IN THE MATTER OF	*	**BEFORE THE MARYLAND**
SPENCER F. JOHNSON, M.D.	*	**STATE BOARD OF PHYSICIANS**
Respondent.	*	**Case Numbers: 2017-0105A**
License No. D51645	*	**& 2017-0219A**

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

FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Spencer F. Johnson, M.D., is a psychiatrist, originally licensed to practice medicine in Maryland in 1997. On January 31, 2018, Disciplinary Panel A of the Maryland State Board of Physicians ("Board") charged Dr. Johnson with unprofessional conduct in the practice of medicine. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii). The charges alleged that Dr. Johnson had an inappropriate sexual relationship with a patient's adult daughter and that he provided financial support to the patient and her daughter. The charges also alleged that Dr. Johnson improperly disclosed confidential medical information about two patients.

On August 14 and 15, 2018, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. On November 13, 2018, the ALJ issued a proposed decision concluding that Dr. Johnson was guilty of unprofessional conduct in the practice of medicine. The ALJ recommended that Dr. Johnson's medical license be suspended for six months and that he complete courses on confidentiality and professional boundaries.

The Administrative Prosecutor filed exceptions on behalf of the State, arguing that Dr. Johnson's license be revoked. The Administrative Prosecutor also took exception to certain factual findings and legal conclusions made by the ALJ. Dr. Johnson filed a response requesting

that the Board Disciplinary Panel B ("Panel B") uphold the findings of facts and conclusions of law, but asked Panel B to shorten the suspension period. On February 27, 2019, both parties appeared before Panel B for an exceptions hearing.

FINDINGS OF FACT

The Panel adopts the ALJ's Proposed Findings of Fact and, except as expressly stated in this decision, the Discussion section.[1] The ALJ's Proposed Findings of Fact ¶¶ 1-27 and the Discussion (pages 8-29, 30-32) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1.[2] The findings of fact were proven by the preponderance of the evidence and are summarized below.

Dr. Johnson treated Patient 1, a 58-year-old woman, from March 23, 2009, until August 10, 2016, for psychiatric conditions. Patient 1 was often driven to her appointments by her 40-year-old daughter, Person 1. Dr. Johnson met Person 1 at Patient 1's appointment and, in 2012, hired Person 1 to perform "fetish" or "glamour" videos of Person 1 smoking. During the filming of some of these videos, Dr. Johnson regularly paid Patient 1 up to $250 per day to babysit Person 1's children (Patient 1's grandchildren). Person 1 and Dr. Johnson also engaged in a sexual relationship during this period. Over the course of their relationship, Dr. Johnson gave Person 1 gifts and money valued between $25,000 and $30,000.

In July 2015, Dr. Johnson paid $2,000 to a funeral home for part of Patient 1's son's funeral costs. Also, in July 2015, Dr. Johnson encouraged Patient 1 and Person 1 to open a hair salon, which they did. Dr. Johnson purchased furniture for over $400 for the salon and paid the

[1] The Panel does not adopt the ALJ's discussion titled "Was the Respondent's sexual relationship with Person 1 unprofessional conduct in the practice of medicine?" (pages 29-30). Panel B also modifies the citations to the Business Occupations Article on Pages 29 and 30 to the Health Occupations Article.

[2] Names have been redacted in the ALJ decision for purposes of confidentiality.

monthly rent of approximately $900 per month for at least a year. Dr. Johnson also socialized and drank wine with Patient 1 and Person 1 at the hair salon.

Beginning in March 2011, Dr. Johnson treated Patient 2, a 40-year-old woman. When he spoke to Patient 2, Dr. Johnson referred to patients in his waiting room as "retarded." Also, in front of Patient 1 and Person 1, Dr. Johnson referred to Patient 2's 14-year-old daughter, another one of his patients, as "retarded." Additionally, Dr. Johnson talked about Patient 2's diagnosis in front of Person 1 and stated, in front of Person 1 and Patient 1, that Patient 2 would frequently request a change in her medication during her therapy sessions.

On August 6, 2016, Dr. Johnson and Person 1 had a physical altercation in the stairwell in the office building where Dr. Johnson's office was located. The police were called, and both Person 1 and Dr. Johnson sought treatment for injuries they sustained during the fight. After the altercation, Dr. Johnson terminated his treatment of Patient 1. The Board finds these facts by a preponderance of the evidence.

LEGAL ANALYSIS

Unprofessional Conduct in the Practice of Medicine, Health Occ. § 14-404(a)(3)(ii)

In determining whether Dr. Johnson's actions constitute unprofessional conduct in the practice of medicine, Panel B has considered whether his conduct was unprofessional and whether it was "in the practice of medicine."

Unprofessional Conduct

Unprofessional conduct is defined as "conduct which breaches the rules or ethical code of a profession, or which is conduct unbecoming a member of good standing of a profession." *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577, 594 (2004). Unprofessional conduct may also be found when a physician abuses his or her status as a

physician in such a manner as to harm patients or diminish the standing of the medical profession in the eyes of a reasonable member of the general public. *Id.* at 601.

Panel B finds that the rules or ethical code of the profession include the *American Psychiatric Association's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 2013 Edition* ("Principles of Ethics"). The Principles of Ethics are guidelines reflecting the ethical parameters and professional boundaries for psychiatrists.

The Principles of Ethics warn against the blurring of boundaries between psychiatrists and their patients. The Principles of Ethics require a psychiatrist to "be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus upon the well-being of the patient." Principles of Ethics § 1.1. The Principles of Ethics further state, a "psychiatrist shall not gratify his or her own needs by exploiting the patient." *Id.* The Principles of Ethics also provide that "[a] physician shall uphold the standards of professionalism, [and] be honest in all professional interactions." *Id.* at § 2.

In *Finucan*, a physician was found guilty of unprofessional conduct in the practice of medicine for having sexual relationships with patients. *Finucan*, 380 Md. at 586. The expert in *Finucan* explained why sexual relationships with patients are problematic:

> First, the sexual relationships may grow out of and become entangled with the physician-patient relationship. Second, a physician places himself or herself in the position of being able to exploit his or her intimate knowledge of his or her patients and their families in order to advance the physician's sexual interests. Third, a physician is placed in a position where he or she may lose objectivity and place his or her own needs for gratification above the patient's wishes or best interests. Finally, there is a real danger that these relationships may damage the patient in a number of ways.

Finucan, 380 Md. at 599.

Pertaining to confidentiality, "[a] physician . . . shall safeguard patient confidences and privacy within the constraints of the law." Principles of Ethics § 4. Further, "[c]onfidentiality is essential to psychiatric treatment . . . based in part on the special nature of psychiatric therapy as well as the traditional ethical relationship between physician and patient." *Id.* at § 4.1. Moreover, "[b]ecause of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration." *Id.*

These requirements for the protection of confidences are especially vital with respect to psychiatric patients who share their most intimate thoughts and feelings with the understanding and expectation that the information will remain confidential. *See Salerian v. Maryland State Bd. of Physicians*, 176 Md. App. 231, 249 (2007) (holding that disclosing confidential statements of a patient's psychiatric records constitutes unprofessional conduct in the practice of medicine and patients "should be 'assured that information divulged to the psychiatrist . . . will be held in utmost confidence.'").

In the Practice of Medicine

Unprofessional conduct is deemed "in the practice of medicine" if it is "'sufficiently intertwined with patient care' to pose a threat to patients or the medical profession." *Salerian*, 176 Md. App. at 253 (quoting *Cornfeld v. State Board of Physicians*, 174 Md. App. 456, 474 (2007)). "In the practice of medicine" should not be construed narrowly and should not be limited to the "immediate process of diagnosing, evaluating, examining or treating a patient . . . [because that] would lead to unreasonable results and render the statute inadequate to deal with many situations which may arise." *Board of Physician Quality Assurance v. Banks*, 354 Md. 59,

73 (1999). In *Salerian*, a forensic psychiatrist was found to be guilty of unprofessional conduct in the practice of medicine for disclosing to the media information he obtained from a psychiatric evaluation about the evaluee and his wife. *Salerian*, 176 Md. App. at 248. The court found that disclosing information from a psychiatric evaluation created a "chilling effect on patients and potential patients alike." *Salerian*, 176 Md. App. at 254.

Panel B rejects a narrow definition of "in the practice of medicine," noting that "[c]ourts have not applied an extremely technical and narrow definition of the practice of medicine." *Banks*, 354 Md. at 74. In *Banks*, the Court of Appeals held that harassing behavior towards hospital staff by the physician, Dr. Banks, was "a threat to the teamwork approach of health care" and "caused hospital employees to avoid" Dr. Banks. *Banks*, at 75. Panel B agrees with the State and the ALJ that "the touchstone for determining whether misconduct occurred 'in the practice of medicine' must be whether it was 'sufficiently intertwined with patient care' to pose a threat to patients or the medical profession." *Salerian*, 176 Md. App. at 253 (quoting *Cornfeld*, 174 Md. App. at 474).

DR. JOHNSON IS GUILTY OF UNPROFESSIONAL CONDUCT IN THE PRACTICE OF MEDICINE

The ALJ assessed whether Dr. Johnson was guilty of unprofessional conduct in the practice of medicine by individually and separately analyzing the following four aspects of the case: (1) the blurring of boundaries between Dr. Johnson and Patient 1, (2) Dr. Johnson's disclosure of confidential medical information, (3) Dr. Johnson's sexual relationship with Person 1, and (4) the stairwell altercation involving Dr. Johnson and Person 1. The ALJ found unprofessional conduct pertaining to the first two aspects, but not to the last two. Neither party disputes that Dr. Johnson's failure to maintain proper professional boundaries with Patient 1 and

his improper disclosure of confidential medical information constitute unprofessional conduct in the practice of medicine.

Boundary Violations and Sexual Relationship with Person 1

Dr. Johnson met Person 1, the adult daughter of Patient 1, when Person 1 accompanied Patient 1 to Patient 1's psychiatric appointments. By engaging in a sexual relationship with Person 1, Dr. Johnson became involved in Patient 1's personal life. Dr. Johnson used his physician/patient relationship with Patient 1 to initiate his sexual relationship with Person 1. The ethical principles state that a physician should not gratify his or her own needs by exploiting a patient. *See* Principles of Ethics § 1.1. Dr. Johnson and Person 1 also tried to hide their sexual relationship from Patient 1, which violated Dr. Johnson's obligation to be honest with his patients. *See* Principles of Ethics § 2. A patient must be notified of all information which may have a significant impact on his or her treatment. Furthermore, after becoming aware of the sexual relationship, Patient 1 stated that she disapproved of it and tried to stop it, but Dr. Johnson neither discontinued his treatment of Patient 1 nor ended his sexual relationship with Person 1. By continuing his relationship with Person 1, Dr. Johnson "plac[ed] his own needs for gratification above the patient's wishes or best interests." *Finucan*, 380 Md. at 599. *See also* Principles of Ethics § 1.1.

Dr. Johnson's sexual relationship with Patient 1's daughter resulted in him becoming involved in Patient 1's personal life. As the court in *Finucan* noted, sexual relationships with patients are forbidden, because "[t]he sexual relationships may . . . become entangled with the physician-patient relationship." *Finucan*, 380 Md. at 599. Dr. Johnson encouraged Patient 1 and Person 1 to open a hair salon business. Once it opened, he financially supported the business by buying furniture and paying the rent. He paid Patient 1 for babysitting Person 1's children. Dr.

Johnson helped to pay for the funeral of Patient 1's son. Dr. Johnson socialized and drank wine with Patient 1 at her hair salon. Dr. Johnson's personal and financial entanglements with Patient 1 were intertwined with his sexual relationship with Person 1.

When Dr. Johnson became involved with the personal lives of Patient 1 and Person 1, his psychiatric care of Patient 1 changed. Dr. Johnson's therapy sessions with Patient 1 became shorter. He told Patient 1 that he could come by the salon to prescribe her medications and that she did not need to go into the office any more. Patient 1 felt that she could no longer be as open in treatment with Dr. Johnson because he might tell her daughter (his girlfriend) her confidential communications. As in *Banks*, where patient care was harmed because hospital staff tried to avoid the physician, Dr. Johnson's relationship with Person 1 had a negative impact on his treatment of Patient 1. In short, his sexual relationship with Person 1 was intertwined with patient care. *See Cornfeld* 174 Md. App. at 474; *Salerian*, 176 Md. App. at 253.

The ALJ correctly found that the blurring of boundaries between psychiatrists and patients constitutes unprofessional conduct. The ALJ also correctly explained that such boundaries are necessary to provide objective treatment and to ensure that the physician's needs and interests are not part of the therapeutic decision-making. Inexplicably, however, the ALJ found that, while payments and socialization crossed professional boundaries, Dr. Johnson's sexual relationship with Patient 1's daughter was itself not a boundary violation. The ALJ considered the sexual relationship with Person 1 only in the context of whether the relationship was a violation of the Board's sexual misconduct regulations. COMAR 10.32.17. The Board's sexual misconduct regulations, however, are irrelevant to a determination of whether Dr. Johnson is guilty of unprofessional conduct in the practice of medicine. Dr. Johnson was not

charged under the sexual misconduct regulations, presumably because the sexual misconduct regulations did not apply to the facts of this case.

The ALJ attempted to factually distinguish the *Finucan* case, stating that in the facts in *Finucan*, a physician was found guilty of unprofessional conduct in the practice of medicine for having sexual relationships with patients, while, the facts in this case, Dr. Johnson's sexual relationship was with a patient's daughter. The ALJ, thus, found that *Finucan* was inapplicable. Panel B rejects the ALJ's refutation of *Finucan* and agrees with the reasoning of the Court of Appeals in that case. The entanglement between the sexual relationships and physician-patient relationship, the exploitation of the patient to advance the physician's sexual interests, the loss of objectivity and placing his needs for gratification above the patient's wishes or best interests and potential damage to the patient are just as applicable in this situation where the sexual activity was with the patient's daughter and not the patient. *See Finucan*, 380 Md. at 599.

In the proposed decision, the ALJ stated that the State presented no legal authority to support a finding of unprofessional conduct for having a sexual relationship with a non-patient. However, the legal authority for that finding is the same as the legal authority for the other boundary violations: "'common judgment' of the profession," legal precedent, and the Principles of Ethics. *See Finucan*, 380 Md. at 593. Here, the conduct found to be unprofessional by the ALJ stemmed from Dr. Johnson's sexual relationship with Person 1 and cannot be separated, as the ALJ suggests. Dr. Johnson put his own interests, i.e. *his sexual relationship with Person 1,* above his patient's (Person 1's mother's) medical needs. Dr. Johnson merged his personal and professional relationships, put his own needs for gratification above the patient's psychiatric treatment, and compromised the care of his patient. These are the same concerns and negative outcomes that were discussed by the court in *Finucan.* Dr. Johnson's behavior, as a whole, is

"conduct unbecoming a member of good standing of a profession." *Finucan*, 380 Md. at 594. The Panel does not adopt the ALJ's determination that his sexual relationship was independent of his involvement with Patient 1. Panel B finds that Dr. Johnson is guilty of unprofessional conduct in the practice of medicine based on the sexual relationship and other boundary violations. *See Finucan*, *Salerian,* and the Principles of Ethics.

Disclosure of Confidential Information

The other major instance of unprofessional conduct in the practice of medicine was Dr. Johnson's disclosure of confidential medical information and discussion of other patients in his therapy sessions. Dr. Johnson disclosed Patient 2's diagnosis in front of Person 1 and told Person 1 and Patient 1 that Patient 2 would frequently request a change in her medication during therapy sessions. Dr. Johnson described another patient as "retarded" and said that he felt sorry for that patient. Panel B agrees with the ALJ that "the doctor-patient relationship [should] be maintained in the strictest confidence to allow the patient to allow for trust in the relationship, the linchpin of the therapeutic relationship." These disclosures violated the Principles of Ethics by breaching confidentiality of psychiatric therapy, without the necessary sensitivity to the private nature of disclosures by patients and without considering "[t]he welfare of his patients." Principles of Ethics § 4, 4.1; *see Salerian*, 176 Md. App. at 249 (patients "should be 'assured that information divulged to the psychiatrist . . . will be held in utmost confidence.'"). Panel B finds that Dr. Johnson's disclosures of confidential medical information constitute unprofessional conduct in the practice of medicine.

Stairwell Altercation

Dr. Johnson's relationship with Person 1 came to an abrupt end. Dr. Johnson and Person 1 had a physical altercation in the stairwell of his office building. The police were called, and

both parties had to go to the hospital for their injuries. The ALJ found that Person 1 initiated the stairwell fight and Dr. Johnson acted in self-defense, based on the testimony of Person 1 and Dr. Johnson as well as the police report. The ALJ also found that the altercation did not cause Patient 1 or Patient 2 to end their treatment with Dr. Johnson.

After a review of the evidence related to the stairwell altercation and the ALJ's analysis, Panel B accepts the ALJ's factual findings and finds insufficient evidence to sustain a finding of unprofessional conduct in the practice of medicine by Dr. Johnson during the incident.[3] Panel B does not grant the State's exception, and has not taken the stairwell altercation into consideration in its determination that Dr. Johnson is guilty of unprofessional conduct in the practice of medicine.

CONCLUSION OF LAW

Disciplinary Panel B concludes, as a matter of law, that Dr. Johnson is guilty of unprofessional conduct in the practice of medicine, in violation of Section 14-404(a)(3)(ii) of the Health Occupations Article.

SANCTION

As a sanction, the ALJ recommended a six-month suspension of Dr. Johnson's license to practice medicine and that Dr. Johnson complete coursework in the confidentiality of psychiatric treatment and in proper patient/psychiatrist boundaries. The State argues that Dr. Johnson's license be revoked. Dr. Johnson did not file any exceptions to the ALJ's proposed decision but requested in his response to the State's exceptions that the sanction be reduced. He argues that

[3] Panel B agrees with the State that credibility findings are due only for "demeanor-based credibility assessments specifically," not for "credibility assessments generally." *Elliott*, 170 Md. App. at 394. Here, the findings were not demeanor-based factual findings and, therefore, are not entitled to any deference. *See Department of Health & Mental Hygiene v. Shrieves*, 100 Md. App. 283, 302 (1994). Nevertheless, in light of the evidence presented, Panel B adopts the ALJ's factual findings.

his conduct was less severe that a 2006 Board action concerning a psychiatrist who engaged in boundary violations and was suspended for two years, with all but six months stayed. Dr. Johnson also argues that several mitigating factors apply: he has no prior discipline, this was an isolated incident unlikely to recur, and he has accepted responsibility for his conduct. *See* COMAR 10.32.02.09B(5)(a), (f), (i).

When deciding on a sanction, the disciplinary panel may consider aggravating and mitigating factors in the Board's regulations. COMAR 10.32.02.09B. The following mitigating factor is present in this case: Dr. Johnson has no prior disciplinary record. COMAR 10.32.02.09B(5)(a). Panel B rejects Dr. Johnson's claim that he has been rehabilitated and that this is an isolated incident. COMAR 10.32.02.09B(5)(f), (i).

In terms of aggravating factors, Panel B adopts the ALJ's finding that Dr. Johnson made misleading, false, and incomplete statements in his sworn statement before the Board. He also made false, misleading, and disingenuous statements to the ALJ in his testimony. COMAR 10.32.02.09B)(6)(i). In his testimony he denied having a sexual relationship with Person 1 and denied making some of the payments to Patient 1. Dr. Johnson did not take responsibility for disclosing confidential information regarding Patient 2's diagnosis. Dr. Johnson's boundary violations and disclosures of confidential information were committed deliberately, the boundary violations and disclosures were each factually discrete offenses or series of offenses adjudicated in a single action, and psychiatric patients are especially vulnerable. COMAR 10.32.02.09B(6)(b), (e), and (g).

Dr. Johnson's boundary violations were severe and troubling. As a psychiatrist, his patients are particularly vulnerable and rely on the trust established in a psychiatrist/patient relationship. Dr. Johnson intertwined his personal life with Patient 1 and her daughter with his

professional role as Patient 1's psychiatrist. His sexual relationship with Patient 1's daughter, his financial contributions to Patient 1, and his social relationship with Patient 1 eviscerated the required professional boundaries.

Additionally, Dr. Johnson ignored the ethical principles of confidentiality by improperly disclosing medical information about another patient to a woman with whom he had a sexual relationship. As a psychiatrist, Dr. Johnson's patients divulge to him highly sensitive information and deeply personal thoughts and feelings. His patients may have a mental illness or other serious psychiatric conditions that could carry a serious social stigma. The improper disclosure of psychiatric information jeopardizes the necessity for open and honest communication between patients and psychiatrists.

Disciplinary Panel B imposes the following sanction: Dr. Johnson's license shall be suspended for a minimum period of one year. Dr. Johnson shall enroll in the Maryland Professional Rehabilitation Program and shall follow all the customary provisions for evaluation and treatment. Dr. Johnson shall also complete two courses within a year concerning the confidentiality of the psychiatrist-patient communications and on the proper boundaries in the treatment of patients. Upon petition from Dr. Johnson and upon review of an evaluation by MPRP, Panel B may terminate the suspension and impose any additional terms, if any, upon Dr. Johnson.

ORDER

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

ORDERED that Spencer F. Johnson M.D.'s license to practice medicine in Maryland is **SUSPENDED** for a minimum period of **ONE YEAR.**[4] The suspension goes into effect 30 days from the date of execution of this Order, to give Dr. Johnson time to transition his patients to other providers and the following provisions apply during the suspension:

(1) Dr. Johnson shall not:

(a) practice medicine;
(b) take any actions after the effective date of this Order to hold himself out to the public as a current provider of medical services;
(c) authorize, allow or condone the use of Dr. Johnson's name or provider number by any health care practice or any other licensee or health care provider;
(d) function as a peer reviewer for the Board or for any hospital or other medical care facility in the state;
(e) dispense medications; or
(f) perform any other act that requires an active medical license;

(2) Dr. Johnson shall enroll in the Maryland Professional Rehabilitation Program ("MPRP"). Within **5 business days**, Dr. Johnson shall contact MPRP to schedule an initial consultation for enrollment. Within **15 business days**, Dr. Johnson shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP. Dr. Johnson shall fully and timely cooperate and comply with all of MPRP's referrals, rules, and requirements, including but not limited to, the terms and conditions of any Participant Rehabilitation Agreement(s) and Participant Rehabilitation Plan(s) entered into with MPRP and shall fully participate and comply with all therapy, treatment, evaluations, and toxicology screenings as directed by MPRP;

(3) Dr. Johnson shall sign written release/consent forms, and update them, as required by the Board and MPRP. Dr. Johnson shall sign written release/consent forms to authorize MPRP to make verbal and written disclosures to the Board and to authorize the Board to disclose relevant information from MPRP records and files in a public order. Dr. Johnson shall not withdraw his release/consent;

(4) Dr. Johnson shall also sign any written release/consent forms to authorize MPRP to exchange with (i.e., disclose to and receive from) outside entities (including all of Dr. Johnson's current therapists and treatment providers) verbal and written information concerning Dr. Johnson and to ensure that MPRP is authorized to receive the medical

[4] The suspension will not be terminated if Dr. Johnson fails to renew his license. If Dr. Johnson's license expires while his license is suspended, the suspension period is tolled. COMAR 10.32.02.05C(3).

records of Dr. Johnson, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. Dr. Johnson shall not withdraw his/her release/consent;

(5) within **ONE YEAR**, Dr. Johnson shall successfully complete two Board-approved courses. One course shall be about maintaining confidentiality of the psychiatrist-patient relationship. A second course shall be about maintaining proper boundaries in the treatment of patients and in the psychiatrist-patient relationship. The following terms apply:

(a) it is Dr. Johnson's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;
(b) the disciplinary panel will not accept a course taken over the internet;
(c) Dr. Johnson must provide documentation to the disciplinary panel that he has successfully completed the course;
(d) the course may not be used to fulfill the continuing medical education credits required for license renewal;
(e) Dr. Johnson is responsible for the cost of the course; and it is further

ORDERED that, prior to the termination of suspension, MPRP, or its agents, shall conduct an evaluation to determine whether Dr. Johnson is fit to resume clinical practice, and if so, under what conditions. Dr. Johnson shall fully cooperate with the evaluation; and it is further

ORDERED that after the minimum period of suspension imposed by the Final Decision and Order has passed and if Dr. Johnson has fully and satisfactorily complied with all terms and conditions for the suspension, Dr. Johnson may submit a written petition to Disciplinary Panel B for termination of the suspension. Dr. Johnson may be required to appear before Disciplinary Panel B to discuss his petition for termination. If Disciplinary Panel B determines that it is safe for Dr. Johnson to return to the practice of medicine, the suspension shall be terminated through an order of Disciplinary Panel B, and Disciplinary Panel B may impose any terms and conditions it deems appropriate on Dr. Johnson's return to practice, including, but not limited to, probation. If Disciplinary Panel B determines that it is not safe for Dr. Johnson to return to the practice of medicine, the suspension shall be continued through an order of Disciplinary Panel B for a length

of time determined by Disciplinary Panel B, and Disciplinary Panel B may impose any additional terms and conditions it deems appropriate; and it is further

ORDERED that Dr. Johnson is responsible for all costs incurred in fulfilling the terms and conditions of this Final Decision and Order; and it is further

ORDERED that, if Dr. Johnson allegedly fails to comply with any term or condition imposed by this Final Decision and Order, Dr. Johnson shall be given notice and an opportunity for a hearing. If Disciplinary Panel B determines 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 followed by an exceptions process before a disciplinary panel. If Disciplinary Panel B determines there is no genuine dispute as to a material fact, Dr. Johnson shall be given a show cause hearing before Disciplinary Panel B; and it is further

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

ORDERED that the effective date of the Final Decision and Order is the date the Final Decision and Order is signed by the Executive Director of the Board. The Executive Director signs the Final Decision and Order on behalf of Disciplinary Panel B; and it is further

ORDERED that this Final Decision and Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6); and it is further

07/09/2019
Date

Signature on File

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

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

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

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

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

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

Exhibit 1

MARYLAND BOARD OF	*	BEFORE MICHAEL D. CARLIS,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
SPENCER F. JOHNSON, M.D.,	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	
LICENSE No.: D51645	*	OAH No.: MDH-MBP2-71-18-08607

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

PROPOSED DECISION

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

STATEMENT OF THE CASE

On January 31, 2018, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges (Charges) against Spencer F. Johnson, M.D. (Respondent) alleging a violation of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-508, and 14-601 through 14-607 (2014 & Supp. 2018). Specifically, the Board charged the Respondent with violating section 14-404(a)(3)(ii) of the Health Occupations Article. *Id.* § 14-404(a)(3)(ii) (Supp. 2018); *See* Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d). The disciplinary panel to which the complaint was assigned forwarded the Charges to the Office of the Attorney General for prosecution, and this matter was delegated to the Office of Administrative Hearings (OAH) for issuance of a proposed decision. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a hearing on August 14 and 15, 2018, at the OAH in Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (Supp. 2018); COMAR 10.32.02.04. Andrew E. Vernick, Esquire, and Christopher J. Greaney, Esquire, and Vernick & Associates, represented the Respondent, who was present at the hearing. Victoria H. Pepper, Assistant Attorney General and Administrative Prosecutor, and the Office of the Attorney General, represented the State of Maryland (hereinafter referred to as the Board).

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings before the Board of Physicians, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2018); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate section 14-404(a)(3)(ii) of the Health Occupations Article?[1] If so,

2. What sanction(s) are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits into evidence at the Board's request:

Bd. Ex. 1: Complaint Form, dated August 8, 2016, with attachments;
Bd. Ex. 2: Complaint Form, dated September 5, 2016, with attachments;

[1] I conducted a prehearing conference regarding this case on July 26, 2018. The parties were represented by the same counsel identified above. On July 30, 2018, I issued a Prehearing Conference Report (Report) in which the issues were more specifically identified. The Report also instructed the parties to report any disagreement with "the accuracy or completeness of the Report" to me within seven days. Neither party reported any disagreement. The issues listed in the Report identified the Respondent's acts that by itself or in context allegedly supported the statutory violation: (i) paying a patient to babysit her adult daughter's children while the daughter participated in a video shoot by the Respondent, (ii) encouraging and financially supporting the patient and her adult daughter to open a hair salon, (iii) engaging in a sexual relationship and physical altercation with the adult daughter of a patient, (iv) disclosing confidential medical information about the patient to patient's adult daughter and talking about two additional patients while drinking wine with a patient and her daughter in the hair salon, (v) disclosing confidential medical information about a different patient to the adult daughter of a patient, (vi) making derogatory remarks to a patient about another patient's daughter, who also was a patient, and (vii) calling patients retarded in the presence of a patient during a treatment session. Those specific allegations are addressed in this decision.

Bd. Ex. 3: Transcript of Person 1's interview, dated September 27, 2016;[2]
Bd. Ex. 4: Copies of photographs, hospital records, police report, financial records, and records from Colony South;
Bd. Ex. 5: Subpoena Duces Tecum, dated September 29, 2016;
Bd. Ex. 6: Transcript of Patient 1's interview, dated October 11, 2016;[3]
Bd. Ex. 7: Subpoena Duces Tecum, dated September 26, 2016, with attached medical reports;
Bd. Ex. 8: Subpoena Duces Tecum, dated September 28, 2016, with attached legal documents;
Bd. Ex. 9: Complaint Form, dated November 13, 2016, with attachments;
Bd. Ex. 10: Transcript of Patient 2's interview, dated November 29, 2016;[4]
Bd. Ex. 11: Complaint Form, dated March 10, 2017;
Bd. Ex. 12: Subpoena Duces Tecum, dated March 31, 2017, with attached documents;
Bd. Ex. 13: Electronic communication, dated April 28, 2017;
Bd. Ex. 14: Electronic communication, dated April 28, 2017, with attachments;
Bd. Ex. 15: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 16: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 17: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 18: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 19: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 20: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 21: Electronic communication, dated May 1, 2017, with attachments;
Bd. Ex. 22: Memorandum Of Visit To Patient 1, dated May 24, 2017;
Bd. Ex. 23: Electronic communication, dated May 24, 2017, with attachment;
Bd. Ex. 24: Subpoena Duces Tecum, dated May 25, 2017, with attached medical notes;
Bd. Ex. 25: Transcript of interview of Patient 1, dated July 19, 2017;
Bd. Ex. 26: Subpoena Ad Testificandum, with attached transcript of interview of Arthur Halvorson, dated August 8, 2017;
Bd. Ex. 27: Subpoena Ad Testificandum, with attached transcript of interview of the Respondent, dated August 22, 2017;
Bd. Ex. 28: Agreement For Talent Participation, dated August 14, 2012;
Bd. Ex. 29: Subpoena Duces Tecum, dated August 30, 2017, with attached Lease Agreement;
Bd. Ex. 30: Subpoena Duces Tecum, dated March 31, 2017, with a single attachment;
Bd. Ex. 31: Response to Complaint, dated April 21, 2107, with attachments tabbed 1-22 that correspond to exhibit references in the Response;
Bd. Ex. 32: Charges Under The Maryland Medical Practice Act, dated January 31, 2017;
Bd. Ex. 33: Prescription form, dated August 6, 2018;
Bd. Ex. 35:[5] Order of Reinstatement, dated August 15, 2016; and
Bd. Ex. 36: The Principles of Medical Ethics, 2013 Edition.

[2] Person 1 is used instead of the individual's proper name for privacy reasons.
[3] *See* footnote 2.
[4] *See* footnote 2. Patient 2 was previously known as [redacted]
[5] Bd. Ex. 34 was not admitted. Bd. Ex. 37 was marked for identification, but not admitted.

I admitted the following exhibits into evidence at the Respondent's request:

Resp. Ex. 1: Investigative results, and thirty-two pages for information of various kinds; and
Resp. Ex. 2: Person 1's complaint against Jo-Anne Bragg, dated June 25, 2017.

Testimony

The following witnesses testified for the Board:[6]

- Arthur Halvorson, businessman;[7]
- Amanda Kate Miller, Compliance Analyst with the Board;[8]
- Person 1; and
- Patient 2.

The Respondent testified for himself, and presented the following witness:

- Jo-Anne Bragg, Counselor.

[6] On behalf of the Board, the OAH issued a subpoena to Patient 1 for her appearance and testimony. Patient 2 did not appear or testify at the hearing. Instead, she had provided a note to Ms. Pepper from a physician, dated August 6, 2018, who, at best, suggested her mental health condition prevented her appearance. The hearing proceeded without Patient 1's testimony. During Ms. Miller's testimony, after she was first asked about her interview with Patient 1, the Respondent objected to any testimony about that interview based on Patient 1's failure to appear to testify. I overruled that objection and allowed the investigator's testimony (and the transcript of Patient 1's sworn interview). However, it was agreed that Ms. Pepper would contact Patient 1 to inform her that the subpoena required her attendance, provide her the option to testify by telephone, and instruct her that if she refused to appear or testify by phone, OAH would initiate enforcement of the subpoena through the judiciary. At the end of that day's testimony, the Respondent indicated he no longer wanted to pursue obtaining Patient 1's compliance with the subpoena. The Board raised no objection.

[7] Mr. Halvorson is the sole owner of limited liability companies that own and manage properties, including properties leased by the Respondent to operate his medical practice.

[8] Ms. Miller is the compliance analyst who, with another compliance analyst, conducted interviews with Patients 1 and 2, Person 1, and the Respondent during the Board's investigation of the complaints against the Respondent. A different compliance analyst conducted the interview of Mr. Halvorson.

PROPOSED FINDINGS OF FACT

The Parties stipulated to the following facts:

1. The Board originally licensed the Respondent to practice medicine on February 11, 1997.

2. The Respondent holds an active license to practice medicine in Maryland and the District of Columbia.

3. The Respondent is Board-certified in psychiatry.

4. At all times relevant to this matter, the Respondent maintained an office for the private practice of psychiatry in Prince George's County, Maryland.

5. No prior adverse action has been taken against the Respondent's license to practice medicine.

I find the following facts by a preponderance of the evidence.

6. The Respondent treated Patient 1 as an out-patient at his office in Prince George's County from on or about March 23, 2009, until August 10, 2016. The Respondent discharged Patient 1 as his patient after she failed to respond to the Respondent's discharge letter mailed to her on or about August 10, 2016. The Respondent diagnosed and treated Patient 1 for major depression and generalized anxiety disorder.

7. At the time of hearing, Patient 1 was a fifty-eight year old female. She was not employed when she began treatment with the Respondent, but received a disability retirement allowance from the federal government for at least part of the time during her treatment.

8. On or about July 2015, Patient 1's son, who was Person 1's brother, died. The Respondent paid $2,000.00 to cover at least part of the son's funeral expenses.

9. Person 1 is the adult daughter of Patient 1. At the time of the hearing, Person 1 was forty years old. She would sometimes drive Patient 1 to her appointments with the Respondent, which is how Person 1 met the Respondent.

10. The Respondent treated Patient 2 as an out-patient at his office in Prince George's County. One of the Respondent's intake forms on Patient 2 indicates she began treatment in March 2011. The Respondent diagnosed and treated Patient 2 for obsessive compulsive disorder and bipolar 1 disorder. At the time of the hearing, Patient 2 was forty-eight years old.

11. Patient 2 has a daughter, [redacted], who was fourteen years old at the time of the hearing. She was a patient of the Respondent. He treated her for attention deficit disorder from sometime in 2012 to July 2016.

12. In addition to the Respondent's practice of psychiatry, at all relevant time, he owned and operated a video production company in which he produced video features of different lengths and types. The video company operated from the same professional building where the Respondent had his psychiatry practice, but in a different office.

13. Beginning in or about August 2012, the Respondent engaged Person 1 to perform "fetish" or "glamour" videos. These were smoking videos in which Person 1 would be filmed inhaling and exhaling cigarette smoke. The Respondent paid Person 1 between $100.00 and $300.00 for each video shoot.

14. The Respondent paid Patient 1 up to $250.00 to babysit Person 1's children while Person 1 performed in the glamour or fetish videos and at other times.

15. On a date that is not specifically established in the record, the Respondent and Person 1 began a sexual relationship. During the course of that relationship, the Respondent gave Person 1 money and gifts with a total value between $25,000.00 to 30,000.00.

16. On a date that is not specifically established in the record, the Respondent referred to other patients who were in the waiting area of his office as "retarded" and said they become easily agitated if they have to wait for their appointment. The Respondent said this to Patient 2.

17. On a date that is not specifically identified in the record, the Respondent referred to [redacted] as retarded in front of Patient 1 and Person 1.

18. On a date that is not specifically identified in the record, the Respondent talked about Patient 2's diagnosis in front of Person 1 and said Patient 2 would frequently request a change in her medication during therapy sessions in front of Person 1 and Patient 1.

19. At some time around July 2015, the Respondent encouraged Person 1 and Patient 1 to open and operate a hair salon. In November 2015, the Respondent paid the Maryland Department of Assessments and Taxation $150.00 for Articles of Amendment for [redacted], a limited liability company operated by Person 1 and Patient 1. In addition, the Respondent purchased furniture and paid the monthly rent for the salon.

20. The Respondent would often socialize with Patient 1 and Person 1 at the salon.

21. On August 6, 2016, the Respondent and Person 1 physically fought each other in the stairwell between the third and fourth floor of the office building where the Respondent's psychiatry practice was located.[9] Earlier that day, Person 1 had sent an angry, threatening, and profane text message to the Respondent. She arrived uninvited at the Respondent's office, during office hours, to obtain money from him. The Respondent escorted Person 1 out of the office and into the stairwell where the fight took place.

22. On August 6, 2016, Person 1 sought treatment for injuries that she suffered during the fight at MedStar Southern Maryland Hospital Center (Hospital). Her primary diagnoses included assault by human bite, muscle pain, contusion of multiple sites, fractured nasal bones, and victim of physical assault. She was treated, prescribed medication, and discharged.

[9] The Respondent's psychiatry practice was on the third floor. He also leased office space on the fourth floor, where the video shoots with Person 1 took place.

23. On August 6, 2016, the Respondent sought medical treatment at Patient First. He was diagnosed with contusions and abrasions of the head.

24. Patient 2's last appointment with the Respondent was in May 2016. Sometime toward the end of July 2016, Patient 1 cancelled her last scheduled appointment with him. She never returned. On September 6, 2016, the Respondent sent her a letter terminating the doctor-patient relationship because he had learned she was receiving mental health services elsewhere.

25. On August 10, 2016, the Respondent sent a letter to Patient 1 in which he terminated their doctor-patient relationship.

26. The Respondent did not maintain proper professional boundaries during his treatment of Patient 1.

27. The Respondent disclosed confidential information he obtained during treatment about his treatment of Patient 1, [redacted], and other unidentified patients.

DISCUSSION

Summary of the Complaints that triggered the Charges

The Board received written complaints about the Respondent from Patient 1 and Patient 2. On a date identified in the Charges as on or about August 16, 2016, the Board received Patient 1's complaint.[10] Patient 1 complained she was no longer "comfortable being" a patient of the Respondent "since he physically assaulted my daughter [Person 1] at his workplace." She reported her depression got worse. She described the assault as "almost killing her by stumping & kicking her down the stairs" and she stated it "left me mentally angry and back to my major depression . . . ." Patient 1 traced the origin of her "negative feelings" toward the Respondent to

[10] The Board identified this complaint as Case Number 2017-0150A.\

when he "opposed" [sic] Person 1 for a date during one of her sessions. She described that as "rude," "disrespectful," "cocky," and "distasteful." Patient 1 also complained that the Respondent's relationship with Person 1 caused "conflict" in her treatment "from him repeating to my child my privacy discussions we held during my sessions." Patient 1 felt "violated" and believed the Respondent did not care about her.

On a date identified in the Charges as on or about November 17, 2016, the Board received a complaint from Patient 2.[11] Patient 2 complained that the Respondent disclosed information about her diagnosis and treatment to Person 1. She claimed those disclosures exacerbated a somatic condition that ultimately led to a hospitalization. Patient 2 also complained that the Respondent called [redacted] "retarded" and refused to send her (Patient 2's) medical records to her new psychiatrist.[12]

Legal Context

Section 14-404 of the Health Occupations Article provides as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations — Grounds.**
>
> (a) *In general.* – Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee,[13] place any licensee on probation, or suspend or revoke a license if the licensee:
>
> . . .
>
> (3) Is guilty of:
>
> . . .
>
> (ii) Unprofessional conduct in the practice of medicine . . . .

Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) (Supp. 2018).

---

[11] The Board identified this complaint as Case Number 2017-0219A.
[12] The Board identified this complaint as Case Number 2017-0219A. This complaint is dated November 13, 2016. Patient 2 filed another complaint against the Respondent. This one is dated September 5, 2016.
[13] "Licensee" is "an individual to whom a license is issued, including an individual practicing medicine within or as a professional corporation or professional association." Md. Code Ann., Health Occ. § 14-101(j) (Supp. 2018).

The Board's enforcement powers include a broad range of sanctions upon finding a violation of section 14-404. In addition to those set forth above in section 14-404(a), the Board may impose a financial penalty against an offending physician. Section 14-405.1 provides:

> **§ 14-405.1. Penalty instead of suspension or in addition to suspension or revocation.**
>
> (a) *Imposition of penalty.* — If after a hearing under § 14-405 of this subtitle a disciplinary panel finds that there are grounds under § 14-404 of this subtitle to suspend or revoke a license to practice medicine of osteopathy, or to reprimand a licensed physician or osteopath, the disciplinary panel may impose a fine subject to the Board's regulations:
>
> (1) Instead of suspending the license; or
>
> (2) In addition to suspending or revoking the license or reprimanding the licensee.
>
> (b) *Disposition of funds.* — The Board shall pay any fines collected under this section into the General Fund.

Id. § 14-405.1; *see also* COMAR 10.32.02.09 (addressing disciplinary sanctions and the imposition of fines); and COMAR 10.32.02.10 (providing a chart that lists maximum and minimum sanctions and fines for specific violations).

Preliminary Credibility Determinations[14]

The parties almost exclusively focused on the credibility of Person 1 and the Respondent during their closing arguments. The Board argued that the Respondent's extortion defense is not credible for several reasons.[15] First, the Board argued that the Respondent did not take any reasonable actions in response to Person 1's extortion plan, for example, seeking advice and guidance from a trusted friend or colleague or contacting the police. Second, the Board argued that the affection he showed Person 1 in his electronic communications with her belie his

[14] I address the issue of the Respondent's and Person 1's credibility at the outset of this decision because both are critical witnesses. I later address the Board's specific allegations of unprofessional conduct in the practice of medicine during which I comment on the credibility of Patients 1 and 2.

[15] The Respondent denied a sexual relationship with Person 1. He testified Person 1 extorted him for money and gifts by threatening to expose a made-up sexual affair he was having with her.

extortion defense. Third, the Board argued that the Respondent's "parsing" responses to questions during direct examination undermined his credibility.

The Respondent argued that Person 1 is not credible for at least two reasons. First Respondent argued that during her testimony, Person 1 "readily admitted she had committed a fraud" by using a letter that falsely stated she was employed with a good salary in order to purchase a luxury automobile. Second, Ms. Bragg, an unbiased witness, testified that Person 1 had victimized her by falsely complaining she engaged in unprofessional misconduct while providing service to Person 1.

Person 1's credibility

During the hearing, Person 1 unapologetically admitted to intentionally obtaining and using a wholly false written statement to purchase a luxury automobile. Board Ex. 22 includes a letter on [redacted] letterhead, dated March 13, 2015. The letter is addressed to Person 1 and states:

> [Person 1] please see the following information as proof of your employment with [redacted]
>
> [Person 1] is the site supervisor for all the [redacted] under contract with us. She is responsible for ensuring all work is completed at 4 locations, she has been an employee since 2/03/2014. She is a salaried employee and is exempt from overtime. [Person 1's] salary is $68,000 per year. She has elected not to enroll in or [sic] employee benefits program and has her own health insurance. If you have any questions please contact me at 301-978-1540.

Bd. Ex. 22. This letter is signed by an individual identified as the "Managing Partner." At the hearing, Person 1 admitted that she was unemployed at the time this letter was written. She further admitted that she used this wholly false letter to purchase a BMW X5. During cross-examination, she at first testified that the Respondent allowed her to use Skyrocket Production, his video production company, to purchase the automobile. Upon further questioning, she changed that testimony to say that the Respondent "hooked" this up for her "through one of his

sources." The letter establishes Person 1's willingness to use false statements and deceit to mislead others to unwittingly assist her to obtain something that the truth would have made impossible. By Person 1's unapologetic admission of deceit, I find that her credibility substantially tarnished. Nonetheless, I do not conclude that her testimony is categorically without any probative value. The probative weight, if any, I give to Person 1's testimony about any material fact shall be determined by a consideration of her testimony in the context of the full relevant evidentiary record. However, I decide here that Person 1's testimony, alone, shall be insufficient to support a factual finding.[16]

The Respondent's credibility

In regard to the Respondent, I have equally strong reservations about his credibility for the following reasons. First, the Respondent sworn statements during his interview by the Board on August 22, 2017, were sometimes misleading, false, or incomplete. The following are examples. When asked to discuss his involvement in the salon, he said he encouraged Patient 1 to start a business and agreed to place advertisements about the salon in his office, refer acquaintances to the salon, and provide her the name of someone experienced in setting up businesses. He mentioned nothing else. When shown a document from the Department of Assessments and Taxation and asked why he made payments to that agency on behalf of the salon, he said it "might have been given as a gift." When asked if he could recall paying any other money for the salon, he stated, "I do not." However, when again shown documentation of a purchase his production company made for the salon in October 2015, he testified, "Those I do recall, now that there's, you've shown them to me. I did not remember them before." Finally, when asked questions about paying rent for the hair salon, the Respondent was disingenuous, at

[16] I have not considered Ms. Bragg's testimony in this discussion because the allegations related to Person 1's complaint against her has not been adjudicated.

best. When asked if he paid rent for the salon, he said he was not "responsible" for the rent and did not pay rent for the salon to Mr. Halvorson. That was misleading, disingenuous, and illustrate a willingness to mock honesty. Regardless of to whom the Respondent wrote the rent checks, he paid the rent for the salon to Mr. Halvorson. Mr. Halvorson was interviewed by the Board and he testified at the hearing. In his statements to the Board, he made clear that he dealt directly with the Respondent; that the Respondent knew exactly who he was; and that the Respondent paid rent for the salon. Mr. Halvorson was an unbiased, credible witness. Based on this, and based on my demeanor-based observations of the Respondent during his testimony, and more,[17] I have strong reservations about the Respondent's credibility. Therefore, his testimony, alone, alone is insufficient to satisfactorily establish a fact or adequately refute the combined weight of other evidence.

Factual matters

The hair salon

The Board alleged that the Respondent encouraged Patient 1 and Person1 to open a hair salon business and financially supported [redacted], the salon. The Respondent did not specifically dispute that allegation.

In his recorded interview in August 2017, the Respondent said he "encouraged" Patient 1 to start a hair salon. He admitted he paid to help set up the salon and admitted he paid over $400.00 for a piece of furniture for the salon. At the hearing, the Respondent testified "the relationship with the hair salon as far as I was concerned was with the daughter only."[18] He conceded, however, that he "became aware that [Patient 1] was working there."

[17] It is clear that the Respondent knowingly assisted Person 1 in obtaining the letter falsely attesting to her employment status and salary discussed above.
[18] This testimony contradicted his statement to the Board.

In her recorded interview in October 2016, Patient 1 said the salon was for her and Person 1. Person 1 testified the salon was for her and Patient 1. Person 1 identified documents that showed the Respondent's payment for furniture and to the Department of Assessment and Taxation for the salon. Person 1 also identified electronic messages in which the Respondent admitted paying rent for the salon. Mr. Halvorson testified that the Respondent paid rent for the salon for "at least a year." Accordingly, I find that, during his treatment of Patient 1, the Respondent encouraged Patient 1 and Person 1 to open a hair salon and provided them with regular and significant ongoing financial assistance to operate [redacted].

The sexual and financial relationship with Person 1

Person 1 testified that the Respondent was her "boyfriend" for five years. She testified that she and the Respondent had a sexual relationship. During the Board's interview, Person 1 stated she that she had "sex" with the Respondent and stated they were "intimate," starting sometime in 2012. Person 1 testified that the Respondent frequently gave her money and paid for expensive gifts.

Patient 1 told the Board that she witnessed affection between Person 1 and the Respondent and were with them during bank transactions.

During his testimony, the Respondent specifically denied a sexual relationship with Person 1. During his Board interview, the Respondent also denied a sexual relationship with Person 1, and that he "absolutely" had no sexual relationship with any relatives of his patients. He admitted frequently giving Person 1 money, totaling as much as $30,000.00.

The Respondent contended that he paid Person 1 large sums of money and helped with the salon because Person 1 was extorting him. He claimed she threatened to ruin his marriage and reputation in the community by falsely exposing that they were having a sexual affair. In regard to the hair salon, he also explained his largess this way: "I was hoping that over time it

would be enough revenue generated that the hair salon would be my way out of this." The Respondent provided no corroboration of any of this this testimony.

In addition, the Respondent explained that he "had never been in a situation like that before, and I didn't know what to do . . . who I could turn to for help." He testified he did not contact the police or seek advice from a colleague because he "didn't know that that would be a resource." The Respondent testified, however, that he "informally" spoke to a friend, who is an attorney, about the extortion. The Respondent did not offer this friend as a witness to corroborate that conversation or explain why the friend was unavailable to testify. It simply does not make common sense that the Respondent would not offer the only witness who could support the theory of his case, unless, of course, there was actually no friend to testify. Accordingly, for this reasons discussed above about the Respondent's credibility, and considering the above discussion, I am not persuaded by the Respondent's extortion theory explains his generosity toward Person 1. Rather, what makes more common sense is that his largess a function of his sexual relationship with Person 1.

The record also provides additional support for a finding that the Respondent had a sexual relationship with Person 1 and that extortion was not the reason he gave Person 1 a substantial amount of money and assistance for the salon. The additional support comes from very familiar and ostensibly affectionate electronic communications between the Respondent and Person 1. In June 2016, Person 1 commented that the Respondent had not talked to her about business plans and wondered whether he was against her. The Respondent replied that he gave money to her as "a gift" and: "Do not ask me again ever if I'm against you. You know the answer is NO I AM NOT against you." In another message, the Respondent referred Person 1 as "Pepe" and "Sstinker [sic]." In another message, the Respondent assured Person 1 that he was "on a mission [sic] that supports yours." Person 1 referred to the Respondent in a message as

"Daddy." She testified that the Respondent wanted her to call him that. Another exchange of messages included the following from the Respondent: "Quiet Pepe. Pulling the last few pieces together. You are a brat and a stinker. But in spite of it all you are also loved." Person 1 replied: "[H]appy to hear you have love for me. Thanks I needed to hear that."

At the hearing, the Respondent testified that these text messages were his way of trying "to channel back negativity with something neutral or positive." He explained that "Pepe" was a reference to Pepe Le Pew, the anthropomorphic French skunk of Looney Tunes fame, and was meant to be "a double entendre that reflected my feelings but at the same time was neutral." When asked what those feelings were, he listed them as "annoyance," "disgust," "vulnerability," and "anger." He pointed out that the phrase, "in spite of it all you are still loved," was written in the passive voice, presumably underscoring that he had not written that he loved Person 1. When the Respondent was asked why he wrote "friendly text messages" to Person 1, he testified: "Because [Person 1] was or is a person who is very volatile, and I felt like it was better dealing with that type of person to not repay venom with venom, but try to come back in a neutral or even friendly tone to bring her down."

The Respondent's alternative explanations for sending ostensibly friendly and affectionate text messages to someone who he claimed was extorting him for large sums of money are not persuasive. I find that the friendly, playful, and affectionate messages discussed above support Person 1's testimony of a sexual relationship between she and the Respondent. Accordingly, for all the reasons discussed above, I find that the Respondent had a sexual and financial relationship with Person 1 during the time he treated Patient 1.

The physical altercation between the Respondent and Person 1

Person 1 and the Respondent agreed that there was a physical fight between them on August 6, 2016, in the building where the Respondent's medical practice is located. The fight

occurred in the stairwell between the third and fourth floors during the Respondent's office hours.

Person 1 testified she was "very upset" when she entered the Respondent's office to get money she "needed" for her daughter's school supplies and hair styling. Shortly before her arrival, she sent the following electronic message to the Respondent:

> I'm fed up! Every time you feel the need to ignore my text makes me feel like maybe being negative wouldn't hurt fucking nothing. My mother n father [sic] would understand nigga you not going to play with my heart & my livelihood. I'll kill or be killed like I seriously on my kids [sic]. You played with me long enough Doc fuck you and everything in your life. I'm fucking miserable so will everybody else around you will! [sic] I need my MF money every week! I'm sick of your bs!!!! Nobody will stop me from fucking you up like your fucking me up! I know you've been fucking them dirty ass whores in office & the salon. [B]itch.

Bd. Ex. 31, Tab 4.

Person 1 explained the content and tone of the message this way: "I was pissed off with him cheating on me, seeing other women in his office, disrespectful things coming out to the hair salon about his affairs with other women." She tried to minimize the threats and hostility as follows: "I was just venting. I was mad, I was upset. I was hysterical, and I was upset with him."

Person 1 testified that when she arrived at the Respondent's office at around 2:40 p.m., he led her to the stairwell and when the door shut behind them, "he started hitting me in my face with a closed fist ongoing times." According to Person 1's testimony, the Respondent was calling her names, kicking her in her stomach, and trying "to kill" her by making her fall backwards down the stairs. Person 1 testified that she fought back by "grabbing" and "scratching" the Respondent.

The Respondent testified that he had fifteen patients scheduled for the day of the fight. He testified that Person 1's threatening email made him angry and frightened. He testified he

feared for his and his staff's safety, and he alerted Ashley White, his secretary, to possible trouble and instructed her to keep the door locked.[19] According to the Respondent, he was in the back "consulting area" when Person 1 arrived. He testified he walked Person 1 out of the office "to the stairwell," while she was arguing and cursing him. He further explained:

> I got into the stairwell and asked her to leave, and she pushed me against the wall of the stairwell, and I assumed a defensive posture and pushed back against her as far as I can remember, and then I ran down the, before that happened, she landed a few blows on me. As I tried to defend myself and fend [her] off by pushing with my arms raised, and I ran down the hall to where a security company is that was in the building and knocked on the door and asked them to help me .

The Respondent denied that his hands ever came in contact with Person 1's face and testified that her bloody face and injuries "could only have been sustained when I was trying to fend her off in a defensive posture and she was lunging towards me." He insisted he "did not hit her."

The Prince George's County Police responded to the scene at 3:09 p.m. The responding officer reported:

> On 08/06/2016 at 1509 hours I . . . responded to . . . a fight. Upon my arrival I made contact with [Person 1] and [the Respondent]. [Person 1] was screaming and throwing her arms around in an aggressive manner. For my safety and the safety of citizens on the scene I placed [Person 1] into handcuffs until my back-up arrived. [The Respondent] was calm at the time of my arrival. [Person 1] and [the Respondent] were checked for open warrants with negative results. [Person 1] and [the Respondent] were advised and sent on their way.

Bd. Ex. 31, Tab 7.[20]

---

[19] The record includes a written statement from Ms. White, which is signed and dated on August 14, 2016. She described Person 1's countenance when she walked into the office as "visibly upset." Ms. White reported that she heard yelling and tussling after about four minutes and when she looked outside she saw a security guard and Person 1 in the Respondent's face pointing her finger at him, yelling at him, and taking a swing at him. She saw the Respondent grabbing Person 1's arms "and pushing her towards the wall trying to keep her off of him." Bd. Ex. 31, Tab 6. Ms. White reported that she called 911 at the Respondent's request.

[20] Person 1 and the Respondent filed criminal complaints against each other and the District Court of Maryland entered a nolle prosequi disposition in both cases.

Medical records show that Person 1 was treated at the Hospital that same day. Her chief complaints were "problems with her face," assault, and "problem with abdomen." She was given a tetanus shot and prescriptions for hydrocodone, amoxicillin, and acetaminophen. She was discharged with the following diagnoses: "Assault by human bite, Muscle pain, Contusion of multiple sites, Fracture nasal bones [diagnosed via a computed tomography scan], Victim of physical assault." *Id.* Tab 7.

The Respondent was treated at Patient First shortly after 8:00 p.m. on August 6, 2016. His complaint was "facial injuries." He was diagnosed with contusion and abrasion of "other part of head." *Id.* Tab 10.[21] It is unclear what, if any, treatment he.

Based on the review of the evidence discussed above, I find that the Respondent and Person 1 engaged in a physical fight on August 6, 2016, in the building where Respondent conducts his practice, during his office hours, and while patients were scheduled.

The Board took the position that it did not matter who started or was the aggressor at this fight. In its closing argument, the Board argued the fight should not have occurred at all and commented that it occurred in "an office"[22] while the Respondent "is having office hours." I disagree. A doctor, even one licensed by the Board to practice medicine, has the right to defend him- or herself against assault and battery. Surely, a licensed psychiatrist who practices marriage therapy cannot be impermissibly engaging in unprofessional conduct in the practice of medicine if he defends himself against an irate husband who barges into the psychiatrist's office while he is in session only with the wife and attacks the psychiatrist because he thinks the psychiatrist is having an affair with his wife. A license to practice medicine does not strip a doctor of the right to self-defense. In this regard, I find several facts significant.

---

[21] The photographs of the Respondent's purported facial injuries that are part of the record at Bd. Ex. 31, Tab 11 are too dark to show any injuries.

[22] This is not supported by the record.

First, the Respondent did not invite Person 1 to his office on the day of the fight. Person 1 arrived angry; she wanted money from the Respondent and to confront him about his "infidelity."

Second, Person 1 made it clear to the Respondent that she was "fed up" with him; she was ready "to kill or be killed" and to "fuck[]" him up.

Third, upon learning Person 1 was in the office, the Respondent ushered her into the stairwell, away from his office and possible contact with patients. This action protected his patients and staff.

Fourth, after the fight in the stairwell, the Respondent sought assistance from the building's security staff. He also instructed Ms. White to call 911. These actions are inconsistent with that of an aggressor, but fully consistent with the behavior of a victim.

Finally, the policeman who arrived at the scene only placed Person 1 in handcuffs because she was out of control and aggressive; the Respondent was calm.

Despite the disparity in the injuries between the Person 1 and the Respondent, and the disconnect between the Respondent's description of his relatively subdued behavior and Person 1's injuries, I find that it is more likely than not that Person 1 was the aggressor. Moreover, I find that the Respondent attempt to protect patients and his staff from what he had good reason to believe might be an ugly scene.

Payment to Patient 1 for babysitting Person 1's children

Ms. Miller accurately testified that Patient 1 stated in her interview that that the Respondent paid her up to $250.00 to babysit Person 1's children while Person 1 did video shoots for the Respondent. Person 1 testified that the Respondent paid Patient 1 to babysit her children whenever she went out with the Respondent. During the Board's interview and at the hearing, the Respondent specifically denied that he paid Patient 1 to babysit Person 1's children.

Patient 1's statements during the Board's interview are reliable hearsay because they are sworn statements, and the Respondent had an opportunity to cross-examine Ms. Miller, the interviewer. Although the Respondent could not cross-examine Patient 1, and I had no opportunity to observe her demeanor as a witness, I give some probative weight to Person 1's testimony and Patient 1's statement. The testimony and statement are mutually corroborative, and competent evidence in the record has established that the Appellant made payments of substantial amounts of money to and on behalf of Person 1 and Patient 1. Accordingly, I find that the Respondent paid Patient 1 to babysit Person 1's children on a number of occasions.

Payment for the funeral of Patient 1's son

Person 1 testified that the Respondent paid for her brother's funeral. She said the same thing during the Board's interview of her. Person 1 also identified Board Exhibit 23 as a financial statement obtained by Patient 1 that shows a payment of $2,000.00. Person 1 testified this payment was for her brother's funeral.

The Respondent implicitly admitted he paid part of the funeral expenses. On cross-examination, the Board asked him whether he believed it was a "professional boundary violation" to have paid Patient 1's son's funeral. He testified: "Once again, I've learned since this **that was a boundary issue.** I really was not aware of it at the time. It was done in the context, again, with the [Person 1], and I didn't pay for the whole funeral."

Based on the above discussion, I find that the Respondent paid for at least part of Patient 1's son's funeral expenses.

Calling patients retarded

Person 1 testified that the Respondent told her that [redacted] was retarded.

Patient 2 testified that Patient 1 told her that the Respondent called [redacted] retarded while they were driving together in August 2016. Patient 2 also testified that she asked the

Respondent during a therapy session why he was rushing her through it, and the Respondent replied he had retarded people waiting for him and they "tend to get agitated." Patient 2 made the same statements during the Board's interview of her. Patient 2 also told the Board that Patient 1 said the Respondent told her he felt sorry for Patient 2.

The Respondent specifically denied calling [redacted] or any patient in his waiting room retarded. He explained: "That's a word, no, the answer is no. That's not a word that I use or would use to describe people." He further testified: "We moved away from that diagnostic word, it's now intellectually disabled, and it, the word is, is used in a derogatory way. It's just not appropriate."

Based on my observation of Patient 2 during her testimony, and on my review of her testimony and statements to the Board, I find Patient 2 to have been a credible witness. I give her testimony significant probative weight. Accordingly, I find that the Respondent referred to patients in his waiting room as retarded and easily agitated.

In addition, I also find that the Respondent called [redacted] retarded to Person 1 and Patient 1, and he told Patient 1 he felt sorry for Patient 2 because of [redacted]. I found above that the Respondent used "retarded" to refer to patients in his office's waiting room. There is no evidence in the record from which to find that Patient 2 ever told Patient 1 or Person 1 that [redacted] was the Respondent's patient or that Patient 2 discussed [redacted]'s medical status or condition with either Patient 1 or Person 1. Accordingly, I am persuaded that it is more likely than not that the Respondent described [redacted] as retarded to both Patient 1 and Person 2.

Socializing and drinking wine at the hair salon with Person 1 and Patient 1

During the Board's interview of Patient 1, she said that the Respondent drank wine with her and Person 1 "over twenty times, maybe more than that."

Person 1 testified that the Respondent visited her and Patient 1 at the hair salon where they talked about "everything" as if they were "family." She did not testify that they drank wine together.

The Respondent specifically denied he had "drinks" with Patient 1 or Person 1 at the hair salon.

Patient 1's statement that the Respondent drank wine while visiting the hair salon is not corroborated. Person 1 did not testify that the Respondent drank wine with them. The only evidence of that is Patient 1's statement during the interview. I am not persuaded by that statement, alone, that the Respondent drank wine while visiting Patient 1 or Person 1 at the hair salon.

However, in regard to visiting the hair salon, both Person 1 and Patient 1 made statements under oath that he did. In addition, the Respondent admitted to significant involvement in the opening and ongoing operation of the salon. It was, he claimed, a possible way out from under Person 1's extortionist threats. Therefore, by his own account, he had a financial interest to visit the salon. In addition, the Respondent's intimate relationship with Person 1 also gave him a reason to visit the salon. Based on these reasons, I find that the Respondent visited the hair salon where he socialized with Patient 1 and Person 1.

Disclosure of confidential patient information

Person 1 testified that the Respondent would "discuss his patients' diagnoses" around her. More specifically, Person 1 testified that the Respondent told her that Patient 2 was "OCD" and "crazy." In addition, Person 1 testified that the Respondent told her that Patient 1 had a "depressional [sic] problem" and was "a wreck trapped inside of a cage that's radical, angry. If she got out, she would, she would destroy, she would kill."

Patient 1 told the Board that the Respondent told Person 1 that she (Patient 1) was really sick and crazy and had a "split personality." Patient 1 also said that the Respondent described Patient 2 as "suffering with depression" and had "OD" or "ODC," was "crazy as hell," and was "bipolar"

Patient 2 testified that Person 1 told her the Respondent talked about her (Patient 2's) diagnosis and talked about how she would "constantly ask [the Respondent] to change [her] medication." Patient 2 also told the Board that the Respondent told Patient 1 that [redacted] was "retarded" and he felt sorry for Patient 2.

The Respondent denied disclosing "private health information" about Patients 1 or 2 to anyone. He specifically denied telling Person 1 that Patient 1 was like a trapped "rat" in a cage that would destroy or kill or was crazy.[23]

In defending against the allegation that he disclosed confidential information about Patient 2, the Respondent argued Patient 2 had a close social relationship with Person 1 and Patient 1, suggesting that Patient 2 talked about her mental health status and treatment with them as their friend. In support of this defense, the Respondent pointed out that Patient 2 was a client at the hair salon, and she admitted she formed a friendship with Person 1 and Patient 1 that grew closer over time.

The Respondent's argument fits into his broader defense that the complaints filed against him filed with the Board are the fruition of Person 1's threats to ruin his life, if he did not submit to her extortionist demands. According to the Respondent, his decision in early August 2016 to stop giving in to Person 1's extortionist demand for money triggered the false complaints against him. In this theory, Patient 2 is presumably either knowingly or unwittingly complicit in this nefarious plan; that is, she told Patient 1 and Person 1 about her diagnosis and the Respondent's

[23] Person 1's testimony was that the Respondent referred to Patient 1 as a "wreck," not as a "rat."

refusal to change her medicine during the normal course of their friendship, but agreed to deny that she had done so out of the same close friendship.

I am not persuaded by the Respondent's theory. As mentioned above, I found Patient 2 to have been a credible witness. She acknowledged a friendship with Person 1 and Patient 1, which grew closer over time. She also acknowledged that she told them that the Respondent was her psychiatrist. However, Patient 2 insisted that she is a "very private person" and has never discussed her diagnosis or treatment with anyone. I believe her, and I give determinative weight on this issue to her testimony. Accordingly, I find that the Respondent discussed confidential information about Patient 2 with Person 1. I specifically find that the Respondent talked about Patient 2's diagnosis and that she frequently asked him to change her medication. I also find that the Respondent talked to Patient 1 about [redacted].

However, I am not persuaded by Person 1's testimony that the Respondent disclosed information about Patient 1's mental condition to her. As discussed above, Person 1 is not sufficiently credible to find something as a fact based on her testimony alone. Patient 1's statements to the Board about what the Respondent told Person 1 about her is not directly corroborated by Person 1's testimony. Based on this, I am not persuaded that the Respondent told Person 1 that Patient 1 was really sick and crazy, had a "split personality" or depressional [sic] problem," or was "a wreck trapped inside of a cage that's radical, angry. If she got out, she would, she would destroy, she would kill."

Legal analysis

Neither party's closing argument cited to any statutory or case law. Section 14-404 authorizes the Board to discipline a physician who "is guilty of [u]nprofessional conduct in the practice of medicine." Neither the statute nor any enabling regulation defines "unprofessional conduct in the practice of medicine."

In its opening statement, the Board referred to *Finucan v Maryland Board of Physician Quality Assurance*, 380 Md. 577 (2004), and *Salerian v. Maryland State Board of Physicians*, 176 Md. App. 231 (2007), as case law that addresses the meaning of unprofessional conduct in the practice of medicine.[24]

The *Finucan* decision addressed whether a physician's sexual relationship with patients was unprofessional conduct in the practice of medicine. The Court stated the following:

> A parallel sexual relationship between a physician and a patient compromises the physician-patient relationship, violates the ethics of the profession, and reflects on the fitness of the physician to practice medicine. Finucan used his professional skills and his knowledge of his three female patients' personal and familial situations to play upon their emotional vulnerabilities, even if they facially consented to the sexual relationships. The facts support a finding that he abused his professional status and knowledge by losing objectivity and recommending treatment for them for his own gratification, rather than for what objectively was best for the patients. For these reasons, a physician who enters into such a dual relationship commits unprofessional conduct "in the practice of medicine."

Finucan, 380 Md. at 595-596. The case before me does not involve a physician in a sexual relationship **with a patient**. The holding in *Finucan* is not applicable to the case before me.

The *Salerian* decision addressed whether a psychiatrist's disclosure of information about an individual that the psychiatrist obtained during a forensic interview of the individual as a member of the individual's defense team was unprofessional conduct in the practice of medicine. In this case, the psychiatrist learned about the individual's history of "sexual betrayal and exploitation" of his wife during the forensic interview. The psychiatrist (Salerian) revealed that

---

[24] "'Practice medicine' means to engage, with or without compensation, in medical (i) Diagnosis; (ii) Healing, (iii) Treatment; or (iv) Surgery." It includes "doing, undertaking, professing to do, and attempting any of the following: Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual: 1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or 2. By appliance, test, drug, operation, or treatment; (ii) Ending of a human pregnancy; and (iii) Performing acupuncture as provided under § 14-504 of this title. Md. Code Ann., Health Occ. § 14-101(o) (Supp. 2018).

activity to the individual's wife and, after the individual and the defense team discharged his engagement with them, to the media.

The Court addressed several arguments raised by Salerian. Of possible relevance here, Salerian argued that his disclosure of information to the media was not while he was "practicing medicine" because it occurred after his "association" with the individual and his defense team had ended. The Court rejected this argument by explaining: "[Salerian's] ethical duty to maintain Evaluee's confidences did not end when [Salerian] was terminated from the defense team . . . ." *Salerian*, 176 Md. App. at 252. The Court further identified the standard to determine whether a physician's conduct was "in the practice of medicine": "The touchstone for determining whether misconduct occurred 'in the practice of medicine' must be whether it was 'sufficiently intertwined with patient care' to pose a threat to patients or the medical profession." *Id.* at page 253 (quoting *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456, 476 (2007)).

The record also includes the American Psychiatric Association's The Principles of Medical Ethics, 2013 Edition (Principles). Although the Principles were not referred or cited to during either party's closing argument, the Board addressed the following principles during its cross-examination of the Respondent:

> • *A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.*
>
> 1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.
>
> . . .
>
> • *A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.*
>
> 1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification.

. . . Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to treatment goals.

Bd. Ex. 36.

Was the Respondent's blurring of boundaries between him and Patient 1 unprofessional conduct in the practice of medicine?

I have found that the Respondent provided encouragement and significant financial support for the creation and operation of [redacted], the hair salon. Although the Respondent testified that "the relationship with the hair salon as far as I was concerned was with the daughter (Person 1) only," he admitted he became aware that Patient 1 was working there. Moreover, what he told the Board directly contracted his testimony. He told the Board that his encouragement to open a hair salon and financial support to set it up and operate it was for Patient 1. In addition, I have also found that the Respondent socialized with Patient 1 at the hair salon. Patient 1 and Person 1 both stated the socialization was frequent. I have further found that the Respondent paid for at least part for Patient 1's son's funeral. He admitted this. He also paid Patient 1 up to $250.00 to babysit Person 1's children.

The principles of ethics for the psychiatric profession warn psychiatrists against the blurring of boundaries between them and their patients: "The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor-patient relationship, and thus the well-being of the patient." This is for an obvious critical reason: providing treatment that advances the patient's best interest requires the psychiatrist to be objective so that his needs and interest do not become part of therapeutic decision-making. The blurring of professional boundaries in his relationship with patient 1 constituted unprofessional conduct in the practice of medicine. The Respondent made no legal argument to the contrary. In

fact, he acknowledged the inappropriateness of it: "I've learned since this [payment of the funeral expenses] that that was a boundary issue."

Was the Respondent's disclosure about patients unprofessional conduct in the practice of medicine?

I have found that the Respondent discussed information derived from his treatment of Patient 2 to Patient 1 and Person 1. I have also found that the Respondent described patients waiting to be seen by him in treatment as retarded and easily agitated, and he described [redacted], another patient of his, to others as "retarded" and commented he felt sorry for Patient 2.

These disclosures and comments violate the Respondent's professional duty to maintain strict confidentiality about the treatment relationship. It is axiomatic in the profession of psychiatry — "because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist" — that the doctor-patient relationship be maintained in the strictest confidence to allow the patient to allow for trust in the relationship, the linchpin of the therapeutic relationship. The Respondent's disclosures to or in front of others about his patients constitute unprofessional conduct in the practice of medicine.

Was the Respondent's sexual relationship with Person 1 unprofessional conduct in the practice of medicine?

The Board did not contend that the Respondent's sexual relationship with Person 1 was, by itself, unprofessional conduct in the practice of medicine. The Board contended that the sexual relationship's negative impact on the therapeutic relationship between the Respondent and Patients 1 and 2 made it a violation of section 14-404(a)(3)(ii) of the Business Occupations Article.[25]

[25] COMAR 10.32.17.02 addresses a sexual misconduct by licensed physicians. It prohibits sexual impropriety with a "key third party," which is "an individual who participates in the health and welfare of the patient concurrent with the physician-patient relationship." COMAR 10.32.17.02B(1)(a). The Board did not contend that Person 1 was a "key third party" for either Patient 1 or Patient 2.

Patient 2 testified that she was "very shocked" and "it just blew me away" upon learning that the Respondent had a "romantic" relationship with Person 1.

Patient 1 told the Board her sessions with the Respondent changed after he started "dealing" with Person 1. She explained that he spent less time with her in sessions or she did not have to come to his office because he said she could just "call" him.

The Board offered no legal authority to support its contention that a psychiatrist's sexual relationship with a consenting adult who is a non-key third party of a patient violates section 14-404(a)(3)(ii) of the Business Occupations Article. I do not find Patient 2's reactive shock or blown mind transforms what was not sexual misconduct into unprofessional conduct in the practice of medicine.

In regard to Patient 1, there was no evidence to corroborate her testimony that the Respondent's treatment of her changed in any way due to the Respondent's sexual relationship with Person 1.

Was the fight between the Respondent and Person 1 unprofessional conduct in the practice of medicine?

Just as above, the Board did not contend that the fight between the Respondent and Person 1 was, by itself, unprofessional conduct in the practice of medicine. It contended that the fight's negative impact of the Respondent's therapeutic relationship with Patients 1 or 2 is what made the fight professional misconduct in the practice of medicine in violation of section 14-404(a)(3)(ii) of the Business Occupations Article.[26]

[26] COMAR 10.32.17.02 addresses a sexual misconduct by licensed physicians. It prohibits sexual impropriety with a "key third party," which is "an individual who participates in the health and welfare of the patient concurrent with the physician-patient relationship." COMAR 10.32.17.02B(1)(a). The Board did not contend that Person 1 was a "key third party" for either Patient 1 or Patient 2.

Patient 2 testified the she received a text message from Person 1 that said the Respondent had tried to kill her and kick her down the stairs. Patient 2 testified she was "flabbergasted" and "felt hurt" for Person 1. Patient 2 testified that she decided to end her and [redacted]'s treatment with the Respondent because "the trust . . . is gone." In relation to this issue, I am not persuaded that Patient 2 discontinued her treatment with the Respondent based on the fight for several reasons. First, she does not mention that in either of her complaints to the Board. Second, in her interview with the Board, she said that the Respondent's disclosures about her and [redacted] made her "extremely distraught" and she started to look for a new psychiatrist. Also, her testimony about this issue was unclear. She testified the fight was the reason she decided to stop treatment with the Respondent but **immediately** pivoted from that to testify about her loss of trust in the Respondent based on the disclosures. In reviewing this testimony, it seemed to me that the Patient was actually connecting her decision to find a new therapist to the disclosure that to the fight. Furthermore, as discussed above, I find Person 1 was clearly at-fault for this fight; the Respondent had not invited her to his office; she came to the office angry and ready to fight,; and the Respondent removed her from the office to avoid her behavior from having any effect on his patients. Furthermore, Person 1 told Patient 1 that the Respondent tried to kill her, something that is not supported by the record. Therefore, Patient 2 was reacting to something that has not been found on the record before me to have been a fact.

Patient 1 did not tell the Board that she ended treatment with the Respondent. She told the Board that she received a letter from the Respondent that he was ending his treatment of her. Patient 1 said she did not know why the Respondent stopped his treatment of her, but she accepted it and looked for someone else to treat her. I do not find that Patient 1 discontinued

treatment with the Respondent as a result of the fight. Furthermore, I do not conclude that the fight constituted unprofessional conduct in the practice of medicine as it relates to Patient 1.

Sanctions

The Board seeks to impose the disciplinary sanction of revocation. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2018); COMAR 10.32.02.09A(2), (3)(a)(iv); COMAR 10.32.02.10. The Board also seeks to require that, should the Respondent apply for the reinstatement of a license, he appear before the Board for it to determine any preconditions he must satisfy to resume the practice of psychiatry. *See* COMAR 10.32.02.06B; COMAR 10.32.02.09A(5).

I do not adopt the Board's sought-after sanction of revocation. While I have found that the Respondent engaged in unprofessional conduct in the practice of medicine, I have not found that the competent and probative evidence in the record before me fully satisfies the Board's burden of proof on all the issues presented.

I have determined that the Respondent had engaged in unprofessional conduct in the practice of medicine because he failed adequately to maintain proper boundaries in his treatment of Patient 1 and because he impermissibly disclosed and discussed Patient 1's mental health condition and treatment to others and made improper statements about [redacted] and other unidentified patients in front of others. These are serious violations and deserving of a sufficiently severe sanction to protect the public; however, the maximum sanction of revocation, is too harsh. I recommend a mandatory six-month suspension of the Respondent's license to practice medicine and a requirement that before the suspension may be withdrawn, the Respondent satisfactorily complete a continuing education class or other comparable education

or training program, chosen by the Board, that addresses (1) maintaining confidentiality of the psychiatrist-patient relationship and (2) maintaining proper boundaries in the treatment of patients and in the psychiatrist-patient relationship. This recommendation is made for the reason mentioned above and because the Respondent has not been the recipient of a prior complaint before this Board since his initial licensure in February 1997. Under COMAR 10.32.02.09B(5)(a), the absence of a prior disciplinary record is a mitigating factor that may be considered in determining appropriate discipline.

PROPOSED CONCLUSIONS OF LAW

I conclude the following:

A. The Respondent violated section 14-404(a)(3)(ii) of the Health Occupations Article of the Annotated Code of Maryland. Md. Code Ann., § 14-404(a)(3)(ii) (Supp. 2018).

B. The Respondent's misconduct subjects him to a sanction from a minimum of a reprimand to a maximum of a revocation of his license to practice medicine, and a fine from a minimum of $5,000.00 to a maximum of $50,000.00.[27] *Id.*; COMAR 10.32.02.09A, B; COMAR 10.32.02.10B(3)(c).

PROPOSED DISPOSITION

I **PROPOSE** the following:

A. The Charges filed by the Maryland State Board of Physicians against the Respondent on January 31, 2018, be **UPHELD** consistent with this Decision.

B. The Respondent's license be suspended for a mandatory six-month period after which the suspension shall end, but only as long as the Respondent has successfully completed a continuing education class or other comparable education or training program in (1) maintaining

[27] The Board did not request a fine, and I do not recommend one.

confidentiality of the psychiatrist-patient relationship and (2) maintaining proper boundaries in the treatment of patients and in the psychiatrist-patient relationship.

C. The Board shall approve the continuing education class or comparable education or training program.

November 13, 2018
Date Decision Mailed

Michael D. Carlis
Administrative Law Judge

MDC/da
#176030

NOTICE OF RIGHT TO FILE EXCEPTIONS

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

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

Copies Mailed To:

Andrew E. Vernick, Esquire
Christopher J. Greaney, Esquire
Vernick & Associates
111 Annapolis Street
Annapolis, MD 21401

Spencer F. Johnson, MD
[redacted]

Victoria H. Pepper, 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

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

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

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