

BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation Against: )  
)  
)

PETER CHARLES GLEASON, M.D. )

File No. 16-2008-192888

Physician's and Surgeon's )

Certificate No. G87635 )

Respondent. )  
\_\_\_\_\_ )

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 26, 2010.

IT IS SO ORDERED February 24, 2010.

MEDICAL BOARD OF CALIFORNIA

By: Shelton Duruisseau  
Shelton Duruisseau, Ph.D., Chair  
Panel A

1 EDMUND G. BROWN JR.  
Attorney General of California  
2 JOSE R. GUERRERO  
Supervising Deputy Attorney General  
3 JANE ZACK SIMON  
Deputy Attorney General [State Bar No. 116564]  
4 455 Golden Gate Avenue, Suite 11000  
San Francisco, CA 94102-7004  
5 Telephone: (415) 703-5544  
Fax: (415) 703-5480  
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7 *Attorneys for Complainant*  
*Medical Board of California*

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BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

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In the Matter of the Accusation Against:

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**PETER CHARLES GLEASON, M.D.**  
1783 Forest Drive  
Annapolis, MD 21401

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Physician's and Surgeon's  
Certificate No. G87635

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Respondent.

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IT IS HEREBY STIPULATED AND AGREED by and between the parties to the  
above-entitled proceedings as follows:

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Case No. 16-2008-192888

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

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3. At all times relevant herein, Respondent has been licensed by the Medical Board of California under Physician's and Surgeon's Certificate No. G87635. The certificate is renewed and current.

4. An Accusation ("Accusation") in case number 16-2008-192888 was filed with the Medical Board of California and is currently pending against Respondent. The Accusation, together with all statutorily required documents, was duly served on Respondent. A copy of the Accusation is attached as "Exhibit A."

5. Respondent has carefully read and understands the charges and allegations in the Accusation. Respondent has also carefully read and understands the effects of this Stipulated Settlement and Disciplinary Order ("Stipulation".)

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every one of these rights.

7. For the purpose of resolving the charges and allegations in Accusation No. 16-2008-192888, without the expense and uncertainty of further proceedings, Respondent agrees that cause exists to discipline his California physician's and surgeon's certificate pursuant to Business and Professions Code sections 2305 and 141.

8. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

9. This Stipulated Settlement shall be subject to the approval of the Board. Respondent acknowledges that he shall not be permitted to withdraw from this Stipulated

1 Settlement unless it is rejected by the Board. Respondent understands and agrees that Board staff  
2 and counsel for complainant may communicate directly regarding this Stipulated Settlement,  
3 without notice to or participation by Respondent. If the Board fails to adopt this Stipulated  
4 Settlement as its Order, the Stipulated Settlement shall be of no force or effect, it shall be  
5 inadmissible in any legal action between the parties, and the Board shall not be disqualified from  
6 further action in this matter by virtue of its consideration of this Stipulated Settlement.

7 10. The parties agree that facsimile or electronic copies of this Stipulated  
8 Settlement, including facsimile or electronic signatures on it, shall have the same force and effect  
9 as an original.

10 11. In consideration of the foregoing admissions and stipulations, the parties  
11 agree that the Board may, without further notice or formal proceeding, issue and enter the  
12 following Disciplinary Order:

13 **DISCIPLINARY ORDER**

14 **A. PUBLIC REPRIMAND**

15 IT IS HEREBY ORDERED THAT Respondent Peter Charles Gleason, M.D., as  
16 holder of Physician's and Surgeon's Certificate No. G87635, shall be and hereby is **publicly**  
17 **reprimanded** pursuant to Business and Professions Code section 2227. This Public Reprimand  
18 is issued as a result of action undertaken by the Maryland State Board of Physicians as follows:

19 On or about July 10, 2008, the Maryland State Board of Physicians issued a Final  
20 Decision and Order regarding Respondent's license to practice medicine in  
21 Maryland. The Maryland Board made findings that Respondent, a psychiatrist,  
22 regularly and over a long period of time, prescribed medications for a patient  
23 without noting either their side-effects or the patient's responses to the  
24 medications. He kept scant notes of his treatment of the patient, and his records  
25 failed to reflect the dosage, strength or frequency of the powerful medications he  
26 prescribed. The Maryland Board concluded that Respondent "has lost touch with  
27 the importance of maintaining adequate medical documentation." Based on these  
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1 findings, the Maryland Board issued a reprimand, placed Respondent's Maryland  
2 license on probation for a minimum of six months, and required Respondent to  
3 successfully complete comprehensive courses in medical records and in  
4 psychopharmacology for child and adolescent patients.

5  
6 **B. EDUCATION PROGRAM:** Within 60 calendar days of the effective  
7 date of this Disciplinary Order, Respondent shall enroll in and complete courses in both medical  
8 records documentation and prescribing practices relating to children and adolescents. The  
9 courses shall be at Respondent's expense, approved in advance by the Board or its designee.  
10 Courses taken after the acts that gave rise to the charges in the Accusation, but prior to the  
11 effective date of the Disciplinary Order may, in the sole discretion of the Board or its designee, be  
12 accepted towards the fulfillment of this condition if the courses would have been approved by the  
13 Board or its designee had the course been taken after the effective date of this Disciplinary Order.  
14 Respondent shall submit a certification of successful completion to the Board or its designee not  
15 later than 15 calendar days after successfully completing the course, or not later than 15 calendar  
16 days after the effective date of the Disciplinary Order, whichever is later. Failure to participate in  
17 or successfully complete the education program outlined above shall constitute unprofessional  
18 conduct and grounds for further disciplinary action.  
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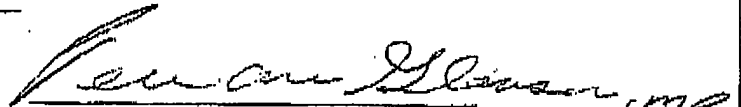
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ACCEPTANCE

I have read the foregoing Stipulated Settlement and Disciplinary Order in its entirety. I fully understand the terms of the Stipulated Settlement and their legal significance and the consequences of signing the Stipulated Settlement, and that I agree to this Stipulated Settlement. I stipulate and agree that a FAX or electronic copy of my signature shall be binding as an original.

DATED: 1/27/10

  
PETER CHARLES GLEASON, M.D.  
*Respondent*

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: \_\_\_\_\_

Respectfully Submitted,  
EDMUND G. BROWN JR.  
Attorney General of California

\_\_\_\_\_  
JANE ZACK SIMON  
Deputy Attorney General

*Attorneys for Complainant*

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ACCEPTANCE

I have read the foregoing Stipulated Settlement and Disciplinary Order in its entirety. I fully understand the terms of the Stipulated Settlement and their legal significance and the consequences of signing the Stipulated Settlement, and that I agree to this Stipulated Settlement. I stipulate and agree that a FAX or electronic copy of my signature shall be binding as an original.

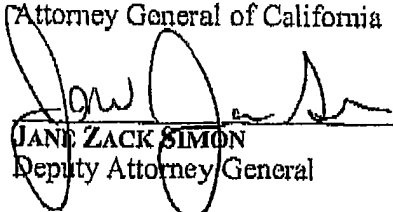
DATED: \_\_\_\_\_

PETER CHARLES GLEASON, M.D.  
*Respondent*

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 1.28/2016

Respectfully Submitted,  
EDMUND G. BROWN JR.  
Attorney General of California  
  
JANE ZACK SIMON  
Deputy Attorney General  
*Attorneys for Complainant*

1 EDMUND G. BROWN JR., Attorney General  
of the State of California  
2 JOSE R. GUERRERO  
Supervising Deputy Attorney General  
3 JANE ZACK SIMON  
Deputy Attorney General [SBN 116564]  
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San Francisco, California 94102  
5 Telephone: (415) 703-5544  
Facsimile: (415) 703-5480  
6

7 Attorneys for Complainant

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against: ) **Case No. 16-2008-192888**  
12 )  
13 **PETER CHARLES GLEASON, M.D.** ) **A C C U S A T I O N**  
1009 Bay Ridge Avenue )  
14 Annapolis, MD 21403 )  
15 )  
16 Physician's and Surgeon's )  
Certificate No. G87635 )  
17 )  
18 Respondent. )

19  
20 The Complainant alleges:

21 **PARTIES**

- 22 1. Complainant Barbara Johnston is the Executive Director of the Medical  
23 Board of California (hereinafter the "Board") and brings this accusation solely in her official  
24 capacity.  
25 2. On or about December 16, 2005, Physician's and Surgeon's Certificate No.  
26 G87635 was issued by the Board to Peter Charles Gleason, M.D. (hereinafter "respondent").  
27 Respondent's certificate is renewed and current, with an expiration date of April 30, 2009.



1 an agency of the federal government, or another country."

2 4. Respondent is subject to discipline within the meaning of section 141 and  
3 is guilty of unprofessional conduct within the meaning of section 2305 as more particularly set  
4 forth herein below.

5 **FIRST CAUSE FOR DISCIPLINE**

6 (Discipline, Restriction, or Limitation Imposed by Another State)

7 5. On or about July 10, 2008, the Maryland State Board of Physicians issued  
8 a Final Decision and Order regarding respondent's license to practice medicine in Maryland. The  
9 Maryland Board made findings that respondent, a psychiatrist, regularly and over a long period  
10 of time, prescribed medications for a patient without noting either their side-effects or the  
11 patient's responses to the medications. He kept scant notes of his treatment of the patient, and  
12 his records failed to reflect the dosage, strength or frequency of the powerful medications he  
13 prescribed. The Maryland Board concluded that respondent "has lost touch with the importance  
14 of maintaining adequate medical documentation." Based on these findings, the Maryland Board  
15 issued a reprimand, placed respondent's Maryland license on probation for a minimum of six  
16 months, and required respondent to successfully complete comprehensive courses in medical  
17 records and in psychopharmacology for child and adolescent patients.

18 Attached hereto as Exhibit A is a true and correct copy of the Final  
19 Decision and Order issued by the Maryland State Board of Physicians.

20 6. Respondent's conduct and the action of the Maryland State Board of  
21 Physicians as set forth in paragraph 5, above, constitute unprofessional conduct within the  
22 meaning of section 2305 and conduct subject to discipline within the meaning of section 141(a).

23 **PRAYER**

24 **WHEREFORE**, Complainant requests that a hearing be held on the matters  
25 herein alleged, and that following the hearing, the Board issue a decision:

26 1. Revoking or suspending Physician's and Surgeon's Certificate Number  
27 G87635, heretofore issued to respondent Peter Charles Gleason, M.D.

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- 2. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants;
- 3. Ordering respondent, if placed on probation, to pay the costs probation monitoring; and
- 4. Taking such other and further action as the Board deems necessary and proper.

DATED: October 20, 2008

  
\_\_\_\_\_  
**BARBARA JOHNSTON**  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California

Complainant

# **Exhibit A**

IN THE MATTER OF  
  
PETER C. GLEASON, M.D.  
  
License No. D 24640

\* BEFORE THE  
\*  
\* MARYLAND STATE  
\*  
\* BOARD OF PHYSICIANS  
\*  
\* Case Number 2005-0922  
\*

\* \* \* \* \*

FINAL DECISION AND ORDER

On February 7, 2007, the Board charged Peter C. Gleason, M.D. ("Dr. Gleason") with failing to provide quality medical care and failure to keep adequate medical records in his care of one patient, in violation of Sections 14-404(a)(22) and (40) of the Medical Practice Act, Md. Code Ann., Health Occ. § 14-101 *et seq.*

An evidentiary hearing was held before an Administrative Law Judge ("ALJ") of the Office of Administrative Hearings, and on October 31, 2007 the ALJ issued a proposed decision. Dr. Gleason filed written exceptions to the proposed decision, and the State filed a response to those exceptions. Both parties appeared before the Board for an oral exceptions hearing. This is the final decision of the Board on this case after considering the complete administrative record, including the written and oral exceptions filed by the parties.

## FINDINGS OF FACT

The Board adopts Findings of Fact #1- 38 proposed by the ALJ on pp. 3 - 9 of the proposed decision. (The proposed decision of the ALJ is hereby incorporated into this Final Decision and Order and attached as Attachment A.)

## CONCLUSIONS OF LAW

The Board will modify the conclusions of law proposed by the ALJ. The Board agrees with Dr. Gleason that this patient presented an especially difficult case, and the Board is not convinced that Dr. Gleason's prescribing practices alone violated the standard of quality care mandated by Md. Code Ann., Health Occ. § 14-404(a) (22). The Board therefore does not adopt the proposed conclusion of law that Dr. Gleason violated that provision of the statute. The Board concludes that there was no violation of the statute in this regard.

The Board, however, agrees with the conclusions of law proposed by the ALJ with respect to Dr. Gleason's failure to maintain adequate medical documentation within the meaning of Md. Code Ann., Health Occ. § 14-404(a) (40). As the ALJ found, Dr. Gleason "regularly prescribed medications for Patient A without noting either their side-effects or Patient A's responses to them." Dr. Gleason kept scant notes of his long-term

treatment of this patient, at one point treating the patient for 16 months with utterly deficient documentation, and his records sometimes did not reflect the dosage, strength or frequency of these powerful prescribed medications. The ALJ stated that "[i]t is clear that [Dr. Gleason] has lost touch with the importance of maintaining adequate medical documentation." The Board entirely agrees and concludes that Dr. Gleason violated Md. Code Ann., Health Occ. § 14-404(a) (40).

### SANCTION

The Board will reprimand Dr. Gleason and impose a period of probation. The conditions of probation will include the requirement that Dr. Gleason complete comprehensive courses in medical record keeping and in psychopharmacology for child and adolescent psychiatric patients.

### ORDER

It is therefore hereby **ORDERED**, that Peter C. Gleason, M.D., License Number D 24640, be **REPRIMANDED**; and it is further

**ORDERED** that Dr. Gleason be placed on **PROBATION** for a minimum of six months **and** until all of the following conditions are satisfied:

1. Dr. Gleason shall enroll in and successfully complete a comprehensive course in medical record keeping, at his own expense. Prior

to enrolling, Dr. Gleason shall submit the curriculum of any proposed course to the Board for approval. The Board will approve the course only if it deems the proposed course adequate to fulfill the need. Dr. Gleason is responsible also for submitting to the Board written proof that he has successfully completed the course. The course shall be in addition to any Continuing Medical Education courses normally required of all physicians.

2. Dr. Gleason shall enroll in and successfully complete a comprehensive course in psychopharmacology for child and adolescent patients, at his own expense. Prior to enrolling, Dr. Gleason shall submit the curriculum of any proposed course to the Board for approval. The Board will approve the course only if it deems the proposed course adequate to fulfill the need. Dr. Gleason is responsible also for submitting to the Board written proof that he has successfully completed the course. The course shall be in addition to any Continuing Medical Education courses normally required of all physicians; and it is further

**ORDERED** that Dr. Gleason shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

**ORDERED** that if Dr. Gleason violates any of the terms and conditions of probation or of this Order, the Board may impose any sanction

that the Board may have imposed in this case under §§ 14-404(a) or § 14-405.1 of the Medical Practice Act, including additional probation, a reprimand, additional suspension, revocation and a monetary fine. If the Board has reasonable cause to believe that Dr. Gleason has violated any of the conditions of probation or of this Order, Dr. Gleason will have the burden of demonstrating his compliance with the conditions; and it is further

**ORDERED** that Dr. Gleason shall not petition the Board for early termination of his probationary period, probationary conditions or any of the terms of this Order; and it is further

**ORDERED** that there will be no early termination of this probation, and it is further

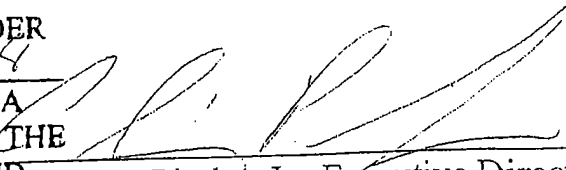
**ORDERED** that Dr. Gleason is responsible for all costs of his compliance with the conditions of this Order and the conditions of probation, and it is further

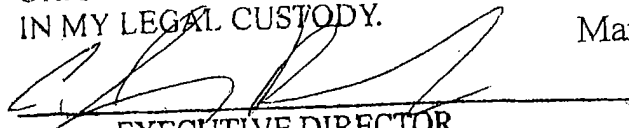
**ORDERED** that at the end of the six-month probationary period, and after he has successfully completed all of the conditions of probation, Dr. Gleason may petition the Board for termination of probation; and it is further

**ORDERED** that this Final Decision and Order of the Maryland State Board of Physicians is a public document pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.*

SO ORDERED this 16th day of July, 2008.

I HEREBY ATTEST AND CERTIFY UNDER  
PENALTY OF PERJURY ON 9/23/08  
THAT THE FORGOING DOCUMENT IS A  
FULL, TRUE AND CORRECT COPY OF THE  
ORIGINAL ON FILE IN MY OFFICE AND  
IN MY LEGAL CUSTODY.

  
C. Irving Pinder, Jr., Executive Director  
Maryland State Board of Physicians

  
EXECUTIVE DIRECTOR

MARYLAND BOARD OF PHYSICIANS Notice of Right to Appeal

If the Dr. Gleason is dissatisfied with this Final Decision and Order of the Board, he has the right to file a direct judicial appeal of this decision with the circuit court, under Md. Code Ann., State Gov't § 10-222, Md. Code Ann., Health Occ. § 14-408(b) and the Maryland Rules of Procedure at 7-200 *et seq.*

If Dr. Gleason files an appeal, the Board is a party and should be served with the court's process at the following address:

**Maryland State Board of Physicians  
4201 Patterson Avenue  
Baltimore, MD 21215**

In addition, if an appeal is filed, Dr. Gleason is requested to send a copy to the Board's counsel, Thomas W. Keech, Esq. at the Office of the Attorney General, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201.

The Administrative Prosecutor is no longer a party to this case and need not be served or copied.

STATE OF BOARD OF PHYSICIANS

v.

PETER C. GLEASON, M.D.,

License No. D24640,

RESPONDENT

\* BEFORE LATONYA B. DARGAN,  
\* AN ADMINISTRATIVE LAW JUDGE  
\* OF THE MARYLAND OFFICE  
\* OF ADMINISTRATIVE HEARINGS  
\* OAH Case No.: DHMH-SBP-71-07-18824  
\* SBP Case No.: 2005-0922

\* \* \* \* \*

PROPOSED DECISION

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

STATEMENT OF THE CASE

On February 20, 2007, the Maryland State Board of Physicians (Board) filed charges against Peter C. Gleason, M.D., License No. D24640 (Respondent), for alleged violations of Sections 14-404(a)(22) and (40) of the Health Occupations Article. Md. Code Ann., Health Occ., §§14-101 to 14-509 (2005 & Supp. 2007).

On June 14, 2007, I conducted an in-person pre-hearing conference. I issued a Pre-Hearing Conference Report and Order on July 5, 2007. On July 31 and August 2, 2007, I conducted a hearing at the Maryland Office of Administrative Hearings (OAH) in Hunt Valley, Maryland. Md. Code Ann., § 14-405(a) (2005). Assistant Attorney General Janet Brown appeared on behalf of the Board. The Respondent represented himself.

The contested case provisions of the Administrative Procedure Act, the Board's Rules of Procedure, and the OAH's Rules of Procedure govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2004 & Supp. 2007); Code of Maryland Regulations (COMAR) 10.32.02 and 28.02.01.

### ISSUES

- 1) Did the Respondent violate the provisions of §§ 14-404 (a)(22) and (40) of the Health Occupations Article; and, if so,
- 2) what is the appropriate sanction?

### SUMMARY OF THE EVIDENCE

#### Exhibits

The following exhibits were admitted into evidence on behalf of the Board:

- Board #1: February 20, 2007 Statement of Disciplinary Charges
- Board #2: A. Dr. Peter A. Kahn's August 30, 2006 Peer Review Report  
B. Dr. Kathryn H. Watt's August 31, 2006 Peer Review Report
- Board #3: A. Dr. Peter A. Kahn's *Curriculum Vita*  
B. Dr. Kathryn H. Watt's *Curriculum Vita*
- Board #4: A. The Board's May 2, 2006 letter to the Maryland Psychiatric Society  
B. Documents submitted for peer review:  
i. Mr. and Mrs. R.'s June 7, 2005 complaint<sup>1</sup>  
ii. Transcript of April 6, 2006 interview with Mrs. R.  
iii. The Respondent's December 28, 2005 response to the complaint  
iv. Transcript of April 7, 2006 interview with the Respondent

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<sup>1</sup> In order to protect the confidentiality of the complainant patient and his family, the patient's parents are referred to throughout this decision only by their last initial and the patient is referred to throughout this decision as Patient A.

- v. Medical records for Patient A, as received from the Respondent
- vi. Medical records for Patient A, as received from Calvert Psychiatric Associates

Board #5: Documents received from Mrs. R. at April 6, 2006 interview

Board #6: Vic Tolentino's November 29, 2006 Investigative Report

The Respondent did not submit any exhibits.

### Testimony

The Board presented the testimony of the following witnesses:

1. Kathryn H. Watt, M.D., accepted as an expert in General Psychiatry and Child & Adolescent Psychiatry
2. Peter A. Kahn, M.D., accepted as an expert in General Psychiatry and Child & Adolescent Psychiatry
3. Mrs. R., Patient A's mother

The Respondent did not testify and he did not present any witnesses.

### FINDINGS OF FACT

After considering the evidence, I find the following facts by a preponderance of the evidence:

1. At all times relevant to this matter, the Respondent was a licensed physician in Maryland. The Respondent last renewed his license, License No. D24640, in Summer 2004, and the license expired on December 31, 2006.
2. From 1984 through approximately April 2003, the Respondent practiced psychiatry with Calvert Psychiatric Associates (CPA), where he treated patients on both inpatient and outpatient bases.

3. Sometime in April/May 1998, the Respondent began providing psychiatric treatment to Patient A (DOB: 11/28/94), who was three years old at the time.
4. At the time Patient A was referred to the Respondent, his pediatrician had diagnosed Patient A with Attention Deficit Hyperactivity Disorder (ADHD).
5. In response to the ADHD diagnosis, the Respondent initially prescribed Ritalin for Patient A.
6. From April/May 1998 through 1999, the Respondent saw Patient A on a monthly basis for medication management. Sometime in 1999, the Respondent began seeing Patient A every other month at a CPA satellite office in Annapolis, Maryland.
7. In June 2001, Patient A's behavior deteriorated to the point that he experienced frequent angry outbursts and threatened to harm himself and animals. At that time, Mrs. R., Patient A's mother, arranged for him to be treated by a psychologist for these behavioral difficulties. The Respondent continued to provide Patient A with medication management.
8. In September 2001, Patient A became increasingly aggressive, experienced auditory command hallucinations, and began urinating in dresser drawers. As a result, he was admitted to Sheppard Pratt Hospital (Sheppard Pratt) in Towson, Maryland for one week.
9. During Patient A's September 2001 hospitalization at Sheppard Pratt, Mrs. R. was unable to reach the Respondent, despite efforts to do so, to advise him that Patient A had been hospitalized.

10. The Respondent does not have records of his treatment of Patient A from April/May 1998 through September 2001.

11. On or around April 23, 2002, Patient A returned to CPA to resume medication management with the Respondent.

12. On April 23, 2002, the Respondent completed a New Patient Evaluation Form for Patient A. At that time, the Respondent diagnosed Patient A with "Impulse Control Disorder/ADH". The Respondent prescribed Risperdol at .25 mg every three hours as needed for agitation, Clonidine at 0.1 mg, and Metadate at 60 mg. The Respondent's notes did not indicate at what frequency the Clonidine and Metadate should be administered.

13. In May 2002, the Respondent continued to prescribe Risperdol to Patient A. The Respondent changed the Clonidine prescription to 0.1 mg, three times per day and changed the Metadate prescription to 20 mg, three times per day. The Respondent did not document a progress note to explain the frequency of the Clonidine and Metadate dosages. The Respondent also did not document the rationale for the changed Metadate dosage.

14. On June 5, 2002, the Respondent saw Patient A. At that time, the Respondent documented that "EKG at ER was okay," but did not document why an EKG was performed. The Respondent did not document Patient A's responses to the prescribed medications of Clonidine, Metadate and Risperdol.

15. On June 5, 2002, the Respondent changed Patient A's Metadate prescription from 20 mg to 60 mg and changed the Clonidine prescription to 0.2 mg. The Respondent's documentation did not contain a frequency at which the

Metadate was to be administered. Although the Respondent noted the frequencies at which the Clonidine and Risperdol were to be administered, his notations were illegible.

16. Sometime in June 2002, the Respondent began prescribing Ritalin at 10 mg, to be administered to Patient A while he was in school. The Respondent did not document the rationale for reinstating Ritalin in Patient A's medication regimen.
17. On September 29, 2002, the Respondent saw Patient A, but he did not document Patient A's responses to the prescribed medications of Clonidine, Metadate, Risperdol and Ritalin. The Respondent also did not document any aspects of Patient A's current mental status.
18. On September 29, 2002, the Respondent prescribed long-acting Ritalin at 20 mg, four times a day for Patient A. The Respondent did not document the rationale for changing the medication type or for increasing the dosage.
19. Sometime in October 2002, the Respondent changed Patient A's prescription to slow-release Ritalin at 20 mg, four times a day, but did not document the rationale for the change.
20. On November 6, 2002, the Respondent again saw Patient A. At that time, the Respondent did not document Patient A's responses to the four prescribed medications.
21. On November 6, 2002, the Respondent's documentation of the dosage amount of Risperdol was illegible, as was the documentation of the frequency at which Clonidine was to be administered to Patient A.

22. On March 24, 2003, the Respondent saw Patient A. The Respondent did not document Patient A's responses to his prescribed medications. The Respondent also did not document any aspect of a Patient A's current mental status.
23. On March 24, 2003, the Respondent added Straterra to Patient A's medication regimen at a dosage of 25 mg up to 75 mg. The Respondent did not document the frequency at which Straterra was to be administered, nor did he document the rationale for its addition.
24. In an undated progress note, the Respondent discontinued the administration of Clonidine to Patient A and added Tenex at 2 mg to Patient A's medication regimen. The Respondent did not document the rationale for either change. The frequency at which Tenex was to be administered was illegible.
25. From the time Patient A resumed treating with the Respondent in April 2002 through April 2003, Mrs. R. experienced frequent difficulty speaking to the Respondent. Mrs. R. attempted to reach the Respondent by calling his assistant Carolyn Hu and leaving messages, or by calling the Respondent's cellular telephone number, but her calls were frequently not returned.
26. At the end of April 2003, the Respondent left the group practice at CPA for a part-time solo practice in Annapolis, Maryland.
27. The Respondent saw Patient A at his solo practice from May 2003 through September 2004.
28. The Respondent's record of his treatment of Patient A from May 2003 through September 2004 consisted of four pages of clinical notes. Two pages

were undated, one page was an October 2002 medication note, and the fourth page was a September 25, 2004 evaluation.

29. One of the undated progress notes has a partial date of "9/". In the "9/" note, the Respondent increased Patient A's dosage of Straterra to 75 mg. The Respondent also resumed prescribing Clonidine at 0.1 mg. The Respondent did not document the rationale for the increased dosage of Straterra or the for resumption of Clonidine.
30. In another undated progress note, the Respondent discontinued Ritalin, but he did not document the rationale for doing so. The Respondent also prescribed Dexedrine to Patient A, but did not document the rationale for adding Dexedrine to the patient's medication regimen.
31. On September 25, 2004, the Respondent saw Patient A. The only mental status impression the Respondent documented was the word "worry." The Respondent did not document any response Patient A had to the various prescribed medications.
32. On September 25, 2004, the Respondent diagnosed Patient A with Obsessive Compulsive Disorder (OCD), but he did not document the rationale for the diagnosis. The Respondent also prescribed Lexapro at 5 mg per day, to increase to 30 mg per day, but he did not document a rationale for adding Lexapro.
33. On September 25, 2004, the Respondent prescribed Ritalin for Patient A, in long-acting form at a dosage of 120 mg per day, and in regular form at a dosage of 30 mg per day. There is no documentation of when Ritalin was re-

instituted. The Respondent also did not document why it was prescribed at such a high dosage.

34. In October 2004, Patient A's problematic behavior increased to the point that he was setting fires in the neighborhood and expressing homicidal and suicidal ideation. Mrs. R. attempted to contact the Respondent to discuss Patient A's behavior, but the Respondent did not return her calls.

35. On October 9, 2004, Patient A was admitted to Sheppard Pratt, where he remained until October 15, 2004. The Respondent had no involvement in the Patient's October 2004 stay at Sheppard Pratt because Mrs. R. did not advise him that Patient A had been hospitalized.

36. On or around October 24, 2004, the Respondent advised Mrs. R. that he was closing his solo practice. The Respondent further advised Mrs. R. that upon her request he would forward Patient A's records to subsequent treating psychiatrists.

37. In early 2005, Patient A was referred to Kennedy Krieger Institute where he began treatment with a behavioral psychiatrist.

38. In early 2005, Mrs. R. sent a request for records to the Respondent via facsimile. In response, she received the two undated pages of clinical notes and the October 2002 medication note.<sup>2</sup> Mrs. R. made subsequent record requests via first-class mail, but her correspondence was returned to her by the United States Postal Service.

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<sup>2</sup> The Respondent provided the September 25, 2004 progress note to the Board during its investigation.

## DISCUSSION

### *Alleged Statutory Violations*

The Board charged the Respondent with violating the following provisions of Section 14-404 of the Health Occupations Article:

a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, 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; ...

(40) Fails to keep adequate medical records as determined by appropriate peer review.

In a physician disciplinary proceeding, the Board bears the burden of proof by a preponderance of the evidence. Md. Code Ann., Health Occ., § 14-405(b)(2)(2005). The Board argued that the Respondent failed to meet appropriate standards of care in his treatment of Patient A when the Respondent: (i) failed to adequately monitor Patient A's severe symptoms; (ii) prescribed a high dose of Ritalin (150 mg per day) without medical justification; (iii) prescribed Ritalin at higher than usual doses without indicating the potential risks/side effects of the drug; (iv) failed to consider the possibility that the increase in Patient A's problematic behavior in September and October 2004 was a side effect of the high dosage of stimulants (Ritalin) that had been prescribed for Patient A; (v) failed to indicate attention to the possibility that the introduction of Lexapro to Patient A's medication regimen could result in the emergence of suicidal ideation; (vi) failed to monitor Patient A's status while on Lexapro; (vii) discontinued or initiated medications

without providing medical rationale for doing so; and, (viii) failed to be adequately available by telephone in the event of emergency. (*see* Board #1, pp. 12-13).

The Board further argued that the Respondent failed to meet appropriate standards of care in his medical documentation of Patient A's treatment when he: (i) failed to consistently document the absence or presence of side effects when prescribing high doses of a psycho-stimulant (Ritalin); (ii) failed to document responses to treatment; (iii) failed to adequately and consistently document the details of dispensed medications, such as the frequency and/or strength of dosing; (iv) failed to document a rationale for the addition, discontinuation, or resumption of medications; (v) failed to document a rationale for the September 25, 2004 diagnosis of OCD; (vi) failed to document office visits and prescribed medications between May 2003 and September 24, 2004; (vii) failed to produce the complete medical record of Patient A; (viii) failed to date all entries into the medical record; and, (ix) failed to maintain a legible medical record. (*see* Board #1, p. 13)

Dr. Kathryn Watt, who was accepted as an expert in General Psychiatry and in Child and Adolescent Psychiatry and who served as one of the assigned peer reviewers during the Board's investigation, testified at length about the problematic nature of the Respondent's medical documentation for and treatment of Patient A. Dr. Watt, who presented as very knowledgeable, testified that in her opinion the Respondent's treatment of Patient A did not meet the standards of quality medical care. (T. 43; *see also* Board #2B).

Dr. Watt was troubled by the Respondent's consistent failure to keep a record of Patient A's symptoms and how Patient A responded to the various prescribed

medications. (T. 44). In Dr. Watt's expert opinion, the standard of care requires that with any medication change, a physician document the reason for the change and document how the patient responds to the change. (T. 67). Dr. Watt further testified that it is important to keep track of a patient's responses to prescribed medications so that adjustments can be made to dosages and medication types if necessary. (T. 49-50, 58). In Dr. Watt's opinion, the Respondent's consistent failure to document the basis for Patient A's medication changes, or to document how Patient A responded to the changes, violated the standard of care. (T. 49-50, 61, 67).

Dr. Watt applied her opinion to the specific example of the Respondent's use of Ritalin with Patient A. She testified that 130 mg of Ritalin is an unusually high dose for a nine-year-old child (Patient A's age at the time he was on the 150 mg/day dosage of Ritalin). (T. 74). She noted that Ritalin in high doses can cause the kind of behaviors seen in Patient A, such as the auditory hallucinations and urination in dresser drawers. (T. 58). Dr. Watt further noted that given Patient A's extreme aggressiveness and out-of-control behavior in September 2004, it was very likely that Ritalin was not helping him. (T. 74-75). According to Dr. Watt, the standard of care requires a re-assessment of the use of Ritalin, including efforts to determine whether Ritalin was causing the increased symptoms, and the Respondent's notes do not reflect that he ever ruled Ritalin out as the cause of Patient A's most troubling symptoms. (T. 58-60, 64, 74-75, 78).

In addition to the problems with the Respondent's use of Ritalin with Patient A, Dr. Watt was also troubled by the Respondent's decision to prescribe Lexapro for Patient A in September 2004. Dr. Watt testified that in September 2004, there was a great deal of information in the medical literature about Lexapro's likelihood to lead to an increase in

suicidal ideation when prescribed to child or adolescent psychiatric patients. (T. 44). According to Dr. Watt (and as demonstrated by a review of the available documentation), the Respondent's notes do not document that the Respondent had any awareness of this possible side-effect. (T. 44; *see generally*, Board #4B, pp. PG10157-10160). In Dr. Watt's opinion, the Respondent did not adequately follow Patient A's responses to Lexapro. (T. 44). Dr. Watt was further of the opinion that it was inappropriate for the Respondent to prescribe Lexapro to Patient A when the Respondent was only in the office once per month. (T. 80).

Dr. Watt additionally testified as to the importance of adequate record-keeping. Dr. Watt candidly acknowledged that without reasonable note-taking, doctors are often unable to remember everything about a patient's care. (T. 62). In her expert opinion, good note-taking makes it easier to track patient care and for other physicians to take over the care of a patient when the primary care physician is unavailable. (T. 63). According to Dr. Watt, the Respondent's documentation of his May 2003 through September 2004 treatment of Patient A did not conform to the standard of care because it was often illegible and the Respondent failed to maintain a pharmacy log that accurately reflected the dosage strength and frequency of the prescribed medications. (T. 79).

Dr. Watt was also confounded by the Respondent's September 24, 2004 diagnosis that Patient A was suffering from OCD. According to Dr. Watt, the Respondent's notation of "worrying," with no other symptoms indicated, is insufficient to support a completely new diagnosis. (T. 75-76). As Dr. Watt noted:

Pretty much everybody worries, and we don't all have OCD. You need to – it needs to meet certain criteria, where you're worrying excessively well beyond what most people worry about. Over – and you

tend to worry about the same things over and over, there's some compulsions, which are ritualized behaviors that the child feels the need to engage in. That's part of it also.

(T. 75-76). Dr. Watt went on to state that the standard of care requires that a complete description of symptoms be present before a diagnosis of a new condition is made. (T. 76).

Dr. Watt also addressed the Respondent's inability to produce the records of Patient A's treatment when asked to do so. In Dr. Watt's opinion, the standard of care was breached when Mrs. R. was unable to obtain Patient A's medical records from the Respondent despite an almost two-year period of requesting them. (T. 85-86). According to Dr. Watt, people are entitled to their medical records, and when the Respondent was unable to locate Patient A's, he should have typed a summary of Patient A's treatment to give to Mrs. R. in lieu of the complete record. (T. 86).

Dr. Peter Kahn, who was accepted as an expert in General Psychiatry and in Child and Adolescent Psychiatry and who served as the other peer reviewer in this case, corroborated Dr. Watt's testimony in many key aspects. (*See generally*, Board #2A). Like Dr. Watt, Dr. Kahn presented as a knowledgeable, thoughtful witness. He corroborated Dr. Watt's opinion as to the inadequacy of the Respondent's records of treatment for Patient A, describing the records as "incomplete" and "scanty." (T. 230). Dr. Kahn was likewise troubled by the Respondent's failure to document the presence or absence of side effects from Ritalin, his failure to provide information supporting the September 2004 diagnosis of OCD, and his failure to consider the possibility that the new September 2004 symptoms were the result of Patient A being on an unusually high dose of Ritalin. (T. 233-234, 235-236). In Dr. Kahn's opinion, it is a violation of the standard

of care to fail to either document the side-effects and reactions to prescribed medications, or to assess whether new symptoms are a function of currently prescribed medications. (T. 240-241).

Dr. Kahn elaborated on the issues surrounding the Respondent's prescription of Lexapro for Patient A. Dr. Kahn testified that Lexapro is in a class of drugs known as Selective Serotonin Reuptake Inhibitors (SSRIs). Dr. Kahn noted that in September 2004, there was a great deal of medical literature that discussed the link between the prescription of SSRIs to children and adolescents and increased instances of suicidal ideation in those patient populations. (T. 238-240). In Dr. Kahn's opinion based on the available medical records, the Respondent did not consider the possibility that prescribing Lexapro for Patient A could lead to the appearance of suicidal ideation. (T. 238-239). Dr. Kahn was further of the opinion that the Respondent's failure to monitor how Patient A responded to Lexapro constituted a violation of the standard of care. (T. 240-241).

Dr. Kahn additionally testified about the Respondent's availability, or lack thereof, to Patient A and his family. According to Dr. Kahn, doctors need to be reasonably available to their patients, and it was problematic that the Respondent so often failed to respond to Mrs. R.'s attempts to contact him. (T. 244). Both Dr. Watt and Dr. Kahn felt that the Respondent's failure to respond to Mrs. R.'s phone calls when Patient A was hospitalized in September 2001, and his failure to follow-up on the hospitalization by contacting either Mrs. R. or Sheppard Pratt, were violations of the standard of care. (T. 84, 246-247).

It must be noted that the Respondent did not testify and he did not present the testimony of his assistant Carolyn Hu, despite identifying her as a possible witness during

the pre-hearing conference. The Board urged me to consider the "missing witness rule" and to apply it to the Respondent's failure to present any witnesses. "The 'missing witness rule' or 'empty chair doctrine' permits an adverse inference to be drawn from a party's failure to call a material witness, when the circumstances are such that the party should naturally have called the missing witness." *Bereano v. State Ethics Commission*, 174 Md.App. 146, 182 (2004) (quoting, *Maryland Evidence Handbook* §409(B), at 142 (3<sup>rd</sup> ed. 1999)). The Court of Appeals has further clarified the "missing witness rule," noting that, "[t]he unfavorable inference applies, however, only where it would be most natural under the circumstances for a party to speak, call witnesses or present evidence." *Radin v. Supervisor of Assessments of Mont. Co.*, 254 Md. 294, 301 (1969). The *Bereano* court specifically held that it was appropriate for an administrative fact-finder to utilize the "missing witness rule" when a party failed to call a witness in circumstances where it was natural for the party to do so. 174 Md.App. at 188.

I find that the Board has overwhelmingly satisfied its burden of proof this case. Drs. Watt and Kahn, both accepted as experts, testified credibly and persuasively as to the various breaches of the standard of care committed by the Respondent. Their testimony is supported by a review of the documentary evidence. Furthermore, their testimony is unrefuted. I am frankly stymied by the fact that the Respondent, in his solo practice, treated Patient A for approximately 16 months but was only able to produce four pages of clinical notes. With the exception of the September 25, 2004 evaluation, those notes are incomplete on their face, as they are either undated or partially illegible in key respects. Dr. Watt characterized the September 25, 2004 evaluation as a "real" note because it is adequate despite its sparseness (T. 73, 77), but even that document is

problematic due to the Respondent's determination of a new diagnosis despite a lack of sufficient medical rationale. The record also demonstrates that during the Respondent's time with CPA, he regularly prescribed medications for Patient A without noting either their side-effects or Patient A's responses to them. (*see* Board #4Bvi).

Mrs. R. also credibly testified about her difficulties in obtaining Patient A's medical records from the Respondent, and in speaking with the Respondent about Patient A's care. Mrs. R.'s testimony on these points was unrefuted. It is significant to note that in the Respondent's response to the Board as well as in his interview with Drs. Watt and Kahn, the Respondent indicated that Carolyn Hu took his messages and relayed them to him. (Board #4Biii, Testimony of Drs. Watt and Kahn). Ms. Hu, however, did not testify before me to shed light on whether Mrs. R.'s messages ever reached the Respondent. Under the "missing witness rule," I draw a negative inference from the fact that Ms. Hu did not testify even though the Respondent identified her as a possible witness. I find it likely that Ms. Hu would have been unable to refute Mrs. R.'s testimony about the difficulties Mrs. R. experienced in contacting the Respondent.

#### *Proposed Sanctions*

The Board argued that the appropriate sanction in this case is a 30-day suspension, effective as of the date the Board issues its final order. The Board further argued that the Respondent should be required to attend two comprehensive, Board-approved continuing medical education courses in (i) medical record documentation, and (ii) psychopharmacology in child/adolescent psychiatric patients, and to provide written documentation of course completion before an application for reinstatement is

considered. The Board additionally argued that the Respondent should be required to personally appear before a re-instatement inquiry panel.

For his part, the Respondent felt that a 30-day suspension was too harsh. He indicated his willingness to take a record-keeping course. He further indicated that he would only take the psychopharmacology class if ordered to do so.

After a review of all the evidence in this matter, I find that the Board's proposed sanctions are appropriate. The evidence demonstrates that the Respondent violated appropriate standards of medical care in a number of ways during the course of his treatment of Patient A. It is clear that the Respondent has lost touch with the importance of maintaining adequate medical documentation. He was not sufficiently vigilant in monitoring Patient A's responses to the multiple medications he prescribed, and he was insufficiently available to Patient A during times of crisis (the September 2001 hospitalization). In light of the numerous ways in which the Respondent's conduct breached applicable standards of care, a 30-day suspension along with the continuing medical education classes is a reasonable sanction.

#### CONCLUSIONS OF LAW

Based on the Foregoing Findings of Fact and Discussion, I conclude as a matter of law that the Respondent violated Health Occupations Article §§ 14-404(22) and (40) (2005). I further conclude as a matter of law that as a result of the Respondent's violations, the Board may discipline the Respondent. Health Occupations Article § 14-404(a)(2005).

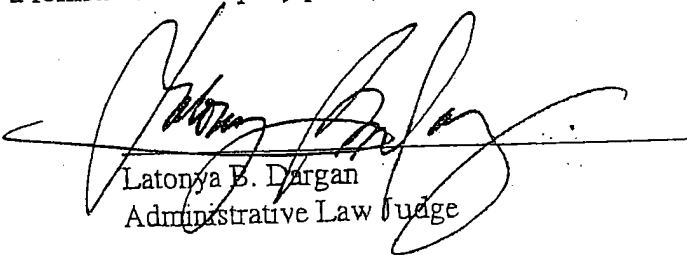
## PROPOSED DISPOSITION

I PROPOSE that the Maryland State Board of Physicians' February 2, 2007 charges against Respondent Peter C. Gleason, M.D., License No. D24640, be **UPHELD**.

I further PROPOSE that the Respondent's license be **suspended** for a period of 30 days, effective on the date the Board issues its final order in this matter, and that an application for reinstatement not be considered until the Respondent complies with the following conditions:

- 1) Complete a comprehensive, Board-approved course in the subject of medical records documentation;
- 2) complete a comprehensive, Board-approved course in the subject of psychopharmacology in child/adolescent psychiatric patients;
- 3) provide written documentation to the Board of the completion of both courses;
- 4) complete an application for reinstatement; and,
- 5) personally appear before a reinstatement inquiry panel.

October 31, 2007  
Date

  
Latonya B. Dargan  
Administrative Law Judge

#92668

## NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file written exceptions to this Proposed Decision with the Board of Physicians within fifteen days of receipt of the decision. Md. Code Ann., State Gov't § 10-216 (2004) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

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STATE OF BOARD OF PHYSICIANS

v.

PETER C. GLEASON, M.D.,

License No. D24640,

RESPONDENT

\* BEFORE LATONYA B. DARGAN,

\* AN ADMINISTRATIVE LAW JUDGE

\* OF THE MARYLAND OFFICE

\* OF ADMINISTRATIVE HEARINGS

\* OAH Case No.: DHMH-SBP-71-07-18824

\* SBP Case No.: 2005-0922

\* \* \* \* \*

FILE EXHIBIT LIST

Board Exhibits:

- Board #1: February 20, 2007 Statement of Disciplinary Charges
- Board #2: A. Dr. Peter A. Kahn's August 30, 2006 Peer Review Report  
C. Dr. Kathryn H. Watt's August 31, 2006 Peer Review Report
- Board #3: A. Dr. Peter A. Kahn's *Curriculum Vita*  
C. Dr. Kathryn H. Watt's *Curriculum Vita*
- Board #4: A. The Board's May 2, 2006 letter to the Maryland Psychiatric Society  
C. Documents submitted for peer review:  
vii. Mr. and Mrs. R.'s June 7, 2005 complaint  
viii. Transcript of April 6, 2006 interview with Mrs. R.  
ix. The Respondent's December 28, 2005 response to the complaint  
x. Transcript of April 7, 2006 interview with the Respondent  
xi. Medical records for Patient A, as received from the Respondent  
xii. Medical records for Patient A, as received from Calvert Psychiatric Associates
- Board #5: Documents received from Mrs. R. at April 6, 2006 interview

Board #6: Vic Tolentino's November 29, 2006 Investigative Report

Respondent Exhibits:

The Respondent did not submit any exhibits.