IN THE MATTER OF	*	**BEFORE THE**
CHARLES W. HICKS III, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D32670	*	**Case Number: 2222-0043**

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FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Charles W. Hicks III, M.D., is a board-certified psychiatrist, who was originally licensed to practice medicine in Maryland in 1985. On March 21, 2023, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Dr. Hicks with unprofessional conduct in the practice of medicine; failing to meet appropriate standards, as determined by appropriate peer review, for the delivery of quality medical and surgical care; failing to comply with the provisions of § 12-102 of the Health Occupations Article; failing to cooperate with a lawful investigation conducted by the Board; and failing to keep adequate medical records. *See* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii), (22), (28), (33), (40). The charges alleged that Dr. Hicks collected medications from patients and dispensed the collected medications to other patients; dispensed medications without obtaining a dispensing permit; failed to conduct toxicology screenings; failed to search the prescription drug monitoring program ("PDMP"); failed to perform appropriate assessments, work-ups, diagnoses to justify the co-prescribing of opioids and benzodiazepines; failed to prescribe naloxone; failed to keep adequate medical records; and did not cooperate with the Board's investigation by failing to provide records months after they were required to be produced.

On April 8 and 9, 2024, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings ("OAH"). At the hearing, the State introduced seventy-one exhibits that were admitted into evidence. The State presented testimony from a Board compliance analyst and a physician (the "State's expert"), a psychiatrist, who was qualified as an expert in psychiatry and the standard of care for dispensing and prescribing medications, including controlled dangerous substances ("CDS") in a psychiatric practice, the return and disposal of prescription drugs, including CDS and the standards of adequate medical records. Dr. Hicks introduced fifteen exhibits and testified on his own behalf.

On July 5, 2024, the ALJ issued a proposed decision concluding, as a matter of law, that Dr. Hicks committed unprofessional conduct in the practice of medicine, Health Occ. § 14-404(a)(3)(ii); failed to meet appropriate standards, as determined by appropriate peer review, for the delivery of quality medical and surgical care, Health Occ. § 14-404(a)(22); failed to comply with the provisions of § 12-102 of the Health Occupations Article, Health Occ. § 14-404(a)(28); failed to cooperate with a lawful investigation conducted by the Board, Health Occ. § 14-404(a)(33); and failed to keep adequate medical records, Health Occ. § 14-404(a)(40). As a sanction, the ALJ recommended a reprimand, one-year probation; a permanent prohibition on applying for a dispensing permit; a permanent prohibition from prescribing opioids; a permanent prohibition from taking patients used, donated, or returned prescription drugs or other medications; Dr. Hicks to attest in an affidavit compliance with the forgoing prohibitions during probation; a course in medical recordkeeping and CDS prescribing prior to the end of one-year of probation; and a $5,000 fine.

Both Dr. Hicks and the State filed exceptions. Dr. Hicks filed exceptions relating to concerns regarding the Board's investigation and the adequacy of the peer review, the conclusions

of law concerning the standard of quality medical care and recordkeeping, Health Occ. § 14-404(a)(22) and (40), and objected to the permanent conditions as part of the sanctions recommended by the ALJ. The State did not raise any objections to the conclusions of law but objected to the recommended sanctions. Neither party challenged the proposed factual findings of the ALJ. On September 11, 2024, counsel for both parties appeared before Disciplinary Panel A ("Panel A" or the "Panel") of the Board for an exceptions hearing.

FINDINGS OF FACT

Panel A finds that the following facts were proven by the preponderance of the evidence:

Background

Dr. Hicks is licensed to practice medicine in the State of Maryland, license number D0032670, with an expiration date of September 30, 2026, and was licensed to practice in Maryland during the relevant period. Dr. Hicks had a Controlled Substance Certificate of Registration, issued by the United States Department of Justice, Drug Enforcement Administration, on September 24, 2018, that expired on October 31, 2021. Dr. Hicks held a Controlled Dangerous Substances Registration Verification issued by Maryland, on June 1, 2017, that expired on May 31, 2020. Dr. Hicks has hospital privileges and has been board-certified in psychiatry since approximately 1988. Dr. Hicks was a staff psychiatrist for the Veterans Administration, Mental Health Clinic, and the director of its Drug Dependence Treatment Program, from 1988 to 1992. In September 1991, Dr. Hicks began his private psychiatric practice. He typically treated patients suffering from major depression and bi-polar disorder. He would incorporate electric convulsive therapy (ECT) when patients did not respond to other treatments. He generally treats patients in blocks of sixty to ninety minutes, and his most common diagnosis of his patients is major depression. Dr. Hicks also worked at a hospital three days a week where

he consulted and provided ECT. In all, Dr. Hicks practices medicine an average of seventy to eighty hours a week. Some patients have been his patients for more than twenty years.

Dr. Hicks makes patient treatment notes on scraps of papers for his later review. He stated that he did not consider his scrap notes as part of the patient's "official" medical records. Dr. Hicks does not employ a support staff other than his wife, from time to time. He has not billed any patients for the last nine to ten years.

Complaint, Investigation, and Compliance with the Board's Subpoenas

On September 15, 2021, the Board received an anonymous complaint against Dr. Hicks for inappropriately prescribing medications to a patient, later identified as Patient 1. On November 12, 2021, the Board's investigator began her investigation of the complaint. The investigator reviewed online reviews and found concerns from a second patient, Patient 2. On December 2, 2021, the Board investigator visited Dr. Hicks' practice with a colleague. The investigators presented two subpoenas to Dr. Hicks. One subpoena, which sought immediate production of medical and billing records for Patients 1 and 2, and a second subpoena for medical and billing records of ten randomly selected patients, Patients 3-12, who were identified through the PDMP, with a production date of ten days.

On December 2, 2021, Dr. Hicks provided handwritten scrap notes for Patients 1 and 2 but stated that he had not proofread his typed records for these two patients. The investigator agreed that she would copy and return the handwritten notes and receive the typed notes after they had been proofread. On December 6, 2021, the investigator returned the handwritten notes, and Dr. Hicks provided additional records for Patients 1 and 2. On December 21, 2021, Dr. Hicks, through counsel, asked if the record request could be limited to January 1, 2016, through the present, and, on December 22, 2021, the Board agreed. The Board also agreed to an extension of time to January

7, 2022, to produce the records. On January 6, 2022, Dr. Hicks asked for additional time to comply with the subpoena, and the Board granted additional time to January 14, 2022. On January 14, 2022, Dr. Hicks submitted additional records for Patients 1 and 2. Dr. Hicks submitted records for Patient 3 and Patient 4, on January 20, 2022; for Patient 5, on January 27, 2022; for Patient 6, on January 31, 2022; additional records for Patient 3 and records for Patient 7 and Patient 8, on February 9, 2022; for Patient 9, on March 8, 2022; for Patient 10, on March 25, 2022; for Patient 11, on March 30, 2022; additional records for Patient 1, on April 8; and a final production of records for Patient 12, on May 18, 2022.

Dr. Hicks never submitted any billing records because he did not bill any patient since 2014 and had not received payments from patients at his private practice since that time. Dr. Hicks did not inform the Board that he did not bill patients until the hearing before the ALJ. Dr. Hicks also did not certify that he produced all requested medical records, as requested.

The Board sent the medical records to two peer reviewers, on May 31, 2022. The Board received the completed peer reviews, in October and November 2022. The State's expert's review was received, on November 30, 2022. Dr. Hicks provided a supplemental response, on December 19, 2022. Panel B of the Board issued charges against Dr. Hicks, on March 21, 2023.

Collection and Dispensing of Used Medications

The investigation revealed that some of Dr. Hicks' patients would donate to him their used[1] prescription medication when the medications were no longer needed or wanted by the patients. The most common returned medications were antidepressants and major tranquilizers. Dr. Hicks also received CDS medications. Dr. Hicks accepted any medication that was provided to him by

[1] "Used" means medications that were returned by the patient in bottles, envelopes, or other receptacles that were opened and not fully depleted.

a patient, since, approximately, 1984. Dr. Hicks stored the used prescription medication inside two unlocked desk drawers in his personal medical office. Dr. Hicks locked his personal medical office door when he was not present. During the December 2, 2021, visit by the Board's investigators, the investigator located approximately 150 pill bottles with various quantities of prescription medication and some envelopes labeled with prescription drug names. Some of the medications were expired, with expiration dates as early as 1995. Some prescriptions of the medications were by Dr. Hicks, while others were by other providers. Patient names were redacted or the label was partially affixed on some containers. Some of the prescription bottles containing medication had no identifying label. Dr. Hicks did not document when prescriptions were returned. He did not log or track the used prescriptions. He would perform internet searches for images of pills to ensure that the pills were what the bottle stated they were. He generally would not track the expiration date of the medications.

Dr. Hicks did not only collect these used medications, he would also dispense them. Dr. Hicks dispensed these medications as starter dosages or to patients in acute distress. He would pull off the label and put a little note with instructions about how to take the medication. He also said he would administer the medications for patients to take immediately. In addition to dispensing to patients, Dr. Hicks also dispensed the returned medications to a family member and to a friend. Dr. Hicks does not possess, and did not possess, a State issued dispensing permit when he dispensed these medications.

Patient Specific Issues

Patient 1

Patient 1 was diagnosed with a mood disorder. Dr. Hicks also prescribed several different opioids, including hydrocodone, to Patient 1 for headaches. The State's expert testified that for the

migraines, Dr. Hicks should have referred Patient 1 to a neurologist. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone.

Patient 2

Patient 2 was being treated for anxiety and ADHD. Dr. Hicks prescribed Patient 2 very high doses of the benzodiazepine, diazepam (Valium), 15 mg per day, and prescribed the stimulant Adderall. The State's expert testified that there was not a sufficient medical justification identified for prescribing Valium or Adderall. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, and did not conduct toxicology screenings for Patient 2.

Patient 3

Patient 3 was being treated for depression and, in some notes, "bipolar depression." Patient 3 was prescribed a benzodiazepine (Klonopin), a stimulant (Adderall), and opioids (Oxycodone with acetaminophen), all in high doses. There was no indication why the stimulant was prescribed. The State's expert testified that the opioids should not have been prescribed by a psychiatrist and there was no indication for stimulant use for this patient. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone.

Patient 4

Patient 4 was being treated for depression. Dr. Hicks prescribed opioids (Oxycodone with acetaminophen) and a benzodiazepine (Xanax). Dr. Hicks also prescribed Sumatriptan for migraines and an antibiotic for a sinus infection. The State's expert report stated that the opioids and benzodiazepines were prescribed for unclear reasons. The State's expert also testified that Dr. Hicks' prescribing for a sinus infection and migraines was outside the scope of his expertise. Dr.

Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone.

Patient 5

Patient 5 was being treated for depression. Dr. Hicks prescribed to Patient 5 a benzodiazepine (Xanax), opioids, and a stimulant (Adderall) concurrently. He also prescribed cyclobenzaprine (Flexeril), a muscle relaxant. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone.

Patient 6

Patient 6 was diagnosed with depression, ADHD, and alcohol dependence. Dr. Hicks prescribed to Patient 6 the stimulant Adderall and benzodiazepines. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, and did not conduct toxicology screenings for Patient 6.

Patient 7

Patient 7 was diagnosed with depression. Patient 7 was prescribed several different anti-depressants, a benzodiazepine (Xanax) and a stimulant (Adderall). Patient 7 was taking a monoamine oxidase inhibitor (MAOI) as an anti-depressant. An MAOI is usually used as a last line of treatment, because it has significant potential side effects and can interact with different medications and foods. Dr. Hicks failed to closely monitor Patient 7's blood pressure. Patient 7 was also prescribed Atorvastatin, to control high cholesterol. Patient 7 was also prescribed opioids for anxiety, which is not an appropriate medication for that condition. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, and did not conduct toxicology screenings for Patient 7.

Patient 8

Patient 8 was diagnosed with depression. Dr. Hicks prescribed an opioid (Oxycodone), a benzodiazepine (Ativan), and a stimulant (Ritalin) concurrently. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone for Patient 8.

Patient 9

Patient 9 was prescribed a benzodiazepine (Klonopin), a stimulant (Ritalin), and an opioid (Percocet) concurrently. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone for Patient 9.

Patient 10

Patient 10 was diagnosed with bipolar depression. Dr. Hicks prescribed to Patient 10 a MAOI, an anti-psychotic, benzodiazepines, high doses of Ambien, and opioids. Dr. Hicks also managed Patient 10's hypothyroidism. Dr. Hicks did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone for Patient 10.

Patient 11

Patient 11 was diagnosed with depression. Dr. Hicks prescribed opioids (Hydrocodone with acetaminophen), a benzodiazepine (Triazolam), and a stimulant (Dextroamphetamine) concurrently. Dr. Hicks did not use a controlled substance contract, failed to check PDMP before prescribing, did not conduct toxicology screenings, and failed to prescribe naloxone for Patient 11.

Patient 12

Patient 12 was diagnosed with bipolar depression. Dr. Hicks prescribed Patient 12 two different benzodiazepines, two different depressants, an anti-psychotic, and a stimulant. He did not document why he prescribed those medications. Dr. Hicks also did not use a controlled substance contract, failed to check PDMP before prescribing, and did not conduct toxicology screenings for Patient 12.

ANALYSIS

Collecting, Storing, and Dispensing Returned Medications

Dr. Hicks accepted returned or "donated" prescription medications, including antidepressants, major tranquilizers, and CDS, and dispensed these used medications to patients, family members, and friends. The Board finds that his collection and storage of approximately 150 pill bottles and in labeled and unlabeled envelopes in his unlocked desk drawers and his dispensing of these collected medications to be highly problematic and unprofessional. As the State's expert explained, there are strict guidelines for accepting and dispensing medications and there is a danger in collecting medications. Medications can become contaminated and returned prescriptions medications are at risk of being mistakenly labeled or identified. His dispensing of these used medications to his patients, family, and friends constitutes unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii).

Further, a physician may not dispense without a dispensing permit or another limited exception for dispensing. Health Occ. § 12-102(c)(2)(ii)C specifically requires a dispensing permit to dispense medications, except for starter dosages or samples, which are required to be appropriately labeled under § 12-102(d)(2)(i) and 12-102(f)(1)(i). Because Dr. Hicks did not have

a dispensing permit and did not comply with the starter dosage or sample labeling requirements, the Panel finds that he violated Health Occ. § 14-404(a)(28).

Standard of Care Violations

"[A] physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances." *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 200 (1975).

The State's expert found there to be a violation of the standard of care for accepting returned, non-controlled and controlled substances, storing the substances in an unlocked desk and dispensing them to patients. Health Occ. § 14-404(a)(22). The Panel also finds that this practice was a violation of the standard of care.

Dr. Hicks consistently practiced outside his scope of practice.

Dr. Hicks prescribed opioids for pain for Patients 3, 4, 5, 8, 9, 10, and 11; opioids for headaches for Patient 1; Sumatriptan for migraines and antibiotics for a sinus infection for Patient 4; a muscle relaxant for Patient 5; and cholesterol medication for Patient 7. Dr. Hicks treated hypothyroidism for Patient 10. The State's expert testified that it is unusual to treat psychiatric conditions with opioids. Treating muscle pain with a muscle relaxant, Sumatriptan for migraines, Atorvastatin for cholesterol, and opioids for headaches or chronic pain are all outside of Dr. Hicks' scope of practice. The State's expert testified that it was a violation of the standard of care for Dr. Hicks to treat patients outside the scope of his expertise and that Dr. Hicks should have "stayed in his lane" and treated patients for psychiatric issues. While the State's expert conceded that it was not strictly prohibited for a psychiatrist to prescribe opioids, and a psychiatrist might, for example, prescribe it for acute pain on an in-patient unit, the State's expert said that Dr. Hick's prescribing opioids for chronic pain management in an outpatient setting was a violation of the standard of

care. As will be discussed below, Dr. Hicks did not comply with the standard of care in several aspects of his opioid treatment that may be a consequence of his acting outside the area of his expertise, such as his failing to check PDMP, failing to conduct toxicology screenings, failing to prescribe naloxone, and failing to enter into CDS contracts. The Panel agrees that Dr. Hicks repeatedly and consistently practiced outside his scope of psychiatry including treating many patients for chronic pain using opioids in a manner that violated the standard of care.

Dr. Hicks failed to check the PDMP before prescribing opioids and benzodiazepines.

Dr. Hicks failed to check the PDMP before prescribing opioids and benzodiazepines for all twelve patients. Pursuant to Health-Gen. § 21-2A-04.2(a)(1)(i), prescribers must request at least the prior 4 months of prescription monitoring data for a patient before initiating a course of treatment for the patient that includes prescribing or dispensing an opioid or a benzodiazepine. If a patient's course of treatment continues to include prescribing or dispensing an opioid or a benzodiazepine for more than 90 days after the initial request for prescription monitoring data, the provider is required to request prescription monitoring data for the patient at least every 90 days until the course of treatment has ended. Health Gen. § 21-2A-04.2(a)(1)(ii). Prescribers should assess that data when deciding whether to prescribe or dispense an opioid or benzodiazepine. Health Gen. § 21-2A-04.2(a)(1)(iii). The State's expert testified that checking the PDMP is required by the standard of care. Dr. Hicks acknowledges that he did not check the PDMP in accordance with the applicable law and that he knew about this requirement. Panel A finds this to be a violation of the standard of care for all twelve patients.

Dr. Hicks prescribed benzodiazepines and opioids concurrently.

The State's expert testified that there is a high risk of respiratory depression when a patient is taking opioids and benzodiazepines concurrently. In other words, patients may stop breathing

when these medications are taken together. Dr. Hicks concurrently prescribed opioids and benzodiazepines for Patients 3, 4, 5, 8, 9, 10, and 11. The State's expert found that his concurrent prescribing of opioids and benzodiazepines for these patients was a violation of the standard of care. Panel A accepts the State's expert's opinion and finds that Dr. Hicks violated the standard of care by prescribing opioids and benzodiazepines concurrently for those patients.

Dr. Hicks failed to conduct toxicology screenings.

For all twelve of the patients reviewed, Dr. Hicks failed to perform toxicology screenings to measure levels of medication or drugs in a patient's body; to confirm that the patients are taking the prescribed medications, such as opioids and benzodiazepines; and to determine whether the patient was taking any illicit substances or other medications that could interact negatively with the medications he was prescribing. The State's expert found that failing to conduct toxicology screenings was a violation of the standard of care and the Panel agrees.

Dr. Hicks failed to have patients sign controlled substance agreements.

Dr. Hicks did not require that his patients sign a controlled substances agreement or contract when he prescribed them CDS for chronic use. These agreements are between the prescriber and patient, and they document how the medications are going to be prescribed, the purpose and elements, and what measures the patient needs to follow. The State's expert found the failure to enter into controlled substance agreements to be a violation of the standard of care, and Panel A agrees with the State's expert.

Dr. Hicks prescribed an MAOI inappropriately.

The State's expert testified that to take an MAOI, as usually a last line of treatment, the physician needs to monitor blood pressure closely. Additionally, an MAOI should not be used for patients who are also using stimulants. Dr. Hicks treated Patients 7 and 10 with an MAOI and

prescribed stimulants concurrently and did closely monitor the patients' blood pressure at each visit. According to the State's expert, this was a violation of the standard of care, and the Panel agrees.

Failure to prescribe naloxone (Narcan) to patients prescribed opioids.

Dr. Hicks failed to prescribe naloxone, an opioid antagonist that can reverse an unintentional opioid overdose, to patients who were dispensed or prescribed opioids. Patients 1, 3, 4, 5, 8, 9, 10, and 11 were prescribed opioids for pain, but were not prescribed naloxone. The State's expert opined that failing to prescribe naloxone for these patients who had been prescribed opioids was a violation of the standard of care. Panel A agrees and finds that Dr. Hicks violated the standard of care by failing to prescribe naloxone to those patients.

Adequacy of the Medical Records

At the exceptions hearing, Dr. Hicks' counsel noted that "he's aware of the fact that he needs to bring his record keeping in line with more modern practices in in terms of the use of [Electronic Medical Records.]" The State's expert noted that many of Dr. Hicks' records were concerning because they lacked clarity and were difficult to follow; however, the State's expert found no violation for the records of ten patients despite these shortcomings. The Panel finds no violation for failing to keep adequate medical records for any of the patients at issue.

Failing to Cooperate with a Lawful Investigation of the Board

The Board subpoenaed the records of twelve of Dr. Hicks' patients. The subpoena required the immediate production of the medical and billing records for Patients 1 and 2 on December 2, 2021, and the medical and billing records for Patients 3-12 within 10 business days after December 2, 2021. Dr. Hicks provided handwritten notes for Patients 1 and 2. On December 21, 2021, Dr. Hicks, through counsel, requested that the timeframe for the records be limited to five years and

requested an extension. The Board agreed to limit the duration of the subpoena from January 1, 2016, to the subpoena date and provided an extension until January 7, 2022, to produce the records. On January 6, 2022, Dr. Hicks, through counsel, requested an additional extension and the Board responded by providing an additional extension until January 14, 2022. On January 14, 2022, Dr. Hicks, through counsel, provided the records for Patients 1 and 2 and informed the Board that he was not able to provide the remaining records for Patients 3-12 by January 14, 2022, but would continue to gather and produce the remaining records as promptly as possible. The Board received the remaining records piecemeal, with four more patient records produced in January, two more patient records produced in February, and three produced in March. A supplement for Patient 1 was produced in April and the final records in response to the December 2, 2021 subpoenas were not produced until May 18, 2022. The full production took over four additional months after the initial required production date. The Panel finds that his failure to provide the records by the twice extended deadline constituted a failure to cooperate with the Board's subpoenas, in violation of Health Occ. § 14-404(a)(33).

DR. HICKS' EXCEPTIONS

Dr. Hicks admits to several of the alleged violations. Dr. Hicks admitted that he violated the standard of care, Health Occ. § 14-404(a)(22), by failing to check the PDMP. He admitted that he dispensed medications without a dispensing permit and that doing so was a violation of the requirements for Maryland physicians. Dr. Hicks does not challenge the charges of unprofessional conduct, Health Occ. § 14-404(a)(3)(ii); dispensing without a permit, Health Occ. § 14-404(a)(28); and failing to cooperate with a Board investigation, Health Occ. § 14-404(a)(33). Dr. Hicks, however, objects to the standard of care and recordkeeping violations, as discussed below.

The subject of the initial complaint was closed without finding a violation.

Dr. Hicks first argues that because the underlying anonymous complaint, which alleged misconduct, was never proven, it was, therefore, improper for the Board to continue to pursue its investigation. The Board's investigation indicated several significant violations, including violations that Dr. Hicks does not dispute. Dr. Hicks cites to no law and presents no arguments why violations of the Maryland Medical Practice Act, Health Occ. §§ 14-101—14-702, should be ignored simply because the allegations that are the subject of the charges were not contained as part of the original complaint. Indeed, it would be harmful to the public to ignore dangerous conduct or violations of the practice act uncovered by an investigation simply because the complaint was not substantiated. The Board follows the facts that are uncovered from its investigation of the complaint. The Panel rejects this exception.

The Board investigator requested immediate production of records without notice.

Dr. Hicks argues that the Board's attempt to enforce a subpoena against Dr. Hicks was improper because the subpoena, which was served during an in-person visit, demanded immediate production of documents and because Dr. Hicks was not informed at that time of his right to counsel.

Dr. Hicks argues that the Board was not permitted to require immediate production of the records in response to the subpoena, but he cites to no legal authority prohibiting subpoenas requiring immediate production. The Board is unpersuaded that the subpoena for immediate production was inappropriate in this circumstance, because the documents concerning Patients 1 and 2 could have been destroyed or modified. Even for Patients 1 and 2, Board staff allowed additional time to produce the records that concerned the standard of care and recordkeeping. The Board considered all the produced records for his standard of care violations, including those

produced months later, in April 2022. With respect to the recordkeeping violations, because the Panel has dismissed the recordkeeping charge, this issue is moot.

Dr. Hicks also argues that the Board's attempt to enforce a subpoena during an in-person visit that demanded immediate production of documents was improper because Dr. Hicks was not informed at that time of his right to counsel. An individual may "be represented by counsel . . . during any stage of the disciplinary proceedings." COMAR 10.32.02.03F(1). Dr. Hicks appears to suggest that there is a *Miranda* warning requirement for a *subpoena duces tecum*, however, *Miranda* warnings only apply to custodial interrogations in criminal investigations. *State v. Thomas*, 282 Md. App. 545, 565 (2011) (citing *J.D.B. v. North Carolina*, 564 U.S. 261, 269 (2011)). There is simply no requirement that the Board provide the equivalent of *Miranda* rights during its service of a subpoena in an administrative investigation.

Dr. Hicks' handwritten notes

Dr. Hicks argues that his handwritten notes are not part of the "official" record and should not have been considered when analyzing his records. The Panel does not understand the distinction that Dr. Hicks is arguing between official records and handwritten notes, but because the Panel has dismissed the recordkeeping charge, the Panel need not make a finding on this issue and declines to do so.

The Board did not request additional records prior to submitting records to peer review while the peer review only covered the most recent six-year period.

Dr. Hicks argues that the Board erred in having the peer reviewers review six years of records "without making any attempts to obtain a full and complete set of records." Dr. Hicks' production, however, was limited to six years at his own request. Dr. Hicks, through his counsel, notified the Board that some patients had a 20-to-30-year history, and the production of the records

would constitute "a significant . . . burden." Dr. Hicks requested that the production of the records be limited to the time starting in January 2016. Dr. Hicks wrote that "[i]f at a later date the Board perceives that there is a need to go back further in time we would then be able to provide these additional records as indicated." The Board granted this request.

Dr. Hicks' assertion that the Board never attempted to obtain the full records is not an accurate claim. Contrary to Dr. Hicks' claim, the Board attempted to obtain the full records when it issued its subpoenas. It was only because of Dr. Hicks' own request to limit the production, to the period starting in 2016, that the Board limited its demand to six years. Indeed, it took about five months just to receive the six years of records and no doubt would have taken much longer to receive the full records for thirty years of patient records.

However, the central issue to the Panel is whether the State's expert was able to make determinations about whether the standard of care had been met based on the records she received. The State's expert explained, "I was able to conduct a full peer review. . . . Because I was still able to understand the medications prescribed, and still able to determine that it was still a breach of the standard of care." The State's expert determined that she could make such determinations without the full thirty years of records. The Panel accepts the State's expert's assessment of the records needed for a proper review. As discussed above, many of the specific violations found were based on issues that occurred during the six-year period. For example, Dr. Hicks failed to check the PDMP in accordance with the statutory requirements, failed to perform toxicology screenings, failed to prescribe naloxone, and did not enter into pain agreements with patients between 2016 and 2022.

Dr. Hicks claims that he was critiqued for his records not being sufficiently comprehensive or explaining a treatment history or diagnosis, and he further claims that such information was in

older records that existed but were never produced. In his exceptions, Dr. Hicks does not provide any specific examples or cite to any of the full records he produced that rebut any of the standard of care violations charged. Even at the hearing at OAH, the only specific challenge to a specific conclusions of the State's expert was Dr. Hicks' testimony regarding a single alleged deficiency for a single patient, Patient 10. Dr. Hicks challenged the State's expert's report's statement that an MAOI was prescribed for unclear reasons and should not be used as a first line treatment given the high risk for hypertensive crisis. Dr. Hicks testified that the MAOI was not prescribed as the first line treatment, and several different medications were attempted first. Dr. Hicks did not cite to any evidence (testimonial or additional medical records) to refute the inappropriate co-prescribing of an MAOI and stimulants, to rebut that it was below the standard of care to fail to check blood pressure while prescribing an MAOI or to address any violations pertaining to any of the other eleven patients. In this Order, the Panel found violations for Dr. Hicks practicing outside the scope of practice, failing to check the PDMP before prescribing opioids and benzodiazepines, prescribing benzodiazepines and opioids concurrently, failing to conduct toxicology screenings, failing to have patients sign controlled substance agreements, and failing to prescribe naloxone (Narcan) to patients prescribed opioids, and prescribing an MAOI inappropriately. Dr. Hicks's exceptions regarding the standard of care did not cite to any records unavailable to the State's expert that he claims would have changed her conclusions on these topics.

The Panel declines to reject the ALJ's ruling based on vague conclusory statements that claims that older records not considered by the State's expert change the conclusion about whether the standard of care was met, without explanation or citation to specific records.

The Standard of Care Violations

Dr. Hicks claims, "there was no underlying legal basis or requirement for multiple of the 'standard of care' criticisms he proceeded to render against Dr. Hicks as an expert," including the need for toxicology screenings for patients prescribed opioids. In this exception, Dr. Hicks seems to suggest that all medical treatment requirements cannot be found to be violations unless the requirements are expressly stated in statute or regulation. Dr. Hicks seems to misunderstand the concept of the "standard of care." Dr. Hicks was under a duty to use that degree of care and skill which is expected of a reasonably competent psychiatrist acting in the same or similar circumstances. The state presented such evidence through the expert report and expert testimony of one of the peer reviewers. The ground at issue, Health Occ. § 14-404(a)(22), expressly anticipates that the Panel will determine whether the licensee has met the standard of care as determined by expert peer review rather than rules explicitly laid out in a statute. *See State Board of Physicians v. Bernstein*, 167 Md. App. 714, 728 (2006) ("The focus of the hearing was expert testimony about the appropriate standard of care."). This exception is denied.

The expert was sent the complaint, interview transcripts, and a site visit memorandum.

Dr. Hicks next claims that the expert peer reviewer should not have been sent Dr. Hicks' interview transcripts, a site visit memorandum, or the complaint, because those materials were prejudicial. Specifically, Dr. Hicks posits that by merely possessing the allegations of sexual misconduct contaminates the expert's opinion regarding the standard of care violations.

The ALJ was able to assess the credibility and potential bias of the witness and found no bias. While not an identical situation, the Court of Appeals of Maryland (now the Maryland Supreme Court) rejected the proposition that "the combination of investigative and adjudicative functions necessarily creates an unconstitutional risk of bias in an administrative adjudication."

Consumer Protection Div. v. Morgan, 387 Md. 125, 194 (2005). In that case, the Court rejected a claim that members who participate in an investigation are disqualified from adjudicating, holding "that the Consumer Protection Division does not violate Maryland's or the Federal Constitution's Due Process provisions when it investigates, prosecutes, and adjudicates a case," because "there is no evidence in the record of special facts and circumstances posing an intolerably high risk of unfairness." *Id.* at 194, 195. Just as the Maryland Supreme Court found that actively investigating a matter does not create an intolerably high risk of unfairness by the adjudicating body, here, the expert's exposure to allegations under investigation are not special facts or circumstances that create an intolerably high risk of unfairness.

The State's expert stated, "my review is based on the medical records" and that she guarded against potential biasing information by "reviewing one chart at a time and taking breaks" and confirmed that, regarding the additional information, "I don't think it changes what I write for each of the charts." The State's expert's descriptions of violations were well-founded and based on a thorough review of the medical records. And the Panel's decision is based on the expert testimony and opinions regarding the medical charts and the specific violations that the expert found. The Panel does not find that providing the complaint or interview transcripts at issue prejudiced the expert's findings. The exception is denied.

The expert was consulted by the prosecutor before charges were issued.

The expert provided a peer review report on November 30, 2022, that found a violation of the standard of care in all twelve cases reviewed. Dr. Hicks provided a response to the peer review reports, on December 19, 2022. Board Panel B voted to issue charges on January 25, 2023. At some point before March 21, 2023, when the charges were issued, the administrative prosecutor contacted the State's expert to review the draft charges. Dr. Hicks incorrectly claims that the

expert "help[ed] draft [the] charging document." The expert testified that she only reviewed the charging document after it was drafted. Dr. Hicks then argues that it was improper for the expert to review the charges drafted by the administrative prosecutor before they are issued, suggesting that it is akin to a judge allowing a prosecution witness to help decide the judgment. The administrative prosecutor, however, is akin to a prosecutor, not a judge. This situation is an example of a prosecutor consulting with the prosecution's witness. Dr. Hicks does not articulate in what way a prosecutor consulting with a prosecution witness to assure the accuracy of the charging document would create bias. Rather he just claims that the expert was a "honorary administrative prosecutor," and such a consultation is "disturbing on its face," and he questions the "legitimacy and objectivity" of the expert. The administrative prosecutor committed no error in consulting with the State's expert to assure that the charges as drafted were a fair and accurate summary of the violations and did not contain any mischaracterizations of the State's expert's conclusions. The Panel believes that the administrative prosecutor's consultation with the State's expert was appropriate. The Panel denies Dr. Hicks' exception.

CONCLUSIONS OF LAW

Based on the foregoing conduct, Disciplinary Panel A concludes, as a matter of law, that Dr. Hicks: is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); failed to meet appropriate standards, as determined by appropriate peer review, for the delivery of quality medical and surgical care in this State, in violation of Health Occ. § 14-404(a)(22); failed to comply with the provisions of section 12-102 of the Health Occupations Article, in violation of Health Occ. § 14-404(a)(28); and failed to cooperate with a lawful investigation conducted by the Board, in violation of Health Occ. § 14-404(a)(33). The

Panel dismisses the charge of failing to keep adequate medical records, Health Occ. § 14-404(a)(40).

SANCTION

As a sanction, the ALJ recommended that the Board impose a reprimand; one-year probation; a permanent prohibition on applying for a dispensing permit; a permanent prohibition from prescribing opioids; a permanent prohibition from taking patients used, donated or returned prescription drugs or other medications;, an affidavit attesting compliance with the forgoing prohibitions; an affidavit attesting that he did not possess used, donated, or returned prescription medications during the probation period; a course in medical recordkeeping and CDS prescribing prior to the end of the one-year probation; and a $5,000 fine.

The ALJ explained that the Board's mission is to protect the public and not to punish physicians. The ALJ cited the sanctioning guidelines, which provide for sanctions between a reprimand and revocation for grounds (3)(ii), (22), and (33), and between a Reprimand and two-year Suspension for ground (28). COMAR 10.32.02.10B. The fines range between $10,000 to $25,000 for ground (3)(ii), between $5,000 and $50,000 for ground (22), $2,500 and $50,000 for ground (28), and between $10,000 and $50,000 for ground (33). COMAR 10.32.02.10B. The ALJ recognized applicable mitigating factors, finding that Dr. Hicks voluntarily admitted failing to secure and improperly dispensing prescription medications, and made full disclosure. Dr. Hicks further implemented remedial measures and made good faith efforts to rectify the consequences of his misconduct, has rehabilitation potential, and did not act in a premeditated fashion. The ALJ also considered aggravating factors, such as a pattern of detrimental conduct and that his actions make it difficult for future physicians to conduct proper follow-up.

The Panel has considered the mitigating factors that apply to Dr. Hicks' case, including his lack of disciplinary history, his voluntary admission of some of the misconduct, and his rehabilitative potential. COMAR § 10.32.02.09(B)(5). The Panel has also considered the aggravating factors including, the potential for patient harm and that he engaged in a pattern of misconduct. COMAR § 10.32.02.09(B)(6).

Both parties agree that a reprimand, probation, and coursework on CDS and recordkeeping are appropriate, and exceptions were not filed regarding these sanctions. At the exceptions hearing Dr. Hicks' counsel specifically stated "[Dr. Hicks]'s accepting of . . . the recommended class of coursework on recordkeeping practices." The Panel adopts those agreed upon sanctions of reprimand, probation, and coursework on CDS and recordkeeping.

Dr. Hicks takes exception to the ALJ's permanent prohibitions on: prescribing opioids, dispensing medications, and obtaining a dispensing permit. He claims there is insufficient legal foundation concerning his standard of care and that his prescribing practices should not be permanently impaired. The State argued in response that these sanctions were commensurate with the dangerous nature of his prescribing and dispensing practices and will protect the public from potential future harm.

The Panel agrees that, had it adopted Dr. Hicks' conclusion that the standard of care was met, it may have removed the permanent conditions on dispensing and prescribing opioids. However, the Panel adopted the ALJ's findings regarding the standard of care violations and finds these violations to be quite worrisome. Dr. Hicks prescribed outside his area of expertise, most notably, prescribing opioids for chronic pain in an outpatient psychiatric setting. Dr. Hicks prescribed benzodiazepines and opioids concurrently. The concurrent use of opioids and benzodiazepines significantly increases the risk of respiratory depression. Dr. Hicks failed to

prescribe naloxone, an opioid antagonist that can prevent overdose. He failed to obtain controlled substance agreements from his patients. His patients were never required to have toxicology screenings, making it difficult to determine whether the patients were taking their medications as prescribed or taking any other medications that could have negative outcomes in concert with his opioid prescribing. The Panel finds that these practices substantially increase the risk for consequential negative patient outcomes. Dr. Hicks has not acknowledged that he committed any of these errors and contended that he did nothing wrong aside from failing to check the PDMP. Based on his failure to acknowledge these deficiencies as violations, even after these problems were identified by the State's expert, Panel A is not confident that Dr. Hicks will change his behavior voluntarily and believes that that Dr. Hicks would continue to prescribe opioids outside his psychiatry specialty and without following the standard of care, if these conditions are not imposed. As such, a permanent prohibition on prescribing opioids is warranted. The Panel will adopt the ALJ's permanent restriction on opioid prescribing.

Dr. Hicks admitted that he erred when he collected and re-dispensed medications, including CDS. However, the Panel believes Dr. Hicks should have known this was inappropriate. As the ALJ noted, secondhand medicines are not reliable and there are no guarantees that such medicines have not been compromised in ways that are unseen or unforeseen to a practitioner. The Panel finds this violation egregious, and the Panel believes it is necessary for the health and safety of the public for Dr. Hicks to cease all dispensing in his practicing, not apply for a dispensing permit in the future, and cease collecting and storing used or donated prescriptions. The Panel will change the affidavit of compliance provided quarterly for the duration of probation to a permanent condition requiring an affidavit of compliance provided annually.

The State takes exception to the ALJ's proposed sanction as well. The State argues that the Panel should require Dr. Hicks to utilize a supervisor and should increase the fine from $5,000 to $10,000. The State argues that a supervisor would aid him in complying with the standard of care, recordkeeping, and with his billing practices. The State also argues that a $10,000 fine would be more commensurate with the conduct at the hearing and his "flash of hubris and annoyance with criticism" during the hearings. Dr. Hicks argues that a supervisor is unnecessary to confirm his participation in appropriate recordkeeping and CDS classes and is unnecessary to ensure compliance with his billing process, which was not at issue in this case. He also claims that a $10,000 fine is unwarranted in light of his clear attempts at rehabilitation.

As to the State's exceptions, the Panel agrees with the State that Dr. Hicks' violations regarding the standard of care are serious. Dr. Hicks characterizes the role of supervision as serving merely as a method to assure that an individual is attending a course. That is not the goal or value in imposing supervision. Supervision will provide Dr. Hicks with one-on-one training with a supervisor who will review his patient records with him and provide Dr. Hicks with direct feedback and recommendations regarding how to improve his practice. Considering the significant deficiencies regarding the standard of care, the Panel agrees with the State that a supervisor is crucial to provide Dr. Hicks with necessary feedback to improve his practice to align with the appropriate standard of care. The Panel, therefore, will adopt this recommended change to the ALJ's proposed sanction. The Panel, however, agrees with the ALJ that the $5,000 fine is an adequate monetary sanction for the violations presented in this matter.

The Panel, thus, will impose a reprimand; permanent prohibitions on prescribing opioids, dispensing medications, and obtaining a dispensing permit, with annual affidavits to confirm these prohibitions are being met; and will impose probation for one year, which will include the

requirements that Dr. Hicks complete courses in recordkeeping and CDS prescribing, within six months; and that he receives supervision, for a minimum of one year, from a supervisor, who shall provide the Panel with four quarterly reports to the Board; and a $5,000 fine is imposed.

ORDER

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

ORDERED that **CHARLES W. HICKS III, M.D.**, is **REPRIMANDED**; and it is further

ORDERED that Dr. Hicks is **PERMANENTLY PROHIBITED** from accepting used, donated, or returned prescription medications; and it is further

ORDERED that Dr. Hicks is **PERMANENTLY PROHIBITED** from applying for a dispensing permit; and it is further

ORDERED that Dr. Hicks is **PERMANENTLY PROHIBITED** from dispensing prescription medications, and **PERMANENTLY PROHIBITED** from dispensing starter doses or samples of medication; and it is further

ORDERED that Dr. Hicks is **PERMANENTLY PROHIBITED** from prescribing opioids beginning 30 days from the date of this order; and it is further

ORDERED that on every January 31st thereafter, if Dr. Hicks possesses a Maryland medical license, he shall provide the Board with an affidavit verifying that he has not applied for a dispensing permit, dispensed any prescriptions, prescribed opioids, and that he did not receive any used, donated, or returned prescription drugs or medications in the past year; and it is further

ORDERED that, if Dr. Hicks fails to provide the required annual verification of compliance with this condition:

(1) there is a presumption that Dr. Hicks has violated the permanent condition; and
(2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing.

IT IS FURTHER ORDERED that Dr. Hicks is placed on **PROBATION** for a minimum period of **ONE YEAR.**[2] During the probationary period, Dr. Hicks shall comply with the following probationary terms and conditions:

(1) Within **SIX MONTHS,** Dr. Hicks is required to take and successfully complete courses in: (1) medical recordkeeping, and (2) Controlled Dangerous Substances (CDS) prescribing. The following terms apply:

(a) It is Dr. Hicks' responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses begin;

(b) Dr. Hicks must provide documentation to the disciplinary panel that he has successfully completed the courses;

(c) The courses may not be used to fulfill the continuing medical education credits required for license renewal;

(d) Dr. Hicks is responsible for the cost of the courses;

(2) Within **ONE YEAR,** Dr. Hicks shall pay a civil fine of **$5,000.** The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate Dr. Hicks' license if Dr. Hicks fails to timely pay the fine to the Board; it is further

(3) Dr. Hicks shall be subject to supervision for a minimum of **ONE YEAR** by a disciplinary panel-approved supervisor, who is board-certified in Psychiatry, as follows:

(a) within **30 CALENDAR DAYS** of the date of this Order, Dr. Hicks shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom Dr. Hicks is offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of Dr. Hicks and that there is no personal or professional relationship with the supervisor;

(b) Dr. Hicks' proposed supervisor, to the best of Dr. Hicks' knowledge, should not be an individual who is currently under investigation, and has not been disciplined by the Board within the past five years;

[2] If Dr. Hicks' license expires while he is on probation, the probationary period and any probationary conditions will be tolled. COMAR 10.32.02.05C(3).

(c) if Dr. Hicks fails to provide a proposed supervisor's name within 30 calendar days from the effective date of the order, Dr. Hicks' license shall be automatically suspended from the 31st day until Dr. Hicks provides the name and background of a supervisor;

(d) the disciplinary panel, in its discretion, may accept the proposed supervisor or request that Dr. Hicks submit a name and professional background, and written notice of confirmation from a different supervisor;

(e) the supervision begins after the disciplinary panel approves the proposed supervisor;

(f) the disciplinary panel will provide the supervisor with a copy of this Final Decision and Order and any other documents the disciplinary panel deems relevant;

(g) Dr. Hicks shall grant the supervisor access to patient records selected by the supervisor from a list of all patients, which shall, to the extent practicable, focus on the type of treatment at issue in Dr. Hicks' charges;

(h) if the supervisor for any reason ceases to provide supervision, Dr. Hicks shall immediately notify the Board and shall not practice medicine beyond the 30th day after the supervisor has ceased to provide supervision and until Dr. Hicks has submitted the name and professional background, and written notice of confirmation, from a proposed replacement supervisor to the disciplinary panel;

(i) it shall be Dr. Hicks' responsibility to ensure that the supervisor:

(1) reviews the records of 10 patients each month, such patient records to be chosen by the supervisor, and not chosen by Dr. Hicks;
(2) meets in-person with Dr. Hicks at least once each month and discuss in-person with Dr. Hicks the care Dr. Hicks has provided for these specific patients;
(3) be available to Dr. Hicks for consultations on any patient;
(4) maintains the confidentiality of all medical records and patient information;
(5) provides the Board with a minimum of **FOUR** quarterly reports which detail the quality of Dr. Hicks' practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and
(6) immediately reports to the Board any indication that Dr. Hicks may pose a substantial risk to patients;

(j) Dr. Hicks shall follow any recommendations of the supervisor;

(k) if the disciplinary panel, upon consideration of the supervisory reports and Dr. Hicks' response, if any, has a reasonable basis to believe that Dr. Hicks is not

meeting the standard of quality care or failing to keep adequate medical records in his practice, the disciplinary panel may find a violation of probation after a hearing; and it is further

ORDERED that, after Dr. Hicks has complied with all terms and conditions of probation, including the receipt of four satisfactory reports from the peer supervisor, and the minimum period of probation imposed by the Final Decision and Order has passed, Dr. Hicks may submit to the Board a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. Dr. Hicks may be required to appear before the disciplinary panel to discuss his petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if Dr. Hicks has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that a violation of probation constitutes a violation of this Order; 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 the disciplinary panel which has imposed the terms and conditions of this Order; and it is further

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

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

ORDERED that after the appropriate hearing, if the disciplinary panel determines that Dr. Hicks has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand Dr. Hicks, place him on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke his 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. Hicks; and it is further

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

01/24/2025
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. Hicks 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. Hicks 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