Circuit Court for Prince George's County
Case No. CAL 16-42220

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 515

September Term, 2017

HAROLD O. ALEXANDER

v.

MARYLAND STATE BOARD OF PHYSICIANS

Eyler, Deborah S.,
Nazarian,
Graeff,

JJ.

Opinion by Eyler, Deborah S., J.

Filed: May 30, 2018

*This is an unreported opinion and therefore may not be cited either as precedent or as persuasive authority in any paper, brief, motion, or other document filed in this Court or any other Maryland court. Md. Rule 1-104.

Harold Alexander, M.D., the appellant, appeals from the judgment of the Circuit Court for Prince George's County affirming a final decision of the Maryland State Board of Physicians ("the Board"), the appellee. The Board found that Dr. Alexander violated two provisions of the Maryland Medical Practice Act ("MMPA"), codified at Md. Code (1981, 2014 Repl. Vol.), sections 14-401 *et seq*. of the Health Occupations Article ("HO"). It sanctioned Dr. Alexander by revoking his medical license.

Dr. Alexander presents three questions for review,[1] which we have condensed and rephrased as two:

> I. Were the Board's findings that he violated standards of quality care and committed unprofessional conduct in the practice of medicine supported by substantial evidence in the record and legally correct?
>
> II. Was the Board's decision to impose the sanction of revocation authorized by statute and neither arbitrary nor capricious?

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[1] The questions as posed by Dr. Alexander are:

> I. Did the Maryland Board of Physicians err as a matter of law by finding a single alleged instance of violation of the standard of care with no aggravating factors constituted unprofessional conduct and that revocation was the appropriate penalty when the applicable regulations did not contemplate such penalty?
>
> II. Did the Maryland Board of Physicians err as a matter of law by failing to make any independent findings of fact with respect to its conclusion that Dr. Alexander acted unprofessionally?
>
> III. Did the Maryland Board of Physicians err by finding the evidence demonstrated a violation of the applicable standard of care?

For the following reasons, we answer both questions in the affirmative and shall affirm the judgment of the circuit court.

FACTS AND PROCEEDINGS

Dr. Alexander became licensed to practice medicine in Maryland on June 21, 1978. At all relevant times, he was board certified in obstetrics and gynecology. Since 2011, he has not had privileges at any hospital.

The events giving rise to this case occurred in February and March 2014. At that time, Dr. Alexander was practicing as a gynecologist on a part-time basis in an office in Forestville leased by another practitioner, Javaka Moore, M.D.[2] He saw patients three evenings a week and on Saturdays, primarily performing medical abortions.[3] He employed office assistants on an as-needed basis, but none were licensed medical providers.

In 2012 and 2013, Dr. Alexander was the subject of disciplinary proceedings. On August 22, 2012, he entered into a consent order with the Board to resolve charges that he had violated MMPA subsections 14-404(a)(22), (a)(40), and (a)(3)(ii), for failure to meet the standards of quality care, inadequate documentation, and engaging in

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[2] Dr. Moore previously had practiced with Dr. Alexander, but during the relevant time period, was operating his own practice independent from Dr. Alexander's practice.

[3] A medical abortion is the termination of a pregnancy by administering drugs that induce fetal demise and labor. By contrast, in a surgical abortion, fetal demise is induced, and the demised fetus is removed from the uterus by means of surgical tools.

unprofessional conduct with patients based upon kissing, hugging, inappropriate sexual comments, and inappropriately shredding medical records. The August 22, 2012 Consent Order imposed a minimum three-month suspension and two years' probation and referred Dr. Alexander to complete a medical record-keeping tutorial and a tutorial in ethics.

More than seven months later, by order of April 4, 2013, the Board terminated the suspension of Dr. Alexander's medical license and imposed a period of at least two years' probation with terms and conditions.

While Dr. Alexander remained on probation, the Board began investigating whether he was performing surgical abortions in an unlicensed facility.[4] On October 26, 2013, the Board issued a Cease and Desist Order prohibiting Dr. Alexander from performing surgical abortions at his office,[5] and, on January 13, 2014, it filed new charges alleging that Dr. Alexander had violated the April 4, 2013 probation order and had failed to meet the standards of quality care.

While the Cease and Desist Order and the new charges were pending, the incident precipitating the Board's actions that are challenged in the instant appeal occurred. Around 7 p.m. on February 28, 2014, a 27-year-old female patient from Denmark ("Patient A") came to see Dr. Alexander at his office, along with her husband. She was

[4] Effective July 23, 2012, the Maryland Department of Health promulgated regulations requiring that surgical abortions be performed only in licensed facilities and establishing the licensure criteria. *See* COMAR 10.12.01 *et seq.*

[5] The Cease and Desist Order also prohibited him from prescribing controlled dangerous substances, but that provision subsequently was modified.

between 28 and 29 weeks pregnant and was seeking to terminate her pregnancy due to significant fetal anomalies, including spina bifida with myelomeningocele,[6] and bilateral ventriculomegaly.[7] It was her first pregnancy.

Dr. Alexander's office assistant, Angelica Johnson, gave Patient A intake paperwork to complete in the reception area. Patient A then met with Dr. Alexander in an examination room. He obtained her medical history, checked her vital signs, and performed a physical examination and an ultrasound. The ultrasound revealed no fetal heartbeat. Dr. Alexander also used a stethoscope to listen for a fetal heartbeat but could not detect one. He documented in Patient A's medical record that the fetus had died *in utero*. According to Dr. Alexander, he advised Patient A that one option was to return to Denmark to deliver the stillborn fetus; she elected instead to go forward with a medically induced delivery at that time.

Sometime before midnight, Dr. Alexander administered an intrauterine injection of digoxin and lidocaine in a hypertonic saline solution. Digoxin and lidocaine are used to induce fetal demise by arresting the fetal heart, while hypertonic saline induces labor. Patient A also was given an oral dose of Mifeprex to induce labor. Dr. Alexander inserted nine laminaria sticks, a mechanical cervical dilator made of kelp, into Patient A's

[6] Spina bifida is a neural tube defect in which the spine and spinal cord do not form properly. *Dorland's Illustrated Medical Dictionary*, at 1748 (32d ed. 2012). It ranges in severity from mild to severe. Myelomeningocele, meaning that the spinal canal fails to close in numerous locations, is the most severe form of spina bifida. *Id.*

[7] Ventriculomegaly is an enlargement of the ventricles of the brain. *Id.* at 2048.

cervix. Around midnight (March 1, 2014), Dr. Alexander intravenously administered midazolam, a sedative, to Patient A. He then discharged her to a nearby hotel room where she was staying with her husband. He told her to return at 9 a.m.

Patient A called Dr. Alexander about four hours later and advised that she was in labor. Dr. Alexander met her at his office at 5 a.m. He administered misoprostol, a drug used to induce labor and ripen the cervix, sublingually. Patient A was put under conscious sedation with intravenous midazolam and was given Nubain, a narcotic painkiller, intravenously. Additional doses of midazolam were administered at 7 a.m. and at 9 a.m. Around 9 a.m., Dr. Alexander delivered the stillborn fetus and the placenta. Dr. Alexander checked Patient A's vital signs at 9:15, 9:30, and 9:45 a.m. He gave her an intramuscular injection of Pitocin to cause her uterus to contract and prevent hemorrhaging. He wrote her a prescription for Percocet, a narcotic painkiller. Patient A was discharged from Dr. Alexander's office by 10 a.m. She did not return for any follow-up care.

Dr. Alexander does not accept third-party payments. He charged Patient A $9,500 for his services. She submitted a claim to her insurer, Cigna, for reimbursement for the procedure. Cigna requested an invoice from her provider. Patient A contacted Dr. Alexander's office on March 7, 2014. He provided her a handwritten note on his prescription pad stating: "Patient had a spontaneous loss of pregnancy and delivered non-viable pregnancy 3/1/14 (Dead Fetus in utero)." Patient A handwrote at the bottom of that note "$9,500."

Cigna suspected that Patient A had had a planned abortion. Because Patient A's "medical benefits abroad" coverage only applied to emergency care, not to planned procedures, Cigna denied the claim and began a fraud investigation. On June 18, 2014, a Cigna fraud investigator referred the matter to the Board. At that time, Dr. Alexander's license was suspended under a consent order he had entered into with the Board on April 16, 2014, to resolve the January 13, 2014 charges. By order dated July 21, 2014, the Board stayed the suspension of Dr. Alexander's license and imposed a term of three years' suspension.

The Board assigned the new investigation to Dana Mullen, a compliance analyst. On Tuesday, October 7, 2014, at 10:20 a.m., Ms. Mullen and another Board staff member made an unannounced site visit to Dr. Alexander's office. Dr. Alexander was not present because, as mentioned, he only worked evenings and Saturdays. Ms. Mullen called Dr. Alexander on his cell phone, and he agreed to come in. Ms. Mullen served him with an "Initial Contact" letter,[8] and subpoenas for Patient A's medical records, his appointment logs for the period of February 1, 2014, through September 30, 2014, and to appear for an interview with Board staff. Dr. Alexander advised Ms. Mullen that Patient A's medical records were in a locked file cabinet and that he did not have the key, and that he did not keep any appointment logs. He told Ms. Mullen he would fax the record to her by 5:30 p.m. that same day. He did not do so.

[8] That letter advised Dr. Alexander that the Board was investigating charges that he had "performed a late term abortion on [Patient A] and billed it as a miscarriage."

On October 16, 2014, Dr. Alexander appeared at the Board offices for an interview with Ms. Mullen. At that time, he provided Patient A's medical record but did not provide appointment logs. He explained that the delay in securing the record was occasioned by the fact that the medical record had been stored off-site.[9] The medical record included Patient A's intake paperwork; her prior ultrasound reports;[10] consent forms she signed; and Dr. Alexander's notes from February 28 and March 1, 2014. He stated that Patient A was referred to him for a second trimester medical abortion due to fetal anomalies. He denied ever performing third trimester medical abortions. He said that after he determined that Patient A's fetus had died *in utero*, he proceeded with a "second trimester induction of labor [following his] usual protocol."

On October 28, 2014, Ms. Mullen conducted a second unannounced site visit to Dr. Alexander's office and took photographs of two of the four examination rooms. Aside from an ultrasound machine, the photographs did not show the presence of any specialized medical equipment or surgical devices.

Dr. Alexander sat for a second interview with Board staff on November 24, 2014.

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[9] Dr. Alexander testified at the administrative hearing that he had been moving all his records that were more than a few months old out of Dr. Moore's offices and to the offices of a non-profit foundation for which he volunteered. That foundation was not in the business of storing medical records but agreed to allow Dr. Alexander to maintain his files in locked file cabinets in their offices.

[10] Patient A had an ultrasound on January 6, 2014, at 21 weeks and 1 day, that had not shown any definite anomalies. A subsequent diagnostic ultrasound performed on February 22, 2014, had detected significant fetal anomalies.

The Board submitted Patient A's medical records, transcripts of Dr. Alexander's interviews, and other relevant materials for peer review to two board certified OB/GYNs: Ishrat Rafi, M.D., and Matrice Browne, M.D. ("Dr. M. Browne"). On February 10, 2015, both peer reviewers submitted reports finding that Dr. Alexander had violated the standard of quality care for induction of labor after 28 weeks gestation, which they opined required him to transfer Patient A to a higher-level care facility, such as a hospital, to manage labor and delivery of the stillborn fetus. They also concluded that Dr. Alexander had violated the standard of quality care by administering an intrauterine injection of digoxin, which, as mentioned, is a drug used to cause fetal demise, despite having documented that Patient A's fetus had died *in utero*. Dr. Rafi opined in her report that Dr. Alexander also had failed to properly document Patient A's estimated blood loss and the condition of the fetus; Dr. M. Brown opined that the documentation had been adequate.

On July 8, 2015, the Board charged Dr. Alexander with two violations of the MMPA under section 14-404(a): subsection (a)(3)(ii) (unprofessional conduct in the practice of medicine); and subsection (a)(22) (failure to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient setting).

Dr. Alexander requested a contested case hearing, and the matter was transferred to the Office of Administrative Hearings.

On January 12-13, 2016, and February 1, 2016, a hearing was held before an administrative law judge ("ALJ"). The Board took the position that Dr. Alexander failed to meet appropriate standards of quality care[11] for the treatment of Patient A both because he did not refer her to a higher level facility for the induction of labor and because his recordkeeping of his treatment of Patient A was wholly inadequate.[12] The Board argued that the breaches were so egregious as to rise to the level of unprofessional conduct in the practice of medicine. Dr. Alexander responded that the management of labor and delivery of a demised fetus in an outpatient setting was appropriate and consistent with the standard of care and that his recordkeeping was adequate, as one of the peer reviewers had found.

The Board called four witnesses: Drs. Rafi and M. Browne, both of whom were accepted as experts in the field of obstetrics and gynecology; Ms. Mullen; and Elizabeth Ward, a Cigna fraud specialist. It introduced into evidence forty exhibits, including Patient A's medical record; transcripts of Dr. Alexander's interviews with Board staff; photographs of Dr. Alexander's office; the peer review reports prepared by Drs. Rafi and M. Browne; medical literature relied upon by Drs. Rafi and M. Browne pertaining to the standard of care; and the prior Board orders.

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[11] For ease of discussion, we shall use the phrase "standard of care" interchangeably with the phrase "standards of quality care."

[12] The Board noted that it did not charge Dr. Alexander with inadequate documentation under MMPA section 14-404(a)(40), but that it nonetheless could present evidence bearing on recordkeeping if it fell below the standard of care.

Patient A's medical record included a signed consent form for a medical abortion, entitled "Mifeprex/Misoporstol [sic] Abortion Consent & Information." In that consent form, she acknowledged that she was "fewer than 9 weeks (63 days) pregnant." (Patient A was more than 28 weeks or 196 days pregnant.) Patient A also signed an "Operative Risks, Complication, and Consent" form that applied to early abortion by "vacuum aspiration," a type of surgical abortion procedure.

A document entitled "Examination Sheet" and dated February 28, 2014, stated that "no [fetal heart rate was] auscultatable"[13] or could be seen by ultrasound.

An untitled page in the medical record contained sections labeled: "Physical Examination," "Pelvic Exam," "Operative Report," "Tissue Examination," "Post Procedure/Discharge Orders," and "Discharge Diagnosis." In the "Physical Examination" section, Dr. Alexander handwrote in the margins the medications administered to Patient A on February 28, 2014. In the "Pelvic Exam" section he circled "Neg," noted that she was 28 weeks pregnant with "Multiple anomalies," and noted that she was administered "Misoprostol 800 Sl: @ 5 AM. 3/1/14."[14] In the "Operative Report" section, Dr. Alexander wrote in the margin that he would "administer dig[oxin] & lidocaine despite absence of F[etal] H[eart] R[ate]." In a box next to the section titled

[13] "Auscultatable" means audible and refers to Dr. Alexander's attempt to listen to the fetal heart rate with a stethoscope. He testified that he did not "have a doppler to confirm [the absence of a fetal heart rate].

[14] "Sl" stands for "sublingual," meaning that the medication was placed under Patient A's tongue. *Dorland's*, at 1791.

"Tissue Examination," Dr. Alexander had checked off "Nubain" "20 mg I.V." and had handwritten "9 AM." He also checked off "Midazolam," but did not specify a dose. Next to that drug, he had handwritten "X4" followed by an arrow to a handwritten notation "5A, 7, 9A, 12." The "Tissue Examination" section showed that between 5 a.m. and 9 a.m. on March 1, 2014, Patient A had a vaginal delivery of a "non viable fetus + placenta intact," that there was "mod[erate]" tissue, and that the fetus was "seen." The line for "Blood Loss" was blank. The "Post Procedure" section noted that Patient A's vital signs were checked "@ 15 minutes," that she received 2 cc of Pitocin and a prescription for Percocet. Her "Discharge Diagnosis" was "28 wk [intrauterine pregnancy], Multiple Anomalies, Medical Abortion." She was stable for discharge and had minimal bleeding.

Patient A had not signed or dated an anesthesia consent form in her medical record, despite there being a line for a signature bearing an "X" mark, nor had she signed on the line indicating that she had been "discharged from the recovery room with no complaints" and had "received [her] post-operative medications and instructions." Dr. Alexander had signed and dated both forms, however.

Dr. Rafi testified that Dr. Alexander breached the standard of care in his treatment of Patient A and in his documentation of that treatment. She opined that Dr. Alexander's treatment records for Patient A were confusing because they did not show the dates and times that various medications were administered to the patient. She further opined that the standard of care required Dr. Alexander to clearly document the time that each drug

was administered and, with respect to the IV sedatives, to document the patient's vital signs at the time of each administration. Dr. Rafi also took issue with Dr. Alexander's failure to document the "estimated blood loss" and to describe the fetal anomalies he observed post-delivery.

Dr. Rafi opined that Dr. Alexander breached the standard of care by administering digoxin because its only indication is to cause fetal demise, which already had occurred. She emphasized that the lack of an observed fetal heartbeat on ultrasound was conclusive of that fact.

The third breach identified by Dr. Rafi was the failure to transfer Patient A to a higher-level facility for labor and delivery. That breach rose to the level of unprofessional conduct, in Dr. Rafi's view, because delivery in a private office setting was "dangerous" and could have "cause[d] harm to the patient." Dr. Rafi explained that in the third trimester (which she testified begins at 28 weeks, 0 days) the size of the fetus makes it more likely that the patient will require surgical intervention, experience excessive bleeding, or develop an infection. She relied primarily on a "Practice Bulletin" issued by the American College of Obstetricians and Gynecologists ("ACOG") for the "Management of Stillbirth" ("ACOG Bulletin") for her opinion that delivery in a higher-level facility was required. The ACOG Bulletin, which was introduced into evidence at the hearing, stated that "[a]fter 28 weeks of gestation, induction of labor should be managed according to usual obstetric protocols."

Dr. M. Browne concurred that Dr. Alexander breached the standard of care by inducing labor and delivering Patient A in an "office setting." He should have transferred her to a hospital or, at the very least, to a "birthing center" or "ambulatory care center [with] . . . surgical capabilities." Dr. M. Browne opined that this was necessary for the "safety of the mother" in the event of "excessive blood loss, uterine rupture" or other complications. She also had relied upon the ACOG Bulletin to form her opinion. She opined that Dr. Alexander's office was not a higher-level facility and that his conduct in treating Patient A in that setting had been unprofessional.

Dr. M. Browne also opined that the administration of digoxin to Patient A was contrary to the standard of care because, as the medical literature establishes, its only indication is to cause fetal demise, and here fetal demise already had been confirmed.

Dr. M. Brown had reconsidered her initial opinion that Dr. Alexander's documentation of his treatment of Patient A was adequate. Upon further review of the medical record, she concluded that there was not "enough detail to quantify or justify the actions [Dr. Alexander] took." She opined that the treatment notes were "disorganized" and did not include key information, such as the time of delivery of the fetus and of discharge of the patient. Moreover, Dr. Alexander had failed to include any description of the fetal anomalies he observed post-delivery, which would have been important for the patient should she become pregnant again.

Ms. Mullen testified about the Board's investigation, and Ms. Ward testified about Cigna's fraud investigation and referral to the Board.

In his case, Dr. Alexander testified and called one witness: Charlie Browne, M.D. ("Dr. C. Browne"), who also was accepted as an expert in the field of obstetrics and gynecology. Dr. Alexander testified about his education and training, the history of his medical practice, and his record keeping protocols. As pertinent, he explained that he had ceased practicing as an obstetrician around 2008 and limited his practice to gynecological well visits and abortions. He no longer performed surgical abortions, however, as a result of the 2013 Cease and Desist Order.

Dr. Alexander testified that he had managed stillbirths in his practice and that the "specific risks with stillbirth come in when there is an excessive length of time between the time of fetal death and delivery." He specified that a length of "more than a month" could increase a patient's risk of "excessive bleeding." Otherwise, he opined, there was no difference in the risk to the patient in managing a stillbirth versus managing a medical abortion.

Dr. Alexander testified that he had sold his surgical instruments to Dr. Moore around 2012, when he transferred the practice to him, but that those instruments remained in the office and he was allowed to use them if he "needed to." The office also was equipped with a "crash cart."

Regarding his treatment of Patient A, Dr. Alexander testified that he met with her and her husband for the first time on February 28, 2014, around 9 p.m. Patient A was "anxious" and "tearful." She told him she wished to terminate her pregnancy due to fetal anomalies and he went over the consent forms and the follow-up treatment. He then

performed an ultrasound and was "stunned" to find there was no fetal heartbeat. He advised Patient A that she "might want to return to Denmark and not hav[e] anything done[.]" She responded that she wished to go forward with the procedure.

Dr. Alexander made a "judgment call to not eliminate the digoxin and lidocaine from the abortion protocol" because, in his view, those drugs posed no risk to Patient A. He opined that, in his experience, digoxin is effective to help prime the cervix for delivery and its use would "ensure fetal demise" in the unlikely chance that he was mistaken about the absence of a fetal heartbeat.

Dr. Alexander testified about an article, Warren M. Hern, et al., *Outpatient Abortion for Fetal Anomaly and Fetal Death From 15–34 Menstrual Weeks' Gestation; Techniques and Clinical Management,* 81 Obstetrics & Gynecology 301 (1993),[15] (hereinafter "*Hern*"), which he maintained supported his position that his treatment of Patient A was within the standard of care and was not unprofessional conduct in the practice of medicine. The study in *Hern* followed 124 patients receiving medical and/or surgical abortions at a "single private office outpatient abortion facility located across the street from a community hospital" over a period of ten years. *Hern* at 301. The objective of the study was to "determine the safety of providing outpatient abortion services for women with complicated advanced pregnancies." *Id.* The authors described the

[15] Dr. Hern is considered the foremost authority on late term medical and surgical abortions.

procedures used to induce labor and the pain management measures used. They explained that if the fetus was not delivered "within a few hours after artificial rupture of the membranes, [dilation and evacuation] was performed."[16] *Id.* at 302. They concluded that the advantages of performing late abortion for fetal anomalies and fetal death in an outpatient setting were numerous and included

> a selected and highly supportive staff, the availability of a full range of specialty instruments not usually available in community hospitals or even in teaching hospitals, privacy and maintenance of patient confidentiality, informal procedures that reduce patient anxiety, availability of individual counseling and support throughout the experience for both the patient and her family, lower cost, fewer bureaucratic controls, reduced political vulnerability to the community pressures experienced by hospital boards, and greater flexibility in counseling and preoperative and operating schedules.

Id. at 305.

The authors in *Hern* emphasized, however, that "all possible precautions [must be taken] to minimize risk to the patient," including the presence of physicians with "specialized training and experience" as well as "highly skilled" nursing staff who "function as an integrated part of the surgical team," the availability of "[s]pecific appropriate instruments," "[s]pace for routine minimum recovery period of 2 hours," and, for abortions after 25 weeks gestation, "a full-service hospital (with blood bank, intensive care unit, and operating room)" within 5 minutes distance of the outpatient clinic. *Id.*

[16] Dilation and evacuation, known as a D&E, is a surgical abortion involving the dilation of the cervix, followed by the surgical removal of the contents of the uterus.

On cross-examination, Dr. Alexander was asked how he would have responded if Patient A had not fully expelled the fetus and/or the placenta, or if she had experienced excessive bleeding. He answered that he had never had that situation occur, but if he had had "any inkling of a situation that needed to be operative, [he] would transfer the patient." He did not have a transfer agreement with either of the two nearest hospitals, both of which were approximately 10 minutes from his office. Therefore, he would have called 911 and arranged for Patient A to be transported by ambulance to the hospital.

Dr. C. Browne testified that he was the medical director at a women's health clinic near Seattle, Washington, and the director of second trimester services at Planned Parenthood of Greater Washington and Northern Idaho. He also worked part time as a clinical instructor at the University of Washington. In those capacities, he had "induced fetal demise in the second trimester" in thousands of cases. The latest gestational age at which he had performed a medical induction of fetal demise was "29 and a half weeks."

Dr. C. Browne also was asked about the *Hern* article. He testified that he agreed with the authors' conclusion that "outpatient abortion may be performed safely in most cases of fetal disorder, including death through 34 menstrual weeks under proper conditions." He disagreed with the authors' conclusion that registered nurses were required to assist with the procedure but agreed that highly trained staff were necessary. He agreed that surgical instruments would be necessary, noting in response to questioning that, even in a medical abortion, forceps could be required to assist to remove the placenta. He opined that, while the recovery period of 2 hours referenced in *Hern*

was "reasonable," he believed an hour would be sufficient for many patients. Dr. C. Browne disagreed that a hospital within 5 minutes of an outpatient clinic was absolutely necessary for abortions after 25 weeks but agreed that within "5 to 10 minutes is reasonable."

Dr. C. Browne opined that Dr. Alexander "was not in violation of the standard of care by performing Patient A's procedure in an outpatient setting," that the administration of digoxin and lidocaine did not "pose an undue risk to [Patient A]," and that Dr. Alexander did not engage in unprofessional conduct in his management of Patient A's care. He opined that Dr. Alexander's recordkeeping "could have been more complete," but that it was not so inadequate as to amount to a violation of the standard of care.

On April 29, 2016, the ALJ issued a Proposed Decision. The ALJ made forty-four numbered factual findings pertaining to Dr. Alexander's disciplinary history, his treatment of Patient A, his documentation of that treatment, and the Board investigation. The following is a summary of the pertinent findings.

On February 28, 2014, Patient A was 28 weeks, 6 days pregnant, based upon the date of her last menstrual period. She was seeking an abortion due to fetal anomalies. Dr. Alexander could not detect a fetal heartbeat by ultrasound or by auscultation. He gave Patient A digoxin, lidocaine, hypertonic saline, Mifeprex, and laminaria. At midnight on March 1, 2014, he administered midazolam and discharged Patient A to a nearby hotel. At 5 a.m., she returned to his office. He gave her misoprostol, Nubain, and midazolam. The fetus was delivered stillborn at 9 a.m. Patient A was given an injection

of Pitocin and discharged sometime "shortly after 9:45 am" with a prescription for Percocet. She received no follow-up care from Dr. Alexander.

Findings numbered 45 through 56 pertained to the standard of care. As pertinent, the ALJ found that the standard of care for the treatment of a 28-week pregnant patient with confirmed intrauterine fetal death was to refer the patient to a higher-level facility and that Dr. Alexander violated that standard by instead delivering her in an office setting. The standard of care required Dr. Alexander to document in a patient's medical record the date, time, and provider of an exam, vital signs checks, and administration of medication. Dr. Alexander did not meet that standard. The standard of care required that a patient be continually observed, with vital signs checked, while under IV sedation. Dr. Alexander violated that standard by discharging Patient A after administering midazolam at midnight on March 1, 2014, and by not monitoring her vital signs while she was under IV sedation later that morning. The standard of care required a physician to document the precise time the fetus and placenta were delivered and the details of the delivery, including estimated blood loss, none of which were documented by Dr. Alexander. The standard of care required that there be an indication for medication to be administered. Dr. Alexander violated that standard of care by administering digoxin and lidocaine to induce fetal death after confirming the absence of a fetal heartbeat, *i.e.*, that fetal death already had taken place. The standard of care required a physician to have medical records reasonably accessible. Dr. Alexander violated that standard by failing to produce

Patient A's medical record on October 7, 2014, when it was first requested by Board staff.

In the "Discussion" section, the ALJ elaborated on these findings. She credited the testimony of Dr. Rafi that the gestational age of Patient A's fetus alone required that she be transferred to a higher-level facility for induction of labor and delivery; in addition, the presence of the fetal anomalies and the fact that the fetus had been dead for an undetermined period of time put Patient A at higher risk of bleeding and infection. Known complications at that gestational age include entrapment, which would require surgical intervention. The ALJ credited Dr. M. Browne's testimony that transfer to a higher-level facility was necessary to protect Patient A's safety, given the known risks of uterine rupture and excessive blood loss. The ALJ also credited Drs. Rafi and M. Browne's testimony that the use of digoxin was not indicated in Patient A and therefore was a violation of the standard of care.

The ALJ rejected Dr. C. Browne's testimony that Dr. Alexander did not violate the standard of care by performing the procedure on Patient A in an outpatient setting, and that the administration of digoxin and lidocaine did not pose any undue risk to the patient. She noted that Dr. C. Browne did not explain why it was appropriate for Dr. Alexander to follow the procedure for a medically induced termination of pregnancy after determining that fetal demise already had occurred, nor did he identify any known benefit to Patient A from the administration of digoxin and lidocaine. Dr. C. Browne "failed to acknowledge important facts and failed to adequately explain his reasons for concluding that [Dr.

Alexander] met the standard of care." For those reasons, the ALJ found that the "detailed testimony" given by Drs. Rafi and M. Browne "far outweigh[ed]" Dr. C. Browne's testimony.

The ALJ also discussed the medical publications relied upon by Dr. Alexander, most of which were authored by Dr. Hern. She noted that only two of the articles were applicable to a pregnancy at 28 weeks gestation and only the *Hern* article discussed above involved fetal anomalies such as were present here. While Dr. Hern performed abortions in an outpatient setting from 15–34 weeks gestation, he did so in an office located directly across the street from a community hospital that was "specially equipped and staffed to provide assistance for woman seeking late abortion." Dr. Hern also provided surgical abortions in that setting and was equipped to intervene surgically during a medical abortion. He described in detail the protocols followed from the onset of labor to the discharge of the patient, at least one to two hours after delivery. The ALJ contrasted the setting described by Dr. Hern with Dr. Alexander's practice, which was ten minutes away from the nearest hospital. Dr. Alexander did not have a transfer agreement in place with either hospital and would have needed to call 911 to arrange transport for a patient in the event of a serious complication. Dr. Alexander had no specially trained staff to assist him, relying only on office assistants with no medical training, had no surgical equipment of his own, and was barred from performing surgical abortions. The ALJ concluded that the "testimony and documents . . . convincingly demonstrated that

[Dr. Alexander's] treatment of Patient A and his documentation in her medical record violated the standard of care."

Turning to the unprofessional conduct charge, the ALJ agreed with Drs. Rafi and M. Browne that "conduct that does not meet the standard of care is unprofessional conduct." The ALJ further found that Dr. Alexander's inability to provide Ms. Mullen with Patient A's medical record promptly was unprofessional conduct.

The ALJ recommended that the Board sanction Dr. Alexander with revocation considering his disciplinary history and the findings relative to his treatment of Patient A.

On June 2, 2016, Dr. Alexander filed exceptions to the ALJ's proposed decision. He excepted to the weight given to the Board's expert witnesses by the ALJ in light of their lack of experience performing and reviewing "medically induced late term terminations" and the lack of weight given to Dr. C. Browne's testimony in light of his significant experience in that field. The ALJ's "failure to properly weigh the expert testimony infect[ed] her entire analysis," in his view, and "render[ed] her Decision erroneous."

He also excepted to the ALJ's findings of violations of the standard of care, for several reasons. He asserted that the Board's charges did not give him notice that he could be found to have violated the standard of care for failure to monitor Patient A's vital signs, failing to document the time the fetus and placenta were delivered, and failing to promptly produce Patient A's medical record. He argued that the finding that performing a "medically induced abortion" in an outpatient setting violated the standard

of care was "contradicted by substantial evidence in the record." Similarly, the finding that he violated the standard of care by administering digoxin and lidocaine was contradicted by "[t]he weight of the evidence." He maintained that the evidence did not support the findings that his recordkeeping and storage of records violated any applicable standards of care.

Dr. Alexander also excepted to the finding of unprofessional conduct. He argued that the ALJ's decision "impermissibly" "collapse[d]" the statutory requirements for violations of the standards of quality care and for unprofessional conduct, rendering the latter violation meaningless.

On July 27, 2016, the Board heard argument on Dr. Alexander's exceptions. On October 27, 2016, it issued its "Final Decision and Order" ("the Final Decision"). The Board adopted the ALJ's findings of fact numbered 1–44 in their entirety, none of which were excepted to and all of which were "proved by a preponderance of the evidence."

Turning to the exceptions, the Board first considered whether the ALJ erred by finding that Dr. Alexander had violated the standard of care because of the setting in which Patient A was treated. It noted that the parties disputed the nature of the procedure performed, with Dr. Alexander characterizing it as a "medically induced abortion" and the attorney for the Board characterizing it as "the delivery of a stillborn fetus." "[I]n light of the undisputed evidence documented in the medical records that there was no fetal heart rate" when Patient A presented to Dr. Alexander on February 28, 2014, the Board rejected Dr. Alexander's characterization of the procedure as an abortion.

The Board reasoned that, in the absence of a fetal heart rate, Dr. Alexander should have referred Patient A to a higher-level facility. It found that Dr. Alexander "exercised poor clinical judgment by disregarding his own medical assessment of the patient and treating the patient he expected rather than the patient who actually presented." The administration of digoxin was "not medically indicated" and was "unnecessary." "Further, at 28 weeks, the delivery of a stillborn fetus needed to occur at a higher level of care facility due to the increased risks involved." In particular, the "advanced gestation of the fetus, the documented medical abnormalities . . ., and the intrauterine fetal death that occurred at an unknown time . . . increased the risk for infection and bleeding, the potential for complications to arise with the delivery, and the possibility of requiring surgical intervention." The procedure involved more risks than a medically induced abortion at the same gestation and Dr. Alexander "failed to appreciate the increased risk[.]"

The Board emphasized that Dr. Alexander delivered the stillborn fetus without the assistance of medical staff and without the surgical equipment needed to perform surgery if the need arose. He lacked hospital privileges, was barred from performing surgical abortions, and did not have a transfer agreement in place. The procedure, as performed, was "unnecessary, not medically indicated, and had the potential to cause serious harm to the patient when performed in Dr. Alexander's private office setting." For all those reasons, the Board denied Dr. Alexander's exception to the finding that he violated the

appropriate standards for the delivery of quality medical care by delivering a 28-week stillborn fetus in an office setting.

The Board then turned to Dr. Alexander's exception to the proposed unprofessional conduct finding. It agreed with him that a finding of a standard of care violation did not "necessarily mean that the conduct was unprofessional." It reasoned, however, that "certain violations of the standard of care may be 'so egregious as to amount to unprofessional conduct in themselves.'" (quoting *Geier v. Md. State Bd. of Physicians*, 223 Md. App. 404, 437 (2015)). It concluded that the standard of care violations committed by Dr. Alexander were so "egregious and so unsound as to amount to unprofessional conduct in themselves." He performed an "unnecessary procedure that was not medically indicated." As he acknowledged in his testimony, "generally speaking stillbirths can be managed conservatively and in most instances patients will go into labor and will deliver the fetus." Rather than manage Patient A's case conservatively, Dr. Alexander chose to follow "the steps of performing a medically induced abortion, as if the fetus was still viable . . . administer[ing] digoxin without any documented medical indication[.]"

Dr. Alexander also failed to follow "usual obstetric protocols," which required that labor be induced in a higher-level facility. The fact that Patient A's fetus had "an intrauterine fetal death at an unknown point in time," put her at "increased risk . . . for infection and bleeding." These risks could not be managed safely at Dr. Alexander's private office and the "potential for harm was great."

In light of these findings, the Board determined that it was unnecessary to address Dr. Alexander's exception to the finding that he also violated the standard of care by keeping inadequate records and by failing to promptly turn over records to the Board, rendering his exception on the basis of improper notice of those charges moot. The Board did not find that Dr. Alexander violated the standard of care or committed unprofessional conduct with regard to the storage of his records.

The Board also rejected Dr. Alexander's exception premised on the ALJ's weighing of the expert testimony. The Board reasoned that Dr. C. Browne's testimony "was based on the incorrect assumption that the procedure in question was a medically induced abortion" and, for that reason, it was not well founded or supported in the record. In contrast, Drs. Rafi and M. Browne had offered opinions about the management of a stillbirth, which were "founded on the specific facts of this case and supported by the ACOG [Bulletin]."

The Board concluded that revocation was the appropriate sanction for Dr. Alexander's violations of the MMPA and was statutorily authorized. In so ruling, the Board considered Dr. Alexander's "conduct and poor judgment in this case, which had potential to cause serious patient harm" and his "extensive prior disciplinary history with the Board dating back to May of 2012 and that the Board's previous attempts at rehabilitation ha[d] been unsuccessful." He had "repeatedly demonstrated . . . poor judgment and inattentiveness to patients during complicated procedures," undermining the Board's confidence in his "ability to safely practice medicine."

On November 17, 2016, Dr. Alexander filed a petition for judicial review in the circuit court. On April 25, 2017, the circuit court entered a judgment upholding the Final Decision of the Board. This timely appeal followed.

STANDARD OF REVIEW

In an appeal from a judgment of the circuit court on judicial review of a final agency decision, we look "through" the decision of the circuit court and review the decision of the agency. *People's Counsel v. Country Ridge Shopping Ctr., Inc*., 144 Md. App. 580, 591 (2002). *See also Baltimore Lutheran High Sch. Ass'n, Inc. v. Emp't Sec. Admin*., 302 Md. 649, 662 (1985) (appellate court review of an agency decision identical to circuit court review). Our review of the agency decision is circumscribed. *See Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 67 (1999). It is "limited to determining if there is substantial evidence in the record as a whole to support the agency's findings and conclusions, and to determine if the administrative decision is premised upon an erroneous conclusion of law." *United Parcel Serv., Inc. v. People's Counsel*, 336 Md. 569, 577 (1994). In applying these standards, we review the record in the light most favorable to the agency and "defer to [its] fact-finding and drawing of inferences" if supported by any evidence in the record. *Banks*, 354 Md. at 68. We review purely legal decisions *de novo*. *See People's Counsel v. Loyola College in Md*., 406 Md. 54, 67-68 (2008). However, with respect to the agency's legal conclusions, we give "considerable weight" to the agency's "interpretation and application of the statute which the agency administers." *Banks* at 69. *See also Marzullo v. Kahl*, 366 Md. 158,

173 (2001) (appellate court must accord appropriate deference to agency expertise even with respect to conclusions of law).

DISCUSSION

I.

Dr. Alexander contends there was not substantial evidence in the administrative record to support the Board's finding that his treatment of Patient A violated the applicable standards of care. And, even if that finding was supported by substantial evidence, the Board "misapplied the law" by finding that he committed unprofessional conduct based solely upon the same standard of care violations. He asserts that the Board's decision means that a violation of the standard of care "automatically constitutes unprofessional conduct," rendering the distinction between violations of HO sections 14-404(a)(22) and 14-404(a)(3)(ii) meaningless.

The Board responds that the record amply supports its finding that Dr. Alexander violated the standard of care by "performing an unnecessary procedure, inducing fetal demise to an already deceased fetus, and failing to refer the patient to a higher-level facility for the induction of labor and delivery of the stillborn fetus"; and the record further supports its conclusion that the egregious nature of the violations amounted to unprofessional conduct. We agree with the Board.

a.

The Board's findings that Dr. Alexander violated the standards of quality care were well-supported by the record. It found that Dr. Alexander performed an

unnecessary procedure by administering digoxin to induce fetal demise after confirming fetal death by auscultation and by ultrasound. Dr. Alexander documented in Patient A's medical record the absence of a fetal heart rate and that he had decided to administer digoxin and lidocaine "despite absence of FHR." Drs. Rafi and M. Browne testified that the *only* indication for the administration of digoxin and lidocaine is to cause fetal demise and that because fetal demise already had been confirmed by ultrasound, it was unnecessary to give those drugs. This was substantial evidence supporting the Board's finding that the administration of digoxin and lidocaine was unnecessary and provided no medical benefit to Patient A and thus was a violation of the standard of care.[17]

The Board's finding that the induction of labor and delivery of a 28-week stillborn fetus in an office setting violated the standard of care also was supported by substantial evidence in the record. The Board adopted the ALJ's finding that Patient A was 28 weeks and 6 days pregnant on February 28, 2014. The evidence established that Patient A's fetus had died *in utero* on some unknown date prior to her appointment with Dr. Alexander. Thus, while he had expected to be performing a medical abortion, he actually was managing a still birth. The ACOG Bulletin introduced into evidence and relied upon

[17] Dr. Alexander asserts that Drs. Rafi and M. Browne admitted on cross-examination that they were unaware of any standard of care for the administration of digoxin. It was clear from their testimony, however, that they were speaking about the lack of a standard of care for its administration in a case where fetal demise already had occurred. In other words, because there was no medical indication for it, there could be no standard of care governing its use in those cases and it was a clear breach of the standards of care of a confirmed stillbirth to administer it.

by Drs. Rafi and M. Browne stated that beyond 28 weeks gestation, a stillborn fetus should be delivered according to "usual obstetric protocols," meaning delivery in a hospital or birth center.[18] The Board plainly did not err by concluding that Dr. Alexander violated the standard of care by delivering Patient A's stillborn fetus in a private medical office examination room.

b.

We also perceive no error in the Board's finding that Dr. Alexander's violations of the standard of care amounted to unprofessional conduct in the practice of medicine. Conduct is unprofessional if it "'breaches the rules or ethical code of a profession or conduct which is unbecoming a member in good standing of a profession.'" *Finucan v. Md. Bd. of Physician Quality Assurance*, 380 Md. 577, 593 (2004) (quoting *Shea v. Bd. of Medical Exam'rs*, 81 Cal.App.3d 564, 575 (1978)). The Board correctly stated that not every violation of the standard of care amounts to unprofessional conduct, but that "certain violations" will meet that threshold. This is consistent with Maryland law, which holds that a physician may be charged and found guilty of multiple violations of the MMPA based upon the same underlying conduct. *See Kim v. Md. State Bd. of Physicians*, 423 Md. 523, 547-48 (2011) (affirming Board's final decision finding that a

[18] The *Hern* article, which Dr. Alexander relied upon to support his view that he complied with the standard of care, also made clear that even if Patient A's fetus had not died *in utero*, induction of fetal demise in Dr. Alexander's office setting would not have met the standard of care.

physician violated HO §§ 14-404(a)(11) & (36) for willful false statements, *and* committed unprofessional conduct in violation of §14-404(a)(3), based upon a false statement on an application for renewal of his license that he was not involved in a medical malpractice action); *Geier*, 223 Md. App. at 439–40 (affirming a decision of the Board that determined that a physician's violations of the standard of care in his treatment of autistic patients "were so egregious as to amount to unprofessional conduct in themselves").[19]

The evidence established that Dr. Alexander's violations of the standard of care were egregious. He pursued a course of treatment for Patient A that was unnecessary and had the potential to cause her serious harm. He did so without any appreciation of the risks inherent in delivery of a late term stillbirth in an office setting. As the Board found, Dr. Alexander's office "lacked the safeguards and resources that are available at a higher-level facility[.]" The evidence supporting that finding was abundant. Dr. Alexander had no trained medical staff to assist him. While surgical instruments allegedly were present in the office, they were not present in the examination room and no longer belonged to Dr. Alexander. Dr. Alexander was not licensed to perform surgical abortions and

[19] Dr. Alexander misstates the Board's conclusion as being that a violation of the standard of care always amounts to unprofessional conduct. This is directly contrary to the Board's decision: "The Panel agrees that a standard of care violation may not automatically constitute unprofessional conduct[.]" He also cites numerous out-of-state cases to support his proposition that the Board erred in this regard. We decline to discuss those cases given that the Board's legal analysis was fully consistent with on point Maryland authority.

testified that he interpreted that restriction to apply to any intervention in Patient A's delivery. His plan, should a complication arise, such as bleeding or entrapment, was to cease the procedure and merely call 911. It would have taken at least 10 minutes for Patient A to be transported to the nearest hospital for emergency care. Drs. Rafi and M. Browne testified unequivocally that Dr. Alexander's treatment of Patient A in this setting placed her at serious risk of harm. The Board did not err by finding that Dr. Alexander's conduct breached the rules of the medical profession and amounted to unprofessional conduct.

II.

Dr. Alexander contends the Board impermissibly imposed the sanction of revocation for the finding of unprofessional conduct, requiring remand for the Board to "fashion and articulate a lawful sanction." He asserts that the sanctioning guidelines at COMAR 10.32.02.10 do "not allow a penalty of revocation for the alleged transgression the [Board] called "'unprofessional conduct,'" and because the Final Decision does not specify the basis for the imposition of that sanction, it must be vacated.

The Board responds that Dr. Alexander waived this argument because he did not raise it before the Board and that, in any event, revocation was a lawful sanction. We agree.

"A reviewing court is not authorized to overturn a lawful and authorized sanction unless the 'disproportionality [of the sanction] or abuse of discretion was so extreme and egregious that the reviewing court can properly deem the decision to be arbitrary or

capricious.'" *Md. Aviation Admin. v. Noland*, 386 Md. 556, 581 (2005) (quoting *MTA v. King*, 369 Md. 274, 291 (2002) (internal quotation marks omitted). HO section 14-404(a) authorizes the Board to "reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee" violates any of the grounds set forth therein, including the two grounds violated by Dr. Alexander.

Pursuant to HO section 1-606(b)(2), the Department of Health promulgated COMAR 10.32.02.10 to provide guidelines for disciplinary panels relative to the imposition of sanctions for violations of the MMPA. The guidelines set forth maximum and minimum sanctions and fines for each violation. The guidelines for a sanction for "immoral or unprofessional conduct in the practice of medicine" is divided into four subparts:

> (a) Sexual impropriety as defined by the Board's regulations at COMAR 10.32.17.02; (b) A sexual violation as defined in the Board's regulations at COMAR 10.32.17.02; (c) Ethical violations that are not sexual in nature; and (d) Attesting to earning but failing to earn required number of continuing medical education (CME) credits.

For each of those violations, the maximum guidelines sanction is revocation. Dr. Alexander asserts that because none of the "subsections is applicable to [his] alleged transgressions," his violations do not fall within the category of unprofessional conduct sanctionable by revocation.

We agree with the Board that Dr. Alexander waived this argument because he failed to raise it in his exceptions before the Board. In any event, the argument lacks merit. As already discussed, the term "unprofessional conduct" has been interpreted by

Maryland appellate courts to be more expansive than these four subcategories and to encompass any conduct that breaches rules or ethical guidelines or is unbecoming a member in good standing of a profession, including violations of the standard of care. *See Finucan*, 380 Md. at 593; *Geier*, 223 Md. App. at 439-40. The guidelines cannot and do not limit the Board's statutory authority to impose revocation as a sanction.

Having concluded that the sanction was authorized, the only issue is whether the sanction imposed was so disproportionate as to be arbitrary or capricious. For the reasons already discussed, Dr. Alexander's violations were egregious. In fashioning the appropriate sanction, the Board was authorized, pursuant to COMAR 10.32.02.09B(6), to consider as aggravating factors Dr. Alexander's prior disciplinary history, the fact that the violations had the potential to cause harm to Patient A, and the prior attempts to rehabilitate Dr. Alexander. The Board's decision to revoke Dr. Alexander's license was neither arbitrary nor capricious under the circumstances.

JUDGMENT OF THE CIRCUIT COURT FOR PRINCE GEORGE'S COUNTY AFFIRMED. COSTS TO BE PAID BY THE APPELLANT.