IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Daniel S. Smithpeter, M.D.,	*	**STATE BOARD OF**
Respondent.	*	**PHYSICIANS**
License No. D 50266	*	**Case No. 2006-0403**

* *

FINAL DECISION AND ORDER

I. Introduction

Daniel S. Smithpeter, M.D. ("Dr. Smithpeter") was charged by the Board on June 1, 2010, with committing immoral and unprofessional conduct in the practice of medicine, under § 14-404(a) (3) of the Medical Practice Act, by engaging in sexual misconduct with a patient during medical appointments in his office.

A two-day evidentiary hearing was held on December 14th and 15th, 2010, before an Administrative Law Judge ("ALJ") of the Office of Administrative Hearings. The ALJ issued a Proposed Decision on March 11, 2011, finding that Dr. Smithpeter did engage in sexual misconduct with a patient during medical appointments and that this constituted unprofessional and immoral conduct in the practice of medicine. Dr. Smithpeter filed exceptions with the Board, the State responded, and an oral exceptions hearing was held before the Board on July 13, 2011.

This document results from that exceptions hearing and constitutes the Board's Final Decision and Order. In arriving at this decision, the Board has considered the entire record in this case, including the record made before the ALJ, the ALJ's Proposed

Decision, the written exceptions and responses to exceptions filed by the parties, and the oral exceptions argument.

II. FINDINGS OF FACT

The Board adopts Findings of Fact 1 through 43 set out in the Proposed Decision of the ALJ at pages 7-12. The Proposed Decision of the ALJ is incorporated into this Final Decision and Order and is attached as Attachment A. With respect to Finding of Fact 38, the Board amplifies that proposed finding as follows. Dr. Smithpeter discharged the patient from his care on or about October 11, 2005, but the patient was not in fact discharged from the practice at that time, and her care was in fact transferred to Dr. Garcia, another physician in the practice. The patient then saw Dr. Garcia on October 20, 2005 and November 3, 2005, as a patient of the practice.

Dr. Smithpeter, a psychiatrist, saw the patient on a regular basis for approximately three years at Delmarva Family Resources, a health care entity of which he was the owner. Dr. Smithpeter began to engage in flirtatious talk with the patient and to ask her about her sexual habits during some of these appointments, then began standing in front of the closed door of his office as she left, blocking her way out, and hugging her and then kissing her before she left. Over time, this sexual activity, which the patient participated in to some degree, proceeded to fondling, digital stimulation of genital areas and, on at least one occasion, oral sex.

III. CONSIDERATION OF EXCEPTIONS

The Board has carefully considered both the written and oral exceptions presented by counsel on behalf of Dr. Smithpeter. In a case such as this, where the only direct evidence of what happened is the conflicting testimony of the only two

persons involved, the Board gives weight to the credibility determination made by the ALJ. The ALJ found that the patient was sincere and that her demeanor at the hearing was "consistent with the responsibility and guilt she described [that] she felt over the Respondent's acts." (ALJ at 22-23) The Board has found no strong reason in the record to reverse this credibility determination of the ALJ.

Credibility in General

Dr. Smithpeter presented a plethora of reasons why, he argues, the patient's testimony should not be believed. The overall presentation of this argument was severely marred, however, by misstatements[1] and mischaracterizations of the evidence, as well as the presentation of two lines of defense that are factually contradictory. The Board understands that it is the State's burden to prove the case by a preponderance of the evidence and that Dr. Smithpeter could prevail even without presenting any defense at all if the State did not present sufficient evidence in its own case. The State, however, produced testimony that, if accepted as true, was sufficient to meet that burden. The challenges to the reliability of that testimony have been ineffective, as is set out below.

The ALJ discredited Dr. Smithpeter's defense because it rested on two contradictory factual assertions: (1) the patient concocted the story out of revenge because Dr. Smithpeter had not supported her attempts to get her driver's license back and to obtain custody of her children; and (2) the patient had emotional problems and a borderline personality disorder, and her account of the sexual encounters was the result

[1] Counsel argued before the Board that the patient was unaware of a certain physical characteristic of Dr. Smithpeter's anatomy. Exceptions hearing at 8, 14. This argument directly contradicted the evidence at the evidentiary hearing on that issue. Tr. 211; St. Ex. 9, p. 56.

of a mental or personality disorder. In simpler terms, the defense is that the complaint was part of a calculated plot of revenge, or the result of a delusion suffered by the patient. The mere fact that the defense is based on alternative and contradictory versions of fact does not mean that the Board does not need to consider each of them.[2]

Defense of Delusions

The primary defense, that the patient's report is the result of delusions, is contradicted by the great weight of the evidence. In Dr. Smithpeter's direct testimony, he discussed at length borderline personality disorders, delusions and hallucinations, explaining that they can cause a false belief. (Tr. 162-66) He testified that a mention of all of these terms can be found in the patient's records, and his testimony certainly inferred that the patient suffered from all three. On cross-examination, however, he admitted that the patient did not have hallucinations (Tr. 194-95; 207-09), that she was not delusional (Tr. 195-96; 203-04; 207-09) and that in the three years of his seeing her he had not diagnosed her as having a borderline personality disorder or being psychotic. (Tr. 206-07)

Dr. Smithpeter's reference in his direct testimony to hallucinations (Tr. 163) is illustrative of this line of argument. Despite his disavowal on cross examination of the argument that she suffered from hallucinations (Tr. 194-95; 207-09), he argued again later, through counsel before the Board, that she did suffer from hallucinations. This contradicted not only his own testimony on cross examination but also the report of the patient's therapist, who reported that an earlier reference to hallucinations was made in error. (St. Ex. 23, p. 497) Similarly, Dr. Smithpeter testified that the patient had thought

[2] The Board does not necessarily agree with the implication in the ALJ's decision that the assertion of two contradictory lines defense makes it unlikely that either is true.

that another physician was trying to "poison her" (Tr. 165-66), but the therapist who actually wrote those words put them in context in the treatment notes which were also in the record. The patient had been hospitalized as a teenager and, in her own words, "shot up" with Thorazine. (St. Ex. 23, p. 489) She felt that the Depakote prescribed in the past by another physician had the same effect as Thorazine. (*Id.*) Because of her religious beliefs, she had some conflict in accepting psychiatric treatment in general (*Id.*, p. 448), and she remained concerned about the long-term effect of Depakote on the liver and pancreas. (*Id.*, Tr. 496) In this context, the therapist eventually concluded that this statement was not a report of a delusion or a hallucination. (*Id.*, p. 497) The patient's statement appears to the Board to be simply a layperson's expression, in the vernacular, of a bad memory of taking Depakote. Dr. Smithpeter's counsel's repeated references to alleged delusions and hallucinations, even at the exceptions hearing,[3] and even after Dr. Smithpeter himself admitted on cross examination that he saw no evidence of such in his three years of treating her (Tr. 194-95), did little but place obstacles in the way of the Board's objective consideration of the evidence and arguments in this case.

Similarly, Dr. Smithpeter testified that the patient had undergone electro-convulsive therapy (or "ECT"), and he opined at some length about ECT's ability to "punch[] holes in peoples' memories" and "produce[] amnesia." (Tr. 165) On cross examination, however, he admitted that ECT, though it could cause a lapse in memory, could not produce a false memory. (Tr. 215-16) The direct testimony on this issue was

[3] *See, e.g.*, Exceptions hearing at 11-12.

thus also misleading, and its presentation did not do anything to enhance Dr. Smithpeter's overall credibility with the Board.

In any case, none of these arguments persuaded the Board that hallucinations, delusions or a borderline personality played any part in the patient's allegations against Dr. Smithpeter.

Indicia of Credibility

The Board has taken note of the statement of the patient's regular therapist that the patient, during three years of therapy, never gave her a reason to doubt her word. (St. Ex. 57, pp. 26, 32-34) The Board also notes the opinions of both her later treating psychologist and her later treating psychiatrist that the patient does not suffer from any mental or emotional condition, the symptoms of which would likely cause her to fabricate a story. (St. Ex. 62 p. 14; St. Ex. 64, pp. 18-19) These observations from the record are not the sole basis of the Board's credibility finding, nor is the Board relying on any expert testimony to determine credibility; but the treating professionals' opinions that she does not suffer from a disorder which in itself would be likely to cause her to fabricate a story do nothing to detract from that finding.

Nor does the entire record give the Board any significant reason to doubt the patient's testimony, even though her memory of dates was less than perfect. The patient has lived a chaotic life, apparently due in part to her bipolar disorder, and she has been subject to spousal abuse and massive disruptions of both her occupational, personal and family life. She has been prescribed numerous different psychotropic drugs and has been hospitalized numerous times over the years. She has been subject to electroconvulsive therapy. It is reasonable to believe, as the ALJ did, that, In the

midst of this chaotic life, the patient would not always recall the exact dates of events that happened long ago. The Board also has not doubted her credibility on account of this factor.

There were also other indicia of reliability in the patient's testimony. Her former therapist recalled that the patient had reported that Dr. Smithpeter had made comments about her eyes – a contemporaneous report that matched the patient's testimony that Dr. Smithpeter's first comment of a flirtatious nature was a compliment about her beautiful blue eyes. *See* St. Ex. 57, pp. 18-19. Likewise, and documented in the therapy records, the patient complained to the therapist, that Dr. Smithpeter was asking her questions about her sexual relationship with her husband (St. Ex. 23, p. 488) – a notation that matched an allegation in the complaint.

Termination From The Practice

The evidence concerning the patient's termination from the practice also tends to support the patient's version of events. The patient reported that, shortly after she visited the office with a male friend whom she identified to Dr. Smithpeter as her "boyfriend," she was told on the phone the next time she called to schedule an appointment that "he [Dr. Smithpeter] will not see you anymore." The practice had instead set up another appointment with another psychiatrist in the practice, Dr. Garcia. (St. Ex. 9, pp. 44-46) She testified that she believed that this was Dr. Smithpeter's way of carrying out his oft-repeated threat that, if their sexual activities came to light, he would never see her again. (Tr. 36, 117)

Dr. Smithpeter, on the other hand, testified that she was discharged from the practice because of her violation of the treatment contract and for missing appoint-

ments. (Tr. 168-69) This is supported to some extent by a clinical note in the record. (St. Ex. 23, p. 258) Dr. Lindy Lewis, the clinical therapy supervisor, did state that she was discharged from the practice. (St. Ex. 24, p.12) When asked why she was actually seen next by Dr. Garcia, another psychiatrist in the practice, Dr. Lewis replied, "Well, because she went – and I don't know all the circumstances." (*Id.* p. 14) He admitted that he was "very vague" on the details of how the patient "ended up with Dr. Garcia." (*Id.*, pp. 13-14) The office record seems to indicate that the office referred her to Dr. Garcia. (St. Ex. 23, p. 617) She was seen by Dr. Smithpeter for a medication check on October 4, 2005, missed an appointment on October 7, 2005, came for a medication check with Dr. Smithpeter on October 11, 2005, then was evaluated by Dr. Garcia on October 20, 2005 and then was seen by Dr. Garcia for a medication check on November 3, 2005. (St. Ex. 23, pp. 235-36)

The evidence is far from clear, but it appears that the patient was not, in fact, discharged from the practice on October 11, 2005, after the clinical meeting. It appears more likely that she was discharged from Dr. Smithpeter's care and referred to Dr. Garcia, who was still within the practice. This matches the patient's testimony that she called for an appointment and was told that "he" would not see her any more. Dr. Smithpeter's participation in the clinical meeting of October 11, 2005 also appears to be a highly unusual event. Dr. Smithpeter admitted that he didn't participate at all in the patients' therapy, even in emergency situations, and confined himself strictly to medication checks. (St. Ex. 25, pp. 11, 13-14, 52, 60) The therapist stated to the Board that Dr. Smithpeter consistently (and sometimes vehemently) refused any suggestion that he be involved in the overall therapeutic plan. (St. Ex. 57, pp. 20-22) Dr.

Smithpeter, of course, could have been suddenly involved in this case solely for clinical reasons, but the Board doubts this.

In addition, there was certainly nothing new in the patient overmedicating herself and failing to comply with her treatment contracts, conditions that the therapists had been documenting for at least three years. (St. Ex. 23, pp. 239, 253, 444, 447, 458, 460, 470, 501, 503, 506, 507, 508, 512, 514, 516, 528, 529, 539, 544, 547, 550, 552, 554, 555-56, 561, 563, 571, 574, 579, 585, 599, 603, 604) Similarly, the necessity of referring her to substance abuse treatment had been a long-term concern. (St. Ex. 23, pp. 502, 506, 539, 559, 593) All of these factors, including Dr. Smithpeter's sudden involvement, the apparent sudden change in the philosophy of treating this difficult patient, and the referral to Dr. Garcia, detract somewhat from Dr. Smithpeter's defense that the patient was discharged from the practice solely because of clinical events. Altogether, the Board believes that the evidence on this issue lends more support to the patient's version of events.

Defense of Revenge

In her years-long attempt to control the symptoms of her bipolar disorder while maintaining her employment and pursuing a safe and normal family relationship with her children, her father and her then-husband, the patient was often in need of psychotropic medications, therapy, help from others recovering from emotional and addiction issues, interventions by the police, hospitalizations, her employer's assistance programs, and other sources of aid. Though she was heavily dependent on these other sources, there is no indication in the record that she had a tendency to hold a grudge or to exact revenge on these sources on the numerous occasions when she did not get from these

sources what she thought she needed. The ALJ evaluated her credibility as sincere, and remorseful for her participation in the sexual acts initiated by Dr. Smithpeter, rather than vengeful. The patient also reported that she was feeling much better emotionally at the time of the hearing, and the Board doubts that she would undergo the considerable emotional strain and make the sustained effort required to continue to pursue her allegations, years later, if her real motivation were simply revenge. Although Dr. Smithpeter at times did not comply with the patient's various requests, the Board does not believe that the patient concocted false accusations out of revenge.

Previous Statements Regarding The Sexual Events

Dr. Smithpeter argues that the patient made an inconsistent statement in a deposition given in an unrelated civil case in 2005, and that she is therefore either a liar or delusional. (Tr. 247-48) The statement in that deposition is simply not that inconsistent with the patient's complaint. Asked at the deposition why she was no longer seeing Dr. Smithpeter, the patient stated at first that he had become "frisky" and inappropriate; but that she didn't want to discuss it further. (Resp. Ex. 1, pp. 55-56) Pressed by counsel, she stated that she did not develop a sexual or emotional relationship with him (*Id.* at 67-69) but that "he couldn't keep his hands to himself. That's all I have to say on the matter." (*Id.* at 69) When pressed further, she admitted that he had tried to touch private parts of her body. When asked if he was successful, she stated: "I don't want to discuss this. It makes me sick. It just makes me sick." (*Id.* at 69) She never answered that particular question. Pressed as to whether she was asked to touch private areas of his body, she said "no," but stated that "It progressed" over a year's period. (*Id.*, p. 71)

The Board accepts, as did the ALJ, the patient's explanation that she originally intended to tell no one of these incidents, and that when she did mention them, she minimized them at first. The deposition itself reveals that same pattern, as well as the high level of stress the patient suffered in revealing these incidents to strangers. The patient had voluntarily participated in what she later described, not as a "relationship," but as "sex games" with Dr. Smithpeter. (Tr. 105) She knew that it was wrong. (Tr. 39) In all of her disclosures, she revealed the incidents only reluctantly, over time, and minimized the degree of her participation at first. When she revealed these activities to some of her friends, she used the vernacular rather than clinical terms (St. Ex. 84, p. 11), and so it is difficult to tell exactly what words she used in talking to her friends. In responding to the attorney's questions at the depositions, she evaded and quibbled and never did answer all of the questions; nevertheless, she did reveal that there had been inappropriate sexual activities with the doctor, something that it was apparently not in her interest to reveal. The ALJ found that her reluctant and gradual revelation was entirely in keeping with the way a patient would react if that patient herself felt guilt and remorse over her own participation in these sexual activities. (ALJ at 23) The Board has found no reason in this record to overturn that credibility determination of the ALJ. The Board adopts that credibility determination.

Additional Exceptions

None of the other exceptions have merit or are worthy of extended discussion. Dr. Smithpeter points to the fact that there was no couch in the last treatment room, but the patient met him for these appointments in at least two different rooms in at least two different locations. *See, e.g.,* St. Ex. 25, pp. 27-28. The arguments about the chron-

ology of her relationship with her friend, the man who came with her to the Delmarva office on one occasion, appear to be based on misapprehensions about her testimony. The argument that the nurses outside could hear what was said in the treatment room was misleading, as no one testified that the content of a conversation could be heard through the door. *See, e. g.*, the statement of Ms. Bromley at St. Ex. 50, p.12. Dr. Smithpeter's subpoenas for certain medical records were appropriately quashed because he failed to comply with the provisions of the Confidentiality of Medical Records Act, Md. Code Ann., Health Gen. §§ 4-306 & 4-307 and because the patient's mental health records were otherwise privileged. Md. Cts. & Jud. Proc. § 9-109(a) & (b).

It would have been especially egregious in this case, where Dr. Smithpeter admitted on cross-examination that in his three years of psychiatric treatment of this patient that he did not find her to be subject to delusions or hallucinations or a borderline personality disorder (Tr. 194-96, 204, 206-10), and where this case directly implicated neither Dr. Smithpeter's medical treatment nor the patient's medical condition, to permit Dr. Smithpeter to obtain the patient's confidential psychiatric records. That issue was never reached, however, because Dr. Smithpeter did not give the notice to the patient required by the statutes prior to subpoenaing her medical records. *See* Md. Health Gen. Code Ann. § 4-306(b)(6). The ALJ's authority to subpoena records is set out in COMAR 28.02.01.11B(2) and is derived from the statutory authority set out in Md. State Gov't Code Ann. § 10-206. Nothing in that authority permits the overriding of the safeguards set out in Md. Health Gen. Code Ann. § 4-306(b)(6). The Board has considered these and all of the other exceptions and finds them to be without merit.

Altogether, the determination of this case rests on the credibility of two witnesses. Their testimony as to what happened in that closed medical office was divergent, and the parties obviously scoured the record for other evidence that would support each party's version. Nothing conclusive was found. Nevertheless, the patient's poor recall of dates, and her slow (and sometimes initially only partial) admissions of her own involvement when first mentioning these events, was over-shadowed by other factors. She had revealed parts of this story to various people over the years, including her therapist at the time. These previous statements support her testimony that these events occurred. Her statement that she was originally discharged not from the practice, but from Dr. Smithpeter's care, was supported by the evidence from Delmarva itself. All of the evidence, taken as a whole, supports the patient's version of events more than it supports Dr. Smithpeter's version. In any case, the evidence does not provide a strong reason why the Board should reverse the credibility determination made by the ALJ. The Board will not do so. The Board adopts the credibility determination made by the ALJ. The Board finds that Dr. Smithpeter committed these acts.

IV. CONCLUSIONS OF LAW

The Board adopts the conclusions of law proposed by the Administrative Law Judge. The inappropriate sexual acts with the patient, as described above in the findings of fact, constitute immoral and unprofessional conduct in the practice of medicine, within the meaning of § 14-404(a)(3)(i) & (ii) of the Medical Practice Act. *See also* COMAR 10.32.17.03B ("sexual misconduct" as defined in COMAR 10.32.17.02B(3) constitutes a violation of § 14-404(a)(3)).

V. SANCTION

The act of a psychiatrist in engaging in sexual activities with a patient is a violation of professional ethics. Dr. Smithpeter used the authority and trust granted to him as a psychiatrist to subject this patient to his sexual overtures and acts while engaged in a medical appointment in his office. This is a violation of the trust that any psychiatrist owes a patient. It is not a defense that the patient herself consented to these activities. Dr. Smithpeter admitted in his own testimony that a psychiatrist who has sexual involvement with a patient over several patient visits should suffer "serious consequences," such as being "[r]evoked" or "suspended." (Tr. 182) The Board agrees, and it has consistently imposed serious sanctions on physicians who violate the trust placed in them by the patient in this manner.

The Board will suspend Dr. Smithpeter for three years but will stay two years of that suspension if he meets certain conditions. The Board has considered the prior Board cases cited by Dr. Smithpeter, but none of them presented the same circumstances as found in his case. Most significantly, the *Shellhas, Durry, Haswell* and *Lazaro* cases were consent orders. As the Board has stated in the past, the dispositions in consent orders are often more lenient, for a variety of reasons. *See Maryland State Board of Social Work Examiners v. Chertkov*, 121 Md. App. 574, 588 (1998). In any case, the sanctions in three of these four cases are as severe, or more severe, than that imposed in this case. The Board imposes the sanctions that it believes each individual circumstance calls for. The *Slatkin* case, referred to by Dr. Smithpeter at the oral exceptions hearing, resulted in a lesser sanction that that imposed here. The *Slatkin* case was an exception, however, because the Board took

into consideration Dr. Slatkin's forty-year history of service without a previous complaint and the fact that the sexual activities in the *Slatkin* case were not so extensive. In this case, the Board has imposed a more lenient sanction on Dr. Smithpeter than would normally be called for, because he was not providing psychotherapy, because the patient participated to some degree in what she called these "sex games" initiated by Dr. Smithpeter, and because there was no issue of sexual assault. It is of course Dr. Smithpeter's responsibility, and not that of the patient, to refrain from these sexual activities. This is a sacred obligation that all physicians, but especially psychiatrists, owe to their patients, and the Board cannot tolerate such a deliberate violation of this obligation as occurred in this case.

VI. ORDER

Based on the above Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that Dr. Smithpeter's license to practice medicine in the State of Maryland be, and it hereby is, **SUSPENDED** for three years, beginning on the date of this Order; and it is further

ORDERED that the suspension will be **STAYED** after both of the following events have occurred:

(1) one year has passed from the date of this suspension; and

(2) Dr. Smithpeter has successfully completed the conditions set out in the paragraph below; and it is therefore further

ORDERED, as a condition of qualifying for the stay after the one-year period has expired, Dr. Smithpeter must successfully complete a one-on-one course in professional

ethics with an emphasis on boundary issues, such course to be approved in advance in writing by the Board; and it is further

ORDERED that should Dr. Smithpeter fail to meet condition set out in the paragraph immediately above within the one-year period, the suspension will not be stayed but will remain in full force and effect for the full three-year term; and it is further

ORDERED that Dr. Smithpeter shall be responsible for all costs incurred in fulfilling the terms and conditions of this order; and it is further

ORDERED that this Final Opinion and Order shall be considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2004).

SO ORDERED this 15 day of December, 2011.

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

NOTICE OF RIGHT TO APPEAL

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

If Dr. Smithpeter files an appeal, the Board should be notified at the following address:

Maryland State Board of Physicians
c/o Thomas W. Keech
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201.

MARYLAND BOARD OF	* **BEFORE M. TERESA GARLAND,**
PHYSICIANS	* **AN ADMINISTRATIVE LAW JUDGE**
v.	* **OF THE MARYLAND OFFICE**
DANIEL S. SMITHPETER, M.D.,	* **OF ADMINISTRATIVE HEARINGS**
RESPONDENT	* **OAH No.: DHMH-SBP-71-10-32409**
LICENSE No.: D50266	* **CASE No.: 2006-0403**

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PROPOSED DECISION

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

STATEMENT OF THE CASE

On June 1, 2010, the Maryland Board of Physicians (Board) issued charges against Daniel S. Smithpeter, M.D. (Respondent), charging him with immoral conduct or unprofessional conduct in the practice of medicine, in violation of Md. Code Ann., Health Occ. § 14-404(a)(3)(i) & (ii) (Supp. 2010), and engaging in sexual misconduct, in violation of the Code of Maryland Regulations (COMAR) 10.32.17.03A. The Board forwarded the charges to the Office of the Attorney General (State) for prosecution.

On December 14 and 15, 2010, I convened a hearing at the Office of Administrative Hearings (OAH) in Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (2009). Robert J. Gilbert, Assistant Attorney General and Administrative Prosecutor, of the Office of the Attorney General, represented the State. Marc K. Cohen, Esquire, and Ian Friedman, Esquire, represented the Respondent.

The contested case provisions of the Administrative Procedure Act, the Rules of Procedure before the Board, and the Rules of Procedure of the OAH govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2009 & Supp. 2010); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

The issues are:

1. Whether the Respondent violated section 14-404(a)(3)(i) or (ii) of the Health Occupations Article of the Annotated Code of Maryland;

2. Whether the Respondent violated COMAR 10.32.17.03A; and

3. If so, whether the permanent revocation of the Respondent's license to practice medicine in the State of Maryland is consistent with the law.

SUMMARY OF THE EVIDENCE

Exhibits

The following exhibits were admitted for the State:[1]

1. Copy of Investigative Report by the Board, dated April 6, 2010
2. Complaint filed by the Patient, dated December 21, 2005
3. Letter to Patient, dated May 18, 2006
4. Subpoena Duces Tecum (SDT) to Rite Aid Pharmacies, dated June 8, 2006
5. SDT to Giant Pharmacy, dated June 8, 2006
6. SDT to Motor Vehicle Administration (MVA), dated June 8, 2006
7. SDT to Criminal Justice Information System (CJIS), dated June 8, 2006
8. SDT to Nancy Gregor, Johns Hopkins Health Systems (JHHS), dated June 14, 2006

[1] The descriptions of the State's exhibits were adopted substantially verbatim from the State's Exhibit List.

9. Transcription of Interview with the Patient/Complainant, dated June 16, 2006

10. MVA records received on or about June 19, 2006

11. Records received from CJIS on or about June 21, 2006

12. Records received from JHHS on or about June 27, 2006

13. Additional documents received from JHHS on or about July 3, 2006

14. Records received from Rite Aid Pharmacy on or about July 17, 2006

15. Records received from Giant Pharmacy on or about July 25, 2006

16. Memorandum of Unannounced Visit, dated January 18, 2007

17. Letter to Respondent, dated January 18, 2007, with SDT and Subpoena Ad Testificandum (SAT), dated January 16, 2007

18. Letter to Respondent, dated January 19, 2007, with Information Form

19. SDT to Delmarva Family Resources, dated January 16, 2007

20. SDT to Delmarva Family Resources, dated January 16, 2007

21. SAT to Respondent, dated January 16, 2007

22. Records received from Delmarva Family Resources on or about January 8, 2007

23. Medical Records received from Delmarva Family Resources on or about January 8, 2007

24. Transcript, Interview of Lindy Lewis, Ph.D., dated January 18, 2007

25. Transcript, Interview of the Respondent, dated January 19, 2007

26. Facsimile (Fax) received from Respondent on or about January 26, 2007

27. Fax received from Sexual Assault Legal Institute (SALI) on or about March 5, 2007

28. E-mail received from Frank Foxwell on or about July 16, 2007

29. Letter to Respondent, dated December 4, 2008

30. Memorandum of Unannounced Visit, dated December 10, 2008

31. SDT to Delmarva Family Resources, dated December 9, 2008

32. SDT to Delmarva Family Resources, dated December 9, 2008

33. Receipt of SDT service via hand delivery, dated December 9, 2008

34. Fax to Frank Foxwell, with attachment, dated December 10, 2008

35. Letter to Complainant, dated December 11, 2008

36. Letter to Teresa Torney, dated December 11, 2008

37. Letter to Andrea Travis, dated December 11, 2008

38. Letter to Crystal Bromley, dated December 11, 2008

39. Fax to Eugene H. Rubin, M.D., Ph.D., with attachments, dated December 11, 2008

40. Letter to Nicole Douglas, dated December 11, 2008

41. Letter to Patricia Snyder, dated December 11, 2008

42. Letter to Charles Sutton, dated December 11, 2008

43. Letter to Gail Stevens, dated December 11, 2008

44. Letter to Lisa Edsall, dated December 11, 2008

45. Letter to Eugene H. Rubin, M.D., Ph.D., dated December 11, 2008

46. Fax response from the Respondent to the Board regarding the complaint, dated December 16, 2008

47. SAT to Gail Stevens, dated December 18, 2008

48. Transcript of interview with Gail Stevens, dated December 12, 2008

49. SAT to Crystal Bromley, dated December 22, 2008

50. Transcript of interview with Crystal Bromley, dated December 24, 2008

51. "Return to Sender" mail received on or about December 31, 2008

52. Records received from Delmarva Family Resources on or about January 5, 2009

53. Additional records received from Delmarva Family Resources on or about January 5, 2009

54. "Undeliverable as Addressed" mail received on or about January 5, 2009

55. Letter to Respondent, dated January 12, 2009, with blank authorization

56. Signed Authorization for Release of Information received on or about January 20, 2009

57. Transcript of Interview with Patricia Snyder, dated January 21, 2009

58. Letter to Stephen Slatkin, M.D., dated January 22, 2009 with SAT attached

59. Fax sent to Eugene H. Rubin, M.D., Ph.D., dated January 23, 2009

60. Fax sent to Ann E. Bradley, dated January 23, 2009

61. Correspondence received from Ann E. Bradley on or about February 4, 2009

62. Transcript of Interview with Steven Slatkin, M.D., dated February 9, 2009

63. Fax sent to Richard Greenbaum, Ph.D., with attachments, dated February 10, 2009

64. Transcript of Interview with Richard Greenbaum, Ph.D., dated February 20, 2009

65. E-mail to Jay H. Cutler on or about March 4, 2009

66. Letter to Complainant, dated March 4, 2009

67. Letter to Jay Cutler, dated March 5, 2009

68. Letter to Jay Cutler, dated March 10, 2009

69. Certified mail returned to the Board on or about Match 10, 2009

70. Authorization for Release of Information received from Complainant on or about March 13, 2009

71. Fax sent to Jay Cutler, with attachment, dated March 17, 2009

72. Transcript, Interview of Jay Cutler, dated March 20, 2009

73. Letter to Richard Greenbaum, Ph.D., with attachments, dated March 23, 2009

74. Letter to Three Lower Counties Community Services, Inc., with attachments, dated March 25, 2009

75. Records received from Richard Greenbaum, Ph.D., on March 27, 2009

76. Additional records received from Richard Greenbaum, Ph.D., on or about April 3, 2009

77. Records from Three Lower Counties Community Services, Inc., received on or about April 6, 2009

78. Transcription of Dr. Greenbaum's Notes, dated April 1, 2009

79. Letter to Wayne Slate with SAT, dated May 6, 2009

80. Letter to SALI with attachments, dated May 6, 2009

81. E-mail to Frank Foxwell, dated May 7, 2009

82. Memorandum of Telephone Interview, Wayne Slate, RN, dated May 11, 2009

83. E-mail response from Frank Foxwell and subsequent exchange, dated May 11, 2009

84. Transcript of Interview with Melody Pearson, dated May 11, 2009

85. E-mail to Craig Cutter, dated May 13, 2009

86. Response from SALI, received on or about May 13, 2009

87. E-mail to Craig Cutter, dated May 18, 2009

88. SDT to N. Craig Cutter, dated May 14, 2009

89. E-mail from Craig Cutter, dated May 14, 2009

90. Records from Craig Cutter, received on or about June 4, 2009

91. Maryland Board of Physicians (MBP) Practitioner Profile System of Respondent, printed on May 6, 2009

92. American Medical Association (AMA) Physician Profile of Respondent, printed on February 23, 2010.

The following exhibit was admitted for the Respondent:

Resp. 1: December 7, 2005 Patient Deposition Transcript[2]

Testimony

The Patient[3] testified on behalf of the State. The Respondent testified on his own behalf.

FINDINGS OF FACT[4]

I find the following by a preponderance of the evidence:

1. At all times relevant to this proceeding, the Respondent was and is a licensed physician in the State of Maryland.
2. The Respondent was licensed to practice medicine on March 26, 1996, under license number D50266. He is board-certified in adult psychiatry and child and adolescent psychiatry.
3. The Respondent maintains a professional office at Delmarva Family Resources (Delmarva or clinic), 805 N. Salisbury Boulevard, Suite 3100, Salisbury, Maryland 21801.
4. The Patient's initial intake appointment at Delmarva Family Resources occurred on March 18, 2002. Between March 18, 2002 and July 2002, the Patient saw a number of doctors, including the Respondent, at the Respondent's clinic. (Ex. 23).
5. The Patient began treatment with the Respondent in June or July 2002 at the Respondent's outpatient clinic, Delmarva (Ex. 23; T. 160). Delmarva had offices in Easton and Salisbury.[5]

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[2] I admitted this document over the objection of the State.
[3] The Patient's name will not be used in this decision to protect her confidentiality.
[4] Throughout this decision, "T" denotes a reference to the trial transcript; "t" denotes the page of the transcript within the numbered State's exhibit.
[5] Delmarva had other offices during the relevant time-frame, at least one of which has since closed and which are not germane to this case.

6. The Patient has been diagnosed with Bipolar Disorder (mixed), Post Traumatic Stress Disorder, Depression, and Alcohol Dependence. (Ex. 62, t. 4; Ex. 64, t. 8; Ex. 23).
7. Between 2002 and 2005, the Respondent prescribed the Patient a number of different medications to treat her illnesses. Those medications included: Seraquil, Klonopin, Abilify, Ambien and Ativan. (Ex. 62., t. 8; Ex. 23).
8. The Patient has been hospitalized six times for her psychiatric illnesses and has attempted suicide by overdosing on prescription medication. (Ex. 9, t. 9).
9. The Patient underwent Electroconvulsive therapy (ECT) in June 2004. (T. 165; Ex. 23).
10. The Patient does not suffer from delusions or hallucinations. (T. 194 and 196; Ex. 25, t. 96).
11. The Patient has never been diagnosed with Borderline Personality Disorder.
12. The Patient saw the Respondent for medication management one to two times per month over an approximately three and one-half year period. She first saw the Respondent in the Easton office. In 2004, the Patient began seeing the Respondent in the Salisbury office.[6]
13. The Respondent did not see the Patient for psychotherapy. The Patient saw Pat Snyder at Delmarva for psychotherapy. Pat Snyder left Delmarva in August 2004 and the Patient continued to see her at Three Lower Counties Community Services. (Ex. 25, t. 96-98; Ex. 77). The Patient's relationship with Pat Snyder ended on April 27, 2005. (Ex. 77, p. 1231).
14. The Patient saw another therapist, Pat Beall, at Marshy Hope Family Services, LLC, for an undetermined period of time after April 27, 2005.
15. The Respondent saw patients at the Salisbury office on Tuesdays from 10:00 am until 4:00 pm. (Ex. 25, t. 10). He scheduled appointments at fifteen minute intervals, with each appointment spanning between seven and twelve minutes. (T. 151).

[6] It is unclear from the testimony and documentation whether the Easton office closed or the Patient simply found it more convenient to see the Respondent in Salisbury.

16. Prior to a patient's appointment, a nurse would "prep" the patient's chart with the diagnosis, date of appointment and the patient's current medications, and review with the patient any events which may have occurred between appointments. The nurse would brief the Respondent prior to his treating the patient. (T. 150).

17. The Respondent did not write prescriptions in the exam room. He wrote them at the nurse's station or a nurse would write the prescriptions. (T. 151).

18. The Respondent's Salisbury clinic has two offices, his office and a "spare" office. The doors on both offices have windows which are sufficiently covered by opaque materials such that it is not possible to see into the office from the hall when the door is closed. The nurse's station is approximately six feet from the Respondent's office and ten feet from the "spare" office. (Ex. 30).

19. Voices within the Respondent's office could only be heard in the nurse's station if the voices were loud. (Ex. 80).

20. The Respondent's office, where he saw the Patient for medication management, contains a desk and two chairs. (T. 46 and T. 156).

21. Beginning sometime in mid-2004, the Respondent started to make comments to the Patient regarding her eyes and her clothing when she would attend her medication management appointments. (T. 31). The Respondent also asked the Patient questions about whether she was secreting breast milk, having sexual intercourse with her husband or masturbating. (T. 31-33; Ex. 29).

22. During this time, the Respondent began standing by the doorway of his office to hug the Patient as she was leaving. (Ex.2; T. 34).

23. The Respondent's actions progressed to kissing the Patient on the mouth, touching her buttocks under her skirt, putting his finger in her vagina, exposing his penis to her and using her hand to masturbate him. (Ex. 2; T. 34-35).

24. The Patient performed fellatio on the Respondent on one occasion. (T. 37, 89).

25. The Respondent performed or attempted to perform cunnilingus on the Patient on at least one occasion. (Ex. 9, t.62; Ex. 2, t. 89; T. 37).

26. The Respondent told the Patient "anything that goes on behind these doors stays behind these doors or I'll never see you again." (T. 36; Ex. 2). He threatened to stop seeing her as a patient if she told anyone. (Ex. 2; Ex. 78, t. 14-16). The Respondent also asked the Patient, "Why are you doing this to me?" (Ex. 78, t. 15-16; Ex. 2; T. 38).

27. The Patient was dependent on the Respondent to provide her with her psychiatric medication. (T. 33-34).

28. The Patient hoarded the medications the Respondent and others prescribed to her. (T. 45; Ex. 2; Resp. Ex. 1, t. 87-89).

29. The Patient overdosed on Ativan on September 10, 2004 and February 4, 2005. (Ex. 23).

30. The Patient told her psychotherapist, Pat Snyder, that the Respondent made comments about her eyes and attire close in time to when the event occurred. (Ex. 57, t. 18-19). The Patient did not tell Pat Snyder anything further. (T. 57).

31. The Patient told Jay Cutler (Cutler), an acquaintance from Alcoholics Anonymous whom she met in 2005, that the Respondent "would corner her on her way out and put his hands on her." The Respondent's actions "made her uncomfortable." (Ex. 72, t. 5; T. 38).

32. Cutler told the Patient to switch psychiatrists and then report him to the Board. (Ex. 72, t. 7).

33. Cutler accompanied the Patient to one of her appointments with the Respondent and remained in the waiting area. (Ex. 72, t. 8-9; T. 38).

34. The Patient told the Respondent on that day that Cutler was her boyfriend in hopes "all the fooling around would quit." (T. 38).

35. The Patient told her friend, Melody Pearson (Pearson), that the Respondent had engaged her in sexual activity. (Ex. 84, t. 5). Pearson drove the Patient to her appointments with the Respondent three to five times thereafter. (Ex. 84, t. 4). When the Patient got into Pearson's car after her appointments, she would tell Pearson of the sexual activity which had occurred during the appointment. (Ex. 84, t. 9, 11).

36. Pearson encouraged the Patient to "report" the Respondent and leave his practice. (Ex. 84, t. 16; Ex. 9, t. 67).

37. The Patient was reluctant to leave the Respondent's care because she felt he knew her well. (Resp. Ex. 1, t. 72; T. 33, 113).

38. The Respondent discharged the Patient on or about October 11, 2005. (Ex. 23, p. 258; T. 114).

39. The Patient was hospitalized on October 19, 2005, shortly after the Respondent discharged her. (Ex. 23, p. 259).

40. On November 8, 2005, the Patient began seeing Dr. Richard Greenbaum in connection with her legal issues regarding custody of her children. (Ex. 78, t. 3-5).

41. On December 6, 2005, in a conversation about "weird psychiatrists," the Patient disclosed to Dr. Greenbaum that the Respondent kissed her "several times" and "took his pants down and exposed himself." She would not, when asked for more information, discuss the matter further during that session. (Ex. 78, 12-13).

42. On December 13, 2005, the Patient further described to Dr. Greenbaum the Respondent's behavior. (Ex. 78, t. 14-19).

43. On or about December 21, 2005, the Patient filed a complaint against the Respondent with the Board.

DISCUSSION

The Law

Section 14-404(a)(3) of the Health Occupations Article of the Annotated Code of Maryland provides that the Board "may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee: . . . (3) Is guilty of: (i) Immoral conduct in the practice of medicine; or (ii) Unprofessional conduct in the practice of medicine [.]"

COMAR 10.32.17.03 explains that section 14-404(a)(3) of the Health Occupations Article "includes, but is not limited to, sexual misconduct."

> "Sexual misconduct" means a health care practitioner's behavior toward a patient, former patient, or key third party, which includes:
>
> (a) Sexual impropriety;
>
> (b) Sexual violation; or
>
> (c) Engaging in dating, romantic, or sexual relationship which violates the code of ethics of the American Medical Association, American Osteopathic Association, American Psychiatric Association, or other standard recognized professional code of ethics of the health care practitioner's discipline or specialty.

COMAR 10.32.17.02B(3).

Summary of the Evidence

The Patient

The Patient testified that she began as a patient at Delmarva in approximately 2000[7] and saw the Respondent for medication management beginning in June or July 2002. The other member of her treatment team was Pat Snyder, whom she saw for psychotherapy at Delmarva and later at Three Lower Counties Community Services. Her psychotherapy sessions lasted approximately 40 minutes and her appointments with the Respondent could last up to fifteen minutes.

According to the Patient, the Respondent began complimenting her about her eyes and her attire during her appointments with him. In subsequent appointments, the Respondent asked the Patient if she was excreting breast milk and whether she was masturbating. At the time of the Respondent's inquiries, the Patient and her husband were experiencing marital difficulties. The Patient said that she had previously told the Respondent that she and her husband had not "slept together" in a year-and-a-half and his response was one of surprise. The Patient described the progression of the Respondent's behavior and stated that he began by hugging her. She thought he was just reaching out to her because, at the time the hugging began, her father was dying. The Respondent would stand by the door of his office at the conclusion of their appointment and hug the Patient before allowing her to exit. The hugging then escalated when the Respondent "ran his hands up my skirt. And a few times he would "masturbate me with his fingers." (T. 36). When asked to describe the type of sexual contact the Respondent had with her, the Patient responded, "Usually hugging, kissing on the mouth, oral sex, no intercourse, although he did come and sit down beside me one day on the couch and he whispered in my ear if I wanted him to "F" me. It doesn't get any more embarrassing than that." (T. 37).

[7] Delmarva's records indicate that the Patient's first appointment, as evidenced by her intake sheet, was on March 18, 2002. (Ex. 23)

The Patient was asked to describe any "forms of oral sex" she had with the Respondent. She testified, "Just one time. A couple of times he tried it on me - - I mean we had a ten to fifteen minute window there. So we didn't go too far. We never had sexual intercourse, like I said. I think orally, I might have stimulated him one time." (T. 37). The Patient stated in her complaint, "[The Respondent] tried to perform oral sex on me. He put his mouth against the bare skin of my crotch and tried to give me oral sex. I pushed him away. He asked me to touch his penis, which I did. He asked me to give him blow jobs, which I did not do." (Ex. 2). Because the Patient had previously denied performing fellatio on the Respondent, she was asked why she now claims she had. The Patient answered, "Because it is an embarrassment. It's an embarrassing issue." (T. 37). The Patient recounted how the sexual activity between her and the Respondent had occurred within the timeframe of the office visit because, "It only takes a couple minutes fill out a prescription pad of two or three or four or whatever he was prescribing for me at the time. The rest of the time we would talk about other things or he would be fondling me." (T. 40-41). The Patient stated that the reason she filed her complaint, at the behest of Dr. Greenbaum, was that "I just wouldn't want to see it done to any other patient." (T. 41).

Upon cross examination, the Patient described the Respondent's office as having a desk, two chairs and some pictures on the wall. (T. 46). She also said that she had previously seen the Respondent at a different office in which the Respondent was unable to provide sufficient time with his patients. Upon his relocation to the Salisbury office,[8] he spent more time with the patients, including her. (T. 50-51). The Patient recalled the move to the Salisbury office occurred possibly in early 2004 and that most of the fondling happened in 2005. (T. 55). No fondling or sexual acts occurred in the Easton office. The Patient kept a journal for her therapist which she brought to the hearing. When the Respondent's counsel asked her if she wrote of the Respondent's inappropriate

[8] It was not clear whether the Easton office continued to operate or that the Patient simply transferred from the Easton office, where the Respondent had hours on Wednesday, to Salisbury, where he had hours on Tuesday.

behavior, she answered, "No. I had no intentions of telling anybody...because I was attracted to him...and I believed he was attracted to me. What happened, happened. It doesn't make it right." (T. 58). The Patient admitted that she denied performing oral sex on the Respondent in her initial complaint with the Board (Ex. 2), but did so out of "sheer embarrassment." (T. 90). She further stated to Respondent's counsel, "There is no way you would understand." (T. 91). The Patient said that she brought Cutler to one of her office visits and told the Respondent Cutler was her boyfriend. (T. 80). The Patient strongly denied telling Pearson that she and the Respondent engaged in sexual intercourse. (T. 95-96). When confronted with her previous reluctance to speak about the Respondent's sexual interactions with her during a December 7, 2005 deposition related to the Patient's family law issues, the Patient said, "...I felt threatened, but I don't anymore."

The Respondent

The Respondent graduated from the University of Missouri Medical School on May 16, 1992, and began practicing medicine in Maryland as a board-certified psychiatrist in 1995. He is also board-certified in child and adolescent psychiatry, forensic psychiatry and addiction psychiatry. He established Delmarva in 1998.

The Respondent testified that he schedules patients every 10 to 15 minutes for medication management (T.150), patients schedule their appointments with the front desk (T. 151, 166) and he sees 28-35 patients per day. He described his office as having a desk and two wing-back chairs. (T. 156). When the Respondent's office door is closed, no one can see into the office. (T. 183). The Respondent admitted that he asked the Patient whether she was expressing breast milk, but did so in the context of managing her medications. (T. 158-9). He testified that the Patient told him she was not experiencing her menstrual cycle and she wondered if any of her medications could be the cause. The Respondent said that he was concerned that one of the Patient's antipsychotic medications was elevating her prolactin level and did, indeed, ask her if she was expressing breast

milk as that would also be a side effect of the medication. As a result, the Respondent testified that he ordered a prolactin level test, which revealed her level was elevated. (T. 158-9). Other than asking the Patient about the expression of breast milk, the Respondent denied the Patient's allegations of sexual misconduct.

The Respondent testified that the Patient's diagnosis in 2002, when she began treatment with him, was bipolar disorder, personality disorder-not otherwise specified, alcohol abuse and narcotic or opiate abuse. (T. 160). The Respondent described perception and memory deficits which may occur in persons diagnosed with bipolar disorder, most specifically bipolar disorder with psychotic features, which does not pertain to the Patient's diagnosis. (T. 163-64). The Respondent further described in some detail borderline personality disorder as it relates to one's ability to accurately perceive events around him or her. (T. 164). Additionally, the Respondent said that Electroconvulsive therapy could produce "amnesia." (T. 165). The reason cited for discharging the Patient from his care was that she "presented to the clinic...at times intoxicated, clearly under the influence." (T. 167). There came a time that the Patient requested a written recommendation from the Respondent to have her children returned to her custody and also to have her driving privilege restored. The Respondent refused to make either recommendation and testified that he "did not register any anger from her" as a result of his denial of the Patient's request. (T. 171).

On cross examination, the Respondent testified that he may have had a conversation with the Patient regarding whether she was having sexual relations with her husband, but the conversation would have been in the context of her complaint about missing her menstrual cycle. (T. 186-87). The Patient was compliant with her appointments. (T. 193; Ex. 25, t. 143). Although he admitted that the Patient did not suffer from delusions or auditory or visual hallucinations (T. 194-95), the Respondent asserted that the Patient was "lying and confabulating" in accusing him of inappropriate sexual conduct with her. (T. 197). A "confabulation... is the making up of a story to

fill memory gaps, or to fill a perception of how they see the world and those around them." (T. 197). However, none of the Respondent's progress notes of the Patient noted any memory deficit or delusional content. (Ex. 23). When Dr. Garcia (who treated the Patient after the Respondent but before Dr. Slatkin) examined the Patient in October 2005, after the Respondent discharged her, he found no evidence of disorganized speech, hallucinations or delusional thinking. (T. 202). The Respondent admitted that he never diagnosed the Patient with borderline personality disorder, or having delusions or hallucinations. (T. 206). The Respondent did not treat the Patient for a psychotic disorder. (T. 214). There is no documentation in the Respondent's progress notes that the Patient appeared for any appointments at Delmarva from August through October in an intoxicated condition. (T. 218; Ex. 23, p. 254-56).

Analysis

As outlined above, under section 14-404(a)(3)(i) and (ii) of the Health Occupations Article of the Annotated Code of Maryland, the Board may revoke the license of a physician who is guilty of immoral or unprofessional conduct in the practice of medicine. "'Practice medicine' means to engage, with or without compensation, in medical . . . [t]reatment" and "includes doing . . . treating . . . [or] prescribing for . . . any physical ailment . . . of an individual[.]" Md. Code Ann., Health Occ § 14-101(n) (Supp. 2010).

Under COMAR 10.32.17.02B(3), section 14-404(a)(3) of the Health Occupations Article "includes . . . sexual misconduct," which is "a health care practitioner's behavior toward a patient [or] former patient . . ., which includes: (a) [s]exual impropriety; (b) [s]exual violation; or (c) [e]ngaging in a . . . sexual relationship which violates the code of the American Medical Association[.]" "'Sexual impropriety' includes . . . [u]sing the health care practitioner-patient relationship to initiate . . . a . . . sexual relationship[.]" COMAR 10.32.17.02B(2)(b)(iii).

The State has the burden to prove the Charges by a preponderance of the evidence. *See* Md. Code Ann., State Gov't § 10-217 (2009); Md. Code Ann., Health Occ., § 14-405(b)(2) (2009); *Comm'r of Labor and Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34, 684 A.2d 845, 853 (1996), *citing Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959); *Garrett v. State*, 124 Md. App. 23, 28, 720 A.2d 1193, 1195 (1998). In other words, the evidence of the Respondent's sexual misconduct, when considered and compared with the evidence opposed to it, must have more convincing force and produce a belief that it is more likely true than not true. *Coleman v. Anne Arundel County Police Dep't*, 369 Md. 108, 125, note 16, (2002).

The Parties' Arguments

The State implicitly argued that I should give dispositive weight to the Patient's testimony that the Respondent engaged in sexual conduct with her during her medical treatment. According to the State, the Patient's testimony is credible because she has no motive to lie. The Patient disclosed portions of the Respondent's behavior during the relevant time period and then disclosed the majority of the abusive behavior to Dr. Greenbaum shortly after the Respondent terminated his medical relationship with her. The Patient holds herself at least partially responsible for what happened with the Respondent because she participated in the acts and did not leave the Respondent's medical care when she had the ability to do so. The State argued that the Respondent's allegations that the Patient suffered from borderline personality disorder, delusions, and hallucinations, and appeared intoxicated for at least one appointment with the Respondent are not supported by the evidence. The Patient's motivation for coming forward with her allegations of sexual misconduct were not motivated by vengeance or anger, but a sense of duty to prevent such a thing from happening to another patient.

The Respondent implicitly argued that I should give dispositive weight to his denial of any sexual relationship with the Patient. Moreover, the Respondent argued that I should find the

Patient's testimony untrustworthy because of her inaccuracies regarding dates. He argued that such inaccuracies may be because of delusions, misperceptions or memory lapses. The Respondent emphasized that the Patient signed a statement for Dr. Greenbaum which omitted information regarding oral sex and that, therefore, that statement was a lie. Further, the Patient's failure to tell doctors at Delmarva that she was hoarding drugs because she was considering suicide also brands the Patient as a liar. The Respondent emphatically argued that the Patient was delusional and that she had previously denied having a sexual relationship with the Respondent in the context of a deposition taken in furtherance of a family law matter. Additional inconsistencies elucidated by the Respondent included the Patient's failure to disclose to Lower Three Counties Community Services that she had been sexually abused, her inconsistency in admitting to having had or having performed oral sex, her lack of recollection of whether the Respondent wore boxers or briefs, and her asserted dependence on the Respondent for continuance of her prescriptions when there were many other doctors writing prescriptions for her during the relevant time period. He characterized the Patient as retributive, angry, delusional, and a liar.

For the following reasons, I find that it is more likely than not that the Respondent has engaged in sexual misconduct with the Patient in the practice of medicine. First, the statements of the Patient have been substantially consistent. The Patient told Pat Snyder of the comments the Respondent made about her eyes and attire at a time close to when the events occurred. She also told Cutler that the Respondent was acting inappropriately with her and when Cutler accompanied her to one of her appointments, she told the Respondent that Cutler was her boyfriend in the hopes the "fooling around" would stop.

I do not attribute much weight to the accuracy of Pearson's memory except to the extent that the Patient told her enough details that caused Pearson to urge the Patient to discontinue her relationship with the Respondent. Pearson told the Board's investigator that her memory could be

"a little sketchy." (Ex. 84, t. 9). The Patient adamantly denied ever telling Pearson that she and the Respondent had sexual intercourse and I find that assertion credible. I have no way to judge the credibility of witnesses with whom I have had no personal contact except to gauge the internal consistency of their statements. Within Pearson's statement, there are numerous times when she fails to recall details of the Patient's conversations with her regarding the Respondent. So, while I believe the Patient told Pearson enough to cause Pearson to be concerned, I do not believe the Patient told her that she engaged in intercourse with the Respondent.

Further, I do not find that the Patient's failure to disclose her participation in performing oral sex upon the Respondent reflective of her veracity or credibility. The acts initially disclosed by the Patient were acts in which she was the compliant or acquiescent participant. The Respondent was the one performing the acts upon her...kissing, hugging, putting his hand up her skirt, and him using her hand to masturbate him. During her testimony and throughout her statements made in furtherance of the State's investigation, the Patient clearly felt a sense of responsibility, embarrassment and guilt over what transpired and the fact that she did not end her relationship with the Respondent or report his conduct. In the earlier stages of the Patient's disclosure, I find it wholly consistent with her sense of guilt and responsibility that she did not admit to having performed oral sex on the Respondent, thus assuming the role of an active participant and not wholly a victim of the Respondent. Moreover, the Patient's December 7, 2005 deposition (Resp. Ex. 1, p. 69) supports my finding that the Patient clearly was not in an emotional position at that time to sustain questions regarding the Respondent's sexual behavior toward her. She stated that he could not keep his hands to himself and she did not want to discuss the matter further because it made her sick.

The record does not support an ulterior motive for the Patient to lie. She testified that she never wrote of the Respondent's sexual behavior with her in her journal because she never intended

to tell anyone. While she told Pat Snyder of the initial comments the Respondent made which caused her discomfort, she did not disclose anything further. She told Cutler and Pearson about some of the behaviors, enough to cause each to urge her to leave the Respondent's practice. The Respondent told the Patient that if she disclosed his sexual behavior with him, he would discharge her and end the relationship. While the testimony was unclear as to precisely when Cutler accompanied the Patient to the Respondent's office and when the Patient told him that Cutler was her boyfriend, the evidence does not support the Respondent's testimony that he discharged the Patient for being intoxicated during an appointment with him.

I find it more likely than not that he discharged the Patient because he believed she had disclosed what had been happening in his office. Further, it was only after the Respondent discharged the Patient that she disclosed the incidents to another professional, and initially it was only a bit of information. The Patient's offering of that initial information to Dr. Greenbaum appeared inadvertent and was offered in the context of discussing odd psychiatrists. It was not calculated to disengage the Respondent of his license to practice medicine or to initiate or prevail in a civil suit.[9] Dr. Greenbaum noted that, when the Patient made her disclosure, she appeared sad and somber. That demeanor is not reflective of a person who is angry or out to seek revenge upon another. In addition, the Patient endured the indignity of having her entire psychiatric history exposed to investigators, attorneys and others with whom she has no relationship of trust. I do not believe the Patient would have followed through with her allegations under these circumstances had they not been true.

There is nothing in the record which would lead me to conclude that the Patient has any memory impairment resulting from her ECT or otherwise. While she was not precise to the date and time the events with the Respondent occurred, she had very good recall of the timing of key events.

[9] The Patient did not initiate a civil action against the Respondent.

The Patient testified as to the year she began seeing the Respondent in Salisbury and the relationship between that event and when the sexual acts began. The Patient had a sincere recollection and was able to testify consistently throughout the investigative process, including at the instant hearing. Someone with a memory loss or impairment would not have been so consistent. Moreover, there is nothing in the Patient's medical record which indicates her memory is anything other than intact.

Additionally, I find it entirely conceivable that the Respondent could perform each of the sexual acts described by the Patient in the seven to twelve minute timeframe during which he testified their appointments spanned. I find it possible that such activities could occur, behind closed doors, within five feet of the nurses' station without drawing the attention of others in the office.

Finally, the Respondent's credibility is significantly undermined by the fact that he implied or stated outright, on numerous occasions, that the Patient had been diagnosed with borderline personality disorder. He stated so in his testimony before the Board (Ex. 25, t. 99-100, 141) and he did so upon direct examination during the hearing. Even after the Respondent admitted on cross-examination that the Patient does not have borderline personality disorder, the Respondent argued in closing that the Patient could have been delusional. There is no extrinsic evidence that the Patient suffered from any delusions. The Respondent mischaracterized many of the Patient's statements, which further diminished his credibility. For example, he argued in closing that the Patient testified that she went to see Dr. Greenbaum after the Respondent discharged her to "get it off my chest." The testimony was clear that the Patient went to Dr. Greenbaum in conjunction with her custody matter and when she told Dr. Greenbaum of the misconduct of the Respondent, she said, "It felt good to get it off my chest." (T. 39, lines 19-20). Another example of mischaracterization was the Respondent's argument that the Patient testified that there was a sofa in the Respondent's office when, in fact, that was not the case. The Patient never testified that the sofa to which she was referring was in the Respondent's office. (T. 37). Lastly, the Respondent argued that the Patient

denied having a "relationship" with the Respondent in the December 7, 2005 deposition and that, consequently, she is a liar. In fact, the Patient testified on cross examination that she did not have a relationship with the Respondent because "That, to me, would entail a lot more than just playing around with each other..." (T. 104). "It just wasn't a relationship." (T. 105).

In his letter to the Board, the Respondent characterized the Patient as angry over his discharge of her and her allegations "lies in order to exact revenge." (Ex. 46). However, in his three or more years of treating the Patient, none of his records describe the Patient as angry. She is most often described as sad and depressed, never angry. My observation of the Patient during the hearing was just that.

While years have passed between the Patient's initial disclosure and the hearing of this matter, I find the Patient's testimony is substantially consistent with her initial statements made more than five years ago to Dr. Greenbaum. Additionally, I find the Patient's demeanor and relative level of distress during her deposition on December 7, 2005 (Resp. Ex. 1)[10] as well as at the hearing of this matter, to be consistent with the responsibility and guilt she described she felt over the Respondent's acts. I am persuaded that the Respondent engaged in sexual misconduct in the practice of medicine with the Patient. COMAR 10.32.17.03B.

The Respondent initiated a sexual relationship with the Patient. Pursuant to COMAR 10.32.17.02B(3), sexual misconduct includes sexual impropriety. Under COMAR 10.32.17.02B(2)(b)(iii), sexual impropriety includes using the doctor/patient relationship to initiate a sexual relationship. Accordingly, I find that the Respondent engaged in sexual misconduct with the Patient when the Respondent used the patient/doctor relationship to initiate sexual relationships with her.

[10] While this exhibit was admitted over the State's objection, I am affording the relevant excerpts pertaining to the Patient's interactions with the Respondent substantial weight since the statements were taken within one month of the Respondent's discharge of the Patient.

What Discipline is Reasonable?

The State indicated that the Board seeks permanently to revoke the Respondent's license. The Respondent argued not with respect to sanctions, only as to the Respondent's culpability.

I have found that the Respondent abused his profession to satisfy his sexual desires. In the process, he exploited the vulnerabilities of an individual who sought his help. The Legislature has given authority to the Board to revoke a physician's license under these circumstances. There is nothing in this record that would support a finding that revocation would be an abuse of the Board's discretionary authority or otherwise be inconsistent with the law.

CONCLUSIONS OF LAW

I conclude that the Respondent violated section 14-404(a)(3)(i) & (ii) (Supp. 2010) of the Health Occupations Article of the Annotated Code of Maryland and COMAR 10.32.17.03B. I further conclude that, as a result, the Board is authorized to revoke the Respondent's license. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2010).

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board on June 1, 2010, against the Respondent be **UPHELD**.

I further **PROPOSE** that the Board's determination that the Respondent's license should be revoked be **UPHELD**.

March 11, 2011
Date Decision Mailed

M. Teresa Garland
Administrative Law Judge

MTG/fe
DOC# 120032

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions, in writing, to this Proposed Decision with the Board of Physicians within fifteen days of issuance of the decision. Md. Code Ann., State Gov't § 10-216 (2009) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

Decision Mailed To:

Barbara K. Vona, Chief of Compliance
State Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215

C. Irving Pinder, Executive Director
State Board of Physicians
4201 Patterson Avenue, 3rd Floor
Baltimore, MD 21215

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

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

Marc K. Cohen, Esquire
Ober, Kaler, Grimes & Shriver
120 East Baltimore Street
Baltimore, MD 21202

Ian I. Friedman, Esquire
Ober, Kaler, Grimes & Shriver
120 East Baltimore Street
Baltimore, MD 21202

Daniel S. Smithpeter, M.D.
805 North Salisbury Boulevard
Suite 3100
Salisbury, MD 21801

Daniel S. Smithpeter, M.D.
c/o Delmarva Family Resources
2013 Northwood Drive, Suite 1
Salisbury, MD 21801

Paul T. Elder, M.D., Chairman
State Board of Physicians
4201 Patterson Avenue, 3rd Floor
Baltimore, MD 21215

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