IN THE MATTER OF	*	**BEFORE THE**
JING ZHANG, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D60930	*	**Case Number: 2016-0624B**

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CONSENT ORDER

Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged **JING ZHANG, M.D.** (the "Respondent"), License Number: D60930, with violations under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") §§ 14-101 *et seq.* The pertinent provision of the Act are as follows:

Health Occ. II § 14-404(a)

> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital or any other location in this State; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

FINDINGS OF FACT

Disciplinary Panel B makes the following Findings of Fact:

I. BACKGROUND

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. She was initially licensed in Maryland on October 1, 2003. The Respondent's license is presently active and is scheduled for renewal on September 30, 2019.

2. The Respondent was board-certified in psychiatry but allowed the certification to lapse in December 2015.

3. The Respondent does not hold any hospital privileges.

4. From June 2006 to May 2016, the Respondent was employed at a multi-disciplinary practice ("Practice A")[1], in Columbia, Maryland, where she treated patients with depression, anxiety, bipolar and attention deficit hyperactivity disorder ("ADHD").

5. From approximately January 2013 to August 2013, the Respondent was also employed at a mental health and substance abuse counseling center ("Practice B") in Columbia, Maryland, where she treated substance abuse patients.

6. The Respondent is currently employed as the Director of Neuroscience for a pharmaceutical company ("Corporation A") in New Jersey and does not treat patients in a clinical setting.

II. COMPLAINT

7. On February 10, 2016, the Board received a complaint from the Prince William County Police Department in Manassas, Virginia, alleging that the Respondent prescribed controlled dangerous substances ("CDS") to a patient ("Patient A") without seeing him in person for two years. The complaint further alleged that on multiple occasions, the Respondent mailed Patient A's prescriptions to his home when he missed appointments.[2]

8. Thereafter, the Board initiated an investigation.

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[1] In order to maintain confidentiality, names of patients and his employers will not be used in this Consent Order.

[2] The Prince William County Police Department became aware of the Respondent during an investigation into allegations that Patient A was forging prescriptions in the Respondent's name.

9. On March 16, 2016, the Board issued subpoenas to various pharmacies for drug surveys of patients for whom the Respondent prescribed CDS. The drug surveys revealed that the Respondent prescribed CDS to approximately 13 out-of-state patients, including Patient A.

10. The drug surveys also revealed that the Respondent prescribed CDS to a family member ("Patient B").

11. On March 16, 2016, the Board notified the Respondent of its full investigation and requested a written response, which the Board received on April 8, 2016.

12. On May 18, 2016, the Board issued a subpoena for 10 patient medical records, including Patients A and B, chosen from various drug surveys. The Board also requested summaries of care for the 10 patients.

13. On June 6, 2016, the Board received 10 patient records and summaries of care from the Respondent.

14. On June 14, 2016, a member of the Board's staff interviewed the Respondent under oath.

15. On September 19, 2016, in furtherance of its investigation, the Board transmitted the 10 patient records (and other relevant documents) received from the Respondent for peer review by two physicians ("the reviewers"), both board-certified in general psychiatry and addiction psychiatry. On November 29, 2016, the Board received the reviewers' respective reports. The results of the peer review are set forth below.

16. On December 1, 2016, the Board sent a copy of both reviewers' reports to the Respondent and requested a supplemental response. The Respondent submitted a supplemental response on December 20, 2016.

III. PATIENT-SPECIFIC FINDINGS

Patient A

1. Patient A, a male in his 30s, began seeing the Respondent in July 2009. Patient A presented with symptoms of attention deficient disorder ("ADD") and anxiety. However, the Respondent documented that Patient A did not present a typical ADD diagnosis and his symptoms were more suggestive of anxiety and depression.

2. The Respondent prescribed bupropion,[3] which was later switched to Adderall[4] and Effexor[5]. The Respondent also added quetiapine[6] to Patient A's treatment course.

3. The Respondent titrated Patient A's dosage of Adderall in response to Patient A's reports of increased work-related stress and anxiety. The Respondent also prescribed Xanax.[7]

4. In August 2012, Patient A began a graduate school program out-of-state. The Respondent continued Patient A on Adderall and added Lexapro[8] and Xanax.

5. In November 2012, the Respondent documented an exchange of information for coordination and transfer of care to Patient A's local psychiatrist. It is unclear from the Respondent's medical record for Patient A whether the psychiatrist concurred with the ADD diagnosis, had treated Patient A for ADD or prescribed a schedule II CDS for Patient A.

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[3] Antidepressant (brand name: Wellbutrin)
[4] Schedule II CDS
[5] Antidepressant (brand name: Venlafaxine)
[6] Antipsychotic (brand name: Seroquel)
[7] Schedule IV CDS
[8] Antidepressant

6. In May 2013, the Respondent increased Patient A's Adderall from 15mg BID[9] to 20mg BID and provided a three-month supply. The Respondent also continued Xanax. Patient A reported that he discontinued Lexapro in Fall 2012.

7. In September 2013, the Respondent documented that Patient A complained of increased depression, insomnia, worry, weight loss and financial problems. The Respondent prescribed Effexor XR, Seroquel and Klonopin,[10] in addition to Adderall and Xanax. In early 2014, Patient A took a leave of absence from school and returned to Virginia.

8. From approximately December 2013 through October 2015, the Respondent did not see Patient A for face-to-face appointments. The Respondent and Patient A corresponded via text message and telephone calls.

9. During this time, the Respondent electronically prescribed non-scheduled medications, and left CDS prescriptions at the front desk for Patient A to pick up. On a "few occasions", the Respondent mailed Adderall prescriptions to Patient A's home address in Virginia.

10. The Respondent documented monthly follow-ups with Patient A, during which the Respondent made medication changes in response to Patient A's reported worsening symptoms and various medication side effects.

11. At various times, the Respondent prescribed Lithium[11], then Lamictal[12], as well as increased Patient A's Adderall dosage to 30mg BID.

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[9] Twice daily.
[10] Schedule IV CDS
[11] Antipsychotic
[12] Antipsychotic

12. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient A for the following reasons:

a. The Respondent failed to perform a thorough evaluation of Patient A's symptoms and history prior to arriving at a diagnosis of ADD;

b. The Respondent failed to address with Patient A the variable and sometimes lengthy time between appointments, despite Patient A's instability;

c. The Respondent accepted at face value Patient A's financially-motivated requests to change his medications to short-acting, even though the number of dispensed pills doubled and the overall cost may not have changed;

d. The Respondent failed to ensure that she was the only prescriber of CDS for Patient A;

e. The Respondent recommended counseling for Patient A, but, if it did occur, the Respondent failed to discuss the benefit to Patient A or how the therapist perceived medication benefit; and

f. The Respondent continued to prescribe medications with high abuse potential for 23 months, without a face-to-face appointment.

Patient B

13. Patient B, a female in her 70s, is a relative of the Respondent, and has multiple, chronic medical conditions.

14. The Respondent cited language and cultural barriers for why Patient B did not see other health care providers.

15. Between August 2011 and April 2016, the Respondent prescribed various scheduled and unscheduled medications for Patient B.

16. The Respondent failed to keep notes regarding her treatment of Patient B, only documentation of prescriptions.

17. The Respondent's medical record for Patient B does not include any notes or documents from other treating providers indicating the need for a temporary or emergency prescription.

18. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient B for the following reasons:

a. The Respondent failed to conduct physical examinations, psychiatric examinations, mental status examinations, or routine laboratory studies; and

b. The Respondent failed to coordinate Patient B's care with any other providers.

19. The Respondent failed to keep adequate medical records for Patient B for the following reasons:

a. The Respondent failed to keep a medical record for Patient B; and

b. The Respondent failed to document an evaluation or treatment plan and failed to coordinate her care of Patient B with other health care providers.

Patient C

20. Patient C, a male in his 30s, began seeing the Respondent in November 2009. Patient C had a history of bipolar disorder and substance abuse, and reported multiple incarcerations. Patient C also had diagnoses of ADHD and general anxiety.

21. The Respondent prescribed Lithium, progressing from 600mg to 900mg per day, then ultimately 1200mg per day.

22. Initially, the Respondent saw Patient C for monthly follow-up appointments, and documented the need for laboratory studies to obtain a Lithium level.

23. The Respondent did not obtain laboratory studies for Lithium levels or drug screening, despite prescribing several scheduled medications and Patient C's strong history of polysubstance abuse.

24. Patient C was often non-compliant with follow-up visits and used multiple pharmacies to fill prescriptions due to his extensive work-related travel.

25. The Respondent continued to prescribe scheduled medications despite evidence of Patient C's non-compliance, including lost prescriptions, extended time between follow-up appointments, and at least one relapse when Patient C used heroin for one month. Patient C was also involved in a car accident and sought opioid pain medications from other providers and from the Respondent, which she did not prescribe.

26. Despite the Respondent's documentation that Patient C's psychosocial status had deteriorated significantly (marital problems, financial instability, and legal issues), the Respondent failed to monitor Patient C more closely.

27. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient C for the following reasons:

a. The Respondent failed to appropriately monitor Patient C's kidney and liver function while prescribing Lithium;

b. The Respondent prescribed medications with high abuse potential, but failed to utilize urine toxicology testing to monitor Patient C's compliance;

c. The Respondent failed to address safe driving while taking benzodiazepines, despite Patient C's employment as a long-distance truck driver;

d. The Respondent prescribed another highly-abused benzodiazepine after Patient C relapsed with opioids and returned to care after an absence of several months;

e. The Respondent failed to utilize objective measures to monitor Patient C's compliance; and

f. The Respondent failed to provide Patient C with the higher level of care that his diagnoses necessitated.

Patient D

28. Patient D, a male in his 20s, began seeing the Respondent in May 2013 for treatment of opioid dependence and generalized anxiety disorder. Patient D had a history of substance abuse and sought Suboxone treatment with the Respondent.

29. At Patient D's initial visit, the Respondent failed to conduct a physical examination or check vital signs to substantiate Patient D's report of mild withdrawal symptoms.

30. The Respondent also failed to require a urine toxicology screen at intake.

31. During the treatment period, the Respondent prescribed various medications for Patient D, including Suboxone, Ambien[13], Paxil[14], Visteril, Celexa[15], Seroquel[16] and Wellbutrin[17].

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[13] Schedule IV CDS
[14] Antidepressant

32. The Respondent also documented his recommendation that Patient D participate in individual therapy.

33. In January 2014, the Respondent prescribed Xanax 0.5 mg BID for Patient D's anxiety and panic symptoms. The Respondent documented that Patient D's wife would monitor the pills and conduct pill counts, if necessary.

34. In April 2014, the Respondent documented that Patient D was taking Xanax 1mg rather than 0.5mg to achieve the desired effect. The Respondent discussed the addictive potential of Xanax and encouraged reduction of its use. However, the Respondent continued to prescribe Xanax 1mg #90, which Patient D refilled monthly.

35. In October 2014, Patient D relocated to South Carolina, but continued to see the Respondent for care.

36. Initially, the Respondent saw Patient D for follow up appointments approximately monthly, however, visit frequency became variably longer.

37. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient D for the following reasons:

a. The Respondent failed to conduct a physical examination at intake to evaluate Patient D's withdrawal symptoms;

b. The Respondent failed to utilize urine toxicology testing to monitor Patient D's compliance;

c. The Respondent made regular recommendations for therapy but failed to coordinate care with other providers;

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[15] Antidepressant
[16] Antipsychotic
[17] Antidepressant

d. The Respondent failed to provide Patient D with the higher level of care that his diagnoses necessitated;

e. The Respondent continued to prescribe scheduled medications for Patient D despite evidence of misuse; and

f. The Respondent failed to utilize objective measures to monitor Patient D's compliance.

38. The Respondent's conduct, as set forth above, constitutes a violation of one or more of the following provisions of the Act under Health Occ. II §§ 14-404(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital or any other location in this State; and (40) Fails to keep adequate medical records as determined by appropriate peer review.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B concludes that as a matter of law the Respondent violated Health Occ. II § 14-404(22), for failing to meet the standard of care, and Health Occ. II § 14-404(40), for failing to keep adequate medical records.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by Disciplinary Panel B hereby:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS.**[18] During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1. The Respondent shall not prescribe any medication to a patient without evaluating the patient face-to-face;

2. Respondent shall not prescribe Controlled Dangerous Substances until Respondent successfully completes a Board disciplinary panel-approved course for psychiatrists in appropriate prescribing, focused on the prescribing of Controlled Dangerous Substances. The course shall be completed within six (6) months. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license reviewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

3. Within six (6) months, the Respondent shall successfully complete a Board disciplinary panel-approved course in medical recordkeeping. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license reviewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

4. Should the Respondent return to clinical practice at any time Respondent shall notify the Board. If the Respondent returns to the clinical practice of medicine Disciplinary Panel B or its agents may conduct a chart or peer review of the Respondent's practice at Panel B's discretion;

5. The Panel will issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request a review of the Respondent's CDS prescriptions from the beginning of each quarter;

3. The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

[18] If the Respondent's license expires while the Respondent is on probation, the probationary period will be tolled.

BE IT FURTHER ORDERED that, after **TWO (2) YEARS**, the Respondent may submit a written petition to Disciplinary Panel B requesting termination of probation. There shall be no early termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel B. The Respondent may be required to appear before the Board or Panel B to discuss her petition for termination. The Board or Panel B will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or Panel B; and it is further

ORDERED that, after the appropriate hearing, if the Board or Disciplinary Panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Disciplinary Panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Disciplinary Panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

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

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014 Repl. Vol. & 2016 Supp.).

January 4, 2018
Date

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

CONSENT

I, Jing Zhang, M.D., License No. D60930, by affixing my signature hereto, acknowledge that:

1. I am represented by counsel, Bradford Roegge, Esquire, and I have consulted with counsel in this matter. I have knowingly and voluntarily agreed to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Disciplinary Panel B, I agree and accept to be bound by the foregoing Consent Order and its conditions.
2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. II, Code Ann. § 14-405 (2014 Repl. Vol.) and Md. State Gov't II, Code Ann. §§ 10-201 *et seq.* (2014 Repl. Vol.).
3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to

call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law, and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Panel A that might have followed any such hearing.

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice as a social worker.

6. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

Dec. 26, 2017
Date

Jing Zhang, M.D.
Respondent

NOTARY

YU TANG
Notary Public
Montgomery County
Maryland
My Commission Expires Oct 8, 2018

STATE OF MD

COUNTY OF Montgomery

I HEREBY CERTIFY that on this 26th day of Dec, 2017, before me, a Notary Public of the State and County aforesaid, personally appeared Jing Zhang, M.D., License Number: D60930, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal:

Notary Public

YU TANG
Notary Public
Montgomery County
Maryland
My Commission Expires Oct 8, 2018

My Commission expires: _____