IN THE MATTER OF	*	**BEFORE THE**
ELIZABETH A. LILLY, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D05627	*	**Case Number: 2219-0033B**

* *

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **Elizabeth A. Lilly, M.D.** (the "Respondent"), License Number D05627, to practice medicine in the State of Maryland. Panel B takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2018 Supp.), having concluded that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS[1]

Panel B has reasonable cause to believe that the following facts are true:

I. BACKGROUND

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Board initially issued the Respondent a license to practice medicine in Maryland on March 17, 1970, under License Number D05627. Her license is active through September 30, 2020.

[1] The statements about the Respondent's conduct set forth in this document are intended to provide the Respondent with reasonable notice of the basis for this suspension. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this action.

2. The Respondent is board-certified in and has self-designated her specialty as psychiatry and neurology. She is a solo practitioner in Crownsville, Maryland.

3. The Board has previously disciplined the Respondent's medical license. On or about July 17, 2014, the Board charged the Respondent with violations of the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101 *et seq.*, specifically with unprofessional conduct in the practice of medicine. The Board alleged that the Respondent provided financial assistance to patients, including a $39,000 check written to a patient for the purchase of a car. The Respondent then stopped payment on the check, and the car was repossessed. On or about November 18, 2014, the Respondent entered a Consent Order to resolve the charges, in which the Board reprimanded the Respondent and required her to take a one-on-one ethics tutorial focusing on boundary violations.

II. COMPLAINT

4. On or about August 10, 2018, the Board received an anonymous complaint alleging that the Respondent was prescribing one of her patients an "extreme amount of alprazolam[.]" The complaint further alleged that the Respondent prescribed "600 pills in one month" to the patient. Attached to the complaint was documentation that allegedly supported these allegations.

III. BOARD INVESTIGATION

5. The Board initiated an investigation into the anonymous complaint.

A. Patient Records

6. On or about November 7, 2018, the Board provided the Respondent with a copy of the complaint and supporting documentation and requested her written response.

The Board also served the Respondent with a subpoena for eleven (11) patient records ("Patients 1-11").[2] Board staff believed that one patient (Patient 11, discussed *infra*) was a family member of the Respondent.

7. On or about December 2, 2018, the Respondent provided the Board with patient records for Patients 1-10 and provided a treatment summary for each patient. She did not provide any additional written response to the complaint.

B. Interview of the Respondent

8. As part of its investigation, Board staff interviewed the Respondent under oath on or about March 14, 2019.

9. The Respondent stated that her patients sign a treatment authorization form, but she was unsure if that form included a medication agreement that addressed compliance with controlled substances. The Respondent also said that she does not require urine drug screens for her patients. Instead, she has relied on other providers or treatment programs to notify her if they found an abnormal drug screen in one of her patients.

10. The Respondent explained that if a patient reported lost or stolen medication, "I try to give enough until the end of when it's due, but if it's all of it, I have to give it." If a patient loses a prescription, the Respondent will generally rewrite it and "try to" confirm that the patient has not filled both prescriptions.

11. When asked about whether she checked the Prescription Drug Monitoring Program ("PDMP"), the Respondent stated that she now checks it at least once every

[2] To maintain confidentiality, the names of all witnesses, facilities, employees, and patients will not be used in this document but will be provided to the Respondent on request.

three months for each patient who receives alprazolam or clonazepam. When asked to explain, the Respondent said that she generally prescribes benzodiazepines to patients once per month and patients "have to call me once a month. So even if I don't see them, so every three months they have to call me or if they come in and I give it, I can do it that way. That way I don't have to worry about checking because I can't." Prior to July 2018, the Respondent did not routinely check PDMP, but said that she relied on pharmacies' reports about when a patient had filled a prescription for benzodiazepines.

12. The Respondent also discussed her care of Patient 1, whom the Respondent described as a "very difficult" patient. The Respondent said that she continued to prescribe alprazolam to Patient 1 even when the Respondent knew that Patient 1 was noncompliant with her medication. The Respondent explained that she routinely prescribed alprazolam to Patient 1 once per month, but it "was always being lost or all kinds of things, stolen. Then I don't know what was true. This is a person you can't trust." Despite that sentiment, the Respondent refilled and replaced Patient 1's prescriptions because the Respondent "did not want her to have a convulsion."

13. During the interview, the Respondent had difficulty answering when she last saw Patient 1 in person, as well as when she last had a phone consultation with her despite referring to Patient 1's file. When asked about treatment dates, the Respondent repeatedly referred to Patient 1's illicit drug use, troubled personal relationships, and sharing of prescriptions, but did not provide responsive dates. Board staff often had to ask the same or similar questions multiple times before the Respondent provided a clear answer.

14. When asked about her prescribing Patient 1 600 alprazolam pills in one month as alleged in the complaint, the Respondent explained that it "was because . . . if she had lost this and that or burglarized or whatever, it would have been maybe she was getting that many, and that was only, maybe they found it one time, you know." When asked to clarify, the Respondent said that the month that happened, July 2018, "was [when] she might have been losing it and of course she wasn't coming in on a regular basis."

15. The Respondent said that she has not discharged any patients for diverting or being noncompliant with prescriptions because, except for Patient 1, she did not know of any other patients diverting or being noncompliant.

16. When asked about prescribing to Patient 11, the Respondent admitted that he or she was a family member and admitted to prescribing him or her a controlled dangerous substance ("CDS"). The Respondent said she did not keep any records for Patient 11.

C. Peer Review

17. As part of its investigation, the Board referred ten patient records obtained from the Respondent (Patients 1-10) and related materials to a peer review entity.

18. Two peer reviewers, who were each Board-certified in psychiatry, separately reviewed the ten patient records. On or about July 31, 2019, the peer reviewers submitted their reports to the Board.

19. The peer reviewers concurred that the Respondent did not meet the standard of quality care for all ten patients for reasons including, but not limited to:

a. The Respondent failed to provide comprehensive assessments or include findings related to the specific criteria necessary to diagnose psychiatric conditions (Patients 1-10);

b. The Respondent did not discuss treatment plans with patients, to include the benefits and risks of medications with the high potential for addiction, psychological dependence, and misuse (Patients 1-10);

c. The Respondent failed to consider alternative treatments, justify certain medication changes, or assess the effects or reactions to new medications or dosages, to include the possible interactions between medications including stimulants and sedatives (Patients 1-10); and

d. The Respondent continued to prescribe and refill benzodiazepines in the presence of chronic substance use disorder and noncompliant behavior with no documented attempts to withdraw or taper the patient off the medication (Patient 1).

20. The peer reviewers concurred that the Respondent did not maintain adequate medical records for all ten patients for reasons including, but not limited to:

a. Records lacked clarity to allow another provider to understand rationale and criteria used to establish initial diagnoses, treatment plans, and medications attempted and patient medical responses (Patients 1-10); and

b. Records of prescription histories were disorganized and did not include internal tracking lists, but instead relied on external sources to report on patients' regular prescriptions and dispensing (Patients 1-10).

D. Expanded Report of Peer Reviewer 2

21. On or about September 16, 2019, Peer Reviewer 2 wrote a letter to the Board expanding on his previously submitted peer-review report.

22. Peer Reviewer 2 expressed "grave concerns" about the Respondent's ability to practice medicine safely as well as his belief that it is "very likely that at least some of her patients are put at risk by the inadequacy of her care." He based his concerns on, among other things, the Respondent's "repeatedly sending replacement prescriptions for

patients despite highly suspicious circumstances behind the alleged need for replacements, overly frequent prescribing of a combination of sedatives and stimulants[.]" Peer Reviewer 2 also noted the Respondent's "frequent prescribing of benzodiazepines to patients taking opiates and in one case to a patient with an active heroin addiction, which puts these patients [at] risk for respiratory depression and death."

23. Peer Reviewer 2 also expressed concern about the Respondent's fitness to practice medicine based on the "very disorganized state of her records," and "patient summaries [that] are rambling, disorganized and difficult to follow."

E. The Respondent's Supplemental Response

24. On or about September 27, 2019, the Respondent submitted her supplemental response after being provided copies of the peer reviewers' reports.

25. The Respondent acknowledged "that there were deficiencies in her note-taking and record keeping," but insisted that "none of her patients were ever placed in a dangerous or unhealthy position." The Respondent also asserted that she has now changed her recordkeeping and prescribing practices.

26. Regarding Patient 1, the Respondent claimed that she "was very careful to make sure she was fully aware of [Patient 1's] symptoms as well as the medication she was on." However, the Respondent did not address how she attempted to manage Patient 1's aberrant behavior or explain that she prescribed 600 alprazolam pills to Patient 1 in less than one month.

F. Patient 11

27. On or about December 2, 2018, the Respondent provided the Board with a "Certification of Medical Records" for Patient 11, the Respondent's family member. The

Respondent wrote, "I have not prescribed medications for [Patient 11] for least a year for [a controlled substance] so far as [he or she] and I can recall." She did not provide any medical records for Patient 11.

28. The Board issued subpoenas to three pharmacies for copies of prescriptions that the Respondent wrote for Patient 11.

29. Records received from Pharmacy 1 showed that the Respondent prescribed a Schedule IV CDS to Patient 11 on or about June 5, 2014. The prescription was for a one-month supply, with four refills available.

30. Records received from Pharmacy 2 showed that the Respondent prescribed a Schedule IV CDS to Patient 11 on or about April 30, 2017, for a one-month supply, and on May 27, 2017, for a one-month supply with three refills available.

31. Records received from Pharmacy 3 showed that the Respondent prescribed a Schedule IV CDS to Patient 11 on or about October 16, 2017, for a one-month supply with two refills available; on or about January 15, 2018, for a one-month supply with two refills available; on or about April 10, 2018, for a one-month supply with two refills available; and on or about July 3, 2018 for a one-month supply.

32. The records received from all three pharmacies showed that the Respondent prescribed the same Schedule IV CDS to Patient 11 on all the dates listed. The records from Pharmacies 2 and 3 show that the Respondent prescribed or provided refills of the controlled substance to Patient 11 for approximately 15 consecutive months, from on or about April 30, 2017, to on or about July 3, 2018, contradicting her statement that she had not prescribed to Patient 11 since "at least" December 2017 (*see* ¶ 25, *supra*).

CONCLUSION OF LAW

Based on the foregoing Investigative Findings, Panel B concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2018 Supp.) and Md. Code Regs. 10.32.02.08B(7)(a).

ORDER

Based on the foregoing Investigative Findings and Conclusion of Law, it is, by a majority of a quorum of Panel B, hereby

ORDERED that pursuant to the authority vested in the Board by Md. Code Ann., State Gov't § 10-226(c)(2) and Md. Code Regs. 10.32.02.08B(7)(a), the license of **Elizabeth A. Lilly, M.D.**, License Number D05627, to practice medicine in the State of Maryland is **SUMMARILY SUSPENDED**; and it is further

ORDERED that a post-deprivation summary suspension hearing in accordance with Md. Code Regs. 10.32.02.08E has been scheduled for **Wednesday, October 30, 2019, at 1:00 p.m.** before Disciplinary Panel B at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; and it is further

ORDERED that at the conclusion of the post-deprivation summary suspension hearing held before Panel B, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031; and it is further

ORDERED that a copy of this Order for Summary Suspension shall be filed with the Board in accordance with Md. Code Ann., Health Occ. § 14-407 (2014 Repl. Vol. & 2018 Supp.); and it is further

ORDERED that this Order for Summary Suspension is an Order of Panel B and, as such, is a **PUBLIC DOCUMENT**. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

10/16/2019
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians