IN THE MATTER OF	*	**BEFORE THE**
SANJEEV SINGHAL, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D61258	*	**Case Number: 2218-0201**

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FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Sanjeev Singhal, M.D., is a psychiatrist, originally licensed to practice medicine in Maryland in 2004. On October 15, 2019, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Dr. Singhal with immoral and unprofessional conduct in the practice of medicine. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(i) and (ii). The charges alleged that Dr. Singhal had an inappropriate sexual relationship with a former psychiatric patient's spouse.

On July 28, 29, and 30, 2020, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings. On October 2, 2020, the ALJ issued a proposed decision concluding that Dr. Singhal was guilty of unprofessional conduct in the practice of medicine for sending a text message to a patient that attempted to make the patient feel guilty for filing a complaint against Dr. Singhal, but did not find immoral conduct. The ALJ recommended that Dr. Singhal be reprimanded and pay a fine of $5,000.

Dr. Singhal filed exceptions arguing that the case should be dismissed entirely. The Administrative Prosecutor filed exceptions on behalf of the State, arguing that, in addition to sending the text message to the patient, the sexual relationship with the former patient's wife should also be found to be unprofessional. The Administrative Prosecutor also took exception to

certain factual findings and legal conclusions made by the ALJ. Finally, the Administrative Prosecutor took exception to the ALJ's proposed sanction and argued that Dr. Singhal's license should be revoked. Dr. Singhal filed a response to the State's exceptions. On January 13, 2021, both parties appeared before Board Disciplinary Panel A (the "Panel" or "Panel A") for an exceptions hearing.

FINDINGS OF FACT

The Panel adopts the ALJ's Proposed Findings of Fact, and adds certain facts discussed below and throughout this Final Decision and Order. The ALJ's Proposed Findings of Fact ¶¶ 1-24 are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1.[1] The ALJ's proposed findings of fact were proven by the preponderance of the evidence and are summarized below.

Dr. Singhal treated a patient ("Patient 1") for symptoms of anxiety and depression beginning in September 2014 at the encouragement of his wife. Patient 1's wife had previously worked with Dr. Singhal as a receptionist. Dr. Singhal treated Patient 1 for eleven sessions, from September 2014 through December 2015, diagnosing him with moderate to severe major depressive disorder and unspecified anxiety.

At one point, while Patient 1 was seeing Dr. Singhal, Dr. Singhal drove to Patient 1's home to show Patient 1 and Patient 1's wife Dr. Singhal's new Tesla and to give them rides in the car. After dropping Patient 1 back at the house, Dr. Singhal drove for over an hour alone with Patient 1's wife and took her to get ice cream. During the ride Dr. Singhal told Patient 1's wife that he had a dream about her.

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

At Patient 1's last appointment, on December 22, 2015, Dr. Singhal's note stated that Patient 1 would return in one month. Patient I did not formally terminate his medical relationship with Dr. Singhal but stopped attending medical appointments. Dr. Singhal never formally discharged Patient 1 as a patient but did not follow-up or reschedule the missed appointments.

In 2016, Dr. Singhal asked Patient 1's wife to help select the music for a retirement party for an individual with whom they had worked. In June 2016, Dr. Singhal and Patient 1's wife attended that retirement party. After the party, Dr. Singhal and Patient 1's wife went to Dr. Singhal's car and began kissing and then to his office for further sexual acts, which included oral sex. After that, Dr. Singhal and Patient 1's wife continued to talk or text nearly every day. Dr. Singhal continued the sexual relationship, which included sending sexual messages to Patient 1's wife with photographs of their bodies and approximately four or five in-person encounters. In December 2017, Patient 1 discovered his wife's sexual relationship with Dr. Singhal. Dr. Singhal and Patient 1's wife then terminated their sexual relationship. Patient I filed a complaint against Dr. Singhal at Dr. Singhal's place of work. After Dr. Singhal's employer instructed him not to communicate with Patient 1 or his wife, Dr. Singhal sent a text message to them on January 5, 2018, that stated that they "should be happy to know that [they] have successfully damaged [his] present and future."

Based on the Panel's evaluation of the testimony of Patient 1, Patient 1's wife, and Dr. Singhal, Panel A makes certain additional factual findings that were not found by the ALJ:

1. Dr. Singhal discussed sexual side effects of medications that he had prescribed to Patient 1 prior to his sexual relationship with Patient 1's wife. As part of the discussion, Dr. Singhal discussed Patient 1's problems during sex, asked questions

about sexual positions that Patient 1 used with his wife, frequency of sex, and whether he drank alcohol before sex.

2. When Patient 1 first met with Dr. Singhal, he reported a loss of interest in hobbies and seclusion from everyone other than his wife and children. Dr. Singhal recommended that Patient 1 "get back into his hobbies" and "separate from the rest of his family." Specifically, Dr. Singhal recommended that Patient 1 seclude himself from his wife and children and engage with his hobbies when he was feeling depressed. He also recommended giving his wife space.
3. Dr. Singhal had a sexual or romantic interest in Patient 1's wife long before the sexual contact began in June 2016.[2]

The Panel may overturn the ALJ's credibility determinations

Before determining whether Dr. Singhal's engaged in unprofessional conduct in the practice of medicine, Panel A must resolve the significant factual disputes between the State's position and Dr. Singhal's. The central issue is whether Patient 1 or Dr. Singhal was more credible in their discussion of the medical sessions.

As an initial matter, Panel A must determine whether it must defer to the ALJ on these credibility determinations. The State claims that the Panel does not owe deference to the ALJ's findings pertaining to Patient 1's, Patient 1's wife's, or Dr. Singhal's testimony because the ALJ did not make demeanor-based credibility determinations. *Department of Health & Mental Hygiene v. Shrieves*, 100 Md. App. 283, 299 (1994). Dr. Singhal responds that the ALJ's

[2] While this was not included in the ALJ's factual findings, the Panel makes this finding and adopts this statement based on the ALJ's conclusion that Dr. Singhal "had feelings for [Patient 1's wife] for a considerable period" of time prior to the start of their relationship, as demonstrated by his long car ride with Patient 1's wife and involving her with the planning of their colleague's retirement party. ALJ's Proposed Decision at 23-24.

credibility determinations were, in fact, demeanor-based and therefore were owed deference under the *Shrieves* case. *Shrieves*, 100 Md. App. at 299. As an example of a demeanor-based credibility determination, Dr. Singhal relies upon the ALJ's finding that he was "intentionally evasive" when discussing matters pertaining to the sexual relationship with Patient 1's wife but was "methodical and logical" when discussing his treatment of Patient 1.

Under *Shrieves*, substantial deference is due only to the ALJ's demeanor-based credibility findings. *Id.* at 302 ("where credibility is pivotal to the agency's final order, ALJ's findings *based on the demeanor of witnesses* are entitled to substantial deference and can be rejected by the agency only if it gives strong reasons for doing so") (emphasis added). A witness's demeanor is outward behavior and appearance, such as facial expressions, tone of voice, gestures, posture, eye-contact with questioner, and readiness or hesitancy to answer questions, but does not include conclusory statements that a witness was "persuasive" and "credible." *State Bd. of Physicians v. Bernstein*, 167 Md. App. 714, 759-60 (2006).

In this case, the ALJ's credibility determinations were not demeanor based. The ALJ rejected Patient 1's testimony as embellished based on Patient 1's bias against Dr. Singhal and alleged inconsistencies between his complaint, statements to the Board, and his testimony before the ALJ. Inconsistencies and bias do not create demeanor-based credibility determinations, but can be determined from the cold record. *See e.g. Maryland Board of Physicians v. Elliott*, 170 Md. App. 369, 393 (2006).

Similarly, the ALJ's statement that Dr. Singhal should be believed in part because he was "methodical and logical" and, in part, not believed because he was "intentionally evasive" do not constitute demeanor-based findings. The Panel can determine whether Dr. Singhal's testimony was logical and organized and intentionally evasive based on a cold record. The ALJ did not cite

any appearances or outward behaviors as her reason for believing or disbelieving Dr. Singhal. As such, the Panel owes no deference to the ALJ's credibility determinations and is free to accept the ALJ's credibility determinations or make its own credibility determinations based on the record.

Panel A's Credibility Determinations of Patient 1 and Dr. Singhal

The largest factual disputes are related to whether Dr. Singhal's discussions during his psychiatric sessions with Patient 1 were intended to help him initiate a sexual relationship with Patient 1's wife. The ALJ concluded that there was no credible evidence that Dr. Singhal exploited the patient-physician relationship for his own benefit. The ALJ concluded that Dr. Singhal had not inquired about Patient 1's sex life to pave the way for his own sexual relationship with Patient 1's wife. Nor did the ALJ find that Dr. Singhal overmedicated Patient 1 or encouraged him to pursue hobbies outside his marriage to estrange him from his wife. The ALJ made these findings after determining that Patient 1 was not a reliable witness based on numerous alleged embellishments or supposed inconsistencies between his interview with the Board and his testimony at the hearing. The ALJ found that Dr. Singhal, by contrast, was partially credible, finding that while he provided intentionally evasive answers during his cross examination about the sexual relationship, his testimony related to his treatment of Patient 1 was credible because his testimony was logical and methodical.

The State argues that the ALJ was wrong to discount Patient 1's testimony and conclude that Dr. Singhal, therefore, did not exploit the psychiatrist/patient relationship for his own gain. The State argued that Dr. Singhal engaged in exploitative behavior in advising Patient 1 to give his wife space. The State noted that Patient 1's wife also believed that she was slowly being

"reeled in" by Dr. Singhal. Finally, the State argues that Dr. Singhal had discussions with Patient 1 about Patient 1's sex with his wife.

Patient 1's inconsistent statements

First, the Panel finds that the inconsistencies in Patient 1's testimony were generally either insignificant differences or based on Patient 1's speculation rather than dishonesty. In contrast, Dr. Singhal consistently was dishonest, downplaying his wrongdoing and fabricating mitigating conduct. Only when it was revealed that his testimony would be contradicted did Dr. Singhal testify truthfully.

The ALJ notes that Patient 1's complaint stated that the sexual relationship began while he was a patient, but he later acknowledged that it did not. The ALJ, thus, concludes that Patient 1 was embellishing the details in his complaint. However, based on its evaluation of Patient 1's interview with the Board, the Panel finds that Patient 1's inconsistent statements about whether the treatment and sexual relationship overlapped stem not from dishonesty or embellishment, but rather Patient 1's uncertainty as to when his wife's sexual relationship with Dr. Singhal began. In his interview with the Board, Patient 1 stated both that the sexual relationship began in June 2016, which was after his treatment ended, and also that Dr. Singhal visited him to show off his car while he was a patient and when the sexual relationship had already begun. These inconsistencies reflect Patient 1's lack of memory of when Dr. Singhal visited his house and when the sexual relationship started rather than Patient 1's intent to mislead the Board. Patient 1's error is understandable. He did not know about the sexual relationship between Dr. Singhal and his wife until a year and a half after it began, and only found out about the details of the relationship second-hand from his wife, which explains his imprecise statements to the Board.

Another of Patient 1's inconsistencies, according to the ALJ, was Dr. Singhal's discussion with Patient 1 about Patient 1's sex with his wife. During the Board investigation, Patient 1 claimed that *Dr. Singhal* asked about whether he could "finish" during sex because it was a possible side effect of the medication. Patient 1 told Board staff that Dr. Singhal asked him about sexual positions and frequency of sex. In his testimony before the ALJ, Patient 1 testified that *he* brought up his inability to finish during sex and that he asked Dr. Singhal about whether it was a side effect of the medication he was taking. In both instances, Patient 1 thought that Dr. Singhal's questions were inappropriate and odd. Panel A finds that the inconsistency about who initiated the conversation about sex is relatively minor and are not indicative of Patient 1's dishonesty.

The ALJ found that this purported inconsistency demonstrated Patient 1's lack of credibility, but did not point out that Dr. Singhal himself testified inconsistently on the same topic. In his interview with the Board, Dr. Singhal stated that they "did not have any discussion [about sexual matters]." During testimony before the ALJ, Dr. Singhal stated that he discussed sexual side effects of the medication with Patient 1.

Based on the cold record, the Panel finds Patient 1 more credible than Dr. Singhal. The Board finds that Dr. Singhal brought up the sexual positions, which was gratuitous. Additionally, the Board finds that his knowledge of the sex life of Patient 1 and his wife gave him intimate knowledge that he could use in his pursuit of Patient 1's wife.

Ultimately, the Panel finds that it is not important whether Dr. Singhal or Patient 1 initiated the conversation, what is important is that Dr. Singhal probed Patient 1 about his sex life with his wife and knew and potentially used that information before Dr. Singhal initiated a sexual relationship with Patient 1's wife.

Similarly, the Panel finds it to be of minimal importance that Patient 1 claims that the sessions were up to two hours in duration, while the medical records and testimony from Dr. Singhal's assistant indicate appointment times of 25-30 minutes. In Patient 1's statement to the Board, he said that the sessions would last one-and-a-half to two hours. In his testimony before the ALJ, Patient 1 was adamant that the sessions were 45 minutes to an hour because he would return to work 20 minutes late from his hour-long lunch break and the doctor's office was only ten minutes away. In contrast, Dr. Singhal's secretary testified that Dr. Singhal saw four patients an hour in 15 minute sessions, with occasional 30 minute sessions. The medical records indicate that most sessions were 25-30 minutes. It seems that Patient 1's memory about the length of the sessions was based in part on his late return to the office. However, Dr. Singhal's secretary testified that the clinic ran behind schedule and there were often people waiting. The Panel finds that it is likely that the medical records are accurate. Patient 1's sessions likely took the recorded 25-30 minutes and after some period of waiting, and made him late to get back from his lunch break. However, his inflated estimates that the visits took longer than they did are not indicative of dishonesty any more than Dr. Singhal's secretary was dishonest in her estimate that most visits took only 15 minutes. The Panel does not find that the inconsistency regarding appointment time is compelling evidence of intentional dishonesty or lack of credibility.

Patient 1's other supposed inconsistencies or embellishments were not instances of inconsistency or dishonesty, but speculation based on Patient 1's feelings that Dr. Singhal betrayed him. In his interview and complaint, Patient 1 stated that he was worried that he was being overmedicated and that his wife was being drugged. Patient 1 readily admitted in his statement to the Board that he believed that his wife was acting in a daze or fog, but that his accusation of Dr. Singhal drugging her was "purely me speculating." While these claims were

unsubstantiated, Panel A finds that they did not arise from dishonesty or embellishment to mislead the Board, but rather were understandably caused by Patient 1's feeling of betrayal and the loss of trust he had in his physician after he found out about Dr. Singhal's sexual relationship with his wife. In short, the Panel finds Patient 1 believed that Dr. Singhal may have overmedicated him.

Finally, the ALJ found that Dr. Singhal's recommendation to Patient 1 to separate himself from his family and pursue his hobbies by himself was not designed to purposefully separate Patient 1 from his wife. The Panel disagrees. When he started treatment with Dr. Singhal, Patient 1 complained that he had lost interest in hobbies and that he had tried to seclude himself from everyone except his wife and kids. Patient 1 did not seek to separate himself from his wife and had not expressed an interest in doing so. Dr. Singhal, nevertheless, used the information to encourage Patient 1 to separate from his wife and kids when he was feeling down and told him that he should give his wife space and pursue hobbies by himself rather than spending time with his wife. The Panel finds that Dr. Singhal's attempts to create more space between Patient 1 and his wife were designed to estrange Patient 1 from his wife, laying the groundwork for Dr. Singhal's sexual pursuit of her.

Dr. Singhal's inconsistent statements

In contrast to the statements by Patient 1, Dr. Singhal's testimony was often inconsistent but in a way that indicates a lack of honesty and demonstrates an attempt to minimize his poor conduct. During the investigation interview, Dr. Singhal would mislead the Board and would revise his statements once he realized that the Board already knew the truth.

First, Dr. Singhal made the same error as Patient 1 and initially claimed that his sexual relationship with Patient 1's wife overlapped with Patient 1's medical appointments. In a

previous statement, Dr. Singhal reported that he had seen Patient 1 for an additional treatment to address Patient 1's depression after the sexual relationship began, but that Dr. Singhal felt that it would be a conflict of interest to continue to treat Patient 1 and thus referred Patient 1 to another physician in the practice. This was incorrect. Dr. Singhal sent a follow-up letter explaining that he had remembered incorrectly, and that Dr. Singhal had not seen Patient 1 as a patient after the sexual relationship began. Dr. Singhal did not merely misremember the timeline, rather, he invented a story about referring Patient 1 to another physician based on his concerns of a conflict. The patient referral did not occur. Dr. Singhal fabricated the referral to minimize his culpability.

Another example concerns the timing of when the sexual relationship began. Patient 1's wife testified that she and Dr. Singhal began their sexual relationship in June 2016 at a retirement party for a friend, where they engaged in kissing, touching, and eventually oral sex in Dr. Singhal's car and Dr. Singhal's office. In his interview with the Board, Dr. Singhal first stated that his relationship with Patient 1's wife became physical or sexual in September or October 2016. When asked more details about the June encounter with Patient 1's wife, he described it as standing next to each other and "it got a little physical at that time . . . [a]nd subsequently there were more sort of text exchanges that got more intimate in nature." When asked about the nature of the physical contact at the June party, he asserted that it was "kissing [and] hugging" and that this occurred only in his car. When further pressed about whether there was oral sex, Dr. Singhal admitted that there was oral sex as well. When asked if he ever had sex, including oral sex with Patient 1's wife in his office, Dr. Singhal admitted to doing so only one time, but not following the June 2016 retirement party. In his testimony at the hearing, Dr. Singhal contradicted his prior testimony after hearing Patient 1's wife's testimony that they had

oral sex in his office in June 2016. Dr. Singhal admitted that they were in the car and then ended at his office with kissing, touching and oral sex.[3] Dr. Singhal's statements were not only inconsistent in a way that consistently minimized his conduct, but disregarded the truth. The Panel finds that Dr. Singhal's inconsistent statements demonstrate his intent to deceive.

Factual dispute regarding the intent and meaning of the text message

The other factual dispute between the parties is related to the text message Dr. Singhal sent to Patient 1 and his wife. After Patient 1 found out about the sexual relationship between his wife and Dr. Singhal, Patient I reported the incident to Dr. Singhal's employer. Dr. Singhal's employer told Dr. Singhal not to contact Patient 1 or Patient 1's wife. However, on January 5, 2018, Dr. Singhal sent the following text message to both Patient 1 and Patient 1's wife:

> I apologize for sending this message to you since both of you asked me to stay away from you. I only want to apprise you of my bleak situation. Since both of you have communicated together recently, I'm sending this to both of you together. Subsequent to your complaint to my employer I have been called to appear in front of executives and board members to decide my fate. My understanding is that under the ethical guidelines and legal limitations harshest consequences await me. You should be happy to know that You [sic] have successfully damaged my present and future.

The State's expert indicated that Dr. Singhal's statement that Patient 1 should be happy to know that he damaged Dr. Singhal's career was blaming Patient 1 and Patient 1's wife for harming Dr. Singhal's career. In essence, the State's expert stated that this was "gaslighting," blaming the patient for the potential consequences of Dr. Singhal's own mistakes. The ALJ agreed, finding

[3] In a previous statement Dr. Singhal said that Patient 1's wife attempted to initiate physical contact at the June 2016 party, but that Dr. Singhal rebuffed her and the affair began months later. While this statement was not under oath, it demonstrates Dr. Singhal's changing stories, and reflects why he may have first indicated that the physical relationship began in September or October 2016. It is because Dr. Singhal could not keep his stories straight.

that it was unprofessional, *see* Health Occ. § 14-404(a)(3)(ii), for Dr. Singhal to send a message to Patient 1 and Patient 1's wife that they should be happy to hear that the physician's career was damaged.

Dr. Singhal's response is that he was not blaming Patient 1 for his career problems but was defusing a violent situation, as Patient 1 had threatened violence against Dr. Singhal. Dr. Singhal claims that by telling Patient 1 that Dr. Singhal was going to suffer, it would calm Patient 1 and convince Patient 1 that he had destroyed Dr. Singhal's life and would stop Patient 1 from resorting to actual violence. Dr. Singhal suggests that because there was no testimony that contradicted Dr. Singhal's interpretation regarding the meaning of the text message, and no additional evidence that the text message was intended to intimidate Patient 1 or Patient 1's wife, that the Panel is required to accept his explanation of the meaning of this text message. Dr. Singhal also argues that the State's expert's interpretation of the text message was a conclusion of fact and that it was not her role as an expert to testify regarding the intention of the text message.

The Panel finds that Dr. Singhal's claim that he sent the message to defuse a volatile situation does not ring true. His message does not apologize for his conduct or express contrition or remorse. The message is bitter and accusatory. It simply is not plausible that Dr. Singhal was speaking literally and was trying to defuse matters. The Panel finds instead that Dr. Singhal was venting his frustration and blaming Patient 1 and Patient 1's wife for the consequences he was facing for his behavior.

EXPERT OPINIONS AND ALJ ANALYSIS

The State relied on the opinions of an expert, a psychiatrist, who concluded that there were three areas of immoral or unprofessional conduct in the practice of medicine. First, the

State's expert opined that Dr. Singhal's sexual relationship with Patient 1's wife was immoral and unprofessional conduct in the practice of medicine. Second, she found that Dr. Singhal's social interactions with Patient 1 and his wife, including visiting their house to show his car was unprofessional, but not immoral behavior. And, third, the expert found that sending the text message about his professional problems was immoral and unprofessional.

Dr. Singhal's expert reviewed the same incidents and found that none of the conduct rose to the level of unprofessional or immoral conduct in the practice of medicine, in part, because Patient 1 was no longer a patient when the sexual relationship with his wife began and when the text messages were sent. Further, the expert concluded that, while Dr. Singhal crossed boundaries during the visit to Patient 1's house, none of the conduct reached the level of immoral or unprofessional conduct.

The ALJ agreed with Dr. Singhal's expert that the sexual relationship and social interactions were not violations, but agreed with the State's expert that the text message was unprofessional conduct in the practice of medicine but found that it was not immoral.

EXCEPTIONS

The State and Dr. Singhal both filed exceptions. The State argued: (1) that the ALJ erred in finding Patient 1 not credible, and that the Panel should find that Dr. Singhal exploited the psychiatrist/patient relationship to advance his own agenda; (2) that the ALJ erred in concluding that Dr. Singhal's behavior, especially in regards to the sexual relationship was not unprofessional conduct; (3) that the ALJ failed to consider whether the treatment was definitively concluded after their last session; and (4) that Board precedent supports a finding of unprofessional conduct and a more severe sanction. The Panel agrees with the first exception, finding, as discussed above, that Patient 1 was credible and Dr. Singhal was not. As the Panel

will discuss below, the Panel agrees with the second exception that Dr. Singhal's conduct was unprofessional and immoral in the practice of medicine. The Panel does not agree with the State's third exception. The Panel does not accept the sanction recommended by the ALJ, the State, or Dr. Singhal and will address the appropriate sanction below.

Dr. Singhal also filed an exception with regard to the text message incident, arguing that the ALJ erred in finding that the text message was in the practice of medicine, since it concerned a former, rather than a current patient, and erred in finding it to be unprofessional conduct, arguing that the intention of the text message was intended to soothe Patient 1 and was not meant to make him feel guilty or to chastise him. The Panel uphold the ALJ's recommendation on this point and rejects Dr. Singhal's exception.

Whether Dr. Singhal's Actions Constitute Immoral or Unprofessional Conduct in the Practice of Medicine, Health Occ. § 14-404(a)(3)(i) & (ii)

"Immoral Conduct" is determined by the "common judgment" of the profession as determined by the professional licensing board. *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577, 594 (2004). 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*, 380 Md. at 594. 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. In the *Finucan* case, Dr. Finucan had a sexual relationship with three patients. The Court of Appeals noted several issues with the sexual relationships that caused the relationship to be considered unprofessional and immoral conduct.

> 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. The Board revoked Dr. Finucan's license. The Court found 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." *Id.* The Court found that by abusing the trust his patients placed in him as their physician and by taking advantage of what he knew about them from their personal lives he acted unprofessionally and immorally. *Id.* at 598. Finally, the Court noted the harm that occurred to the patients. Two of his patients sought therapy and one attempted suicide. *Id.* at 598-99.

The American Psychiatrist Association Commentary on Ethics in Practice also requires that therapeutic boundaries be preserved because "Psychiatrists must never exploit or otherwise take advantage of their patients, must avoid patient interactions that are aimed at gratifying the psychiatrist's needs and impulses, and not use their position to influence the patient in a manner that may undermine or threaten treatment goals." APA Commentary on Ethics in Practice § 3.2.6.

The second element of this violation is whether the immoral and unprofessional conduct occurred "in the practice of medicine." Immoral or 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." *Cornfeld v. State Board of Physicians*, 174 Md. App. 456, 474 (2007) (quoting *Board of Physician Quality Assurance v. Banks*, 354 Md. 59, 76-77 (1999)). "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." *Banks*, 354 Md. at 73.

Dr. Singhal's sexual relationship with Patient 1's wife

As the Court of Appeals found in the *Finucan* case, the Panel finds that Dr. Singhal exploited the intimate knowledge he obtained from treating Patient 1 to help him engage in a sexual relationship with Patient 1's wife. The *Finucan* Court stated: "Dr. 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." *See Finucan*, 380 Md. at 596. Here, Dr. Singhal asked about Patient 1 and Patient 1's wife's sexual positions and knew about Patient 1's sexual difficulties, placing himself in a position to exploit the intimate patient information. *See Finucan*, 380 Md. at 599. The Court of Appeals observed that "Dr. Finucan . . . capitalized on his knowledge that Patient D's husband was in training on the Eastern Shore." *Id.* at 598. Similarly, here, Dr. Singhal used his position as Patient 1's psychiatrist to advise him to give Patient 1's wife "space" which strained their relationship. Dr. Singhal had a sexual interest in Patient 1's wife. The advice he gave to Patient 1 put Dr. Singhal in a position where he put his own gratification above that of his patient, which the *Finucan* Court ruled was immoral and unprofessional. *Id.*

Finally, Dr. Singhal's behavior harmed Patient 1. In *Finucan*, "although we do not know the reason for Patient D's apparent suicide attempt (because she did not testify), we do know that the attempt occurred while she and Dr. Finucan were cohabiting. Dr. Finucan's conduct runs afoul of the maxim '*primum non nocere*' or 'first, do no harm.'" *Id.* at 598-99. Dr. Singhal acknowledged in his interview that his sexual relationship with Patient 1's wife would negatively

affect the Patient 1's mental health as it would create a stressful experience. In the Panel's view, this was a significant understatement. After finding out about the sexual relationship, Patient 1 was devastated and angry. Patient 1 lost forty pounds in two months and was so despondent over the sexual relationship that he made suicide plans, putting a loaded rifle in his mouth. Patient 1 also thought about harming Dr. Singhal, going to lengths to encourage his wife to hide the knife he generally kept in the car, and telling a therapist about his thoughts on harming Dr. Singhal. Patient 1 also explained that his ability to trust others diminished as a result of the affair.

Dr. Singhal was a psychiatrist providing care to a vulnerable patient with clinical depression and anxiety. The State's expert explained that when a patient seeks psychiatric care, the patient reveals private fears and sources of distress. The patient trusts that the physician will help, and not harm the patient. The State's expert explained that it is the moral and professional responsibility of the psychiatrist to promote the patient's health and well-being and to treat the patient with respect and beneficence, and that such responsibility does not end when the treatment ends. The Panel agrees.

The ALJ found that because the conduct occurred several months after the patient-physician relationship ended, Dr. Singhal's sexual relationship with Patient 1's wife was not "sufficiently intertwined with patient care to constitute misconduct in the practice of medicine." *Banks,* 354 Md. at 76-77. Panel A declines to accept the ALJ's analysis. In his exceptions, Dr. Singhal goes even further, claiming that unless there was a specific statute or regulation that prohibited sexual conduct with a former patient's spouse, the Panel is incapable of finding immoral or unprofessional conduct in the practice of medicine. The Panel disagrees.

The Court of Appeals has stated that "the expertise of the [administrative] agency in its own field should be respected." *Maryland Aviation Admin. v. Noland,* 386 Md. 556, 572 (2005).

The Administrative Procedure Act permits a specialized administrative body such as the Board to "use its experience, technical competence, and specialized knowledge in the evaluation of evidence." Md. Code Ann., State Gov't § 10-213(i).

Panel A agrees with the State that Dr. Singhal's conduct was "'sufficiently intertwined with patient care' to pose a threat to patients or the medical profession." *Cornfeld*, 174 Md. App. at 474 (quoting *Banks,* 354 Md. at 76-77). The *Cornfeld* Court explained that this "may be established by evidence that the physician abused his status as a physician in a manner that either harmed patients, created a substantial risk of harm to them, or diminished the standing of the medical profession as caregivers." *Id.* at 478. Here, Dr. Singhal's insidious conduct began during treatment, harmed his former patient, and diminished the standing of the medical profession.

First, the exploitative behavior began while Dr. Singhal was still Patient 1's doctor. Dr. Singhal's knowledge about Patient 1's sexual problems was information he obtained during treatment sessions. Dr. Singhal's advice caused Patient 1 to become more distanced from his wife occurred during treatment sessions. But even the conduct that occurred after Patient 1 stopped seeing Dr. Singhal was in the practice of medicine. The Panel does not find that the duty to refrain from exploiting a patient immediately ends after the patient stops being a patient. Indeed, it would be absurd to think that a physician who intended to exploit a patient could simply terminate the relationship and proceed to exploit the information gleaned from the treatment.

The American Medical Association guidelines state that a sexual relationship with a former patient is unethical when the physician "uses or exploits trust, knowledge, emotions, or influence derived from the previous [medical] relationship, or if a romantic relationship would

otherwise foreseeably harm the individual." AMA Guidelines § 9.1.1. The Panel finds that exploiting trust, knowledge, and engaging in other behavior that could harm a former patient are unethical whether such exploitation is sexual, financial, or otherwise. Dr. Singhal's sexual relationship with Patient 1's wife, while occurring after the patient-physician relationship ended, was part of the same string of conduct and cannot be so easily separated from his role as physician merely because his sexual relationship with Patient 1's wife was not consummated until after the treatment sessions ended.

Second, Dr. Singhal's conduct harmed Patient 1. As discussed above, Patient 1 exhibited significant signs of harm as indicated by his suicide attempts, extreme weight loss, loss of trust, and anger and expressions of violence towards Dr. Singhal. The fact that the sexual relationship did not occur until Patient 1 was a recent former patient does not eliminate this element. The severe harm that Patient 1 suffered by Dr. Singhal's actions taken approximately six months after the treatment sessions ended is still significant. Here, Patient 1 suffered real and serious harm, unlike other cases where unprofessional conduct was found even when there was potential for harm to the patients and not actual harm. *See Board of Physician Quality Assur. v. Banks*, 354 Md. 59, 72-73 (1999) (holding that harassing co-workers was in the practice of medicine because it could be a threat to patient care).

Finally, Dr. Singhal's conduct diminishes the status of the profession as caregivers and diminishes the standing of the medical profession. Patients need to be able to trust that the information they tell their medical professionals, and psychiatrists in particular, will not be used in furtherance of the physician's self-interest at the expense of the patient's well-being. The American Psychiatrist Association Commentary on Ethics in Practice notes that "psychiatric patients may be especially vulnerable to undue influence and the psychiatrist should be sensitive

and careful that his/her conduct does not physically, sexually, psychologically, spiritually or financially exploit or harm the patient." APA Commentary on Ethics in Practice 3.1.1. If the Board tolerated betrayal of patient trust by finding that a psychiatrist who discussed a patient's sensitive personal matters and began a sexual relationship with a patient's spouse mere months after the treatment sessions had ended was not a violation of Health Occ. § 14-404(a)(3), it would degrade the medical profession by reducing the trust that patients place in their providers, especially psychiatrists.

The Panel finds that Dr. Singhal's sexual relationship with Patient 1's wife and Dr. Singhal's surrounding actions constitute both immoral and unprofessional in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(i) & (ii).

Tesla incident

Another question is whether Dr. Singhal's boundary violation when he visited Patient 1 and Patient 1's wife, while Patient 1 was still a patient, to show them his Tesla reached the level of unprofessional conduct. Dr. Singhal took a short ride with Patient 1 and Patient 1's son down the road for a few minutes and then took a longer ride with Patient 1's wife to get ice cream that took between one and two hours. During the car ride, with Patient 1's wife successfully separated from Patient 1, Dr. Singhal told Patient 1's wife that he had a dream about her. When they returned, Patient 1 was upset it had taken so long and said something to Dr. Singhal to express his displeasure about the length of time it had taken. Dr. Singhal brushed off Patient 1's concern, blaming traffic and telling Patient 1 that he needed to calm down.

Both experts opined that this visit and the car ride with Patient 1's wife crossed boundaries, but while the State's expert found that this rose to the level of unprofessional conduct in the practice of medicine, Dr. Singhal's expert found it did not. The ALJ was more

persuaded by Dr. Singhal's expert. Though noting that Dr. Singhal minimized the fact that he was attracted to Patient 1's wife, the ALJ found that Dr. Singhal's prior professional and social relationship with Patient 1's wife, as a former coworker, and their keeping in touch as friends factored into the ALJ's conclusion that the social encounter was not an unprofessional conduct violation.

The Panel rejects Dr. Singhal's attempts to detract from his duties as Patient 1's psychiatrist because of his prior existing relationship with Patient 1's wife. The APA Commentary on Ethics in Practice § 3.2.6 states that a psychiatrist "must avoid patient interactions that are aimed at gratifying the psychiatrist's needs and impulses . . . [and] interactions that could potentially cause harm or misunderstanding should be avoided." Further, this is not limited to sexual or financial relationships, "non-sexual social relationships may negatively affect the therapeutic relationship."

Here, both Patient 1 and Patient 1's wife recall that Dr. Singhal initiated the encounter and sought out the meeting to show them his car. In doing so, Dr. Singhal was engaging in a social encounter with a patient. Second, taking Patient 1's wife, to whom he was sexually attracted, on a long car ride, was inappropriate. Dr. Singhal's discussing with her his dream of her relates directly to his romantic pursuit of her. And while no sexual contact occurred during the car ride, he certainly imparted on her that he had thoughts about her. The Panel finds that Dr. Singhal was testing the waters, so to speak, to determine the likelihood of a sexual relationship with Patient 1's wife. His conduct during this incident crossed the line.

Finally, all the fact witnesses recall that Patient 1 was upset because of the lengthy car ride. Dr. Singhal dismissed the critique. The Panel finds that Dr. Singhal did not prioritize

Patient 1's well-being or his anxieties when he decided to take Patient 1's wife for a lengthy car ride.

Dr. Singhal's expert and the ALJ excuse this behavior by noting the prior relationship between Dr. Singhal and Patient 1's wife. However, this relationship compounds the unprofessional conduct by Dr. Singhal. The prior relationship militates towards Dr. Singhal's duty for increased vigilance regarding patient-physician boundaries, not less. Dr. Singhal was obligated to identify and respect potential boundary concerns with treating a friend's spouse and to recognize that by accepting Patient 1 as a patient, he was now obligated to prioritize his professional and psychiatric role over that of his friendship with Patient 1's wife. If Dr. Singhal could not professionally handle treating Patient 1 primarily as a patient rather than as a conduit to Patient 1's wife, then he should not have agreed to treat Patient 1.

As the State's expert explained in her report, when a psychiatrist has more than one role with a patient, the first obligation is towards the patient. The State's expert opined that "he should have been aware that his role with regards to [the wife] needed to change from that of a former colleague to one where [the wife] was the spouse of his patient." Once Dr. Singhal took Patient 1 as a patient, Dr. Singhal owed Patient 1 additional duties that were not diminished due to his prior relationship with Patient 1's wife. The State's expert noted that Dr. Singhal should have restricted social contact with Patient 1's wife and not gone to their house. The Panel agrees. The existence of the prior relationship should have caused Dr. Singhal to be *more* careful in his interactions with Patient 1's wife. Instead, Dr. Singhal brazenly visited Patient 1's house, had an inappropriate conversation about a dream that he had with Patient 1's wife, aggravated Patient 1 who he knew had anxiety issues, and then dismissed Patient 1's anxieties.

Because this incident occurred while Patient 1 was a current patient, neither party spends much time discussing whether this was in the practice of medicine. The Panel finds that because this instance included inappropriate social interactions with Patient 1 and Patient 1's wife, Dr. Singhal crossed a boundary, and this occurred in the practice of medicine. Further, when Dr. Singhal returned Patient 1's wife to the house, Dr. Singhal was indifferent to Patient 1's anxiety and concerns about the length of the car ride, which affected Patient 1's well-being and treatment relationship with Dr. Singhal, placing this conduct to the practice of medicine. The Panel finds Dr. Singhal's actions involving this Tesla incident constituted unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

Text Message

Dr. Singhal excepts to the ALJ's finding that the text message incident was unprofessional in the practice of medicine. After Patient 1 found out about the sexual relationship between his wife and Dr. Singhal, Patient 1 reported the incident to Dr. Singhal's employer. Dr. Singhal's employer told Dr. Singhal not to contact Patient 1 or Patient 1's wife. However, on January 5, 2018, Dr. Singhal sent a text message to both Patient 1 and his wife that said, "My understanding is that under the ethical guidelines and legal limitations harshest consequences await me. You should be happy to know that You [sic] have successfully damaged my present and future." The ALJ found it unprofessional for Dr. Singhal to reach out to say that the patient should be happy to hear that the physician's career was damaged. In the finding of fact section above, the Panel addressed Dr. Singhal's exceptions claiming that he was not blaming Patient 1 for his career problems, but, rather, was defusing a violent situation and arguing that the State's expert should not have testified to the intention of the text message. As discussed above, the Panel finds that the text message was sent to vent his frustration and place

blame on the Patient 1 and his wife. The Panel rejects Dr. Singhal's claim that he was not blaming Patient 1 for his professional problems. The Panel accepts the ALJ's finding that sending this text message to Patient 1 and his wife constitutes unprofessional conduct.

Dr. Singhal was trying to make his former patient, who suffered from depression and anxiety, take blame for reporting Dr. Singhal's wrongdoing to Dr. Singhal's employer. There was no medical purpose or benefit to sending the message, the message reinflamed the feelings of a breach of trust that Patient 1 had felt, and Dr. Singhal had been told not to communicate further with Patient 1.

Dr. Singhal claims that because he sent the text message when Patient 1 was no longer a patient, the conduct did not occur in the practice of medicine and because the type of conduct was not specifically listed in the statute or regulations, it cannot be considered unprofessional in the practice of medicine. The Panel finds that these arguments are without merit.

The ALJ explained that Patient 1's complaint to Dr. Singhal's employer was based on his role as Dr. Singhal's patient and pertained to Patient 1's care and treatment. The Panel agrees with the ALJ's analysis. The fact that Patient 1 was no longer a patient when he sent the text message does not remove this conduct from the practice of medicine. Dr. Singhal's contact with Patient 1 arose directly out of the physician-patient relationship they previously had. Moreover, the purpose of sending this text message was to cause further turmoil to his former patient by trying to make him feel at fault for Dr. Singhal's employment problems. Dr. Singhal still owed a duty to Patient 1 not to try to cause more discomfort to the patient. A physician who lashes out at a former patient for reporting alleged misbehavior that emanated from their physician-patient relationship had definite potential to worsen Patient 1's condition. The Panel upholds the ALJ's finding of unprofessional conduct in the practice of medicine and denies Dr. Singhal's exception.

Sexual Misconduct Arguments

State's argument about whether Patient 1 was a current patient

The State argues that the Panel should take into consideration the fact that Dr. Singhal stated that he was unsure if Patient 1 intended to return to his office for future appointments. Dr. Singhal responds that Patient 1 was not a current patient and suggests that the State is now arguing that Patient 1 was a current patient, and he was not given sufficient notice that he was being charged with having a sexual relationship with a spouse of a current patient, which would be a violation of the Board's sexual misconduct regulations. Dr. Singhal notes that there are no facts to support that Patient 1 was still a patient at the time the sexual relationship began with Patient 1's wife.

The Panel agrees with Dr. Singhal that Patient 1 was not a current patient when the sexual relationship began. The Panel agrees with the ALJ that the physician-patient relationship ended in February or March of 2016. The sexual relationship began in June 2016, after the physician-patient relationship ended. Dr. Singhal was not charged with sexual misconduct, and there were no allegations of facts in the charging document to support that Patient 1 was a patient in June 2016.

Dr. Singhal's due process argument

Dr. Singhal argues that finding him guilty of unprofessional conduct would violate his due process. He argues that Md. Code Ann., Health Occ. § 1-212 required the Board to define in regulation the boundaries of disallowed sexual relationships. He suggests that because sexual behavior with a former patient's spouse is not prohibited in the regulations, then it is, by its omission, permitted. The Panel rejects this argument.

As an initial matter, Dr. Singhal misinterprets Health Occ. § 1-212. Section I-212 requires that all health occupation boards to create regulations to prohibit sexual misconduct and for disciplinary sanctions to enforce the regulation. Nowhere does the statute state that sexual conduct that is not listed as prohibited is permissible behavior. Instead, the statute explicitly states that this addition of sexual misconduct in the regulations "does not negate any other disciplinary action under a health occupations board's statutory or regulatory provisions." Health Occ. § 1-212(d). The sexual misconduct regulations in effect at the time also reject this proposition stating, "Health Occupations Article, 14-404(a)(3) . . . includes, but is not limited to, sexual misconduct." COMAR 10.32.17.03B (2000).

In this case, the Panel did not charge Dr. Singhal with a violation of the sexual misconduct statute or regulations and does not find that Dr. Singhal violated the sexual misconduct regulations. Health Occ. § 1-212; COMAR 10.32.17.03 (2000). The inapplicability of the sexual misconduct regulations does not impact whether Dr. Singhal acted immorally or unprofessionally under Health Occ. § 14-404(a)(3)(i) and (ii). Dr. Singhal argues that the Board cannot find certain sexual behavior that is not in the sexual misconduct regulations to be unprofessional or immoral if it was not a sexual misconduct violation. However, the Board has full discretion in determining what charge to bring. *Maryland Bd. of Physician Quality Assur. v. Felsenberg*, 351 Md. 288, 304 (1998). "A defendant has no constitutional right to elect which of two applicable statutes will form the basis of his indictment and prosecution." *Felsenberg*, 351 Md. at 304 (quoting *Davis v United States*, 385 A.2d 757, 759 (D.C. 1978)). In other words, the Panel need only determine whether the conduct constitutes immoral or unprofessional conduct under grounds § 14-404(a)(3)(i) and (ii). The existence of another possibly applicable ground does not negate the Board's ability to bring an action under the grounds it feels are most

appropriate. As explained above, the principles and analysis from the *Finucan* case support the Panel's finding of immoral and unprofessional conduct in the practice of medicine. Whether or not it would also be sexual misconduct is irrelevant because Dr. Singhal was never charged under those regulatory provisions.[4]

The Board "has discretion over whether to proceed by adjudication or rulemaking in developing a particular policy." *Mesbahi v. Md. State Bd. of Physicians*, 201 Md. App. 315, 332 (2011) (citing *Consumer Protection Div. v. Consumer Publishing Co.*, 304 Md. 731, 754-56 (1985)). Here, the Panel has chosen to consider Dr. Singhal's sexual relationship, the related exploitation, and other wrongdoing by adjudication. Dr. Singhal claims that the Board must follow rulemaking here because this is "a policy of general application, embodied in or represented by a rule, is changed to a different policy of general application." *CBS, Inc. v. Comptroller of Treasury*, 319 Md. 687, 696 (1990). Dr. Singhal has made no showing that prior to this case, it was the generally applicable policy of the Board that a physician could have a sexual relationship with a former patient's spouse. The fact that sex with a key third party was prohibited by the sexual misconduct regulations, does not demonstrate that sex with a former patient's spouse is allowable conduct when the physician exploited that relationship, as occurred here. Rather, the Board's regulations were silent. No policy of general application had been changed and thus, *CBS* is inapplicable.

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[4] The Court of Special Appeals upheld the Board's decision in a similar case where the Board found unprofessional conduct for physician behavior that included sexual misconduct with a patient. *Roane v. Maryland Bd. of Physician*, 213 Md. App. 619, 641 (2013). In that case Dr. Roane admitted behavior for which he could have been, but was not, charged with sexual misconduct. *Id.* The Court found that the sex, the exploitation of the patients, and the evidence concerning the medication exchanged for sex constituted substantial evidence of unprofessional conduct. *Id.* at 639, 641.

Finally, the Panel's findings of wrongdoing go well beyond the sexual relationship alone. Dr. Singhal engaged in many actions that were immoral and unprofessional and part of the pursuit of Patient 1's wife, but were not merely sexual in nature. Dr. Singhal's exploitative conduct, such as his attempts to create "space" between Patient 1 and Patient 1's wife, Dr. Singhal's knowledge of the personal and private information related to Patient 1's sex life with Patient 1's wife, Dr. Singhal's visiting their home and taking Patient 1's wife on a lengthy car ride, and his venting text message that blamed Patient 1 and Patient 1's wife for Dr. Singhal's professional misfortunes were all equally immoral and/or unprofessional. As part of the totality of his conduct in this case, Dr. Singhal's sexual relationship with Patient 1's wife was immoral and unprofessional conduct in the practice of medicine.

CONCLUSION OF LAW

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

SANCTION

As a sanction, the ALJ recommended a reprimand and a $5,000 fine. The State argues that Dr. Singhal's license should be revoked. Dr. Singhal argues that the case should be dismissed and, if not, the maximum sanction should be a reprimand. The ALJ considered aggravating and mitigating factors finding that Dr. Singhal had no disciplinary history and had begun remedial measures. COMAR 10.32.02.09B(5)(a) and (f). Dr. Singhal claims the Panel should consider the mitigating factors that Dr. Singhal has no disciplinary history, did not deny the relationship, cooperated with the Board's investigation, that the relationship was isolated, no

patient was harmed, and he is undergoing a corrective action plan at his work. COMAR 10.32.02.09B(5)(a), (c), (f), (h), and (i).

Panel A has considered that Dr. Singhal does not have a prior disciplinary history and has rehabilitative potential. The Panel also takes into account the fact that the sexual relationship in this case was not directly with a patient. However, Panel A finds that Patient 1 did experience significant harm based on Dr. Singhal's actions, losing 40 pounds in two months and planning and attempting suicide and finds that the aggravating factor for causing patient harm or the potential for causing patient harm is applicable. COMAR 10.32.02.09B(6)(c). Panel A does not find that Dr. Singhal admitted the misconduct in this case. COMAR 10.32.02.09B(5)(c). Dr. Singhal instead displayed a lack of honesty about the details of the sexual relationship with Patient 1's wife and continues to assert that he did not do anything unprofessional or immoral.

Dr. Singhal'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. Singhal's sexual relationship with Patient 1's wife, even though it occurred after he had stopped seeing the patient professionally, violated professional boundaries and caused significant harm to Patient 1, whom he had diagnosed with anxiety and major depressive disorder. Dr. Singhal demonstrated no regard for his former patient's well-being, no regret for the harm that he caused, and, even after the sexual relationship with Patient 1's wife ended, sent a text message to further harm this emotionally vulnerable former patient.

Panel A believes a sanction between the State's recommendation and Dr. Singhal's request is appropriate and will impose a reprimand as well as a suspension of Dr. Singhal's license to practice medicine in Maryland for a minimum period of six months. Dr. Singhal shall enroll in the Maryland Professional Rehabilitation Program ("MPRP") and shall follow all the

customary provisions for evaluation and treatment. Dr. Singhal shall complete a course during his suspension regarding professionalism in the treatment of patients. After six months, and upon petition from Dr. Singhal and upon a finding by MPRP that Dr. Singhal is fit to practice, Panel A will review MPRP's evaluation and if the panel finds he is safe to practice, will terminate the suspension and impose two years of probation with a requirement that he continue in MPRP.

ORDER

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

ORDERED that Sanjeev Singhal, M.D., is **REPRIMANDED**; it is further

ORDERED that Dr. Singhal's license to practice medicine in Maryland is **SUSPENDED** for a minimum period of **SIX MONTHS.**[5] The suspension goes into effect thirty days from the date of execution of this Order, to give Dr. Singhal time to transition his patients to other providers and the following provisions apply during the suspension:

(1) Dr. Singhal 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 his 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. Singhal shall enroll in the Maryland Professional Rehabilitation Program ("MPRP"). Within **5 business days**, Dr. Singhal shall contact MPRP to schedule an

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

initial consultation for enrollment. Within **15 business days**, Dr. Singhal shall enter into a Participant Rehabilitation Agreement and Participant Rehabilitation Plan with MPRP. Dr. Singhal 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. Singhal shall sign written release/consent forms, and update them, as required by the Board and MPRP. Dr. Singhal 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. Singhal shall not withdraw his release/consent;

(4) Dr. Singhal 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. Singhal's current therapists and treatment providers) verbal and written information concerning Dr. Singhal and to ensure that MPRP is authorized to receive the medical records of Dr. Singhal, including, but not limited to, mental health and drug or alcohol evaluation and treatment records. Dr. Singhal shall not withdraw his release/consent;

(5) Within **SIX MONTHS**, Dr. Singhal shall successfully complete a Board-approved course in professionalism. The following terms apply:

(a) it is Dr. Singhal'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 only accept a course taken in-person;
(c) Dr. Singhal 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. Singhal is responsible for the cost of the course; and it is further

ORDERED that after the minimum period of suspension imposed by the Final Decision and Order has passed, if Dr. Singhal has fully and satisfactorily complied with all terms and conditions for the suspension, and if MPRP finds and notifies the Panel that the Dr. Singhal is safe to return to the practice of medicine, Dr. Singhal may submit a written petition for termination of suspension. If Dr. Singhal has complied with the relevant terms of this Order and MPRP endorses Dr. Singhal's return to the practice of medicine with the sole condition that he

remain in MPRP, then the disciplinary panel may administratively terminate Dr. Singhal's suspension through an order of the disciplinary panel and shall impose probation for a minimum period of **TWO YEARS**. During the probationary period, Dr. Singhal shall continue his participation in MPRP and comply with the MPRP terms and conditions discussed above. However, if there are any concerns raised by MPRP about his return to practice or regarding conditions upon which he may return, then Dr. Singhal shall be required to appear before Panel A to discuss his petition for termination. If, after reviewing the report from MPRP, the disciplinary panel determines that it is safe for the Respondent to return to the practice of medicine, the suspension shall be terminated through an order of the disciplinary panel, and the disciplinary panel may impose any terms and conditions it deems appropriate on the Respondent's return to practice, including, but not limited to, probation. If the disciplinary panel determines that it is not safe for the Respondent to return to the practice of medicine, the suspension shall be continued through an order of the disciplinary panel for a length of time determined by the disciplinary panel, and the disciplinary panel may impose any additional terms and conditions it deems appropriate; and it is further

ORDERED that the Respondent shall not apply for the early termination of suspension or of probation; and it is further

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

ORDERED that after the appropriate hearing, if the disciplinary panel determines that Dr. Singhal has failed to comply with any term or condition imposed by this Final Decision and Order, the disciplinary panel may reprimand Dr. Singhal, place Dr. Singhal on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke Dr. Singhal'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. Singhal; 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 A; 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

06/22/2021
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. Singhal 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. Singhal 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 STATE BOARD OF PHYSICIANS	*	BEFORE TRACEY JOHNS DELP,
	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE
SANJEEV SINGHAL, M.D.	*	OF ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: MDH-MBP2-71-20-03959
LICENSE No.: D61258	*	MBP No: 2218-0201B

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

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 October 15, 2019, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Sanjeev Singhal, M.D. (Respondent) alleging violations 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. 2019). Specifically, the Respondent is charged with violating sections 14-404(a)(3)(i) (immoral conduct in the practice of medicine) and 4-404(a)(3)(ii) (unprofessional conduct in the practice of medicine). *See also* 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 another disciplinary panel delegated the matter to the Office of Administrative

Hearings (OAH) for issuance of proposed findings of fact, proposed conclusions of law, and a proposed disposition. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

I held a hearing on July 28-30, 2020, at the OAH in Hunt Valley, Maryland.[1] Health Occ. § 14-405(a) (Supp. 2019); COMAR 10.32.02.04. Kevin A. Dunn, Esquire, represented the Respondent, who was present. Michael J. Brown, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). At the conclusion of the State's case, the Respondent moved for dismissal.[2] I held the motion *sub curia* to be addressed herein. COMAR 28.02.01.12B(6).

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. 2019); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Should the Respondent's Motion to Dismiss/Motion for Judgment be granted?
2. Is the Respondent guilty of unprofessional conduct in the practice of medicine?
3. Is the Respondent guilty of immoral conduct in the practice of medicine?
3. What sanctions, if any, are appropriate?

[1] A prior hearing date of May 18-21, 2020 was administratively postponed due to the COVID-19 pandemic and the temporary suspension of in-person OAH hearings.
[2] Although argued as a motion to dismiss (COMAR 28.02.01.12C), I considered the motion to be a motion for judgment (COMAR 28.02.01.12E) and declined to render a ruling until my review of all the evidence.

SUMMARY OF THE EVIDENCE

Exhibits

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

Bd. Ex. A.1 - NOT OFFERED

Bd. Ex. A.2 - Complaint, received March 15, 2018

Bd. Ex. A.3 - NOT OFFERED

Bd. Ex. A.4 - NOT OFFERED

Bd. Ex. A.5 - Email from [redacted] to [redacted], April 17, 2018

Bd. Ex. A.6 - NOT OFFERED

Bd. Ex. A.7 - NOT OFFERED

Bd. Ex. A.8 - Medical Records for [redacted][3] from [redacted] of Frederick, September 24, 2014 – January 30, 2015

Bd. Ex. A.9 - Transcript, Interview with [redacted], April 16, 2018

Bd. Ex. B.1 - NOT OFFERED

Bd. Ex. B.2 - NOT OFFERED

Bd. Ex. B.3 - NOT OFFERED

Bd. Ex. B.4 - NOT OFFERED

Bd. Ex. B.5 - NOT OFFERED

Bd. Ex. B.6 - NOT OFFERED

Bd. Ex. C.1 - NOT OFFERED

Bd. Ex. D.1 - NOT OFFERED

Bd. Ex. E.1 - NOT OFFERED

Bd. Ex. F.1 - NOT OFFERED

[3] [redacted]'s full name appears throughout the record in this case. However, as his medical care is discussed in detail in this case, I have used only his initials in this proposed decision to protect his privacy.

Bd. Ex. F.2 - NOT OFFERED

Bd. Ex. G.1 - Peer Review Packet to [redacted], M.D., March 27, 2019

Bd. Ex. G.2 - Expert Report of Dr. [redacted], May 2, 2019

Bd. Ex. H.1(pp. 1-2) - Licensing Information[4]

Bd. Ex. I - NOT OFFERED

Bd. Ex. J - NOT OFFERED

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

Resp. Ex. 1 - NOT OFFERED

Resp. Ex. 2 - NOT OFFERED

Resp. Ex. 3 - NOT OFFERED

Resp. Ex. 4 - NOT OFFERED

Resp. Ex. 5 - NOT OFFERED

Resp. Ex. 6 - Maryland Physician Health Program records, February 3, 2018 – July 12, 2018[5]

Resp. Ex. 7 - Note to Supervision File, [redacted], M.D., January 11, 2018

Resp. Ex. 8 - Memo to File, Dr. [redacted], July 17, 2018

Resp. Ex. 9 - Expert Report of [redacted], M.D., December 19, 2018

Resp. Ex. 10 - Email from [redacted], February 21, 2018

Resp. Ex. 11 - Patient billing records, November 19, 2014

Resp. Ex. 12 - NOT OFFERED

Resp. Ex. 13 - Clinical Message, March 19, 2018

[4] Only pages one and two of Exhibit H.1 (Maryland Board of Physicians Practitioner Profile System information) were received in evidence.

[5] The final page of Exhibit 6 is dated July 12, 1918, which I concluded is a typographical error.

Resp. Ex. 14 - NOT ADMITTED

Resp. Ex. 15 - Email from [redacted][6] to Respondent, December 4, 2012

Resp. Ex. 16 - Facebook Message from [redacted] to Respondent, April 1, 2016

Resp. Ex. 17 - Peer Review Packet to Dr. [redacted], November 28, 2018

Resp. Ex. 18 - Response to Board from [redacted], M.S., May 9, 2018

Testimony

The following witnesses testified on behalf of the Board:

- [redacted]
- Dr. [redacted], accepted as an expert in psychiatry and psychiatric practice; and
- [redacted].

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

- Dr. [redacted] accepted as an expert in psychiatry;
- Dr. [redacted] and
- [redacted].

PROPOSED FINDINGS OF FACT

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

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland.

2. At all times relevant to this proceeding, the Respondent was employed in the field of psychiatry as a Medical Director at [redacted] of Frederick.[7] [redacted] offers outpatient mental health services.

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[6] [redacted]'s full name appears throughout the record in this case. However, I have used only her initials in this proposed decision to protect [redacted]'s privacy because [redacted] and [redacted] are married.

[7] [redacted] is a joint venture between [redacted] and [redacted]

3. [redacted] was employed as a receptionist a[redacted] from 2005 until 2012. [redacted] left [redacted] employment when her first child was born but maintained contact with [redacted] staff and attended [redacted] social activities.

4. When [redacted]'s husband [redacted] began to experience symptoms of anxiety and depression, [redacted] contacted the Respondent and inquired whether he would agree to accept [redacted] as a patient; the Respondent agreed.

5. [redacted] never received mental health treatment before and was reluctant to do so. However, knowing the Respondent through his wife's employment a[redacted] and with his wife's encouragement, [redacted] began receiving treatment on September 24, 2014.

6. During his initial evaluation, [redacted] presented the Respondent with a hand-written list of concerns, which included: "constant hunger, strong mood swings, tired no matter how much sleep; can't slow mind down to sleep, frequent headaches (mostly after high stress), lot more stomach aches than usual, short temper, easily overwhelmed, lost interest in hobbies, try to seclude myself from everyone except wife and kids, heart races, medication/situation/ counselor?, negative self interest [sic]." (Bd. Ex. A.8.)

7. The Respondent diagnosed [redacted] with major depressive disorder and unspecified anxiety. (Bd. Ex. A.8.)

8. The Respondent prescribed [redacted] trazadone and Wellbutrin SR. (Bd. Ex. A.8.)

9. [redacted] attended eleven sessions with the Respondent (September 24, 2014; October 7, 2014; October 24, 2014; December 19, 2014; February 27, 2015; May 13, 2015; July 15, 2015; September 15, 2015; October 16, 2015; November 25, 2015; and December 22, 2015). (Bd. Ex. A.8.)

10. The Respondent's treatment of [redacted] was within standards of professional care. (Testimony, Dr. [redacted] Resp. Ex. 9).

11. While [redacted] was a patient in his care, the Respondent drove to [redacted] and [redacted]'s home to show them his new Tesla and give them rides in it. The Respondent took [redacted] for a much longer ride and stopped for ice cream.

12. During the ride in his Tesla, the Respondent asked [redacted] what she thought it meant that she appeared in a dream the Respondent had.

13. [redacted] stopped attending appointments at [redacted] without providing [redacted] with an explanation. The Respondent did not follow-up with [redacted] after [redacted] missed appointments and did not formally discharge [redacted] as a patient.

14. In June 2016, a [redacted] retirement party was held for a former colleague [redacted] knew. The Respondent asked and [redacted] agreed to help him with music for a slide show the Respondent was preparing.

15. [redacted] attended the retirement party and remained in a bar with the Respondent after the party. [redacted] and the Respondent left the bar together and went to the Respondent's car and office for sexual contact.

16. The Respondent and [redacted] continued their consensual extra-marital affair until [redacted] discovered their relationship in December 2017. Thereafter, [redacted] and [redacted] asked that the Respondent not contact them.

17. On December 26, 2017, [redacted] filed a complaint against the Respondent with [redacted]. (Bd. Ex. G.1.)

18. On January 5, 2018, despite being instructed not to contact them, the Respondent sent [redacted] an [redacted] a text message advising that he was aware of the complaint made to [redacted]

[redacted] and that "harshest consequences" await him. The Respondent added, "You should be happy to know that [y]ou have successfully damaged my present and future." (Bd. Ex. G.1.)

19. [redacted] reviewed [redacted]'s complaint and medical file and interviewed the Respondent. [redacted] decided on the following corrective action: completion of a boundaries course; a voluntary referral to the Physician Health Program of Med Chi[8] for evaluation; and, if necessary, treatment; and quarterly supervision meetings with Dr. [redacted]. The Respondent accepted and completed the corrective action. (Bd. Ex. G.1; Testimony, Dr. [redacted] and Respondent.)

20. [redacted] was angry [redacted] did not terminate the Respondent's employment. (Testimony, [redacted])

21. On March 15, 2018, [redacted] filed a complaint against the Respondent with the Board. (Bd. Ex. G.1.)

22. On March 19, 2018, [redacted], M.S.,[9] spoke with the Respondent regarding [redacted]'s statements of homicidal ideation towards the Respondent; [redacted] surrendered a weapon to Ms. [redacted] during a therapy session. (Bd. Ex. C.1; Resp. Ex. 13; Testimony [redacted] and Respondent.)

23. On November 28, 2018, the Board sought an expert review by Dr. [redacted] who concluded that the Respondent was not guilty of either immoral or unprofessional behavior. However, Dr. [redacted] believed that the Respondent crossed boundaries he should not have crossed. (Resp. Ex. 9.)

24. On March 27, 2019, the Board sought an expert review by Dr [redacted] who concluded that (1) in having a sexual relationship with [redacted] and (2) sending the January 5, 2018

[8] "MedChi" is the Maryland State Medical Society. Health Occ. § 14-101(j) (2014).
[9] [redacted] and [redacted] began couples therapy with Ms. [redacted] in January 2018. (Bd. Ex. C.1.)

text message, the Respondent was guilty of immoral and unprofessional conduct in the practice of medicine, and that (3) in having social contact with [redacted] and [redacted] the Respondent was guilty of unprofessional but not immoral conduct in the practice of medicine. (Bd. Ex. G.2.)

DISCUSSION

Burdens of Proof

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

In this case, the State (which is prosecuting the charges for the Board), as the moving party, has the burden of proof, by a preponderance of the evidence. Md. Code Ann., State Gov't § 10-217 (2014); Md. Code Ann., Health-Occ. § 14-405 (Supp. 2019); COMAR 28.02.01.21K(1)-(2)(a); *Comm'r of Labor and Indus. v. Bethlehem Steel Corp.*, 344 Md. 17, 34 (1996) *citing Bernstein v. Real Estate Comm'n*, 221 Md. 221, 231 (1959).

At the close of the State's evidence, the Respondent motioned for dismissal of the case. I held the motion *sub curia* and advised the parties that my ruling would be included in this proposed decision. COMAR 28.02.01.12B(6). The Respondent, as the proponent of a motion, bears the burden of proof by a preponderance of the evidence regarding the motion. COMAR 28.02.01.21K(1), (3).

Legal Framework

The grounds for reprimand or probation of a licensee, or suspension or revocation of a license under the Maryland Medical Practice Act include the following:

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

Health Occ. § 14-404(a)(3)(i) and (ii) (Supp. 2019). Practicing medicine includes "[d]iagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual: 1. [b]y physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or 2. [b]y appliance, test, drug, operation, or treatment...." Health Occ. § 14-101(o) (2014).

A chronological review of decisions pertaining to "conduct in the practice of medicine" is instructive. In *McDonnell v. Comm'n on Med. Discipline*, 301 Md. 426 (1984), the court concluded that the legislature did not intend for a physician's general moral character to be subject to sanction, thus, "in the practice of medicine" "is directly tied to the physician's conduct in the actual performance of the practice of medicine, *i.e.*, in the diagnosis, care, or treatment of patients." *Id.* at 436-437 (attempt by physician to intimidate witnesses scheduled to testify against him at a medical malpractice trial). However, in *Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59 (1999), the court rejected Banks' argument that his sexual harassment of co-workers during the hours of employment was not immoral or unprofessional conduct in the practice of medicine. The *Banks* court found the physician's behavior "sufficiently intertwined with patient care to constitute misconduct in the practice of medicine." *Id.* at 76-77.

In *Finucan v. Maryland Bd. of Physician Quality Assurance*, 380 Md. 577 (2004), the court affirmed the Board's action against Finucan for having "used the physician-patient relationship for purposes of facilitating the engagement of current patients in sexual activities." And in *Cornfeld v. State Bd. of Physicians*, 174 Md. App. 456 (2007), a physician was found to have committed unprofessional conduct in the practice of medicine when he made false statements to the hospital and Board regarding his conduct during a surgical procedure. Finally, in *Kim v. Maryland State Bd. of Physicians*, 423 Md. 523 (2011), the court found that false information by a physician on his renewal application constituted unprofessional conduct in the practice of medicine. *Id.* at 547-548.

As a health care practitioner, the Respondent is prohibited from engaging in sexual misconduct. COMAR 10.32.17.03A. In pertinent part, COMAR 10.32.17.03C provides that sexual misconduct includes, but is not limited to:

> (1) Engaging in sexual harassment of a patient, key third party, employee, student, or coworker regardless of whether the sexual harassment occurs inside or outside of a professional setting;
>
> . . .
>
> (5) Using the health care practitioner-patient relationship to initiate or solicit a dating, romantic, or sexual relationship;
>
> (6) Engaging in a dating, romantic, or sexual relationship which violates §D of this regulation or the code of ethics of the American Medical Association, American Osteopathic Association, American Psychiatric Association, or other professional code of ethics;
>
> (7) Participating in any form of sexual contact with a patient or key third party;
>
> . . .
>
> (9) Causing a patient or key third party to touch the health care practitioner's breasts, genitals, or any sexualized body part;
>
> . . .

Individuals, including spouses, who participate "in the health and welfare of the patient concurrent with the physician-patient relationship" are key third parties. COMAR 10.32.17.02B(2)(a), 10.32.17.02B(2)(b)(i).

A definition of a bona-fide physician-patient relationship appears in the Criminal Law Article, which provides as follows: "a relationship in which the physician has ongoing responsibility for the assessment, care, and treatment of a patient's medical condition." Crim. Law § 5-601(c)(3)(i)(2) (2012 & Supp. 2019).

Arguments of the Parties

The State contends that the Respondent's sexual relationship with [redacted], the wife of former patient [redacted], constitutes immoral and unprofessional conduct in the practice of medicine. The State further argues that the Respondent took advantage of the physician-patient relationship with [redacted] to advance his sexual pursuit of [redacted]

The Respondent does not dispute the extramarital affair. However, the Respondent denies taking advantage of the physician-patient relationship with [redacted] and denies having any conversations with [redacted] about her husband's treatment. The Respondent maintains that his conduct, though regretful, was neither immoral nor unprofessional conduct in the practice of medicine.

Testimony

In support of its case, the State presented the testimony of [redacted] who described his relationship with the Respondent, his course of treatment with the Respondent, and his discovery of the affair. [redacted] testified that during one of his last appointments, he asked the Respondent whether "not being able to… finish during sex" was a medication side effect. (Transcript Vol. I,

p. 40.) [redacted] said the Respondent then inquired about [redacted] and [redacted]'s sexual relations and sexual positions. [redacted] discussed the Respondent's visit to his home while he was a patient, the purpose being to show off his new car. [redacted] testified regarding his brief ride in the Respondent's car, and his wife's extended ride which involved stopping for ice cream. [redacted] also claimed that the Respondent took him to the parking lot during a [redacted] appointment, to help him fix something which was not working properly in his car. He further testified that after the affair was discovered, he believes the Respondent created a fake Facebook page to attempt to contac[redacted]. [redacted] revealed how distraught he became by his wife's infidelity, which led to both suicidal and homicidal ideation. [redacted] testified that he was aware that his therapist warned the Respondent about his level of upset; [redacted] stated that he wanted that barrier in place to make "make sure I don't do something stupid." (Transcript Vol. I, p. 66.) He also retrieved a weapon from his car and gave it to his therapist for safekeeping. [redacted] said he never told [redacted] or the Respondent that he was discontinuing treatment, and he never received any discharge paperwork from [redacted]

On cross-examination, [redacted] acknowledged that after he discovered the affair, he wrote to the Respondent and stated, "I am going to destroy your life. Your life is over." (Transcript Vol. I, p. 75.) Cross-examination also consisted of a thorough discussion of [redacted]'s medical records.

In his complaint to the Board, [redacted] claimed that the Respondent had an affair with [redacted] "that started while I was a patient of his." (Bd. Ex. A.2.) Additionally, he alleged that the Respondent put him on medication too quickly and suggested the Respondent may have drugged his wife. *Id.* When interviewed by the Board, [redacted] claimed the Respondent's medication doses were too high. (Bd. Ex. A.9, pp. 6-8.) He also claimed that the Respondent would ask him "fairly regularly" about his sexual relations with [redacted] and their sessions would last for up to two hours. (*Id.* at 9, 59 and 64.) [redacted] told the Board's investigator that the Respondent only raised his doses,

and never lowered them. (*Id.* at 11.) [redacted] told the investigator that the affair began two months after he stopped going to treatment. (*Id.* at 52.) He also told the investigator that [redacted] and the Respondent communicated with one another about his treatment sessions. (*Id.* at 53.) Regarding the allegation in his complaint about the Respondent drugging [redacted], [redacted] told the investigator that when [redacted] would come home from her liaisons with the Respondent, she would be "in a complete daze, like in a complete fog." (*Id.* at 43.) Her eyes changed from green to "almost gray" and she would be in a "state" that "worried [him] a lot." (*Id.* at 43-44.)

Although sympathetic to [redacted], I find that he embellished the incident to garner more attention from the Board. He stated in his complaint that the affair between the Respondent and [redacted] began when he was a patient, but he later acknowledged that it did not. He also alleged during his Board interview that the Respondent "fairly regularly" inquired about [redacted] and [redacted]'s sex life, but in hearing testimony he said that during a *later* session *he* asked the Respondent about whether his medication could result in sexual side effects, and the Respondent replied with follow-up questions which [redacted] felt were inappropriate. [redacted] claimed that sessions lasted up to two hours in duration, a claim which is not supported by his medical records (Bd. Ex. A.8), [redacted] billing records (Resp. Ex. 11), and Ms [redacted]'s testimony. [redacted] claimed that the Respondent intentionally suggested that he engage in hobbies or activities independent of [redacted] to try and separate them; however, as early as his initial consultation, [redacted] complained about, *inter alia*, "lost interest in hobbies, try to seclude myself from everyone except wife and kids..." (Bd. Ex. A.8.) [redacted] claimed that the Appellant overmedicated him; however, Dr. [redacted] testified that the Respondent's practices appeared to fall within the standards of acceptable medical care. Finally, no evidence exists in the record to support [redacted]'s claim that the Respondent drugged his wife.

The Board also presented the testimony of [redacted]. While her discomfort was obvious, [redacted] provided her answers directly and thoughtfully. I found her recollection of events credible. [redacted] explained that she was employed at [redacted] as a receptionist from approximately 2005 until she left in 2012 to stay home with her first child. As the [redacted] Medical Director, the Respondent was one of her supervisors and she described having a good working relationship with him. However, [redacted] testified about an awkward exchange when she submitted her resignation. Speaking privately with the Respondent, he told her that he was upset to see her go, and he placed his hand on her knee, which left her feeling uncomfortable. [redacted] testified that she maintained contact with the Respondent after leaving [redacted] employment. He agreed to see her niece as a patient. [redacted] also spoke with the Respondent about problems her husband was experiencing, and he agreed to accept him as a patient as well. [redacted] recalled the Respondent telling her on one occasion that her husband missed an appointment. Other than that, [redacted] testified that the Respondent never discussed her husband's treatment or care.

[redacted] stated that while her husband was a patient, the Respondent visited their home one or two times. [redacted] said she did not invite him, but he visited to photograph their horses and to show them his new car.[10] [redacted] said the Responded took [redacted] and their son for a quick ride in the car for no more than a few minutes. The Respondent then took her for a ride for roughly an hour to an hour and a half. On the Respondent's suggestion, he and [redacted] stopped for ice cream during the ride. [redacted] testified that she felt uncomfortable and at one point, the Respondent asked her what she thought it meant that she appeared in a dream that he had. (Transcript Vol. II, p. 265-266.)

[10] There was uncertainty among all witnesses whether the horse photography occurred before or while [redacted] was the Respondent's patient. All witnesses agree that the Respondent's visit with his Tesla occurred while [redacted] was his patient.

Although in his testimony the Respondent denied making any remark to her about his dreams, I find that he made the remark. The statement is peculiar and memorable, and I find that [redacted] would have no reason to fabricate the statement. As stated previously, I found [redacted] very credible in her recollection of events.

[redacted] explained that in 2016 the [redacted] Office Director [redacted] retired, and a party was planned in his honor. The Respondent asked her to assist him with music selections. [redacted] assisted in choosing songs and attended the retirement party which was held at a restaurant in June of 2016. After the event, several attendees (including [redacted] and the Respondent) continued to socialize at a bar inside the restaurant. [redacted] testified that "things got a little heated" (*Id.* at 252) between her and the Respondent, and they went to his car, then the [redacted] office for sexual contact. This interaction began their affair, which lasted until December of 2017.

[redacted] testified that after [redacted] learned of the affair, she became very worried about [redacted]'s suicidal and homicidal ideation. After [redacted] made his complaint to [redacted], he was angry that the Respondent was not fired immediately. (*Id.*at 298.) [redacted] testified that [redacted] verbalized his thoughts about killing the Respondent. (*Id.*) When reflecting on all that transpired, [redacted] believes that the Respondent had feelings for her for quite some time and she "was slowly being reeled in." (*Id.* at 278.)

[redacted]'s hearing testimony was consistent with her interview by the Board on May 7, 2018. During the interview, [redacted] stated that the Respondent did not discuss [redacted]'s treatment with her. She said months later, at the retirement party, the Respondent was "flirty" and she "flirted back." (Board Ex. G1, p. 12.) When the Board asked [redacted] about whether the Respondent could have medicated her during their liaisons, [redacted] acknowledged consuming alcohol but thought it unlikely that he slipped anything into her drinks. Instead, she suggested that he could have hypnotized

her. (*Id.* at 45.) [redacted] also surmised that the Respondent put [redacted] on strong medications and suggested that [redacted] give her space because "it was all part of the plan." (*Id.* at 55.)

Although I found [redacted] to be a credible historian, her speculations are not credible. There is no evidence in the record from which I can conclude that the Respondent hypnotize[redacted] Furthermore [redacted] specifically sought treatment due to a loss of interest in hobbies, so I do not conclude as she claimed that the Respondent's encouragement for [redacted] to engage in his hobbies was purposefully designed to separate [redacted] from [redacted]. Finally, the Board's own expert witness, Dr. [redacted] testified that the Respondent's practices appeared to fall within the standards of acceptable medical care.

Dr. [redacted]

Dr. [redacted] testified on behalf of the Board as an expert in psychiatry and psychiatric practice. She conducted the Board's second expert review. Dr. [redacted] testified that in rendering her opinion, she utilized her years of professional experience as well as the American Psychiatric Association (APA) Commentary on Ethics in Practice. She explained that she used the APA Commentary as opposed to the American Medical Association's (AMA) Code of Medical Ethics because she believed using the code of ethics more specific to psychiatry would be more relevant to the higher degree of care towards patients and their feelings which is necessary in the practice of psychiatry. Regarding her experience, Dr. [redacted] stated that the Hippocratic Oath requires physicians to do no harm. Further, in reviewing this matter, she was reminded of one of her first supervisors who would iterate that patients are "first a patient, always a patient." Dr. [redacted] opined that in having a sexual relationship with [redacted], the Respondent is guilty of both immoral and unprofessional conduct in the practice of medicine. Dr. [redacted] explained that often when there are missed appointments, it is unknown whether patients intend to return and so discharge

letters may not be sent. (Transcript, Vol. I, pp. 176-77.) Thus, Dr [redacted] concluded "that [redacted] was not a clear former patient." (*Id.*) Further, the Respondent's actions certainly hurt [redacted], whose wellbeing should have been the Respondent's primary obligation. She explained that psychiatrists should treat their patients with benevolence and patients, whether regularly attending appointments or not, view psychiatrists as trusted providers.

Dr. [redacted] also opined that after [redacted] and [redacted] expressly requested no further contact from the Respondent, in sending the text message that harsh consequences await him due to [redacted]'s complaint to [redacted], the Respondent is guilty of both immoral and unprofessional conduct in the practice of medicine. She opined that the Respondent's text message was harmful and demonstrated malevolence and self-concern. Dr. [redacted] saw the text message as emotionally abusive because the Respondent appeared to be placing all the blame on his patient, and not acknowledging his personal wrongdoing.

Finally, Dr. [redacted] opined that visiting the home of [redacted] and [redacted] and inviting [redacted] and, at times [redacted] and [redacted], to social events amounted to unprofessional (not immoral) conduct in the practice of medicine. She explained that physicians should avoid dual roles, *i.e.* having a social and professional relationship with a patient. Dr. [redacted] testified that when the Respondent began to treat [redacted], he should have limited social contact with [redacted] and [redacted]. She concluded that visits to [redacted] and [redacted]'s home were boundary crossings the Respondent should have avoided. Likewise, she concluded that the Respondent should not have taken [redacted] for a ride in his car or contacted [redacted] to help gather music selections for the retirement party. Reading from the APA Commentary on Ethics and Practice, Dr. [redacted] said "[b]oundary violations crossings are deviations from customary behavior that do not harm the patient on that occasion and on occasion may facilitate the therapeutic process. Boundary crossings should be undertaken in treatment only in an

intentional manner and weigh – when the benefits clearly outweigh the risks." (*Id.* at p. 183.) Dr. [redacted] saw no evidence that the Respondent weighed the risks of inviting [redacted] or [redacted] and [redacted] to social functions or of coming to their home. Instead, the Respondent's conduct presented to her as purely selfish.

During cross-examination, Dr. [redacted] referred to APA Commentary, Section 3.2.6 and read that "psychiatrists must maintain awareness that their behavior should be directed towards the patient's therapeutic benefit. And behavior that is likely to conflict with that goal should be avoided." (*Id.* at 205.) Dr. [redacted] opined that the Respondent still had a physician-patient relationship with [redacted] at the time of the sexual affair because once [redacted] was a patient, he was always a patient.

Dr. [redacted]

Dr. [redacted] testified on behalf of the Respondent as an expert in psychiatry. She conducted the Board's first expert review and opined that the Respondent is neither guilty of immoral nor unprofessional behavior. However, Dr. [redacted] believes that the Respondent crossed "boundaries he shouldn't have" (Resp. Ex. 9) which did not rise to the level of a guilty finding. In forming her conclusion that the affair occurred outside [redacted]'s treatment period, she relied on the AMA Code of Medical Ethics and her case review. Dr. [redacted] is not aware of any regulation, law or guideline that prohibits a physician from having sexual relations with a former patient's key third party. She did not consider [redacted] a key third party at the time of the affair because the Respondent was no longer treating [redacted] at that time of the affair.

Dr. [redacted]

The Respondent called Dr. [redacted] as a witness, who at the time of this incident, was employed as Vice President and Chief Medical Officer at [redacted] and was one of the

Respondent's supervisors. He created an *ad hoc* medical executive committee which included himself and at least four others to investigate [redacted]'s complaint to [redacted]. The committee concluded that at the time of the affair, the Respondent was no longer treating [redacted] and found "no evidence that the doctor-patient relationship between [the Respondent and [redacted], or any information obtained by [the Respondent] in the course of treatment, influenced the development of the relationship between [the Respondent and [redacted]." (Resp. Ex. 7.) The committee concluded that "[t]here is no evidence that [the Respondent] ever engaged in a sexual relationship with a patient or with a relative of a current patient." (*Id.*)

Dr. [redacted] testified that as a result of the Respondent's behavior, the committee recommended corrective action to include completion of a boundaries course, a voluntary referral to the Physician Health Program of Med Chi (and, if needed, treatment), and quarterly supervision meetings with Dr [redacted]. The Respondent accepted and completed the corrective action. Thereafter, [redacted] renewed the Respondent's employment contract as the Medical Director of [redacted].

During cross-examination, Dr. [redacted] testified that in order to investigate [redacted]'s assertion that the Respondent used information gained during treatment to identify [redacted] as someone who might respond to his advances, he personally reviewed the Respondent's notes. Dr. [redacted] explained that [redacted] saw the Respondent for medication management, and [redacted] also met with a separate clinician for counseling and psychotherapy. Dr. [redacted] observed that the Respondent's notes were focused on medical details and on medication benefits and side effects, and he saw nothing in the notes to support [redacted]'s claim. Dr. [redacted]'s testimony was succinct and matter of fact. He was unimpeached and highly credible.

[redacted]

Ms. [redacted] was called as a witness by the Respondent and testified briefly. [redacted] was her former employer and during her employment, she worked as a front desk receptionist, front desk supervisor and office manager. She knew [redacted] and the Respondent through her employment at [redacted] She also knew that [redacted] was the Respondent's patient. Ms. [redacted] explained that the Respondent had a busy patient caseload, generally four patients per hour. Usually, the office ran behind schedule and Ms. [redacted] explained it was common to have patients waiting to be seen. She described [redacted] as a social place to work, with holiday parties and summer picnics. Social events were advertised by flyers, emails, and Facebook. She never heard any co-worker complain about the Respondent and she never saw him behave flirtatiously. Ms. [redacted] was unimpeached and highly credible.

Respondent

The Respondent testified and explained that [redacted] expanded tremendously under his supervision. He described the office as collegial; co-workers enjoyed socializing with each other, and he encouraged them to do so. In addition to his supervisory role as Medical Director, the Respondent explained that he also saw patients for medication management. Patients typically attended psychotherapeutic sessions with therapists too. The Respondent testified that when [redacted] approached him about treating her husband, he was not accepting new patients, but agreed to do so because she explained that [redacted] would feel more comfortable since he knew the Respondent. The Respondent explained that he saw many patients in a day, as many as twenty-five patients daily, and typed his notes contemporaneously with patient appointments.

After the initial psychiatric evaluation, the Respondent concluded that [redacted] was exhibiting symptoms of major depression and some anxiety. [redacted] reported that he had gained seventy pounds

in recent years and associated the weight gain to his mental health. The Respondent prescribed Wellbutrin SR and Trazadone and testified about why he prescribed those particular medications. He explained that follow up appointments were "med checks" (Transcript Vol. II, pp. 423-25) to determine how [redacted] was tolerating the medications and whether any dose changes were needed. Over the course of treatment, [redacted] lost weight; at times, he reported improvement and other times, worsening of symptoms. [redacted]'s medications dosages were changed accordingly. The Respondent did not recall having any specific discussions with [redacted] about sexual disfunction, only general conversations about potential medication side effects. The Respondent testified that when individuals miss appointments and do not reschedule the missed appointments, they are no longer considered patients. (Transcript, Vol. II, p. 463.) Had [redacted] called to schedule an appointment with the Respondent once the affair began, the Respondent testified that [redacted] would have been referred to another physician or referred outside [redacted] if no one within [redacted] was accepting new patients; the Respondent said he would not have seen [redacted] as a patient during the affair.

The Respondent acknowledged driving to [redacted] and [redacted]'s home to show them his new car. He blamed the longer car ride with [redacted] on getting stuck in traffic and said getting ice cream was his idea because it was hot outside. He said he never told [redacted] that she appeared in a dream. The Respondent acknowledged the affair and expressed shame. The Respondent characterized the affair as spontaneous; he had not planned for it to happen. He testified that he was very worried by threats thereafter which he received from [redacted]. After the complaint was made to [redacted], he testified that he knew it was an employment matter and that [redacted] would not share its findings with [redacted], so he texted [redacted] an [redacted] against their wishes. The Respondent testified that he did so because he wanted them to know [redacted]'s complaint was being taken seriously by

[redacted]. The Respondent said he did not consider his text as patient-blaming, but instead hoped it would calm [redacted]'s upset to know the Respondent was facing consequences. The Respondent testified that he completed [redacted]'s corrective action plan.

When asked on cross-examination how he thought the affair affected [redacted] the Respondent replied tha[redacted] was not his patient at the time. He explained that until [redacted] stopped his treatment, he had only missed one appointment. He had been compliant with treatment, dietary recommendations, and medication. Months of absence from appointments signaled to the Respondent tha[redacted] was not coming back. The Respondent testified that by the end of January or early February, [redacted] would have run out of his medications. The affair began in June.

The Respondent was asked whether it would have been reasonable for [redacted] to expect the Respondent to avoid harming him after his treatment period ended; the Respondent replied yes that it would have been reasonable. However, he could find no clear guidance that he owed a duty to [redacted] as a former patient. (Transcript Vol. III, p. 586.) When asked about dual roles, the Respondent did not view the issue as Dr. [redacted] had. He drew a distinction between treatment involving therapy or relationship issues, verses limited medication management appointments. However, the Respondent admitted that in hindsight, he should have distanced himself from [redacted].

The Respondent answered his attorney's questions more directly than the administrative prosecutor's questions. More than once, I had to interject in cross-examination and direct the Respondent to answer Mr. Brown's questions. The questions were not difficult questions; it was the subject matter that was difficult for him. I find that the Respondent was intentionally evasive, and it was apparent to me that he had feelings for [redacted] for a considerable period before the affair began. It would make no sense to treat [redacted] for ice cream on their extended car ride if he did not. It would make no sense to involve her in choosing retirement party music selections

(when there was a large office of present employees available to assist) if he did not. It would make no sense to sit so closely and flirt back and forth with her in the bar after the retirement party if he did not. And it is absurd that the Respondent testified that he was not attracted to [redacted] *until* their affair began. (*Id.* at 584.) That being said, the Respondent testified very methodically and logically when he spoke of his medical practice. I found him credible when he testified that he wrote notes contemporaneously with his med check appointments. After considering [redacted]'s medical records (Bd. Ex. A.8), [redacted] billing records (Resp. Ex. 11), and Ms. [redacted]'s testimony, I do not believe there was time in his appointment schedule for the Respondent and [redacted] to detour to the parking lot to trouble-shoot a problem in the Respondent's Tesla together. I also do not believe the Respondent asked questions regarding [redacted] and [redacted]'s sexual activity during med check appointments. In sum, I find that the Respondent downplayed his feelings for [redacted] but did not use his physician-patient relationship with [redacted] for an ulterior purpose.

Motion to Dismiss/Motion for Judgment

At the close of the Board's case, the Respondent moved or dismissal of the charges. The Respondent argued that the Board failed in its proof by failing to present an expert to articulate her opinions and failing to present evidence to satisfy the statutory definitions of sexual misconduct. The Board disagreed, arguing that its expert's report clearly identified the factual bases for her opinion and the standards she applied in rendering her opinion. The Board further argued that sexual misconduct and key third party definitions are irrelevant because the Respondent was not charged under the Medical Practice Act sexual misconduct regulations. The Respondent characterized the Board's position as odious and violative of the *Accardi* doctrine. *See United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954) (holding that an agency's failure to comply with its own rule, regulation, or procedure can furnish a basis for reversal of

the agency's action if the rule, regulation, or procedure affects individual rights and obligations or confers a procedural benefit and the individual sustains actual prejudice as a result).

Motions to dismiss are designed to evaluate whether an initial pleading fails to state a claim for which relief may be granted. COMAR 28.02.01.12C. In considering a motion to dismiss, "a court must assume the truth of all well pleaded facts and all inferences that can be reasonably be drawn from them." *Rossaki v. NUS Corp.*, 116 Md. App. 11, 18 (1997).[11] The grant of a motion to dismiss is proper if the complaint does not disclose, on its face, a legally sufficient cause of action. *Id.*

After reviewing the bases for the Respondent's motion, although argued as a motion to dismiss, I consider the motion to be a motion for judgment. The relevant OAH regulation provides as follows:

> E. Motion for Judgment.
>
> (1) A party may move for judgment on any or all of the issues in any action at the close of the evidence offered by an opposing party. The moving party shall state all reasons why the motion should be granted. No objection to the motion for judgment shall be necessary. A party does not waive the right to make the motion by introducing evidence during the presentation of any opposing party's case.
>
> (2) When a party moves for judgment at the close of the evidence offered by an opposing party, the ALJ may:
>
> (a) Proceed to determine the facts and to render judgment against an opposing party; or
>
> (b) Decline to render judgment until the close of all evidence.
>
> (3) A party who moves for judgment at the close of the evidence offered by an opposing party may offer evidence if the motion is not granted, without having reserved the right to do so and to the same extent as if the motion had not been made.

COMAR 28.02.01.12E.

[11] *Rossaki* involves an analysis of Maryland Rules 2-322 (motion to dismiss) which is analogous to COMAR 28.02.01.12C. Analysis of the applicable Maryland Rules of Procedure is instructive on the application of the OAH's Rules of Procedure.

When considering a Motion for Judgment during a non-jury trial, the judge, as the trier of fact, may determine the facts and render judgment against the non-moving party. *Pahanish v. Western Trails, Inc.*, 69 Md. App. 342, 353 (1986).[12] The judge may evaluate the evidence, including making inferences, determining credibility and drawing conclusions. *Id.*

First, the Respondent complained that Dr. [redacted]'s report failed to provide a basis for her opinion. In her report, Dr. [redacted] wrote that she reviewed the information provided to her by the Board and "[a]dditionally, I reviewed a 2015 document from the [APA], titled "APA Commentary on Ethics in Practice. After reviewing these records, I have the following opinions..." (Board Ex. G.2.) I find the Respondent's complaint to be one of semantics rather than substance. Regardless whether Dr. [redacted] used the word "reviewed" or the Respondent's preferred word "relied," it is plainly evident that Dr. [redacted] considered the APA Commentary on Ethics in Practice when she evaluated the Respondent's case. The Respondent was on notice precisely which document to review in order to analyze Dr. [redacted]'s expert opinions and prepare his case. Accordingly, the Respondent's motion for judgment based upon Dr. [redacted]'s report is denied. COMAR 28.02.01.12E.

Second, the Respondent was troubled by the charging decisions in this case. The case centers around the affair between [redacted] and the Respondent, and the Respondent complained that he has been charged "under the amorphous categories of immoral conduct or unprofessional conduct." (Transcript Vol. II, p. 323.) The Respondent argued that under *Accardi*, the Board has ignored its own regulations and denied him due process. Upon review of the Board's "Charges

[12] This language of the Motion for Judgement provision in the OAH rules of procedure is akin to the Maryland Rules regarding Motions for Judgment in the circuit and district courts. *See* Maryland Rules 2-519 and 3-519. Thus, I find that case law interpreting the circuit and district court provisions is persuasive and informative regarding the proper interpretation of the OAH provision.

Under the Maryland Medical Practice Act,"[13] the Board's charging document clearly sets forth, *inter alia*, the charges, allegations of fact, and grounds for discipline. I concur with the Board's position that charging decisions are within the discretion of the disciplinary panel and administrative prosecutor.[14] COMAR 10.32.02.03E. Accordingly, the Respondent's motion for judgment based upon charging decisions is denied. COMAR 28.02.01.12E.

Analysis

The case was well-presented by both sides. The issues regarding alleged immoral and unprofessional conduct involve four subject areas: whether the Respondent exploited the physician-patient relationship to pursue [redacted]; the appropriateness of his visit to [redacted] and [redacted]'s home; the affair; and the Respondent's text message to [redacted] and [redacted] after [redacted]'s complaint to [redacted]

[redacted]

[13] A copy of the charges is contained in the OAH file.

[14] The Board responded that the sexual misconduct definitions under COMAR had been amended, and this case preceded the amendment. The affair was exposed in December 2017. Effective July 1, 2017, COMAR 10.17.32.02B(1)(a) and (b) read as follows:

> (1) Key Third Party.
> (a) "Key third party" means an individual who participates in the health and welfare of the patient concurrent with the physician-patient relationship.
> (b) "Key third party" includes, but is not limited to the following individuals:
> (i) Spouse;
> ...

Effective July 1, 2017, COMAR 10.17.32.03B(3) read as follows:

> (3) "Sexual Misconduct" means a health care practitioner's behavior toward a patient, former patient or a key third party, which includes:
> (a) Sexual impropriety;
> (b) Sexual violation; or
> (c) Engaging in a dating, romantic or sexual relationship which violates the code of ethics of the [AMA], ...[APA], or other standard recognized professional code of ethics of the health care practitioner's discipline or specialty.

Because I conclude that charging decisions are within the discretion of the disciplinary panel and administrative prosecutor and that the Respondent received proper notice of the violations alleged, I do not address the Board's argument regarding changes to COMAR.

Exploitation of the Physician-Patient Relationship

Both Drs. [redacted] and [redacted] are highly persuasive professionals. Drs. [redacted] and [redacted] agreed that the Respondent's treatment of [redacted] was within the standards of professional care. (Testimony, Dr. [redacted]; Resp. Ex. 9). Both agreed that given the practice of psychiatry, it is not unusual that [redacted] did not formally discharge [redacted] after missed appointments. Furthermore, Dr. [redacted], the Respondent's supervisor, did not appear to have concerns with the Respondent's manner of treatment. I find no credible evidence that the Respondent engaged in exploitive behavior designed to pave the way for a relationship with [redacted] during his appointments with [redacted] For reasons stated above, I found [redacted] to be an unreliable witness. Given his many inconsistencies, I am not persuaded that the Respondent inquired about [redacted] and [redacted]'s sexual positions and sexual relations during treatment. Further, the expert witness evidence leads me to conclude that the Respondent did not overmedicate [redacted] as [redacted] alleged. Finally, the Respondent encouraged [redacted] to participate in hobbies, not to separate him from [redacted], but to address [redacted]'s handwritten concern that he had lost interest in his hobbies.

Visiting [redacted] and [redacted]'s Home

While [redacted] was seeing the Respondent for treatment, the Respondent said he came to [redacted] and [redacted]'s home to show them his new Tesla because [redacted] likes cars. [redacted] acknowledged that he likes cars, although he testified that he has no specific interest in Teslas. The Respondent's ride with [redacted] was brief because [redacted]'s son was on his lap (not in a car seat). [redacted]'s ride was much longer, they stopped for ice cream, and the Respondent asked her what she thought it meant that she appeared in his dream. Dr [redacted] saw this behavior as a boundary crossing, not a boundary violation,

and the fact that the Respondent and [redacted] had a nine-year professional relationship before [redacted] became a patient factored into her determination. Dr. [redacted] was more concerned by the interaction, seeing it as unprofessional (not immoral) conduct and entirely avoidable. As stated by Dr. [redacted] "boundary crossings... do not harm the patient on that occasion and on occasion may facilitate the therapeutic process." (Transcript, Vol. I., p. 183.) Dr [redacted] testified that boundary crossings require a benefit risk analysis, and the Respondent's actions did not appear "thoughtful." (*Id.*) While I concur with Dr. [redacted] that the visit was unnecessary and entirely avoidable, I do not find the behavior violative of Health Occupations Article, section 14-404(a)(3). I am more persuaded by Dr. [redacted]'s analysis, which considered the Respondent's pre-established relationship with [redacted]. Although I found that the Respondent minimized the fact that he was attracted to [redacted], they considered one another friends. The parties agreed that the Respondent and his family attended [redacted] and [redacted]'s wedding. The parties agreed that [redacted] and [redacted] had been to the Respondent's home for office picnics. [redacted] maintained contact and friendship with the Respondent after her [redacted] employment. For these reasons, the Respondent's boundary crossing is not so clearly unprofessional conduct in the practice of medicine.

The Affair

Individuals, including spouses, who participate "in the health and welfare of the patient *concurrent with the physician-patient relationship*" are key third parties. COMAR

10.32.17.02B(2)(a) [emphasis added], 10.32.17.02B(2)(b)(i).[15] While there is no evidence in the record that [redacted] participated in [redacted]'s treatment, as his spouse she was arguably a key third party.[16]

The Board offered no direct legal authority to support its contention that the affair violated sections 14-404(a)(3)(i) and (ii) of the Health Occupations Article. Dr. [redacted] concluded that the affair "violated the contract the Respondent had with [redacted] which was 'First do no harm.'" (Board Ex. G2.) Dr. [redacted] saw no violation because the affair began six months after the last appointment between the Respondent and [redacted]. (Resp. Ex. 9.) Apparently having viewed the situation similarly to Dr. [redacted] required a corrective action but continued the Respondent's employment. In considering the opinions, I find Dr. [redacted]'s interpretation overly broad. "[B]ecause there is a punitive aspect to the proceedings, statutes which authorize the imposition of sanctions against the licensed professional should be strictly construed against the

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[15] Likewise, effective July 1, 2017, COMAR 10.17.32.02B(1)(a) defined a key third party as an individual who participates in the health and welfare of the patient *concurrent* with the physician-patient relationship.

[16] Currently, COMAR 10.32.17.03D, Sexual or Romantic Relationships, provides that a health care practitioner may not engage in sexual behavior with:

(1) A current patient;
(2) A key third party if the key third party's decisions directly affect the health and welfare of the patient or if the relationship could otherwise compromise the patient's care based on the following considerations, which include, but are not limited to:
(a) The nature of the patient's medical problem and the likely effect on patient care;
(b) The length of the professional relationship;
(c) The degree of emotional dependence on the health care practitioner;
(d) The importance of the clinical encounter to the key third party and the patient; and
(e) Whether the health care practitioner-patient relationship can be terminated in keeping with ethics guidance and what implications doing so would have for the patient; and
(3) A former patient upon consideration of the following factors:
(a) Duration of the health care practitioner-patient relationship;
(b) Nature of the health care services provided;
(c) Lapse of time since the health care practitioner-patient relationship ended;
(d) Extent to which the former patient confided personal or private information to the health care practitioner;
(e) Degree of emotional dependence that the former patient has or had on the health care practitioner;
(f) Extent to which the health care practitioner used or exploited the trust, knowledge, emotions, or influence derived from the previous health care practitioner-patient relationship; and
(g) Whether the health care practitioner-patient relationship was terminated in order to enter into a romantic or sexual relationship.

There was no such corollary COMAR language at the time of the affair.

disciplinary agency." *McDonnell*, 301 Md. at 436. The Board alleged immoral and professional conduct *in the practice of medicine*. Practicing medicine includes "[d]iagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual: 1. [b]y physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or 2. [b]y appliance, test, drug, operation, or treatment...." Health Occ. § 14-101(o) (2014). The Respondent was performing none of these activities in relation to [redacted] at the time of the affair. [redacted] no longer considered the Respondent a treatment provider, and the Respondent no longer saw [redacted] as a patient. [redacted]'s last appointment was in December 2015; the affair began in June 2016. [redacted]'s medication would have run out by the end of January or early February. And both Drs. [redacted] and [redacted] agreed that the lack of a formal discharge letter was not unusual. The Criminal Law article defines a bona-fide physician-patient relationship as "a relationship in which the physician has ongoing responsibility for the assessment, care, and treatment of a patient's medical condition." Crim. Law § 5-601(c)(3)(i)(2) (2012 & Supp. 2019). The Respondent had no ongoing responsibility for the assessment, care, and treatment of [redacted]'s medical condition in June 2016. Case law pertaining to misconduct in the practice of medicine involves explicit sexual exploitation of the physician/patient relationship, egregious sexual harassment of co-workers, or deliberate, self-interested dishonesty. The Respondent's affair with [redacted] beginning six months after [redacted]'s final appointment with the Respondent is not "sufficiently intertwined with patient care to constitute misconduct in the practice of medicine." *Banks*, 354 Md. at 76-77. Thus, I decline to accept Dr. [redacted]s interpretation of the APA to find that the Respondent's behavior violated sections 14-404(a)(3)(i) (immoral conduct in the practice of medicine) and 4-404(a)(3)(ii) (unprofessional conduct in the practice of medicine).

The Text Message

After [redacted] discovered the affair, he and [redacted] told the Respondent not to have any contact with them. There was testimony about an effort by the Respondent to have contact via a fake Facebook page, and the Respondent denied doing so; I find the evidence weak and inconclusive. However, after having been told not to contac[redacted] an[redacted] the Respondent learned o[redacted]'s complaint to [redacted] and on January 5, 2018 sent the following text message:

> I apologize for sending this message to you since both of you asked me to stay away from you. I only want to apprise you of my bleak situation. Since both of you have communicated together recently, I'm sending this to both of you together. Subsequent to your complaint to my employer, I have been called to appear in front of executives and board members to decide my fate. My understanding is that under the ethical guidelines and legal limitation, harshest consequences await me. And you should be happy to know that you have successfully damaged my present and future.

(Board Ex. G.1.) Dr. [redacted] considered this text immoral and unprofessional conduct in the practice of medicine. (Board Ex. G.2.) She found the text manipulative and emotionally abusive. Dr. [redacted]'s report did not specifically address the text message (Resp. Ex. 9.), nor did her testimony. The Respondent testified that he did not intend his text to be patient-blaming, manipulative or abusive. He explained that he knew [redacted] was very angry and wanted [redacted] to know the matter has being taken seriously by his employer.

The Board offered no direct legal authority to support its contention that the text violated sections 14-404(a)(3)(i) and (ii) of the Health Occupations Article. Dr. [redacted] s explanation for her conclusion relied upon her interpretation of the message, considering it to be abusive. The Respondent testified that he knew [redacted] was very angry and hoped to allay any fears [redacted] may have had that the matter would not be taken seriously. Although I can read most of the text message from both points of view, the tipping point is when the Respondent wrote, "And you should be happy to know that you have successfully damaged my present and future."

The Merriam-Webster Dictionary defines "immoral" as "conflicting with generally or traditionally held moral principles."[17] It defines "unprofessional" as "characterized by or conforming to the technical or ethical standards of a profession."[18] I do not find the language immoral, but it is unprofessional. Should a patient complain about a physician, a patient should not expect the physician to reach out to say the patient should be happy the physician's career is now damaged. There is no better word to explain such conduct than unprofessional.

Unlike *McDonnell*, wherein the Court of Appeals concluded that intimidation of expert witnesses, although improper, was not directly tied to the physician's conduct in the actual practice of medicine, the Respondent was not communicating with a trial witness. The Respondent was communicating with a former patient [redacted] and his wife. [redacted]'s complaint to [redacted] was based on his role as the Respondent's patient. [redacted] complained that the Respondent used information obtained in the course of treatment to targe[redacted] for his advances. (Board Ex. D.1.) Regardless of the merits of the complaint, it pertained to [redacted]'s care and treatment as the Respondent's patient. For this reason, I am persuaded that the Respondent's message was unprofessional, not immoral, and "sufficiently intertwined with patient care to constitute misconduct in the practice of medicine" because the Respondent's patient care was now under review as a result of [redacted]'s complaint. *Banks*, 354 Md. at 76-77.

Sanctions

The Board seeks to impose the disciplinary sanction of revocation. Md. Code Ann., Health Occ. § 14-404(a) (2014); COMAR 10.32.02.09A(2), (3)(a)(iv); COMAR 10.32.02.10. 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

[17] Merriam-Webster Online Dictionary. 2020. http://merriam-webster.com (27 September 2020).
[18] *Id.*

fully satisfies the Board's burden of proof on all the issues presented. Accordingly, I do not adopt the Board's sought-after sanction of revocation.

I have determined that the Respondent engaged in unprofessional conduct in the practice of medicine because his January 5, 2018 text message was unethical by suggesting to [redacted] a former patient, that he should be happy his complaint damaged the Respondent's career.

However, no evidence of a broader pattern was presented. The Respondent has no prior disciplinary history and Dr. [redacted] spoke well of him. In addition, I note that the Respondent's employer, [redacted], formulated a corrective action to which the Respondent agreed and complied. 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. Likewise, pursuant to COMAR 10.32.02.09B(5)(f), rehabilitation, the Respondent exhibits rehabilitative potential because he agreed to and completed [redacted]'s corrective action.

In light of my findings, I recommend that a reprimand is appropriate.[19] Given the level of unprofessionalism displayed by writing to [redacted] an[redacted], "[a]nd you should be happy to know that you have successfully damaged my present and future," I also find that a fine is appropriate and recommend a $5,000.00 fine.[20]

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent is guilty of unprofessional conduct, but not of immoral conduct. Md. Code Ann., Health Occ. § 14-404(a)(3)(i) and (ii) (Supp. 2019). As a result, I conclude that the Respondent is subject to disciplinary sanction of a reprimand for the cited violation. *Id.*;

[19] Sanctioning guidelines provide that the maximum penalty for a violation of section 404(a)(3) of the Health Occupations Article is revocation and the minimum is a reprimand, for ethical violations that are not sexual in nature. COMAR 10.32.02.10B.

[20] Sanctioning guidelines provide a range of $5,000.00 to $50,000.00 for a fine. COMAR 10.32.02.10B(3)(c).

COMAR 10.32.02.09A(3)(a)(i). I further conclude that the Respondent is subject to a fine of $5,000.00 for the cited violation. COMAR 10.32.02.09A(3)(d).

PROPOSED DISPOSITION

I **PROPOSE** that the charge filed by the Maryland State Board of Physicians against the Respondent on October 15, 2019, for unprofessional conduct be **UPHELD** and the charge filed for immoral conduct be **DISMISSED**; and

I **PROPOSE** that the Respondent be sanctioned by imposition of a reprimand; and

I **PROPOSE** that the Respondent be ordered to pay a fine of $5,000.00.

October 2, 2020
Date Decision Issued

Tracey Johns Delp / tjp
Tracey Johns Delp
Administrative Law Judge

TJD/emh
#187184

NOTICE OF RIGHT TO FILE EXCEPTIONS

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

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

Copies Mailed to:

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

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

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

Kevin A. Dunne, Esquire
Law Office
720 Morningside Drive
Towson, MD 21204

Sanjeev Singhal, M.D.
[redacted]

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