IN THE MATTER OF	*	**BEFORE THE**
SHABNAM DADGAR, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D72779	*	**Case Number: 2223-0016**

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FINAL DECISION AND ORDER

PROCEDURAL HISTORY

Shabnam Dadgar, M.D., is board-certified in Obstetrics and Gynecology and was originally licensed to practice medicine in Maryland in 2011. On September 23, 2023, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Dr. Dadgar with "failing to meet appropriate standards, as determined by appropriate peer review, for the delivery of quality medical and surgical care" (the "standard of care") and "failing to keep adequate medical records." Md. Code Ann., Health Occ. § 14-404(a)(22), and (40). The charges alleged that Dr. Dadgar failed to request, obtain, and review the Patient's prior medical records, failed to engage in differential diagnosis or consider other diagnoses when treating the patient, and conducted invasive procedures without indication and without patient consent.

On March 4, 5, 6, 7, and 11, 2025, an Administrative Law Judge ("ALJ") held an evidentiary hearing at the Office of Administrative Hearings ("OAH") via Webex. At the hearing, the ALJ admitted into evidence sixteen joint exhibits, five exhibits introduced by the State and fourteen exhibits introduced by Dr. Dadgar. The State presented testimony from a Board compliance analyst, a physician and a Certified Registered Nurse Practitioner from the hospital that Dr. Dadgar performed the procedures (the "Hospital"), and a physician expert (the "State's

expert"). Dr. Dadgar testified on her own behalf and presented a physician expert ("Dr. Dadgar's expert").

On June 9, 2025, the ALJ issued a proposed decision concluding, as a matter of law, that Dr. Dadgar failed to meet the standard of care, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40). As a sanction, the ALJ recommended a reprimand and a suspension until she undergoes an evaluation by the Maryland Professional Rehabilitation Program ("MPRP") to determine whether she is fit to practice medicine safety. Upon her return to practice, Dr. Dadgar would be placed on probation for one year with a peer supervisor with relevant terms and conditions.

Dr. Dadgar filed twenty-two pages of written exceptions, and the State filed a Motion to Strike, claiming the exceptions violated the Board's regulations that limit exceptions to fifteen pages. Dr. Dadgar did not respond. The Disciplinary Panel A Chair granted the motion but allowed Dr. Dadgar to resubmit written exceptions within the page limit. Dr. Dadgar resubmitted exceptions. The State filed a response. Dr. Dadgar's written exceptions claimed that the ALJ committed legal and factual errors in finding a violation of the standard of care and recordkeeping, Health Occ. § 14-404(a)(22) and (40), objected to questions pertaining to Dr. Dadgar's religion, and objected to the proposed sanction. The State responded that Dr. Dadgar failed to comply with the standard of care, rebutted Dr. Dadgar's legal and factual arguments, and claimed the sanction was appropriate. On August 13, 2025, counsel for both parties appeared before Disciplinary Panel A (the "Panel") of the Board for an exceptions hearing. At the hearing, Dr. Dadgar focused on questions pertaining to Dr. Dadgar's religion and the sanction.

FINDINGS OF FACT

The Panel adopts the parties' Stipulations of Fact ¶¶ 1-6 and ALJ's Proposed Findings of Fact ¶¶ 1-2, 4-39 and, except as expressly stated in this decision, the Discussion section. The ALJ's Stipulations of Fact ¶¶ 1-6, Proposed Findings of Fact ¶¶ 1-2, 4-39, and the Discussion (pages 12-29) are incorporated by reference into the body of this document as if set forth in full. *See* attached ALJ Proposed Decision, Exhibit 1. Finding of Fact 3 is not adopted and replaced with the following:

3. On June 15, 2021, Disciplinary Panel B reprimanded the Respondent's license, permanently prohibited her from performing cryosurgery, required her to take a course in medical recordkeeping, and fined her $7,500.

The findings of fact were proven by the preponderance of the evidence and are summarized below:

Dr. Dadgar is licensed to practice medicine in the State of Maryland, license number D72779, with an expiration date of September 30, 2026, and was licensed to practice in Maryland during the relevant period.

On September 12, 2021, a fifteen-year-old female (the "Patient") obtained a COVID-19 vaccine. On September 16, 2021, the Patient presented at the emergency department of a hospital ("Hospital 2")[1] complaining of pain and vaginal itching. After a physical examination and sexually transmitted disease testing and infectious disease workup, the differential diagnosis was vulvar ulcers that appeared to be Lipschütz ulcers. The Patient was discharged with pain medications, ice packs and lidocaine jelly, and instructed to be seen for follow-up in two weeks. Lipschütz

[1] For confidentiality and privacy reasons, the patient and hospitals referenced in this document will not be identified by name.

ulcers are painful genital ulcers which typically occur in sexually inactive young women. It is a rare condition and a diagnosis of exclusion, where other conditions must be ruled out. On September 17, 2021, the Patient went to the emergency department at Hospital 3, complaining of worsening vaginal pain, inability to sit or lay down, accompanied by nausea and vomiting. She was again diagnosed with Lipschütz ulcers and discharged. Later on Friday, September 17, 2021, the Patient arrived at Dr. Dadgar's medical practice after being referred by her pediatrician, presenting with vaginal ulcers and extreme pain. The Patient's mother told Dr. Dadgar that she had been seen in the emergency department for the ulcers.

Dr. Dadgar was unable to obtain a urine sample or perform a complete or adequate physical examination due to the Patient's pain and discomfort. Dr. Dadgar facilitated the overnight admission of the Patient to the pediatric unit of the Hospital, so she could examine her the following day, because the Patient could not return to the office due to religious observance, and Dr. Dadgar was concerned about urinary retention. Dr. Dadgar observed the Patient at the Hospital on September 18 and 19, 2021. On September 19, 2021, the Patient remained in unbearable pain and Dr. Dadgar was unable to perform a physical examination, so it was decided that Dr. Dadgar would perform a physical examination and vaginoscopy under anesthesia. Dr. Dadgar obtained written consent from the Patient's parents to perform a vaginoscopy under anesthesia and a pelvic ultrasound.

While the Patient was under anesthesia, Dr. Dadgar collected samples and biopsies of the vulvar ulcers, however, also conducted a sexual assault forensic evaluation on the Patient and measured the vagina to assess her virginity. Dr. Dadgar had not obtained consent from the Patient or her parents to conduct a sexual assault forensic evaluation. Dr. Dadgar also did not obtain consent to conduct an examination to measure the vagina to assess the Patient's virginity or sexual

naivety. While the Patient was under anesthesia, Dr. Dadgar measured the Patient's vagina, both by measuring the length with a scope and by inserting fingers into her vagina and three fingers into the Patient's rectum to determine whether the patient was sexually naïve because she suspected sexual assault. Dr. Dadgar took photographs of the "virginity testing" utilizing the vaginoscopy scope. As discussed further below, the American College of Obstetrics and Gynecology has stated that virginity testing is not medically indicated or a valid medical procedure. During the procedure, the crisis center was contacted and Dr. Dadgar collected samples for a rape kit. Hospital staff informed the Patient's parents that a report of suspected sexual assault would be made to child protective services. The Patient's parents became upset and fired Dr. Dadgar. The patient was transferred to another hospital, Hospital 4, on September 21, 2021. The Patient's pain decreased, and the Patient was discharged from Hospital 4 on September 23, 2021. The discharge diagnosis was Lipschütz ulcers.

On November 10, 2021, the Board received a Mandated 10-Day Report from the Hospital noting concerns about Dr. Dadgar's "behavior, poor judgment and poor documentation in the medical record." The Board initiated an investigation and received a written response from Dr. Dadgar on January 13, 2021. The Board subpoenaed the Patient's medical records from each of the hospitals and from Dr. Dadgar and sent them for peer review by two doctors who were board certified in obstetrics and gynecology. The peer reviewers determined that Dr. Dadgar violated the standard of care and kept inadequate medical records. The peer reviews were provided to Dr. Dadgar, who, on March 23, 2023, submitted a supplemental report that was considered by Panel B. On September 23, 2023, Panel B issued charges against Dr. Dadgar.

ANALYSIS

Standard of Care Violations

Disciplinary Panel B charged Dr. Dadgar with a violation of the standard of care. "[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).

At the evidentiary hearing, the State introduced a witness who was admitted as an expert in overall general medical specialty of obstetrics and gynecology, including gynecological care provided to pediatric and adolescent patients. More specifically, he was also admitted as an expert in gynecological exams generally including pediatric and adolescent patients and including informed consent. He was admitted as an expert in the evaluation, diagnosis, and treatment of gynecological conditions, including Lipschütz ulcers, and an expert in the evaluation, diagnosis and treatment of suspected sexual abuse or assault in patients including mandated reporting requirements, and an expert in complete medical documentation in OB/GYN care. This expertise was found based on his practice for the past nineteen years in the United States as a subject matter expert for the credentialing board of obstetricians and as a gynecologist who had seen hundreds or more children and adolescents. Dr. Dadgar's witness was accepted as an expert in obstetrics and gynecology with a subspecialty focused on the practice of pediatric and adolescent gynecology.

The State's expert found a violation of the standard of care by Dr. Dadgar because she did not engage in appropriate medical decision making, specifically, she failed to consider a differential diagnosis. A differential diagnosis is a process to determine the cause of a patient's symptoms. By taking a patient's history including prior treatments, conducting an examination, and performing testing, a physician can confirm, refute or otherwise diagnose the condition

through this differential diagnosis process. In her outpatient location, Dr. Dadgar was unable to examine the Patient's ulcers due to the Patient's pain and was able to take only a limited history. However, Dr. Dadgar's assessment included pruritus vulvae (which means itching), acute vaginitis, acute vulvitis, encounter for examination and observation for other specified reasons, and other specified noninflammatory disorders of vulva and perineum. This very limited differential diagnosis was insufficient and did not consider Lipschütz ulcers on the list of possible diagnoses. At the Hospital, Dr. Dadgar continued the evaluation. The patient notes reflect that a history was taken from the Patient without her mother present. The plan at the Hospital was to continue antibiotics and antivirals, but the medical records contained no explanation of what condition those medications would be treating. Dr. Dadgar did not further explain her differential diagnosis in her operative note either. Dr. Dadgar's notes and analysis never considered the possibility of Lipschütz ulcers, the diagnosis ultimately found by medical professionals at all three other hospitals where the Patient was seen and medically evaluated.

Instead, Dr. Dadgar focused on sexual abuse as the cause for the Patient's vulvar lesions, which prevented her from considering other possible diagnoses.[2] Specifically, Dr. Dadgar claimed to "recognize[] almost immediately the tell-tale signs of sexual assault." Having made this conclusion, Dr. Dadgar sought to perform an examination under anesthesia to assess sexual assault or abuse and to ascertain whether the vagina was consistent with the family's claim that the Patient was sexually naïve. However, Dr. Dadgar did not obtain informed consent for these procedures from either the family or the Patient herself, and, instead, obtained informed consent for a

[2] The motivations for Dr. Dadgar's "tunnel vision" in concluding sexual assault are irrelevant to the Panel's determination. The Panel need not determine Dr. Dadgar's rationale for focusing on sexual abuse as the cause of the ulcers to the exclusion of other diagnoses, but merely that she did so.

vaginoscopy (using a scope to visualize the inside of the vagina) under anesthesia and an ultrasound to ostensibly further investigate the lesions/ulcers. Dr. Dadgar's failure to obtain consent before performing a sexual assault examination and collection and testing to determine whether the patient was sexually naïve (the so-called virginity testing), including a rectal examination despite having decided to do so prior to the anesthesia was a violation of the standard of care. Dr. Dadgar claims that she did not immediately focus on sexual abuse as the cause for the lesions but, based on her contractions and inconsistencies in written statements to the Board and in testimony at the hearing before the ALJ, the Panel finds her to not to be a credible witness.

Finally, the testing conducted by Dr. Dadgar to determine whether the Patient was sexually naïve was by itself a violation of the standard of care. Dr. Dadgar measured the length of the vagina. Dr. Dadgar inserted three fingers into the Patient's vaginal orifice and inserted three fingers into the patient's rectum. The State's expert stated there was no reason to measure the size of the vagina and that there was no reason to insert fingers into the vagina or rectum of a 15-year-old. The State's expert opined that these actions were "appall[ing]" and "might be an abuse in itself." There was no medical indication to measure the size of the vagina by the invasive procedure of inserting her fingers. The State's expert opined that it was not a medical procedure. Dr. Dadgar testified that she measured the length of the vagina and claimed that the length was long for a sexually naïve 15-year-old. The State's expert explained that these examinations to determine whether the patient was sexually naïve appear to be "virginity testing."

The American College of Obstetricians and Gynecologists ("ACOG") has called for the elimination of the practice of "virginity testing" explaining that it is not a medically indicated or valid procedure and raises ethical concerns. ACOG explained that physical examinations purporting to assess virginity are without basis and are a violation of human rights. It is also

difficult to see how a rectal examination would be relevant to assessing the vaginal ulcers or would have been done absent a prior decision to assess whether sexual assault had occurred when the examination for which informed consent was obtained was only for a vaginoscopy and ultrasound. Dr. Dadgar's expert did not opine on the propriety of doing such an exam and whether such examination was a violation of the standard of care but did testify that there is no testing that can be done to determine virginity, and that the length of the vagina has no bearing on whether you can determine whether the patient is a virgin or not. Dr. Dadgar's expert opined that the vagina and rectum appeared to be enlarged but also noted that the rectum and vagina will dilate with anesthesia and noted that a patient's vagina "is not usually measured" and noted that there is no normal length to a vagina. The State's expert testified that the lack of consent, the inappropriate procedures, and the lack of a differential diagnosis were violations of the standard of care, while Dr. Dadgar's expert wrote in her report that there was no violation of the standard of care. The Panel finds the State's expert's testimony compelling and finds that Dr. Dadgar violated the standard of care by failing to conduct a differential diagnosis, failing to obtain patient consent before performing a sexual assault examination, and measuring the vagina and inserting her fingers into the vagina and rectum to measure their size.

The Patient saw Dr. Dadgar on Friday afternoon, and Dr. Dadgar did not obtain medical records from the hospital that the Patient had visited prior to seeing Dr. Dadgar. The State's expert opined that the standard of care required Dr. Dadgar to obtain those prior records. The Panel, however, finds no violation for failing to obtain the medical records from the other institutions late on Friday or early Saturday morning because of the difficulty in obtaining ER records during that timeframe.

Medical Recordkeeping Violation

The State's expert was also accepted by the ALJ as an expert in appropriate and complete medical documentation in obstetrical and gynecological care. The State's expert opined that Dr. Dadgar's medical records were substandard. In Dr. Dadgar's expert's report, she admitted that the records "could have been more detailed and robust," but opined that they exceeded the standard for adequacy of records. Dr. Dadgar's expert did not testify at the hearing about the adequacy of the medical recordkeeping. The ALJ found that the State's expert's opinion was more probative and logical than the opinion of Dr. Dadgar's expert regarding the adequacy of Dr. Dadgar's recordkeeping. The Panel thoroughly considers the testimony of Dr. Dadgar's expert. The weight of the evidence supports the testimony of the State's expert. The Panel adopts the ALJ's conclusion.

DR. DADGAR'S EXCEPTIONS

Dr. Dadgar filed exceptions, claiming that she complied with the standard of care, kept adequate medical records, and argued that the State's case was compromised by religious and cultural bias.

The Standard of Care Violations

Whether Dr. Dadgar violated the standard of care by failing to request prior medical records

Dr. Dadgar argues that the ALJ erred in finding a violation of the standard of care based on her failure to request records from prior visits to two hospitals where the Patient was previously treated. Dr. Dadgar cited her expert's testimony about the difficulty in obtaining ER records on a Friday afternoon or Saturday. Dr. Dadgar also rebutted the claim that she should have checked the Chesapeake Regional Information System for our Patient ("CRISP"), noting that CRISP was

not a viable or accessible tool because she did not have access to CRISP, and because it was not relevant to the nature of the care she provided.

In response, the State argues that Dr. Dadgar's expert witness admits that it would be helpful to have obtained the prior records and that the standard of care required her to at least attempt to obtain those records.

The Panel concludes that it was not a standard of care violation in this circumstance to not request patient records and agrees with Dr. Dadgar's expert's opinion that it would have been difficult to obtain ER records over the weekend. Dr. Dadgar's exception pertaining to this element of the standard of care violation is granted and the Panel does not find a violation of the standard of care based on her failure to request records.

Whether Dr. Dadgar performed a differential diagnosis and prejudged the cause for the patient's pain

Dr. Dadgar claims that she undertook a reasonable differential diagnosis using the limited tools available because the Patient was in too much pain to be examined and that she had not predetermined that the Patient had been sexually assaulted. She claims that she "had no expectations whatsoever." She claims that she was objective by "taking cultures, performing a biopsy, and conducting a clinical examination to rule out other causes." Finally, Dr. Dadgar claims that the State's expert was incorrect in believing that her insertion of fingers into the vaginal and rectal orifice was "virginity testing" and asserts that she was merely documenting as many findings as she could and was not measuring the vagina to determine whether the patient was a virgin.

Dr. Dadgar's exceptions claims before the Panel are belied by her previous statements to the Board in her written response to the complaint and her written response to the peer reviews. Dr. Dadgar specifically told the Board in her response to the complaint that her examination was

to determine whether there had been sexual assault. She told the Board that she "recognized almost immediately the tell-tale signs of sexual assault." She claimed that pre-marital sexual activity would jeopardize the Patient's prospects of marrying and suggested that "this [was an] alternative agenda to the safety, health and well-being of her patient . . . and recommended to the patient's parent that she perform an internal exam under anesthesia in order to properly rule out sexual assault or abuse." Dr. Dadgar testified that "rectum [examination] is part of a pelvic examination, particularly when . . . you suspect an assault." Considering these statements of Dr. Dadgar, the Panel rejects her claim that she did not focus on sexual abuse and related complications. The Panel does not find credible her latest assertion that she was just making observations and had not already made up her mind about sexual assault.

Similarly, Dr. Dadgar's claim that the State's expert was merely speculating that her manual exam was virginity testing is belied by Dr. Dadgar's own testimony and letters. Dr. Dadgar testified "So, when you're sexually naïve around that age, the length of the vagina should be anywhere from two to four inches. Hers measured about seven." She explained to the Board that she performed the examination under anesthesia "to determine under anesthesia, whether the vagina was consistent with the family's claim that the patient was sexually naïve." In other words, part of her examination was to test whether the Patient was sexually naïve – that is virginity testing. The Panel rejects this exception as unsupported by the evidence.

Dr. Dadgar claims that the consent was sufficient

Dr. Dadgar further claims that consent she obtained was sufficient, and she maintains that the ALJ was wrong to rely on the State's expert's testimony that a sexual assault forensic exam required separate informed consent. She argues that both parents consented in writing to an examination under anesthesia, it was in the Patient's best interest to complete all necessary

diagnostic procedures while the Patient was anesthetized, and the signed consent form permitted her to act based on intraoperative findings. This argument is unsupported because informed consent requires informing a patient about the anticipated procedures. As Dr. Dadgar's previous statements to the Board revealed, she had already decided to perform the sexual assault examination and virginity testing prior to the procedure.

The State's expert testified that a physician should counsel a patient about the patient's condition prior to performing the procedure, provide information about different alternatives available for the condition with the risks and benefits of each alternative, the exact procedure that the physician will perform, and the potential complications. He opined that the informed consent should be detailed to the patient's understanding and documented in the medical records. This is part of the training in obstetrics and gynecology. In addition, the State's expert testified that informed consent does not allow a physician, having obtained consent for one procedure, to perform other procedures that the patient did not consent to.

"Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected." *Sard v. Hardy*, 281 Md. 432, 443 (1977) (quoting *Cobbs v. Grant*, 104 Cal.Rptr. 505, 514 (1972)). It is plausible that, in certain cases, new intraoperative findings could require an expansion of the scope of examination. However, a physician who has anticipated a certain procedure in advance, cannot purposefully avoid obtaining informed consent from the Patient or their parents, perform the procedure without consent, and later claim that the procedure was necessary. In this case, Dr. Dadgar obtained parental consent that was limited to vaginoscopy and ultrasound. Dr. Dadgar's claims at the hearing that she only decided to perform these examinations after the procedure began is belied by her previous statements to the Board

claiming that she "recommended to the patient's parents that she perform an internal exam under anesthesia in order to properly rule out sexual assault or abuse." While that statement was false, because Dr. Dadgar never informed the parents or the Patient that the examination was to determine whether there was sexual assault or abuse, the statement makes it clear that Dr. Dadgar had already determined that this was the purpose of the examination. Dr. Dadgar claimed that she was conducting this examination, at least in part, to determine "whether the vagina was consistent with the family's claim that the patient was sexually naïve" and "in order to properly rule out sexual assault or abuse." The Panel, therefore, finds that Dr. Dadgar began the procedures with the intent of assessing the patient's sexual naivety/virginity and whether there was a sexual assault. Dr. Dadgar was required to obtain consent for those anticipated procedures and did not do so.

Dr. Dadgar claims that Health Occ. § 1-221.1 permitted her examination without obtaining consent

Dr. Dadgar asserts that the ALJ failed to consider Health Occ. § 1-221.1. She further claims that Health Occ. § 1-221.1 permits examinations of the vagina and anus under anesthesia when medically necessary during surgery. Health Occ. § 1-221.1 contains exceptions to a prohibition on performing pelvic, prostate, and rectal examinations under anesthesia if: (1) prior informed consent has been obtained; (2) performance of the examination is within the standard of care; (3) the patient is unconscious and the examination is required for diagnostic or treatment purposes; or (4) an emergency exists and it is impractical to obtain the patient's consent.

Dr. Dadgar's citation to Md. Code Ann., Health Occ. § 1-221.1 is unavailing. This statute created restrictions on performing pelvic, prostate, and rectal examinations on unconscious patients, with four enumerated exceptions, and added authority for Health Occupations Boards to sanction a health practitioner who performs such examinations. Dr. Dadgar was not charged with

violating Health Occ. § 1-221.1. It cannot be used as a catch-all exception that would permit a violation of the standard of care under Health Occ. § 14-404(a)(22).

The legislative history is clear that Health Occ. § 1-221.1 was not created to make it easier for health care practitioners to perform pelvic and rectal examinations without informed consent, rather, it was created to codify the existing requirements limiting pelvic and rectal examinations without consent or make it more difficult to perform those examinations without prior informed consent. The statute was introduced based on a 2007 committee opinion by ACOG that criticized the practice of medical students and trainees practicing performing pelvic examinations on unconscious patients or patients under anesthesia without patient consent. 2019 Fiscal and Policy Note Enrolled SB 909. The Policy Note clarifies that this law was added to increase the requirements of informed consent, not to loosen them. The floor report explained that the ACOG report is an official opinion but not a legal requirement. As MedChi wrote in a letter of information, "[o]btaining informed consent prior to conducting these procedures is already the law in Maryland," citing *Shannon v. Fusco*, 438 Md. 24, 46 (2014) ("the doctrine of informed consent imposes on a physician a duty to disclose material information that 'a physician knows or ought to know would be significant to a reasonable person in the patient's position in deciding whether or not to submit to a particular medical treatment or procedure[.]'").

Health Occ. § 1-221.1 does not serve as a shield to protect doctors from having to obtain informed consent from unconscious patients. As the floor report explained, quoting the ACOG opinion, the purpose is "to respect a patient's right to make informed decisions. Patients should be given the opportunity to consent or refuse treatment." Here, Dr. Dadgar purposefully chose not to inform the patient about an anticipated procedure, in violation of the standard of care, and suggests the statutory provision shields her violation. This is the opposite of the clear legislative

intent. Health Occ. § 1-221.1 is not a free pass to perform vaginal or rectal examinations without consent but rather was created as an impediment to do so. The Panel rejects this exception.

Claim of Qualified Immunity

Dr. Dadgar further argues that she is entitled to qualified immunity for performing sexual assault testing without informed contest based on her role as a mandatory reporter. She claims that she had a duty as a mandated reporter to preserve all evidence. Fam. Law § 5-708 ("Any person who makes or participates in making a report of abuse or neglect under § 5-704, § 5-705, or § 5-705.1 of this subtitle or a report of substantial risk of sexual abuse under § 5-704.1 of this subtitle or participates in an investigation or a resulting judicial proceeding shall have the immunity described under § 5-620 of the Courts and Judicial Proceedings Article from civil liability or criminal penalty.") She claims that Maryland encourages a public policy favoring prompt reporting and protects individuals who "in good faith makes or participates in a making a report of abuse or neglect." *Rite Aid Corp. v. Hagley*, 374 Md. 665, 679 (2003) (emphasis removed).

The State argues that Fam. Law § 5-708 concerns civil and criminal liability, not administrative enforcement actions. As a secondary argument, the State argues that these statutes do not contemplate removing the Board's power to enforce the Medical Practice Act.

The Panel agrees with the State's argument that Fam. Law § 5-708 applies to "civil liability or criminal penalty," not to administrative actions. *See e.g., Matter of Cricket Wireless, LLC*, 259 Md. App. 44, 68 (2023) (an administrative action against a professional license "is neither civil or criminal in nature") (citing *Nelson v. Real Estate Commission*, 35 Md. App. 334, 340-41 (1977); *Anne Arundel County Bar Association, Inc. v. Collins*, 272 Md. 578 (1974)). Courts regularly distinguish between criminal, civil, and administrative actions. *See Gannon & Sons, Inc. v.*

Emerson, 291 Md. 443, 451 (1981) (noting that a single course of conduct can result in administrative, civil, and criminal sanctions); *Att'y Grievance Comm'n of Maryland v. Unnamed Att'y*, 298 Md. 36, 46 (1983) (same); *Reisch v. State*, 107 Md. App. 464, 483 n. 10 (1995) (same). When the legislature intends to make administrative immunity available, as well as criminal and civil immunity, it says so. *See Scarbrough v. Transplant Res. Ctr. Of Maryland*, 242 Md. App. 453, 462 (2019) (discussing an anatomical gift law that explicitly provided immunity "for the act in a civil action, a criminal prosecution, or an administrative proceeding."). Dr. Dadgar provides no evidence that Fam. Law § 5-708 was intended to provide immunity to physicians from administrative actions, such as the current Board action.

However, even if immunity was possible, this Order does not subject Dr. Dadgar to sanction for reporting the sexual assault to Child Protective Services or collecting the samples required for a sexual assault forensic examination. Dr. Dadgar admits that another physician reported the case to Child Protective Services. Rather, Panel B charged Dr. Dadgar with a violation of the standard of care based on her failure to obtain patient consent prior to performing an examination on the Patient and for conducting the virginity testing examination. Dr. Dadgar did not seek consent for a sexual assault forensic examination, perhaps anticipating that she would not be able to obtain consent from the family. Instead, Dr. Dadgar decided to forgo obtaining consent for a sexual assault forensic examination and instead obtained consent only for a vaginoscopy and ultrasound.

Under *Hagley*, "the Legislature intended to encourage the good faith reporting of suspected child abuse to authorities without the fear of civil and criminal liability for reports later determined to be unfounded." *Rite Aid Corp. v. Hagley*, 374 Md. 665, 678 (2003). There is no indication that it was intended to allow physicians to ignore the standard of care or to perform

invasive procedures without patient consent. Dr. Dadgar is not subject to sanction for reporting abuse or for incorrectly concluding that sexual assault was the cause of the Patient's pain, but rather because she violated the standard of care by not conducting a differential diagnosis, failing to obtain patient consent before conducting the sexual assault examination, and for performing virginity testing, a procedure that had no valid clinical indication in the circumstances. Again, Dr. Dadgar is attempting to twist a law that was intended to protect minor patients from abuse in order to protect herself from her own violations of the patient's rights. Eliminating a physician's obligations to obtain a patient's informed consent and to meet the standard of care would put patients at risk.

The Deference given to the State's Expert

The ALJ found that the State expert's testimony provided her with valuable information and insights and adopted his conclusions. Dr. Dadgar claims that the ALJ incorrectly deferred to the expert and claims that the State's expert was not qualified to judge Dr. Dadgar because Dr. Dadgar's practice certification specialty was in Pediatric and Adolescent Gynecology (PAG) and the State's expert did not have a PAG certification. Dr. Dadgar maintains that the State's expert lacked comparable experience in treating children and adolescents. Dr. Dadgar's expert had the PAG specialty certification. Dr. Dadgar argues that the standard of care is closely tied to the provider's experience with the specific patient population.

The State argued that the State's expert has significant experience with children and adolescents, that the State's expert's testimony was credible and more logical and consistent than the testimony of Dr. Dadgar's expert.

The Panel agrees with the State's arguments. The Panel also agrees with the State's argument that "[i]t is the scope of the witnesses' knowledge and not artificial classifications by

title that should govern." *Blackwell v. Wyeth*, 408 Md. 575, 620 (2009). The State's expert testified that he has seen "at least hundreds, maybe more" of pediatric gynecologic patients. The Panel finds this experience to be more than sufficient to testify about this case. The State's expert testified compellingly about informed consent, differential diagnosis, medical recordkeeping, and about the test Dr. Dadgar performed regarding sexual assault and vaginal size measurements. Dr. Dadgar does not explain how the recordkeeping, informed consent, or differential diagnosis standards would differ for adults and children and why the State's expert's opinion was insufficient. In his testimony, the State's expert often referred to his sources and provided in-depth and clear explanations. The Panel found the State's expert's experience to be substantial and impressive and found his testimony compelling and convincing. The Panel denies Dr. Dadgar's exception.

Medical Recordkeeping Violations

The State's expert opined that Dr. Dadgar's medical records were substandard because they were missing several important sections. The ALJ found that the State's expert's opinion was more probative and logical than the opinion of Dr. Dadgar's expert regarding the adequacy of Dr. Dadgar's recordkeeping. Dr. Dadgar argues that her expert testified that the operative notes were sufficient and consistent with the evolving clinical findings. Dr. Dadgar further argued that the structure of her documentation was appropriate and that any concerns with the tone, word choice, and phrasing is due to a language barrier.

The Panel adopts the ALJ's conclusion. The Panel also finds that the State's expert opinion was well grounded. The medical records were not substandard because of a language barrier, tone, and word phrasing. Rather, the problems with Dr. Dadgar's records were due to her substandard documentation.

Arguments Claiming Religious and Cultural Bias and the Patient's Community

The ALJ's proposed decision focuses on whether Dr. Dadgar violated the standard of care and medical recordkeeping requirements. The ALJ noted in a footnote that no weight was given to Dr. Dadgar's ethnicity and religion.

In her written and oral exceptions, Dr. Dadgar claims that the State's questions regarding her religion and ethnicity during cross-examination injected an incorrect, biased, and religiously charged theme into the proceedings. Dr. Dadgar argues that questions asked during her cross-examination by the State about her religion and introduction of her mahr (a part of the Muslim marriage contract) as an exhibit demonstrate religious persecution. The State argues that a line of questioning regarding Dr. Dadgar's statements about the Patient's "community" was appropriate, and that because the ALJ did not adopt the State's position, the entire argument is moot.

In her response to the complaint and response to the peer review, Dr. Dadgar made statements about how a victim of sexual abuse in a religious devout community would act, and she also made statements about her understanding of the Patient's "orthodox religious community." Dr. Dadgar's claim that the Patient's parents had an "alternative agenda" about her marriageability and her implication that the family was not concerned about "the safety, health and well-being of the patient" suggest that she may have harbored biases regarding the Patient's "orthodox religious community." Questions about these potential biases would have been legitimate avenues of inquiry on cross examination. However, the issue for the Panel to address here is whether the objections to the State's cross-examination questions were properly overruled when the administrative prosecutor asked questions about where Dr. Dadgar was from, whether she was Muslim, whether she identified as Muslim around 2021, whether she was a practicing Muslim when she was married, and whether she had an Islamic marriage ceremony. The State also

introduced Dr. Dadgar's Muslim marriage contract as Exhibit 5. Dr. Dadgar timely objected to these questions and to the admission of the exhibit, but the ALJ overruled the objections.

The reason for the questions, as described by the State, was that two witnesses had testified that Dr. Dadgar claimed that she knew the patient's community, she was part of their community and that the administrators did not understand the community. The reason for the exhibit was to impeach the witness based on the answer to the questions about her religion.

To the extent that Dr. Dadgar is objecting to the relevancy of testimony and relevancy of the proffered exhibit, the Panel must review the evidence in light of whether it is "relevant evidence" which is defined as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." *Rosov v. Md. State Bd. of Dental Examiners*, 163 Md. App. 98, 119 (2005) (quoting Md. Rule 5-401). Here, a witness testified that Dr. Dadgar had made comments "to the effect of she knew the child wouldn't disclose sexual abuse to her, to Dr. Dadgar, because of her community" and "I recall the word 'Muslim.' That word sticks out in my mind as being said, but I don't recall kind of the context."

Here, it was clear that the Patient was Jewish, not Muslim, and there was no evidence that they shared an ethnicity or religion. As such, there was no reason to ask questions about whether Dr. Dadgar was Muslim or where she was from. Questions to probe Dr. Dadgar's biases and her knowledge of the Patient's community or questions about a shared community could have been appropriate, however, those types of questions were not asked during cross-examination. Questions pertaining to Dr. Dadgar's religion or country of origin are not relevant.

Because the questions were about her religion and had no connection to the treatment or potential biases towards the Patient, the Panel finds that these questions were not proper and will

not consider the answers to those questions. The marriage contract was admitted for impeachment purposes and impeachment is generally a valid mode of questioning to attempt to demonstrate dishonesty. However, here, because the original questions that were being challenged were invalid and will not be considered, the exhibit is likewise also inappropriate and will not be considered. The Panel finds that the testimony in response to the cross-examination questions and Exhibit 5 were admitted in error and the Board will not consider the entire cross-examination, State Exhibit 5, and the part of the redirect examination that was specifically rebutting the cross-examination.

The next issue is whether this admission of irrelevant information prejudiced the ALJ or tainted the ALJ's proposed decision. The Panel finds that it did not. In answering the first objection, the ALJ explained that "I think there has been testimony throughout these proceedings where different witnesses have talked about the Respondent saying things about her community, mentioning the word Muslim, et cetera. So, I'm going to overrule the objection, I guess, and I'll allow the question just for context and bringing it all together because there has been a lot of conversation about this patient's community and Dr. Dadgar's knowledge thereof. Using it for those purposes only." In response to the impeachment exhibit, the ALJ explained regarding the Administrative Prosecutor: "I can't read her mind. So I'm going to have to give her some latitude." Finally, the judge further explained her reasoning in response to another objection stating:

> All that I can say is it's the State's burden in this case. I am not here to tell anyone how to present their case because that is not my job, my role, my responsibility.
>
> So I will allow [the Administrative Prosecutor] to continue. I'm going to give all of this information the weight that I feel it deserves in making the ultimate decision in this case. There are lots of documents in this case. I have not had the opportunity to review all the documents in this case. That's just not the nature of how these proceedings go. These cases can be very exhausting on the trier of fact. And so I have not had the time or the energy to try to go through all of the documents every night in order to sort of know exactly what is here and is not here.

> I've heard testimony from multiple witnesses in this case. And at the end of the day, I have to weigh all of the testimony presented against all of the paper evidence presented against what the charges are and make a decision. And that is not a decision I'm going to take lightly. I'm going to consider everything in making that decision.
>
> And so at this point, I will allow [the Administrative Prosecutor] to continue. I apologize for – or I'm sensitive, I should say, to how Dr. Dadgar feels. But please understand that I am not imputing anything one way or another at this point to your religion, your background, your culture, et cetera. In the context of this case and statements that were made and testimony that was presented, this is the impeachment that [the Administrative Prosecutor] wishes to pursue. I'm going to allow her to pursue it, and then we're going to move on.

The Panel finds that the ALJ was motivated by wanting to allow the Administrative Prosecutor to put on her case, with the knowledge that if irrelevant information was admitted, she could simply give no weight to that evidence. That is exactly what the ALJ did in her Proposed Decision. The ALJ determined that the evidence was clear that Dr. Dadgar and the Patient do not share an ethnicity or religious background and Dr. Dadgar's religion and ethnicity were given no weight to the proposed findings of fact, proposed sanctions, or proposed ruling. The ALJ did not make any findings of fact based on the cross-examination, and none of the analysis considered any of the information from the cross-examination. The Panel believes that the ALJ did not demonstrate prejudice or bias nor did her proposed decision. Dr. Dadgar claims that the ALJ's relegation of the "theme" to a footnote "disregards basic tenets of fairness, impartiality, and objectivity." It is unclear how the ALJ's adopting the conclusions proposed by Dr. Dadgar that "the Respondent and the Patient do not share the same ethnicity or religious background" and giving no weight to her ethnicity and religion demonstrates a disregard for tenets of fairness or objectivity. The ALJ did not make any findings of fact related to Dr. Dadgar's religion, national origin, or ethnicity. The ALJ did not address it in the discussion section, other than to explain in

a footnote that it was given no weight. The Panel does not find that the ALJ has demonstrated a lack of impartiality or objectivity.

Dr. Dadgar's exception is granted. The Panel has not considered Dr. Dadgar's ethnicity or religion. The Panel has, therefore, not considered the evidence presented on cross-examination and the part of the redirect examination that was specifically rebutting the cross-examination. The Panel also has not considered State's Exhibit 5.

CONCLUSIONS OF LAW

Based on the foregoing conduct, Disciplinary Panel A concludes, as a matter of law, that Dr. Dadgar 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); and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40).

SANCTION

As a sanction, the ALJ recommended that the Board impose a reprimand for her failure to keep adequate medical records; a suspension until she undergoes an evaluation by MPRP to determine whether she is fit to practice medicine safely and until MPRP determines that she is safe to practice medicine. Upon her return to practice, Dr. Dagar would be placed on probation for one year with a peer supervisor who would review ten patient charts every month.

The ALJ found that there were no mitigating factors and that the aggravating factors included that Dr. Dadgar had prior discipline, the offense caused patient harm, as the Patient is a fifteen-year-old minor who underwent an invasive procedure without her consent or the consent of her parents, and Dr. Dadgar performed "virginity testing" denounced by the American College of Obstetricians and Gynecologists. The violation involved a combination of factually discrete

offenses and previous attempts to rehabilitate were unsuccessful. The ALJ found that Dr. Dadgar's lack of remorse after an opportunity to reflect and instead doubled down on her claim that she did nothing wrong was concerning.

Prior Disciplinary History

Dr. Dadgar's first exception pertaining to the sanction is that the ALJ described the prior discipline as including probation, while the prior Order did not include probation. The State concedes this "minor error" in the response. The Panel agrees with this exception and has considered the prior discipline of a reprimand, a permanent restriction on cryosurgery and a fine without any probation.

Objection to the Suspension

In her written exceptions, Dr. Dadgar claims that the suspension and evaluation by MPRP are not appropriate because she was found fit to practice in a report issued by MPRP on January 11, 2023. The State argued in support of the suspension by noting her failure to document critical information, failing to engage in a differential diagnosis, failure to request medical records from the other hospital, conducting an invasive procedure without medical justification, failing to obtain informed consent, and failing to accept accountability.

In oral exceptions, Dr. Dadgar argued that she was denied "due process," specifically, "notice and an opportunity to be heard" because she was not informed prior to the State's closing that the state was seeking a suspension of her license. She also generally argues that, as a standard of care case, Dr. Dadgar's fitness to practice was not at issue.

Dr. Dadgar's exceptions are without merit. Dr. Dadgar fails to cite any report issued by MPRP on January 11, 2023. Such a report does not appear to be in the record, and the Panel cannot consider a report that is outside the record. *See* COMAR 10.32.02.05B(1)(e) ("The disciplinary

panel may not accept additional evidence through the written exceptions process."). This exception is denied on that basis.

With respect to her claim of a violation of due process because the State did not notify her about the proposed sanction, Dr. Dadgar claims that she had no notice and no opportunity to be heard. This claim is belied by the record. The Board was required to "state the sanction proposed or the potential penalty, if any, as a result of the agency's action." State Gov't § 10-207(b)(3). The Panel provided notice of possible sanctions in the charging document that initiated the proceedings. Specifically, it notified Dr. Dadgar that the Board "may impose disciplinary sanctions against the Respondent's license, . . . including revocation, suspension, or reprimand, and may place the Respondent on probation." Dr. Dadgar is, thus, incorrect that she was not provided notice of the possible sanctions. Similarly, Dr. Dadgar was given the opportunity for a hearing on the sanction as part of the five-day hearing. Dr. Dadgar's counsel explicitly stated at OAH that she made the decision not to discuss the sanction because "I did not believe that that was something I needed to talk about, given that we have requested a dismissal." Thus, Dr. Dadgar had an opportunity for a hearing on the sanction, and she voluntarily chose not to address the sanction at that time. The ALJ did not violate Dr. Dadgar's due process as it pertains to the sanction.

The Panel has considered the lack of mitigating factors that apply to Dr. Dadgar's case. COMAR § 10.32.02.09(B)(5). The Panel has also considered the aggravating factors including, the prior disciplinary history, the patient harm, and the combination of discrete offenses. COMAR § 10.32.02.09(B)(6)(e).

The Panel believes that the procedure performed by Dr. Dadgar involved a serious standard of care violation. The Panel also takes into account that the violation is based on a single patient

rather than a series of patients. To prevent future standard of care violations, the Panel will extend the recommended peer supervisor condition from the recommended one year to eighteen months. The Panel also believes that a peer supervisor along with probation should be sufficient to protect the public and that a suspension and enrollment in MPRP is not warranted. As a result, the Panel will impose a reprimand, probation for a minimum of eighteen months and a peer supervisor until Dr. Dadgar has received six satisfactory quarterly reports for the term of probation.

ORDER

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

ORDERED that **SHABNAM DADGAR, M.D.**, is **REPRIMANDED**; and it is further

ORDERED that Dr. Dadgar is placed on **PROBATION** for a minimum period of **EIGHTEEN MONTHS**.[3] During the probationary period, Dr. Dadgar shall comply with the following probationary terms and conditions:

> Dr. Dadgar shall be subject to supervision for a minimum of **EIGHTEEN MONTHS** by a disciplinary panel-approved supervisor, who is board-certified in Obstetrics/Gynecology, as follows:
>
> > (a) within **30 CALENDAR DAYS** of the date of this Order, Dr. Dadgar shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom Dr. Dadgar 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. Dadgar and that there is no personal or professional relationship with the supervisor;
> >
> > (b) Dr. Dadgar's proposed supervisor, to the best of Dr. Dadgar's knowledge, should not be an individual who is currently under investigation, and has not been disciplined by the Board within the past five years;
> >
> > (c) if Dr. Dadgar fails to provide a proposed supervisor's name within 30 calendar days from the effective date of the order, Dr. Dadgar's license shall be automatically

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

suspended from the 31st day until Dr. Dadgar provides the name and background of a supervisor;

(d) the disciplinary panel, in its discretion, may accept the proposed supervisor or request that Dr. Dadgar 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, any advisory letters, and any other documents the disciplinary panel deems relevant;

(g) Dr. Dadgar 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. Dadgar's charges;

(h) if the supervisor, for any reason, ceases to provide supervision, Dr. Dadgar 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. Dadgar 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. Dadgar's 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. Dadgar;

(2) meets in-person with Dr. Dadgar at least once each month and discuss in-person with Dr. Dadgar the care Dr. Dadgar has provided for these specific patients;

(3) be available to Dr. Dadgar for consultations on any patient;

(4) maintains the confidentiality of all medical records and patient information;

(5) provides the Board with a minimum of **SIX** quarterly reports which detail the quality of Dr. Dadgar's 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. Dadgar may pose a substantial risk to patients;

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

(k) if the disciplinary panel, upon consideration of the supervisory reports and Dr. Dadgar's response, if any, has a reasonable basis to believe that Dr. Dadgar is not meeting the standard of quality care or failing to keep adequate medical records in

her practice, the disciplinary panel may find a violation of probation after a hearing; and it is further

ORDERED that, after Dr. Dadgar has complied with all terms and conditions of probation, including the receipt of six satisfactory reports from the peer supervisor, and the minimum period of probation imposed by the Final Decision and Order has passed, Dr. Dadgar 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. Dadgar may be required to appear before the disciplinary panel to discuss her petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if Dr. Dadgar 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. Dadgar is responsible for all costs incurred in fulfilling the terms and conditions of this Order; and it is further

ORDERED that, if Dr. Dadgar allegedly fails to comply with any term or condition imposed by this Order, Dr. Dadgar 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. Dadgar 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. Dadgar has failed to comply with any term or condition imposed by this Order, the disciplinary panel may reprimand Dr. Dadgar, place her on probation with appropriate terms and conditions, suspend her license with appropriate terms and conditions, or revoke her 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. Dadgar; 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).

11/24/2025
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. Dadgar 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. Dadgar files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

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

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

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

Exhibit 1

MARYLAND STATE BOARD OF	*	**BEFORE JOCELYN L. WILLIAMS,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
SHABNAM DADGAR, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	**OAH No.: MDH-MBP2-71-24-08425**
LICENSE No.: D72779	*	**BOARD CASE No.: 2223-0016 B**

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

PROPOSED DECISION

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

STATEMENT OF THE CASE

On September 23, 2023, a disciplinary panel of the Maryland State Board of Physicians (Board) issued charges against Shabnam Dadgar (Respondent) alleging violations of the State law governing the practice of medicine. Md. Code Ann., Health Occ. §§ 14-101 through 14-509, and 14-601 through 14-607 (2021 & Supp. 2024) (Act).[1] Specifically, the Respondent is charged with violating sections 14-404(a)(22) and (40) of the Act, based on allegations of failing "to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical surgical care performed in an outpatient surgical facility, office or hospital, or any other

[1] Unless otherwise noted, all references to the Health Occupations Article cite the 2021 Volume and 2024 Supplement of the Maryland Annotated Code.

location in this state" and "failing to keep adequate medical records as determined by appropriate peer review, respectively." Code of Maryland Regulations (COMAR) 10.32.02.03E(3)(d).

The disciplinary panel to which the complaint was assigned forwarded the charges to the Office of the Attorney General for prosecution, and another disciplinary panel delegated the matter to the Office of Administrative Hearings (OAH) for issuance of a proposed written decision. COMAR 10.32.02.03E(5); COMAR 10.32.02.04B(1).

On July 17, 2024, I held a first scheduling conference via the Webex videoconferencing platform (Webex). Katherine Vehar-Kenyon, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). The Respondent appeared and was represented by Natasha Wesker, Esquire. On July 17, 2024, dates were scheduled for a second scheduling conference on August 9, 2024, and a pre-hearing conference (Conference) on December 3, 2024.

On August 9, 2024, I held a second scheduling conference via Webex. Ms. Vehar-Kenyon represented the State. The Respondent appeared and was represented by Ms. Wesker. On August 9, 2024, I issued a Scheduling Order setting forth the dates for a Conference and the hearing on the merits.

On December 3, 2024, the parties were not yet prepared to proceed as they needed to discuss the stipulation of basic facts and medical records that would eliminate the need for the testimony of numerous witnesses. The parties agreed to continue the Conference until January 17, 2025. On January 17, 2025, I held a third Conference via Webex. Ms. Vehar-Kenyon represented the State. Ms. Wesker represented the Respondent. At the Conference, dates were selected for the hearing on the merits.

I held the hearing on March 4, 5, 6, 7, and 11, 2025, via Webex. Health Occ. § 14-405(a); COMAR 10.32.02.04. Ms. Vehar-Kenyon represented the State. Ms. Wesker represented the Respondent, who was present.

Procedure is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings Before the Board of Physicians, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021 & Supp. 2024); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. Did the Respondent violate Health Occ. § 14-404(a)(22) by failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical surgical care performed in an outpatient surgical facility, office or hospital, or any other location in this state?

2. Did the Respondent violate Health Occ. § 14-404(a)(40) by failing to keep adequate medical records as determined by appropriate peer review?

3. If so, what sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

The State and the Respondent stipulated to the admissibility of the following exhibits, pre-marked as Joint Exhibits:[2]

1. Patient Medical Record from the Respondent
2. Patient Medical Record from [redacted]

[2] The documents for Joint Exhibits 1-5 are located on the flash drive which is located in the pocket of the front cover of the binder.

3. Patient Medical Record from [redacted]

4. Patient Medical Record from [redacted]

5. Patient Medical Record from [redacted]

6. Maryland Board of Physician Profile for the Respondent the Respondent

7. Respondent's – Final Decision and Order in Prior Disciplinary Action – June 15, 2021

8. Mandated 10-Day Report from [redacted] – November 11, 2021

9. Respondent's Written Response with Attachments – January 13, 2022

10. Curriculum Vitae of [redacted] M.D. – October 22, 2024 (updated)

11. Expert Report of [redacted] M.D., including journal articles referenced therein – March 6, 2023

12. Respondent's Supplemental Response – March 23, 2023

13. [redacted] email to Respondent – October 11, 2021

14. Charges Under the Maryland Medical Practice Act – September 28, 2023

15. Curriculum Vitae of the Respondent

16. Respondents Professional Boundaries Institute Medical Recordkeeping Course Certificate – September 12, 2021

Unless otherwise noted, I admitted the following exhibits offered by the State into evidence:

1. Transcript of Dr. [redacted] s Interview with Board – October 5, 2022

2. Transcript of Dr. [redacted] s Interview with Board – November 4, 2022

3. Curriculum Vitae of [redacted] M.D.

4. Expert Report of [redacted] M.D. – February 5, 2023

5. Excerpt of Reported Maryland Court of Appeals Nos. [redacted] [the Respondent] and [redacted], filed April 7, 2020

I admitted the following exhibits offered by the Respondent into evidence:

1. Respondent's American Board of Gynecology (ABOG) Board Certification (R001)
2. Curriculum Vitae of [redacted] M.D. (R002-004)
3. Expert Report of [redacted], M.D. (R005-R010)
4. Maryland Report of Suspected Abuse/Neglect Form 180 w/instructions (R011-R012)
5. MD Child Protective Services (CPS) Mandated Reporting Guidelines (relevant excerpt) (R013)
6. National Center for Victims of Crime: Child Abuse Statistics (R014)
7. University of California, Irvine PACE CME[3] Ethics Course, 23.0 hours, January 26, 2025 (R015)
8. CME Medical Recordkeeping Seminar, 10.5 hours, January 24, 2025 (R016)
9. Ulcer of Lipshutz: a rare and unknown cause of genital ulceration, November 20, 2018 (R017-R024)
10. Lipshutz ulcers: uncommon diagnosis of vulvar ulcerations, February 15, 2016 (R025-R026)
11. Lipshutz Ulcer: An Unusual Diagnosis that Should Not be Neglected, June 2, 2021 (R027-R029)
12. Lipshutz Ulcers: Classic Presentation of an Uncommon Condition, May 3, 2023 (R030-R036)
13. Acute genital ulceration (Lipshutz ulcer), May 22, 2024 (R037-R061)
14. Analyzing Operative Note Structure in Development of a Section Header Resource, by Genevieve B. Meltona, Yan Wang, Elliot Arsoniadis, Serguei V.S. Pakhomov, Terrence J. Adam, Mary R. Kwaana, David A. Rothenberger, and Elizabeth S. Chen, MEDINFO 2015: eHealth-enabled Health[4]

[3] These acronyms were not defined during the hearing.
[4] There are no page numbers for this exhibit, as it was provided during the hearing.

Testimony

The following witnesses testified on behalf of the State:

- Molly Dicken, Compliance Analyst for the Board;
- [redacted] M.D., Shady Grove Medical Center;
- [redacted] CRNP,[5] DNP, Shady Grove Medical Center;[6]
- [redacted] M.D., PhD, MBA who I found to be: (1) an overall expert in the general medical specialty of obstetrics and gynecology including gynecological care provided to pediatric and adolescent patients; (2) an expert in gynecological examinations generally, to include pediatric and adolescent patients, including informed consent; (3) an expert in the evaluation, diagnosis and treatment of gynecological conditions including Lipschutz ulcers; (4) an expert in evaluation, diagnosis and treatment of suspected sexual abuse or assault in patients including mandated reporting requirements; and (5) an expert in the appropriate and complete medical documentation in obstetrical and gynecological care.

The Respondent testified and presented the following witness:

- [redacted] M.D., who I found to be an expert in OB/GYN, with subspeciality focus practice designations in minimally invasive gynecologic surgery and pediatric and adolescent gynecology.

[5] Certified Registered Nurse Practitioner.
[6] Doctor of Nursing Practice.

STIPULATIONS OF FACT

The parties stipulated to the following Findings of Fact:

1. The Respondent was originally issued a license to practice medicine in Maryland on July 19, 2011, under License Number D72779.

2. The Respondent has retained continuous licensure in the State of Maryland since July 19, 2011.

3. The Respondent's license expires on September 30, 2026, subject to renewal.

4. The Respondent is also licensed to practice medicine in Washington, D.C. and Virginia.

5. The Respondent is board-certified in Obstetrics and Gynecology (OB/GYN).

6. At all times relevant, the Respondent owned and practiced at a private health care facility and had privileges at [redacted] in Rockville, Maryland (the Hospital).

PROPOSED FINDINGS OF FACT

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

1. The Respondent holds focused practice designations in minimally invasive gynecologic surgery (MIGS) and pediatric adolescent gynecology (PAG) through the American Board of Gynecology (ABOG).

2. The Respondent has a prior disciplinary history.

3. On June 15, 2021, the Board reprimanded the Respondent's license and placed her on probation for two years subject to probationary conditions, which included a $7,500.00 fine; successful completion of training in medical recordkeeping within six months; and the Respondent was required to comply with all laws, rules, and regulations governing the practice

of medicine. The Board also permanently prohibited the Respondent from performing cryosurgery.

Medical Records and Documentation:

4. The purpose of medical documentation for patients, by the physician, is to provide a history of diagnosis, conditions, the status of those conditions, and prior treatment.

5. Adequate medical documentation should provide enough information for another physician to step in and assume the patient's case, and medical personnel rely on the medical records created by others. This is commonly known as "continuity of care." There are potential dangers and risks if the medical documentation is not accurate or complete. Adequate medical records are also important for morbidity and mortality to ensure competent care was provided, for insurance purposes, and for legal purposes.

[redacted]'s[7] Medical Care:

6. Pursuant to subpoenas, the Board obtained medical records for [redacted]'s (the Patient) medical treatment from September 16, 2021, through September 23, 2021.

7. At all times relevant to these proceedings, the Patient was an adolescent female, fifteen years of age.

8. On or about September 12, 2021, the Patient received a COVID-19 vaccine.

9. On September 16, 2021, the Patient presented at the emergency department of [redacted] complaining of pain and vaginal itching. A physical examination and sexually transmitted disease testing and infectious disease workup were done. The differential diagnosis was vulvar ulcers that appeared to be Lipschutz ulcers. Supportive care and spontaneous resolution were discussed, and the Patient was prescribed

[7] The patient's initials are being used to preserve confidentiality.

ibuprofen, Tylenol, ice packs and lidocaine jelly. The Patient was discharged and instructed to be seen for follow-up in two weeks. (Jt. Ex. 3).

10. Lipschutz ulcers are painful genital ulcers which typically occur in sexually inactive young women. The condition is rare and there is no known test to diagnose them. The diagnosis is one of exclusion, in that other sexually transmitted diseases must be ruled out. (Resp. Ex. 9).

11. A diagnosis of exclusion requires obtaining a history, reviewing previous evaluations, building diagnoses, a focused exam to confirm or refute medical decision making, and formulating a differential diagnosis - as medical professionals conduct an investigation and narrow down results to reach a final diagnosis.

12. On September 17, 2021, the Patient presented at the emergency department of [redacted] complaining of worsening vaginal pain, unable to sit or lay down, accompanied by nausea and vomiting. The Patient was diagnosed with Lipschutz ulcers. She was prescribed lidocaine jelly, oral percocet, and topical Clobetasol propionate ointment. Sitz baths were also recommended. The Patient was discharged and instructed to follow up with her pediatrician or a gynecologist. (Jt. Ex. 4).

13. Some medical records from emergency room visits are available online through the Chesapeake Regional Information System for our Patients (CRISP). Not all medical providers have direct access to CRISP.

14. On September 17, 2021, the Patient presented at the Respondent's medical practice, after being referred by her pediatrician. The Patient was complaining of vaginal ulcers and extreme pain. The Patient's mother told the Respondent that the Patient was previously seen in the emergency department for the same vaginal ulcers.

15. The Respondent was unable to obtain a urine sample, or to perform a complete and adequate physical examination of the Patient due to her level of pain and discomfort.

16. The Respondent facilitated the overnight direct admission of the Patient to the pediatric unit of the Hospital, so she could attempt to examine her the following day, as the Patient could not return to the office due to religious observances, and she was concerned about urinary retention and wanted the Patient to have access to medical care.

17. The Respondent observed the Patient at the Hospital on September 18, 2021, and September 19, 2021.

18. On September 19, 2021, the Respondent noted that the Patient remained in unbearable pain, and she was unable to conduct a physical examination, so a decision was made that the Respondent would perform a physical examination and vaginoscopy under anesthesia.

19. The Respondent spoke to the Patient and her Parents and obtained written consent to perform a vaginoscopy under anesthesia and a pelvic ultrasound. (Jt. Ex. 1, p. J0015-J0018).

20. On September 21, 2021, the Respondent performed a vaginoscopy on the Patient, and was able to observe the vulvar ulcers, while the Patient was under anesthesia.

21. While the Patient was under anesthesia, the Respondent requested a sexual assault kit, collected samples and biopsies of the vulvar ulcers.

22. The Respondent did not obtain consent from the Patient or her parents to collect samples for a sexual assault kit. (*Id.*)

23. While the Patient was under anesthesia, the Respondent performed "virginity testing" on the Patient, by measuring the Patient's vagina. This is evidenced in her operative note when she states, "I could easily insert all my three fingers in the vagina." (Jt. Ex. 1, p. J0059). There is further evidence in her response to the Board charges, in which she explained

that she was attempting to determine if the Patient was sexually naïve, as was reported by the parents.

24. While the Patient was under anesthesia, the Respondent also took photographs of the "virginity testing" utilizing the vaginoscopy scope. (Jt. Ex. 1, pp. J0060-J0061).

25. The American College of Obstetrics and Gynecology (ACOG), has stated that it:

> is committed to supporting the health and human rights of adolescents and women and, in alignment with the Word Health Organization and the United Nations, calls for the elimination of the practice of "virginity testing.". "Virginity testing" is not a medically indicated or valid procedure and its practice raises important ethical concerns. Physical examinations purported to assess "virginity" are without basis. "Virginity testing" has been associated with adverse psychosocial and physical outcomes and is considered to be a violation of human rights. ACOG is supportive of legislative efforts that seek to prevent virginity testing.

(Jt. Ex. 11, p. J0698-J0699)

26. The Respondent did not document why she performed "virginity testing" in her operative note, and did not obtain consent from the Patient or her parents to perform "virginity testing." (Jt. Ex. 1, pp. J0015-J0018).

27. Following the vaginoscopy, Hospital staff informed the Patient's parents that a report of suspected sexual assault would be made to child protective services. The Patient's parents became upset, fired the Respondent, and she was no longer allowed to provide care for the Patient.

28. The Patient remained at the Hospital from September 17, 2021, through September 21, 2021.

29. On September 21, 2021, the Patient was discharged from the Hospital and transferred to [redacted]

30. While at [redacted]s, the Patient's pain decreased, and her condition improved. On September 23, 2021, the Patient was discharged from [redacted]The discharge diagnosis was Lipschutz ulcers. (Jt. Ex. 5, p. J0466).

Board Investigation:

31. On or about November 10, 2021, the Board received a Mandated 10-Day Report (Report) from the Hospital. The Report stated, in pertinent part, that the Hospital had concerns about the Respondent's "behavior, poor judgement and poor documentation in the medical record." (Jt. Ex. 8).

32. A Report is required for any changes to employment or privileges.

33. The Board initiated a preliminary investigation and sent the Respondent a letter on December 22, 2021, requesting that she provide a response regarding the Report.

34. On January 13, 2021, the Respondent provided a written response to the Board. (Jt. Ex. 9).

35. Subsequently, the Board investigated the Report received regarding the Respondent. The investigation included obtaining all medical records for the Patient and referring the investigatory file to Livanta, a peer review entity.

36. Livanta engaged the services of Dr. [redacted] and Dr. [redacted] (the Peer Reviewers) to conduct peer reviews of the Respondent's medical records and care of the Patient.

37. The Board provided the Respondent with the reports summarizing the Peer Reviewer's findings.

38. On March 23, 2023, the Respondent provided the Board with a supplemental response. (Jt. Ex 12).

39. On September 23, 2023, the Board issued charges against the Respondent.

DISCUSSION

Burden of Proof

When not otherwise provided by statute or regulation, the standard of proof in a contested case hearing before the OAH is a preponderance of the evidence, and the burden of proof rests

on the party making an assertion or a claim. State Gov't § 10-217 (2021); COMAR 28.02.01.21K. To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cnty. Police Dep't*, 369 Md. 108, 125 n.16 (2002).

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

Legal Framework

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

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> . . . .
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [or]
>
> . . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

Health Occ. § 14-404(a)(22), (40) (Supp. 2024).

As announced *In the Matter of Steven A. Pickert, M.D.*, Case No. 2002-0829 (December 21, 2006),

> The Board's longstanding position... has been that inadequate medical record keeping is a violation of the standard of care. The Board re-affirms its position that medical recordkeeping deficiencies themselves are inimical to the delivery of quality medical care if they would make it impossible for a subsequent treating physician to ascertain the patient's condition or current regimen of treatment so as to continue treating the patient.

Id. at pp. 3-4.

The Charges

The Board charged the Respondent with failing to meet the standard of care, in violation of section 14-404(a)(22) of the Health Occupations Article, by:

a. Failing to request, obtain, and review the Patient's prior medical record;
b. Failing to engage in a differential diagnosis and consider other diagnoses when treating the Patient;
c. Conducting an invasive procedure without indication and patient consent.

(Jt. Ex. 14, p. 4).

The Board charged the Respondent with failing to keep adequate medical records, in violation of section 14-404(a)(40) of the Health Occupations Article, by:

a. Failing to document the procedure performed;
b. Failing to document the indication for the procedure performed;
c. Failing to document the pre-operative diagnosis or diagnoses in the Patient's operative report.

(*Id.*)

Arguments of the Parties

The State argued that the Respondent's medical recordkeeping is substandard and fails to contain the requisite information to ensure continuity of care, which is a violation of the standard of care. The State further avers that the operative note for the vaginoscopy performed under anesthesia lacks details about the procedures performed, the reason for the procedures and pre-

operative and post-operative differential diagnoses. Further, the State alleges that the Respondent did not meet the standard of quality medical care because she performed invasive procedures on the Patient without obtaining consent from the Patient or her parents.

Additionally, the State argued that the Respondent should have obtained medical records from the Patient's previous emergency department visits at [redacted] and [redacted] The State seeks a reprimand, suspension pending an evaluation of fitness to practice medicine, and once found fit, a minimum of one year probation with supervision to include specific monitoring criteria by the supervisor.

The Respondent argued that Dr. [redacted] was not an appropriate peer reviewer because he did not hold the same focused practice designations that she holds from ABOG. She maintained that Dr. [redacted] does not have her level of experience in seeing and treating children and adolescents. The Respondent asserted that she met the standard of care and that while her medical notes and operative note may not have been optimal, they were adequate. The Respondent further argued that English is not her first language and that may factor into the quality of her medical notes.

She argued that the Hospital and the Board were engaged in religious persecution,[8] that the State has proven its attempt at character assassination and failed to meet its burden of proof. The Respondent asserts that she treated the Patient carefully and effectively and that performing the vaginoscopy under anesthesia met the standard of care. She acknowledged that she suspected sexual abuse and that she conducted a biopsy, ultrasound and cultures to rule it out. The Respondent maintains that she went above and beyond the call of duty and that she would

[8] Arguments were raised regarding bigotry as the Hospital's motivation for issuing the Report in this case, and allegations were made by the Respondent that the Board and the State were engaging in religious persecution, racial and ethnic profiling, and harassment against the Respondent. I do not find these arguments and allegations persuasive or relevant to the ultimate decision I must make in this case, which is whether the Respondent violated the standard of care and kept adequate medical records. Therefore, I will decline to address them any further.

rather be wrong about sexual assault, then to look the other way and ignore the signs. She urged me to dismiss all the charges.

Expert Witness Testimony

> On the issue of expert testimony, the Supreme Court of Maryland has held:
>
> The premises of fact must disclose that the expert is sufficiently familiar with the subject matter under investigation to elevate his opinion above the realm of conjecture and speculation, for no matter how highly qualified the expert may be in his field, his opinion has no probative force unless a sufficient factual basis to support a rational conclusion is shown.

Bohnert v. State, 312 Md. 266, 274 (1988) (social worker's expert testimony that child under the age of fourteen was a victim of sexual abuse was inadequately supported and was inadmissible in prosecution for second-degree sexual offense) (citing *State, Use of Stickley v. Critzer*, 230 Md. 286, 290 (1962)).

> The Maryland Rules provide:
>
> Expert testimony may be admitted . . . if the court determines that the testimony will assist the trier of fact to . . . determine a fact in issue. In making that determination, the court shall determine . . . whether a sufficient factual basis exists to support the expert testimony.

Md. Rule 5-702.

The State offered Dr. [redacted] as its expert. The Respondent offered Dr. [redacted] as her expert. I accepted both experts in the respective fields for which they were offered. Drs. [redacted] and [redacted] each have decades of experience and vast training in obstetrics and gynecology. Each witness provided me with valuable information and insights. An expert opinion may nevertheless be tested for bias. As noted by the Supreme Court of Maryland in *Wrobleski v. de Lara*, 353 Md. 509 (1999):

> The professional expert witness advocating the position of one side or the other has become a fact of life in the litigation process. Practicing lawyers can quickly and easily locate an expert witness to advocate nearly anything they desire. In each part of the country, if you need an expert medical witness to state that plaintiff suffered a whiplash injury, call expert X; if you need a medical expert to

> dispute that fact, call expert Y. The use of the expert witness has become so prevalent that certain expert witnesses now derive a significant portion of their total income from litigated matters.

Id. at 515-516 (internal citations omitted).

I heard nothing during the hearing to suggest that either Dr. [redacted] or Dr [redacted] were biased in their views. However, the Respondent argued that she holds focus practice designations in MIGS and PAG, which Dr. [redacted] does not hold, and therefore he is not an appropriate peer reviewer. I am not persuaded by this argument, as Dr. [redacted] is a physician in an OB/GYN practice, holds a focus practice designation in MIGS and demonstrated that he has sufficient experience working with children and adolescents. His testimony was credible, and I conclude that his lack of a PAG focus practice designation has no bearing on his ability to provide his expert opinion in this case. Additionally, Dr. [redacted] clearly testified to the distinctions between the details necessary for adequate office notes verses hospital operative notes, and the standard of care, which are the focus of this case.

Both experts had no apparent interest in the outcome of the hearing and had no role in determining whether the Respondent will be sanctioned. They were paid for their work in this case and rightly so, and there was no evidence either witness derives a significant amount of his or her income by testifying as an expert in matters such as the instant case.

I also note that both experts are more familiar than I am with the technical, scientific, and medical terms used. I deferred to the experts on some of the issues before me and evaluated the expert opinions of each expert as to whether the Respondent failed to meet the standard of care for quality medical care and/or failed to keep adequate medical records. Each expert offered opinions, and I gave those opinions the weight I determined they deserved but did not adopt any experts' opinions as my own. I have briefly summarized their opinions below.

Dr. [redacted]

Dr. [redacted] is a Board-certified OB/GYN and holds a MIGS focused practice designation. He has been a practicing OB/GYN physician for twenty years, consistently treating patients of all ages from children through adults. He sees a substantial number of children and adolescents in his private clinic practice and while supervising residents.

Dr. [redacted] testified that he had reviewed all the medical records for the Patient. He described and summarized the medical records for the care provided to the Patient at [redacted] and [redacted], prior to being seen by the Respondent; and the Respondent's care both in her office and at the Hospital. He stated that medical record keeping and documentation are an essential component of patient care and should include the patient's history, describe the physical examination performed, procedures performed and the medical decision making. Dr. [redacted] further explained that the purpose of medical recording and documentation is for patient care, to ensure the standard of care is being met; for continuity of care, as other medical personnel rely the medical records created by others and there are potential dangers and risks if the medical documentation is not accurate or complete; for morbidity and mortality, to ensure competent care was provided; for insurance purposes; and for legal purposes.

Dr. [redacted] described how physicians arrive at a differential diagnosis. He stated that patients come in with symptoms, and that physicians are tasked with asking broad questions that eventually narrow in scope, until possible diagnoses are reached. Dr. [redacted] testified that physicians gather information from the patient's past, current, and family medical histories and medications, and they perform a physical examination to confirm, refute or rearrange their differential diagnosis. He explained that there is also a chronological component, as the patient's condition evolves, the medical diagnosis should also evolve. Dr. [redacted] stated that the medical decision making should be documented to ensure continuity of care.

Dr. [redacted] opined that the Respondent did not engage in appropriate medical decision making or consider a differential diagnosis, which represented a breach in the standard of care. He stated that the Respondent had tunnel vision and was focused on sexual abuse as the cause for the Patient's vulvar lesions, which prevented her consideration of other diagnoses.

Dr. [redacted] further opined that the Respondent did not meet the standard of care, particularly in her operative report/note for the procedure performed on the Patient on September 19, 2021, at the Hospital. He referenced an article "Analyzing Operative Note Structure in Development of a Section Header Resource," which cited the specific components to be documented after performing procedures or surgeries as identified by the Joint Commission, which is the body that certifies hospitals to operate, and reviews the care provided to patients to ensure it is standard.

> [The] Joint Commission designates eleven required elements for operative notes:
>
> 1. name(s) of primary surgeon/ physician and assistants,
> 2. pre-operative diagnosis,
> 3. post-operative diagnosis,
> 4. name of the procedure performed,
> 5. findings of the procedure,
> 6. specimens removed,
> 7. estimated blood loss,
> 8. date and time recorded,
> 9. indications for the procedure,
> 10. intra-operative complications, and
> 11. a full description of the procedure.

(Resp. Ex. 14, p. 1).

Dr. [redacted] explained that the Respondent's operative note from September 19, 2021, did not meet the standard of care, as it does not include an indication for the procedure, a pre-operative diagnosis or a post-operative diagnosis. He also opined that the Respondent should have requested and obtained the Patient's medical records from her two previous emergency department visits at [redacted] and [redacted] Dr. [redacted] testified that a reasonably competent

physician would have requested medical records, which would have helped in treating the Patient. He explained that the Patient was seen and treated for the same condition twice before being seen by the Respondent, and that it cost money to repeat investigations that could be obtained.

Dr. [redacted] further explained that the Respondent performed both a sexual assault examination and collection, and an invasive procedure without the consent of the Patient or her parents, which violated the standard of care. He stated that the Respondent exhibited tunnel vision from the time she initially saw the Patient in her office on September 17, 2021, believing that the Patient had been sexually assaulted. Dr. [redacted] testified that this tunnel vision hampered the Respondent's ability to exercise appropriate medical decision making and to come up with a differential diagnosis, which violated the standard of care.

Dr. [redacted] explained the importance of obtaining consent from patients and/or their family members if they are unable to consent. He stated that informed consent should document the procedures to be performed and that patients must trust that while under anesthesia only those procedures they have consented to will be performed. Dr. [redacted] testified that physicians cannot perform procedures that are not medically indicated. He explained that he reviewed the consent obtained by the Respondent prior to the Patient's procedure on September 19, 2021, and noted that the consent did not include a sexual assault examination and collection of samples or a consent to "virginity testing." Dr. [redacted] further explained that Respondent in her responses to the Board stated that she immediately recognized the signs of sexual assault upon her first encounter with the Patient in her office on September 17, 2021. However, she failed to obtain consent from the Patient or her parents to perform a sexual assault exam and she should have collected sexual assault samples prior to conducting her examination under general anesthesia to preserve evidence.

Dr. [redacted] opined that the Patient was likely suffering from Lipchutz ulcers, which occurred as a reaction to the COVID-19 vaccine she received on September 12, 2021. He explained that Lipchutz ulcers are ulcers or lesions that appear on the vulva, are rare, can be very painful, require supportive care and will resolve on their own within days to weeks. Dr. [redacted] stated that there is no definitive test to diagnose Lipchutz ulcers, and that it is a diagnosis of exclusion after ruling out other possible causes for the presence of vulvar ulcers or lesions.

Dr. [redacted]

Dr [redacted] s a Board-certified OB/GYN and holds MIGS and PAG focused practice designations. She has been a practicing OB/GYN physician for thirty-five years, consistently treating patients of all ages from children through adults. She sees a substantial number of children and adolescents in her private clinic practice.

Dr. [redacted] testified that she reviewed all the medical records for the Patient. She described and summarized the medical records for the care provided to the Patient at [redacted] and [redacted] prior to being seen by the Respondent; the Respondent's care both in her office and at the Hospital; the peer review reports; the transcripts from the Board's investigation, and the Respondent's response to the Board's charges. She concurred that medical record keeping, and documentation are an essential component of patient care.

Dr. [redacted] agreed that obtaining the Patient's medical records and test results from her previous emergency department visits would have been helpful, but she averred that the Respondent would have been unable to obtain them on a Friday afternoon, when the Patient first presented at her office or over the weekend when she continued to treat her at the Hospital, and stated that she does not believe the Respondent has access to CRISP.

Dr. [redacted] also disagreed with Dr. [redacted] 's characterization of the Respondents office note and operative notes. She characterized the Respondent's medical record keeping as

adequate, and opined that the Respondent made different findings once she performed the vaginoscopy under anesthesia, so her differential switched from infectious to trauma. She opined that she could infer the Respondent was trying to gather more information. Dr. [redacted] testified that she does not perform sexual assault examinations, but she was aware that informed consent is taken prior to conducting the exam, and that the medical professional conducting the exam should inform the patient or someone on their behalf as to what will be done.

Dr. [redacted] explained that there is no normal length for a vagina, and vaginal length is not something that is usually measured. She was familiar with the ACOG guidelines regarding "virginity testing," agreed that it was inappropriate to conduct such testing, and that there is no test to confirm virginity. Dr. [redacted] stated that the length of the vagina has no bearing on determining virginity.

Testimony of the Respondent

The Respondent is a Board-certified OB/GYN and holds MIGS and PAG focused practice designations. She has been a practicing OB/GYN physician for thirteen years, consistently treating patients of all ages from children through adults. She sees a substantial number of children and adolescents in her private, solo clinic practice. The Respondent stated that thirty to forty percent of her practice involves the treatment of adolescent patients, and the remainder of her practice involves seeing patients age thirty-five to forty years old who are done with childbearing but are experiencing other issues. She testified that she sees approximately 100-120 patients per week.

The Respondent explained that she sees patients for a range of gynecological issues including abdominal bleeding, fibroids, cramps, hormone replacement therapy, post-menopausal bleeding, contraception, cancer screening, infections, sexually transmitted diseases, vaginal discharge and annual examinations. She further explained that she sees approximately two

pediatric patients per month who are referred by their pediatricians for vaginal itching, smelly discharge, vulvar itching, labial adhesion, abnormal bleeding or premature puberty. The Respondent stated that she accepts commercial insurance and approximately fifty percent of her patients are insured through Medicaid.

The Respondent testified that she learned how to write medical records in medical school, utilizing the SOAP method – subjective and objective assessment plan. She stated that she participated in a medical record keeping course on September 11-12, 2021, under a consent order with the Board. The Respondent testified that she also took an additional course in medical recordkeeping on January 24, 2025, and an ethics and professionalism course January 25-26, 2025. She stated that she is glad she took the most recent courses, that she learned a lot of new changes and wants to improve.

The Respondent testified extensively regarding her knowledge and experience in identifying and treating patients who have been the victims of sexual assault. She highlighted that she is a mandated reporter of sexual abuse and that she evaluates five to six adolescents a year for sexual assault and that child protective services has reached out to her for her opinion and referred patients to her. The Respondent testified that she believes child abuse is under-reported and provided statistics on adolescent sexual assault and the long-term consequences experienced by victims of sexual assault.

The Respondent recounted in great detail her interaction with the Patient in her office on September 17, 2021, her facilitating the Patient's admission to the Hospital and her monitoring of the Patient's condition while at the Hospital. The Respondent described the Patient as experiencing unbearable pain, unable to provide a urine sample or to allow the Respondent to examine her.

The Respondent noted that the Patient's condition appeared unresponsive to pain medications and other treatments while at the Hospital, and she was still unable to perform a visual exam as every attempt seemed to aggravate the Patient more. The Respondent explained that this was a very unusual case, and that by the following day she made the decision to perform an examination of the Patient under anesthesia, using a vaginoscopy. She testified that she explained the procedure, the possible complications, and the risks of doing nothing, after which the Patient's mother signed the consent forms.

The Respondent testified that upon conducting the examination of the Patient under anesthesia and observing the vulvar ulcers and lesions, she suspected that they could be caused by a sexual assault. She explained that she contacted the forensic unit for a sexual assault kit, collected samples and cultures and completed the sexual assault kit for processing. The Respondent stated that she also took samples and a biopsy of the lesions to reach a diagnosis. She testified that she had no expectations, she just wanted answers.

The Respondent explained that she measured the Patient's vagina; orifice, and that a Patient who is sexually naïve should have a vagina that is two to four inches long, but that that Patient's vagina measured seven inches, which indicated sexual assault was a possibility. She stated that she did not have a ruler or other tools, so she inserted her three, gloved fingers inside the vaginal orifice to take her measurements. The Respondent explained that she did not reach a diagnosis for the Patient's vulvar ulcers on September 19, 2021, but her final impression was possible chronic trauma from suspected sexual abuse.

The Respondent conceded that reviewing the medical records from the Patient's previous emergency department visits to [redacted] and [redacted] would have been helpful, but she was adamant that she could not have obtained the records prior to Sunday, September 19, 2021, when she performed the examination and vaginoscopy of the Patient under anesthesia. She averred

that pain control is a human right and providing comfort to a sick child was the priority. The Respondent testified that once the Patient was transferred to [redacted] s no diagnosis was provided, just a differential diagnosis that the vulvar ulcers were most likely Lipschutz ulcers.

The Respondent explained that maybe her English was not articulated clearly in her operative note of September 19, 2021, but that she fulfilled all the requirements, that her documentation was good and more than adequate, and that any competent physician reading her note would understand. She stated that she did more than was required.

Analysis/Sanctions

Under sections 14-404(a)(22) and (40) of the Health Occupations Article, and subject to the Respondent's right to this hearing, a disciplinary panel may reprimand any licensee, place any licensee on probation and establish conditions of probation, or suspend or revoke a license if the licensee fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State or fails to keep adequate medical records as determined by appropriate peer review.

The Board's regulations include a sanctioning matrix that reflects the minimum and maximum penalties for conduct that is subject to disciplinary action. COMAR 10.32.02.10. Under this matrix, the maximum penalty for a violation of section 14-404(a)(22) of the Health Occupations Article is revocation of the Respondent's license, and the minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $5,000.00.

Under this matrix, the maximum penalty for violation of section 14-404(a)(40) of the Health Occupations Article is suspension of the Respondent's license for one year, and the

minimum penalty is a reprimand. The maximum fine for violation of this section is $50,000.00, and the minimum fine is $2,500.00.

The Board's regulations also identify mitigating and aggravating factors for imposing a penalty outside of the regulatory range. Mitigating factors include:

> (a) The absence of a prior disciplinary record;
> (b) The offender self-reported the incident;
> (c) The offender voluntarily admitted the misconduct, made full disclosure to the disciplinary panel and was cooperative during the disciplinary panel proceedings;
> (d) The offender implemented remedial measures to correct or mitigate the harm arising from the misconduct;
> (e) The offender made good faith efforts to make restitution or to rectify the consequences of the misconduct;
> (f) The offender has been rehabilitated or exhibits rehabilitative potential;
> (g) The misconduct was not premeditated;
> (h) There was no potential harm to patients or the public or other adverse impact; or
> (i) The incident was isolated and is not likely to recur.

COMAR 10.32.02.09B(5).

Aggravating factors may include, but are not limited to, the following:

> (a) The offender has a previous criminal or administrative disciplinary history;
> (b) The offense was committed deliberately or with gross negligence or recklessness;
> (c) The offense had the potential for or actually did cause patient harm;
> (d) The offense was part of a pattern of detrimental conduct;
> (e) The offender committed a combination of factually discrete offenses adjudicated in a single action;
> (f) The offender pursued his or her financial gain over the patient's welfare;
> (g) The patient was especially vulnerable;
> (h) The offender attempted to hide the error or misconduct from patients or others;
> (i) The offender concealed, falsified or destroyed evidence, or presented false testimony or evidence;
> (j) The offender did not cooperate with the investigation; or
> (k) Previous attempts to rehabilitate the offender were unsuccessful.

COMAR 10.32.02.09B(6).

It is of note that the Respondent did not raise any mitigating factors for my consideration,[9] and the State argued that there are none. Therefore, I find there are no mitigating factors for me to consider.

I considered aggravating factors, as follows:

- The Respondent has a previous administrative disciplinary history, for which she was reprimanded, placed on probation and fined just three months before the violations alleged in this case;
- The offense had the potential or actually did cause the Patient harm, as the Patient is a fifteen-year-old minor who underwent invasive procedures without her consent or the consent of her parents, and the Respondent performed virginity testing which is specifically denounced by ACOG.
- The Respondent committed a combination of factually discrete offenses adjudicated in a single action;
- Previous attempts to rehabilitate the Respondent were unsuccessful, in that she was previously ordered to complete a course on medical record keeping, and agreed to comply with all laws, rules, and regulations governing the practice of medicine.

In her testimony and written submissions to the Board, it is evident that the Respondent is a passionate physician who cares deeply about her profession and patients. Unfortunately, it also appears that the Respondent is unwilling to acknowledge that her medical recordkeeping was substandard. I found Dr. [redacted]'s opinion more probative and logical than Dr. [redacted] regarding the adequacy of the Respondent's record keeping.

Additionally, the Respondent failed to accept accountability for a serious violation in the standard of care for the Patient in this case when she performed what was characterized by both the State's expert Dr. [redacted] and her own witness Dr. [redacted] as virginity testing. The

[9] The Respondent's counsel focused the vast majority of her closing argument on allegations of religious and ethnic persecution, and arguing that the Hospital and the Board have a vendetta against the Respondent. I made it clear on the record during the hearing and will restate here that the Respondent's ethnicity and religion were given no weight in my proposed findings of facts, proposed sanctions or proposed ruling in this case. There was testimony by Dr. [redacted] and Ms [redacted] which alluded to the Respondent and the Patient being from the same community. However, based on the evidence presented, it is abundantly clear that the Respondent and the Patient do not share the same ethnicity or religious background.

Respondent performed both a sexual assault kit and very invasive virginity testing procedure on a fifteen-year-old, without her consent or the consent of her parents.

It is of particular concern that even after the lapse of time between the procedure performed in September 2021, and the pendency of this hearing which afforded the Respondent an opportunity to review all the medical records and hear the testimony presented from witnesses, the Respondent remains adamant that all of her actions and the procedures performed were justified, medically appropriate and met the standard of care.

The Respondent exhibited no remorse for her actions and maintains that her suspicion that the Patient had been sexually assaulted justified her actions, and her ignoring the differential diagnosis of Lipschutz ulcers which had been previously made by other physicians who examined the Patient before and after the Respondent. Additionally, the Respondent's testimony during the hearing was in stark contrast to her written responses to the Board. In her written response to the Board, in which the Respondent avers that she "recognized almost immediately the tell-tale signs of sexual assault, including unusual behavior by the parents in denying the potential of sexual assault." (Jt. Ex. 9, p. J0576). However, during the hearing the Respondent testified that she first suspected sexual assault when she examined the Patient under anesthesia. These contrasts and discrepancies call into question the Respondent's credibility.

In this case, the Board seeks to impose the disciplinary sanctions pursuant to Health Occ. § 14-404(a); COMAR 10.32.02.09A(3)(a); and COMAR 10.32.02.10. Considering the evidence presented, my findings, the arguments of the parties, and the identified aggravating factors, I agree with the Board and find the following represents an appropriate sanction:

1. The Respondent be reprimanded for her failure to keep adequate medical records.
2. The Respondent be suspended until she undergoes a comprehensive evaluation by the Maryland Professional Rehabilitation Program (MPRP) to determine whether she is fit to practice medicine safely and MPRP determines that she is safe to practice medicine.

3. Upon the Respondent's return to medicine, the Respondent will be placed on probation for one year, under supervision.

4. The Respondent's supervisor shall:
   - Review the records of ten patients each month, such patient records to be chosen by the supervisor and not the Respondent;
   - Meet in-person with the Respondent at least once each month and discuss in-person with the Respondent the care the Respondent has provided for these specific patients;
   - Be available to the Respondent for consultations on any patient;
   - Provide the Board with quarterly reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and
   - Immediately reports to the Board any indication that the Respondent may pose a substantial risk to patients.

I find that these sanctions are the only way the Board can determine whether the Respondent has been sufficiently rehabilitated to continue the practice of medicine. Under the applicable law, the Board may also impose a fine instead of or in addition to disciplinary sanctions against a licensee who is found to have violated section 14-404. COMAR 10.32.02.09A(3)(d). In this case, the Board is not seeking a fine, and I decline to propose the imposition of a fine.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Proposed Findings of Fact and Discussion, I conclude, as a matter of law, that the Respondent violated the charged provisions of the law. Md. Code Ann., Health Occ. §§ 14-101 through 14-509, and 14-601 through 14-607 (2021 & Supp. 2024). Specifically, by failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in the State (§ 14-404(a)(22)); and failing to keep adequate medical records as determined by appropriate peer review (§ 14-404(a)(40)).

I further conclude that the Respondent is subject to disciplinary sanctions for the cited violations. *Id.*; COMAR 10.32.02.09.

PROPOSED DISPOSITION

I **PROPOSE** that charges filed by the Maryland State Board of Physicians against the Respondent on September 28, 2023 be **UPHELD**; and

I **PROPOSE** that the Respondent be sanctioned as follows:

1. The Respondent be Reprimanded for her failure to keep adequate medical records.

2. The Respondent be Suspended until she undergoes a comprehensive evaluation by the Maryland Professional Rehabilitation Program (MPRP) to determine whether she is fit to practice medicine safely and MPRP determines that she is safe to practice medicine.

3. Upon the Respondent's return to medicine, the Respondent will be placed on probation for one year, under supervision.

4. The Respondent's supervisor shall:
   - Review the records of 10 patients each month, such patient records to be chosen by the supervisor and not the Respondent;
   - Meet in-person with the Respondent at least once each month and discuss in-person with the Respondent, the care the Respondent has provided for these specific patients;
   - Be available to the Respondent for consultations on any patient;
   - Provide the Board with quarterly reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and
   - Immediately report to the Board any indication that the Respondent may pose a substantial risk to patients.

[redacted]

June 9, 2025
Date Order Mailed

Jocelyn L. Williams
Administrative Law Judge

JLW/st
#217083

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision may file written exceptions with the disciplinary panel of the Maryland State Board of Physicians that delegated the captioned case to the Office of Administrative Hearings (OAH), and request a hearing on the exceptions. Md. Code Ann., State Gov't § 10-216(a) (2021); COMAR 10.32.02.05. Exceptions must be filed within fifteen (15) days of the date of issuance of this proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the Disciplinary Panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Christine A. Farrelly, Executive Director.

A copy of the exceptions should be mailed to the opposing attorney, and the other party will have fifteen (15) days from the filing of exceptions to file a written response addressed as above. *Id.* The disciplinary panel will issue a final order following the exceptions hearing or other formal panel proceedings. Md. Code Ann., State Gov't §§ 10-216, 10-221 (2021); COMAR 10.32.02.05C. The OAH is not a party to any review process.

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