dr. [redacted]'s office, she answered questions on a form entitled "Maryland Prenatal Risk Assessment" (MPRA). The MPRA recorded information about Patient B, including education, languages spoken, payment status, obstetrical history and any psychosocial or medical risks. On the MPRA, Patient B indicated that during the past six months she had used marijuana.

19. On or about April 3, 2012, Patient B was admitted to [redacted], having experienced extreme nausea in the course of her pregnancy. At admission, Patient B was diagnosed with Hypokalemia, Severe Anemia, Dehydration, and Hyperemesis Gravidarum. Patient B's admitting physician was the Respondent. On admission, Patient B denied marijuana use.

20. At [redacted], Patient B was treated with intravenous hydration, Zofran (for nausea), and Potassium. Patient B was discharged from [redacted] on April 6, 2012, but returned home with a peripherally inserted central catheter (PICC line) to continue the administration of medication. Patient B's PICC line was removed on or about April 26, 2012.

21. On April 10, 2012, Patient B returned to the practice for an office visit and was seen by Ms. [redacted] At this time, Patient B was feeling much better on the Zofran, with no nausea or vomiting.

22. During Patient B's next office visit, on May 9, 2012, when she was seen by Dr. [redacted], she was sent for several tests, including a drug test to detect cannabinoid use. The test results, received on May 14, 2012, were positive for cannabinoid.

23. Patient B's next two visits, on May 18 and 30, 2012, with Dr. [redacted] and Ms. [redacted] respectively, were uneventful.[11]

24. On June 18, 2012, Patient B returned to the office for a routine visit and was seen by the Respondent. On this day, Ms. [redacted] was out of the office on leave. This was Patient B's first office visit with the Respondent. Patient B's weight, body mass index and blood pressure were measured by Ms. [redacted] at the beginning of the visit. Ms. [redacted] did not remain in the examining room as a chaperone.

25. During his examination of Patient B, the Respondent directed and assisted Patient B in lifting her shirt and placed a stethoscope on her chest. In the process, the Respondent handled Patient B's breasts. The Respondent also lifted Patient B down from the examining table and had her face away from him, standing, as he lowered her pants, felt her spine in several places and made a remark about her appearance.

26. During the visit, the Respondent discussed the May 9, 2012 cannabis positive drug test with Patient B and warned her that if she had another positive cannabis result, she would be discharged from the practice.

27. Patient B quickly left the office, appearing angry and upset, without making arrangements for a routine two-week follow-up visit or for taking a planned glucose tolerance test (GTT).

[11] Office notes indicate that when Dr. [redacted] received Patient B's lab results on May 14, 2012, he wrote "Pls. instruct pt. to stop smoking marijuana!" The note also indicates that Ms. [redacted] delivered the message to Patient B on May 15, 2012. (Resp. #17)

28. Patient B did not return to the office until August 1, 2012, when she was seen by Ms. [redacted]. Ms. [redacted] asked Patient B why she waited so long to schedule her appointment and chided her for the lapse in care. At the visit, Ms. [redacted] ordered several tests, including the GTT.

29. When Patient B stopped by the reception desk to schedule her next appointment, the receptionist informed her that she would be next seen by the Respondent. Patient B told the receptionist that she refused to be examined by the Respondent, and proceeded to explain her reasons. At that time, the receptionist suggested that Patient B write down the information Patient B was verbally conveying to her.

30. Patient B proceeded to sit in the office lobby area and write a letter directed" To whom it may concern," dated August 1, 2012, in which she described, in great detail, her recollection of events that occurred during her June 18, 2012 office visit with the Respondent. Patient B's letter included the following:

> On June 18, 2012 I was for the first time a patient of [the Respondent] at 27 weeks pregnant. [The Respondent] did his entire examination WITHOUT a nurse present assisting him. During this examination [the Respondent] insisted that he check my vitals with a stethoscope and asked me to lift my shirt. As I began to lift my shirt he assisted me lifting my shirt above my breast. He then told me that he needed to get underneath my breast with the stethoscope so I myself lifted my breast for him to do so. He then told me he needed me to remove my breast from my bra in order to do the exam efficiently. I removed my breast from the bra but still continued to hold my breast myself without exposing my nipple. He then moved my hand from my breast and grabbed my breast with his own hand saying to me "It's okay, I can do it." He then proceeded to move the stethoscope from one side of my ribcage under my breast to the other while he very inappropriately fondled my breast. He then repeated these actions on my other breast. When he finished I proceeded to pull my shirt down he again moved my hands and said "I got it" and pulled my shirt down covering my breast and stomach. He then lifted me by my sides off the exam table and asked me to stand with my back facing him as he sat in the short rolling doctor's chair. He then began to press on my lower back with his thumbs. After pressing

about two times on each side of my spine, he pulled my pants down exposing only my buttocks. He then continued to press on my lower back apx 3-4 more times. He then pulled my pants back up. As I turned around to face him he remarked "you look cute and everything is fine." (emphasis in original) (State #25 and Resp. #17)

The letter went on to explain that, as a result of the Respondent's actions, Patient B did not complete her testing, and did not return to the office until her August 1, 2012 appointment.

31. After writing the letter, Patient B hand-delivered it to Ms. [redacted].

32. Patient B continued to be seen at the practice until her child was born on September 9, 2012, but was only seen by Dr. [redacted] or Ms. [redacted]. During one of her August 2012 prenatal visits, Patient B informed Dr. [redacted] that she had consulted an attorney and was contemplating legal action on account of what she described as the Respondent's actions on June 18, 2012.

33. On August 24, 2012, Dr. [redacted] wrote a letter to the Respondent, informing the Respondent that, due to Patient B's allegations, Dr. [redacted] would be conducting an investigation and advised the Respondent that his employment was suspended without pay, until further notice. Dr. [redacted] directed the Respondent that he should not return to the office or have contact with office employees, with the exception of Ms. [redacted] whom he should contact by email, if necessary.[12]

34. On or about August 31, 2012, the Respondent resigned from the practice.

35. On October 31, 2012, [redacted] Esquire, sent letters to Dr. [redacted] Ms. [redacted] and the Respondent, informing them that he was representing Patient B with

[12] Prior to writing this letter, Dr. [redacted] had engaged attorneys [redacted] and [redacted] to advise him on office policies and the development of an office employees' handbook. In the August 24, 2012 letter, Dr. [redacted] advised the Respondent that Mr. [redacted] would also be conducting an investigation of Patient B's allegations, and that the Respondent could also contact Mr. [redacted] or Ms. [redacted] by email.

respect to her claims regarding her treatment on June 18, 2012. In the letter, Mr. [redacted] stated that Patient B demanded payment of $125,000.00 in order to resolve her claims against the practice.

36. Patient B never filed a lawsuit against Dr. [redacted] Ms. [redacted] or the Respondent.

Respondent's Employment at [redacted]

37. In September 2012, the Respondent began working for [redacted] which provided gynecological services, including surgical and medical abortions, in outpatient surgery centers. [redacted] operated offices and surgery centers in Baltimore, Maryland; Cheverly, Maryland; Frederick, Maryland; Silver Spring, Maryland; and Fairfax, Virginia. The Respondent worked in all of [redacted]'s offices.

38. A surgical abortion conducted early in a pregnancy is generally in the form of dilatation and curettage (D & C). In a D & C, a speculum is inserted to expand the patient's vagina to facilitate the insertion of successively wider dilators to dilate the patient's cervix. A tenaculum, or clamp, is used to keep the area open, while a cannula, attached to a suction machine, is inserted through the cervix to the uterus and rotated through and around the organ, to collect and expel tissue containing the products of conception.

39. Following a D & C, the contents collected through the cannula are examined to ensure that the procedure has been successful and that all remnants of conception have been removed.[13]

[13] Another term used by witnesses for very early products of conception, including placental tissue, was "villi."

40. Most surgical abortions include various types of anesthesia to relieve pain and/or place the patient in a "twilight" state during the procedure. The forms of anesthesia can include intravenous or topical applications.

41. A medical abortion involves ingestion of a medication to cause the uterus to contract and expel the products of conception.

Patient A

42. Patient A was thirty-four years old (date of birth: November 23, 1978) at the time she was a patient at [redacted].

43. On April 10, 2013, Patient A came to [redacted] to terminate a 6.2-week pregnancy by a D & C. On that day, Patient A arrived at [redacted] around 8:30 a.m., accompanied by her partner, [redacted].

44. Because Patient A wanted to avoid pain during the procedure, she agreed to the administration of anesthesia to produce a twilight state in which she would not feel pain or retain a precise memory of the procedure.

45. Prior to the D & C, Patient A was prepped with a sonogram, urine sample and blood test, and she filled out paperwork.

46. At approximately 11:00 a.m., Patient A was taken to a treatment room, where [redacted], a medical assistant, was present. Ms. [redacted] proceeded to assist Patient A onto a table and place her feet into stirrups. Ms. [redacted] also placed a drape over Patient A, who had undressed herself.

47. At this point, the Respondent entered the room, and, after a brief discussion, intravenously administered 2mg of Midazolam and 25mg of Ketamine to Patient A.

48. Midazolam is a benzodiazepine medication, which reduces anxiety and is used as a short-term amnestic agent.[14] Patients who are administered Midazolam generally retain no memory of a procedure performed under the medication.

49. Ketamine can create a dreamlike state, and can also cause vivid hallucinations. Midazolam is frequently used in combination with Ketamine to mitigate some of the unpleasant effects of Ketamine.

50. Patients administered a combination of Midazolam and Ketamine are not rendered completely unconscious, and are considered partially awake. The purpose of the medication is to create a sedated effect, with minimal pain and no memory of the procedure.

51. After administering Midazolam and Ketamine to Patient A, the Respondent proceeded to perform the D & C. During the procedure, the Respondent explained his actions, step-by-step. At several points, Patient A complained of a feeling of "pressure." After extracting the material from the suction tube, the Respondent tasked Ms. [redacted] with taking the specimen to a room across the hall, called the "scrub room," to check for the products of conception.

52. Ms. [redacted] left the examination room. The Respondent remained in the examination room, standing by the open door.

53. Upon inspection, which included hydrating the specimen to better discern its contents, Ms. [redacted] determined that the specimen did not contain enough tissue to ensure that all of the products of conceptions had been extracted.

[14] Midazolam is also known as "Versed."

54. Because of the insufficiency of the first specimen, the Respondent performed the D & C a second time to extract more material to complete the abortion. During both D & C procedures, Patient A complained several times of pain and cramping.

55. Following the extraction, Ms. [redacted] again left the treatment room to examine the contents. The Respondent remained in the room with Patient A.

56. Again, although the second sample was greater and contained more blood, Ms. [redacted] reentered the room and reported that the contents still contained insufficient tissue to confirm a complete termination of Patient A's pregnancy.

57. As a result of the questionable termination, the Respondent administered Methotrexate, a medication to induce a medical termination of the pregnancy, to Patient A and gave her Misoprostol pills.[15] Because the Respondent was concerned that Patient A might have an ectopic pregnancy, he also counseled her to follow-up with her primary Ob/Gyn physician if she experienced pain.

58. After the medical procedures, at around 11:35 a.m., Patient A was taken to the recovery room, where her vital signs were taken and recorded by another [redacted] staff member. Following the last taking of her vital signs, at around 11:55 a.m., Patient A was discharged and left [redacted].

59. At some point shortly after Patient A's discharge, Ms. [redacted] noticed that Patient A still owed a $40.00 balance for the services performed. Ms. [redacted] called Patient A and left a message. Because the [redacted] telephones were not working properly, Ms. [redacted] used her cell phone and left a message with her cell phone number for Patient A.

60. Later that day, [redacted] returned to [redacted] to deliver the $40.00 balance. While speaking to Ms. [redacted] he handed her his cell phone to speak to Patient A. Patient A

[15] Methotrexate, which interferes with placental growth, and Misoprostol, which causes contractions, are given to induce a medical abortion, which, unlike a D & C, would also terminate an ectopic pregnancy.

asked Ms. [redacted] whether it was routine for the doctor to check her rectum during the procedure. Ms. [redacted] answered that it sounded odd, but suggested that Patient A speak to the Respondent or [redacted] management, since she wasn't certain.

61. Later that evening, Patient A called Ms. [redacted] Patient A expressed concern about her experience and related that the Respondent has placed his finger in her rectum and asked how it felt and whether she liked it. Ms. [redacted] advised Patient A to call the [redacted] corporate number with her complaint, and inform the authorities if she remained concerned.

62. Later that evening, Patient A called the [redacted] "1-800" corporate number and reported her description of the Respondent's actions.

63. On the next day, June 11, 2013, Patient A contacted the Prince George's County Police Department to report the incident, and was directed to the Cheverly Police Department. Officers from the Cheverly Police Department interviewed Patient A at her home and obtained a statement from her describing the incident. The Cheverly Police Department took no further action in the matter.

64. Ms. [redacted] spoke to her [redacted] manager, [redacted] about Patient A's accusation, but did not immediately discuss it with the Respondent. On several occasions following the incident, the Respondent stated to Ms. [redacted] that he believed he was never alone in the room with Patient A and appeared to seek affirmation from Ms. [redacted], which was not forthcoming. Thereafter, Ms. [redacted] avoided working with the Respondent at [redacted] when she could.

65. On or about May 9, 2013, for matters unrelated to Patient A, [redacted]'s Maryland offices were closed due to the suspension of its license by the Maryland Office of Health Care Quality (OHCQ) for violations of Maryland's surgical abortion facility regulations.

MBP's Investigation

66. On April 23, 2013, the Board received a complaint from Patient A regarding the Respondent's alleged actions on April 10, 2013.[16]

67. On May 10, 2013, MBP conducted an unannounced site visit at [redacted] to issue Subpoenas Duces Tecum and conduct interviews.[17]

68. On May 14, 2013, MBP wrote to the Respondent and requested an interview.

69. On May 28, 2013, Dana Mullen, MBP Compliance Analyst, interviewed Patient A.

70. On May 29, 2013, MBP sent the Respondent a notice for an interview on June 5, 2013.

71. On June 13, 2013, MBP sent subpoenas to the Cheverly Police Department for Patient A's police report and to [redacted] for Patient A's medical records. On July 11, 2013, MBP received Patient A's medical records and on August 16, 2013, MBP received the Cheverly Police Department report.

72. On August 20, 2013, Ms. Mullen interviewed Ms. [redacted], accompanied by Andrea Paskin, another MBP Compliance Analyst.

73. On or about July 23, 2013, the Board received an Adverse Action from [redacted] regarding discipline of the Respondent in another matter. During the course of its investigation of this action, MBP learned of Patient B's 2012 complaint to Dr. [redacted].

74. On October 10, 2013, MBP faxed a subpoena to Dr. [redacted]'s office for Patient B's medical records and for copies of any and all complaints received regarding the Respondent.

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[16] On July 20, 2013, the Board also received information from [redacted] later known as [redacted], regarding the Respondent. Any allegations received at that time are not part of the instant case.

[17] Although Ms. Mullen's report notes an interview with [redacted] at [redacted], a record of this interview was not included in the instant record.

75. On or about November 6, 2013, Ms. Mullen obtained Patient B's August 1, 2012 statement, as well as the letter from Mr. [redacted], from Dr. [redacted]'s office.

76. On December 16, 2013, Ms. Mullen, accompanied by Joshua J. Schafer, another MBP Compliance Analyst, telephonically interviewed Ms. [redacted] and, separately, Ms. [redacted] of Dr. [redacted]'s office staff.

77. On December 20, 2013, Ms. Mullen, accompanied by Mr. Schafer, telephonically interviewed Patient B.

78. On January 14, 2014, Ms. Mullen, accompanied by Mr. Schafer, telephonically interviewed Dr. [redacted]

79. On February 27, 2014, MBP sent a letter to the Respondent, scheduling an interview for March 18, 2014.

80. On March 18, 2014, Ms. Mullen, accompanied by Doreen Noppinger, another MBP Compliance Analyst, interviewed the Respondent.[18] At this time, the Respondent also submitted a written response to the Board's allegations.

81. On March 28, 2014, MBP sent the Respondent a subpoena for a list of names of individuals identified during his Board interview.

82. On March 31, 2014, MBP received a list of individuals who had resigned from Dr. [redacted]'s office.

83. On April 9, 2014, Ms. Mullen conducted a phone interview with [redacted] a former administrative employee of Dr. [redacted] who worked in the office during the Respondent's employment.[19]

[18] The Respondent's counsel, Mr. Doran, was also present during the interview.
[19] Unlike Ms. Mullen's other interviews, which were taken under oath and transcribed, the telephone interview with Ms. [redacted] was reported in a memorandum submitted by Ms. Mullen.

84. On April 23, 2014, Ms. Mullen wrote to Donovan Dietrick, M.D., who had agreed to conduct an expert review of material regarding the Respondent. Included in the letter was a Focus of Review, briefly describing MBP's investigation. The correspondence also included the following:

- Patient A's Complaint
- Response to Patient A's Complaint
- Patient A's transcribed interview
- Cheverly Police Department Report
- Respondent's June 5, 2013 transcribed interview
- Ms. [redacted]s transcribed interview
- Complaint from [redacted]
- Response to [redacted]omplaint
- Patient B's Complaint
- Ms. [redacted]s statement
- Dr. [redacted]'s transcribed interview
- Ms. [redacted]s transcribed interview
- Respondent's March 18, 2014 transcribed interview
- Respondent's [redacted]Quality Assurance file
- Memorandum of Ms. [redacted]'s interview
- Respondent's Summary of Care of Patient A
- Patient A's medical record (supplied by the Respondent)
- Patient B's medical record (supplied by Dr. [redacted]'s office

85. On May 16, 2014, Dr. Dietrick sent Ms. Mullen his review of the Respondent's case.

86. Following her receipt of Dr. Dietrick's report, Ms. Mullen issued a Report of Investigation, describing her analysis of the case and listing the process of her investigation.

87. On September 29, 2014, MBP issued Charges against the Respondent for violation of the Act.

Respondent's Licensing/Disciplinary History

88. On August 15, 2003, the Respondent entered into an Agreed Order with the Texas State Board of Medical Examiners that constituted a Public Reprimand, based on a finding that the Respondent violated a provision of the Texas law governing medical practice by failing to completely disclose information submitted in his hospital privilege application.

89. On December 14, 2004, the Respondent entered into a Consent Agreement and Order with the Commonwealth of Pennsylvania, Department of State before the State Board of Medicine (Pennsylvania Board), consenting to a Public Reprimand based on the August 15, 2003 Agreed Order with the Texas State Board of Medical Examiners.

90. On August 26, 2011, the Respondent entered into an Agreed Order with the Texas Medical Board, and agreed to enroll in and successfully complete at least eight hours of continuing medical education in an approved course on medical recordkeeping, and to pay an administrative penalty in the amount of $3,000.00. The disciplinary action was based on a finding that the Respondent did not thoroughly document an alleged discussion with a patient of the finding in laparoscopic photographs taken and all available treatment options prior to performing a hysterectomy.

91. On August 31, 2012, the Pennsylvania Board issued a Final Order Adopting Hearing Examiner's Adjudication and Order, ordering a Public Reprimand, based on the August 26, 2011 Agreed Order with the Texas State Board of Medical Examiners.

92. On November 20, 2012, the Respondent entered into a Consent Order with MBP, consenting to a Reprimand. The Reprimand was based on the August 31, 2012 Final Order of the Pennsylvania Board.

93. On May 29, 2013, MBP issued an Order for Summary Suspension of [the Respondent's] License to Practice Medicine. The Order was based on the OHCQ's investigation of [redacted] and findings of multiple violations in the operation of [redacted]'s offices. Following a Post-Deprivation Hearing on June 12, 2013, the Board continued the Respondent's suspension.

94. On June 30, 2013, the Medical Board of California (California Board) suspended the Respondent's California medical license based on the Respondent's Maryland suspension.

95. On July 10, 2013, the Government of the District of Columbia Department of Health (D.C. Board) issued the Respondent a Notice of Summary Action to Suspend License, based on the Respondent's Maryland suspension.

96. On July 24, 2014, the Virginia Medical Board (Virginia Board) suspended the Respondent's medical license based on the Respondent's Maryland suspension.

97. On February 27, 2014, the Respondent entered into a Consent Order with MBP, following charges issued on January 7, 2014. The charges involved a number of the Respondent's actions while working at [redacted][20] The Consent Order terminated the Respondent's May 29, 2013 Summary Suspension and imposed a Suspension for nine

[20] The Consent Order, signed by the Board on February 28, 2014, referred to the Respondent's employer as [redacted], an entity essentially the same as [redacted]

months, effective May 29, 2013, and placed the Respondent on Probation for a minimum period of eighteen months. The Consent Order further provided that the Respondent successfully complete an approved course in medical recordkeeping, as well as other restrictions on his association with [redacted] The Consent Order additionally dismissed the charge of unprofessional conduct in the practice of medicine and permitted the Respondent to petition the Board at the end of the probationary period to request termination of probation.

98. On March 5, 2014, MBP issued an Order Terminating Suspension and Imposing Probation, terminating the Respondent's May 29, 2013 nine-month suspension and placing him on probation for eighteen months, with conditions.

99. On April 8, 2014, the California Board issued a Termination of the Respondent's Out-of-State Suspension Order.

100. On June 27, 2014, the Texas Medical Board issued an Agreed Order constituting a Public Reprimand of the Respondent, based on the actions of MBP and the D.C. Board.

101. On August 27, 2014, the California Board issued a Decision and Order (effective September 26, 2014) imposing a Public Reprimand on the Respondent and ordering that he complete a continuing medical education course related to the area of appropriate supervision and delegation to non-physician staff, within sixty days of the effective date of the Order.

102. On July 2, 2014, the Respondent entered into a Consent Order with the D.C. Board, in which he agreed to essentially the same sanctions imposed by MBP, based on the MBP findings and Orders.

103. On November 14, 2014, the Pennsylvania Board issued a Corrected Final Order Adopting Hearing Examiner's Adjudication and Order, issuing a Reprimand and placing the Respondent on indefinite probation, based on the actions of MBP.[21]

104. At the present time, the Respondent holds medical licenses in Maryland and California. The Respondent's medical license is suspended in Virginia and inactive in Pennsylvania. The Respondent has not renewed his medical license in Washington, D.C. and Texas.

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 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).

In addition, the Board charged the Respondent with violating provisions of COMAR 10.32.17, as follows:

> **.01 Scope.**
>
> This chapter prohibits sexual misconduct against patients or key third parties by individuals licensed or certified under Health Occupations Article, Titles 14 and 15, Annotated Code of Maryland.

[21] The Pennsylvania Board issued the indefinite probation "until such time as [the Respondent's] Maryland license to practice medicine and surgery has been restored to active, unrestricted, nonprobationary status." (State #16).

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms defined.

(1) Key third party.

(a) "Key third party" means an individual who participates in the health and welfare of the patient concurrent with the physician-patient relationship.

(b) "Key third party" includes, but is not limited to the following individuals:

(i) Spouse;

(ii) Partner;

(iii) Parent;

(iv) Guardian;

(v) Surrogate; or

(vi) Proxy designated by durable power of attorney.

(2) Sexual Impropriety.

(a) "Sexual impropriety" means behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient or a key third party regardless of whether the sexual impropriety occurs inside or outside of a professional setting.

(b) "Sexual impropriety" includes, but is not limited to:

(i) Failure to provide privacy for disrobing;

(ii) Performing a pelvic or rectal examination without the use of gloves;

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

(iv) Initiation by the health care practitioner of conversation regarding the health care practitioner's sexual problems, sexual likes or dislikes, or fantasies.

(3) "Sexual misconduct" means a health care practitioner's behavior toward a patient, former patient, or key third party, which includes:

(a) Sexual impropriety;

(b) Sexual violation; or

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

(4) Sexual Violation.

(a) "Sexual violation" means health care practitioner-patient or key third party sex, whether or not initiated by the patient or key third party, and engaging in any conduct with a patient or key third party that is sexual or may be reasonably interpreted as sexual, regardless of whether the sexual violation occurs inside or outside of a professional setting.

(b) "Sexual violation" includes, but is not limited to:

(i) Sexual intercourse, genital to genital contact;

(ii) Oral to genital contact;

(iii) Oral to anal contact or genital to anal contact;

(iv) Kissing in a romantic or sexual manner;

(v) Touching the patient's breasts, genitals, or any sexualized body part;

(vi) Actively causing the patient or key third party to touch the health care practitioner's breasts, genitals, or any sexualized body part;

(vii) Encouraging the patient to masturbate in the presence of the health care practitioner or

masturbation by the health care practitioner while the patient is present;

(viii) Offering to provide practice-related services, such as drugs, in exchange for sexual favors; and

(ix) Intentionally exposing the health care practitioner's breasts, genitals, or any sexualized body parts.

.03 Sexual Misconduct.

A. Individuals licensed or certified under Health Occupations Article, Titles 14 and 15, Annotated Code of Maryland, may not engage in sexual misconduct.

B. Health Occupations Article, §§ 14-404(a)(3) and 15-314(3), Annotated Code of Maryland, includes, but is not limited to, sexual misconduct.

In its charges, the Board also cited the American Medical Association's Opinion on Physicians with Disruptive Behavior, which provides, in pertinent part:

Opinion 9.045

(1) Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

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 Physicians Quality Assurance*, 380 Md. 577, 593, *cert. denied*, 543 U.S. 862 (2004).

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

Respondent's Employment in Dr. [redacted]'s Office[22]

Dr. [redacted] hired the Respondent with the intent of expanding his Ob/Gyn practice, particularly in the area of surgical procedures. As a physician board certified in Ob/Gyn, the Respondent's credentials exceeded those of Dr. [redacted] Dr. [redacted] also employed a number of medical assistants and office staff members, some of whom had served with him for many years, and who possessed deep loyalty to Dr. [redacted] A few of Dr. [redacted]'s employees were raucous and frequently engaged in sexualized humor and provocative behavior, which was benignly tolerated by Dr. [redacted] In some ways, the Respondent fit into this faction, and did not limit his exposure to office antics, although the office generally acknowledged his high level of competency as a physician and his efficient efforts at modernizing and streamlining the practice.

"Ice" Incident

The communal break room was the scene of the "ice" incident. In the break room, employees, including Ms. [redacted], often loosened their inhibitions, telling jokes and acting in a generally silly manner. Ms. [redacted] was notorious throughout the office for her lewd humor and dancing, in which she revealed portions of her body. A number of the employees, and even Dr. [redacted], found her amusing, and frequently condoned her clownish behavior. Others found it disturbing, and tried to distance themselves from Ms. [redacted]

The Respondent appeared neutral to Ms. [redacted] and her office antics. Although he was a more recent member of the team, he frequently joined other office staff in the break room. On

[22] One of the Board's charges named an "Employee C," an unidentified administrative assistant in Dr. [redacted]'s office, who allegedly stated that a number of patients complained about the Respondent's "inappropriate comments," that the practice kept a list of patients who refused to see him, and that he routinely saw patients without a chaperone. No such list was produced, and no credible testimony was offered to support these allegations, although there was testimony that certain patients had preferred clinicians. Therefore, I did not find these particular charges supported by the evidence in the case.

the day in question, the Respondent was relaxing in the break room with a cup of ice, accompanied by employees [redacted] and [redacted]. In time, Ms. [redacted] joined the group. While there was little dispute as to whether ice from the Respondent's cup made contact with Ms. [redacted], the method and nature of the exposure differed.

I found the testimony of Ms. [redacted] and Ms. [redacted] more persuasive than that of the Respondent. Although much was made of Ms. [redacted]'s propensity for off-color humor and behavior, her version of events was related in a matter-of-fact manner and was corroborated by Ms. [redacted], who was unemotional, sincere, and to the point. Both Ms. [redacted] and Ms. [redacted] who were present at the scene, authored contemporaneous and confirming accounts. In contrast, the Respondent dramatically denied placing the ice down Ms. [redacted]'s pants, and engaged in a somewhat frenetic and distasteful explanation of his actions, claiming that because Ms. [redacted] deliberately passed noxious gas in his face while placing her food in the refrigerator, he had no choice but to spit ice from his mouth and throw it at her to evade the stench. The Respondent insisted on re-enacting the event, with extended and embellished descriptions of the purportedly odoriferous offense.

Much of the Respondent's presentation on this matter emphasized Ms. [redacted]'s behavior, rather than his own. I found descriptions of Ms. [redacted]'s antics more illustrative of the tenor of the office, rather than her culpability in the Respondent's actions. However, any suggestive or offensive movements she may have otherwise made in the office do not absolve the Respondent of his puerile response. It was clear that not all of Dr. [redacted]'s employees embraced Ms. [redacted]'s humor; some, including [redacted] and [redacted], deliberately absented themselves from the break room to sidestep the raucous atmosphere. If not always an active participant, the Respondent surely did not avoid the often bawdy environment, and found it amusing. Rather than believing that the Respondent engaged in a shocked and disgusted

response to Ms. [redacted] I find it more likely than not that when Ms. [redacted] aised her bottom in proximity to the Respondent as she bent over to place something in the refrigerator, he simply responded to an irresistible urge to "playfully" lift her waistband and drop a piece of ice down her pants. I do not believe that it was a malicious or even lascivious act, but simply an immature impulse exercised in misplaced frivolity.

However, even if not done in malice, the Respondent's action reflected poorly on the medical profession. As a medical professional, the Respondent should have held himself to a higher standard of behavior, and refrained from engaging in juvenile humor that had a distinct possibility of being highly offensive. Dr. Dietrick, the State's expert, offered that the Respondent's conduct "degrades the atmosphere of professionals in the office and also degrades the safety in a medical environment by...intimidation and lack of respect." (Tr. P.815)[23] Moreover, the Respondent's testimony, replete with elaborate excuses, convoluted poses and extensions of blame, further eroded his dignity, and, as will be further noted, he repeated the behavior throughout the hearing in testimony regarding the other incidents that led to the charges in this case. For these reasons, I found the Respondent's rendition of the "ice" incident less credible than that of other witnesses and consequently found his actions in the matter to have constituted unprofessional conduct in the practice of medicine in violation of section 14-404(a)(3)(ii) of the Health Occupations Article.

COMAR 10.32.17 prohibits sexual misconduct by a physician with patients or "key third parties." In this matter, Ms. [redacted] as an assistant in Dr. [redacted] s practice and a co-worker of the Respondent's, could qualify as a key third party who participates in the health and welfare of the patient concurrent with the physician-patient relationship. The definitions of sexual misconduct in the regulation are fairly broad, ranging from sexual activities involving identified

[23] Dr. Adashek, the Respondent's expert, did not offer an opinion as to the Respondent's conduct while employed by Dr. [redacted]

body parts to gestures encompassing a sexual connotation. However, while the Respondent came in proximity to Ms. [redacted]'s body when he stretched her waistband and dribbled the ice down her pants, the act was only marginally sexual, if at all. The regulation defines a "sexual violation" as engaging in any conduct that is sexual or may be interpreted as sexual. Although the action may have shocked Ms. [redacted] and made her feel extremely uncomfortable, she did not appear to interpret it as an overtly sexual act, but merely as an action that made her feel "awkward." (Tr. p.25) In itself, the act was more sophomoric than salacious. Since, in effect, it skirted the edge of a sexual nature, and was simply inane, I cannot identify it as sexual misconduct, impropriety, or violation, per COMAR 10.32.17.02.

"Desk" Incident

Had the "desk" incident occurred in isolation, it may never have raised the attention of the Board. For some reason, viewed differently by the participants, the Respondent became upset in the office, and, acting in frustration, but without restraint, shook Ms. [redacted]'s desk and kicked a wall. Contrary to the Board's assertion that Ms. [redacted] was frightened or intimidated by the Respondent's actions, Ms. [redacted] appears to have left the office primarily due to her interest in separating herself from the situation, and not out of fear.

More concerning than the Respondent's behavior in Ms. [redacted]'s office was the discrepancy between the testimony of the Respondent, Ms. [redacted] and Ms. [redacted] regarding the reason for the Respondent's outburst. Neither Ms. [redacted] nor Ms. [redacted] could specifically remember the event or situation that precipitated the Respondent's anger.[24] The Respondent, however, again engaged in a highly agitated narrative of the alleged catastrophic loss of crucial office and patient data, to justify his physical response. Surely, had the office experienced such a calamitous event, Ms. [redacted], the veteran office manager, would have remembered. Even Ms.

[24] Ms. [redacted] speculated that the cause may have been a remark she made that the Respondent considered "stupid." (Tr. p.620)

[redacted] who appeared to have been an ally of the Respondent, had no recollection of an event that the Respondent feverishly described as a disaster. As in the "ice" incident, the Respondent over-embellished his testimony, rendering it less credible.

However, as to the primary issue of whether the Respondent's actions in Ms. [redacted]'s office constituted unprofessional conduct in the practice of medicine, the answer is less clear. The Respondent lost his temper, albeit in an excited and potentially destructive manner. Obviously, something in the notoriously dysfunctional office aroused his ire, and he momentarily lost control. His actions, however, were not deliberately directed to any individual, nor did they cause physical damage. Although Dr. Dietrick characterized the Respondent's outburst as intimidating, the evidence suggests that the witnesses present were exasperated, at best, rather than frightened. Ms. [redacted] simply wanted to exit the scene, not flee. While the Respondent's anger may have reflected a less than admirable human response to frustration, it alone does not rise to behavior that would negatively affect the practice of medicine. For that reason, I do not find that the "desk" incident constituted unprofessional conduct in the practice of medicine.

Patient B

The parties offered starkly divergent testimony regarding the Respondent's treatment of Patient B. Patient B was resolute in her description of events, detailed and precise. Patient B described the progression of her difficult pregnancy, albeit in dramatic terms, including her hospital stay in which she required intravenous medication and, eventually, a PICC line at home. Additionally, Patient B freely admitted her marijuana use during pregnancy, couching it in terms of protecting her unborn child with nutrition, to mitigate her general inability to retain food due to unremitting nausea. This justification, while a bit strident, was sincere. Whether or not Patient B also used marijuana for other reasons, she clearly had an interest in maintaining some nutrition during the most arduous part of her pregnancy.

Patient B was adamant in her recall that the Respondent did not have a chaperone with him during her June 18, 2012 examination. Her description of the Respondent's actions in touching and moving her breasts and lowering her pants while palpating her back was specific and consistent. Patient B's explanation of her extended absence from the practice following the June 18, 2012 examination was reasonable, given her accusation. Her testimony in the hearing was straightforward and steady.[25]

On the other hand, aspects of the Respondent's denial of Patient B's version of events, and particularly the testimony of his supporting witnesses, were in direct contravention of Patient B's claims, and in part, unconvincing. The question as to whether there was a chaperone during the examination, and, if so, which office member acted in that role, was crucial, and also led to the diminished credibility of the witnesses. The Respondent asserted that during the entire visit, he was accompanied by a chaperone; however, he could not recall the identity of the staff member acting in that capacity.[26] Ms. [redacted] stated that she only knew of two occasions when the Respondent examined a patient without a chaperone, and Patient B's June 18, 2012 visit was not one of those occasions. Ms. [redacted] estified under oath that she was the Respondent's chaperone on June 18, 2012, and was present during the entirety of Patient B's examination and departure from the office. All of these assertions were questionable, if not overtly false.

The Respondent thoroughly discounted Patient B's accusation, and completely denied her claims. Although he could not identify which staff member assisted him that day, he asserted that he "never" saw a patient without a chaperone. The Respondent speculated that Patient B based her untrue allegations on her anger at the Respondent for chastising her for her drug use

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[25] Patient B testified that June 18, 2012 was her first interaction with the Respondent. Although the records indicate that the Respondent was the admitting physician during Patient B's April 2012 hospitalization, I did not find it unreasonable to believe that she may not have been aware that he was so designated, considering the circumstances of her treatment

[26] The record indicates that Ms. [redacted] took Patient B's vital signs prior to the June 18, 2012 examination; however, there was no claim that she was the chaperone.

during pregnancy and his threat to expel her from the practice should she continue. However, Patient B's last blood test that revealed marijuana use was taken on May 9, 2012, with the results available and sent to the office on or about May 14, 2012. Patient B was seen by Dr. [redacted] on May 18, 2012 and Ms. [redacted] on May 30, 2012, and each was aware of her most recent positive test for marijuana.[27] The Respondent, whose medical knowledge was essentially unquestioned, testified that traces of marijuana may remain in one's system for 30 days following the last use, so it was not clear that Patient B had continued to use marijuana following her hospitalization. The Respondent's recitation of events implied that his strong admonition and threat was the office's first awareness and alarm over the Respondent's alleged continued drug use. The time scenario raises doubt as to the Respondent's interpretation of events. While it may be that during the examination, he noted the nearly six-week old blood test and even strongly cautioned Patient B, his characterization of her reaction appeared self-serving and a smoke screen for his denial of her claim.

Ms. [redacted]'s testimony similarly raised questions. Ms. [redacted] appeared to have a preternaturally detailed recollection of Patient B's rushed and angry departure from the office on June 18, 2012. Ms. [redacted] stated that nearly three years after the fact, as a mere bystander, whose desk was "around the corner" from the examination room, she specifically recalled the harsh words spoken by Patient B, as well as her actions, as she left. I found her absolute recall unlikely. According to Ms. [redacted] her clear recollection was based on her duty of making sure pregnant patients with drug issues attended scheduled appointments. Ms. [redacted] offered that when the office received a patient's lab results indicating a positive drug test, she would send a letter to the patient and have the physician counsel them during their next appointment. However, there is no evidence that such a letter was ever sent to Patient B.

[27] Upon receiving Patient B's May 9, 2012 lab results, Dr. [redacted] had Ms. [redacted] call Patient B and warn her regarding her marijuana use.

Ms. [redacted]'s testimony was completely undercut by the revelation that, contrary to her assertion, she was not even in the office on June 18, 2012.[28] In her testimony, Ms. [redacted] without reservation, attested to her presence during the Patient B's June 18, 2012 examination by the Respondent. She stated, in great detail, a description of the examination, disavowing Patient B's narrative, but offered a gentler version of the Respondent's message to Patient B regarding drug use. Ms. [redacted] also claimed that she was utterly unaware of Patient B's claim, although she was ultimately served with notice of Patient B's intent to seek legal action against the practice. It is hard to fathom why Ms. [redacted], who otherwise appeared to be knowledgeable and professional, would fabricate a story that was so eminently untrue. Admittedly a personal friend of the Respondent, unfortunately, Ms. [redacted]'s false testimony hurt more than helped her former colleague.

Dr. Dietrick, the Board's expert, offered that Patient B's version of events contained numerous inappropriate actions undertaken by the Respondent. Although he noted that there is no strict legal requirement for a chaperone, Dr. Dietrick submitted that it is most inadvisable to examine a patient unaccompanied, and markedly unprofessional to be present when a patient disrobes. Dr. Dietrick also questioned the necessity for conducting a breast exam on a patient who is twenty-nine weeks into a pregnancy and indicated that manipulating her breast in the manner described would not have be customary in a cardiac exam.

Patient B's alleged motives are not pristine. It is true that she used marijuana while pregnant, a practice that was strongly discouraged by her physicians. She did not reveal her reasons for missing a number of appointments and complaining about the Respondent's actions

[28] In rebuttal, the State presented evidence from [redacted] and [redacted] the biller in Dr. [redacted]'s office, of Ms. [redacted]'s scheduled absence from the office on June 18, 2012 and a gap in her office production on that day. (State #45 and #47)

for over a month and a half. Patient B consulted with an attorney, who ultimately threatened a claim against the practice. However, when stacked against the flimsy and rebutted testimony on behalf of the Respondent, I find it more likely than not that Patient B's claims were true. That she would have hurriedly left the office without making another appointment after such gratuitous touching by the Respondent is believable, and her subsequent absence from the office is consistent with having a bad experience and delaying return. Her description of the Respondent's June 18, 2012 examination was clear and not overly inflated or salacious. It is entirely plausible that during this visit, Patient B's first office examination by the Respondent, that, unsupervised, he touched her body as described, in a manner unexpected by Patient B, and not in conformance with a standard, routine mid-pregnancy exam. As such, I find that the Respondent's June 18, 2012 examination of Patient B constituted unprofessional conduct in the practice of medicine in violation of section 14-404(a)(3)(ii) of the Health Occupations Article.

Since I found Patient B's version of events more credible than that of the Respondent, I must consider whether his actions constituted impermissible sexual impropriety, misconduct, or violation under COMAR 10.32.17.02. By failing to provide Patient B privacy for disrobing, the Respondent engaged in sexual impropriety under COMAR 10.32.17.02B(2)(b)(i). Patient B's perception of the Respondent's actions as sexually suggestive or demeaning also encompass sexual impropriety under COMAR 10.32.17.02B(2)(a). Under COMAR 10.32.17.02B(4)(a), a sexual violation can encompass engaging in any conduct with a patient that may be reasonably interpreted as sexual, and, under COMAR 10.32.17.02B(4)(b)(v), includes touching a patient's breasts, genitals, or any other sexualized body part. By gratuitously handling Patient B's breasts and exposing her buttocks, the Respondent's actions met the definition of a sexual violation. Additionally, under COMAR 10.32.17.02B(3)(a) and (b), behavior that includes sexual impropriety and sexual violation constitutes sexual misconduct. Accordingly, I find that the

Respondent engaged in sexual misconduct under COMAR 10.32.17 in his examination of Patient B on June 18, 2012.

Respondent's Employment with [redacted]

Following his resignation from Dr. [redacted]'s practice, the Respondent began working for [redacted] in September 2012, until his summary suspension on May 29, 2013.[29] While other disciplinary matters may have arisen from the practice of medicine at [redacted], this case is focused on the treatment of Patient A.

Patient A

Conflicting testimony surrounded the allegations of Patient A. Both Patient A and Ms. [redacted] described, in detail, a process that included two attempts at suctioning and an occasion in which the Respondent remained alone in the room with Patient A. The Respondent's version of events starkly contradicted that scenario, citing only one procedure and asserting that he was accompanied by Ms. [redacted] throughout the procedure.[30]

It is difficult to reconcile the narratives; the record notes only one procedure, yet it is of questionable veracity. Moreover, the primary accusation by Patient A, that the unchaperoned Respondent placed his finger in her rectum and made a rude remark,[31] is clouded by the administration of Midazolam and Ketamine, which both experts agreed could produce a skewed and dreamlike experience.

When asked about the possible hallucinogenic effects of the Midazolam/Ketamine combination on Patient A's perception of the procedure, each expert conceded that the

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[29] Shortly thereafter, on or about June 5, 2013, the OHQC filed a Notice of Intent to Revoke Surgical Abortion Facility Licenses against all of [redacted]'s Maryland clinics.

[30] The Respondent offered testimony from Dr. [redacted], formerly of [redacted] stating that he had been told by Dr. [redacted] another [redacted] physician, now deceased, about Ms. [redacted] recounting of events to her, that indicated that she accompanied the Respondent throughout Patient A's procedure. I found Dr. [redacted]'s testimony in this regard so attenuated as to render it unpersuasive, and gave more weight to the essentially consistent testimony of Ms. [redacted] who categorically denied she had ever related to Dr. [redacted] that she had not left the Respondent alone in the room with Patient A.

[31] Patient A claimed that as the Respondent inserted his finger in her rectum he asked "Baby, do it feel good?"

medication mixture may well have caused Patient A to have an inaccurate, or even farfetched recollection of events. Dr. Adashek, the Respondent's expert, explained that Midazolam, a benzodiazepine, is a long-acting amnestic, anti-anxiety relaxant medication that "sort of numbs the mind, makes you fairly forgetful." (Tr. P.739) Dr. Adashek termed Ketamine as a general anesthetic that does not change a patient's ability to breathe or heart rate, but noted that Ketamine can have some "annoying side effects." (Tr. P.739) He described the side effects as the potential for "vivid dream-like states and nightmares" and noted that the federal Food and Drug Administration (FDA) has warned on the Ketamine package insert that this emergent reaction[32] occurs in approximately twelve percent of patients. (Tr. P.744-45) Dr. Adashek further elaborated in his description of Ketamine reactions contained in the medication's FDA special note, which warns that "psychological manifestations vary in severity between pleasant dream-like states, vivid imagery, hallucinations, and emergence delirium. In some cases these states have been accompanied by confusion, excitement and irrational behavior which a few patients recall as an unpleasant experience." (Tr. p.746) Dr. Adashek, however, also noted that the administration of Midazolam can mitigate some of Ketamine's more severe side effects.

In his testimony, Dr. Dietrick endorsed the opinion he rendered in his written report, as follows:

> During the course of a dilatation and curettage for pregnancy termination, there is no indication to perform a rectal examination except occasionally prior to the start of the procedure if there is doubt to the position of the uterus or severe retro flexion of the uterus. If true, a gratuitous rectal penetration and comments such as stated are indeed unprofessional conduct and sexual impropriety. However, Midazolam is an amnesic[33] agent and Ketamine has hallucinogenic properties. Despite [Patient A's] vivid remembrance of portions of the procedure and her nurse's feeling that [the Respondent] tried to get her to lie for him after the charges were lodged, it is not possible for me to determine the

[32] An "emergent reaction" is one experienced while coming out of anesthesia.
[33] During the hearing, the words "amnesic" and "amnestic" were used interchangeably.

> veracity of the complaint lodged by [Patient A] due to the mental state potentially induced by these anesthetic agents. (State # 34)

The doubt sewn by each expert's concerns about the reliability of recollections derived under the influence of the combination of Midazolam and Ketamine during Patient A's D & C render her recitation of the alleged improper touching highly questionable. Even if only twelve percent of Ketamine users have been documented to encounter the most severe side effects of the medication, the suggestion, recognized by both experts, that Patient A's description could be compromised by delusion, precipitates my reluctance to find that the improper action actually occurred.

Of the three participants in the procedure, I found Ms. [redacted] the most credible. Her testimony was calm and consistent. She methodically related the series of events in which, even after two attempts, the Respondent was unable to suction enough tissue to confirm the termination of Patient A's pregnancy. Ms. [redacted] explained how she examined the contents extracted from Patient A at each attempt, and even drew a diagram of the room to explain where all the participants were located. (Resp. #20)[34] Given the timeline, I found her description plausible, and believed her account that she briefly left the room to examine the second sample, with Patient A and the Respondent remaining in the examination room unaccompanied.

I also found Ms. [redacted] description of the Respondent's repeated attempts to conform her description of the procedure to his own persuasive and disturbing. Clearly, the Respondent had an interest in securing Ms. [redacted] agreement as to the timeline of events and Patient A's reaction. His tenure at [redacted] followed his unpleasant experience with Dr. [redacted] nd Patient B's complaint of inappropriate touching. However, even if the Respondent's motivation was to

[34] Although, on rebuttal, Ms. [redacted] stated that although she originally testified that when she returned to the room, the Respondent was standing by a cabinet, she later remembered that he remained seated on the stool at the base of the table, I found this change essentially irrelevant, since there was little distance between the stool and the cabinet. This difference did not erode Ms. [redacted] credibility.

simply avoid another investigation into what he considered a false accusation, the pressure he exerted on Ms. [redacted] was misplaced and unseemly.

Additionally, I found the Respondent's explanation of the discrepancy between his and Ms. [redacted] ecollection of events puzzling. Although the Respondent stated more than once in his testimony that during what he described as a single procedure, Patient A repeatedly complained of pressure in her rectum, and wrote a second note, at 12:00 p.m., after the initial 11:35 a.m. note at the completion of the procedure, emphasizing that statement, neither Patient A nor Ms. [redacted] mentioned this alleged recurrent complaint. Moreover, when asked how Ms. [redacted] account could be so different from his, the Respondent accused Ms. [redacted] of having been bribed by Patient A, without any evidence whatsoever to substantiate his claim. I found this accusation, emphatically presented by the Respondent, bizarre at best.

However, based on both Dr. Adashek's and Dr. Dietrick's expert testimony regarding the potentially mind-altering effects of the combination of Midazolam and Ketamine administered to Patient A, I cannot find, by a preponderance of the evidence, that the Respondent placed his finger in her rectum, as she described. While I am certain that Patient A fully believed the improper touching ensued, and was not deliberately fabricating her account, if even the State's expert questioned her reliable description of events, I cannot find it more likely that not that it occurred.

Although the State did not meet its burden to prove the allegations claimed by Patient A, the Respondent's defense of these allegations fit a pattern that he displayed throughout the hearing. At each turn, his responses were so embellished, exaggerated, and dramatized as to diminish his credibility. It was unclear whether the Respondent was simply nervous, or whether he calculated that his more outlandish and quasi-detailed descriptions would render his testimony more believable. Independent of his motives, whether the Respondent was reeling from Ms.

[redacted]'s bodily emissions, railing against Patient B's drug use, or accusing Ms. [redacted] of corrupt motives, his attempts at deflection were unpersuasive.

MBP's Investigation

At several points during the hearing, the Respondent suggested that the Board's investigation was somehow improper or insufficient. In the course of her investigation, Ms. Mullen conducted interviews, under oath, with Patient A, Ms. [redacted] Ms. [redacted] Ms. [redacted] Patient B, Dr. [redacted] and the Respondent. Ms. Mullen also spoke with Ms. [redacted] over the phone and produced extensive notes of their conversation. The Board obtained Patient A's and Patient B's medical records, as well as other documents pertinent to the allegations regarding the Respondent.

The Respondent argued that the Board's failure to interview Ms. [redacted] rendered its investigation inadequate. I disagree; while her input, particularly as expressed in the hearing, may have added somewhat to the Board's investigation, it certainly would not have proven exculpatory to the Respondent. The other witnesses the Respondent produced, who were not included in the Board's investigation, were complimentary of the Respondent's skills as a physician, but were unable to shed any significant light on the Board's specific allegations.[35] The general consensus of these witnesses was that the Respondent was a highly competent Ob/Gyn, with a direct and forthright manner, who placed great effort and emphasis in attending to patients' needs and promoting office efficiency. While the testimony offered by these witnesses added to my understanding of the Respondent's practice and character, their input would not likely have proven particularly relevant to the Board's case, nor would it have likely prevented or influenced the Board's ultimate action. Consequently, I cannot find that the Board's investigation of the Respondent was inadequate or improper.

[35] These witnesses included [redacted] and Dr. [redacted]

Sanctions

In this case, the State is seeking to impose, at a minimum, a one-year suspension of the Respondent's medical license, and a requirement that he be referred by MBP or Med Chi to the Maryland Professional Rehabilitation Program for evaluation of behavioral issues, and that the Respondent be mandated to attend and abide by all of the measures recommended, including therapy. The State additionally requested that I recommend that after the Respondent's suspension, he remain on probation for five 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. COMAR 10.32.02.09 sets forth the general sanctioning guidelines for physicians, providing in pertinent part as follows:[36]

> **.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;

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

(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.

(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 a fairly extensive disciplinary history. The majority of sanctions imposed upon the Respondent by various jurisdictions were due to reciprocity between jurisdictions, rather than a multiplicity of violations. Nonetheless, I am compelled to take the Respondent's disciplinary history into consideration in recommending a sanction in this case.

In 2003, the Respondent was issued a reprimand by the Texas State Board of Medical Examiners for failing to disclose information in his hospital privilege application. As a result of the action in Texas, the Pennsylvania Board reciprocally issued its own reprimand of the Respondent. In 2011, the Respondent entered into an Agreed Order with the Texas Medical Board to complete an approved course in medical recordkeeping and pay an administrative penalty, based on a finding that the did not thoroughly document discussing medical findings and options with a patient prior to a hysterectomy. As a result of the 2011 Texas Agreed Order, the Respondent received reciprocal reprimands from the Pennsylvania Board and the MBP (based on the action of the Pennsylvania Board). In 2013, MBP summarily suspended the Respondent's license based on an investigation that revealed multiple violations at [redacted], and continued the suspension subsequent to a post-deprivation hearing. As a result of MBP's summary suspension, the Respondent's license was also reciprocally suspended by the California Board, the D.C. Board, and the Virginia Board. In 2014, MBP terminated the Respondent's summary suspension and imposed a nine-month suspension, effective May 29, 2013, and a period of probation for a minimum of eighteen months. The Respondent's suspension terminated on March 5, 2013, at which time his probation, with conditions, commenced. In 2014, the Texas Medical Board, the California Board, the D.C. Board and the Pennsylvania Board imposed reciprocal discipline on the Respondent based on the actions of MBP. At the current time, the Respondent holds active medical licenses in Maryland and California. His medical license in Virginia remains suspended, is inactive in Pennsylvania, and was not renewed in Washington, D.C., and Texas.

The Respondent is not currently engaged in the clinical practice of medicine, although his present position in the field of Medical Informatics requires an active medical license for board certification. He has transitioned to an area of administrative medicine, drawing on his

considerable technological skills. The Respondent's current concern is in the area of Electronic Medical Records (EMR), and operating a medical/computer software service.

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 Recommended Decision, I have essentially come to a split conclusion: that the State has proven by a preponderance of the evidence two actions by the Respondent that constituted unprofessional conduct in the practice of medicine, in violation of the Act, and that the State failed to prove, by a preponderance of the evidence, that two other incidents alleged by the Board rose to such a violation.

The Respondent's behavior in the "ice" incident and his treatment of Patient B exhibited unprofessional conduct. The "ice" incident, while seemingly adolescent and trivial, reduced the Respondent to a level unbecoming a member of the medical profession. In spite of the low humor that infected Dr. [redacted]'s office staff, and particularly that of Ms. [redacted] the Respondent plainly should have had the sense to separate himself from such immature behavior and maintain a dignified demeanor. This is not to say that the Respondent ought not to have associated with office staff; to the contrary, it was in his, and the office's interest, to forge cordial working relationships with his co-workers. However, when it descended into childish and lewd reciprocity, the Respondent crossed the line. As a professional, the Respondent had an obligation to engage in model behavior and appropriate decorum in the office setting. In this vein, he clearly failed.

The Respondent's treatment of Patient B displayed a failure to conduct an appropriate examination. The Respondent sloppily left himself vulnerable by not having an accompanying chaperone. His examination of Patient B included aspects not customary in a routine mid-pregnancy appointment, and appeared gratuitous and opportunistic. Clearly, Patient B felt

deeply uncomfortable and, ultimately, violated. I cannot fathom the Respondent's reason for touching Patient B's breasts, pulling down her pants and manipulating her lower back. I acknowledge that the Respondent continues to deny that these actions occurred; however, even had he offered that they had been proper components of an examination, I would have found his assertion specious, at best.

Adding an additional layer to my analysis was the Respondent's histrionic demeanor in the hearing. While the Respondent remained calm and passive throughout the testimony of other witnesses, when it came his turn to testify, he became overexcited and accusatory, blaming everyone but himself for all the trouble into which he had fallen. The Respondent's excuses were farcical, and might have even been amusing, had the underlying subject not been so serious.

The Respondent has already been subject to a suspension and a lengthy probationary period in another matter before the Board. While the instant charges temporally overlap some of the charges that led to his previous discipline, they are not insignificant, and cannot be ignored. Accordingly, and taking into consideration the factors contained in COMAR 10.32.02.09 and my proposed dismissal of two of the Board's charges, I recommend that the Respondent be suspended from the practice of medicine for six months, followed by a year of probation, with a referral to the Maryland Professional Rehabilitation Program for a behavioral evaluation, with any attendant recommendations, and a requirement to attend any applicable course in medical ethics the Board may impose.

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). I further find that the Respondent engaged in sexual misconduct. COMAR 10.32.17.03. 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 September 29, 2014, be **UPHELD** in part and **DISMISSED** in part, and

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

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

July 23, 2015
Date Decision Issued

Harriet C. Helfand
Administrative Law Judge

HCH/kkc
156608

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: Geneva Goode, Administrative Aide to Supervisor, 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.

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