UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MARYLAND

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HAROON I. HAMEED, M.D. :

1300 4th St. SE, Unit 203 :

Washington, DC 20003 :

Plaintiff, :

:

v. : Civil Action No. _____

:

MARYLAND STATE BOARD OF PHYSICIANS, :

4201 Patterson Avenue :

Baltimore, MD 21215, :

CHRISTINE A. FARRELLY, in her individual :

and official capacities as Executive Director :

of the Maryland Board of Physicians, :

DOREEN NOPPINGER, in her individual and :

official capacities as Compliance Manager, :

TROY GARLAND, in his individual and official :

capacities as Compliance Analyst (2021–2025), :

ALEXANDRA FOTA, in her individual and official :

capacities as Compliance Analyst (2020–2021), :

and JOHN AND JANE DOE BOARD MEMBERS, :

in their individual and official capacities as members :

of the Maryland Board of Physicians, :

4201 Patterson Avenue :

Baltimore, MD 21215 :

Defendant. :

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COMPLAINT

I. INTRODUCTION

1. This is a civil rights and tort action arising from the Maryland State Board of Physicians' repeated publication of false and stigmatizing information concerning Plaintiff Haroon I. Hameed, M.D., despite administrative findings contradicting those statements and expert evaluations to the contrary.
2. Plaintiff alleges violations of his rights under the Due Process Clause of the Fourteenth Amendment, actionable under 42 U.S.C. § 1983, as well as defamation under Maryland law.
3. Attached hereto as Exhibit A is Plaintiff's Curriculum Vitae, demonstrating his professional credentials and experience.
4. Attached hereto as Exhibit B is the expert letter from Dr. Gregory Skipper, concluding that Plaintiff was not opioid-addicted.
5. Attached hereto as Exhibit C is the Joint Stipulations of Fact entered into by Plaintiff and the Maryland Board.
6. Attached hereto as Exhibit D is the ALJ's Decision and Recommended Order, dismissing key charges.
7. Attached hereto as Exhibit E is documentation from Plaintiff's rehabilitation program confirming full compliance and no findings of addiction.
8. Attached hereto as Exhibit F is a screenshot of the Maryland Board’s continued public display of the false addiction charge.

II. JURISDICTION AND VENUE

9. This Court has jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. § 1343(a)(3). Plaintiff's claim for defamation arises under Maryland state law and is within the supplemental jurisdiction of this Court pursuant to 28 U.S.C. § 1367.
10. Venue is proper in this district under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to these claims occurred in Maryland.

III. PARTIES

11. Plaintiff Haroon I. Hameed, M.D., is a licensed physician, licensed and practicing in the state of Maryland, and a resident of Washington, D.C.
12. Defendant Maryland State Board of Physicians is a state agency responsible for licensing and disciplining medical professionals in Maryland.
13. Defendant Christine A. Farrelly is sued in her individual and official capacities as Executive Director of the Maryland Board of Physicians.
14. Defendant Doreen Noppinger is sued in her individual and official capacities as Compliance Manager for the Board.
15. Defendant Troy Garland is sued in his individual and official capacities as Compliance Analyst (2021–2025).
16. Defendant Alexandra Fota is sued in her individual and official capacities as Compliance Analyst (2020–2021).
17. Defendants John and Jane Doe Board Members are sued in their individual and official capacities as members of the Maryland Board of Physicians who participated in or ratified actions against Plaintiff. Plaintiff will amend the Complaint to identify them by name following discovery.

IV. FACTUAL ALLEGATIONS

18. Plaintiff was charged in 2020 by the Maryland Board with, among other things, addiction to or habitual abuse of narcotics (opioid addiction), habitual intoxication, and professional incompetence.
19. Two experts, including Dr. Gregory Skipper—a nationally recognized leader in physician addiction medicine—and another clinical evaluator, testified that Plaintiff neither suffered from addiction or habitual intoxication, and was not professionally incompetent.
20. An Administrative Law Judge (ALJ) found that the charges of professional incompetence and habitual intoxication were not proven and dismissed them.
21. Throughout the four years following the 2021 Final Order, Plaintiff remained under supervision by providers and monitoring entities directly affiliated with or reporting to the Maryland Board of Physicians. At no point did any of these providers or programs corroborate the charges of opioid addiction or habitual intoxication. No evidence ever emerged to support those allegations, which were originally rejected by the ALJ and discredited by expert testimony.
22. Despite these findings, the Board and other Defendants rejected the ALJ's conclusions and re-imposed the charge of habitual intoxication in the Board's final order.

Clarification Regarding Scope of Claims:

Plaintiff acknowledges that he did not seek judicial review of the 2021 Final Order issued by the Maryland Board of Physicians. This action does not seek to overturn or modify that order. Instead, Plaintiff brings this Complaint to address the Board's continued and public dissemination of specific stigmatizing charges that were rejected by the ALJ,

discredited by expert witnesses, and for which the last 5 years of supervision by direct or indirect Board-related and reporting providers and entities failed to show any proof of. These actions have caused reputational and economic harm well beyond the conclusion of formal disciplinary proceedings.

23. Dr. Hameed's other rehabilitation program providers also found no evidence of habitual intoxication or addiction, as documented in communications and letters submitted to the Board.
24. The Board and other Defendants suspended Plaintiff's license in 2020 and later placed him on probation after reinstatement in 2021. The probation formally ended in 2025.
25. Throughout the period of probation and beyond, the Board and other Defendants continued to publicly display the dismissed charges of opioid addiction and habitual intoxication on its physician verification portal and other public records.
26. As a result, Dr. Hameed has been unable to renew his DEA license, which prevented him from practicing medicine and engaging in lucrative opportunities, including surgery center ownership and other medical practice-related business ventures.
27. As a direct result of the Board's continued public dissemination of false and stigmatizing allegations—specifically opioid addiction and habitual intoxication—Plaintiff was unable to secure users for a proprietary artificial intelligence-based medical charting application he developed, due to physician and non-physician executive decision makers who decided not to engage with Dr. Hameed. Despite strong performance metrics, internal testing, and endorsements from industry leaders—including the CEO of Clearway Pain Solutions, the largest pain management group in the United States—numerous prospective users, including both physician clients and non-physician practice executives,

declined to adopt the platform after reviewing Plaintiff's public disciplinary history. In multiple instances, parties conducting due diligence explicitly cited the Board's postings as the reason for disengagement. The reputational damage not only stalled market adoption but also led to the attrition of key software engineers, developers, and collaborators who withdrew from the project due to concerns about reputational risk. These compounded harms materially undermined a business that had previously been valued at over $25 million.

28. The Board and other Defendants knew or should have known that these statements were false, particularly in light of: (a) the expert reports from their own rehabilitation consultants; (b) the Administrative Law Judge's findings rejecting the charges; and (c) five years of monitoring and clinical assessments by Board-affiliated providers, none of which corroborated the allegations.

V. CLAIMS FOR RELIEF

COUNT ONE – VIOLATION OF DUE PROCESS ("STIGMA PLUS") UNDER 42 U.S.C. § 1983

29. Plaintiff incorporates by reference the preceding paragraphs.
30. Defendants, acting under color of state law, published stigmatizing and false charges (including opioid addiction) on public platforms.
31. These charges were central to the deprivation of Plaintiff's liberty interest in practicing medicine and harmed his reputation and business.
32. Defendants failed to provide procedural safeguards before or after publishing these stigmatizing charges.

33. Plaintiff suffered economic loss and reputational damage as a result.

COUNT TWO – REPUTATIONAL HARM AND INTERFERENCE WITH LIVELIHOOD UNDER 42 U.S.C. § 1983

34. Defendants' continued publication of defamatory content after internal and judicial review found it unproven constitutes a willful violation of Plaintiff's constitutional rights.
35. These actions impeded Plaintiff's ability to obtain DEA licensing, practice medicine, and engage in commerce.
36. Defendants acted with deliberate indifference to Plaintiff's rights.

COUNT THREE – DEFAMATION (MARYLAND COMMON LAW)

37. Defendants published false statements regarding opioid addiction and habitual intoxication.
38. Defendants did so knowing the ALJ and expert witnesses had found these charges unsupported.
39. Defendants' statements were made with actual malice or reckless disregard for the truth.
40. Defendants' continued publication after reinstatement and probation ending in 2025 constitutes a new defamatory act within the statute of limitations.
41. Under Maryland law, defamation requires proof of a false statement made to a third party with fault amounting to at least negligence, resulting in reputational harm. See *Smith v. Danielczyk*, 400 Md. 98, 115 (2007); *Hearst Corp. v. Hughes*, 297 Md. 112, 119–20 (1983).
42. Plaintiff suffered damages of over $30 million, including:

1. Lost income of $5 million (based on historical earnings of $550,000 per year and the inability to accept a surgical center buy-in at Clearway Pain Solutions valued at additional income of $450,000/year or more),
2. Loss of enterprise value of at least $25 million tied to a highly scalable AI medical charting company that failed to secure physician users due to the public posting of false charges, and
3. Additional reputational, economic, and emotional harm resulting from the Defendants' conduct.

VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court:

A. Enter judgment in favor of Plaintiff and against Defendants;

B. Declare that Defendants violated Plaintiff's constitutional rights under 42 U.S.C. § 1983;

C. Award Plaintiff compensatory damages in an amount exceeding $30 million;

D. Award punitive damages for willful misconduct and malice;

E. Award costs and reasonable attorneys' fees under 42 U.S.C. § 1988;

F. Order Defendants to remove or correct public records that continue to state false charges;

G. Grant any other relief this Court deems just and proper.

JURY DEMAND

Plaintiff demands a trial by jury on all issues so triable.

Respectfully submitted,

/s/ Haroon I. Hameed, M.D.
Haroon I. Hameed M.D.
Pro Se Plaintiff
1300 4th St. SE, Unit 203
Washington, DC 20003
drharoonhameed@yahoo.com
(202) 600-6124

TABLE OF EXHIBITS

Exhibit A – Curriculum Vitae of Dr. Haroon I. Hameed

Exhibit B – Expert Letter by Dr. Gregory Skipper

Exhibit C – Joint Stipulations of Fact

Exhibit D – ALJ Decision and Recommended Order

Exhibit E – Public Display of Disproven Addiction Charge

Exhibit F – Pending: Maryland Physician Rehabilitation Program Records

Note: Plaintiff is currently seeking records from the Maryland Professional Rehabilitation Program (MPRP) to confirm full compliance. Exhibits and allegations will be supplemented or amended as discovery or documentation becomes available.

Exhibit A

Haroon Hameed MD
Curriculum Vitae

Demographic Information

Current Affiliations/Appointments/Employment

1. Director of Regenerative Medicine: Clearway Pain Solutions, MD (2/2019-present)
2. CEO/Founder, The Duality Companies, Inc. (6/2021-present)

Personal Data

Cell phone: --redacted--
Email: --redacted --

American Board of Medical Specialties (ABMS) - Board Certification Exams

1. American Board of Physical Medicine and Rehabilitation (ABPMR) – passed 2014
2. Pain Medicine Subspecialty Board (ABPMR) – passed 2015

Education, Medical Training, and Research

1. ***Undergraduate Education***: Concord University, Athens, WV (06/1994 - 05/1995)
2. ***Medical Education***: Allama Iqbal Medical College, Lahore, Pakistan (08/1995 - 06/2001)
3. ***Pre-residency employment*** *(more below):* General Surgery, St. John Hospital and Medical Center, Detroit, Michigan (05/2002-06/2002) – to replace a PGY-1 resident
4. ***1st Internship***: General Surgery, St. John Hospital and Medical Center, Detroit, Michigan

(07-2002-06/2003)

5. ***1st PGY-2***: General Surgery, SUNY Health Science Center in Brooklyn, Brooklyn, New York (07/2003 - 06/2004)
6. ***Post graduate Fellow - Research Fellowship***: Peripheral Nerve Regeneration (Microsurgery) Lab - Johns Hopkins University, Departments of Orthopedic and Plastic Surgery (10/2004-06/2006) – Mentors : Thomas Brushart MD, Chair of Hand and Microsurgery, Vice Chair of Orthopedic Surgery and Richard Redett MD, Vice Chair Pediatric Plastic Surgery
7. ***Post-graduate Fellow – Research***: Long-Term Local Anesthetics on Post-Incisional Pain - Johns Hopkins University, School of Medicine, Department of Anesthesia, Division of Pain Medicine (11/2006-12/2006) - Mentor: Srinivasa Raja MD, Chairman, Division of Pain Medicine
8. ***2nd Internship***: Internal Medicine - Maryland General Hospital (7/2007-6/2008)
9. ***Residency***: Physical Medicine & Rehabilitation, Johns Hopkins University, School of Medicine (7/2008-6/2011)
10. ***Fellowship***: Pain Medicine, Department of Anesthesia and Critical Care Medicine, Johns Hopkins University, School of Medicine (7/2011-7/2012)
11. ***2nd Fellowship***: Endoscopic and Arthroscopic Spine Interventions, MidAtlantic Pain and Spine Physicians (9/2012-3/2013)
12. ***Masters in Business Administration***: Kelley School of Business, Indiana University (2021-2023)
13. ***Masters in Machine Learning Candidate***: Georgia Institute of Technology (2022-present)
14. ***CFA Institute Related Activity*** – Passed CFA Level 1 Exam (February 2022), Passed CFA Level 2 Exam (May 2024), Candidate CFA Level 3 Exam – Specialization: Private Markets Pathway (February 2026)
15. ***JD Candidate*** – Albany Law School FlexJD

Medical Employment

1. ***Surgical Hospitalist -*** Surgical Hospitalist, Good Samaritan Hospital, Baltimore, MD (6/2005 – 7/2012)
2. ***Interventional Pain Physician***: Spine Care Center, Manassas, VA (4/2013-11/2013)
3. ***Director of Surgical Services, Director of Neuromodulation, Medical Director of Eastern Shore Offices***: KURE Pain Management, Annapolis, MD (4/2014-1/2017)
4. ***Interventional Pain Physician***: Pain Physicians of Central Florida (9/2018-2/2019)
5. ***Director of Regenerative Medicine:*** Clearway Pain Solutions, MD (2/2019-present)

Business/Finance/Technology Employment and Activities

1. ***CEO/CFO/CTO/Founder:*** The Duality Companies, Inc. (06/2021-present)
    a. **AI Medical Charting Product** – obtained investment of $100K, and bootstrapped rest, wrote decision algorithm for a self-adapting pain management intake survey to diagnose and treat patients in less than 30 questions on average. Features built include SMS-based check-ins, online payments with extensive claims and collections reporting, extensive provider decision-making reporting, ads with reporting, etc. Certifications obtained include HIPAA, SOC2 Type 2, PCI-DSS. One year pilot in the largest pain management practice in the US, Clearway Pain Solutions showed increased physician professional fee collections of up to $5000 per day, and mid-level provider collections of up to $1000 per day

as compared to prior to use of the application when compared to previous 1 year period.

b. **AI Public Company Valuation and Options Trading Recommendation Product** – created a public company valuation and analysis tool using the last 10 years of SEC data, real-time securities and option pricing, insider trading, and last one year of news data scraped in real time to create options trading recommendations at 1, 3, 5, 7, and 14 days, and 1, 3, 6, 9, and 12 months. Low profitability of this product due to market saturation and pricing pressure.
c. **AI Small Claims Legal Case Paperwork Generator with Filing and Service options** – created a legal case documents generator for small claims, as well as traffic and criminal cases, with filing and service options for 8 states (AZ, CA, FL, IL, IN, MI, NV, and TX), with call center for live support.

Other Pre-residency Activities

Externship in Pediatrics : Princeton Community Hospital, Princeton, WV (06 / 2001 - 06 / 2001)
Research Fellow- Department of Clinical Trials: Charleston Area Medical Center, Charleston, WV (07 / 2001 - 09 / 2001)
Externship in Cardiology: Princeton Community Hospital, Princeton, WV, and Bluefield Regional Medical Center, Bluefield, WV (10/2001-11/2001)
Externship in Nephrology: Princeton Community Hospital, Princeton, WV (11/2001-01/2002)
Externship in General surgery/Thoracic Surgery: Bluefield Regional Medical Center, Bluefield, WV (01/2002-03/2002)

Medical Research Activities and Publications

Medical Peer Reviewed Publications

1. A. Höke, R. Redett, **H. Hameed**, R. Jari, C. Zhou, Z. B. Li, J. W. Griffin, and T. M. Brushart. Schwann Cells Express Motor and Sensory Phenotypes That Regulate Axon Regeneration. *Journal of Neuroscience*. 2006. Vol. 26, pp 9646-9655
2. Ky P, **Hameed H**, Christo PJ. Independent Medical Examinations: facts and fallacies. *Pain Physician*. 2009 Sep-Oct;12(5):811-8.
3. Hameed M, **Hameed H**, Erdek M. Pain Management of Pancreatic Cancer. *Cancers*. 2011, 3(1), 43-60.
4. McGreevy K, **Hameed H**, Erdek MA. Updated perspectives on occipital nerve stimulator lead migration: case report and literature review. *Clin J Pain.* 2012 Nov;28(9):814-8.
5. Parr AT, Manchikanti L, **Hameed H**, Conn A, Manchikanti KN, Benyamin RM, Diwan S, Singh V, Abdi S. Caudal epidural injections in the management of chronic low back pain: a systematic appraisal of the literature. *Pain Physician.* 2012 May-Jun;15(3):E159-98.
6. Hansen H, Manchikanti L, Simopoulos TT, Christo PJ, Gupta S, Smith HS, **Hameed H**, Cohen SP. A systematic evaluation of the therapeutic effectiveness of sacroiliac joint interventions. *Pain Physician.* 2012 May-Jun;15(3):E247-78.
7. Simopoulos TT, Manchikanti L, Singh V, Gupta S, **Hameed H**, Diwan S, Cohen SP. A systematic evaluation of prevalence and diagnostic accuracy of sacroiliac joint interventions. *Pain Physician.* 2012 May-Jun;15(3):E305-44.

8. Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, Brown KR, Bruel BM, Bryce DA, Burks PA, Burton AW, Calodney AK, Caraway DL, Cash KA, Christo PJ, Damron KS, Datta S, Deer TR, Diwan S, Eriator I, Falco FJ, Fellows B, Geffert S, Gharibo CG, Glaser SE, Grider JS, **Hameed H**, Hameed M, Hansen H, Harned ME, Hayek SM, Helm S 2nd, Hirsch JA, Janata JW, Kaye AD, Kaye AM, Kloth DS, Koyyalagunta D, Lee M, Malla Y, Manchikanti KN, McManus CD, Pampati V, Parr AT, Pasupuleti R, Patel VB, Sehgal N, Silverman SM, Singh V, Smith HS, Snook LT, Solanki DR, Tracy DH, Vallejo R, Wargo BW. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part I--evidence assessment. *Pain Physician.* 2012 Jul;15(3 Suppl):S1-65.
9. Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, Brown KR, Bruel BM, Bryce DA, Burks PA, Burton AW, Calodney AK, Caraway DL, Cash KA, Christo PJ, Damron KS, Datta S, Deer TR, Diwan S, Eriator I, Falco FJ, Fellows B, Geffert S, Gharibo CG, Glaser SE, Grider JS, **Hameed H**, Hameed M, Hansen H, Harned ME, Hayek SM, Helm S 2nd, Hirsch JA, Janata JW, Kaye AD, Kaye AM, Kloth DS, Koyyalagunta D, Lee M, Malla Y, Manchikanti KN, McManus CD, Pampati V, Parr AT, Pasupuleti R, Patel VB, Sehgal N, Silverman SM, Singh V, Smith HS, Snook LT, Solanki DR, Tracy DH, Vallejo R, Wargo BW. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. *Pain Physician.* 2012 Jul;15(3 Suppl):S67-116.
10. Diwan S, Manchikanti L, Benyamin RM, Bryce DA, Geffert S, **Hameed H**, Sharma ML, Abdi S, Falco FJ. Effectiveness of cervical epidural injections in the management of chronic neck and upper extremity pain. *Pain Physician.* 2012 Jul-Aug;15(4):E405-34.
11. Falco FJ, Manchikanti L, Datta S, Sehgal N, Geffert S, Onyewu O, Zhu J, Coubarous S, Hameed M, Ward SP, Sharma ML, **Hameed H**, Singh V, Boswell MV. An update of the effectiveness of therapeutic lumbar facet joint interventions. *Pain Physician.* 2012 Nov;15(6):E909-53.
12. Manchikanti L, Abdi S, Atluri S, Benyamin RM, Boswell MV, Buenaventura RM, Bryce DA, Burks PA, Caraway DL, Calodney AK, Cash KA, Christo PJ, Cohen SP, Colson J, Conn A, Cordner H, Coubarous S, Datta S, Deer TR, Diwan S, Falco FJ, Fellows B, Geffert S, Grider JS, Gupta S, **Hameed H**, Hameed M, Hansen H, Helm S 2nd, Janata JW, Justiz R, Kaye AD, Lee M, Manchikanti KN, McManus CD, Onyewu O, Parr AT, Patel VB, Racz GB, Sehgal N, Sharma ML, Simopoulos TT, Singh V, Smith HS, Snook LT, Swicegood JR, Vallejo R, Ward SP, Wargo BW, Zhu J, Hirsch JA. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Physician.* 2013 Apr;16(2 Suppl):S49-283.
13. Manchikanti L, Falco FJ, Benyamin RM, Caraway DL, Deer TR, Singh V, **Hameed H**, Hirsch JA. An update of the systematic assessment of mechanical lumbar disc decompression with nucleoplasty. *Pain Physician.* 2013 Apr;16(2 Suppl):SE25-54.
14. Manchikanti L, Benyamin RM, Singh V, Falco FJ, **Hameed H**, Derby R, Wolfer LR, Helm S 2nd, Calodney AK, Datta S, Snook LT, Caraway DL, Hirsch JA, Cohen SP. An update of the systematic appraisal of the accuracy and utility of lumbar discography in chronic low back pain. *Pain Physician.* 2013 Apr;16(2 Suppl):SE55-95.
15. Brushart TM, Aspalter M, Griffin JW, Redett R, **Hameed H**, Zhou C, Wright M, Vyas A, Höke A. Schwann cell phenotype is regulated by axon modality and central-peripheral location, and persists in vitro. *Exp Neurol.* 2013 May 21;247C:272-281.
16. Cohen SP, **Hameed H**, Kurihara C, Pasquina PF, Patel AM, Babade M, Griffith SR, Erdek ME, Jamison DE, Hurley RW. The effect of sedation on the accuracy and treatment outcomes for diagnostic injections: a randomized, controlled, crossover study. Pain Med. 2014 Apr;15(4):588-602.

17. Manchikanti L, Hirsch JA, Cohen SP, Heavner JE, Falco FJ, Diwan S, Boswell MV, Candido KD, Onyewu CO, Zhu J, Sehgal N, Kaye AD, Benyamin RM, Helm S 2nd, Singh V, Datta S, Abdi S, Christo PJ, **Hameed H**, Hameed M, Vallejo R, Pampati V, Racz GB, Raj PP. Assessment of methodologic quality of randomized trials of interventional techniques: development of an interventional pain management specific instrument. Pain Physician. 2014 May-Jun;17(3):E263-90.
18. Cohen SP, **Hameed H**, Pasquina PF, Hurley RW. Sedation for diagnostic injections: prioritizing patient interests. Pain Med. 2014 Nov;15(11):1980-1.

Medical Non-Peer reviewed (Invited) Publications

1. **Hameed H**, Hameed M, Christo P. The Effect of Morphine on Glial Cells as a Potential Therapeutic Target for Pharmacological Development of Analgesic Drugs. *Current Pain and Headache Reports*. Curr Pain Headache Rep. 2010 Apr;14(2):96-104.
2. Christo PJ, Li S, Gibson SJ, Fine P, **Hameed H**. Effective treatments for pain in the older patient. Curr Pain Headache Rep. 2011 Feb;15(1):22-34.

Medical Book Chapters

1. **Hameed H**, Hameed M, Erdek M, Raja SN. Nerve injury and Complex Regional Pain Syndrome. In: Mashour G, Lydic R. eds. *The Neuroscientific Foundations of Anesthesiology*. London. Oxford University Press, 2010
2. Huang JHY, **Hameed H**, Cohen SP. Muscle Relaxants and Myofascial Pain. In: Benzon HT, Raja SN, Cohen SP, Lui SS, and Fishman SM, eds. *Essentials of Pain Medicine and Regional Anaesthesia*, 3rd edition. Philadelphia, Elsevier, 2010
3. Hameed M, **Hameed H**, Cohen SP. Miscellaneous Adjuvant Analgesics, , Comprehensive Pain Medicine and Interventional Pain Management Board Review, ASIPP
4. **Hameed H**, Hameed M, Christo PJ. Neuropathic Pain, Comprehensive Pain Medicine and Interventional Pain Management Board Review, ASIPP
5. Hameed M**, Hameed H**, Christo PJ. Complex Regional Pain Syndrome, Comprehensive Pain Medicine and Interventional Pain Management Board Review, ASIPP Hameed M**, Hameed H**, Christo PJ. Cancer Pain, Comprehensive Pain Medicine and Interventional Pain Management Board Review, ASIPP
6. Huang JHY, **Hameed H**, Cohen SP. Muscle Relaxants and Myofascial Pain. In: Benzon HT, Raja SN, Cohen SP, Lui SS, and Fishman SM, eds. *Essentials of Pain Medicine and Regional Anaesthesia*, 4th edition. Philadelphia, Elsevier, 2016
7. **Hameed H**, Hameed M, Cohen SP. Vertebroplasty and Kyphoplasty. In: Benzon HT, Raja SN, Cohen SP, Lui SS, and Fishman SM, eds. *Essentials of Pain Medicine and Regional Anaesthesia*, 4th edition. Philadelphia, Elsevier, 2016

Medical Abstract Presentations

1. Brushart TM, Redett R, **Hameed H**, Li Z, Zhou C, Hoke A. Schwann cells express sensory and motor phenotypes that control axon regeneration, Program No. 29.7. Washington D.C., Society for Neuroscience 2006
2. Brushart, TM, Redett R, **Hameed H**, Jari R, Zhou C, Bo-Li Z, Griffin JW, Hoke A. Schwann Cells Express Motor and Sensory Phenotypes that Regulate Axon Regeneration. Orthopaedic Research Society 2007.
3. **Hameed H**, Silver K, Arene N, Singh S. Carotid Artery Dissection with Ischemic Stroke and Aphasia following Chiropractic Manipulation of the Cervical Spine. Association of

Academic Physiatrists. 2009

4. Goff B, Ky P, **Hameed H**, Erdek M. Narcosis Following Catheter-tip Migration and Subsequent Pump Mechanism Failure: Experience with an Infusaid-400 Intrathecal Drug Delivery System. International Spine Intervention Society 2009
5. **Hameed H**, MD, Goff B, Ky P, Erdek M. Spinal and peripheral neuromodulation for angina and migraine. American Academy of Pain Management 2009
6. **Hameed H**, Joshi T, Singh S. Anemia Associated With Heterotropic Ossfication Successfully Managed With Etidronate: A Case Report. American Academy of Physical Medicine and Rehabilitation 2009
7. **Hameed H**, Goff H, Ky P, Hameed M, Erdek M. Spinal and peripheral neuromodulation for angina and migraine. Poster No. 120. American Academy of Pain Medicine 2010

Previous Clinical Research in Medicine

1. Randomized Controlled Trials

a. Randomized, double-blind, comparative-effectiveness study comparing epidural steroid injections to gabapentin in patients with lumbosacral radiculopathy (PI - Steven Cohen MD)
b. Randomized, cross-over study evaluating the effect of sedation on pain relief after diagnostic injections. (PI - Steven Cohen MD)
c. A single-blind, randomized, comparative effectiveness study of endoscopic discectomy versus epidural steroid injections for lumbosacral radiculopathy secondary to lumbar intervertebral disc herniations: A cross-over study. (PI – Frank Falco MD)
d. A single-blind, randomized, comparative effectiveness study of rotator cuff tenotomy versus subacromial bursa steroid injections for shoulder pain secondary to rotator cuff tendinitis: A cross-over study. (PI – Frank Falco MD)
e. A prospective, randomized, comparative effectiveness study of spinal cord stimulation versus a combination of spinal cord stimulation and peripheral nerve field stimulation for the treatment of axial low back pain with symptomatic lumbosacral radiculopathy: A cross-over study. (PI – Frank Falco MD)

Basic Science and Translational Research Interests in Medicine

1. Investigation of new uses of Occipital Nerve Stimulation/Second Generation and Peripheral Neurostimulation
2. Investigation of Mechanism of Actions of Occipital Nerve Stimulation, Other Peripheral Nerve, and Spinal Cord Stimulation

Educational and Organizational Activities

Resident and Fellow Education

1. *'Resident and Fellow Lecture Series'* – created for the annual ASIPP meetings since 2010
a. 2010 – One day session
b. 2011 – Two day session
c. 2012 – Two day session

Funded Medical Educational Grants and Projects

1. *'Frontiers in Interventional Pain Management' Lecture* – for highly coveted speakers – for the Resident and Fellow Lecture Series at the Annual ASIPP meetings – 2010, 2011, 2012

Funded Legal and/or Legislative Educational Grants and Projects

1. ***'Legislative Awareness Health Policy and Advocacy Fellowship' (ASIPP)*** – Created for physicians to spend one month in Washington DC, working within a Congess member's office, mentored by ASIPP board members ie Laxmaiah Manchikanti MD, David Kloth MD, and Frank Falco MD, and myself. Our fellow(s) aim to develop ties with congress members and their staffers, and important Washington DC political establishments and engage in lifelong advocacy for the IPM community

    a. **2010** - $4000 award – one recipient – He was set up to worked in Rep. Ed Whitfield's office with his Legislative Aids and has since been retained as a consultant on Pain legislation. On meetings that were set up for him, he was invited to write editorials for the journals "Science", and "Health Affairs". We also created meetings with the Brooking's Institution, CATO institute, Heritage Foundation, Commonwealth Fund, American Society of Anesthesiologists, etc.

    b. **2011** - $25,000 award –distribution to 3 recipients who will work with Congress members' offices, ie Legislative Aids etc. on Pain related legislation, as well as work and network with other important DC institutions

    c. **2012** - $25,000 award – distribution to 3 recipients who worked with Congress members' offices, ie Legislative Aids etc. on Pain related legislation, as well as work and network with other important DC institutions

2. ***'Legislative Awareness Health Policy and Advocacy Fellowship' (NANS)*** – Created for physicians to spend one month in Washington DC, working within a Congess member's office, mentored by NANS board members ie David Kloth MD, and Joshua Prager MD, and myself. Our fellow(s) aim to develop ties with congress members and their staffers, and important Washington DC political establishments and engage in lifelong advocacy for the IPM community

    a. **2013** - $25000 award
    b. **2014** - $25,000 award
    c. **2015** - $25,000 award

Leadership Experience in Medicine

1. ***American Society of Interventional Pain Physicians (ASIPP)***
    a. Member, Board of Directors – 2009-2015
    b. Member, Public Relations and Political Advocacy Committee of Board of Directors - 2009-2015
    c. Member, Research Committee of Board of Directors - 2009-2015
    d. Founder & Chairman of Resident and Fellow Section (RFS) - 2009-2011
    e. Member, Education Committee of RFS - 2009-2012

f. Member, Membership Committee of RFS - 2009-2012
g. Founder & Director, Legislative Awareness, Health Policy, and Advocacy Fellowship 2009-2012

2. American Medical Association (AMA)
a. Alternate Delegate to AMA House of Delegates – representing AMA-RFS 2009-2012
b. Delegate to the RFS Assembly - 2009 to 2012 - representing ASIPP
c. Chair, Rules Committee – 2010 RFS Interim Meeting
d. Alternate Delegate to AMA House of Delegates – representing ASIPP 2012-2015

3. Maryland Society of Interventional Pain Physicians
a. Secretary, 2010-2012

4. Maryland State Medical Society (MedChi)
a. President, Resident and Fellow Section – 2011-2012
b. Delegate, to House of Delegates – representing MedChi Resident and Fellow Section 2010-2012
c. Member, Legislative Council 2010-2012

5. American Medical Political Action Committee (AMPAC)
a. Attendee, AMPAC 2011 Campaign School – a fully funded experience designed to educate physicians how to run a political campaign

6. North American Neuromodulation Society (NANS)
a. AMA-SSS Delegate (2015-2018)
b. Member, Advocacy and Policy Committee – 2012-2023
c. Member, Research Committee – 2012-2020
d. Member, Resident and Fellow Advisory Committee – 2012-2020
e. Delegate to the AMA Current Procedural Terminology (CPT) Committee – (2015-2017)
f. Delegate to the AMA Relative Value Scale Update Committee (RUC) - (2015-2017)
g. Delegate, AMA House of Delegates (2018-2023)

Medical Professional Society Lectures

1. American Society of Interventional Pain Physicians (ASIPP), 12th Annual Meeting, June 26th - 30th 2010
   a. Therapeutic Lumbar Facet Joint Procedures: Current Evidence

2. American Society of Regional Anesthesia and Pain Medicine (ASRA), 12th Annual Pain Medicine Meeting, November 21st-24th 2013
   a. Pain management in Special Populations: Considerations for Patients with Secondary Gain
   b. Overuse/Repetitive Strain Injuries
   c. Pain and Obesity

3. American Society of Interventional Pain Physicians (ASIPP), 16th Annual Meeting, April 4th - 6th 2014
   a. Thoracic outlet syndrome
   b. Ultrasound workshop

Haroon Hameed MD
Curriculum Vitae

Medical Professional Societies

1. American Society of Interventional Pain Physicians (ASIPP)
2. Society for Neuroscience (SFN)
3. American Medical Association (AMA)
4. North American Neuromodulation Society (NANS)
5. International Spine Intervention Society (ISIS)
6. American Academy of Pain Medicine (AAPM)
7. American Society of Regional Anesthesia and Pain Medicine (ASRA)
8. Association of Academic Physiatrists (AAP)
9. American Academy of Physical Medicine and Rehabilitation (AAPMR)
10. American Academy of Pain Management

Finance Professional Societies

1. American Finance Association (AFA)

Law Professional Societies and Committee Memberships

1. ***American Bar Association (ABA)***

    a. **ABA Litigation Section**
        i. Trial Evidence & Practice Committee
        ii. Class Actions & Derivative Suits Committee
        iii. Alternative Dispute Resolution Committee
        iv. Young Advocates Committee
        v. Corporate Counsel Committee
        vi. Business Torts & Unfair Competition Litigation Committee

    b. **ABA Business Law Section**
        i. Business Law Section Middle Market and Small Business Committee
        ii. Mergers and Acquisitions Committee
        iii. Business and Corporate Litigation Committee
        iv. Securitization and Structured Finance Committee
        v. Corporate Counsel Committee
        vi. Legal Analytics Committee
        vii. Law Student Committee
        viii. Private Equity and Venture Capital Committee
        ix. Derivatives and Futures Law Committee
        x. Business Bankruptcy Committee
        xi. Leadership Development Committee
        xii. Young Lawyer Committee

2. ***American Association for Justice (AAJ)***

Leadership Experience in Law

Haroon Hameed MD
Curriculum Vitae

1. ***Albany Law School***

    a. **Student Bar Association**
        i. FlexJD Senator (08/2024-04/2025)
        ii. 2L Senator (FlexJD) (04/2025-present)

    b. **Class Action and Mass Torts Society**
        i. President (10/2024 – present)

    c. **Business Law Society**
        i. FlexJD Representative (9/2024-4/2025)
        ii. Vice President (4/2025-present)

2. ***American Bar Association (ABA)***

    a. **ABA Business Law Section**
        i. Vice Chair - Law Student Committee (01/2025-present)

Academic Awards

1. Concord University – Full Tuition Scholarship (1994)
2. National Merit Scholarship (1995)
3. John Marshall Scholarship, Marshall University WV (1995)– highest academic scholarship (full tuition, room, board & stipend)
4. Ethel M. Bowen Scholarship (1995) – Bluefield Bank, Bluefield, WV
5. Pharmacology – 1st Division (1998)

Other Selected Activities

1. The Kabbalah Center. 1st Leadership Retreat. Invited member 2007
2. Involved Events. A Worldwide DJ Charity Organization. Board of Directors. 2008
3. The Lee Strasberg Theatre and Film Institute. New York. One year acting conservatory
4. The New York Film Academy. Acting Workshop
5. The Studio Theatre. Washington DC. Acting Workshop
6. Member, MENSA

Volunteer Experience

1. Princeton Community Hospital. Volunteer in Radiology department. 1995

Exhibit B

Center for Professional Recovery

PROFESSIONALS TREATMENT PROGRAM

12/16/2020

Re: Haroon Hameed
To Whom It May Concern:

Dear Members of the Board of Physicians:

I am writing to you on behalf of Haroon Hameed M.D. who I understand will be appearing before a Panel of the Board for consideration of a Consent Order. I have been provided a copy of the Consent Order language and have reviewed the Charges and Order of Summary Suspension. I noted that Dr. Hameed has been charged with violations among which I have found 3 to be somewhat inconsistent with his presentation to the Center for Professional Recovery for which I serve as the Medical Director.

By way of background, I am Board Certified in both Addiction Medicine and Internal Medicine, a Distinguished Fellow with the American Society of Addiction Medicine, a Certified Medical Review Officer, the Medical Director of PBI Education, and the former Medical Director of the Alabama Physician Health Program (1999-2011). I am intimately familiar with rehabilitation and recovery of impaired professionals and work collaboratively with a doctorate level team of skilled and conscientious clinicians in a small, intensive 8-bed inpatient facility in California designed to treat impaired professionals including physicians, attorneys, judges etc.

I have included with this letter for the Board's review, a copy of my C.V. with task force appointments, awards, publications and special appearances. I provide this backdrop to ensure the Board that I have devoted the past 20+ years of my professional life to treating professionals with all aspects of impairment including alcohol and drug abuse.

I have had the opportunity to work with Dr. Hameed and I and the staff at the Professional Treatment Program are continuing to get to know him. He has shared with us his understanding of the current circumstances and has been forthcoming in sharing documents issued by the Board of Physicians. We have also reviewed the excellent evaluation report from the Caron Foundation. Our clinical team, including our addiction psychiatrist, Dr. Hameed's current psychologist and other therapists involved in his care, have met together and discussed his case. Dr. Hameed presents as a dedicated, skilled and driven physician who has a deep, sincere desire to

help his patients. He also presents as bright, attentive and charismatic. This presentation is somewhat incongruent with the facts of his case and he exhibits some denial regarding all that has transpired. This is not unusual as a defensive mechanism among physicians in this situation, but he appears open and willing and we are hopeful he will be responsive to treatment.

While there have clearly been past episodes of gross impairment, our clinical team feels confident at this time that he is not physically or mentally incompetent. We are not yet in a position to advocate that he is yet fit to return to duty but we are hopeful that he will respond to treatment and that we will be able to advocate for him to return to work at the appropriate time.

Based on my review of the Charges and Order of Summary Suspension, coupled with our evaluations at the Center for Professional Recovery, there is no evidence of Dr. Hameed being habitually intoxicated, at least recently. Dr. Hameed admits there have been occasions when he used prescribed medications in excess of the recommended dosage, and that he inappropriately used alcohol to help him sleep when he was suffering from chronic pain prior to his surgery. In our careful review of the data and our assessment we are making diagnoses of Alcohol Use Disorder, Moderate, Unspecified Opioid Related Disorder and Unspecified Sedative Hypnotic Related Disorder. It will be important that he understand and accept these diagnoses. However, these diagnoses do not, in my medical opinion, necessarily constitute “habitual intoxication” as that terminology is understood by those of us who specialize in Addiction Medicine. Many individuals with addictive disorders are high functioning for many years and show only episodic impairment, and not “habitual intoxication.”

Additionally, "Professional Incompetence” presents with certain baseline criteria that we do not see in the case of Dr. Hameed. He is well trained and his performance at work has been praised by his leadership, with whom we have interviewed. Dr. Hameed has expressed remorse for all that has transpired and has shown a recent commitment to total abstinence which he began several weeks prior to his enrollment in our program.

We are hopeful that as is the case with many physicians we treat, that upon successful completion and discharge from our program, that Dr. Hameed will be permitted to return to his employment under a carefully constructed monitoring agreement we will help develop with the Maryland Physician Rehabilitation Program that will assure his safe return to practice. I assure you that if we do not see adequate progress and/or we do not believe he is safe to return to practice from our clinical perspective we will not advocate as such for him. Please feel free to contact me with any questions regarding the above stated opinions at (310) 633-4595.

Sincerely,

Gregory Skipper, MD
Distinguished Fellow, American Society of Addiction Medicine
Board Certified in Addiction Medicine and Internal Medicine
Director, Center for Professional Recovery

Exhibit C

MARYLAND STATE	*	**BEFORE BRIAN PATRICK WEEKS**
BOARD OF PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE OF**
HAROON I. HAMEED, M.D.	*	**ADMINISTRATIVE HEARINGS**
Respondent	*	**OAH Numbers: MDH-MBP-71-20-25356**
License Number: D63269	*	**MDH-MBP-72-20-25355**

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

PARTIES JOINT STIPULATIONS OF FACT

1. The Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on June 3, 2005, under License Number D63269. The Respondent's license is set to expire on September 30, 2022.
2. The Respondent is board-certified in physical medicine and rehabilitation. The Respondent is employed as a physician at Clearway Pain Solutions with offices located throughout Maryland.
3. On June 3, 2020 the Board received a complaint alleging that the Respondent had performed a radiofrequency ablation instead of a cervical facet block on August 28, 2019.
4. The Respondent admits that he performed a radiofrequency ablation instead of a cervical facet block on August 28, 2019.

5. The patient for whom the Respondent performed the August 28, 2019 procedure was satisfied with the treatment provided and the resulting pain relief from the radiofrequency ablation.

6. On or about March 15, 2011, the Respondent was charged with Driving While Impaired by Alcohol, for which he later received a Probation Before Judgment.

7. Between December 23, 2015 and January 2017, and then from October 2019 until May 20, 2020, the Respondent was prescribed narcotic pain medication [1] by pain management professionals in order to treat chronic pain syndrome related to conditions that required hip replacement surgery.

8. The Respondent's medical condition required surgical intervention on February 20, 2020, which surgery was successfully performed by a Board-certified orthopedic surgeon.

9. Following an expected and protracted period of convalescence and rehabilitation following surgical intervention, the Respondent has fully recovered and has discontinued all use of prescription pain medication.

10. On February 17, 2020 prior to orthopedic surgery, the Respondent was observed by staff as unable to weight bear and keep his balance while attempting to extract medication from a vial with a syringe.

11. Staff privately questioned the Respondent whether he was impaired. He stated that he was in extreme pain and became emotional.

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1 To maintain confidentiality, the Respondent's medication will not be disclosed in this document, but will be provided to the Respondent upon request.

12. Facility staff recommended that the Respondent discontinue treatment of patients for the day.

13. The Respondent performed no further procedures on February 17, 2020. Facility staff reported the incident to human resources.

14. On May 5, 2020 the Respondent overslept and arrived at work 10-15 minutes late.

15. The Respondent admits that he ingested 10 mgs. of oxycodone and 1.5 mg of Lunesta sometime in the night before to aid with sleep and pain.

16. This medication was prescribed by a medical professional to treat the Respondent's documented insomnia.

17. The Respondent admits that he consumed 1-2 alcoholic beverages the night before between 10:00-11:00 p.m.

18. The Respondent admits that when he arrived at the facility on the morning of May 5, 2020, he was impaired by sleep deprivation, use of a sleep aid in excess of the prescribed dose, and use of a Schedule II narcotic pain medication prescribed to alleviate his chronic pain. The Respondent did not see any patients that day.

On behalf of Dr. Haroon Hameed

By: Anuj Patel Date: 4/9/21

with authorization from Natasha Wesker to E-Sign for Submission

Natasha S. Wesker
Natasha Wesker Law, LLC

On behalf of the State of Maryland

By: Anuj Patel Date: 4/9/21

Anuj Patel
Assistant Attorney General
Maryland Office of the Attorney General
Health Occupations Prosecution & Litigation Division

By: _____ Date: 4/9/21

K. F. Michael Kao
Assistant Attorney General
Office of the Attorney General
Health Occupations Prosecution & Litigation Division

Exhibit D

MARYLAND STATE BOARD OF	*	**BEFORE BRIAN PATRICK WEEKS,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
HAROON I. HAMEED,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	**OAH Nos.: MDH-MBP1-71-20-25356** **MDH-MBP1-72-20-25355**
LICENSE No.: D63269	*	

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

PROPOSED DECISION

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

STATEMENT OF THE CASE

On November 5 and 6, 2020, the Maryland State Board of Physicians (Board) issued charges against and summarily suspended the license to practice medicine of Haroon I. Hameed, M.D. (Respondent) for alleged violations of the State law governing the practice of medicine (the Act). Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2020); Md. Code Ann., State Gov't § 10-226(c) (2014); Code of Maryland Regulations (COMAR) 10.32.02.08. Specifically, the Board charged the Respondent with violating the following sub-subsections of Section 14-404(a): (3)(ii) (unprofessional conduct in the practice of medicine), (4) (incompetence), (7) (habitual intoxication), (8) (addiction or habitual use of narcotic or controlled dangerous substance (CDS)), and (9) (providing professional services while under the influence of alcohol or using any narcotic or CDS) of the Act. Health Occ.

§ 14-404(a)(3)-(4), (7)-(9) (Supp. 2020); COMAR 10.32.02.03E(3)(d). The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

On December 7, 2020, I held a telephone scheduling conference at the OAH in Hunt Valley, Maryland. Michael Kao and Anuj Patel, Assistant Attorneys General and Administrative Prosecutors, represented the State of Maryland (State). Natasha Wesker, Esquire, represented the Respondent, who was not present. At the outset of the conference, the parties informed me that a meeting with the Disciplinary Committee for Case Resolution had been scheduled for December 16, 2020. As such, the Respondent agreed to waive the requirement that the OAH set a hearing within thirty days of the request for a hearing on the summary suspension. COMAR 10.32.02.08I. After consultation with the parties, we selected February 1-5, 2021 as the dates for the hearing.

On January 13, 2021, the Respondent, who was at a residential rehabilitation center in California, requested a continuance until he had completed his recommended treatment under the care of Dr. Gregory Skipper, the Respondent's designated treating physician and expert witness. On January 14, 2021, the State indicated that it consented to a continuance of the matter. For the reasons stated on the record at a telephone prehearing conference on January 19, 2021, I denied the Respondent's request for a postponement, but allowed the Respondent to send an additional request with documentation, along with agreed-upon proposed hearing dates. COMAR 28.02.01.16. On January 20, 2021, Dr. Skipper sent a letter explaining the basis for the postponement request, and on January 28, 2021, I granted the postponement request and rescheduled the hearing for April 19-21 and 26-28, 2021.

On March 5, 2021, the Respondent filed a Motion *in Limine* (Motion) to preclude the introduction of communications allegedly obtained by Kathryn Wathen, R.N. (Nurse Wathen), in violation of the Maryland Wiretap Act,[1] and any evidence "derived therefrom." Md. Code Ann., Cts. & Jud. Proc. § 10-405(a) (2020). On March 29, 2021, I held a motion hearing by telephone. At the motion hearing, the State agreed that it would not seek to introduce the disputed communications into evidence at the hearing and would redact any reference to the communications in its documentary evidence. In exchange for this agreement by the State, the Respondent withdrew the Motion while on the record.

On April 14, 2021, the Respondent filed a request for postponement because of a medical emergency. After receiving documentation of the emergency, I granted the request and selected the following dates for the hearing: May 6-7 and 18-20, 2021.

I held a remote video hearing on May 6, 7, 18 and 19, 2021.[2] Health Occ. § 14-405(a)-(b) (Supp. 2020); COMAR 10.32.02.04; COMAR 28.02.01.20B. Mr. Kao and Mr. Patel represented the State. John Murphy, Esquire, represented the Respondent, who was present.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act (APA), the rules for hearings before the Board, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2020); COMAR 10.32.02; COMAR 28.02.01.

[1] Md. Code Ann., Cts. & Jud. Proc. §§ 10-401 to 10-414 (2020).
[2] Since we concluded on May 19, 2021, the final date of May 20, 2021 was cancelled.

ISSUES

1. Whether the Respondent violated the following sub-subsections of Section 14-404(a) of the Act:
    a. (3)(ii) (unprofessional conduct in the practice of medicine),
    b. (8) (addiction or habitual use of narcotic or CDS),
    c. (9) (providing professional services while under the influence of alcohol or using any narcotic or CDS),
    d. (7) (habitual intoxication), or
    e. (4) (incompetence)?
2. Whether the Board violated the emergency suspension provisions of the APA or the Board's regulations governing emergency suspensions by issuing an order of suspension before giving the Respondent an opportunity to be heard?
3. Whether the Respondent's actions pose a substantial likelihood of risk of serious harm to the public health, safety, or welfare, which require the Board to continue the summary suspension?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following joint exhibits offered by the parties:

Jt. Ex. 1 - Respondent's written response, Information Form, Authorization for Release of Information and Curriculum Vitae (CV), August 14, 2020 (J001 - J010)

Jt. Ex. 2 - Spectrum Compliance Drug Test Result Details, September 9, 2020 (J011 - J015)

Jt. Ex. 3 - Maryland Physician Health Program (MPHP) Initial Consultation, August 31, 2020 (J016 - J022)

Jt. Ex. 4 - MPHP Consent for Release of Confidential Information, signed October 19, 2020 (J023)

Jt. Ex. 5 - MPHP Participant Information, August 23, 2020 (J024 - J025)

Jt. Ex. 6 - MPHP Financial Consent Form, signed by Respondent August 23, 2020 (J026)

Jt. Ex. 7 - MPHP Consent for Release of Confidential Information to Board, October 19, 2020 (J027)

Jt. Ex. 8 - MPHP Practice Cessation Agreement, November 9, 2020 (J028)

Jt. Ex. 9 - Ralph Raphael, Ph.D., Psychological Evaluation, November 11, 2020 (J029 - J038)

Jt. Ex. 10 - Dr. Raphael Evaluation Update, November 16, 2020 (J039 - J041)

Jt. Ex. 11 - MPHP Participant Monitoring and Advocacy Contract, signed November 13, 2020 (J042 - J043)

Jt. Ex. 12 - MPHP Clinical Management Plan, signed February 23, 2021 (J044 - J045)

Jt. Ex. 13 - MPHP Toxicology Protocol, signed November 13, 2020 (J046)

Jt. Ex. 14 - MPHP Client Contract Disclosure, November 13, 2020 (J047)

Jt. Ex. 15 - MPHP Case Management Contact Notes, various dates (J048 - J051)

I admitted the following exhibits into evidence on behalf of the State, unless otherwise noted:

Bd. Ex. 1 - Board complaint form, received June 3, 2020 (S0001 - S0005)

Bd. Ex. 2 - Excerpts from Respondent's file from Clearway Pain Solutions (Clearway), various dates (S0006-S0024)

Bd. Ex. 3 - Initial contact letter to Respondent with complaint, Information Form and Authorization for Release of Information, July 31, 2020 (S0025 - S0033)

Bd. Ex. 4 - Emails between Nurse Wathen and Board staff regarding former employee Amanda Wertz, various dates (S0034 - S0035)

Bd. Ex. 5 - Email from Leslie Cumber, Esq., regarding Respondent's employment with Clearway, August 24, 2020 (S0036 - S0037)

Bd. Ex. 6 - Email from Nurse Wathen attaching text messages with Benjamin Foo, M.D., August 26, 2020 (S0038 - S0048)

Bd. Ex. 7 - Email from Nurse Wathen attaching notification to Human Resources Department at Clearway regarding May 5, 2020 incident, August 26, 2020 (S0049 - S0054)

Bd. Ex. 8 - Email from Nurse Wathen attaching screenshots of text conversation with Respondent on or about February 17, 2020, undated (S0055 - S0061)

Bd. Ex. 9 - Email from Kathryn Wathen, R.N. attaching incident reports from February 17, 2020 (S0062 - S0066) – *pre-marked but not offered*

Bd. Ex. 10 - Interview transcript of Barbara Harms, R.N., August 26, 2020 (S0067 - S0093)

Bd. Ex. 11 - Interview transcript of Nurse Wathen, August 26, 2020 (S0094 - S0141)

Bd. Ex. 12 - Excerpts of Respondent's September 23, 2019 Emergency Department record – Sibley Memorial Hospital, printed September 28, 2020 (S0142 - S0156)

Bd. Ex. 13 - Excerpts of Respondent's April 27, 2020 Emergency Department record – Sibley Memorial Hospital, printed September 28, 2020 (S0157 - S0173)

Bd. Ex. 14 - Email from Kathryn Wathen, R.N. attaching screenshots of text conversation with Amanda Wertz, R.N. (S0174 - S0175) – *offered but not admitted*

Bd. Ex. 15 - Email from Nurse Harms, May 16, 2020 (S0176)

Bd. Ex. 16 - Interview transcript of Morgan Meekins, September 10, 2020 (S0177 - S0198)

Bd. Ex. 17 - Respondent's court record from Maryland District Court for Anne Arundel County, generated September 14, 2020 (S0199 - S0204)

Bd. Ex. 18 - A copy of original prescription from Elizabeth Matesa, P.A., to Respondent, February 19, 2020 (S0205 - S0206)

Bd. Ex. 19 - Excerpts from Respondent's medical record - Clearway, undated (S0207 - S0227)

Bd. Ex. 20 - Copies of original prescriptions from Amit Patel, P.A., to Respondent, various dates (S0228 - S0240)

Bd. Ex. 21 - Interview transcript of Georgia Harper, P.A., September 16, 2020 (S0241 - S0252)

Bd. Ex. 22 - Interview transcript of Respondent, September 29, 2020 (S0253 - S0296)

Bd. Ex. 23 - Respondent's medical record from David Cohen, M.D., various dates (S0297 - S0305)

Bd. Ex. 24 - Informed Consent Form for Patient AS, signed August 28, 2019 (S0306)

Bd. Ex. 25 - Interview transcript of Nurse Wertz, November 4, 2020 (S0307 - S0320)

Bd. Ex. 26 - Dr. Raphael CV, undated (S0321 - S0322)

Bd. Ex. 27 - Caron Treatment Center Assessment/Discharge Information (S0323) – *offered but not admitted*

Bd. Ex. 28 - Respondent's licensing profile, printed October 14, 2020 (S0324 - S0340)

Bd. Ex. 29 - Board's Report of Investigation, December 9, 2020 (S0341 - S0352)

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

Resp. Ex. 1 - Transcript of Devyn Tucker, September 23, 2020 (RES 001)

Resp. Ex. 2 - Letter from Astrid Richardson-Ashley, LCSW, April 6, 2021 (RES 011)

Resp. Ex. 3 - Dr. Skipper CV, May 30, 2020 (RES 013)

Resp. Ex. 4 - Letter from Dr. Skipper, December 16, 2020 (RES 035)

Resp. Ex. 5 - Psychiatry Follow-Up Note from Matthew Goldenberg, D.O., December 16, 2020 (RES 037)

Resp. Ex. 6 - Treatment Discharge Report from Center for Professional Recovery (CPR), January 21, 2021 (RES 042)

Resp. Ex. 7 - Letter from Dr. Skipper, March 29, 2021 (RES 056)

Resp. Ex. 8 - Brian Gill, LICSW, CV, undated (RES 058)

Resp. Ex. 9 - Kolmac Outpatient Recovery Centers (Kolmac) Intake Evaluation Note, January 19, 2021 (RES 060)

Resp. Ex. 10 - Letter from Mr. Gill, April 1, 2021 (RES 061)

Resp. Ex. 11 - Ehsan Abdeshahian, MD, CV, undated (RES 062)

Resp. Ex. 12 - Dick Prodey Alcohol Education Lecture Summaries 1-16, undated (RES 065)

Resp. Ex. 13 - University of California, Irvine School of Medicine PBI Medical Ethics and Professional Course Certificate, completed February 26-27, 2021 (RES 117)

Testimony

The following witnesses testified on behalf of the State:

- Alexandra Fota, Board Compliance Analyst;
- Nurse Wathen; and
- Nurse Harms.

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

- James Hammond, Certified Registered Nurse Anesthesiologist;
- Dr. Skipper, Medical Director at CPR, accepted as an expert in addiction medicine;
- Mr. Gill, Clinical Director at Kolmac; and
- Dr. Abheshahian, Senior Vice President at Clearway.

FACTUAL STIPULATIONS

1. The Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on June 3, 2005, under License Number D63269. The Respondent's license is set to expire on September 30, 2022.

2. The Respondent is board-certified in physical medicine and rehabilitation. The Respondent is employed as a physician at Clearway with offices located throughout Maryland.

3. On June 3, 2020, the Board received a complaint alleging that the Respondent had performed a radiofrequency ablation instead of a cervical facet block on August 28, 2019.

4. The Respondent admits that he performed a radiofrequency ablation instead of a cervical facet block on August 28, 2019.

5. The patient for whom the Respondent performed the August 28, 2019 procedure was satisfied with the treatment provided and the resulting pain relief from the radiofrequency ablation.

6. On or about March 15, 2011, the Respondent was charged with driving while impaired by alcohol (DWI), for which he later received probation before judgment (PBJ).

7. Between December 23, 2015 and January 2017, and then from October 2019 until May 20, 2020, the Respondent was prescribed narcotic pain medication by pain management

professionals in order to treat chronic pain syndrome related to conditions that required hip replacement surgery.

8. The Respondent's medical condition required surgical intervention on February 20, 2020, which surgery was successfully performed by a Board-certified orthopedic surgeon.

9. Following an expected and protracted period of convalescence and rehabilitation following surgical intervention, the Respondent has fully recovered and has discontinued all use of prescription pain medication.

10. On February 17, 2020, prior to orthopedic surgery, the Respondent was observed by staff as unable to weight bear and keep his balance while attempting to extract medication from a vial with a syringe.

11. Staff privately questioned the Respondent whether he was impaired. He stated that he was in extreme pain and became emotional.

12. Facility staff recommended that the Respondent discontinue treatment of patients for the day.

13. The Respondent performed no further procedures on February 17, 2020. Facility staff reported the incident to Human Resources.

14. On May 5, 2020, the Respondent overslept and arrived at work ten to fifteen minutes late.

15. The Respondent admits that he ingested 10 mg of oxycodone and 1.5 mg of Lunesta sometime in the night before to aid with sleep and pain.

16. This medication was prescribed by a medical professional to treat the Respondent's documented insomnia.

17. The Respondent admits that he consumed one to two alcoholic beverages the night before between 10:00-11:00 p.m.

18. The Respondent admits that when he arrived at the facility on the morning of May 5, 2020, he was impaired by sleep deprivation, use of a sleep aid in excess of the prescribed dose[3], and use of a Schedule II narcotic pain medication prescribed to alleviate his chronic pain. The Respondent did not see any patients that day.

19. Procedure records obtained by the Board from Clearway between February 2019 and June 2020 show that when not out on medical leave, Respondent would on average see more than twenty (20) patients for procedures each day, three days per week. In the one year leading up to his February 2020 surgery, Respondent performed close to, if not in excess of, 3,000 patient procedures.

20. On August 31, 2020, the Respondent voluntarily entered the MPHP.

21. On November 5, 2020, the Board summarily suspended Respondent's license to practice medicine without a pre-deprivation hearing, affording him instead the opportunity for a post-deprivation show cause hearing later that month.

22. On November 9, 2020, the Respondent voluntarily signed a contract with the MPHP titled "Voluntary Practice Cessation Agreement."

23. On November 11, 2020, Ralph Raphael, Ph.D., performed a psychiatric evaluation[4] of the Respondent for the MPHP.

24. On November 18, 2020, counsel for the parties appeared before the Board's Disciplinary Panel B and jointly requested a continuance of the post-deprivation show cause hearing until December 16, 2020, to afford Respondent time to comply with the recommendations of Dr. Raphael. The Board denied that consent request, after which Respondent waived his show cause hearing and requested an evidentiary hearing with OAH.

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[3] The parties did not stipulate to what the prescribed dose was.
[4] This should read psychological evaluation. *See* Jt. Ex. 9.

25. Between November 22, 2020 and November 25, 2020, the Respondent received inpatient substance abuse treatment from the Caron Treatment Center in Pennsylvania.

26. Between December 7, 2020 and January 21, 2021, the Respondent received inpatient substance abuse treatment from the CPR in California.

27. Between January 21, 2021 and March 21, 2021, the Respondent received outpatient substance abuse treatment from the Kolmac Clinic.

28. Since leaving the Caron Treatment Center on November 25, 2020, the Respondent has undergone repeated random drug and alcohol testing without any positive findings.

PROPOSED FINDINGS OF FACT

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

1. Clearway provides pain management consultations for patients, prescriptions for pain medications, and surgical interventions to relieve pain. (Bd. Ex. 10, S0069).

2. Clearway provides treatment to approximately twenty-five to thirty patients each day at its offices in Easton and Kent Island. (Bd. Ex. 10, S0070).

3. The Respondent was born on February 24, 1978. (Jt. Ex. 5, J0024).

4. The Respondent has a girlfriend of many years, but the relationship has been off and on and they do not live together. (Jt. Ex. 6, J0034). The Respondent's girlfriend has expressed concerns to him regarding the impact of the Respondent's drinking on his health. (Jt. Ex. 6, J0035).

5. The Respondent had a blood alcohol content level of 0.11 g/dL when the police stopped him for speeding at a rate of 77 mph in a posted 45 mph zone on March 15, 2011. (Jt.

Ex. 6, J0036; Bd. Ex. 17, S0204). The Respondent did not immediately report the PBJ for DWI to the Board. (Resp. Ex. 6, RES051).

6. In or about spring 2016, the Respondent reported to the Annapolis Clearway location and the medical assistant reported to Nurse Wertz that she believed that he was drunk because the room smelled of alcohol. Nurse Wertz asked if the Respondent had drunk alcohol that day; he denied drinking that day but admitted drinking the night before. Nurse Wertz called her manager, and the manager stated that the Respondent was cleared to work that day. The Respondent treated patients that day. (Bd. Ex. 25, S0309-S0311).

7. On an unspecified date, Dr. Freas, Clearway CEO, prescribed Lunesta, a medication to assist with sleep, for the Respondent. (Bd. Ex. 22, S0262). Lunesta is a controlled medication. (Dr. Skipper testimony, 5/18, T. 389).

8. Nurse Wathen began working at Clearway in May 2018. (Bd. Ex. 11, S0095). Her title was Nurse Administrator and she had supervisory responsibility for patient care technicians and nurses, primarily at the Kent Island and Easton locations of Clearway. (Wathen testimony, 5/6, T. 162-163). She worked approximately twenty hours a week with the Respondent. (*Id.*, T. 164).

9. On August 28, 2019, while patient AS was still sedated from the radiofrequency ablation procedure, the Respondent asked Nurse Wathen to change the informed consent form to state that AS had consented to a radiofrequency ablation rather than a cervical facet block, which is the procedure that AS had consented to. Nurse Wathen told the Respondent that she would not change the consent form and that he should go speak to the patient and tell her what happened. After speaking with Deborah Bloodsworth, the Vice President of Clearway, the Respondent again asked Nurse Wathen to change the informed consent form, and she refused. The Respondent changed the informed consent form by adding a slash and "RFA" to the form. The

Respondent did not have the patient acknowledge the change by signing the form. The Respondent noted the error in the patient's medical record but did not fill out an incident report. (Bd. Ex. 11, S0113-S0117; Bd. Ex. 24).

10. On September 23, 2019, the Respondent was admitted to Sibley Memorial Hospital because of abdominal and chest pain that had lasted for the preceding two to three days. The attending doctor at Sibley diagnosed the Respondent with acute pancreatitis, caused by hypertriglyceridemia and opined that a possible cause was the Respondent's alcohol use. The Respondent reported alcohol use of three drinks per day five days a week. The attending doctor prescribed oxycodone for the Respondent. (Bd. Ex. 12).

11. On an unspecified date in 2019, the Respondent obtained a prescription for oxycodone to help manage pain from his treating physician, Dr. Freas. He later obtained additional prescriptions from physician assistants from Clearway, Nathan Turner and Amit Patel. (Bd. Ex. 22, S0261).

12. Between at least October 2019 and May 2020, the Respondent had a nightly habit of consuming alcohol in conjunction with Lunesta and oxycodone to help him sleep. (Resp. Ex. 6, RES045-046).

13. Between May and November 2020, the Respondent continued to drink at least two beers four to five times a week just before bed to help with sleep. (Respondent testimony, 5/19, T. 507-508).

14. Nurse Harms began working at Clearway in October 2019. (Bd. Ex. 10, S0068). Nurse Harms worked with the Respondent approximately two times a week. (Harms testimony, 5/7, T. 252-253). Occasionally, patients would complain to Nurse Harms about the speed with which the Respondent was performing their procedure. (Bd. Ex. 10, S0075-S0076).

15. On November 19, 2019, Nurse Wathen observed the Respondent in his vehicle in the parking lot of Wishing Well Liquors in Easton thirty minutes after he had left work for the day. On November 20, 2019, the Respondent showed up to Clearway's Easton location after 12:00 p.m. looking disheveled and with bloodshot eyes. He stated that he had slept through his alarms. Staff at Clearway cancelled all the morning appointments and the Respondent treated patients in the afternoon. (Bd. Ex. 11, S0122-S0123; Bd. Ex. 10, S0081).

16. On the night of February 16, 2020, the Respondent took oxycodone and Lunesta and drank alcohol prior to going to bed. (Respondent testimony, 5/18, T. 495).

17. On February 17, 2020, at approximately 9:43 a.m., the Respondent was in the procedure room to treat a patient and was swaying. (Bd. Ex. 2, S0010). Ms. Meekins, a procedure care technician at Clearway, instructed him to stop swaying so that she would not be stabbed with a needle. *Id.* The Respondent completed the procedure, an epidural steroid injection, and Ms. Meekins informed Shelby Jaffray that the Respondent should not perform any more procedures that day. *Id.* The Respondent was not able to work on the patient's chart. (Bd. Ex. 11, S0124). At approximately 9:50 a.m., Nurse Wathen told the Respondent that she needed to speak with him privately. (Bd. Ex. 11, S0101). Nurse Wathen cancelled around thirty appointments that had been scheduled for that day. (Wathen testimony, 5/6, T. 175, 180).

18. On April 27, 2020, the Respondent was admitted to Sibley Memorial Hospital at 2:09 p.m. complaining of shortness of breath that had lasted for about twelve hours. He exhibited slightly slurred speech and appeared mildly intoxicated by alcohol, and lab results tested positive for oxycodone. The Respondent had at least three drinks prior to his admission. (Respondent testimony, 5/19, T. 492). The treating physician informed the Respondent of the danger of mixing alcohol and oxycodone. (Bd. Ex. 13).

19. On May 5, 2020, the Respondent displayed the following signs of intoxication while at Clearway's Easton location:

- slurred speech;
- stumbling;
- bloodshot and glassy eyes;
- disheveled appearance;
- pants falling down to reveal three to four inches of boxer shorts;
- inability to recognize Nurse Harms;
- inability to properly put on his facemask;
- inability to plug in his computer charger without assistance;
- inability to locate his cell phone;
- lighting multiple cigarettes on the wrong end; and
- almost falling out of chair while attempting to sit.

(Bd. Ex. 2, S0019; Bd. Ex. 10, S0071; Wathen testimony, 5/6, T. 189). Nurse Wathen asked the Respondent about a patient's lab results, but the Respondent was not able to follow up with the patient or Nurse Wathen. (Bd. Ex. 10, S0072). Nurse Wathen helped the Respondent turn his computer on and once his computer was on, he could access patient records. (Bd. Ex. 2, 021; Wathen testimony, 5/6, T. 193; Harms testimony, 5/7, T. 241). The Respondent could not figure out how to check in a patient's chart on the electronic medical records system. (Bd. Ex. 16, 0185). Because of the Respondent's intoxication, all patients had to be rescheduled and no work was conducted that day. (Bd. Ex. 2, S0021).

20. On May 7, 2020, Dr. Freas reviewed the company's policies and procedures manual with the Respondent, including those provisions related to the use of prescribed drugs.

Dr. Freas recommended that the Respondent discontinue the use of Schedule II and III substances. (Bd. Ex. 2, S0023-S0024).

21. On May 10, 2020, the Respondent informed Dr. Freas that he had discontinued use of all prescription pain medication except tramadol. (Bd. Ex. 2, S0024). The Respondent continued to drink alcohol. (Resp. Ex. 9, RES060).

22. On May 11, 2020, the Respondent resumed treating patients at Clearway with additional staff oversight. (Bd. Ex. 2, S0008).

23. On May 20, 2020, the Respondent saw Amit Patel, P.A., and stated that he took his last dose of oxycodone on May 14, 2020. (Bd. Ex. 19, S0210).

24. On an unspecified date in June or July 2020, Ms. Meekins observed the Respondent in the office, and he had glassy eyes that were a little red and seemed "out of it." She did not report it to anyone else after her colleague, Ms. Tucker, instructed her not to. (Bd. Ex. 16, S0190-S0191).

25. On August 31, 2020, at 7:47 a.m., the Respondent submitted a urine sample for drug and alcohol screening as part of his participation in the MPHP. (Jt. Ex. 2). The Respondent tested negative for oxycodone but tested positive for alcohol at a level of 0.06 g/dL and had other elevated alcohol markers. (*Id.*, Resp. Ex. 6, RES052).

26. In or around September 2020, the Respondent stopped taking tramadol. (Respondent testimony, 5/19, T. 507).

27. At intake for the MPHP, the Respondent reported that he began drinking alcohol in college. The Respondent reported that he drinks socially and that he typically drinks two beers, and the maximum amount he drinks is three to four drinks. (Jt. Ex. 3, J0018).

28. Dr. Raphael's psychological testing from November 11, 2020 indicated that the Respondent has an alcohol use disorder, and the results indicated a tendency to focus on the

needs of other people while placing a lower priority on taking care of his own needs. The Respondent had little insight into his substance use. The testing did not indicate significant risk for prescription drug abuse. Dr. Raphael recommended that the Respondent should not return to the practice of medicine until at least a month of monitored abstinence, beginning an alcohol education program, and completing at least four sessions with a psychotherapist. (Jt. Ex. 9).

29. Between November 22 and 25, 2020, the Respondent underwent a four-day evaluation at Caron Treatment Center which found that he met the criteria for Severe Alcohol Use Disorder and Unspecified, Uncomplicated Opioid Use Disorder. (Resp. Ex. 2, RES011). The Respondent finished sixteen hours of alcohol education classes offered online by Dick Prodey. (Resp. Ex. 6, RES046). The evaluator at Caron recommended that the Respondent participate in inpatient substance use treatment for healthcare professionals. (Resp. Ex. 2, RES011).

30. On December 7, 2020, the Respondent enrolled in inpatient treatment for healthcare professionals at CPR. The physicians at CPR determined that the Respondent is at high risk of relapse due to the following acute risk factors: lacking coping skills needed to maintain recovery, continued cravings, unresolved co-occurring psychological/emotional factors, poor suitability of home social/living environment for recovery, and work and legal issues. (Resp. Ex. 5, RES040).

31. At the conclusion of his stay at CPR, the treatment team diagnosed the Respondent with Moderate Alcohol Use Disorder. (Resp. Ex. 6, RES054). The treatment team determined that the Respondent needed more time to learn how to apply what he learned during treatment to his current interpersonal and professional issues. The Respondent's primary therapist at CPR concluded that he needed ongoing therapeutic intervention to prevent a relapse.

Dr. Skipper concluded that the Respondent has little insight into his drinking and substance use. (Resp. Ex. 6, RES053, RES055).

32. On January 19, 2021, the Respondent had an intake evaluation with Kolmac. He reported that alcohol has been a concern for one year. (Resp. Ex. 9, RES060).

33. The Respondent completed eight weeks of intensive outpatient therapy at Kolmac. (Respondent testimony, 5/18, T. 345). The program included two hours a day of group therapy and a third hour of education or speakers. *Id.*

34. In February 2021, the Respondent completed a medical ethics and professionalism course offered by the University of California, Irvine School of Medicine. (Resp. Ex. 13, RES117).

DISCUSSION

Standard and Burden of Proof

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests on the party making an assertion or a claim. Md. Code Ann., State Gov't § 10-217 (2014)[5]; COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cty. Police Dep't*, 369 Md. 108, 125 n.16 (2002).

In this case, the State bears the burden to show that Respondent's actions pose a substantial likelihood of risk of serious harm to the public health, safety, or welfare, which require the Board to continue the summary suspension. Md. Code Ann., State Gov't § 10-226(c); COMAR 10.32.02.08. The State also bears the burden to show by a

[5] All future references to the State Government Article are to the 2014 volume.

preponderance of the evidence that the Respondent violated the following sub-subsections of Section 14-404(a): (3)(ii) (unprofessional conduct in the practice of medicine), (4) (incompetence), (7) (habitual intoxication), (8) (addiction or habitual use of narcotic or CDS), and (9) (providing professional services while under the influence of alcohol or using any narcotic or CDS). COMAR 28.02.01.21K(1)-(2)(a).

The Respondent bears the burden to prove by a preponderance of the evidence his assertion, which I consider to be an affirmative defense, that the Board violated the emergency suspension provisions of the APA or the Board's regulations governing emergency suspensions by issuing an order of suspension before giving the Respondent an opportunity to be heard. COMAR 28.02.01.21K(1), (2)(b).

Applicable Law

I. Emergency Suspension Provisions

The APA states:

(c)(1) Except as provided in paragraph (2) of this subsection, a unit may not revoke or suspend a license unless the unit first gives the licensee:

(i) written notice of the facts that warrant suspension or revocation; and

(ii) an opportunity to be heard.

(2) A unit may order summarily the suspension of a license if the unit:

(i) finds that the public health, safety, or welfare imperatively requires emergency action; and

(ii) promptly gives the licensee:

1. written notice of the suspension, the finding, and the reasons that support the finding; and

2. an opportunity to be heard.

State Gov't § 10-226(c).

The Board's regulation governing summary suspensions specifies that the above subsection of the APA governs consideration of a summary suspension of a license. COMAR 10.32.02.08A. The regulation goes on to deviate slightly from the above subsection of the APA by establishing two different types of summary suspension hearings: pre-deprivation and post-

deprivation. COMAR 10.32.02.08. A pre-deprivation hearing affords the licensee the ability to be heard prior to the imposition of a summary suspension. COMAR 10.32.02.08D. A post-deprivation hearing provides the licensee with the ability to be heard after the imposition of a summary suspension. COMAR 10.32.02.08E. To summarily suspend a license without prior notice and an opportunity to be heard, the regulation requires that:

> (a) The disciplinary panel determines that the health, welfare, and safety of the public or the physician imperatively requires immediate suspension;
> (b) Notice and opportunity to be heard before the action is not feasible; and
> (c) The respondent is provided with a postdeprivation opportunity to be heard within 15 days by the disciplinary panel, that voted to summarily suspend the license.

COMAR 10.32.02.08B(7).

II. The Act

The 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;
> (4) Is professionally, physically, or mentally incompetent;
> . . . .
> (7) Habitually is intoxicated;
> (8) Is addicted to, or habitually abuses, any narcotic or controlled dangerous substance as defined in § 5-101 of the Criminal Law Article;
> (9) Provides professional services:
> (i) While under the influence of alcohol; or
> (ii) While using any narcotic or controlled dangerous substance, as defined in § 5-101 of the Criminal Law Article, or other drug that is in excess of therapeutic amounts or without valid medical indication[.]

Health Occ. § 14-404(a)(3)(ii), (4), (7)-(9) (Supp. 2020).

Analysis

The State argued that the Respondent's stipulation that he was impaired when he arrived at work on May 5, 2020 means that he is guilty of unprofessional conduct in the practice of medicine and providing professional services while using a narcotic in excess of therapeutic amounts or without valid medical indication. The State asserted that the Respondent is guilty of unprofessional conduct in the practice of medicine because he performed the wrong procedure on August 28, 2019, and then changed the patient's informed consent form. The State contended that the Respondent habitually abused the narcotic oxycodone by mixing it with alcohol on a regular basis. The State argued that the Respondent's 2011 PBJ for DWI, the ER records from 2019 and 2020, and the Respondent's alcohol treatment reports prove that the Respondent was habitually intoxicated. The State asserted that the Respondent's impairment on February 17 and May 5, 2020 rendered him physically incompetent.

The State argued that the Respondent's history of showing up at work while impaired and then treating patients, as well as his documented mixture of alcohol and oxycodone, provided the extraordinary circumstances which necessitated a summary suspension of the Respondent's license without a pre-deprivation hearing.

With respect to sanctions, the State argued that I should impose a suspension to allow the Board to follow its protocol for reinstatement of the Respondent, but acknowledged that the Respondent should be given the opportunity to immediately petition the Board for reinstatement following the Board's issuance of a final Order in this matter.

The Respondent did not contest the charge of unprofessional conduct. The Respondent argued that the only evidence of abuse of narcotics was from the May 5, 2020 incident, and therefore the State has failed to prove habitual abuse. The Respondent argued that the State failed to prove that he provided professional services while under the influence of alcohol or

while using any narcotic because on February 17, 2020 he was not impaired by alcohol or a narcotic, and on May 5, 2020 he did not provide professional services. The Respondent argued that the State has not shown that he was habitually intoxicated because he only abused alcohol for a limited period of time and was not intoxicated. He also raised a constitutional challenge of vagueness to the term "habitual intoxication." Similarly, the Respondent argued that the State's interpretation of "physical incompetence" is absurd and that it is a due process violation to not define incompetence.

The Respondent further argued that the State failed to show that there were extraordinary circumstances that required the Board to impose an emergency suspension in November 2020. The Respondent argued that the summary suspension should be reversed and that no sanction should be imposed for any other charge because he has already been punished through the imposition of the emergency suspension.

I conclude that the State has proven that the Respondent is guilty of unprofessional conduct in the practice of medicine, that the Respondent habitually abused CDS, and that the Respondent provided professional services while using a narcotic in excess of therapeutic amounts and without valid medical indication.

I conclude that the State has not proven that the Respondent is habitually intoxicated, nor has it proven that the Respondent is physically incompetent.

I conclude that the Board did not violate the APA or the Board's regulations in issuing a summary suspension prior to giving the Respondent an opportunity to be heard.

I conclude that the State has not proven that the Respondent's actions at this time pose a substantial likelihood of risk of serious harm to the public health, safety, or welfare, which require the Board to continue the summary suspension.

In accordance with the Board's sanctioning guidelines, I recommend a sanction of a suspension until the Respondent is in treatment and has been abstinent for six months.

I. Practice Act Violations

A. Unprofessional Conduct in the Practice of Medicine

Judge Harrell, writing for the Court of Appeals in *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577 (2004), and addressing a constitutional challenge to the Act's prohibition of "unprofessional conduct", stated:

> The meaning of terms such as "immoral conduct" and "dishonorable conduct" is determined by the "common judgment" of the profession as found by the professional licensing board. . . . A statute prohibiting "unprofessional conduct" or "immoral conduct," therefore, is not per se unconstitutionally vague; the term refers to "conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession."

Id. at 593 (citations omitted).

The Maryland legislature, through its enactment of the Act, including the prohibition on "unprofessional conduct," has empowered the Board to render a "common judgment" as to the propriety of a physician's behavior. The Board has not attempted to delineate the exact contours of "unprofessional conduct", which is not defined in the statute.[6]

Maryland's appellate courts have been called upon on multiple occasions to consider whether certain conduct by a physician was "in the practice of medicine." Initially, the Court of Appeals narrowly construed the term to mean that the conduct is "directly tied to the physician's conduct in the actual performance of the practice of medicine, i.e., in the diagnosis, care, or

[6] The Board has given notice, through its regulations governing disciplinary hearings, that it "may consider the Principles of Ethics of the American Medical Association" in disciplinary and licensing matters before the Board. Code of Maryland Regulations 10.32.02.16.

treatment of patients." *McDonnell v. Comm'n on Med. Discipline*, 301 Md. 426, 436-437 (1984).[7] Over time, the conduct considered to be "in the practice of medicine" has been expanded by the appellate courts, as has the test for determining when conduct is "in the practice of medicine." *Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59 (1999) (doctor's conduct of sexually harassing co-employees was "in the practice of medicine"); *Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577 (2004) (physician's three sexual relationships with patients were accomplished "in the practice of medicine"); *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456 (2007) (physician's false statements to peer reviewers constituted unprofessional conduct "in the practice of medicine"); *Salerian v. Maryland State Bd. of Physicians*, 176 Md. App. 231 (2007) (conducting a forensic evaluation is "in the practice of medicine").

The test for whether conduct is "in the practice of medicine" is whether it "relates to the effective delivery of patient care." *Cornfeld*, 174 Md. App. at 477-478. The State may show that conduct relates to the effective delivery of patient care by, *inter alia*, "evidence that the physician abused his status as a physician in a manner that either harmed patients, created a substantial risk of harm to them, or diminished the standing of the medical profession as caregivers." *Id.* at 478.

As noted above, the Respondent did not dispute that he was guilty of unprofessional conduct in the practice of medicine for showing up to work intoxicated on May 5, 2020. Additionally, I conclude that the Respondent is guilty of unprofessional conduct on three other occasions.

First, in or about spring 2016, the Respondent reported to the Annapolis Clearway location and the medical assistant reported to Nurse Wertz that she believed that he was drunk

[7] This case pertained to an earlier version of the Medical Practice Act, and specifically a provision prohibiting "immoral conduct of a physician in his practice as a physician." *McDonnell v. Comm'n on Med. Discipline*, 301 Md. 426, 429-430 (1984).

because the patient room smelled of alcohol. When confronted, the Respondent denied drinking that day but admitted drinking the night before. Management-level staff at Clearway allowed him to continue to see patients that day. The Respondent did not address this incident in his interview with the Board or at the hearing. Clearly, smelling of alcohol at work is unbecoming a member in good standing of a profession. *Finucan*, 380 Md. at 593. It stands to reason that not just the medical assistant, but the Respondent's patients could smell alcohol as well since the odor was in the patient room, thereby diminishing the standing of medical professionals as caregivers. *Cornfeld*, 174 Md. App. at 478.

Second, on August 28, 2019, the Respondent performed the wrong procedure on a patient and then changed the patient's informed consent form after the wrong procedure. The Respondent stipulated to the fact that he had performed the wrong procedure. Nurse Wathen testified regarding how the Respondent changed the informed consent form. While the patient was still sedated from the procedure, the Respondent asked Nurse Wathen to change the informed consent form to state that the patient had consented to a radiofrequency ablation rather than a cervical facet block. Nurse Wathen told the Respondent that she would not change the consent form and that he should go speak to the patient and tell her what happened. After speaking with Deborah Bloodsworth, the Vice President of Clearway, the Respondent again asked Nurse Wathen to change the informed consent form, and she refused. The Respondent changed the informed consent form by adding a slash and "RFA" to the form. The Respondent did not have the patient acknowledge the change by signing the form. The Respondent noted the error in the patient's medical record but did not fill out an incident report.

Although the Respondent stressed that the radiofrequency ablation was the "better" procedure and that the patient was satisfied, this is irrelevant. The entire purpose of the informed consent form is to allow the patient to make an informed decision prior to a medical procedure,

not after. The Respondent's focus on the patient outcome and lack of remorse over changing the informed consent form is in some ways more troubling than the fact that he performed the wrong procedure on the patient. The Respondent's conduct, performing the wrong procedure, asking Nurse Wathen to change the informed consent form, then changing it himself after she refused, is unbecoming of a member in good standing of a profession and diminished the standing of the medical profession as caregivers. *Finucan*, 380 Md. at 593; *Cornfeld*, 174 Md. App. at 478.

The third incident was the November 20, 2019 incident when the Respondent showed up extremely late to work on a day he was scheduled to see patients. The Respondent showed up to Clearway's Easton location after 12:00 p.m. looking disheveled and with bloodshot eyes. He stated that he had slept through his alarms. Staff at Clearway cancelled all the morning appointments and the Respondent treated patients in the afternoon. It is unbecoming of a member in good standing of a profession to show up to work over three hours late. *Finucan*, 380 Md. at 593. This incident relates to the effective delivery of patient care because it caused the Respondent's patients from the morning of November 20, 2019, to have to reschedule their appointments. *Cornfeld*, 174 Md. App. at 477-478.

B. Addicted to, or Habitually Abuses, Any Narcotic or CDS

The Act does not define "habitual," "abuses," or "narcotic". Black's Law Dictionary defines the adjective "habitual" as "1. Customary; usual . . . . 2. Recidivist[.]" Habitual Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw. Merriam Webster defines "habitual" in pertinent part as "regularly or repeatedly doing or practicing something or acting in some manner." https://www.merriam-webster.com/dictionary/habitual (last visited July 26, 2021). Black's Law Dictionary defines the verb "abuse" in pertinent part as "[t]o depart from legal or reasonable use in dealing with (a person or thing); to misuse." Abuse Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw. Merriam-Webster

defines the verb "abuse" in pertinent part as "to use without medical justification." https://www.merriam-webster.com/dictionary/abuse (last visited July 26, 2021). Black's Law Dictionary defines the term "narcotic" as "1. An addictive drug, esp. an opiate, that dulls the senses and induces sleep. 2. (*usu. pl.*) A drug that is controlled or prohibited by law." Narcotic Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw.

Oxycodone is a narcotic pain medication. Lunesta is listed in Schedule IV and therefore meets the definition of CDS from Section 5-101 of the Criminal Law Article. 21 C.F.R. § 1308.14(c)(58) (2020); Md. Code Ann., Crim. Law § 5-101 (2021). Therefore, the question is whether the Respondent misused oxycodone and Lunesta.

The Respondent suffered from chronic pain related to conditions that required hip replacement surgery. From October 2019 until May 20, 2020, Dr. Freas and two physician assistants from Clearway, Nathan Turner and Amit Patel, prescribed oxycodone for the Respondent to treat the pain associated with his pre- and post-operative hip issues. On February 20, 2020, the Respondent had hip replacement surgery. The Respondent also suffers from insomnia, and on an unspecified date that the Respondent characterized in his interview with the Board as "several years ago", Dr. Freas, CEO of Clearway, prescribed Lunesta, a sleeping aid, for the Respondent's insomnia.[8]

The Respondent admitted to Dr. Skipper during his intake interview at CPR that he was "drinking nightly to go to sleep, with medications." (Resp. Ex. 6, RES046). Dr. Skipper testified that the Respondent used alcohol primarily as a sleep aid, which is inappropriate. (Dr. Skipper testimony, 5/18, T. 376). The Respondent testified that, after his hip collapsed in October 2019, he drank a scotch or two beers fifteen minutes before sleep for four to five days a week. (Respondent testimony, 5/18, T. 326). On cross-examination, the Respondent admitted

[8] The prescription for Lunesta does not appear anywhere in the record.

that he drank alcohol and took oxycodone and Lunesta the night before the February 17 and May 5, 2020 incidents. (Respondent testimony, 5/19, T. 494-495).

Based on his admitted mixing of alcohol, oxycodone, and Lunesta on a nightly basis between October 2019 and May 2020, I conclude that the Respondent habitually abused oxycodone and Lunesta. The Respondent departed from the reasonable use of oxycodone. The Respondent's prescription for oxycodone notes that it is to be used PRN[9], or on an as-needed basis. Instead, the Respondent took it nightly, in conjunction with alcohol and Lunesta, as a sleep aid, and therefore without medical justification. The Respondent also misused oxycodone and Lunesta by regularly combining these CDS with alcohol. If there was any doubt in the mind of the Respondent, a physician, as to the propriety of mixing alcohol and oxycodone, the treating physician for his April 27, 2020, ER visit at Sibley Hospital disabused the Respondent of that notion when the treating physician informed the Respondent of the dangers of mixing alcohol and oxycodone. Further, at his intake meeting with Dr. Skipper, the Respondent admitted that he would never recommend to a patient that they drink while taking opioids and Lunesta because it is dangerous. (Resp. Ex. 6, 048).

Therefore, the Department has proven that the Respondent's conduct was habitual because it occurred nightly between October 2019 and May 2020, and constituted abuse, because the Respondent misused oxycodone and Lunesta and used these CDS without medical justification when he mixed them with alcohol.

C. Provides Professional Services While Under the Influence of Alcohol or While Using Any Narcotic or CDS

The Act does not define "professional services,", "under the influence of alcohol," or "valid medical indication." Black's Law Dictionary defines the noun "service" in pertinent part

[9] From the Latin *pro re nata*, meaning "for the thing born"

as "the official work or duty that one is required to perform." Service Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw. Merriam-Webster defines the adjective "professional" in pertinent part as "of, relating to, or characteristic of a profession." https://www.merriam-webster.com/dictionary/professional (last visited July 26, 2021). Black's Law Dictionary defines "under the influence" as "deprived of clearness of mind and self-control because of drugs or alcohol." Under the Influence Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw. Merriam Webster defines "under the influence" as "affected by alcohol or drug intoxication." https://www.merriam-webster.com/dictionary/under%20the%20influence (last visited July 26, 2021). Merriam Webster defines "indicated" as "something that is indicated as advisable or necessary." https://www.merriam-webster.com/dictionary/indicated (last visited July 26, 2021).

As a threshold issue, it is necessary to determine whether the Respondent provided professional services on the days that the State alleged that he was under the influence of alcohol or using a CDS. On February 17, 2020, he clearly provided professional services when he gave a patient an epidural steroid injection. Although it is less clear that the Respondent provided professional services on May 5, 2020, I conclude that he did and explain below.

In Nurse Wathen's incident report, she notes that the Respondent was able to turn his computer on and that she helped him change his password. (Bd. Ex. 2, 021). She testified that once his computer was on, he had the ability to access patient records. There is no statement in the record that would establish that he did in fact access patient records on May 5, 2020. In Nurse Harms' interview with the Board, she stated that "[Nurse Wathen] started asking him, there was a patient in question, some . . . . lab results and she said . . . . the lab results are back from Mrs. Jones . . . . And he can't get the computer on, so he starts talking about . . . . he's had

. . . great assistants who would just do that." (Bd. Ex. 10, S072). And Ms. Meekins, in her interview with the Board, stated that "he didn't really know how to use [the electronic records system], couldn't figure out checking in a patient's chart that we had just did a procedure for a couple days prior." (Bd. Ex 16, 0185).

The State cited to *Maryland Board of Physicians v. Mubashar A. Choudry, M.D.*, Case Number 2009-0783, in support of its argument that the Respondent provided professional services on May 5, 2020. In *Choudry*, the physician, a cardiologist, arrived at the hospital where he worked and showed signs that he was under the influence of alcohol. The physician attempted to access a computer to read EKG results but could not remember his password. A colleague gave him the password. While the physician was attempting to log on to the computer, hospital employees accessed the computer and emptied the electronic basket so that the physician could not access EKG results. A fellow doctor told the physician that he was too impaired to work and needed to leave the hospital. The Administrative Law Judge (ALJ) concluded that the physician had gone to the hospital with the notion that he was supposed to read EKGs and had attempted to do so. Therefore, even though the physician had not read EKGs because he was too impaired by alcohol, he had provided professional services while under the influence of alcohol. The Board did not disturb the ALJ's conclusion of law.

Like the physician in *Choudry*, the Respondent was too impaired to initially log on to his computer on May 5, 2020, but was ultimately able to log on with assistance. As noted, there is no evidence that he accessed patient records, but he also did not contest that he could have accessed patient records once logged on. However, the Respondent did more than just log on, he also discussed a patient's lab results with Nurse Wathen and tried to check a patient's chart in the electronic medical records system as described by Ms. Meekins. These activities go further than the physician's conduct in *Choudry*. Therefore, I conclude that the Respondent did provide

professional services on May 5, 2020. Because it is undisputed that on May 5, 2020 the Respondent took both oxycodone and Lunesta in excess of the prescribed amounts, and combined them with alcohol, the State has proven that he provided professional services while using CDS in excess of therapeutic amounts and without valid medical indication.

The State has also proven that the Respondent provided professional services while using CDS without valid medical indication on February 17, 2020 based on the undisputed fact that he gave a patient an epidural steroid injection, and his admission that he combined oxycodone, Lunesta, and alcohol the night before.

D. Habitual Intoxication

The Act does not define "habitual" or "intoxication". Black's Law Dictionary defines the noun "intoxication" as "[a] diminished ability to act with full mental and physical capabilities because of alcohol or drug consumption; drunkenness." Intoxication Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw. Merriam-Webster defines the noun "intoxication" in pertinent part as "the condition of having physical or mental control markedly diminished by the effects of alcohol or drugs." https://www.merriam-webster.com/dictionary/intoxication (last visited July 26, 2021). Black's Law Dictionary defines the adjective "habitual" as "1. Customary; usual . . . . 2. Recidivist[.]" Habitual Definition, *Black's Law Dictionary* (11th ed. 2019), *available at* Westlaw. Merriam Webster defines "habitual" in pertinent part as "regularly or repeatedly doing or practicing something or acting in some manner." https://www.merriam-webster.com/dictionary/habitual (last visited July 26, 2021).

The State argued that the Respondent's conduct from before his 2011 DWI arrest, his two visits to the ER, and the work incidents in February and May 2020 support a conclusion that the Respondent is habitually intoxicated.

The Respondent had a blood alcohol content level of 0.11 g/dL when the police stopped him for speeding at a rate of 77 mph in a posted 45 mph zone on March 15, 2011. (Jt. Ex. 6, J0036; Bd. Ex. 17, S0204). This fact establishes that the Respondent was intoxicated on this date. Further, at the intake interview with Dr. Skipper he stated that he drove after drinking many times prior to the DUI, but had stopped this behavior after the DUI. (Resp. Ex. 6, RES048). This statement does not, on its own, support the inference that the Respondent is habitually intoxicated, because it does not provide sufficient detail regarding the Respondent's level of alcohol consumption on the occasions where he consumed alcohol before driving.

The first visit to the ER was on September 23, 2019. The State pointed to the physician's note from the visit and specifically the statement that the Respondent's hypertriglyceridemia is "probably associated with a fatty liver and alcohol use." (Bd. Ex. 12, 0151). Again, this statement, standing alone and with no explanation from a medical expert as to the basis for the physician's statement, is not sufficiently reliable to establish that the Respondent is habitually intoxicated.

The next incident was the workplace incident in February 2020. The Respondent admitted that he took oxycodone and Lunesta the night before this incident, and that he also consumed alcohol. This admission, alone, does not establish that he was intoxicated. The first individual to observe the Respondent was Ms. Meekins. Nowhere in her testimony does she state specifically that she smelled alcohol on the Respondent. Instead, she stated that she did not smell alcohol but assumed he was impaired by alcohol. (Bd. Ex. 16, 0183). Ms. Meekins also did not state that the Respondent had slurred speech in either her initial incident report or in her interview with the Board. (*Id.*, Bd. Ex. 2, 010). I find the fact that she did not smell alcohol or observe the Respondent slurring his words to be significant since she was the first individual to report concerns about the Respondent's behavior on this date.

Nurse Wathen did not explicitly state that she smelled alcohol on the Respondent in her incident report. (Bd. Ex. 2, 011). She did state in her interview with the Board that the Respondent was "reeking of alcohol." (Bd. Ex. 11, 0100). I do not give any weight to this statement; instead, I give greater weight to her written incident report because it was made closer in time to when the incident occurred. It stands to reason that if the Respondent had been truly "reeking of alcohol," this fact would have been reported by both Nurse Wathen and Ms. Meekins in their written incident reports. Because there is no mention of alcohol in these incident reports, I conclude that the State has not proven by a preponderance of the evidence that the Respondent was intoxicated by alcohol on February 17, 2020.

The other behavior that could potentially be interpreted as indicative of intoxication, such as the Respondent swaying while in the operating room with Ms. Meekins, stumbling, and walking crooked, could also be attributable to the fact that he was in severe pain because of his hip issues, as the Respondent asserted in the aftermath of the incident and in his testimony. Finally, Nurse Wathen's observations about how the Respondent was behaving, such as laughing, trying to high-five her, and speaking loudly, are not corroborated. Even if these behaviors occurred, I conclude that they are not sufficient to establish that the Respondent was intoxicated on this date because of the lack of any evidence establishing the amount of oxycodone, Lunesta, and alcohol consumed by the Respondent the night prior.

The next incident is the ER visit from April 27, 2020. The notes from this visit show that the Respondent had slurred speech. In the portion of the notes that relate to the physical exam conducted at the ER, the physician notes that "Pt slightly slurring speech, appears mildly intoxicated but is fully alert and oriented." (Bd. Ex. 13, 0168). The Respondent admitted to consuming at least three drinks before going to the ER and also tested positive for oxycodone. I conclude that the State has established that the Respondent was intoxicated on April 27, 2020.

Dr. Skipper testified regarding the Respondent's diagnosis of Moderate Alcohol Use Disorder, stating:

> Q Okay. And sort of in layman's terms, what does that mean, Doctor -- those diagnoses? A Well, it means that . . . . he had an alcohol problem that was significant. He had a past history of a DUI. And some of his difficulties and impairment issues that occurred were related to alcohol use. But he was not a chronic, habitual, heavy drinker. It was more episodic. And the criteria that were met were more limited. So, it was called moderate.

(Dr. Skipper testimony, 5/18, T. 370). He further testified regarding the habitual intoxication charge:

> it's not a medical terminology. But like I said, we do encounter patients who drink not around the clock, of course, because they do have to sleep, but you know, that are habitually intoxicated, you know, most of the day or most days. This was not the case with Dr. Hameed. So, he -- in my understanding of what you might mean by habitual intoxication, even though it's not a medical term, we did not feel that he was habitually intoxicated, daily or regular basis. It was episodic.

(*Id.*, T. 380). On the other hand, no medical professional testified or opined that the Respondent is habitually intoxicated.

In summary, the State has proven that the Respondent was intoxicated on three occasions: (1) March 15, 2011 (DUI incident); (2) April 27, 2020 (ER visit); and (3) May 5, 2020 (workplace incident). I conclude that three incidents of intoxication over the course of more than nine years is not sufficient to sustain the Board's charge that the Respondent is habitually intoxicated.[10] *See Maryland Board of Physicians v. Mubashar A. Choudry, M.D.*, Case Number 2009-0783.

E. Professionally, Physically, or Mentally Incompetent

The Act does not define "incompetent." Merriam-Webster defines the adjective "incompetent" in pertinent part as:

> 1a: lacking the qualities needed for effective action

[10] Having concluded that the Board has not met its burden of proof, I decline to address the Respondent's constitutional argument.

b: unable to function properly

. . . .

3: inadequate to or unsuitable for a particular purpose

https://www.merriam-webster.com/dictionary/incompetent (last visited July 26, 2021). Merriam-Webster defines the adverb "physically" in pertinent part as "in respect to the body". https://www.merriam-webster.com/dictionary/physically (last visited July 26, 2021).

In *Blaker v. State Board of Chiropractic Examiners*, 123 Md. App. 243 (1998), the Court of Special Appeals reviewed the Board of Chiropractic Examiners' decision to suspend Dr. Blaker and place him on probation for professionally incompetent treatment of a patient. The language in the statute governing chiropractors mirrors the language governing physicians and states the "Board may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the applicant or licensee . . . (9) is professionally, physically, or mentally incompetent." 123 Md. App. at 249. The Board deemed Dr. Blaker professionally incompetent for: (1) failing to take a complete health history; (2) failing to perform and document an adequate physical examination, including undertaking a basic visual analysis of the patient with his clothing removed and obtaining vital signs; (3) failing to perform neurological, diagnostic, and orthopedic tests; (4) failing to document properly the treatment that was performed on each visit; and (5) failing during the last two visits to diagnose that the Patient's pain was caused by a tumor. *Id.* at 251-52.

Blaker argued that since the term "incompetent" was not defined, the statute was void for vagueness and unconstitutional. The CSA held "the term 'professionally incompetent' ... is plain language commonly understood by members of the chiropractic community and, as such, does not render the statute void for vagueness." *Id.* at 258. The Court further opined that "in any profession, there are minimum standards of performance that must be met for a professional to practice in a competent manner." *Id.*

The Supreme Judicial Court of Maine weighed in on the definition of incompetence with respect to dental licenses and held:

> "Incompetence or unskillfulness" plainly refers to incompetence or unskillfulness in the practice of that profession and does not refer to a dentist's incompetence or lack of skill in any other activity. In common parlance, "incompetence" means a lack of the learning or skill necessary to perform, day in and day out, the characteristic tasks of a given calling in a reasonably effective way. Competency does not mean perfection, and incompetence is not ordinarily established by the showing merely of an isolated instance in which performance has been inadequate.

Bd. of Dental Exam'rs v. Brown, 448 A.2d 881, 883 (Me. 1982). In *Brown*, the Court affirmed the lower court's conclusion that Brown was incompetent for failing to use proper diagnostic procedures (i.e., x-rays), failing to formulate and implement appropriate treatment plans, failing to achieve desired results in a reasonable period of time, and failing to create and maintain adequate patient records. *Id.* at 882.

The State argued that the Respondent was physically incompetent on February 17 and May 5, 2020. As noted above in *Brown*, the term incompetence is not ordinarily used to describe a singular occurrence of being unable to function properly. It is notable that in *Blaker* and *Brown*, the conduct in question took place over a long period of time. Therefore, a better reading of the statutory provision is that the term physical incompetence is applicable in situations where a physician has a physical impairment that substantially impedes their ability to perform the minimum standards of performance of the job on a permanent or semi-permanent basis.

There is nothing about the Respondent's diagnosis of Moderate Alcohol Use Disorder that renders him physically unable to function properly on a permanent or semi-permanent basis. As described above, the Respondent's intoxication was episodic, rather than habitual. Therefore, the State has not proven, based on two instances, over the course of fifteen years of practice,

where the Respondent could not physically provide professional services, that the Respondent is physically incompetent.[11]

II. Summary Suspension

The Respondent argued that the Board failed to meet its burden of demonstrating that extraordinary circumstances necessitated an emergency suspension of the Respondent's license in November 2020. In particular, the Respondent took issue with the Board's decision to deny his request for a continuance to allow Dr. Raphael to evaluate him and make recommendations regarding his return to practice.

The State argued that the February 17 and May 5, 2020, incidents in the workplace, the ER reports, and the lack of workplace monitoring constitute extraordinary circumstances that required it to impose an emergency suspension.

I conclude that the Respondent has not proven that the Board violated either the APA or the Board's own regulations in imposing a summary suspension without an opportunity to be heard.

The APA standard for imposition of an emergency suspension by an agency is that the agency "finds that the public health, safety, or welfare imperatively requires emergency action." State Gov't § 10-226(c)(2)(i). One case construing this provision involved the predecessor to the Board, the Board of Physician Quality Assurance. *See Bd. of Physician Quality Assurance v. Mullan*, 381 Md. 157 (2004). In *Mullan*, the Court upheld a summary suspension even though there was a four-month delay between the filing of the complaint and summary suspension. *Id.* at 173-174. The physician had been the subject of a complaint by a patient alleging that he had

[11] Having concluded that the Board has not met its burden of proof, I decline to address the Respondent's constitutional argument.

treated her son while under the influence of alcohol. *Id.* at 161. Four months later, the Board imposed an emergency suspension. *Id.* at 161-162.

The Court rejected the conclusion of the Court of Special Appeals, which had reversed the Board's decision upholding the summary suspension, that the public health, safety or welfare did not imperatively require a summary suspension because the Board had allowed the Respondent to continue treating patients for four months after receipt of the complaint. *Id.* at 163. The Court held that the "discretion to issue a summary suspension order if the agency so chooses necessarily includes the discretion to issue the order *when* the agency chooses." *Id.* at 168. Ultimately, the Court concluded that the timing of the issuance of the order is subject to judicial review by a court pursuant to the arbitrary and capricious standard of review. *Id.* at 170-171. The Court differentiated the question of the timing of the summary suspension order and the factual question of whether a summary suspension was imperatively required at the time of its issuance, which is subject to a different standard of judicial review, that of the substantial evidence test. *Id.* at 171.

In addition to the APA provision, the Board has its own regulation governing summary suspensions. COMAR 10.32.02.08. To justify a summary suspension prior to a hearing, notice and opportunity to be heard before the action must not be feasible. COMAR 10.32.02.08B(7)(b).[12]

The Board imposed the summary suspension based on the following[13]:

- the 2011 DUI incident;
- the Respondent's prescriptions for CDS;

[12] While a plausible reading of the regulation is that the Board must only meet the standard from the Administrative Procedure Act by determining that the health, welfare, and safety of the public or the physician imperatively requires immediate suspension, the Board agreed with the Respondent's argument that the regulation imposes an additional obligation on the Board if it proceeds to summarily suspend a license without prior notice and an opportunity to be heard.

[13] These factual allegations are in the Board's summary suspension Order.

- the reports of alcohol on the Respondent's breath in the workplace;
- the Respondent's admissions regarding alcohol consumption;
- the April 27, 2020 ER visit where the Respondent was observed to be mildly intoxicated;
- the August 28, 2019 incident where the Respondent performed the wrong procedure;
- the February 17, 2020 incident in which Clearway staff observed the Respondent swaying and suspected that he was impaired and the Respondent's admission that he may have consumed alcohol the night before; and
- the May 5, 2020 incident in which the Respondent was reported to be grossly impaired and the Respondent's admission that he ingested CDS and consumed alcohol.

Taken together, these factual allegations are sufficient to meet the standard for an emergency suspension in the APA and in the Board's regulation. In *Mullan*, one instance of intoxication while treating patients was deemed sufficient to justify an emergency suspension. *Id.* at 172. It is true, as the Respondent argued, that the physician in *Mullan* had a much longer history of alcoholism than the Respondent. However, the Board did not err in concluding that it must exercise its police power in November 2020 to protect the public in light of the above facts. The most obvious risk was to the Respondent's patients. At the time that the Board imposed the emergency suspension, the Respondent was still treating patients and was not subject to any monitoring by Clearway. This is significant because the record amply demonstrates that Clearway's lack of internal controls and tendency to minimize the Respondent's substance abuse

issues, not to mention the active role of its CEO, Dr. Freas, and other staff in prescribing CDS for the Respondent, played a clear role in enabling the Respondent's behavior.

The Respondent's argument that the Board was required to wait to impose the summary suspension until Dr. Raphael evaluated the Respondent is not persuasive. As noted in *Mullan*, the Board has the discretion to issue a summary suspension order when it chooses. The Respondent could have been evaluated for his substance use issues immediately after the May 5, 2020 incident and started rehabilitation, but he did not do so. Instead, he, at the urging of Dr. Freas and with minimal controls or follow-up monitoring by Clearway, stopped taking oxycodone only and immediately returned to work. He did not stop consuming alcohol, and still took tramadol, a CDS. The Board was aware of all these facts, and it did not err in summarily suspending the Respondent without waiting for his appointment with Dr. Raphael.[14]

III. Whether the Respondent's actions pose a substantial likelihood of risk of serious harm to the public health, safety, or welfare, which require the Board to impose a summary suspension?

The State did not explain why, at this time, the Respondent's actions pose a substantial likelihood of risk of serious harm to the public health, safety, or welfare, which requires the Board to keep the summary suspension in place. I conclude that the summary suspension should be lifted by the Board because of the Respondent's efforts to address his alcohol use disorder.

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[14] Dr. Raphael's report does not indicate that the Respondent should immediately return to practice, which provides further support for the Board's imposition of the summary suspension prior to the evaluation. Similarly, Dr. Skipper testified that the Respondent was not ready to return to practice when he was at CPR:

> He was not -- we did not think he was fit to return to duty. Because he's not received adequate treatment and not made enough changes in his life, not -- he had not developed a solid recovery program from alcohol use disorder. He did not address some of the personality characteristics that we thought were important for him to address. And so, we did not by any means think at that date, nine days in the treatment, he was ready to go back to work.

(Dr. Skipper testimony, 5/18, T. 380-381).

The Respondent should be given credit by the Board for his proactive response to his recovery. After the Respondent voluntarily entered the MPHP in August 2020, he first completed an intensive inpatient recovery program at CPR in January 2021, and then completed an eight-week intensive outpatient program through Kolmac in March 2021. He is currently enrolled in continuing care and continues to attend sessions.

Importantly, since leaving the Caron Treatment Center on November 25, 2020, the Respondent has undergone repeated random drug and alcohol testing without any positive findings. He no longer has a valid prescription for oxycodone or any other CDS and has not consumed alcohol since November 2020. As described above, the two instances of unsafe behavior in the workplace by the Respondent were both attributable to his mixing of alcohol, oxycodone, and Lunesta. And Dr. Skipper's uncontroverted testimony is that the Respondent is ready to return to work.

Therefore, since there is nothing to suggest that the Respondent continues to consume alcohol or oxycodone, and it appears that he has made significant steps in his recovery for his alcohol use disorder, I conclude that there is no substantial likelihood of risk of serious harm to the public health, safety, or welfare that requires the emergency suspension to continue.

IV. Sanction

The State seeks to impose an indefinite suspension for the Act violations but allow the Respondent to seek reinstatement directly from the Board pursuant to its regulatory procedures once the Board issues a final Order. COMAR 10.32.02.06A. The Respondent argued that I should not impose a suspension and should give him credit for the length of time that he has been suspended pursuant to the emergency suspension provisions.

Essentially, the parties agreed that the Respondent should be given the opportunity to immediately petition the Board for reinstatement after the Board issues its final Order. I agree.

Pursuant to the regulatory guidelines for sanctions, I recommend a suspension, with credit for the length of time that the Respondent has been subject to the emergency suspension and remained abstinent from CDS and alcohol.

The Board's regulation governing sanctions provides:

> (6) If a licensee has violated more than one ground for discipline as set out in the sanctioning guidelines:
>
> (a) The sanction with the highest severity ranking should be used to determine which ground will be used in developing a sanction; and
>
> (b) The disciplinary panel may impose concurrent sanctions based on other grounds violated.

COMAR 10.32.02.09A(6). Here, the grounds for discipline that have the highest severity ranking are habitual abuse of CDS and providing professional services while using any CDS in excess of therapeutic amounts or without valid medical indication - both of which have a maximum sanction of revocation and a minimum sanction of a suspension until the physician is in treatment and has been abstinent for six months. COMAR 10.32.02.10(b)(8)-(9).

The Board can consider certain mitigating and aggravating factors when determining whether to deviate from the sanctioning guidelines. COMAR 10.32.02.09. The following mitigating factors are present: (1) the absence of a prior disciplinary record; and (2) the offender has been rehabilitated or exhibits rehabilitative potential. The following aggravating factors are present: (1) the offender has a previous criminal or administrative disciplinary history (the 2011 DWI); (2) the offense had the potential for or actually did cause patient harm; (3) the offense was part of a pattern of detrimental conduct; (4) the offender committed a combination of factually discrete offenses adjudicated in a single action; (5) the offender pursued his or her financial gain over the patient's welfare (the Respondent prioritized his productivity as a physician over patient safety by showing up to work on February 17 and May 5, 2020 and insisting that he see patients); and (6) the offender attempted to hide the error or misconduct from patients or others.

Because so many aggravating factors are present, deviation from the Board's sanctioning guidelines is not warranted. Instead, the Board should impose a suspension. The sanctioning guidelines specify that the suspension is until the Respondent is in treatment and has been abstinent for six months. The Respondent has completed inpatient and intensive outpatient treatment and continues to attend sessions for his alcohol use disorder. The Respondent has not taken oxycodone since May 2020, more than six months ago. The Respondent has not taken Tramadol or any other CDS since September 2020, more than six months ago. The Respondent has not consumed alcohol since November 2020, more than six months ago. Therefore, I agree with the parties that the Respondent should be given the opportunity to petition the Board directly for reinstatement immediately after the Board issues a final Order.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated the following sub-subsections of Section 14-404(a): (3)(ii), (8), and (9). Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (8)-(9) (Supp. 2020). As a result, I conclude that the Respondent is subject to disciplinary sanctions of a suspension until the Respondent is in treatment and has been abstinent for six months for the cited violations. *Id.*; COMAR 10.32.02.09A-B; COMAR 10.32.02.10B(8)-(9).

I further conclude as a matter of law that the Respondent did not violate the following sub-subsections of Section 14-404(a): (4) and (7). Md. Code Ann., Health Occ. § 14-404(a)(4), (7) (Supp. 2020).

I further conclude as a matter of law that the Board did not violate the emergency suspension provisions of the Administrative Procedure Act or the Board's regulations governing emergency suspensions by issuing an order of suspension before giving the Respondent an opportunity to be heard. State Gov't § 10-226(c)(2)(i) (2014); COMAR 10.32.02.08B(7).

I further conclude as a matter of law that the Respondent's actions do not pose a substantial likelihood of risk of serious harm to the public health, safety, or welfare, which require the Board to continue the summary suspension. Md. Code Ann., State Gov't § 10-226(c) (2014); Code of Maryland Regulations (COMAR) 10.32.02.08.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on November 5, 2020 be **UPHELD IN PART** and **DISMISSED IN PART**; and

I **PROPOSE** that the Respondent be sanctioned by a suspension until the Respondent is in treatment and has been abstinent for six months; and

I **PROPOSE** that the summary suspension filed by the Maryland State Board of Physicians against the Respondent on November 6, 2020 be **REVERSED.**

July 29, 2021
Date Decision Mailed

Brian P. Weeks
Brian Patrick Weeks
Administrative Law Judge

BPW/da
#192361

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH), and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2014); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2014); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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Exhibit E

IN THE MATTER OF	*	**BEFORE THE**
HAROON I. HAMEED, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
Licensed Number: D63269	*	**Case Number: 7722-0049**

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

ORDER TERMINATING PROBATION

On November 5, 2020, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") issued an Order for Summary Suspension of License to Practice Medicine, wherein Panel B summarily suspended Haroon Hameed, M.D.'s Maryland medical license. On November 19, 2020, the summary suspension was affirmed.

On November 1, 2021, Disciplinary Panel A ("Panel A") of the Board issued a Final Decision and Order, wherein Panel A concluded, as a matter of law, that Dr. Hameed was guilty of unprofessional conduct in the practice of medicine, was habitually intoxicated, was addicted to, or habitually abused a narcotic or CDS, and provided services while under the influence of alcohol or while using any narcotic or CDS or other drug that is in excess of therapeutic amounts or without valid medical indication. The Final Decision and Order reprimanded Dr. Hameed, terminated the Order for Summary Suspension of License to Practice Medicine, dated November 5, 2020, and suspended Dr. Hameed's license to practice medicine with certain terms and conditions including that he enrolls in the Maryland Professional Rehabilitation Program ("MPRP"). The Final Decision and Order further ordered that Dr. Hameed's suspension will be terminated through an order after Panel A and MPRP determine that he is safe to return to the practice of medicine and complied with the terms and conditions of suspension.

On November 30, 2021, after MPRP and Panel A found him safe to return to the practice of medicine and Panel A determined that Dr. Hameed complied with the terms and conditions of suspension,

Panel A issued an Order Terminating Suspension and Imposing Probation,[1] wherein Panel A terminated the suspension imposed by the November 1, 2021 Final Decision and Order and ordered Dr. Hameed to be placed on probation for a minimum period of three (3) years, with certain terms and conditions, including, remaining enrolled in MPRP.

Dr. Hameed has fully and satisfactorily complied with all of the terms and conditions of probation imposed by the November 30, 2021 Order Terminating Suspension and Imposing Probation and three (3) years have passed.

It is thus, by Panel A, hereby

ORDERED that the probation and probationary terms and conditions imposed by the November 30, 2021 Order Terminating Suspension and Imposing Probation are **TERMINATED**; and it is further

ORDERED that the Reprimand remains in effect; and it is further

ORDERED that this is a public document.

01/24/2025
Date

Signature On File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

[1] A copy of the Order for Summary Suspension of License to Practice Medicine, Final Decision and Order, and Order Terminating Suspension and Imposing Probation are incorporated by reference and available upon request.