IN THE MATTER OF	*	**BEFORE THE**
RITCHIE C. SHOEMAKER, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D24924		**Case Numbers: 2010-0765 & 2010-0912**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

The Maryland State Board of Physicians (the "Board") hereby charges Ritchie C. Shoemaker, M.D. (the "Respondent") (D.O.B. 06/13/1951), License Number D24924, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-401 *et seq.* (2009 Repl.Vol.)

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* 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:
>
> (3) Is guilty of:
>
> ...
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> (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 [.]

GENERAL ALLEGATIONS[1]

The Board bases its charges on the following facts that the Board has reason to believe are true:

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on June 19, 1980. The Respondent also holds inactive medical licenses in North Carolina, Pennsylvania and Virginia.

2. The Respondent was board-certified in Family Medicine; however, his board-certification expired in 2006.

3. The Respondent maintains an office for the practice of medicine, the Chronic Fatigue Center, in Pocomoke City, Maryland.

Procedural History

4. By letter dated February 22, 2006, the Board notified the Respondent that it had received a complaint regarding the Respondent's medical practice. The Board further notified the Respondent that the complaint had been closed, but advised him that, "the Board has mandated protocols for alternative medicine practitioners to ensure that prospective patients are fully informed of the nature of your practice regarding alternative medical diagnoses and treatments."

[1]The statements of the Respondent's conduct with respect to the patients identified herein are intended to provide the Respondent with notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent.

5. On August 26, 2009, the Board issued to the Respondent an Advisory Letter. The Board notified the Respondent that an anonymous complaint received by the Board alleged that the Respondent was treating and prescribing for Lyme Disease over the internet. The Board voted to close the case but "strongly advised" the Respondent to comply with the Board's mandated protocols for alternative medicine practitioners to ensure that prospective patients are fully informed of the nature of his practice regarding alternative medical diagnoses and treatments.

Current Complaints

6. On or about April 16, 2010, the Board received a written complaint from an individual who was not a patient of the Respondent. The complainant alleged that the Respondent was soliciting prospective patients on a website that encourages the viewer to take an on-line diagnostic test. The complainant reported that he took the test which included very broad symptom responses. The complainant provided positive responses to a few of the items. Based on the responses, the website suggested that the complainant may be suffering from a biotoxin illness and further suggested that the complainant visit the Respondent's office. The complainant alleged that the Respondent cited "his own non-profit [organization] research to convince people to visit his private practice and purchase unnecessary tests."

7. The Board designated this complaint as Board Case Number 2010-0765.

8. On or about June 2, 2010, the Board received a complaint from a former patient of the Respondent alleging that the Respondent demanded a donation of $100 before seeing him, in addition to complaining about other aspects of the Respondent's treatment of him.

9. The Board designated this complaint as Case Number 2010-0912.

10. In furtherance of its investigation, the Board subpoenaed from the Respondent patient records and directed him to produce a summary of his care of each patient.

11. The patient records and the Respondent's response were then referred to a peer review entity for review of the Respondent's practice. The results of the peer review are summarized below.

The Respondent's Practice

12. The Respondent's patients are generally self-selected; that is, they have identified themselves as suffering from health problems as a consequence of having been exposed to mold and have sought treatment from the Respondent after reading his website or other literature.

13. The Respondent has developed a treatment protocol for a diagnosis he calls Chronic Inflammatory Response Syndrome. The protocol includes the administration of cholestyramine[2] as an initial step if removal from the suspected environmental trigger is not possible or ineffective.

[2] Cholestyramine is a bile acid sequestrant which binds acid in the gastrointestinal tract to prevent its reabsorption.

14. The Respondent enrolled several of the patients whose care was reviewed in an experimental protocol under the auspices of a legitimate Institutional Review Board.

15. In his response to the Board regarding one of the current complaints, the Respondent acknowledged that he requires all patients to "become a member to [his] non-profit research group by paying a fee of $100."

Summary of Peer Review

16. The peer reviewers noted the following deficiencies in all of the cases they reviewed:

    a. Off-label use of potentially toxic drugs (e.g., Actos[3] and Rifampin,[4]). The drugs prescribed by the Respondent are potentially toxic when used for inappropriate purposes;

    b. The Respondent's documentation is not consistently legible;

    c. The Respondent used diagnostic codes for conditions not evident in the patient's record to justify the laboratory studies. The Respondent justified many of the laboratory tests he ordered for each patient using the diagnostic code for "toxic encephalopathy, yet other than the patients' complaint of not thinking clearly, there is no evidence that the patients displayed any clinical signs of encephalopathy. Similarly, for all of the patients whose care was reviewed, the Respondent noted the IDC code for bronchitis (466.0) to justify spirometry;

[3] Actos is a Type 2 diabetes medication that regulates blood sugar.
[4] Rifampin is used with other medications to treat tuberculosis and Neisseria meningitides (a type of bacteria that can cause meningitis.

however, there was no evidence in the patients' record of bronchitis. The Respondent noted that IDC code for premature heart beats (427.61) to justify EKGs for each patient, however, there is no evidence of premature beats in the records;

d. The Respondent failed to document his treatment rationale for starting, adjusting or changing medications or dosages;

e. The Respondent failed to document complete problem lists and medication lists.

17. In addition to the above deficiencies, the Respondent prescribed Procrit (erythropoietin), a glycoprotein that stimulates red blood production, to a patient in a manner that was potentially dangerous to the patient. Procrit is typically prescribed to treat anemia. The patient signed an informed consent form that included the Food and Drug Administration "black box warning" that advised of "increased mortality, serious cardiovascular and thromboembolic events and tumor progression." The black box warning further advises the physician to individualize dosing to achieve and maintain hemoglobin levels within the range of 10 to 12 gm/dL.

18. According to the informed consent form, the Respondent was administering Procrit to "lower C4a and correct chemical disturbances in central nervous system."

19. The patient was not anemic; his hemoglobin was 14.6 gr/dL when the Respondent began administering Procrit.

20. The Respondent administered Procrit on five occasions, two to three days apart. The Respondent monitored the patient's hemoglobin after each Procrit injection; after the fifth injection, the patient's hemoglobin was 15.6 gr/dL. The Respondent failed to document in the patient's record that he discontinued the patient's Procrit after the fifth injection and his reason for doing so.

21. The practice deficiencies set forth in ¶¶ 16 – 20 are examples of the Respondent's failure to meet the standard of quality care.

22. The peer reviewers agreed that it is unprofessional conduct in the practice of medicine for the Respondent to require patients to become a member of his non-profit research group and charge them a fee of $100.

CONCLUSION

The Respondent's conduct constitutes, in whole or in part, unprofessional conduct in the practice of medicine, in violation of H.O. § 140404(a)(3)(ii), and/or failure to meet the standard of quality care, in violation of H.O. § 14-404(a)(22).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, the Board finds that there are grounds for action under H.O. § 14-404(a)(3)(ii), and/or (22), the Board may impose disciplinary sanctions against the Respondent's license including revocation, suspension, or reprimand and may place the Respondent on probation, and/or may impose a monetary fine.

NOTICE OF CASE RESOLUTION CONFERENCE

A Case Resolution Conference in this matter is scheduled for **Wednesday, February 6, 2013, at 10:00 a.m.** the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference and prehearing conference is described in the attached letter to the Respondent. If this matter is not resolved on terms accepted by the Board, an evidentiary hearing will be scheduled.

DOUGLAS F. GANSLER
ATTORNEY GENERAL

11-26-12
Date

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