IN THE MATTER OF	*	BEFORE THE
CHRISTOPHER RUSH, D.C.	*	MARYLAND STATE BOARD
Respondent	*	CHIROPRACTIC EXAMINERS
License Number: 02053	*	Case Number: 04-35C

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

FINAL DECISION AND ORDER

BACKGROUND

On May 16, 2005, the Maryland State Board of Chiropractic Examiners (the "Board") issued Charges against Christopher Rush, D.C. (the "Respondent"), license number 02053, pursuant to its authority under the Maryland Chiropractic Act (the "Act"), Maryland Health Occ. Code Ann., ("H.O.") §§ 3-101 *et seq.*, (2000 Repl. Vol. and 2004 Supp.). Specifically, the Board charged Respondent with violating the following provisions of H.O. § 3-313:

> Subject to the hearing provisions of § 3-315 of this subtitle, the Board may deny a license to any applicant, reprimand any licensee, place any licensee on probation, with or without conditions, or suspend or revoke a license, or any combination thereof, if the applicant or licensee:
>
> (13) Fails to file or record any report as required by law;
>
> (18) Practices chiropractic with an unauthorized person or supervises or aids an unauthorized person in the practice of chiropractic;
>
> (19) Violates any rule or regulation adopted by the Board; [or]
>
> (21) Commits an act of unprofessional conduct in the practice of chiropractic[.]

The regulation that the Board charged the Respondent with violating is Code Md. Regs. tit. 10, § 43.14.03 ("COMAR"), for Respondent's failure to cooperate with a lawful investigation conducted by the Board.

An evidentiary hearing on the merits of the case was held on January 11, 2007 and March 8, 2007, before a quorum of the Board, pursuant to H.O. § 3-315(a). On October 2, 2007, the Board issued a Final Opinion and Order ("Order") that found violations of HO § 3-313(18), (19) and (21) and COMAR 10.43.14.03. Respondent took a timely appeal of the Board's Order in the Circuit Court for Worcester County. Upon consideration of memoranda filed by the Respondent and the Board, as well as oral argument, the Honorable Theodore R. Eschenburg issued the Court's Opinion on October 2, 2008. In the Opinion, the Court ordered that this case be remanded to the Board for a new hearing.

On July 30, 2009, a new hearing was held before a quorum of the Board. At that time, the Board ruled on the preliminary motions. On July 17, 2009, the Respondent filed a Motion for Transfer of Hearing to an Administrative Law Judge. The State filed its response on July 22, 2009.

Pursuant to HO § 3-315(a), and the Administrative Procedure Act ("APA"), specifically Maryland State Gov't Code Ann. ("SG") § 10-205(a)(1), the Board has the authority to conduct a contested case hearing or to delegate that authority to the Office of Administrative Hearings ("OAH"). The option is discretionary on the part of the Board. In addition, COMAR 10.43.02.04C requires all motions to be filed at least fifteen (15) days prior to the hearing. Respondent's motion was filed thirteen (13) days prior to the hearing. Therefore, as there is no legal requirement to refer the case to the OAH,

and because Respondent's motion was not timely, the Board found Respondent's motion to be without merit and denied same.

Following the Board's ruling on Respondent's motion, Respondent moved that Dr. O'Hara, Dr. Sadula, Ms. Jenkins and Ms. Frizzera-Hucek be recused from the hearing. Respondent argued that the presence of the aforementioned Board members creates an appearance of impropriety. Respondent asserted the reason for this is that these Board members were present at the hearing in 2007, when a former Board member, Dr. Ashton, was present as well.

This case had been remanded by the Court for a new hearing due to the appearance of impropriety caused by Dr. Ashton's presence at the prior hearing. Dr. Ashton is no longer a member of the Board. There is no reason that the Board, as it is composed now, would be unable to be fair and impartial. Therefore, the Board denied Respondent's motion.

Respondent made two (2) objections to the State's Exhibits. Respondent objected to State's Exhibit 5, the Affidavit of Trina Palmer. Respondent argued that the affidavit should not be admitted because Respondent does not have the opportunity to cross-examine Ms. Palmer at this hearing today. Respondent, however, did not subpoena Ms. Palmer. Therefore, he waived his right to cross-examine this individual. In any case, hearsay is admissible in the proceeding if it has sufficient indicia of reliability. The Board believes that it does. The Board overruled Respondent's objection and accepted State's Exhibit 5.

Respondent also objected to State's Exhibit 7, the Supplemental Report of Investigative Activity of the Board's investigator, David Ford. Respondent argued that

since Mr. Ford is a witness in the case, then the investigative reports are improper exhibits. The Board's investigative reports are relevant to the case, and they are appropriate exhibits in an administrative hearing. Mr. Ford also was available for cross-examination regarding anything in the reports. The Board overruled Respondent's objection and accepted State's Exhibit 7.

The State of Maryland ("the State") proceeded on the Charges that were issued on May 16, 2005. At the onset of the hearing, however, the State made an oral amendment to the Charges and advised the Board that it would not be going forward with Charges under HO § 3-313(13). The Board accepted the State's amendment to the Charges, and the hearing proceeded.

The Board issues this Final Decision and Order based upon its consideration of the entire record, including the exhibits, witness testimony and oral arguments. For the reasons set forth below, the Board approves and adopts this Final Decision and Order.

SUMMARY OF EVIDENCE

A. Documents

The following documents were admitted into evidence on behalf of the State:

1. Charges Under the Maryland Chiropractic Act – May 16, 2005
2. Subpoena Duces Tecum directed to Respondent – August 12, 2004
3. Report of Investigation, Case No. 04-35C, with attached exhibits:
   a. Complaint from Patient A[1] with attachments – July 26, 2004
   b. Letter from Respondent to Board – September 1, 2004

      Re: Narrative Report – Patient A

[1] For confidentiality purposes, patient names are not identified in this Final Decision and Order. The identity of the patients is known to Respondent, and the Board maintains a list of patient names which corresponds to the alphabetical letters used.

c. Letter from Respondent to Board – October 14, 2004

Re: Low Level Laser Light Therapy

d. Chiropractic Treatment Records – Patient A

4. Letter from the Board to the Respondent – November 26, 2004

Re: Written Questions

5. Affidavit of Trina Palmer – November 30, 2004

6. Responses to Board Interrogatories from the Respondent – December 21, 2004

7. Supplemental Report of Investigative Activity – January 19, 2005

8. Chiropractic Treatment Records – Patient B

9. Chiropractic Treatment Records – Patient C

10. Chiropractic Treatment Records – Patient D

The following documents were entered into evidence on behalf of the Respondent:

A. Respondent's Motion to Transfer of Hearing to an Administrative Law Judge in the Matter of Timothy J. Young

B. Opinion of the Circuit Court for Worcester County – October 2, 2008

C. Final Opinion and Order of the Board – October 2, 2007

D. Board Notice to Licensees Regarding Low Level Laser Use

B. Summary of Pertinent Witness Testimony

The State and the Respondent presented only one witness each at the hearing. The State's witness was Mr. David Ford, who is the investigator for the Board. Respondent testified on his own behalf.

David Ford

Mr. Ford testified that he has been employed as an investigator with the Board for approximately ten years. (T. 37). In the course of his employment with the Board, he has participated in about 30 investigations per year. (T. 37). He testified that when a complaint comes to the Board, the Executive Director assigns it to Mr. Ford for investigation. (T. 86).

Mr. Ford testified that the Board received a written complaint from Patient A on July 27, 2004. (T. 39; State's Ex. 3a). When the Board received this complaint, it was assigned to Mr. Ford, and he was directed "to investigate the case." (T. 86).

In the complaint, Patient A alleged that Respondent incorrectly diagnosed her with a herniated disc in her low back and that Respondent's treatment made her symptoms worse. (State's Ex. 3a). Mr. Ford testified that when he interviewed Patient A, she further alleged that she received laser light therapy treatment from Respondent and from Trina Palmer, Respondent's office assistant. (T. 41; State's Ex. 3).

Mr. Ford testified that he interviewed Patient A, sent a subpoena to Respondent for Patient A's records and interviewed Respondent over the telephone regarding the complaint. (T. 40-41; State's Ex. 2). Mr. Ford further testified that, in response to the subpoena and a request for information regarding Patient A's complaint, Respondent sent to him Patient A's records. (T. 41; State's Ex. 3d).

Respondent also sent a letter to Mr. Ford in which he detailed Patient A's treatment. (T. 43; State's Ex. 3b). The letter, dated September 1, 2004, is titled "Narrative Report" and is four (4) pages long. (State's Ex. 3b). The Narrative Report from Respondent notes that he diagnosed Patient A with a lumbar disc herniation as

well as lumbosacral neuritis/radiculitis, lumbar and cervical disc degeneration and segmental dysfunction of lumbar and cervical spine. (State's Ex. 3b). The Narrative Report addresses Patient A's physical complaints, social history, past medical history, history of present complaint, physical examination, which included a general examination, a spinal examination and a ortho-neurological examination. (State's Ex. 3b). In the Narrative Report, Respondent also reviewed Patient A's limitations of activities of daily living, radiographic examination, diagnoses and treatment. (State's Ex. 3b). Respondent made no mention of his use of laser light therapy on Patient A in the Narrative Report. (T. 43 and 172; State's Ex. 3b).

Mr. Ford testified that, as a result of the allegations in Patient A's complaint, he needed to visit Respondent's office in Berlin, Maryland, where Patient A was treated. (T. 44). Mr. Ford stated that he "needed to go out, take a look and then present the facts back to the Board to have them make a determination." (T. 85). Mr. Ford further testified that, in the course of investigating the specific allegations in a complaint, he also investigates whether the chiropractor is "performing other procedures" and "any other problems there at that particular office." (T. 114-115).

Mr. Ford testified that, on October 13, 2004, he went to Respondent's office in Berlin, Maryland. (T. 45). When Mr. Ford arrived at the office, he presented his business card to the receptionist, and Respondent "came out shortly thereafter" to see why Mr. Ford was there. (T. 45-46). Mr. Ford stated that the focus of his visit was "to check on licenses" and "go into the various treatment rooms where there weren't any patients to see what was there." (T. 46).

Mr. Ford testified that he and Respondent went through various treatment rooms that were unoccupied. (T. 47 and State's Ex. 3). Mr. Ford further testified that he observed a laser light therapy machine in one of the rooms and that Respondent confirmed that he used this machine on Patient A. (T. 47 and State's Ex. 3). Mr. Ford also testified that Respondent told him that he permitted his receptionist, Trina Palmer, to perform laser light therapy on Patient A as well as on Patients B, C and D. (T. 47-48; State's Ex. 3). Mr. Ford testified that, while at Dr. Rush's office, he reviewed the records of Patients A, B, C and D. (T. 47-48; State's Ex. 3).

Mr. Ford testified that, at some point during his visit at Respondent's office, Respondent received a telephone call from his attorney. (T. 50). After speaking briefly on the phone with his attorney, Respondent advised Mr. Ford that the interview was over and, if Mr. Ford had any further questions, he could direct them to Respondent's attorney. (T. 50). Mr. Ford further testified that he understood that the interview was over at that time. (T. 50).

Mr. Ford testified that, as he was walking out of the office, he was going to take a photograph of the laser light therapy machine, which was located in a room across from the room where he and Respondent had been talking. (T. 50). As Mr. Ford got to the threshold of the door, Respondent put his hand around his shoulder and pulled him back out of the doorway. (T. 50, 98 and 100; State's Ex. 3). Mr. Ford further testified that, in all his years as a Board investigator, he never had an individual place his or her hands on him in this manner during the course of an investigation. (T. 51-52).

Mr. Ford testified that he was at Respondent's office approximately 20 – 25 minutes, and he was unable to complete his investigation when he was asked to leave

the office. (T. 52-53). Mr. Ford further testified that Respondent would not permit him to speak to Respondent's wife, who also is a chiropractor in the practice. (T. 53-54). Mr. Ford testified that when he asked Respondent if he could speak to Respondent's wife that Respondent stated that she was seeing patients. (T. 53, 95) Mr. Ford stated that interviewing other chiropractors in a practice is a commonly done in the course of an investigation. (T. 54).

Mr. Ford then testified that, in the course of his investigation of Patient A's complaint, he also contacted Trina Palmer, a former employee of the Respondent. (T. 54; State's Ex. 3). After speaking with Ms. Palmer, Mr. Ford prepared an affidavit that was consistent with the information that Ms. Palmer provided to Mr. Ford regarding her job duties while employed by Respondent. (T. 54-55). Ms. Palmer signed the affidavit on November 30, 2004. (State's Ex. 5).

Mr. Ford testified that Ms. Palmer advised him that she was employed by Respondent from November 2003 through October 2004. (T. 54; State's Ex. 5). During her employment, her job duties included taking patients' blood pressures and pulses, testing for weight imbalances, performing range of motion testing and administering laser light therapy. (T. 54, 106; State's Ex. 5). Mr. Ford explained how Ms. Palmer described a weight imbalancing test that she performed on patients. (T. 54-55). This testing involved "two bathroom scales with a rod that comes straight up from the center of the two scales." (T. 55, 105). Mr. Ford stated that Ms. Palmer advised him that she "was able to measure any imbalance that a patient had in their shoulders" and would assist Respondent with these examinations. (T. 55). Ms. Palmer told Mr. Ford that she was trained in these duties by Respondent's billing clerk. (T. 55; State's Ex. 5).

In furtherance of the Board investigation, Mr. Ford testified that he subpoenaed additional patient records from Respondent. (T. 56-58). Respondent complied with the subpoena and provided the records. (T. 58; State's Ex. 8, 9 and 10).

Mr. Ford returned to Respondent's office on December 22, 2004. (T. 58). At that time, Mr. Ford received the subpoenaed records and was permitted to take a photograph of the laser light unit. (T. 61-61; State's Ex. 7). Mr. Ford also testified that, at the time of his second visit to Respondent' office, the Respondent provided Mr. Ford with a booklet on the laser light therapy machine. (T. 62; State's Ex. 7). Mr. Ford stated that the booklet:

> "explains what reimbursement codes could be used, codes that are described as unspecified modality 97026 and 97039. The codes can be found in the CPT code book under the physical medicine and rehabilitation, along with other physical therapy codes.
>
> The book also provides a sample reimbursement letter which states that 'Phototherapy, also known as light therapy or low level laser therapy, is a physical modality.'"

(T. 62-63; State's Ex. 7) Mr. Ford's testimony was consistent with his investigative reports, State's Exhibits 3 and 7.

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The Respondent testified on his own behalf. Respondent testified that he is a graduate of Bloomsburg University and Sherman College of Chiropractic. (T. 122). Respondent also testified that he became a licensed chiropractor in the State of Maryland in 2001. (T. 121). Respondent and his wife, also a chiropractor, practice chiropractic in an office in Berlin, Maryland. (T. 212).

Respondent testified that, in 2004, he purchased a laser light therapy machine, the Medex unit, and used it on his patients. (T. 126, 131). Respondent explained that,

in using this treatment, he would place the diodes of the machine on the patient's "exposed skin" and turn on the machine. (T. 133-134). He further explained that Trina Palmer, his receptionist, also would turn on the laser and "remove the laser or diodes" from the patient. (T. 134). Respondent stated that he put the laser and diodes on the patient and that Ms. Palmer would assist by holding the diodes. (T. 141, 190). Respondent would leave the treatment room while the diodes were being administered to a patient by Ms. Palmer. (T. 176). Respondent testified that "we used it on six patients." (T. 131).

Respondent testified that both he and Ms. Palmer would make entries in patients' files with regard to laser light therapy treatment. (T. 138-141). Respondent further testified that Ms. Palmer did not make entries in patients' files regarding physical examinations, blood pressures, pulses or range of motion tests. (T. 142).

Respondent stated that he permitted Ms. Palmer to write SOAP notes[2] in patients' files. (T. 174-177). Respondent further stated that, in Patient A's record, Ms. Palmer wrote some of the SOAP notes. (T. 174-175). Respondent testified that Ms. Palmer did not sign the notes, and Respondent also did not co-sign the notes. (T. 175-177). Respondent testified that Ms. Palmer filled out SOAP notes for other patients as well. (T. 177).

Respondent stated that while he permitted Ms. Palmer to perform laser therapy treatment on patients, he did not permit Ms. Palmer to take blood pressure readings, pulses, range of motion testing, weight imbalances or do physical examinations of the patients. (T. 142, 160 and 180). Respondent further testified that he did not own the

[2] The SOAP note is a method of documentation used by health care professionals in a patient's chart. SOAP is an acronym for the 4 components of the note: Subjective, Objective, Assessment and Plan.

type of weight machine for measuring imbalances in his office as Ms. Palmer described in her affidavit. (T. 143; State's Ex. 5). When asked how he derived the weight numbers for Patient A that read 60/55, Respondent did not know. (T. 192; State's Ex. 3d). When asked the same question regarding the weight numbers for Patient C that read 96/100 and for Patient D that read 90/70, Respondent stated that he could have derived the numbers by having the patient put "weight on one foot and then weight on the other because of weight bearing." (T. 192-194; State's Ex. 9 and 10).

With regard to the Board's investigation into the complaint made by Patient A, Respondent testified that he complied with the Board's subpoena for Patient A's records. (T. 144). Respondent further testified, regarding his Narrative Report, that he did not mention that he performed laser light therapy on Patient A because it "was very new," and he "didn't know if it was even a chiropractic treatment or not." (T. 145). Respondent also admitted that his not mentioning the laser light therapy in his Narrative Report was misleading to the Board. (T. 169-172).

Respondent testified that, in the course of the Board's investigation into Patient A's complaint, he initially told Mr. Ford in 2004 that he treated "approximately ten" patients in his practice with laser therapy. (T. 166-167). Respondent conceded that at the previous hearing in this matter in 2007, he had testified that he treated four patients with laser therapy. (T 167). At this hearing, Respondent testified that the actual number of patients whom he treated with laser therapy was six. (T. 167-168).

With regard to Mr. Ford's visit to Respondent's practice on October 13, 2004, Respondent testified that he met with Mr. Ford and that they went through all of the rooms of the office when Mr. Ford first arrived. (T. 147-149). He stated that he showed

him everything and that he "didn't have anything to hide." (T. 149). He also stated that patients were being treated at the time that Mr. Ford was in the office. (T. 191).

Respondent testified that, after receiving a telephone call from his attorney, Respondent advised Mr. Ford that it was "time for him to leave." (T. 156). Respondent further testified that, as Mr. Ford was walking out of the room, Respondent was directly behind Mr. Ford. (T. 156). At that point, Respondent stated that Mr. Ford turned quickly and bumped into Respondent and hit Respondent in the left shoulder. (T. 156-157). Respondent further stated that his contact with Mr. Ford was accidental or incidental and that Respondent did not pull Mr. Ford from the treatment room. (T. 184-186).

Respondent testified that he does not provide physical therapy modalities in his office, that he is not licensed as a physical therapist and that he is not a "supervising chiropractor." (T. 124). Respondent admitted that he was not familiar with the Board's regulations regarding supervision in the practice of chiropractic. (T. 177).

FINDINGS OF FACT

Based upon the testimony and the exhibits presented at the evidentiary hearing, the Board finds the following facts to be true by a preponderance of the evidence:

1. At all times relevant, Respondent was and is licensed to practice chiropractic in the State of Maryland. Respondent initially was licensed on October 5, 2001 and issued license number 02053.

2. At all times relevant, Respondent was practicing chiropractic at Healing Hands Chiropractic, P.C., located at 10776 Gray's Corner Road, Unit #8, Berlin, Maryland 21811.

3. On or about July 27, 2004, the Board received a complaint from Patient A alleging that Respondent was her treating chiropractor from June 17, 2004 through July 18, 2004.

4. In the complaint, Patient A alleged that she provided Respondent with MRI pictures of her spine and that Respondent informed Patient A that she had a herniated disc in her lower spine.

5. Respondent placed Patient A in a treatment plan for which Patient A pre-paid.

6. After Patient A's condition worsened, Patient A terminated the treatment plan and requested a refund. Patient A stated in her complaint that three neurologists later advised Patient A that she did not have a herniated disc.

7. As a result of the Patient A's complaint, the Board opened a lawful investigation.

8. Patient A advised the Board investigator, Mr. Ford, that she received laser light therapy treatments from Respondent and from Respondent's assistant, Trina Palmer.

9. Respondent and Ms. Palmer performed laser light therapy on Patient A and also on Patients B, C, and D. Ms. Palmer would hold and remove the laser diodes from the patients.

10. Ms. Palmer was Respondent's receptionist from November 2003 through October 2004 and is not a licensed heath care professional or a chiropractic assistant.

11. Ms. Palmer's duties as Respondent's employee also included taking patients' blood pressures and pulses, testing patients' weight imbalances and performing range of motion testing on patients.

12. Ms. Palmer wrote SOAP notes in Patient A's file. Ms. Palmer did not sign the notes, and Respondent did not co-sign the notes.

13. Ms. Palmer also wrote SOAP notes in files for other patients of Respondent. In other words, in some instances, the record of a patient's subjective complaints, objective manifestations, the practice's assessment of the problem and the treatment plan for a patient were those created by Ms. Palmer.

14. In the course of the Board's investigation, Respondent complied with subpoenas, provided records and wrote a Narrative Report to the Board with regard to Patient A.

15. In the Narrative Report, Respondent intentionally omitted that he provided laser light therapy to Patient A. His omission was misleading to the Board.

16. On October 13, 2004, Mr. Ford, the Board's investigator, lawfully entered Respondent's place of business as part of the Board's investigation of Patient A's complaint.

17. While Mr. Ford was at Respondent's office, patients were being treated by Respondent's wife who also is a chiropractor in the office.

18. Mr. Ford was able to review and inspect patient records, professional licenses and unoccupied rooms while at Respondent's office.

19. During Mr. Ford's inspection of the office and records, Respondent's attorney returned Respondent's earlier phone call.

20. As a result of that phone call, Respondent advised Mr. Ford that the interview was over and that Mr. Ford must leave the premises.

21. Mr. Ford asked Respondent if he could speak to Respondent's wife before he left, and Respondent advised him that he could not.

22. As Respondent and Mr. Ford were leaving the room where they had been speaking, Mr. Ford proceeded to the threshold of the doorway of a room where the laser light therapy machine was located. Mr. Ford was going to take a picture of the laser light therapy machine.

23. As Mr. Ford attempted to take the picture, Respondent put his hand on Mr. Ford's shoulder and pulled him out of the doorway.

24. Respondent deliberately prevented Mr. Ford from taking the photograph in the course of the Board's lawful investigation.

25. Respondent is not licensed as a physical therapist, nor is he a supervising chiropractor.

26. Respondent is not familiar with the Maryland regulations regarding supervision in the practice of chiropractic.

DISCUSSION

A. LAWFUL INVESTIGATION

Pursuant to HO § 3-205(b)(4), the Maryland State Board of Chiropractic Examiners (the "Board") is mandated by the Maryland General Assembly to investigate any "alleged violation" of the Maryland Chiropractic Act (the "Act"), that is HO §§ 3-101 *et seq.* When the Board receives a complaint against a licensee, it must review the complaint in consideration of the Act. If the allegations in a complaint, on its face, rise

to the level of a violation of the Act, if true, then the Board is obligated to the citizens of Maryland, as well as required by statute, to open an investigation into the matter.

In the case at bar, the Board received a complaint from Patient A against Respondent. Patient A alleged in her complaint, among other things, that (1) Respondent incorrectly and falsely diagnosed her condition, and (2) Respondent's treatment made Patient A's condition worse. Other allegations included Respondent misleading Patient A and trying to sell Patient A unwanted products and services. If true, these allegations could be violations of the Board's statute, HO § 3-313(8), (9), (11), (19) and/or (21). Accordingly, the Board was statutorily required to investigate this case, and this was a lawful investigation of the Board.

The Board's investigator, Mr. Ford, proceeded as he would in any other case in that he contacted and interviewed the complainant, the Respondent and any potential witnesses. Mr. Ford also subpoenaed records from Respondent and propounded written questions to Respondent.

As also was appropriate and common in investigations, Mr. Ford presented himself at Respondent's place of business. This is done in order to inspect the area where the allegations took place, as well as to review professional licenses, patient records and to garner any additional information about Respondent's practice. It is not uncommon for an investigator to bring a camera for photographic documentation of the office.

Pursuant to Maryland Health Gen. Code Ann. ("HG") § 2-104(l)(1), the Board's investigator "may enter, at any reasonable hour, a place of business or public premises if the entry is necessary to carry out a duty under this article or under the Health

Occupations Article." Furthermore, Respondent "may not deny or interfere with an entry under this subsection." (HG § 2-104(l)(2)). Thus, not only is a subpoena unnecessary for the investigator to proceed under this statute, but Mr. Ford's presence in Respondent's office was appropriate and legally sound.

B. CREDIBILITY

The Board must determine what evidence and witnesses are credible, and to what extent, in this case. Mr. Ford's testimony was consistent with both of the investigative reports entered into evidence. Mr. Ford's job as Board investigator is to gather information and report it to the Board. An investigator should not have any interest in reporting false information to the Board. There was no indication at the hearing that Mr. Ford had any such interest. Mr. Ford's demeanor did not appear to reflect any malice on his part toward Respondent, and he appeared to be interested in simply stating the plain facts of the case in a professional manner. Thus, the Board found Mr. Ford to be a credible witness.

Respondent's testimony, however, was not helpful in his defense of the charges against him. Respondent was inconsistent in his responses to the question regarding how many patients he had treated with laser light therapy. In the past, Respondent had told the investigator that the answer to that question was ten. At the hearing in 2007, he said that the number was four. At this hearing, he said that the true number is six.

In the early stages of the investigation, when Respondent had the opportunity to explain his treatment of Patient A, Respondent submitted a four-page account to the Board, detailing everything from Patient A's past medical and social history to present complaint, diagnosis and treatment, but failing to mention that he treated Respondent

with laser light therapy. When cross-examined on this point, Respondent admitted making the omission deliberately and also admitted that this was misleading to the Board. This certainly makes Respondent less credible in the eyes of the Board.

When Respondent was asked to explain the notations in Patient A's chart pertaining to Patient A's weight that read 60/55, Respondent stated that he did not know how those numbers were derived. With regard to the same question for Patients C and D, Respondent speculated that the numbers could be from the patients weighing on the scale one foot at a time. In any event, he claimed that he could not definitively explain notations in his own patients' files. This testimony was not credible to the Board.

State's Exhibit 5 is a signed and sworn affidavit from Trina Palmer, former employee of Respondent. Ms. Palmer attests that one of her many job duties while working for Respondent included testing for weigh imbalance. Ms. Palmer attests that she would make notations in a patient's file of a patient's weight on his/her right and left side. She also attested that she would examine a patient's posture to see if his/her shoulders and hips were balanced. This was corroborated and further explained in Mr. Ford's testimony. Mr. Ford stated that Ms. Palmer described to him an apparatus resembling two bathroom scales with a rod coming up from the center and a cross bar on the top. Mr. Ford testified that Ms. Palmer stated that she used this apparatus to measure patients' imbalances and that Ms. Palmer assisted Respondent and his wife with these examinations.

The description of weight imbalance testing as provided by Ms. Palmer's affidavit and Mr. Ford's testimony is entirely reasonable and consistent with the numbers 60/55, 96/100 and 90/70 used in the files to describe the patients' weights. It is not credible to

the Board that Respondent does not know the meaning of these notations in his patients' files. The Board did not believe this testimony.

Moreover, regarding State's Exhibit 5, Ms. Palmer attests that her job duties included taking patients' blood pressure readings and pulses, performing range of motion testing examinations and administering laser light therapy to patients. Oddly, Respondent agrees that he permitted Ms. Palmer, the office receptionist, to perform laser light therapy on his patients and to write notes in patients' files, but he insists that he did not permit her to do any of the other activities. The Board has given Respondent's testimony on this issue little credence because of Respondent's less than credible testimony on the weight imbalancing issue.

Respondent did not subpoena Ms. Palmer to testify at this hearing. Only Respondent contradicted those statements in her affidavit, and the Board has found him not to be a credible witness. The Board finds the statements in the affidavit by Ms. Palmer to be credible. The Board believes that Ms. Palmer performed the duties as she described and that she assisted the Respondent in the practice of chiropractic. Respondent thus was practicing with and supervising an unauthorized person in the practice of chiropractic.

Respondent's blatant omission in his Narrative Report was dishonest and misleading, and his testimony has lacked consistency and could not explain notations in his own charts. Additionally, Respondent has an obvious motive to avoid discipline from the Board and has not been forthright in his statements to the Board. The Board does not find Respondent to be a credible witness.

C. BEHAVIOR DURING INVESTIGATION

It was well settled by the Court of Appeals in *Comfeld v. Board of Physicians*, 174 Md. App. 456 (2007), that a doctor's dishonesty in hospital peer review proceedings and Board investigation qualified as unprofessional conduct in the practice of medicine. The same holds true in this case. Respondent was dishonest in his Narrative Report to the Board, and his omission of information was misleading. By being less than fully forthcoming in his response to the Board, he was not compliant with the Board's regulations that directly and specifically require him to cooperate with a Board investigation.

In addition, Respondent physically pulled the Board's investigator out of a room. At no time is it appropriate for a licensee to touch a Board investigator. While Respondent's attorney may have advised Mr. Ford that the interview was over, Mr. Ford was still conducting a lawful investigation and was legally present in Respondent's office. This incident at Respondent's office created undue delay in the investigation of this matter, and Respondent's behavior toward Mr. Ford was unacceptable and constitutes unprofessional conduct.

CONCLUSIONS OF LAW

Based upon the foregoing Summary of Evidence, Findings of Fact and Discussion, the Board concludes as a matter of law that Respondent has violated the following provisions of HO § 3-313:

> Subject to the hearing provisions of §3-315 of this subtitle, the Board may deny a license to any applicant, reprimand any licensee, place any licensee on probation, with or without conditions, or suspend or revoke a license, or any combination thereof, if the applicant or licensee:

(18) Practices chiropractic with an unauthorized person or supervises or aids an unauthorized person in the practice of chiropractic;

(19) Violates any rule or regulation adopted by the Board; [or]

(22) Commits an act of unprofessional conduct in the practice of chiropractic[.]

The Board further concludes as a matter of law that Respondent also has violated the following provisions of COMAR 10.43.14.03:

A. A chiropractor and chiropractic assistant shall:

(8) Cooperate with any lawful investigation conducted by the Board, including:

(a) Furnishing information requested,

(c) Responding to a complaint at the request of the Board, and

(d) Providing meaningful and timely access to relevant patient records[;].

The Board does not find that Respondent violated HO § 3-313(13), fails to file or record any report as required by law, or COMAR 10.43.14.03C(8)(b), fails to comply with a subpoena.

SANCTION

Respondent is an experienced chiropractor. Respondent's lack of knowledge of the Board's statute and regulations is troubling to the Board. By permitting an office receptionist, who has no formal training in physically examining patients, to conduct such physical examinations and to have hands-on contact with patients during various treatments is unacceptable. Additionally, Respondent allowed this receptionist to input SOAP notes in patient files. Respondent testified that he did not know what some notations meant. If the testimony was true, Respondent's practice was dishearteningly

sloppy. If he did know and his testimony is false, he lacks integrity. In either case, Respondent's behavior does not meet the standards that the public is entitled to expect from a licensed professional.

Respondent's actions during the course of the investigation also are unimpressive to the Board, to say the least. The Board expects, and the regulations require, that licensees will fully cooperate with the Board investigator. The Board investigator must be treated with respect and professionalism. To physically touch an investigator in an effort to remove him from the licensee's premises will not be tolerated by the Board. In addition, when responding to the Board regarding a complaint, anything less than full disclosure is misleading to the Board and in violation of the regulations.

Respondent has at no time acknowledged any error or misconduct on his part. On the contrary, he has said, or not said, whatever he has needed to in order to avoid admitting any wrongdoing. This, of course, is the crux of what made him not credible on the witness stand.

In light of the Respondent's misconduct and his failure to acknowledge his errors, the Board shall impose a public reprimand of his license, probation for two years, a fine of $2500.00 for each statutory violation, successful completion of an educational course in ethics and a passing grade on the Board's Jurisprudence Examination. These fines were determined in accordance with COMAR 10.43.10.05.. The Board finds that Respondent actions were willful and made in effort to generate revenue. The Board finds that absent completion of an ethics course and the Jurisprudence Examination, the Respondent is likely to engage again in similar unprofessional conduct to the

detriment of the health of his patients. As the Board's sanctions act as a "catharsis for the profession and a prophylactic for the public," (*McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426, 436 (1984)), it is imperative that chiropractors understand that serious misconduct has ramifications beyond a mere reprimand and is likely to have some effect on one's practice.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 22nd day of October, 2009, by a majority of the full authorized membership of the Board, hereby

ORDERED that Respondent, Christopher Rush, D.C., is REPRIMANDED; and it is further

ORDERED that Respondent's license shall be placed on PROBATION for two (2) years, effective immediately; and it is further

ORDERED that, within six (6) months of the effective date of this Final Decision and Order, Respondent shall pay a fine to the Board in the amount of $7500.00, which shall be paid to the General Fund of the State of Maryland; and it is further

ORDERED that Respondent shall enroll in a Board pre-approved, individual, graduate-level, ethics tutorial, with the following conditions:

1. Respondent shall notify the Board in writing that he enrolled in a Board pre-approved, individual, graduate-level tutorial in professional ethics, which also focuses on record-keeping by healthcare providers;

2. Respondent shall ensure that the tutor submit to the Board an assessment at the completion of the educational tutorial, which includes a report of attendance,

participation and completion of assignments, including a copy of any essay or other written assignment that the Respondent is required to write;

3. Respondent shall successfully complete the individual tutorial in professional ethics within the 2-year probationary period; and it is further

ORDERED that Respondent shall take and pass the Board Jurisprudence Examination within 1 (one) year of the date of this Final Decision and Order; and it is further

ORDERED that there shall be no automatic termination of probation after two (2) years, and Respondent must petition the Board for termination of probation and full reinstatement of his license without restrictions or conditions. If Respondent has satisfactorily complied with all conditions of probation, and there are no outstanding complaints or other disciplinary action pending against Respondent, the Board shall terminate probation. If the Respondent fails to make any such petition, then the probationary status shall continue indefinitely, subject to the terms and conditions set forth in this Final Decision and Order; and it is further

ORDERED that this Final Decision and Order shall be effective from the date it is signed by the Board; and it is further

ORDERED that Respondent's failure to fully comply with the terms and conditions of this Final Decision and Order shall be deemed a violation of probation and of this Final Decision and Order, and that upon such violation the Board may impose any discipline which it might have imposed for Respondent's actions in this case; and it is further

ORDERED that the burden of proof shall be on Respondent to demonstrate compliance with this Final Decision and Order and the terms and conditions of probation; and it is further

ORDERED that Respondent shall abide by the laws and regulations regarding the practice of chiropractic. Failure to do so shall constitute a violation of probation and of this Final Decision and Order; and it is further

ORDERED that any violation of this Final Decision and Order by Respondent shall constitute unprofessional conduct; and it is further

ORDERED that Respondent shall pay all costs associated with carrying out the provisions of this Final Decision and Order; and it is further

ORDERED that, within six (6) months of the date of this Final Decision and Order, pursuant to H.O. §3-315 (g), Respondent shall reimburse the Board for the costs incurred by the Board for court reporting services and for all hearing costs incurred by the Board, in the amount of $1,342.00, as a result of this hearing; and it is further

ORDERED that this is a Final Order of the Maryland State Board of Chiropractic Examiners and, as such, is a PUBLIC DOCUMENT and is reportable to any entity to which the Board is obligated by law to report, and is disclosable under the Maryland Public Information Act, Maryland State Gov't Code Ann. §§10-611 *et seq.*

[signature] for (by direction of Board)
Kay B. O'Hara, D.C.
President
Maryland State Board of
Chiropractic Examiners

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occ. Code Ann. § 3-316, you have a right to take a direct judicial appeal. A petition for appeal shall be filed within thirty (30) days from mailing of this Final Decision and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, Maryland State Gov't Code Ann. §§10-201 *et seq.*, and Title 7, Chapter 200 of the Maryland Rules.

IN THE MATTER OF	*	BEFORE THE STATE BOARD
CHRISTOPHER RUSH, D.C.	*	OF CHIROPRACTIC
Respondent	*	EXAMINERS
License Number: 02053	*	Case Number: 04-35C

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

FINAL OPINION AND ORDER

Pursuant to Md. Code Ann., Health Occ. ("H.O.") § 3-315 (a) and the Code of Maryland Regulations (COMAR) 10.43.02.07, the Maryland State Board of Chiropractic Examiners (the "Board") hereby issues its final decision and order:

I. INTRODUCTION

The events at issue occurred in the fall of 2004. The Board received a complaint that Dr. Rush misdiagnosed Patient A[1], the complainant, and treated her for a back injury she did not have. Based upon this complaint, the Board initiated an investigation of Dr. Rush. During the investigation, the Board's investigator then found that Dr. Rush was improperly using low-level laser therapy ("laser therapy") and employing unlicensed personnel to treat patients. On October 13, 2004, the Board's investigator conducted an unannounced inspection of Dr. Rush's clinic as permitted by Md. Code Ann., Health Gen. § 2-104. During this inspection, Dr. Rush abruptly stopped the interview with the investigator and physically grabbed the Board's investigator and ejected the investigator from the clinic.

II. PROCEDURAL HISTORY

On May 16, 2005, the Board charged Dr. Rush with violating the Maryland Health Occupations Code and its regulations. Specifically, the Board charged Dr. Rush with:

(1) Fail[ing]to file or record any report as required by law in violation

1 The identity of each of the patients is confidential, and therefore, not disclosed in this document.

of Md. Health Occ. Code Ann. § 3-313 (13);

(2) Practic[ing] chiropractic with an unauthorized person or supervises or aides an unauthorized person in the practice of chiropractic in violation of Md. Health Occ. Code Ann. § 3-313 (18);

(3) Violat[ing] any rule or regulation adopted by the Board in violation of Md. Health Occ. Code Ann. § 3-313 (19);

(4) Commit[ing] an act of unprofessional conduct in the practice of chiropractic in violation of Md. Health Occ. Code Ann. § 3-313 (21)...

The regulation that Dr. Rush was charged with violating is found in the Code of Ethics, COMAR 10.43.14 (January 9, 2000). Specifically, the Board charged Dr. Rush with violating the following provisions:

.03 Standards of Practice.

B. A chiropractor and chiropractic assistant shall:

(8) Cooperate with any lawful investigation conducted by the Board, including:

(a) Furnishing information requested,

(b) Complying with a subpoena,

(c) Responding to a complaint at the request of the Board, and

(d) Providing meaningful and timely access to patient records[.]

At the hearing, the Board first heard argument on all pending motions. Dr. Rush requested a subpoena for Dr. Ashton, a member of the Board, to testify. The Board did not issue this subpoena, nonetheless Dr. Ashton was present at the hearing pursuant to his duties as a Board member. The State asked the Board to issue a protective order covering Dr. Ashton. The Board granted the State's request.

Next, Dr. Rush requested that Dr. Ashton be recused from hearing and ruling on this case because he was biased. Dr. Rush declined to voir dire Dr. Ashton, conceding that he did not have any reason to believe that Dr. Ashton had any personal bias against him. After careful consideration and advice of counsel, Dr. Ashton decided that there was no basis for recusing himself. Dr. Ashton was present during both days of the hearing; however, at the conclusion of the second day, Dr. Ashton forthwith departed the hearing and did not participate in the Board's deliberations or vote.

A full evidentiary hearing was held before a quorum of the Board on January 11, 2007, and March 8, 2007. Two witnesses testified for the State, David Ford, Board Investigator, and Dr. Jack Murray, D.C., an expert witness. Dr. Rush, was represented by counsel throughout the proceedings. Dr. Rush testified on his own behalf and presented the following witnesses: Timothy Lucas, Anita Saltmarche, Melyna Worth, and Dr. Paul Goszkowski, an expert in the practice of chiropractic and a former Board member. On the first hearing day, five exhibits, labeled A through E, were admitted on behalf of Dr. Rush. On the second day, 15 exhibits, labeled AA through OO, were admitted on behalf of Dr. Rush. Sixteen documents, numbered 1 - 16, as listed on the "State's Exhibit List," were admitted into evidence as the State's exhibits.

II. SYNOPSIS OF WITNESS TESTIMONY

The State's first witness was David Ford. Mr. Ford testified that he has been the Board's investigator for the past eight years. According to Mr. Ford, Patient A submitted a complaint to the Board dated July 24, 2004. The complaint stated that Patient A had received unnecessary treatment for a non-existent back injury. During Mr. Ford's first interview with the complainant, she stated that she had been treated with low-level laser therapy on several occasions at Dr. Rush's clinic. On a few occasions, Dr. Rush performed the therapy, according to the complainant. On all other

occasions, Ms. Trina Palmer, Dr. Rush's unlicensed receptionist, performed the low-level laser therapy, according to the complainant.

Mr. Ford explained that the use of low-level lasers was a relatively new issue with the Board. The Board issued guidelines for licensees in its January 2004 newsletter. The Board had discussed the issue of low-level laser therapy at its November 13, 2003, meeting and developed a policy for its use. Under the newsletter guidelines, to ensure patient safety, the Board required that all licensees using low-level laser therapy request and be granted approval from the Board and complete a Board approved course on low-level laser therapy before using this therapy. These guidelines were not adopted into the Board's regulations.

On October 13, 2004, Mr. Ford conducted an unannounced inspection Dr. Rush's clinic. Dr. Rush was not immediately available, thus Mr. Ford waited in the waiting room. A short while later, Dr. Rush greeted Mr. Ford. Dr. Rush invited the investigator to meet with him in his office. Initially, Dr. Rush was cooperative and accompanied Mr. Ford in his tour of the clinic. Mr. Ford told Dr. Rush that he recognized a low-level laser apparatus in one of the treatment rooms. Dr. Rush admitted that he had not completed the training required by the Board in its newsletter reminder, nor had he received authorization from the Board to use the device. Dr. Rush further admitted that Ms. Palmer had treated Patient A on at least one occasion with the laser. Dr. Rush explained that he believed that this treatment was appropriate under the Chiropractic Practice Act and implementing regulations.

Mr. Ford interviewed Dr. Rush in his office. During this interview, Dr. Rush disclosed that Ms. Palmer may have treated four patients with the laser device on at least fourteen separate occasions. Mr. Ford also reviewed Patient A's records. Mr. Ford asked Dr. Rush to provide him

with the records for the other patients treated with the laser by Ms. Palmer. When Dr. Rush returned with those records, Dr. Rush received a phone call from his attorney.

After his conversation with counsel, Dr. Rush informed Mr. Ford that he would not talk to him anymore and that Mr. Ford would need to leave his clinic immediately. Mr. Ford asked to speak to Dr. Rush's wife and partner in his practice, Dr. Tracy Rush, D.C. Mr. Ford was told that he would not be allowed to interview her and reiterated that he would have to leave. Dr. Rush stated he would not answer any further questions and if Mr. Ford needed any further information he would have to channel his requests through Dr. Rush's attorney. Dr. Rush then stood up and pointed at the door. Mr. Ford left Dr. Rush's office and walked down the clinic's hallway towards the exit. Mr. Ford again noticed the low-level laser apparatus in one of the treatment areas. Mr. Ford stopped in the doorway of the room which contained the laser and asked Dr. Rush if he could take a photograph of the device. Dr. Rush responded by forcibly grabbing Mr. Ford's shoulder and physically removing him from the doorway. Dr. Rush did not allow the investigator to photograph the examination room and low-level laser. Dr. Rush again told Mr. Ford that if he needed anything else Mr. Ford would have to speak with Dr. Rush's attorney. With that, Mr. Ford left the building. Mr. Ford testified that this incident was the only time that a licensee had ever placed their hands on him and removed him from the premises during his tenure as the Board investigator.

After this incident, Dr. Rush cooperated with the Board's investigation. But it was not until December 22, 2004, that Mr. Ford was allowed to return to the clinic and photograph the laser device. Around the same time, Dr. Rush responded to the Board's written interrogatories.

As a part of Mr. Ford's investigation, he obtained an affidavit from Trina Palmer, Dr. Rush's receptionist. Ms. Palmer. Ms. Palmer is not licensed chiropractic assistant, nor did she have any

other license that would allow her to treat patients. The affidavit was entered into evidence. Ms. Palmer described in the affidavit numerous violations with regard to Dr. Rush's practice. Ms. Palmer stated that her duties included taking the blood pressure and pulse of patients, testing for weight imbalance, performing range of motion testing, and administering low-level laser therapy. Mr. Ford could not identify where Ms. Palmer recorded these actions in Dr. Rush's records. Both Mr. Ford and Dr. Rush agree that Ms. Palmer administered low-level laser therapy.

The State's other witness was Dr. Jack Murray, Jr., D.C. Dr. Murray is a former member and past president of the Board, a supervising chiropractor, holding physical therapy privileges. Dr. Murray was admitted as an expert in the practice of chiropractic. In Dr. Murray's expert opinion, low-level laser therapy is a physical therapy modality.

Dr. Murray was questioned by Dr. Rush about the Board's process for registering and certifying its licensees before they could use low-level lasers in their practice. At the beginning of 2004, the Board announced in its newsletter that all chiropractors would have to certify that they had completed a Board approved course on low-level laser therapy and then request permission from the Board to use this technique. The Board never promulgated regulations on low-level laser therapy. Dr. Murray stated that this procedure did not comport with his understanding of the regulatory process.

Dr. Rush's first witness was Timothy Lucas, owner of Lighthouse Medical Equipment. Mr. Lucas stated that he distributed and sold the low-level laser therapy device at issue. Mr. Lucas trained Dr. Rush and his staff in the use of this device and in safety precautions. Mr. Lucas is not a licensed health practitioner in Maryland or any other state, but believes that low-level laser therapy is not a physical therapy modality and its use should not be regulated by any health occupation board.

In fact, this is what he has advised all his customers, including Dr. Rush. Instead, Mr. Lucas thinks that the device should be classified as energy medicine. On cross-examination, Mr. Lucas admitted that the documentation provided by the manufacturer suggests that low-level laser therapy should be billed as physical therapy for the purpose of reimbursement from an insurer.

Mr. Lucas testified that the MedX company loaned a low-level laser to Dr. Ashton to evaluate. This is the same type of laser that Dr. Rush had in his office. At this point, the Board halted the questioning of Mr. Lucas and instructed Dr. Rush that he already had an opportunity to voir dire Dr. Ashton and had declined to ask him any questions. The Board ruled that this questioning was irrelevant and no further questions would be permitted regarding the relationship between Dr. Ashton and the laser's manufacturer. Dr. Rush again motioned to recuse Dr. Ashton from these proceedings. The request was denied.

Dr. Rush's next witness was Ms. Anita Saltmarche, an employee of the MedX corporation. Ms. Saltmarche is a register nurse. She stated that five of MedX's laser products are approved by the FDA. Ms. Saltmarche believes that the therapy should be considered unregulated energy work. According to Ms. Saltmarche, some of Medx's lasers are so safe that they are sold over the counter. However, the model that Dr. Rush was using is not available over the counter. She stated that she had some contact and dealings with Dr. Ashton about the products her company sells.

Melyni Worth was Dr. Rush's next witness. Ms. Worth used to work with Thor Laser. Ms. Worth specializes in equine lasers. Ms. Worth was contacted by Dr. Ashton for information on Thor's lasers.

Dr. Paul Goszkowski testified as an expert in chiropractic on behalf of Dr. Rush. Dr. Goszkowski testified that low-level laser therapy is a physical therapy modality. Dr. Goszkowski

stated that the procedures set forth in the Board's newsletter were not in regulation, and, therefore, cannot be enforced by the Board. Dr. Ashton contacted Dr. Goszkowski about possibly developing a course on lasers in the practice of chiropractic. Dr. Ashton and Dr. Goszkowski eventually parted ways and their joint program never came to fruition.

Dr. Rush testified last. He has been a licensed Chiropractor in this State since 2001. Dr. Rush owns his own practice in Berlin, Maryland. According to Dr. Rush, he did not know that the use of low-level laser was a physical therapy modality. Further, he was not aware that the Board announced in its newsletter that licensees must submit proof of education and request permission from the Board before they could treat patients with low-level lasers. Dr. Rush conceded that he did not have physical therapy privileges during the period at issue.

Dr. Rush explained that he was informed by Mr. Lucas that lasers were not physical therapy. Further, Dr. Rush claimed that he called the Board and did not get a response to his inquiry. He read the regulations and did not see that lasers were specifically mentioned. Dr. Rush did not think that lasers were regulated by the Board. He denies reading the Board's newsletter and guidance on low-level laser therapy.

Dr. Rush testified that he purchased the laser in May of 2004. Tim Lucas sold him the MedX laser and told him that physical therapists and athletic trainers were using the machine. After selling him the machine, Mr. Lucas trained Dr. Rush and his staff on operating the laser. Ms. Palmer received her training at this time. Dr. Rush testified that between May 2004 and October of 2004, he only treated four patients with the low-level laser.

Dr. Rush described the events of October 13, 2004. He recalled Mr. Ford meeting with him and asking him about Patient A. Dr. Rush allowed Mr. Ford to look around his clinic and answered

his questions about Patient A. He even showed Patient A's file to Mr. Ford. After reviewing the file, Mr. Ford asked to look at some additional files and wanted to speak to Dr. Rush's wife.

Before the investigator was given further access to the files or allowed to speak to anyone else in the practice, Dr. Rush received a call from his attorney. After speaking with his attorney, Dr. Rush told Mr. Ford to leave. Mr. Ford did not leave immediately and was stunned by Dr. Rush's change in demeanor. When Mr. Ford would not leave, Dr. Rush handed the phone to Mr. Ford, and his attorney told Mr. Ford to leave. Mr. Ford acquiesced to his demand and chose to end the interview after this conversation. Dr. Rush testified that he did stand up and motioned Mr. Ford to the door. Dr. Rush admits that he bumped into Mr. Ford. Dr. Rush admitted that he placed his hand on the investigator and pulled him out of the examination room to prevent him from taking a picture of the low-level laser apparatus.

Dr. Rush contradicted most of Trina Palmer's accusations. He denied that she took blood pressure, pulse, range of motion, or patient exams. Dr. Rush admitted that she did administer low-level laser therapy. Dr. Rush admitted that he did not have physical therapy privileges and was not permitted to use physical therapy modalities. Dr. Rush admitted that he was not a supervising chiropractor and was not permitted to utilize chiropractic assistants in his practice.

III. FINDINGS OF FACT

After considering the entire record, including the testimony and exhibits entered into evidence at the hearing, and the arguments of counsel, the Board finds the following facts by preponderance of the evidence:

1. At all times relevant to the charges herein, Dr. Rush was licensed to practice chiropractic in the State of Maryland. Dr. Rush was first licensed on October 5, 2001.

2. At all times relevant, Dr. Rush's practice was named "Healing Hands Chiropractic, P.C.," in Berlin, Maryland.

3. On or about July 27, 2004, the Board received a complaint from Patient A alleging that Dr. Rush had misdiagnosed and treated her for a back problem she did not have.

4. Dr. Rush treated Patient A from June 17, 2004 to July 18, 2004.

5. During Patient A's initial consultation on June 17, 2004, Dr. Rush diagnosed her with a herniated disc in her back by viewing the results of a recent MRI that she brought with her.

6. Subsequent to her treatment from Dr. Rush, three separate neurologists confirmed that she did not have a herniated disc in her back. Patient A complained to the Board and requested a refund of the money she paid to Dr. Rush for treatment in June and July of 2004.

7. As a result of this complaint, the Board opened an investigation into the practice of Dr. Rush.

8. During the Board Investigator's interview with Patient A, she stated that Dr. Rush treated her with low-level laser therapy.

9. On several occasions during this period, Patient A received low-level laser therapy from Trina Palmer, Dr. Rush's unlicensed receptionist.

10. Patient A informed the Board's investigator that she received seven laser therapy sessions at Dr. Rush's clinic, six of which were performed by Dr. Rush's receptionist, Trina Palmer. Trina Palmer is not a chiropractic assistant.

11. Under the guidelines outlined in the Board's newsletter, a chiropractor must obtain prior Board approval to use low-level laser therapy on patients by submitting all training and education material to the Board.

12. The Board records indicate that Dr. Rush had not received prior Board approval to use low-level laser therapy.

13. Under the Board's practice act and implementing regulations, chiropractors are required to have physical therapy privileges to use physical therapy modalities.

14. The Board records also indicate that Dr. Rush did not have physical therapy privileges during the period at issue.

15. On or about October 13, 2004, the Board's investigator visited Dr. Rush's clinic in Berlin, Maryland. The Board's investigator asked Dr. Rush to show him his clinic, and Dr. Rush initially complied.

16. While in Dr. Rush's clinic, the Board's investigator observed a device in one of the treatment rooms that appeared to be a MedX 1100 console pictured in the pamphlet provided by Patient A. Dr. Rush admitted to the Board's investigator that this device was a low-level laser unit, and that he had treated his patients with the device.

17. Dr. Rush told the Board's investigator that he was aware that prior Board approval was required for such a device, but that no courses were immediately available. He informed the Board's investigator that he had treated Patient A with low-level laser therapy.

18. When asked whether Ms. Palmer treated Patient A with the low-level laser unit, Dr. Rush informed the Board's investigator that she had done so on one occasion.

19. On October 13, 2004, Dr. Rush informed the Board's investigator that he began using the low-level laser therapy on his patients in June 2004. He stated that he treated ten of his patients with the device, and directed Ms. Palmer to treat four of those patients, which she did.

20. Dr. Rush informed the Board's investigator that Trina Palmer treated Patient A on

2004. Ms. Palmer informed the Board's investigator that her duties included tasks that were only to be performed by licensed practitioners. These duties included administering low-level laser therapy to patients. She described how she completed these tasks to the Board's investigator.

27. A review of Board records indicated that Trina Palmer was not a chiropractic assistant nor did the Board receive any information indicating that she was a chiropractic assistant trainee or applicant.

28. Trina Palmer further informed the Board's investigator that she was trained by Christine Bassett to complete her duties, the billing clerk at the Dr. Rush's practice, and that Ms. Bassett had performed these patient treatments prior to Trina Palmer.

29. Trina Palmer informed the Board's investigator that she was trained to use the low-level laser therapy device by the sales representative who sold the device to Dr. Rush's practice. Trina Palmer stated that she treated approximately ten patients per day with the low-level laser therapy device while employed by Dr. Rush, and that the laser therapy was not itemized on patient bills because Dr. Rush was aware that prior Board approval was required for the device.

30. On or about November 30, 2004, Trina Palmer signed an affidavit affirming the statements she made to the Board's investigator.

31. On or about November 26, 2004, the Board directed Dr. Rush to respond in writing to fifteen (15) interrogatories.

32. On or about December 21, 2004, Dr. Rush provided a written response to the Board. In his response, Dr. Rush stated that several of his patients received "Phototherapy" provided by Dr. Rush, Chiropractor A, Trina Palmer, and Employee B.

33. Dr. Rush indicated in his written response that training for the device was provided by

Timothy Lucas, a MedX company representative. Mr. Lucas informed Dr. Rush that Trina Palmer was qualified to use the device.

34. Dr. Rush further indicated that he was not aware that low-level laser therapy required Board approval.

35. Dr. Rush also stated in his written response that the phototherapy was not considered physical therapy, but instead was "part of the adjustments/manipulations of [his] office because it deals with the altered function of tissue and nerve dysfunction of the vertebral subluxation."

36. Dr. Rush admitted in his written response that none of the personnel that operated the laser apparatus were registered chiropractic assistants, that he has never had any registered chiropractic assistants employed in his practice, and that he has never had any chiropractors certified as supervising chiropractors in his office.

37. On December 22, 2004, the Board's investigator was allowed to return to the practice and photograph the laser device at issue.

38. On or about February 9, 2005, the Board contracted the services of an expert witness in chiropractic for an opinion as to whether the use of low-level laser therapy at issue constituted physical therapy. On or about April 15, 2005, the Board expert witness provided an opinion indicating that the operation of the device used by Dr. Rush constituted physical therapy.

IV. CONCLUSIONS OF LAW

Based on the foregoing, the Board concludes that Dr. Rush's actions with regard to his interaction with the Board's investigator were improper and did not comport with Board statutes: Md. Health Occ. Code Ann. § 3-313 (19); and further violated H.O. § 3-313 (21), by committing acts of unprofessional conduct in the practice of chiropractic. The Board further found that Dr. Rush

violated its Code of Ethics, COMAR 10.43.14. Specifically the Board finds that Dr. Rush violated the following subsection:

.03 Standards of Practice.

B. A chiropractor and chiropractic assistant shall:

(8) Cooperate with any lawful investigation conducted by the Board.

It is not acceptable for a licensee to physically manhandle a Board investigator. This one act disrupted the investigation for numerous weeks. More significantly, it undermined the Board's ability to perform its duties as a regulatory agency.

During the hearing, it was never divulged precisely why Dr. Rush wanted to prevent the investigator from photographing. It is of no consequence to the Board that the investigator was allowed to return and photograph the device sixty days later. The time that lapsed between the investigator's inspection and his return visit gave Dr. Rush time to cover up any possible violations that may have been present in the practice.

Dr. Rush's actions and failure to cooperate undermine the core functions of the Board, to inspect licensees and investigate complaints. A licensee cannot stop a lawful investigation, and then only agree to cooperate with the investigation after their counsel has fully cleared and reviewed their records and actions. If left unsanctioned, this would leave the Board with a devastating precedent.

The Board finds that Dr. Rush's conduct was unprofessional and in violation of the Chiropractic Practice Act. It was not acceptable for Dr. Rush to grab the investigator by the shoulder and prevent him from photographing his examination room. The Board will not have licensees physically assault and intimidate its investigator.

The Board finds that Dr. Rush performed low-level laser therapy, a physical therapy

modality, and did not have physical therapy privileges. Low-level laser therapy is a mechanical device that uses the physical properties of radiant energy to treat patients. In accordance with Md. Health Occ. Code Ann. § 13-101(i)(2)(iv), the practice of physical therapy includes "administering treatment with therapeutic exercise, therapeutic massage, mechanical devices, or therapeutic agents that use the physical, chemical, or other properties of air, water, electricity, sound, or radiant energy."

Md. Health Occ. Code Ann. § 3-101(f) states:

(1) "Practice chiropractic" means to use a drugless system of health care based on the principle that interference with the transmission of nerve impulses may cause disease.

(2) "Practice chiropractic" includes the diagnosing and locating of misaligned or displaced vertebrae and, through the manual manipulation and adjustment of the spine and other skeletal structures, treating disorders of the human body.

(3) Except as otherwise provided in this title, "practice chiropractic" does not include the use of drugs or surgery, or the practice of osteopathy, obstetrics, or any other branch of medicine.

(4) The definition of "practice chiropractic" does not prohibit a chiropractor from selecting diet and hygiene measures for an individual.

The Board finds that low-level laser therapy meets the definition of physical therapy and is not within the practice of chiropractic.

Specifically, the Board concludes that low-level laser therapy is a physical therapy modality and part of the practice of physical therapy. Because low-level laser therapy is a physical therapy modality, then Dr. Rush committed an act of unprofessional conduct in the practice of chiropractic by allowing Trina Palmer to perform low-level laser therapy on his patients. These actions were in violation of Md. Health Occ. Code Ann. § 3-313(21). Additionally, Dr. Rush practiced chiropractic

with an unauthorized person or supervised or aided an unauthorized person in the practice of chiropractic, in violation of Md. Health Occ. Code Ann. § 3-313(18).

The Board did not find that Dr. Rush failed to file a report or did not maintain proper records. Therefore, Dr. Rush is not held in violation Md. Health Occ. Code Ann. § 3-313(13). After a review of the records and testimony of Dr. Rush, the Board found that Patient A did have a back injury that could be addressed through the practice of chiropractic. The injury may have been unrelated to Dr. Rush's diagnosis, but his treatment of the injury was not professionally unreasonable.

The Board concedes that its guidance and regulation with regard to low-level laser may have been confusing to Dr Rush. and that Board guidance issued its newsletter is not tantamount to a properly promulgated regulation. Given these facts, the Board will not impose any sanction on Dr. Rush for his conduct with the regard to low-level laser.

The sanction and fine levied in this case are soley and exclusively for his actions with regard to the Board's investigator. It is the Board's intention that the fine levied in this case will serve as a warning to other licensees and will signal that the Board's investigator is to be treated professionally, with courtesy and that failure to cooperate with an investigation is a serious matter.

In accordance with COMAR 10.43.10.04(B)(8), the Board fines Dr. Rush $2,500.00, for violating the Board's regulations and failing to cooperate with the Board's investigator and $2,500 for his unprofessional conduct with regard to the Board's investigator, in accordance with COMAR 10.43.10.04(C)(11). The Board specifically excludes any matter relating to low-level laser from the aforementioned sanction.

V. SANCTION

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it

is this 2nd day of October, 2007, by a unanimous of a quorum of the Board,

ORDERED that effective thirty days from the date of this order, Dr. Rush is REPRIMANDED. Concurrently, Dr. Rush is placed on PROBATION for two years, subject to the following conditions:

1. Within 180 days of the date this order is executed, Dr. Rush shall take and pass, the Board's Jurisprudence Examination, bearing responsibility for scheduling coordination with the Board and examination fees;
2. Within 180 days of the date this order is executed, Dr. Rush shall take and pass the National Chiropractic Board of Examiners ('NCBE') Boundaries/Ethics program and examination, bearing responsibility for scheduling coordination with the NCBE, paying all costs/ fees and submitting a certificate of satisfactory completion to the Board's Executive Director;
3. Within 180 days of the date this order is executed, Dr. Rush shall take and complete a Board-pre-approved ethics course, bearing responsibility for scheduling coordination with the instructor, paying all costs/fees and submitting a certificate of satisfactory completion to the Board's Executive Director;
4. Within 180 days, Dr. Rush shall reimburse the Board for all hearing costs incurred by the Board in the amount of $1,965.50; and be it further
5. Within 180 days, Dr. Rush will pay a $5,000 fine to the Board.

ORDERED that should the Board receive a report that Dr. Rush's practice is a threat to the

public health, welfare and safety, the Board may take immediate action against Dr. Rush, including suspension or revocation, providing notice and an opportunity to be heard are provided to Dr. Rush in a reasonable time thereafter. Should Dr. Rush violate the terms of this Order, after providing Dr. Rush with notice and an opportunity for a hearing, the Board may take further disciplinary action against Dr. Rush, including suspension or revocation. Any violation of the terms of this Order shall constitute unprofessional conduct in addition to any applicable grounds under the Act. The burden of proof for any action brought against Dr. Rush as a result of a breach of the terms of this Order shall be on Dr. Rush to demonstrate compliance with the Order; and it is further

ORDERED that Dr. Rush shall practice in accordance with the laws and regulations governing the practice of chiropractic in Maryland; and be it further

ORDERED that this document is a public record, pursuant to Md. Code Ann., State Gov't Article, § 10-611 et seq. and that it shall be forthwith reported to appropriate data bases and disseminated in the Board website and newsletter

OCT 0 2 2007

Date

For/By Direction of Board President

Dr. Duane Sadula, D.C.
President
Maryland State Board of Chiropractic Examiners

NOTICE OF RIGHT OF APPEAL

In accordance with Md. Code Ann., Health Occ. Article, § 3-316, you have a right to take a direct judicial appeal. A petition for appeal shall be filed within thirty days of your receipt of this Findings of Fact, Conclusion s of Law and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, State Gov't Article § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure. If Dr. Rush files an appeal, the Board is a party and should be served with the court's process. The Administrative Prosecutor is not involved in the case at this point and need not be served with or copied on the pleadings.