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IN THE CIRCUIT COURT FOR PRINCE GEORGE'S COUNTY
COURTHOUSE, UPPER MARLBORO, MARYLAND

Otabek Elmurodov MD Plaintiff, *pro se* v. University of Maryland Capital Region Health Family Medicine Residency Program., *et al* Defendant,	Case No.C-16-CV-23-005681 THIRD AMENDED COMPLAINT AND REQUEST FOR JURY TRIAL

Pursuant to the Prince George's County Circuit Court **Scheduling Order** Issued January 30, 2025.

1. NOW COMES the Plaintiff, Otabek Elmurodov MD, proceeding pro se, and respectfully submits this **Third Amended Complaint**, asserting claims against Defendant, **University of Maryland Capital Region Health**, in accordance with the **Prince George's County Circuit Court Scheduling Order (January 30, 2025)**, which permits **amendments to pleadings up to 60 days prior to trial**.

INTRODUCTION

2. This amendment is filed pursuant to **Maryland Rule 2-341**, which allows a party to amend pleadings **without leave of court** if filed within the timeframe established by a scheduling order. Where no scheduling order exists, amendments may be filed no later than **30 days before the trial date.** In this case, the **March 14, 2025, deadline** set by the court expressly authorizes Plaintiff's amendment, making this filing **proper and timely.**

3. Further, Plaintiff **reintroduces previously dismissed claims** that were ruled upon in the **December 9, 2024, Order** of the **Prince George's County Circuit Court**. Specifically:

    1. **Violation of Academic Procedural Rights** – The Court dismissed this claim on the grounds that Maryland law **does not recognize** it as a **separate cause of action.**
    2. **Tortious Interference with Prospective Economic Relations** – The court found that this count was **not sufficiently pleaded**, but did not preclude amendment.

4. Importantly, these claims **were not dismissed with prejudice**, nor did the court certify them as **final** under **Maryland Rule 2-602(b)**, which states that a dismissal must be expressly marked as final when there is "no just reason for delay." Since the **December 9, 2024, Order did not dismiss these claims with prejudice**, nor did it mark them as final, Plaintiff rightfully **amends his complaint to reassert these claims with proper factual and legal support**.

5. **This Third Amended Request for Jury Trial serves as the operative complaint, formally replacing and superseding the Second Amended Request for Jury Trial filed on March 20, 2024.** An amended complaint **completely replaces** the prior version and becomes the controlling pleading. *Young v. City of Mt. Ranier*, 238 F.3d 567, 572 (4th Cir. 2001) ("An **amended complaint supersedes the original complaint and renders it of no legal effect.**"); *Connecticut Gen. Life Ins. Co. v. Advanced Surgery Ctr. of Bethesda, LLC*, 2022 WL 2763200, at *5 (D. Md. July 14, 2022). This amendment is filed **within the court's scheduling order** and aligns with *Md. Rule 2-341(c)*, which permits amendments when justice requires. *Hall v. Babb*, 389 Md. 618, 624 (2005) ("T**he purpose of Rule 2-341 is to allow amendments that promote**

justice and **avoid unnecessary litigation.**"). This filing does not **prejudice Defendants** but ensures **clarity and full adjudication of Plaintiff's claims.**

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CAUSES OF ACTION

6. Plaintiff asserts the following **causes of action** against Defendant:

    I. **Breach of Contract** (*Violation of the GME Resident Agreement*);

    II. **Breach of Covenant of Good Faith and Fair Dealing**;

    III. **Deprivation of Property and Liberty Interests Without Due Process** (*Violation of Maryland Constitution, Article 24*);

    IV. **Intentional Interference with Economic Relationship;**

    V. **Defamation Per Se**.

7. The contractual relationship between Plaintiff and Defendant was governed by a **legally enforceable Graduate Medical Education (GME) contract**, which, pursuant to **Section 5.6 of the contract**, is **governed and construed under Maryland law**. Plaintiff will demonstrate at trial that **Defendant materially breached this agreement**, despite receiving **federal and state funding through the Centers for Medicare and Medicaid Services (CMS) to train resident physicians**. Given the **unique and irreplaceable nature of residency training**, **specific performance** is an appropriate and equitable remedy to **rectify the breach**.

8. WHEREFORE, Plaintiff seeks all available legal and equitable remedies, including **specific performance—reinstatement into residency training** and **restoration of board eligibility** with the **American Board of Family Medicine—compensatory damages,** such as lost wages, potential earnings as a physician if the contract had never been breached, **restitution for**

economic harm under tortious interference and defamation claims, and **any other relief deemed just** and **appropriate** by **this Court.**

JURY TRIAL DEMAND

9. This Complaint is filed in accordance with the **Maryland Rules of Civil Procedure**, including:

    1. **Rule 2-325 (Jury Trial)** – Governing requests for jury trials in civil matters.
    2. **Rule 2-511 (Trial by Jury)** – Affirming the right to a jury determination where applicable.

10. Plaintiff demands a trial by jury on all claims so triable, **pursuant to Article 23 of the Maryland Declaration of Rights**, which guarantees the **fundamental constitutional right to a jury trial in civil** matters involving **disputed factual issues** where the amount in **controversy exceeds a legally prescribed threshold**. Furthermore, **Article 5(b) and (c) of the Maryland Declaration of Rights** provides that, in civil proceedings where the **right to a jury trial is preserved,** parties are entitled to a jury of at least six jurors under Maryland law.

11. Pursuant to these constitutional provisions, **Plaintiff invokes his fundamental right to have all triable factual disputes determined by an impartial jury**, in accordance with the **preponderance of the evidence standard**, which governs civil proceedings in Maryland. Plaintiff will demonstrate that **Defendant's decision to terminate his residency was arbitrary, capricious, and without just cause**, constituting a **material breach** of the **Graduate Medical**

Education (GME) Resident Agreement, which incorporated **institutional GME policies**, **Accreditation Council for Graduate Medical Education (ACGME) Program Standards**, **ACGME Institutional Requirements**, and **ACGME Clinical Competency Committee Guidelines**.

12. Defendant's **wrongful and pretextual termination** of Plaintiff's residency **not only constituted a material breach of contractual obligations but also failed to adhere to established due process safeguards**, thereby depriving Plaintiff of his **protected property and liberty interests under Maryland law**. The termination was executed **without adherence to ACGME-mandated evaluations, procedural protections, or a legitimate remediation process**. Instead, Defendant **arbitrarily imposed probation** on Plaintiff, followed by a **capricious and pretextual termination**, which lacked **any objective basis** and was designed to unjustly remove Plaintiff from the residency program.

13. Defendant further **blatantly denied Plaintiff's request for pre-termination due process**, disregarding fundamental fairness and violating well-established procedural norms. When Plaintiff sought intervention from the **University of Maryland Capital Region Health Human Resources Department**, his requests were **summarily ignored**. Instead of affording Plaintiff a **meaningful opportunity to be heard before termination**, Defendant **offered only a post-termination internal administrative appeal**, which amounted to nothing more than a **sham, Star Chamber process**—a **secretive and arbitrary proceeding** that utterly failed to adhere to the **Rule of Law**. This so-called **appeal process** was **procedurally defective, fundamentally unfair,** and **lacked any genuine opportunity for independent review**, further compounding the **deprivation of Plaintiff's rights**.

14. As a result, Defendant's actions not only violated established **contractual and regulatory frameworks governing Graduate Medical Education programs** but were also **legally defective** and wholly **unjustifiable under Maryland law,** thereby necessitating adjudication through **an impartial jury trial.**

PARTIES

15. **Plaintiff**: Dr. Otabek Elmurodov, a resident and citizen of the State of Maryland, residing at 8821 Lottsford Rd, Apt 173, Largo, MD 20774. Dr. Elmurodov is a licensed medical doctor who was engaged in the Family Medicine Residency Program at **University of Maryland Capital Region Health ("UMCRH")** from November 1, 2021, until his wrongful termination on July 24, 2023. His participation in the residency program was governed by a **GME Resident Agreement**, which outlined the terms and conditions necessary to achieve Board Eligibility and eventual Board Certification in Family Medicine. Plaintiff's **anticipated graduation date was October 31, 2023,** contingent upon the Defendant fulfilling its contractual obligations.

16. **Defendant**: University of Maryland Capital Region Health (**UMCRH**), a private medical institution and the sponsoring entity of the Family Medicine Residency Program, is located at **901 Harry S Truman Dr, Largo, MD 20774**. As the **accredited training institution**, UMCRH had the contractual obligation to provide residency training in compliance with **Accreditation Council for Graduate Medical Education ("ACGME") Institutional Requirements and Program Standards**. The **GME Resident Agreement** was executed between Plaintiff and

UMCRH, making UMCRH solely responsible for compliance with the contractual terms and obligations related to Plaintiff's residency training.

JURISDICTION AND VENUE

17. Plaintiff, **Dr. Otabek Elmurodov**, is a **resident and citizen of the State of Maryland, Prince George's County**, residing at **8821 Lottsford Rd, Apt 173, Largo, MD 20774**. As such, he is subject to the jurisdiction of **Maryland state courts** and brings this action in a proper forum.

18. **Jurisdiction is proper in this Court** pursuant to **Md. Code Ann., Cts. & Jud. Proc. § 6-102**, as Defendant, **University of Maryland Capital Region Health ("UMCRH")**, is **domiciled in Prince George's County, Maryland**, and conducts substantial business operations within the state. UMCRH is a **Maryland entity, subject to suit within this jurisdiction**.

19. **Venue is proper** under **Md. Code Ann., Cts. & Jud. Proc. § 6-201**, as Defendant **regularly conducts business and maintains its principal place of operation in Prince George's County**. Pursuant to **Md. Code Ann., Cts. & Jud. Proc. § 6-202 and § 6-203**, civil actions must be filed in the county where a defendant **resides, conducts business, or where the cause of action arose**—all of which apply to the present case.

20. **Federal jurisdiction is inapplicable** in this matter. Pursuant to **28 U.S.C. § 1332 (Diversity Jurisdiction)**, complete diversity of citizenship is required for federal jurisdiction, which **is not**

met here, as **both Plaintiff and Defendant are citizens of Maryland**. Furthermore, **28 U.S.C. § 1331 (Federal Question Jurisdiction)** does not apply, as the claims arise under **Maryland contract and tort law** rather than federal law.

21. The **amount in controversy exceeds $30,000.00**, meeting the jurisdictional threshold for circuit courts under **Md. Code Ann., Cts. & Jud. Proc. §§ 1-501 and 4-401**. Maryland law mandates that **civil claims exceeding this threshold fall within the jurisdiction of the Circuit Court for Prince George's County**.

22. Maryland state courts have a **vested interest in adjudicating disputes related to contract disputes, wrongful terminations, and employment-related matters** within the broad scope of industries affecting the **State's internal affairs, including its healthcare institutions**. The state has an established legal framework enforcing **legally valid contracts and compensatory damages associated with breach of contract claims**.

23. Pursuant to **Section 5.6 of the GME Resident Agreement ("Governing Law" provision)**, this contract is explicitly governed by the **laws of the State of Maryland**. This provision establishes **Maryland law as the controlling authority for interpretation, enforcement, and resolution of all contractual disputes** arising from the agreement.

24. Plaintiff has **exhausted all available administrative remedies**, including multiple **internal appeals and review procedures before UMCRH**, which **upheld the wrongful termination**.

Given that **no further reconsideration is available under the institution's policies**, this action is appropriately brought before this **Court for judicial review**.

25. WHEREFORE, based on the foregoing, this Court has **proper jurisdiction and venue** to adjudicate this dispute under **Maryland law**, and Plaintiff respectfully submits this action before the **Circuit Court for Prince George's County, Maryland**.

PRELIMINARY STATEMENT

Residency Contract & Governing Policies

26. **Plaintiff, Dr. Otabek Elmurodov**, is a **United States citizen** and **lawful resident** of Prince George's County, Maryland, residing in Largo, Maryland.

27. On **September 16, 2021**, Plaintiff received a **formal offer of appointment** to the **University of Maryland Capital Region Health (UMCRH) Family Medicine Residency Program** at the **Post-Graduate Year 2 (PGY-2) level**.

28. Plaintiff **entered into a Graduate Medical Education (GME) Resident Agreement**, a **legally enforceable contract**, with **Defendant University of Maryland Capital Region Health**

governing the terms of his residency training. A **true and accurate copy of the offer letter** is attached as **Exhibit 7**, and the **GME Resident Contract** is attached as **Exhibit 141**.

29. The **GME Resident Contract** was **executed and signed** by:

    1. **Plaintiff, Dr. Otabek Elmurodov**
    2. **Former Program Director, Dr. Stacy Ross**
    3. **Former Designated Institutional Officer (DIO), Dr. Bradford Schwartz**, on behalf of **Defendant University of Maryland Capital Region Health**

30. The **GME Resident Agreement** is a **legally enforceable contract**, signed **"intending to be legally bound"**, incorporating **Exhibit A** as referenced in **Section 6.0 Acknowledgment**.

    Exhibit A consists of the **Sponsoring Institution's Graduate Medical Education (GME) policies**, which include **27 incorporated GME policies**, governing:

    1. **Resident training**
    2. **Advancement procedures**
    3. **Due process rights**

31. These policies were **approved by former Vice President Veronica Ford in May 2021** and explicitly apply to residency programs at the following UM Capital Region Health institutions:

    1. **UM Bowie Health Center**
    2. **UM Capital Region Health Medical Center**
    3. **UM Laurel Medical Center**
    4. **UM Charles Regional Surgery Center**

32. A **true and accurate copy** of the **GME Policies**, also referred to as the **GME Resident Manual**, is **submitted as Exhibit 147** to this complaint.

Plaintiff's Medical Training, Military Service and

Public Service Commitment

33. Before advancing to the **Family Medicine Residency Program as a PGY-2 on November 1, 2021**, Plaintiff **completed a Transitional Year Residency** at **Detroit Medical Center in Detroit, Michigan**, from **2017 to 2018**, and obtained a **full physician license from the Georgia Composite Medical Board (License #81428)**.

34. As an **ECFMG-certified International Medical Graduate (IMG)**, Plaintiff's **medical diploma is legally recognized as equivalent to that of a U.S. medical school graduate**. Plaintiff **successfully passed all USMLE (United States Medical Licensing Examination) exams on the first attempt**, achieving the following scores:

    1. **Step 1**: 235
    2. **Step 2 CK**: 232
    3. **Step 3**: 218

35. From **2018 to 2021**, Plaintiff **served as a Primary Care and Hospitalist Physician** with the **Indian Health Services (IHS), U.S. Department of Health and Human Services (HHS), at**

Blackfeet Community Hospital in Browning, Montana. During this time, Plaintiff **maintained an unblemished professional record with no disciplinary or malpractice issues**.

36. Plaintiff's tenure at **HHS was marked by exceptional performance**, receiving:

    1. **Level 4 (AM) - "Achieved More than Expected Results"**
    2. **Level 5 (AO) - "Achieved Outstanding Results"**

on the **HHS Employee Performance Plan Development Profile**.

37. Amid the **COVID-19 pandemic**, Plaintiff played a **critical role in addressing physician shortages in rural communities**, serving the **Native American population** at **Blackfeet Community Hospital** and also providing care at **Crow-Northern Cheyenne Hospital, another IHS facility**.

38. The following **exhibits substantiate Plaintiff's medical licensure, professional experience, and performance evaluations**:

    1. **Exhibit 2:** *State of Georgia, Physician License* – Verifying Plaintiff's full medical licensure.
    2. **Exhibit 3:** *HHS Employee Performance Plan* – Documenting Plaintiff's **exemplary performance** as a **Medical Officer, Hospitalist** with the **U.S. Department of Health and Human Services (HHS)**.
    3. **Exhibit 4:** *HHS Employee Performance Plan (2020)* – Highlighting **Plaintiff's achievements and role** as a **Hospitalist**.

4. **Exhibit 5:** *Additional Hospitalist Work During COVID-19 Pandemic* – Providing evidence of **Plaintiff's dedicated service during the healthcare crisis**.

39. Plaintiff **previously served in the United States Army Reserve and Individual Ready Reserve (IRR) component from 2012 to 2020** and received an **honorable discharge**, further demonstrating a **longstanding commitment to public service**.

40. Before entering the **UMCRH Family Medicine Residency Program as a PGY-2**, Plaintiff:

1. **Worked as a physician** with the **Indian Health Service (IHS), U.S. Department of Health and Human Services (HHS)**, serving **underserved Native American communities** at **Blackfeet Community Hospital** for three years.
2. **Previously held a residency contract** with the **Internal Medicine Residency Program at Maimonides Medical Center, Brooklyn, New York**, before transitioning to Family Medicine.

41. The following exhibits substantiate Plaintiff's **military service and professional background**:

1. **Exhibit 6:** *U.S. Army Reserve Enlistment & Discharge Orders* – Verifying Plaintiff's **honorable military service**.
2. **Exhibit 7:** *Advanced Placement, PGY-2 FM Offer* – Documenting Plaintiff's **residency placement in Family Medicine**.
3. **Exhibit 8:** *Contract with Maimonides Medical Center* – Showing Plaintiff's **prior residency contract before joining the Family Medicine Program**.

42. Plaintiff's **career has been dedicated to public service**, including **honorable military service and physician work in underserved communities**.

Residency Appointment,

Expected Promotion & Graduation

43. Plaintiff's **initial appointment covered the PGY-2 year** from **November 1, 2021, to October 31, 2022**. **Under the terms of the GME Resident Agreement**, if **Defendant University of Maryland Capital Region Health** had complied with:

    1. **Contractual obligations outlined in the GME Resident Agreement**
    2. **GME Policies governing resident advancement**
    3. **ACGME Program Requirements & Institutional Standards**
    4. **ACGME Clinical Competency Guidelines**

44. Plaintiff would have been **promoted to PGY-3 on November 1, 2022**, with an **anticipated graduation date of October 31, 2023**, obtaining **Board Eligibility and Certification with the American Board of Family Medicine (ABFM).**

ACGME Accreditation & Compliance Requirements

45. The **University of Maryland Capital Region Health (UMCRH) Family Medicine Residency Program** is **accredited by the Accreditation Council for Graduate Medical Education (ACGME) under Accreditation ID: 1202300556** and is designated as a **Community-Based, University-Affiliated Program**.

46. **Defendant University of Maryland Capital Region Health Medical Center** (hereinafter **"Defendant Sponsoring Institution"**) serves as both the **primary clinical site** and the **Sponsoring Institution** for the residency program.

47. To **maintain ACGME accreditation**, the program is required to **comply with**:

    1. **GME Resident Agreement (Contract)**
    2. **GME Policies governing resident training and advancement**
    3. **ACGME Program Requirements & Institutional Standards**
    4. **ACGME Clinical Competency Guidelines**

48. As the **Sponsoring Institution**, Defendant **enters into an agreement with ACGME**, committing to **adhere to ACGME Institutional Requirements** and ensure **compliance with accreditation standards**.

49. A **true and accurate copy** of the **Family Medicine Residency Program's accreditation details and leadership** at the time when **Plaintiff was enrolled in the residency program**, including **ACGME accreditation status and program IDs**, as well as the **names of the**

Program Director, Interim Program Director, and Program Coordinator, is submitted as **Exhibit 1**.

Financial Significance of ACGME Accreditation

& Medicare Funding

50. **Accreditation is essential** not only for **enhancing the Institution's reputation** as a teaching hospital but also for enabling participation in:

    1. **Electronic Residency Application Service (ERAS)**
    2. **National Residency Matching Program (NRMP)**

51. These programs are **critical for recruiting and selecting medical school graduates** for post-graduate residency training.

52. Additionally, **ACGME accreditation allows the Institution to receive substantial federal and state funding**, including **Medicare funds** sourced from **U.S. payroll taxes**, which include:

    1. **Taxes withheld from employees' wages**
    2. **Employer-paid payroll contributions**

53. These tax funds primarily support **Social Security and Medicare programs** and contribute to **Graduate Medical Education (GME) funding** for residency programs.

54. The **cost of training a family medicine resident in the United States varies**, with recent studies estimating:

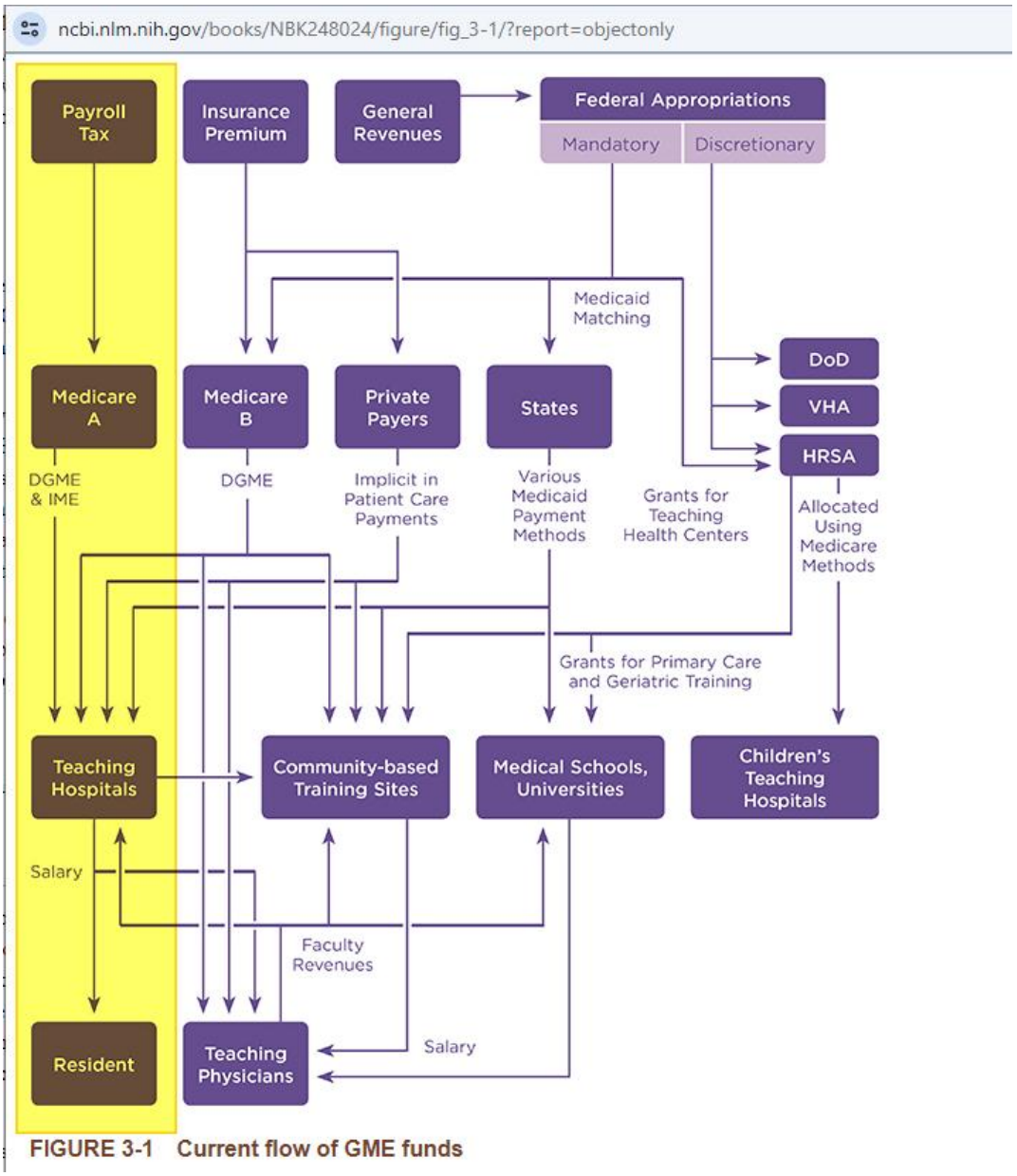
    1. **A median cost of $179,353 per resident per year**, excluding federal GME funds. *(PubMed, 2018; DOI: 10.22454/FamMed.2018.844856).*
    2. **An average cost of $323,000 per resident per year** in traditionally funded programs. *(ResearchGate, 2016).*

55. At the time **Plaintiff was enrolled in the residency program**, the **University of Maryland Capital Region Health Family Medicine Residency Program** hosted **12 residents** at any given time. Based on these **estimated training costs**, the **total annual expenditure for the program** can be calculated as follows:

    1. **Using the $179,353 figure**: **12 residents × $179,353 per resident = $2,152,236 annually**
    2. **Using the $323,000 figure**: **12 residents × $323,000 per resident = $3,876,000 annually**

56. Therefore, the **Sponsoring Institution** received between **$2.15 million and $3.88 million annually** in Medicare and state/federal funding **for the Family Medicine Residency Program**, excluding additional funds for **other residency programs**, such as **Internal Medicine and Pharmacy Fellowship Programs**.

57. This substantial funding underscores the **financial significance of maintaining ACGME accreditation**, making compliance with **ACGME program requirements and institutional standards** critical to the **Institution's financial and operational stability**.



58. **Figure 1 illustrates the current flow of Graduate Medical Education (GME) funds** as outlined by the **National Center for Biotechnology Information (NCBI)**. *(Source: NCBI, "Graduate Medical Education That Meets the Nation's Health Needs," Figure 3-1, available at: https://www.ncbi.nlm.nih.gov/books/NBK248024/).*

59. **Medicare A** serves as a **primary funding source** for **Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments**, which are allocated to **teaching hospitals** to support resident salaries and program operations.

60. **Teaching hospitals distribute these funds** to **residency programs, community-based training sites, medical schools, and universities**, ensuring the sustainability of physician training.

61. **Federal appropriations** and **state Medicaid matching funds** provide **additional financial support** for training programs, particularly for **grants to primary care, geriatric training, and teaching health centers**.

62. The **financial interdependence** between **payroll tax-funded Medicare contributions, private payers, and federal discretionary appropriations** underscores the **critical role of ACGME-accredited institutions in maintaining access to federal and state funding streams**.

63. By accepting **federal Medicare GME funding**, the **University of Maryland Capital Region Health** entered into a **legally enforceable agreement** to maintain **accreditation** and provide **structured medical training**, including **due process protections** and **advancement opportunities** for residents.

64. **GME Institutional Requirements** mandate that sponsoring institutions ensure residents receive **proper training, progression, and support** to achieve **board eligibility**.

65. In exchange for **federal funding**, Defendant was obligated to uphold its **contractual duties**, including **adhering to GME policies, ACGME standards, and ensuring Plaintiff's completion of residency training**.

66. **Terminating Plaintiff without due process and denying proper advancement** violated not only **contractual obligations** but also the **fundamental purpose** of **Medicare-funded physician training**, which is designed to prepare residents to enter the **U.S. healthcare workforce**.

67. Defendant cannot accept **public funds designated for physician training** while simultaneously **failing to fulfill its contractual and accreditation obligations**.

68. **Failure to comply** with these obligations constitutes **a misuse of public funds** and a **violation of the conditions** under which **Medicare GME funding** is granted to **teaching hospitals**.

GME Resident Agreement &

ACGME Contractual Obligations

69. Plaintiff **began the Family Medicine Residency Program as a PGY-2 on November 1, 2021**, filling a vacancy due to a resident resignation. Plaintiff's **GME Resident Agreement** was **executed by Defendant's Program Director, Dr. Stacy Ross, and Designated Institutional**

Officer, Dr. Bradford Schwartz, on behalf of the **University of Maryland Capital Region Health (Defendant Sponsoring Institution)**.

70. The contract was explicitly **"INTENDING TO BE LEGALLY BOUND"**, establishing a **legally enforceable agreement** between Plaintiff and Defendant. This agreement **mandated compliance** with **GME policies, ACGME Program Requirements, Clinical Competency Committee (CCC) guidelines, and ACGME Institutional Requirements**.

71. **Plaintiff reasonably relied on the contract's terms**, expecting that employment and advancement would be governed by **GME policies and ACGME requirements**. As an **ACGME-accredited residency program**, Defendant was **legally and ethically obligated** to uphold these standards to maintain accreditation. **Failure to do so constitutes a breach of contract** and **violates ACGME accreditation criteria**.

72. **ACGME Institutional Requirements impose binding obligations on Sponsoring Institutions** to ensure transparency, due process, and adherence to accreditation standards. Defendant was required to provide **written agreements** outlining residency terms, including **promotion criteria, grievance procedures, due process rights, and contract renewal policies**.

73. Defendant's contract with **ACGME codifies its obligation** to maintain **resident eligibility, selection transparency, financial support, and professional development**. These **contractual obligations protect resident rights and ensure institutional compliance** with accreditation standards.

74. The **University of Maryland Capital Region Health Medical Center**, as the **Sponsoring Institution**, maintains a **Graduate Medical Education (GME) office** responsible for **internal medicine, family medicine, and pharmacy fellowship programs**. The **GME Resident Manual** incorporates **27 institutional policies derived from ACGME requirements**, governing all residency programs.

75. Plaintiff's **wrongful termination resulted from Defendant's violations of ACGME and GME policies**, breaching contractual obligations and **denying Plaintiff the ability to complete training and obtain board certification**.

Violations of GME Policies

& ACGME Standards

76. **GME Policy Violations:**

    1. **GME Policy 102** – Violation of **due process and fair institutional grievance procedures**.
    2. **GME Policy 103** – Failure to follow **corrective action and disciplinary processes**.
    3. **GME Policy 104** – Non-compliance with **resident evaluation standards**.
    4. **GME Policy 105** – Improper **denial of resident advancement** without just cause.
    5. **GME Policy 112** – Breach of **resident agreement terms and conditions**.
    6. **GME Policy 115** – **Program Director failed to uphold responsibilities** for resident oversight.

7. **GME Policy 116** – Neglect of **resident fatigue mitigation protocols**.
8. **GME Policy 122** – Violations of **professionalism standards** within the residency program.
9. **GME Policy 123** – Failure to maintain a **safe and professional resident work environment**.

77. **ACGME Common Program Requirement Violations:**

1. **Program Director Responsibilities (II.A.)** – Deficiencies in **leadership and educational oversight**.
2. **Faculty Qualifications (II.B.)** – Failure to ensure **competent faculty supervision**.
3. **Resident Evaluation & Feedback (V.)** – Lack of **fair and objective resident assessment**.
4. **Well-Being & Fatigue Mitigation (VI.C. & VI.D.)** – Ignoring **resident health and work-hour policies**.

78. **ACGME Clinical Competency Committee (CCC) Guideline Violations:**

1. **Running CCC Meetings (Part 4)** – Failure to conduct **structured resident evaluations**.
2. **Post-Meeting Activities (Part 5)** – Lack of **proper documentation and feedback**.
3. **Legal Issues & Academic Due Process (Part 6)** – Non-compliance with **due process protections**.
4. **Individualized Learning Plans (Part 8)** – **Misuse of ILP as an evaluation tool**, improperly substituting it for **ACGME six-core competency standard evaluations**, leading to **arbitrary non-promotion decisions**.

79. **ACGME Institutional Requirement Violations:**

1. **Failure to adhere to institutional GME policies (IV.)**.
2. **Deficient recruitment & selection policies (IV.B.1.)**.
3. **Improper appointment agreements & contract processes (IV.C.)**.
4. **Non-compliance with promotion & dismissal procedures (IV.D.)**.
5. **Inadequate grievance & harassment policies (IV.E. & IV.I.3.)**.
6. **Failure to enforce non-competition clause prohibitions (IV.M.)**.
7. **Lack of adequate sleep/rest facilities for residents (III.B.7.d.)**.

80. **Supporting Exhibits:**

81. The following exhibits substantiate **Plaintiff's claims regarding contractual obligations, accreditation standards, and institutional policy violations**:

1. **Exhibit 121** – *ACGME Standards Evaluation of Six Core Competencies* – Detailing **evaluation criteria for resident performance**.
2. **Exhibit 141** – *GME Resident Agreement* – A **legally enforceable contract**, governed by and **construed in accordance with Maryland state law**.
3. **Exhibit 147** – *GME Policies / GME Resident Manual* – **Governing policies applicable to medical residents** within Defendant's program.
4. **Exhibit 148** – *ACGME Program Requirements* – Outlining **a** you did **ccreditation standards for residency programs**.
5. **Exhibit 150** – *ACGME Clinical Competency Committee Guidelines (Third Edition)* – Establishing **protocols for resident assessment and progression**.

6. **Exhibit 160** – *ACGME Institutional Requirements* – Defining **Sponsoring Institution obligations** to maintain accreditation and resident protections.

Family Medicine Board Eligibility

82. Plaintiff entered the **Family Medicine Residency Program under a legally enforceable contract**, with the goal of achieving **Board Certification in Family Medicine**. Defendant was obligated to adhere to **GME policies, ACGME Program Requirements, and Clinical Competency Guidelines**, ensuring proper training, promotion, and accreditation compliance.

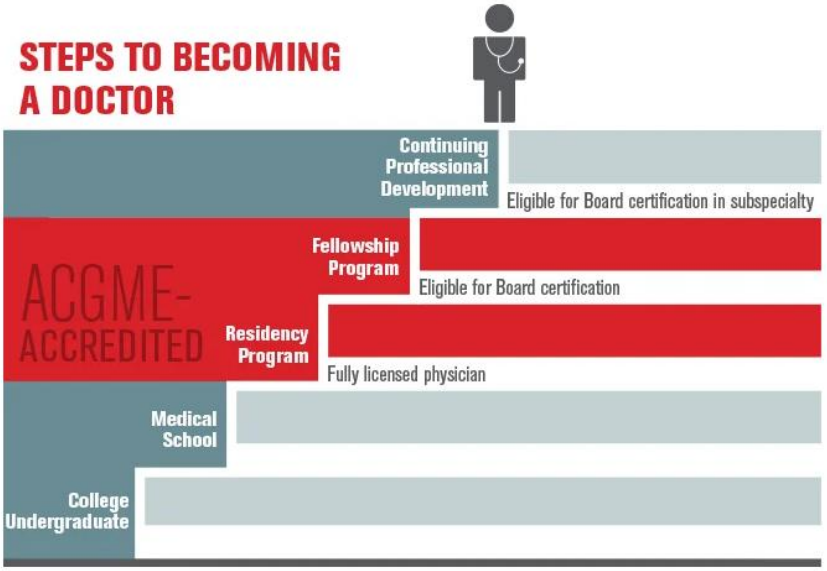
83. **Family Medicine Residency is a three-year (36-month) ACGME-accredited program**. Upon successful completion, residents **graduate and become eligible for board certification**, enabling independent practice and career advancement.

84. **Board eligibility is a prerequisite for Board Certification**, which is achieved by passing the **American Board of Family Medicine (ABFM) certification exam**. Board Certification is a **critical professional credential**, required by most employers, hospitals, and licensing bodies, ensuring physicians meet national competency standards.

85. Physicians lacking Board Certification face **limited career opportunities** and restricted hospital privileges. **Board eligibility is essential for professional advancement, leadership roles, and financial stability**, as it directly impacts employability and career trajectory.

86. The **ABFM mandates that the final 24 months of residency training be completed in one continuous ACGME-accredited program**. Because of Defendant's wrongful termination, Plaintiff is unable to meet this requirement, **rendering nearly two years of training unusable** for Board Certification.

87. Plaintiff completed **21 months of residency training** at Defendant's institution from **November 1, 2021, to July 24, 2023**, but Defendant **only credited 12 months**, disregarding the remaining nine months. This **violates Plaintiff's contractual rights and ACGME accreditation obligations**, severely impeding Plaintiff's path to **Board Certification and professional advancement**.



Source: https://www.acgme.org/about/overview/

Resident Physicians are Hospital Employees

88. Plaintiff **was not merely a trainee** but a **full-time hospital employee**, receiving a **salary with tax withholdings for Social Security, Medicare, and Federal Income Taxes**. Plaintiff also

received **healthcare benefits and paid vacation**, reinforcing the **employment relationship**. Resident physicians **sign employment contracts**, adhere to job descriptions, and contribute **direct patient care services**, which generate revenue for hospitals through Medicare and insurance reimbursements.

89. Courts have recognized that **resident physicians are employees, not just students**. The **Public Employee Relations Board of Prince George's County (1978)** acknowledged that residents operate in a **dual capacity** as both trainees and essential hospital workers, granting them **collective bargaining rights** (*JAMA*).

90. Legal precedent further supports this distinction. In *Khoiny v. Dignity Health,* 76 Cal.App.5th 390, 399-403 (Cal. Ct. App. 2022), the court emphasized that **residents spend a majority of their time—up to 80%—in direct patient care**, making them **predominantly employees rather than students**. The court rejected arguments equating residency programs to purely academic settings, noting that **hospitals rely on residents for core medical services** (*Khoiny, id.*).

91. The **United States Supreme Court in** *Mayo Found. for Med. Educ. & Research v. United States,* 562 U.S. 44, 60 (2011) similarly found that residents are **highly skilled professionals who work long hours under terms of employment comparable to career employees**, concluding they are **employees, not just students** (*Mayo, id.*).

92. In *Regents of University of California v. Public Employment Relations Bd.,* 41 Cal.3d 601, 619 (1986), the California Supreme Court determined that resident physicians provide **critical hospital services**, and despite their training component, their **primary function is to deliver patient care** (*PERB, id.*).

93. The **National Labor Relations Board (NLRB) in** *Boston Med. Center Corp.,* 330 NLRB 152, 160-161 (1999) also ruled that **medical residents are employees** because they **perform essential hospital services, receive compensation, and work long hours in direct patient care** (*Boston Med., id.*).

94. Defendant's assertion that **residency is purely academic and outside judicial review** is **contradicted by legal precedent**. Courts have consistently recognized that **residency programs are employment-based**, and hospitals must comply with **state and federal employment protections**. Wrongful termination of a resident physician **violates employment laws, not just academic policies**.

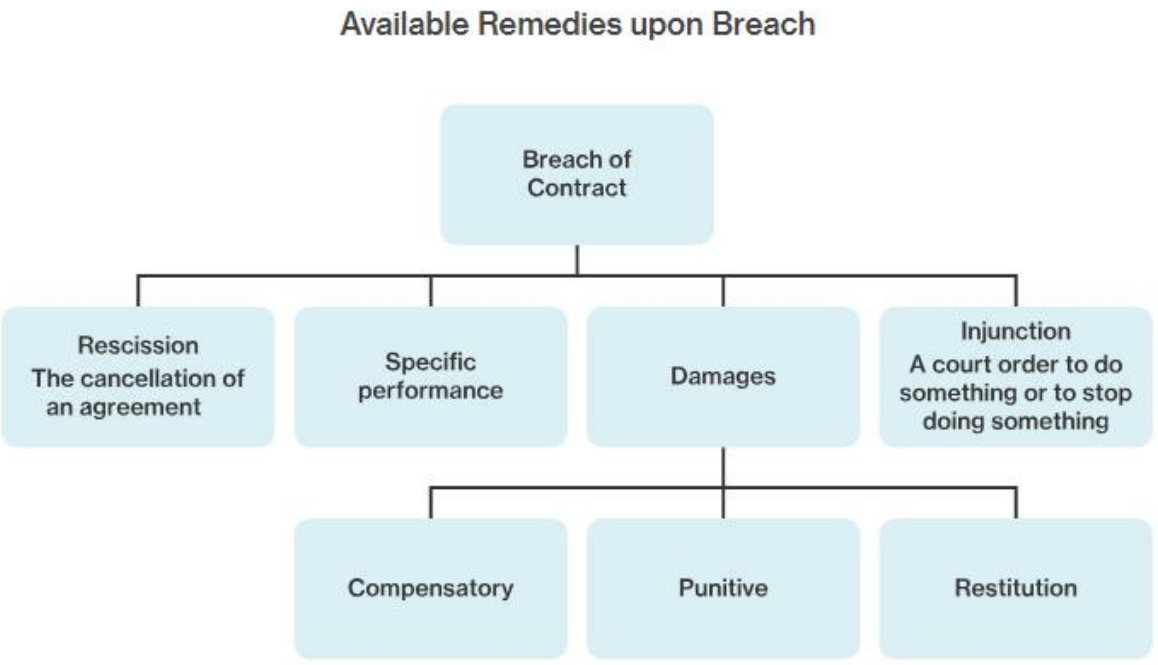
Breach of Contract, Applicable State Laws,

and Remedial Measures

95. Plaintiff's **GME Resident Agreement (Section 5.6)** explicitly states that the contract is governed by **Maryland law**, subjecting its interpretation and enforcement to **Maryland courts' jurisdiction**. Under Maryland contract law, courts apply the **objective theory of contract**

interpretation, enforcing clear and unambiguous terms as written (*Taylor v. Nationsbank*, 365 Md. 166, 178-79 (Md. 2001)). If ambiguity exists, courts consider extrinsic evidence to determine intent (*Kiley v. First Nat'l Bank*, 102 Md. App. 317, 333 (Md. Ct. Spec. App. 1994)).

96. A **breach of contract** occurs when a party **fails to perform contractual obligations without legal justification** (*Md. Code, Com. Law § 22-701*). In Maryland, a **material breach** exists when a **party's failure to perform substantially deprives the other party of an expected contractual benefit** (*RRC Northeast, LLC v. BAA Maryland, Inc.*, 413 Md. 638 (2010)). Courts recognize that contract breaches warrant legal remedies, including **specific performance, compensatory damages, and other relief necessary to restore the injured party** (*Taylor v. Nationsbank*, 365 Md. at 175).



There are various remedies that are available when a party breaches a contract, including rescission, specific performance, injunctions, and monetary damages.

97. Plaintiff's **wrongful termination** constitutes a **material breach of contract**, depriving him of **residency completion, board eligibility, and future career opportunities**. But for this breach, Plaintiff would have completed the program and obtained **Board Certification in Family Medicine**.

98. Plaintiff's case is supported by the **preponderance of the evidence** standard, which requires demonstrating that it is **more likely than not—exceeding a 51% likelihood—that Defendant breached its contractual obligations** (*Md. Rule 5-101*). The **GME-Resident contract, GME policies, ACGME Common Program Requirements, ACGME CCC guidelines, and ACGME Institutional Requirements** establish a framework for due process, fair evaluation, and contractually mandated training. Plaintiff contends that Defendant's actions were **arbitrary and capricious, lacking legal justification, and constituting a material breach of contract**.

99. **Maryland constitutional protections reinforce Plaintiff's right to legal recourse.** Article 19 of the **Maryland Declaration of Rights** guarantees a **remedy for legal injuries**, while Article 24 ensures **due process protections**. Additionally, **U.S. jurisprudence recognizes residency training as a property and liberty interest** protected under the **Fourteenth Amendment** (*Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 60 (2011)). Courts have held that **deprivation of residency training without due process constitutes a legal violation requiring judicial intervention** (*Zaklama v. Mt. Sinai Med. Ctr.*, 842 F.2d 291 (11th Cir. 1988)).

100. Courts have consistently held that **residency contracts are enforceable employment agreements**, entitling resident physicians to **legal protections**. In *Khoiny v. Dignity Health,* 76 Cal.App.5th 390 (Cal. Ct. App. 2022), the court found that **resident physicians are employees, not just students, and are entitled to legal protections in employment-related disputes**. Similarly, in *Bulwer v. Mount Auburn Hosp.,* 473 Mass. 672 (2016), courts affirmed that **wrongful termination of a resident physician is subject to judicial review and contractual remedies**.

101. Plaintiff seeks **specific performance** as the most appropriate remedy, as **monetary damages alone cannot compensate for the loss of board eligibility and professional advancement**. A court order **reinstating Plaintiff into residency** is necessary to **remedy the breach and allow completion of training**.

102. Additional relief includes **compensation for lost wages, attorney fees, and damages** resulting from Defendant's failure to uphold contractual and accreditation obligations. These remedies

aim to restore Plaintiff to the position he would have occupied had the contract been honored, ensuring compliance with both **state and federal due process protections**.

STATEMENT OF FACTS

FIRST SEMIANNUAL PERIOD

Nov 1, 2021 – April 30, 2022

Initial Training Phase &

ILP[1] Implementation

103. At the time Plaintiff began his **employment and residency training at the University of Maryland Capital Region Health (UMCRH) Medical Center**, Dr. Stacy Otalia Ross served as the **Program Director** of the Family Medicine Residency Program. Dr. Ross held this position at **all relevant times** during Plaintiff's training but **resigned under unclear circumstances in June 2023**. Plaintiff understands that Dr. Ross was **expected to be terminated but preemptively resigned**.

[1] IEP - Individualized Learning Plan

104. Unlike other named defendants, **UMCRH declined to provide Dr. Ross with institutional legal support** throughout the litigation. As a result, **Dr. Ross retained separate legal representation at her own personal expense**, while the remaining **individual defendants were provided legal counsel funded by the institution**.

105. Although initially named as a **defendant in this case**, Dr. Ross **was dismissed from the lawsuit by the Prince George's County Circuit Court on December 9, 2024**.

106. As the **founding Program Director**, Dr. Ross exercised **primary authority** over the Family Medicine Residency Program, overseeing **all faculty, resident physicians, and staff** within the department. The Program Director was responsible for **resident evaluations, promotion decisions, and adherence to GME policies**.

107. The **Family Medicine Residency Program** at UMCRH operates under **Accreditation Council for Graduate Medical Education (ACGME) accreditation** and must comply with ACGME's **program and institutional requirements**. The program's primary purpose is to **train and prepare resident physicians**, providing a **clinical learning environment** necessary for professional development.

108. The **ACGME and the American Medical Association (AMA) recognize six core competencies** essential for physician training: **patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice**. These competencies serve as the **foundation for evaluating**

residents' performance, ensuring they meet the **standards required for independent medical practice**.

109. **Refer to Exhibit #121: "ACGME Six Core Standard Evaluation Form"** recommended by ACGME for competency assessment and resident performance evaluation.

Resident Evaluation Standards

& ACGME Requirements

110. The **ACGME Resident Evaluation Requirements** mandate a **structured and objective** approach for assessing resident physicians:

1. **Direct Observation & Feedback (V.A.1.a)**: Faculty members must **monitor and regularly provide performance feedback** during each rotation.
2. **Formal Documentation (V.A.1.b)**: Evaluations must be **recorded and maintained** for each completed educational assignment.
3. **Objective Competency-Based Evaluation (V.A.1.c)**: Resident assessments must include **multiple evaluators**, such as **faculty, peers, patients, and self-assessments**. These evaluations are aggregated by the **Clinical Competency Committee (CCC)** to determine the resident's **progression and readiness for independent practice**.
4. **Semi-Annual Review Meetings (V.A.1.d)**: The **Program Director or a designated faculty member**, in collaboration with the CCC, must:

    - Conduct **semi-annual performance meetings** with each resident.

- Assist in developing **personalized learning plans for individualized training** and **improvement for all residents,** including both **lower-performing and high-performing ('superstar') individuals**
- Implement **corrective action plans** for residents **not meeting expected competency levels**.

111. In addition to **semi-annual** reviews, **ACGME standards mandate an annual summative evaluation** for all residents:

1. **Annual Summative Evaluation (V.A.1.e)**:
   - At least **once per year**, each resident must receive a **comprehensive evaluation** assessing **their readiness for promotion** to the next level of training.
   - This evaluation must be **documented and include clear justification** for **promotion, probation, or non-renewal**.

2. **Resident Access to Evaluations (V.A.1.f)**:
   - Residents **must have access to review their performance evaluations** to ensure **transparency and due process**.
   - The failure to provide **timely access to evaluations** undermines **fairness and prevents residents from addressing deficiencies** in a structured manner.

112. **Refer to Exhibit #10: "ACGME Resident Evaluation Requirement"** (outlined in the "University of Maryland 360-Resident Evaluation" document) for a detailed overview of the evaluation process.

113. **Refer to Exhibit #229: "University of Maryland Medical System Annual Resident Performance Evaluation Form"**, which **confirms the requirement for annual evaluations based on ACGME's Six Core Competencies**

Individualized Learning Plans (ILPs)

in Resident Evaluations

114. The **Accreditation Council for Graduate Medical Education (ACGME) explicitly recognizes Individualized Learning Plans (ILPs) as a standard requirement** for **all residents**, regardless of performance level. ILPs are designed to foster **self-directed learning** and are **not intended to serve as formal evaluations or promotion criteria**.

115. **Key ACGME Guidelines on ILPs**

ILPs Are:

- Created **by the resident, for the resident**, focusing on **self-assessment and improvement**.
- A **core ACGME requirement** applicable to **all residents**, including both **lower-performing and high-performing individuals ("superstars")**.
- **Guided by faculty facilitators** but **not dictated by program leadership**.

ILPs Are NOT:

- A substitute for **formal competency evaluations** or an alternative to ACGME-mandated assessments.
- The **sole responsibility** of program directors or faculty—residents must take the lead in **developing their own ILPs**.
- A **fixed or punitive document**—ILPs should be **revised and adapted** as residents progress in their training.

116. **Refer to Exhibit #16: "ACGME Clinical Competency Committee Guidebook (3rd Edition) on Individualized Learning Plans (ILPs)"** for further reference on the appropriate use and scope of ILPs.

Graduate Medical Education (GME) Oversight

& Institutional Compliance

117. **GME Policy 102 (General Policy of Graduate Medical Education at UMCRH)** establishes that the **Graduate Medical Education Committee (GMEC)** is responsible for:

1. **Ensuring compliance** with ACGME **Institutional Requirements** and **Residency Review Committee (RRC) standards**.
2. **Supervising faculty and resident evaluations** to uphold **high medical education and training standards**.

118. GME Policy 102 further requires residency programs to:

1. Implement **reliable competency assessment methods** aligned with the **ACGME Six Core Competencies**.

2. Maintain **comprehensive records** for residents and the program, including **rotation schedules, licensing information, certifications, and training progress**.

119. **Refer to Exhibit #11: "The Program's Obligation to Utilize Reliable Measures for Assessing ACGME Six Core Competencies"** for further documentation of these requirements.

November 2021 – February 2022

Initial Rotations & Faculty Evaluations

120. Upon commencing residency at **UMCRH** in **November 2021**, Plaintiff completed multiple rotations, including:

- **November 2021** – Neurology consult service with **Drs. Skripko and Chen**.
- **December 2021** – Outpatient pediatrics with **Dr. Corder**.
- **January 2022** – Infectious disease and nephrology consult services with **Drs. Mojtabai and Kharti**.
- **February 2022** – Inpatient cardiology consults with **Drs. Findlay, Newton, Dakak, Sarfarazi, Mmagu, and Shetty**.

121. Throughout this period, Plaintiff **received no negative feedback** from attending physicians. On the contrary, **Drs. Skripko and Dakak provided written statements attesting to Plaintiff's professional competence and medical record-keeping skills**. These letters were submitted to

the Court, directly **refuting allegations of insubordination and performance deficiencies** made by the Program.

122. Plaintiff also provided **occasional inpatient coverage on weekends and when other residents were unavailable**; however, he did not complete a **full inpatient service rotation** during this period.

123. **Refer to:**

- **Exhibit #133:** Statement from **Dr. Nader Dakak**, advocating for rectifying the **unjust treatment of Plaintiff**.
- **Exhibit #134:** Statement from **Dr. Patricia Skripko**, confirming **Plaintiff's competent note-taking abilities and contesting the Program's criticisms**.

March 2022

First Inpatient Rotation & Evaluations

124. In **March 2022**, Plaintiff began his **first inpatient service rotation** as a **senior resident**, working with **Dr. Omar Merchant (PGY-1 intern) and several medical students**. His responsibilities included:

1. **Managing inpatient services**, admitting new patients, and leading **morning rounds**.
2. **Overseeing patient care and coordinating discharges**, including prescribing medications.

3. **Working under direct and indirect supervision** of attending physicians, including **Dr. Prill and Dr. Ibe**.
4. **Serving as the Medical Admitting Officer (MAO)** during **12-hour or 24-hour shifts** every **Monday, Wednesday, and Saturday**, assigning **20-30 patient admissions** from the Emergency Department.

125. As a **senior resident**, Plaintiff **managed an average inpatient census of 15 patients**, handling **half to two-thirds of the total patient load**, while the remaining portion was assigned to the intern. His duties also included covering **nursery and OB patients after hours**. While medical students assisted with documentation, **Plaintiff remained fully responsible for patient care**.

126. Throughout this period, **Plaintiff maintained a record free from any patient safety concerns or negligence**. He **consistently completed all assigned duties before leaving the hospital**.

Clinical Challenges & Learning Curve

127. During this rotation, Plaintiff worked on **refining organizational skills, managing workflow, and balancing multiple responsibilities**, including:

1. **Handling nurse communications** while managing **admissions and discharges**.
2. **Supervising a medical student** who assisted with progress note editing.
3. **Ensuring detailed History and Physical (H&P) documentation**, though some **progress notes were delayed due to reliance on prior documentation practices**.

128. Physician trainees **learn through experience**, and an **initial learning curve is an expected component of Graduate Medical Education (GME)**. The ACGME acknowledges that **progression is a fundamental aspect of professional development**, and occasional inefficiencies should be viewed as part of the educational process.

MAO Role Recognized as Burdensome

129. The **MAO role was later deemed excessively burdensome for residents**. Effective **July 1, 2022**, this duty was reassigned from **family and internal medicine residents to board-certified internal medicine physicians** due to concerns over workload and patient safety.

Feedback by Dr. Ibe (Exhibit #12)

130. Attending physician **Dr. Ibe evaluated Plaintiff's March 2022 inpatient performance**, as documented in **Exhibit #12: "New Innovation Comments – March 2022 Inpatient Family** Medicine Service." Her feedback included:

131. Strengths:

- ✔ **Strong medical knowledge, professionalism, and responsibility.**
- ✔ **Consistently completed all tasks and prioritized patient care.**
- ✔ **Demonstrated willingness to perform procedures.**

132. Areas for Improvement:

- ✘ **Needs improvement in sign-outs, organization, time management, and multitasking.**
- ✘ **More leadership exposure required.**
- ✘ **Workflow performance assessed at an intern level despite strong medical knowledge.**

Unfair Comparison to PGY-2 Peers

133. The **intern-level workflow assessment lacked appropriate context**. Plaintiff's **PGY-2 peers (Dr. Rehman, Dr. Haider, and Dr. Nduka)** began training **16 months earlier**, gaining a **5-6 month advantage in inpatient service rotations** before Plaintiff's first inpatient rotation. A **fair evaluation process should account for these disparities**, ensuring assessments reflect individual training timelines rather than direct comparisons to residents with significantly more inpatient experience.

134. **Refer to: Exhibit #12**: "New Innovation Comments – March 2022 Inpatient Family Medicine Service" (Evaluation by **Dr. Ibe**).

April 2022:

Inpatient Pediatric Rotation

135. In **April 2022**, Plaintiff completed an **Inpatient Pediatric rotation at Children's National Hospital** under the **PHAST - Pediatric Hospitalist Attending Service team**. Throughout this rotation:

1. Plaintiff managed **over 80 pediatric cases**, logging them in **New Innovations**.
2. The rotation was successfully **passed**, and **Dr. Tina Halley recommended further exposure to pediatrics**.
3. Dr. Prill provided **feedback in New Innovations**, but **no additional formal evaluations** were recorded.
4. Plaintiff adapted to a **new EMR system (Cerner vs. Epic)**, marking his **first inpatient pediatric experience**.

136. **Refer to Exhibit #13:** April 2022 - Email exchanges with **Dr. Tina Halley** and **Dr. Prill's evaluation of the pediatric rotation** at Children's National Hospital.

Implementation of Individualized

Learning Plan (IEP)

137. Graduate Medical Education (GME) acknowledges that **resident learning curves vary**, and direct comparisons **without considering individual timelines can lead to biased evaluations**. **ILPs are a core ACGME requirement** applicable to **all residents**, including those requiring improvement and high-performing individuals ("superstars"). ILPs are **intended for self-assessment and improvement**, created **by the resident, for the resident**.

138. Despite this, the Program **unilaterally developed an Individualized Educational Plan (IEP) for Plaintiff** without his direct involvement, in violation of **ACGME Clinical Competency Committee (CCC) guidelines**. The **ILP process contained the following flaws**:

    1. **The IEP assessments remained unchanged throughout Plaintiff's training**, reinforcing an **unfounded stigma** rather than reflecting actual progress.
    2. **Allegations regarding Plaintiff's efficiency in note writing and professional traits lacked objective evidence** and were not supported by competency-based evaluations.

139. On **April 18, 2022, Dr. Ibe and Dr. Prill created an ILP without Plaintiff's direct participation**, contrary to ACGME guidelines, which explicitly state:

✔ **ILPs must be resident-driven, focusing on personal growth and competency development.**

✔ **The CCC does not create ILPs; rather, they are co-produced with the resident and a mentor.**

✔ **ILPs are not designed for evaluation, disciplinary actions, or punitive measures.**

140. **Refer to Exhibit #14: Faculty *Memo (April 18, 2022)*** outlining the **2-week Individualized Educational Plan (IEP) and identified Areas of Concern**.

141. **Refer to Exhibit #15:** Schedule and specifics of the **Individualized Educational Plan (IEP) for Plaintiff**.

ACGME Guidance on

Individualized Learning Plans (ILPs)

142. Per **ACGME's "Clinical Competency Committees: A Guidebook for Programs, 3rd Edition, January 2020,"** ILPs are:

- ✔ **Created by the resident/fellow for their own development**.
- ✔ **Guided by a facilitator (faculty member, advisor, or coach)**.
- ✔ **A self-assessment tool aimed at personal and professional growth**.
- ✔ **An iterative process, continuously refined throughout training**.
- ✔ **A required ACGME core component** to foster independent learning.

143. ILPs **are not**:

- ✘ **Evaluations or disciplinary measures**.
- ✘ **Static documents; they must evolve over time**.
- ✘ **The sole responsibility of the program director or CCC**.

144. **Refer to Exhibit #16:** ACGME "Clinical Competency Committees: A Guidebook for Programs, 3rd Edition, January 2020," detailing ILP formulation and implementation.

First Semiannual Period Evaluation Deficiencies

(Nov 1, 2021 – April 30, 2022)

Failure to Conduct Required
ACGME Six-Core Competency Evaluations

145. By the end of the first six months of Plaintiff's residency training on April 30, 2022, the University of Maryland Capital Region Health (UMCRH) Family Medicine Program, under the leadership of former Program Director Dr. Stacy Ross, **failed to conduct the mandatory ACGME six-core competency semiannual evaluation** as required by both the **GME Resident Agreement and the ACGME Program Requirements**

.

Mandatory Semiannual Evaluations

146. The **ACGME mandates** that each resident's performance **must be formally evaluated in writing no less frequently than every six months** per ACGME Program Requirements.These evaluations must provide an **objective assessment** of the resident's progress in **knowledge, skills, and professional growth**, including feedback on milestones relevant to competency progression.

147. Additionally, **GME Policy 104 UMCRH – General Policy on Resident Evaluation** specifically states:

1. "Each resident's performance must be evaluated **formally and in writing no less frequently than every six months**, or more, per ACGME Program Requirements."
2. "The written evaluation must reflect **an objective review of the trainee's progress** in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice."

148. Despite these explicit requirements, **Plaintiff was not provided with any semiannual written evaluation** at the six-month mark of his residency.

Absence of Semiannual Review Meetings

149. Under **ACGME guidelines (V.A.1.d)**, the **Program Director and Clinical Competency Committee (CCC)** are required to:

1. **Conduct semiannual meetings** with each resident to discuss **performance evaluations and progression** on specialty-specific milestones

150. However, **no such meeting took place** between Plaintiff and Dr. Ross at the six-month interval, nor was there any documented discussion regarding his **training progress, areas for improvement, or performance milestones**.

Failure to Maintain Required Written Records

151. Additionally, **GME Policy 104 explicitly mandates** that all evaluations be **documented and maintained in written form**, ensuring accessibility to residents. This requirement ensures compliance with **ACGME accreditation standards** and provides transparency in the evaluation process:

1. The **maintenance of a record of evaluation for each resident** that is accessible to the resident via the Residency Management Suite preferred by the GME Office/Institution.

2. Written evaluations must be communicated to each resident in **a timely manner, no less frequently than semi-annually**, or more frequently as required by specific ACGME Program Requirements.

152. Despite this, **no formal written summary or evaluation exists for Plaintiff's first six months of residency training** at UMCRH. The absence of documentation **demonstrates a fundamental failure in compliance with both ACGME regulations and the GME Resident Contract**.

Violation of Contractual Terms and

ACGME Accreditation Standards

153. The failure to conduct **mandatory semiannual evaluations** by April 30, 2022, **constitutes a direct violation of both ACGME accreditation standards and the GME Resident Contract**. This omission deprived Plaintiff of:

1. **An objective competency-based evaluation** critical for tracking professional progress.
2. **A structured discussion with program leadership** regarding training strengths, deficiencies, and targeted areas for improvement.
3. **A documented assessment of performance milestones**, which would serve as an official record of training progression.

154. This **failure marked the beginning of a broader pattern of non-compliance** by the UMCRH Family Medicine Residency Program, setting a precedent for further **violations of ACGME evaluation standards** throughout Plaintiff's tenure.

155. **Refer to:**

1. **Exhibit #10**: ACGME Resident Evaluation Requirements outlining semiannual review mandates
2. **Exhibit #11:** Program's Obligation to Use Dependable Measures for ACGME Six-Core Competencies.
3. **Exhibit #121**: ACGME Six-Core Competency Standard Evaluation Form, which the Program failed to utilize

SECOND SEMIANNUAL PERIOD

May 1, 2022 – October 31, 2022

May, 2022

156. In accordance with the **IEP Action Plan dated April 18, 2022**, Plaintiff completed **2.5 weeks of inpatient service in May 2022** to address the identified areas for improvement. Evaluations were conducted weekly by **Dr. Amanullah Siddiqui (PGY-1), Dr. Oghenetega Nduka (PGY-2), and Dr. Prill (attending physician).**

Summary of ILP Performance Ratings:

1. ***Poor: 0***
2. ***Fair: 6***
3. ***Good: 10***
4. ***Excellent: 0***

157. No evaluator documented **poor performance**, confirming that Plaintiff **did not fail** the ILP process.

158. **Refer to:**

1. **Exhibit #17:** IEP - Action & Monitoring Plans (May 16-31, 2022)
2. **Exhibit #18:** Evaluations by Dr. Amanullah Siddiqui (PGY-1)
3. **Exhibit #19:** Evaluations by Dr. Nduka (PGY-2)
4. **Exhibit #20:** Evaluations by Dr. Prill (Attending Physician)
5. **Exhibit #21:** ILP Comments (Original Text)

Evaluations and

Observations During ILP Period:

159.**Dr. Amanullah Siddiqui (PGY-1) – Week 1:**

"Plaintiff was motivated to learn and improve. Initially, he took longer to admit patients and complete notes, but improvement was evident. The MAO role seemed overwhelming at first, but he was determined to improve. By the end of the week, a better understanding of workflow emerged, leading to overall progress."

160.**Dr. Amanullah Siddiqui (PGY-1) – Week 2:**

"Substantial improvement in managing MAO duties, time management, and overall morale. Continued progress was noted, though time management remained an area for further development."

161.**Dr. Oghenetega Nduka (PGY-2):**

"Strong clinical acumen, always prioritizes patient care. Initially struggled with multitasking on MAO days but improved steadily. Interactions with medical students significantly improved. Needs to refine prioritization of tasks and multitasking skills."

162.**Dr. Prill (Attending Physician):**

"Documentation is good but not always consistent. Plaintiff communicates respectfully with patients and the healthcare team. Demonstrates enthusiasm for learning but needs further adaptation to the team structure. Capable of teaching and sharing medical knowledge but requires further leadership development. Some delays in note completion impact workflow. With additional time and experience, further improvements are expected."

Final Review by Dr. Prill – June 3, 2022:

163. In her **final assessment of Plaintiff's ILP performance**, Dr. Prill highlighted key strengths and areas for continued growth:

✅ **Strengths:**

- *Eager to learn, motivated, and hardworking*
- *Strong history-taking and patient evaluation skills*
- *Dedicated to completing assigned tasks and responsibilities*
- *Engages in educational discussions and shares knowledge*

⚠ **Areas for Continued Improvement:**

- *Time management and documentation workflow*
- *Note completion should be more timely throughout the day*
- *Leadership development remains an area of focus*
- *Struggles more on MAO days but improving with experience*

164. Despite these challenges, **Plaintiff successfully completed the ILP** and showed **measurable progress** in inpatient workflow management. The **CCC recommended continued monitoring rather than any disciplinary action.**

165. **Refer to:**

1. **Exhibit #22:** Dr. Prill's "New Innovation Comments – May 2022"

2. **Exhibit #23:** CCC Chair's Summary Discussion on June 3, 2022

Clarification Regarding the ILP Process:

1. **Plaintiff did not fail the ILP.**
2. **ILPs are not pass/fail assessments, nor are they intended as disciplinary measures.**
3. **ILPs apply to all residents, from high-performing to those needing improvement.**
4. **ACGME guidelines state that ILPs should be developed by the resident, not imposed by faculty.**
5. **The CCC's conclusion that Plaintiff needed additional monitoring affirms that improvement is a continuous process, not a basis for punitive action.**

166. **Refer to:**

1. **Exhibit #16:** ACGME Clinical Competency Committee Guidebook (3rd Edition, 2020) outlining ILP structure and intent.

167. The **ILP was concluded as a successful intervention**, with **documented progress and no failure designation.** The CCC acknowledged that additional inpatient experience over the summer would further strengthen Plaintiff's training.

June, 2022

Absence of Required CCC Evaluation

168. Despite the **Clinical Competency Committee's (CCC) recommendation** for **continued evaluation of Plaintiff's inpatient performance in June 2022**, **no formal assessment was conducted.**

1. **Dr. Newman served as the attending physician**, overseeing Plaintiff and **Dr. Amanullah Siddiqui (PGY-1)** during the inpatient service rotation.
2. **No verbal or written criticism was provided** to Plaintiff during this period.
3. Plaintiff effectively managed **inpatient workflow, documentation, and Medical Admitting Officer (MAO) responsibilities** without concerns from supervising faculty.

169. Contrary to **the termination letter dated July 24, 2023**, which falsely asserts that **Plaintiff's Individualized Education Plan (IEP) was extended into June 2022**, **this claim is entirely unsubstantiated.**

170. **Refer to:**

1. **Exhibit #24:** Inpatient Rotation with Dr. Newman & Absence of June 2022 Evaluation
2. **Exhibit #26:** Plaintiff's email request for an evaluation post-dismissal (unanswered by Dr. Newman)

July 2022

Outpatient Gynecology Rotation & Vacation

1. Plaintiff completed a **Gynecology rotation** in July 2022.

2. The **New Innovations evaluation for this rotation was completed without any comments and awarded the maximum score.**
3. Plaintiff also took scheduled vacation time during this period.

171. **Refer to:**

1. **Exhibit #25 & #27:** July 2022 Gynecology Rotation Evaluation & Vacation Period

August, 2022

Plaintiff's Performance in the Medical Intensive Care Unit (MICU)

172. In **August 2022**, Plaintiff successfully completed a **Medical Intensive Care Unit (MICU) rotation**, working under the supervision of:

- ✔ **Dr. Imran Siddiqi (ICU Chair)**
- ✔ **Dr. David Porembka**
- ✔ **Dr. William Zimmerman**
- ✔ **Dr. Chen**
- ✔ **Dr. Mohammad Gandi**
- ✔ **Dr. Hendrix Cheralyn**

173. The **MICU rotation** presents significantly greater challenges than the **Family Medicine Inpatient Service (FMIS),** requiring:

1. **12-hour on-call shifts every third or fourth day.**
2. **Responding to all hospital-wide codes and rapid response calls.**
3. **Managing ICU admissions and consults.**
4. **Coordinating patient transfers to the medical floor.**
5. **Conducting bedside sign-outs and participating in attending rounds.**

Patient Caseload & Clinical Responsibilities

1. Plaintiff **managed an active caseload of 5-6 ICU patients daily.**
2. On **on-call days**, Plaintiff was responsible for **35-40 patients, overseeing admissions, sign-outs, and night ICU team coordination.**
3. Responsibilities included **evaluating critically ill patients, adjusting treatment plans, and ensuring continuity of care across shifts.**

Independent Evaluation by ICU Chair, Dr. Imran Siddiqi

174. **Dr. Siddiqi, as ICU Chair, formally evaluated Plaintiff's performance, incorporating feedback from multiple ICU attending physicians.**

1. **His evaluation directly contradicts the program's allegations regarding Plaintiff's supposed deficiencies as a resident.**

2. Dr. Siddiqi's written assessment provides **substantive evidence disproving the Program's claims of underperformance.**

175. **Refer to:**

1. **Exhibit #28:** ICU Rotation Schedule
2. **Exhibit #29:** ICU Rotation Evaluation by Dr. Siddiqi (August 2022)

September, 2022

Emergency Medicine Rotation & Independent Evaluations

Plaintiff's Performance in the Emergency Department (ED)

176. In **September 2022**, Plaintiff successfully completed an **Emergency Department (ED) rotation,** working under the supervision of:

- ✔ **Dr. Brandon Cole**
- ✔ **Dr. Bradford Schwartz (Former DIO & ED Attending)**
- ✔ **Dr. Jane Rupal**
- ✔ **Dr. Nyun Nam**
- ✔ **Dr. Abhinav Gupta**

✔ **Dr. Jeffrey Amoako**

✔ **Dr. Douglas Mayo (ED Chairman)**

177. During this **high-intensity rotation**, Plaintiff:

1. **Managed acute and critical patients in a fast-paced ED environment.**
2. **Demonstrated strong patient management, leadership, and multitasking skills.**
3. **Effectively executed medical decision-making and adhered to documentation protocols.**

Post-Rotation Evaluations from Attending Physicians

178. One year after the **ED rotation**, Plaintiff contacted **multiple attending physicians**, who distinctly recalled his **clinical performance, work ethic, and documentation proficiency.**

1. These **attending physicians completed IEP questionnaires,** assessing key competencies such as **leadership, multitasking, organizational skills, adherence to note submission protocols, and responsiveness to attending directives.**
2. **All evaluations confirmed Plaintiff's competence, directly refuting any allegations of underperformance.**

3. These assessments were provided by **impartial evaluators, including the ED Chairman and the former Designated Institutional Official (DIO),** who actively participated in residency education.

Objective Testimony from Neutral

Emergency Medicine Faculty

179. Dr. **Brandon Cole**, an **Emergency Department (ED) attending physician unaffiliated with the Family Medicine faculty**, provided a **neutral and objective assessment** specifically regarding **Plaintiff's performance in the Medical Admitting Officer (MAO) role.**

180. Since the **primary justification for Plaintiff's Individualized Learning Plan (ILP) was alleged deficiencies in handling MAO duties and inpatient service responsibilities**, Dr. Cole's **independent evaluation** directly contradicts the program's claims, further **refuting the basis for the ILP and associated allegations.**

✔ **Dr. Cole stated:**

"Plaintiff's performance in the MAO role was comparable to his peers."

181. This **objective evaluation from an unbiased attending physician** provides **substantial evidence** that Plaintiff's performance met expected standards, **undermining any assertions of incompetence or need for remedial action.**

182. **Refer to:**

1. **Exhibit #30:** Emergency Medicine Rotation Schedule (September 2022)
2. **Exhibit #32:** List of ED Attending Physicians
3. **Exhibit #33:** Summary of ED Rotation Evaluations
4. **Exhibit #34:** Comments from Dr. Brandon Cole (ED Attending)
5. **Exhibit #35:** Comments from Dr. Nyun Nam (ED Attending)
6. **Exhibit #36:** Comments from Dr. Abhinav Gupta (ED Attending)
7. **Exhibit #37:** Evaluation by Dr. Brad Schwartz (ED Attending & Former DIO)
8. **Exhibit #38:** Evaluation by Dr. Douglas Mayo (ED Chairman)

September 2022 - Outpatient Medicine Evaluation

Faculty Evaluations Reflecting Plaintiff's Professional Growth

183. The evaluations completed in September 2022 by **Dr. Kaysin** and **Dr. Prill**, who serves as the **Clinical Competency Committee (CCC) Chair**, affirm Plaintiff's **steady and significant improvement** in outpatient family medicine. These faculty members focused their evaluations on **clinical skills, patient interactions, and professional development**, reinforcing Plaintiff's positive trajectory in his medical training.

Positive Faculty Feedback on Clinical Performance

184.Dr. Prill commented:

✔ **"Goes above and beyond to gather important information from the chart, is crisp, and asks good questions from patients for history."**

✔ **"Has shown improvement in several areas, especially presenting. He asks for feedback and incorporates it into his practice. I am confident that with more time in the office, he will continue to grow."**

185.Dr. Kaysin highlighted:

✔ **"Maintains a positive 'Can-Do' attitude, which is welcoming and great for team dynamics."**

✔ **"Made measurable progress in patient presentations."**

✔ **"Gaining competence in ambulatory medicine."**

✔ **"Improving in team-based care and appropriately delegating tasks to team members, including ACC, RN, and MA staff."**

✔ **"Demonstrating improvement in office workflow and medical record-keeping."**

186.**Refer to Exhibit #39** – *Outpatient Medicine Evaluation Comments by Dr. Kaysin and Dr. Prill* for faculty-written assessments of Plaintiff's performance.

Recognizing Individual Learning Curves

in Medical Education

187. These evaluations validate that **progress in residency is an individualized process**, and learning curves vary among trainees. The absence of any remarks indicating **regression, stagnation, or failure** underscores Plaintiff's **continuous learning and professional adaptation**.

188. It is important to note that the evaluations do not explicitly mention **leadership or multitasking**—a distinction that further highlights the **evaluators' focus on essential clinical competencies** rather than arbitrary or subjective measures. The absence of any **negative commentary** reflects **Plaintiff's commitment to improvement** and ongoing development within the residency program.

October, 2022

Family Medicine Inpatient & OBGYN Rotation

Positive Faculty Evaluation and Peer Acknowledgment

189. During October 2022, Plaintiff completed a **rotation divided between Obstetrics and Gynecology (OBGYN) and the Family Medicine Inpatient Service**. Dr. **Aseema Cheema**, the attending physician evaluating this period, provided a **positive assessment** of Plaintiff's performance, particularly highlighting his **"very good patient care."**

190. **Refer to Exhibit #40** – *Evaluation by Dr. Aseema Cheema for Family Medicine Inpatient Service & WhatsApp Chat Group Correspondence.*

Demonstrated Leadership and

Performance Under Pressure

191. During a particularly **demanding night shift**, Plaintiff:

✔ Managed **three new admissions** independently.

✔ Orchestrated the **transfer of a critically ill patient** to Georgetown University Medical Center.

192. Plaintiff's **co-residents** recognized and commended his performance:

✔ **Dr. Zankan Mirani (PGY-1):** "Wow!!! That is a lot for one night!"

✔ **Dr. Ijeoma Nwogu (PGY-2):** "Omg! You did all that by yourself… (clapping hands)"

193. This **WhatsApp correspondence**, submitted as evidence, further substantiates **Plaintiff's strong work ethic, ability to manage high-pressure situations, and multitasking proficiency**.

Subsequent Independent Faculty Evaluations

– Refuting IEP Deficiencies

194. Assessments conducted by **non-faculty attending physicians** across subsequent rotations—**Gynecology (July), ICU (August), Emergency Department (September), Inpatient Service and OB&GYN (October 2022)**—demonstrate **no evidence of alleged deficiencies** in:

✔ **Leadership**

✔ **Multitasking**

✔ **Note-taking proficiency**

195. These independent evaluations **not only document Plaintiff's progress and improvement but also categorically refute** the deficiencies alleged in the **unfairly imposed IEP.**

1. These assessments, originating from **a broad spectrum of independent evaluators,** provide an **objective and comprehensive** measure of Plaintiff's professional performance.
2. The documented **absence of performance concerns** in subsequent rotations **contradicts and invalidates** the alleged deficiencies cited by a limited group of faculty members.

Evaluations Reaffirm Plaintiff's

Eligibility for PGY-3 Advancement

196. Evaluations conducted from **May 2022 through October 2022**—spanning **five months following the implementation of the Individualized Education Plan (IEP)—consistently affirmed Plaintiff's progress and clinical competency.**

✔ **Evaluations from multiple unbiased attending physicians and colleagues** attest to **Plaintiff's strengths in leadership, time management, organizational skills, and note editing proficiency.**

✔ The overwhelmingly positive nature of these evaluations **directly contradicts any allegations of deficiencies** used to justify Plaintiff's non-promotion.

197. Plaintiff's documented performance **fully supports** his **qualification for advancement to Post-Graduate Year 3 (PGY-3).**

Full Accreditation of PGY-2 Year

Completion of 12 Months of ACGME-Accredited Residency Training

198. By the end of **October 2022**, marking the completion of Plaintiff's **first appointment contract**, the **University of Maryland Capital Region Health (UMCRH) Family Medicine Program** officially **granted Plaintiff 12 months of ACGME-accredited residency training.**

✔ **The program confirmed this accreditation to the American Board of Family Medicine (ABFM).**

✔ **No rotations completed during the PGY-2 contract were marked as failures.**

Completed Rotations Under ACGME Accreditation

199. Plaintiff successfully completed the following **12 months of accredited training**, with each rotation contributing to **board eligibility requirements**:

- **November 2021:** Neurology
- **December 2021:** Outpatient Pediatrics
- **January 2022:** Nephrology & Infectious Disease
- **February 2022:** Outpatient Cardiology
- **March 2022:** Inpatient Family Medicine Service (FMIS)
- **April 2022:** Inpatient Pediatric Service (Children's National)
- **May 2022:** OB/GYN & ILP-Implemented Inpatient Service
- **June 2022:** Inpatient Family Medicine Service
- **July 2022:** Gynecology
- **August 2022:** Medical Intensive Care Unit (ICU)
- **September 2022:** Emergency Medicine
- **October 2022:** OB/GYN & Inpatient Family Medicine Service

ARBITRARY PROMOTION DENIAL & BREACH OF CONTRACT

Wrongful Denial of Advancement

Failure to Conduct Mandatory Evaluations

200. **By the end of October 2022,** the **University of Maryland Capital Region Health (UMCRH) Family Medicine Program,** under the leadership of **former Program Director Dr. Stacy Ross,**

failed to provide the ACGME-required six-core competency evaluations necessary to assess **a resident's eligibility for promotion.** The absence of both **formative and summative evaluations** before the decision to withhold Plaintiff's promotion to PGY-3 constitutes **a breach of the GME Resident Agreement, a direct violation of incorporated GME policies, ACGME program standards, Institutional Requirements, and the proper application of ACGME Clinical Competency Guidelines.** These failures directly impact the Program's **own accreditation status.**

201. ACGME **Program Requirements, Section V. Resident Evaluation**, explicitly require **two types of assessments**:

✔ **Formative evaluations**—ongoing feedback to identify areas for improvement.

✔ **Summative evaluations**—final determination of whether a resident meets the necessary competency for promotion.

202. The **GME Resident Manual** mandates that **all evaluations must be documented and accessible to the resident**, yet Plaintiff never received an **official summative evaluation** at the conclusion of the **PGY-2 contract**. **Without this required assessment, the decision to extend Plaintiff's contract and deny promotion was arbitrary and without merit**.

Refer to Exhibit #10 – ACGME Resident Evaluation Requirements.

Refer to Exhibit #121 – ACGME Six-Core Competency Standard Evaluation Form.

Refer to Exhibit #229 – University of Maryland Medical System Annual Resident Performance Evaluation Form.

Violation of GME Policies on

Resident Evaluation & Promotion

203. Plaintiff's promotion was denied in **direct violation** of **GME Policy 104 (Resident Evaluation)** and **GME Policy 105 (Resident Advancement),** both of which mandate that **all rotation evaluations** be considered in promotion decisions. However, **Plaintiff's positive evaluations** from rotations in **Neurology, Cardiology, Gynecology, ICU, Emergency Medicine, Outpatient Family Medicine, Inpatient Service, and Obstetrics** were **improperly disregarded**, rendering the decision arbitrary and noncompliant with established GME policies.

✔ **GME Policy 104** states that resident evaluation **must include input from multiple sources**, including **faculty, peers, patients, self-evaluations, and other healthcare professionals**—none of which were included in the Plaintiff's case.

✔ **GME Policy 105** requires that **promotion decisions be communicated no later than four months before the end of the contract**. Plaintiff **was not notified until October 7, 2022**, a **clear violation of policy**.

✔ **GME Policy 115** establishes that the **Program Director** is responsible for ensuring **fair and transparent** evaluations. Dr. Ross failed in this duty.

Refer to Exhibit #44 – GME Policy 104 (Resident Evaluation).

Refer to Exhibit #45 – GME Policy 105 (Resident Advancement).

Illegitimacy of the CCC Decision & Faculty Meeting on August 26, 2022

204. The **Clinical Competency Committee (CCC)** convened on **August 26, 2022**, to determine **whether Plaintiff should be promoted to PGY-3**. Faculty members present allegedly included:

✔ **Dr. Prill (CCC Chair)**

✔ **Dr. Kaysin**

✔ **Dr. Ibe**

✔ **Dr. Tavakoli**

✔ **Dr. Newman**

✔ **Dr. Ross (Program Director)**

205. However, Plaintiff was **not informed** of the **Clinical Competency Committee (CCC)'s decision** until **October 7, 2022**, **more than six weeks later.** Under **ACGME CCC guidelines**, such **unreasonable delays** violate **mandatory transparency and due process requirements.**

206. Furthermore, internal appeal testimony by **Plaintiff's counsel, Mr. Michael Herman, Esq.,** directly challenged the legitimacy of the CCC meeting, raising concerns about whether it ever actually took place as described. Given the circumstances, it is highly likely that **this meeting was fabricated** by former Program Director **Dr. Stacy Ross**, motivated by her **growing personal animosity and unprofessional conduct.**

207. **Refer to Exhibit #42** – Extension of Second-Year Contract.

Failure to Provide Due Process

& Timely Notification

208. Under **GME Policy 105**, residents must be informed of **non-promotion decisions at least four months in advance**. This would have required UMCRH to notify Plaintiff by **July 2022**. Instead,

Plaintiff received notification on **October 7, 2022**, **mere weeks before the contract's renewal date**, depriving him of the opportunity to address concerns.

✔ **No formal warning of non-promotion was issued**.

✔ **Plaintiff was never given a chance to remediate or challenge the decision in real time**.

✔ **The program violated GME Policy 104 (Resident Evaluation), which guarantees due process for promotion-related decisions**.

209. **Refer to Exhibit #45** – GME Policy 105, section requiring promotion decisions to be communicated "**no later than four months**."

Questionable CCC Meeting on August 26, 2022

210. The **denial of Plaintiff's promotion** contradicts **objective evaluations from multiple neutral faculty members** outside of the Family Medicine Program, as well as **evaluations from core faculty members**, including **Dr. Kaysin** and **Clinical Competency Committee (CCC) Chair, Dr. Prill**.

211. **If the August 26, 2022 CCC meeting** had truly taken place and recommended **non-promotion**, then how can it be logically explained that:

1. **Evaluations completed by Dr. Kaysin and Dr. Prill do not reflect any serious concerns** warranting non-promotion.

2. **September 2022 evaluations**, conducted **after** this meeting, **praised Plaintiff's performance** rather than identifying deficiencies justifying non-promotion.

3. **No form of evaluation—neither based on ILP progress nor ACGME six-core competency evaluation standards—was completed** to substantiate the decision allegedly made on August 26, 2022.

212. **The lack of required evaluation data further supports that the decision was purely arbitrary and capricious** with no objective basis.

1. The **only plausible explanation** is that the **CCC meeting on August 26, 2022, likely never occurred** but was **backdated and fabricated** by **former Program Director Dr. Stacy Ross** in an **arbitrary and capricious manner**.
2. This **retroactive documentation** was **likely created to falsely demonstrate compliance** with the **GME Resident Agreement**, **GME Policies**, **ACGME Program Requirements**, and **Institutional Standards**.

213. **ACGME Clinical Competency Committee Guidelines** mandate that such critical **meetings and decisions must be promptly communicated** to the resident, ensuring **transparency and due process**.

1. However, **Plaintiff was not informed of the CCC meeting until six weeks later**, in **direct violation of ACGME standards**.

Refer to Exhibit #39 – Outpatient Medicine Evaluation Comments by **Dr. Kaysin & Dr. Prill** (September 2022).

Refer to Exhibit #150 – ACGME Clinical Competency Committee Guidelines (Transparency Requirements).

Misapplication of ILP

Misuse of Individualized Learning Plan (ILP) for Non-Promotion

214. The **Accreditation Council for Graduate Medical Education (ACGME) explicitly prohibits** the use of **Individualized Learning Plans (ILPs) as disciplinary tools** or as a **basis for promotion decisions**. ILPs are **developmental tools designed for all residents**, including both those in need of improvement and high-performing individuals ("superstars").

✔ **ACGME CCC Guidelines (3rd Edition, p. 32)** – The **Clinical Competency Committee (CCC) must provide formal summative evaluations** to determine resident promotion.

✔ **ILPs are intended for all residents**, serving as a **continuous professional development process**, not an evaluation mechanism.

✔ **GME Policy 104 (Resident Evaluation) explicitly prohibits** the use of **ILP results as an assessment tool** for promotion decisions.

Refer to Exhibit #16 – ACGME CCC Guidebook on ILPs.

Refer to Exhibit #154 – Dr. Prill's Deposition Transcript (November 9, 2023) confirming the ILP was not an evaluation tool.

215. **Despite these clear directives**, UMCRH improperly **relied on Plaintiff's ILP as a justification for denying promotion**. **Plaintiff was not involved in the creation of his ILP**, which contradicts ACGME guidelines requiring that **residents develop their own ILPs in collaboration with faculty mentors**.

✔ **ILPs must not replace formal competency evaluations** conducted through structured **ACGME-approved assessments**.

✔ **Misusing ILPs to deny promotion, refuse contract renewal, or impose disciplinary action violates ACGME guidelines**, as ILPs are **not designed to measure competency but rather to support individual learning and development**.

✔ **The CCC does not create ILPs**—residents must develop them **independently with faculty guidance**, ensuring alignment with personalized learning goals rather than institutional mandates.

216. By **misapplying the ILP process**, UMCRH **bypassed required competency-based evaluations**, **failed to conduct mandatory summative assessments**, and **violated ACGME regulations** by substituting an ILP for an official **promotion determination**. This **constituted a breach of the GME Resident Agreement, a violation of GME policies, ACGME standards, and noncompliance with ACGME Clinical Competency Guidelines regarding the proper use of ILPs**. Furthermore, it **underscores the arbitrary and capricious nature of the Program Director's decision to deny Plaintiff's PGY-3 advancement**.

CCC Chair Dr. Prill's Testimony

Under Oath Regarding the ILP

217. An **Individualized Learning Plan (ILP) is not an evaluative tool**, nor is it intended as a **punitive or disciplinary measure**. This principle is explicitly recognized in **ACGME Clinical Competency Committee (CCC) guidelines** and was **affirmed by Dr. Prill, Chair of the CCC**, during cross-examination by Plaintiff's attorney, **Mr. Michael Herman, Esq.**

218. In **Dr. Prill's deposition on November 9, 2023**, she acknowledged that:

✔ **ILPs are not meant for disciplinary action or resident evaluation.**

✔ **Dr. Prill confirmed in her sworn testimony** that ILPs are meant for **self-directed learning and professional development**, not for determining competency or promotion.

219. These admissions are documented in **Dr. Prill's deposition transcript (November 9, 2023, pages 12, 18, and 35)**, transcribed by **David Corbin, RPR, of Veritext Legal Solutions (Contact: 202-803-8830)**.

Refer to Exhibit #154: Deposition Transcript of Dr. Prill (November 9, 2023) confirming the ILP's intended purpose and misapplication in Plaintiff's case.

Due Process Rights & Material Breach of Contract

Egregious Violation of Due Process Rights

220. The **GME Resident Agreement, Section 2.6** (**Exhibit #141**) unequivocally guarantees **due process protections** before any action is taken that may **result in non-renewal of contract, dismissal, denial of credit, or any action that significantly threatens a resident physician's intended career development**. This obligation is not discretionary; it is a **binding contractual requirement** that the University of Maryland Capital Region Health (UMCRH) was legally mandated to uphold. The institution's outright failure to adhere to these due process requirements constitutes a **deliberate and unlawful deprivation of Plaintiff's rights** under both contractual and accreditation frameworks.

221. These **due process guarantees** are further reinforced by **GME Policy 103** (**Exhibit #147**), which mandates that UMCRH **must implement fair and reasonable procedural protections** for **any decision affecting** a resident's progression. **GME Policy 104** (**Exhibit #147**) explicitly requires the **Program Director to advise residents of their right to appeal** when faced with:

1. **Dismissal** from the program.
2. **Non-renewal** of the residency contract.
3. **Any action significantly threatening their intended career development**, such as **denial of promotion, academic credit or contract extension**.

222. Despite these **explicit contractual and institutional mandates**, UMCRH **failed to provide Plaintiff with notice of his due process rights or afford him any opportunity to challenge the adverse decision**. This was not a mere administrative oversight; it was a **deliberate and knowing violation** of the most fundamental protections afforded to resident physicians under the GME framework. The institution's refusal to provide due process effectively rendered its

decision **arbitrary and capricious**, demonstrating a **willful disregard for Plaintiff's legal rights and professional future**.

Material Breach of Contract Under Maryland Law

223. A breach of contract occurs when a party **fails to uphold their contractual obligations without legal justification**. **Maryland Code, Commercial Law § 22-701** defines a **breach** as:

1. **A failure to perform an obligation in a timely manner.**
2. **A repudiation of contractual duties.**
3. **A violation of a fundamental contractual term or condition.**

224. A **breach is deemed material** if:

1. **The contract explicitly recognizes the obligation as essential.**
2. **The breach deprives the aggrieved party of a significant contractual benefit.**
3. **The breach is likely to cause substantial harm or materially affect the aggrieved party's rights.**
4. **A cumulative effect of repeated contractual violations results in substantial prejudice to the aggrieved party.**

225. Here, UMCRH's **brazen disregard for due process, refusal to provide formal competency-based evaluations, and failure to justify its decision through objective standards constitutes a material breach of contract**. The institution's **unilateral and procedurally defective decision-making process directly deprived Plaintiff of the core benefit of his GME**

contract—an objective, merit-based pathway for professional advancement. The **denial of Plaintiff's promotion without adhering to contractual and accreditation-mandated safeguards** was not just a violation—it was an egregious abuse of power that **undermined the integrity of the entire residency training framework.**

226. **The consequences of this breach are profound:** Plaintiff was **denied the opportunity to advance in his career, subjected to an arbitrary and prejudicial decision-making process, and deprived of the fundamental procedural protections enshrined in both GME policies and ACGME accreditation standards.** The institution's **reckless disregard for its legal and ethical obligations** cannot be justified, excused, or overlooked.

Refer to:

1. **Exhibit #141 – GME Resident Agreement, Section 2.6.**
2. **Exhibit #147 – GME Policies, including:**
    - **GME Policy 103 – Due Process & Corrective/Discipline Procedures.**
    - **GME Policy 104 – Request for Reconsideration Policy (Program Director Obligation).**
3. **Exhibit #150 – ACGME Clinical Competency Committee Guidelines.**
4. **Maryland Code, Commercial Law § 22-701.**

Arbitrary & Capricious Decision

Violation of Contractual Obligations

227. The **denial of Plaintiff's promotion** to PGY-3 was **not based on performance** but was instead an **arbitrary and capricious decision**, violating multiple contractual, institutional, and accreditation-mandated requirements.

✔ Plaintiff successfully completed all required PGY-2 rotations without any failures.

✔ No written formative or summative evaluation exists to justify non-promotion.

✔ All required competency-based assessments were positive, with no faculty feedback supporting an extension.

✔ Plaintiff passed USMLE Step 3 in 2018, satisfying all licensing requirements.

✔ The program failed to provide timely notification of non-promotion, preventing Plaintiff from exercising due process rights.

228. The Decision to Withhold Promotion Violates:

✔ GME Resident Agreement, Section 2.6 – Due Process Obligations

✔ GME Policy 102 – Due Process Protections

✔ GME Policy 103 – Corrective/Disciplinary Process

✔ GME Policy 104 – Resident Evaluation Requirements

✔ GME Policy 105 – Resident Advancement Criteria

✔ GME Policy 115 – Program Director Responsibilities

✔ ACGME Program Requirements

✔ ACGME Institutional Standards

✔ ACGME Clinical Competency Guidelines

✔ Maryland Code, Commercial Law § 22-701, which governs contract

enforcement, as **Section 5.6 of the GME Resident Agreement** stipulates that this contract is governed by the laws of **the State of Maryland**.

229. Conclusion: Clear Breach of Contract & Due Process Violations

✔ The Program failed to conduct required six-core competency evaluations.

✔ No legitimate basis for non-promotion was documented or communicated.

✔ Plaintiff was denied due process, violating both GME and ACGME policies.

✔ The decision to extend the PGY-2 contract was made improperly, arbitrarily, and capriciously.

✔ Plaintiff was granted full 12 months of ACGME-accredited credit yet was unlawfully denied promotion.

230. **The Program's actions constitute a material breach of contract**, warranting **Plaintiff's reinstatement, corrective action, and full legal remedies** under both **Maryland contract law and GME/ACGME due process protections.**

THIRD SEMIANNUAL PERIOD

Extension of PGY-2 year

Legally Binding Six-Month Extension Contract

231. Following the **arbitrary and capricious denial of promotion**, in **breach of contractual terms and conditions**, Plaintiff's **PGY-2 year was extended for an additional six months** through a **newly executed agreement**, formalizing the extension until **April 30, 2023**. This **contract was executed as an addendum** to the **original University of Maryland Capital Region Health (UMCRH) Resident Agreement**, maintaining the **same binding obligations**.

232. The agreement explicitly states that Plaintiff's **PGY-2 year required a six-month extension** based on a recommendation from the **Clinical Competency Committee (CCC),** following a decision by the **Family Medicine Residency Program.** However, as analyzed above, **all decisions were arbitrary, capricious, and in profound violation of the terms and conditions of the initial GME Resident Agreement, its Exhibit A - GME Policies, and the broader ACGME program requirements.**

233. Despite these violations, the **effective date of this extension was October 18, 2022,** while the **formal execution of the agreement did not occur until November 15, 2022.**

234. **Section 2.0 of the contract, titled "Acknowledgment," explicitly requires Plaintiff to adhere to all GME policies** governing the program. The contract **expressly incorporates 27 GME policies** as **Exhibit A**, making adherence to these policies **a condition of entering into the agreement**.

Refer to Exhibit #42 – True and Authentic Copy of the GME Resident Agreement.

Legally Binding Nature of the Extension Contract

235. **This agreement is legally enforceable**, as evidenced by **signatures from all required institutional representatives**. The contract was **executed with the intention to be legally binding**, as stated in its provisions. The **signatories** included:

✔ **On behalf of the Sponsoring Institution (UMCRH):**

1. **Dr. Tommeka Archinard, MD – Chief Medical Officer & Designated Institutional Official (DIO)**
2. **Dr. Stacy Ross, MD – Former Program Director**
3. **Dr. Nader Tavakoli, MD – Chair, Family Medicine Department**

✔ **On behalf of Plaintiff:**

1. **Plaintiff Otabek Elmurodov, MD**

236. **The agreement was signed on November 15, 2022, by Plaintiff, Dr. Ross, and Dr. Tavakoli.** It was **further finalized on December 3, 2022, upon execution by the DIO, Dr. Archinard**. The execution by the **Chief Medical Officer and DIO solidifies its legal enforceability**, ensuring that the contract meets all requirements under **Maryland contract law**.

237. The **contract unequivocally establishes that UMCRH agreed to extend Plaintiff's residency under the explicit terms outlined in the agreement**. By signing the contract, **UMCRH legally obligated itself to abide by all incorporated terms, including compliance with the 27 GME policies attached as Exhibit A**. This makes **any subsequent breaches or noncompliance a direct violation of both contractual and institutional obligations**.

238. **As a legally enforceable agreement, the contract requires that both parties fulfill their obligations in good faith.** Any deviation from its terms, failure to adhere to **due process policies**, or violation of **ACGME and GME policies governing Plaintiff's residency extension** constitutes a **material breach of contract**. Given that **UMCRH explicitly incorporated these policies into the agreement**, failure to uphold them exposes the **Sponsoring Institution to contractual liability**.

Refer to Exhibit #42 – GME Resident Agreement, including Section 2.0 **Acknowledgment of Incorporated Policies**.

239. Conclusion: Contractual Enforceability and Institutional Liability

✔ The residency extension contract is a legally binding agreement with clearly defined obligations.

✔ UMCRH explicitly incorporated GME policies as binding conditions within the agreement.

✔ Any deviation from the agreed-upon policies constitutes a material breach of contract.

✔ Signatures from Plaintiff and key UMCRH officials confirm the contract's enforceability under Maryland law.

✔ Failure to uphold due process obligations and GME policies exposes UMCRH to legal liability.

240. This contract **establishes the legal foundation for Plaintiff's continued training** and **holds UMCRH accountable for any violations** of its terms, policies, or due process obligations.

PGY-2 Extension Monitoring Plan

Failure to Implement the Monitoring Plan

241. As part of the **arbitrary and capricious decision** to extend Plaintiff's PGY-2 contract, the program instituted a **monitoring plan** purportedly designed to address areas identified as needing improvement. This plan was developed by **CCC Chair Dr. Prill**, endorsed by **Program Director Dr. Ross**, and acknowledged by Plaintiff upon signing on **October 7, 2022**. The **six-month extension plan** thus formed a **binding commitment** on the part of the program.

242. The **monitoring plan required short monthly evaluations** assessing **organizational skills, leadership, time management, note editing, and presentation skills**. These evaluations were to be **conducted before regular consultations** between the CCC and Plaintiff, culminating in a **formal semi-annual review in December 2022** and a **final meeting with the Program Director in January 2023**. This structure was intended to serve as a mechanism for performance assessment and improvement.

Refer to Exhibit #42 – Extension of the Second-Year Contract.

243. Despite formally instituting this plan, the Program **failed to conduct the required monthly evaluations** for **October, November, and December 2022, as well as January 2023.** No regular **Clinical Competency Committee (CCC) meetings** were held to assess whether Plaintiff had made improvements in the alleged areas of concern. Furthermore, the Program **never released any six-month semiannual or annual ACGME six-core competency-based evaluations** (Exhibit 229 - University of Maryland Medical System Annual Resident Performance Evaluation Form). Additionally, the **January 2023 meeting with Program Director Dr. Ross never took place,** constituting a **direct violation** of the plan's stipulated framework.

244. The **failure to implement and follow through** on this **performance improvement plan** exposes the Program's decision to extend Plaintiff's PGY-2 contract as a **pretext for obstruction** rather than a genuine effort to address any legitimate concerns. Had the Program been sincere in its commitment to **a structured developmental plan,** it would have ensured compliance with its own agreed-upon evaluation framework. There **should have been** CCC-guided **monthly evaluations for November, December, and January**; instead, the Program conducted a **retaliatory and biased evaluation in February 2023,** motivated by **former Program Director Dr. Stacy Ross's personal animosity.** Notably, in **March 2023,** these evaluations themselves reflected **resolution of the alleged concerns,** such as **lack of organizational skills, leadership, time management, note editing, or insubordination.**

245. These allegations were entirely fabricated by **former Program Director Dr. Ross, who manipulated the CCC Chair into approving her predetermined decisions in an abuse of power.**

246. By **April 2023,** at the **end of the six-month PGY-2 extension,** there was **no third semiannual, formative, or summative ACGME six-core competency-based evaluation** to justify another **non-promotion on April 30, 2023.** This **second denial of promotion** constituted a **blatant violation** of the **legally binding agreement** between the parties.

247. The **complete absence** of required **ACGME standard evaluations** throughout the entirety of **Plaintiff's 21 months of training** further reinforces that the **second non-promotion, like the first, was unjustified, procedurally defective, and followed by an arbitrarily imposed probationary period, culminating in a capricious termination.** This sequence of actions was not only **improper** but constituted a **direct violation of Plaintiff's contractual and due process rights.**

248. Moreover, the **blatant disregard for mandated evaluation protocols, the explicit terms and conditions of the GME Contract, GME Policies, and the broader ACGME standards** renders the **non-promotion, probation, and termination decisions not only procedurally defective but wholly illegitimate and unlawful.** Such egregious violations undermine the **very integrity of the residency training process** and **demand judicial intervention** to rectify this **miscarriage of justice.**

Professional Misconduct in Program Leadership

Unethical Conduct of Program Director

249. The **power imbalance between residents and attending physicians** frequently leads to conflicts, as recognized by the **Council on Ethical and Judicial Affairs of the American Medical Association (AMA)**[2]. These conflicts can take various forms, including:

- ✔ **Verbal abuse, humiliation, and belittlement**
- ✔ **Assignment of tasks as punishment**
- ✔ **Threats of unfair grading or adverse evaluations**
- ✔ **Faculty taking credit for a resident's work**
- ✔ **Discriminatory treatment based on gender, race, or ethnicity**
- ✔ **Unethical conduct in supervisory relationships**

Refer to AMA Council on Ethical and Judicial Affairs Report[3] **– "Disputes Between Medical Supervisors and Trainees."**

250. Plaintiff's documented **interactions with Dr. Stacy Ross, the Program Director,** unmistakably reveal a s**ustained pattern of passive-aggressive conduct** and **retaliatory animus.** This pattern, which persisted over a significant period, culminated **in a series of unjustifiable** and **prejudicial employment decisions, including the denial of a rightful promotion,** the imposition of an **arbitrary and unwarranted probationary period,** and ultimately, **a wrongful termination** that is both **legally indefensible** and contrary to fundamental principles of **due process and fairness.**

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[2] Council on Ethical and Judicial Affairs Report 1—I-93 "Disputes Between Medical Supervisors and Trainees," American Medical Association (1994).

[3] https://archives.law.nccu.edu/siplr/vol6/iss1/5

251. During the discovery phase of this litigation, **on March 6, 2025,** during a deposition conducted vi**a the Zoom platform,** Dr. Tavakoli, testifying **under oath and subject to the penalties of perjury,** unequivocally stated that the termination **letter was to be composed by Dr. Ross prior to her resignation in June 2023.** Notably, Dr. Tavakoli clarified that his role was strictly **administrative, serving merely as an interim Intern Program Director pending the appointment of a permanent successor.** His testimony, in conjunction with the **well-documented pattern of retaliatory conduct by Dr. Ross,** provides **compelling evidence that the adverse employment actions t**aken against the plaintiff were **neither justified** nor **procedurally sound.** Instead, they were executed with r**etaliatory intent,** in clear violation of **fundamental fairness** and established **legal protections against wrongful termination.** This egregious misconduct **demands judicial scrutiny** and **appropriate redress.**

252. Beginning in **October 2022**, Dr. Ross began to express **unwarranted dissatisfaction** with Plaintiff's clinical decisions. One such incident occurred when she **objected to a circumcision procedure** that Plaintiff had performed under **direct attending supervision** during an **OBGYN rotation**. Despite Plaintiff's clear explanation that he had acted under the guidance of **Dr. Henry Adi (Attending OB Physician)** and with **approval from NICU Pediatrician Dr. Skelton**, Dr. Ross **persisted in criticizing** the procedure and questioned Plaintiff's role.

253. Further, **Dr. Ross attempted to undermine Plaintiff's proactive efforts to recruit patients**, contradicting her **own written comments in the PGY-2 contract extension** that Plaintiff needed to build a **larger patient base** in the outpatient setting. Plaintiff successfully **recruited patients without primary care providers**, ensuring compliance with **graduation**

requirements. However, instead of acknowledging this effort, Dr. Ross **voiced discontent**, reflecting **a pattern of moving the goalposts** to justify continued adverse treatment.

254. This **inconsistent feedback and arbitrary criticisms** demonstrated an effort to **manufacture deficiencies** rather than provide a fair and objective assessment of Plaintiff's progress. During this time, Dr. Ross made an **egregious statement** to Plaintiff, saying: **"I appreciate your enthusiasm, but I promise you will get sued by the end of residency."** This statement, beyond being inappropriate, underscores the **malicious and retaliatory intent** underlying the actions taken against Plaintiff.

255. The **circumcision procedure** was carried out **per standard medical protocol**, at the request of the patient's mother and **with full attending supervision**. The patient's family expressed **satisfaction** and subsequently **chose Plaintiff as their primary care physician**. This incident **should have been a non-issue**, yet Dr. Ross's **disproportionate response** exemplifies her **persistent efforts to cast Plaintiff in a negative light**, despite **no medical errors or breaches of professional conduct**.

256. Further illustrating **disparate treatment**, in **November 2022**, Plaintiff **misplaced his N95 mask** amidst the ongoing **COVID-19 pandemic** and was unable to obtain a replacement at the **New Carrollton office**. Although **Plaintiff consistently wore a surgical mask**, **Dr. Ross singled him out for criticism**, despite another faculty member also failing to wear an N95 mask without facing repercussions.

257. **Dr. Ross escalated the matter to Human Resources**, not only critiquing Plaintiff's **mask compliance** but also making **unwarranted and deeply inappropriate personal comments** about **Plaintiff's children**, falsely suggesting that they posed a risk for **disease transmission**. These remarks were **highly unprofessional and inappropriate**.

Refer to Exhibit #46-A – Discussion on Mask Incident Between Plaintiff and Dr. Prill.

258. In apparent **retaliation** for the mask incident, **Dr. Ross assigned Plaintiff an additional on-call shift in inpatient service**, an **unnecessary punitive measure** inconsistent with standard scheduling procedures.

Failure to Uphold Professionalism and Duty of Fair Treatment

259. **ACGME Requirement VI.B.5** mandates that accredited residency programs **maintain an equitable, professional, and respectful learning environment free from discrimination, harassment, or mistreatment**. This obligation extends to all interactions between faculty, residents, and staff.

260. In accordance with ACGME requirements, **UMCRH implemented GME Policy 122 – General Policy on Professionalism**, which reinforces the necessity of a **civil and respectful learning environment** that **prohibits mistreatment, abuse, discrimination, or retaliation**.

Refer to Exhibit #47 – GME Policy 122 UMCRH – General Policy on Professionalism.

261. Under **GME Policy 122**, **Program Directors are required** to model **professionalism, integrity, and fairness** in their decision-making processes. Program leadership is expected to uphold the highest ethical standards and **provide an unbiased, structured learning environment** that fosters **educational and professional growth**.

262. **Dr. Ross's repeated actions**—including **unwarranted criticisms, inconsistent expectations, retaliatory scheduling decisions, and inappropriate remarks about Plaintiff's family**—constitute **a failure to uphold her responsibilities** under both **institutional policy and ACGME requirements**. These violations contributed to an **unjustifiable obstruction of Plaintiff's advancement**, ultimately culminating in **wrongful termination**.

263. If the Court reviews Plaintiff's complaint, it will find **multiple well-documented examples of Dr. Ross's unprofessionalism and unethical conduct.** Under the applicable **preponderance of the evidence** standard, Plaintiff has provided an **extensive body of evidence—fact after fact, exhibit after exhibit**—establishing that Dr. Ross **did not act in good faith.** Her decisions were not rooted in **sound clinical** or **academic judgment** but were **instead consistently tainted by personal animus and retaliatory motives.**

264. **Dr. Ross's misconduct** was widely known **among faculty members** and **the Graduate Medical Education (GME) office,** where concerns regarding her **character and professionalism** were an **open secret.** Her subsequent **resignation from the institution,** presented under the **guise of retirement, further undermines the credibility of her actions.** Notably, after making farewell speeches at retirement events in June 2023, Dr. Ross resurfaced

months later as a program director at the Emeritus Family Medicine Program in Hagerstown, Maryland. This sequence of events raises **significant doubts about the legitimacy of her departure** and further **discredits the motivations** behind the adverse actions taken against Plaintiff.

265. Courts across the country have consistently **overturned university decisions where dismissals were not based on sound academic policies** but rather stemmed from **personal animus or retaliatory intent.** As recognized in *Lachtman v. Regents of University of California,* 158 Cal.App.4th 187, 205 (Cal. Ct. App. 2007), citing *Banks v. Dominican College,* 35 Cal.App.4th 1545, 1551 (Cal. Ct. App. 1995):

> ″A court may overturn a university's decision to dismiss a student for academic reasons only if we find it to be **arbitrary and capricious,** not **based upon academic criteria,** and the result of **irrelevant or discriminatory factors.**″

266. Here, the **overwhelming evidence demonstrates that Plaintiff's termination was not the result of legitimate academic criteria** but was instead d**riven by improper and retaliatory considerations.** Given the weight of the factual record, Dr. Ross's actions—and by extension, Defendants' decision-making process—cannot withstand **legal scrutiny under this well-established standard.**

November, 2022

Obstetrics & Prenatal Care Rotations

267. In **November 2022**, Plaintiff successfully completed the **Obstetrics (OB) rotation**, where he provided **prenatal care services** at the **Mother-Baby-Bus unit** under the supervision of **Dr. Bradford and Dr. Henry Adi**. These attending physicians conducted Plaintiff's performance evaluations for the OB rotation.

268. The **New Innovations evaluation comments** reflect **positive assessments**, with the attending physicians awarding **maximum scores** for maternity care. The evaluation includes specific remarks noting Plaintiff's **competence and dedication** in managing prenatal care services and contributing effectively to patient care.

Refer to Exhibit #46: November 2022 OB Rotation – Mother-Baby-Bus Prenatal Care & OBGYN Evaluations.

269. This evaluation further substantiates Plaintiff's **competency and continued progression** throughout his training. **No deficiencies or concerns** were noted in any of the required skill areas for Obstetrics & Gynecology (OBGYN). The **positive feedback from independent attending physicians contradicts** prior allegations of underperformance and further supports Plaintiff's **rightful eligibility for PGY-3 advancement.**

270. **This documented success undermines the legitimacy of the CCC's non-promotion decision** and serves as **additional evidence of arbitrary and capricious decision-making** by program leadership.

December, 2022

Endocrinology Rotation & Targeted Misrepresentation by Dr. Ross

Successful Completion of Endocrinology Rotation

271. In **December 2022**, Plaintiff **successfully completed an Endocrinology rotation** at **Dr. Irfan Khan's private office**. Dr. Khan, a **board-certified endocrinologist**, evaluated Plaintiff's performance and awarded him **maximum scores** across all **ACGME six-core competencies**, which include:

    - ✔ **Patient Care**
    - ✔ **Medical Knowledge**
    - ✔ **Practice-Based Learning & Improvement**
    - ✔ **Interpersonal & Communication Skills**
    - ✔ **Professionalism**
    - ✔ **Systems-Based Practice**

    Refer to Exhibit #48: Endocrinology Evaluation by **Dr. Irfan Khan** (December 2022).

272. This **objective and independent evaluation directly contradicts** the program's allegations regarding Plaintiff's **competency and performance**. The **positive evaluation from an external attending physician** further **reinforces Plaintiff's eligibility for PGY-3 advancement** and invalidates prior claims of deficiencies.

Targeted Misrepresentation by Dr. Ross

273. **Despite Plaintiff's successful completion of the rotation**, Dr. Ross—**the former Program Director** — **actively attempted to undermine his performance**. During December 2022, **she circulated a confidential internal message among faculty**, falsely asserting that **Plaintiff was neglecting his Endocrinology rotation** and was instead making "**independent decisions on which rotations to attend based on his personal learning preferences.**"

274. This **deliberately misleading communication**—**negative in tone and intent**—indicates **Dr. Ross's calculated attempt** to fabricate a **pretext for punitive action** against Plaintiff. The **pre-meditated nature of her approach** was further revealed when she **expressly planned to raise these unfounded allegations at an upcoming Clinical Competency Committee (CCC) meeting**.

> **Refer to Exhibit #49:** Dr. Ross's Private Comment on New Innovations regarding Endocrinology Rotation.
>
> **Refer to Exhibit #50:** December 2022 Rotation Schedule—Confirming Plaintiff's Endocrinology Rotation Attendance.

Violation of ACGME CCC Guidelines: Prejudicial Conduct in Resident Evaluations

275. **Dr. Ross's actions leading up to the CCC meeting violated established ACGME guidelines**. The **ACGME's "Clinical Competency Committees (CCC), 3rd Edition, Part 4: Running the CCC Meeting, Including Effective Group Process"** explicitly warns against CCC members **arriving at meetings with predetermined judgments**.

✔ CCC members **must not enter discussions with preconceived decisions or "verdicts" about a resident's competency**.

✔ The **evaluation process must be based on a holistic, objective review** rather than the biased opinion of a single faculty member.

✔ Selectively using **prejudicial data** to justify negative evaluations **compromises due process** and **violates ACGME accreditation standards**.

276. **Dr. Ross's conduct blatantly disregarded these principles**, further **confirming her personal animus against Plaintiff** rather than an **objective evaluation of his clinical performance**.

Refer to Exhibit #51: ACGME CCC Guidelines—**"Part 4: Running the CCC Meeting, Including Effective Group Process."**

Dr. Khan's Rebuttal & Support for Plaintiff

277. In **July 2023**, upon learning of **Plaintiff's unjust dismissal**, **Dr. Khan expressed shock and dismay**, writing a **formal letter of support to the Appeal Committee**. In his letter, he:

✔ **Categorically refuted Dr. Ross's false allegations** regarding Plaintiff's Endocrinology rotation.

✔ Affirmed **Plaintiff's strong clinical performance** and professional conduct.

✔ **Denounced the decision as unjust**, attributing it to **bad faith and personal prejudice** rather than merit-based assessment.

Refer to Exhibit #52: Letter of Support from Dr. Irfan Khan—Discrediting Dr. Ross's False Allegations.

Conclusion: Clear Pattern of Retaliation & Due Process Violations

✔ **Independent attending evaluations from Dr. Khan contradict program allegations.**

✔ **Dr. Ross's actions demonstrate targeted retaliation and bad faith.**

✔ **ACGME CCC guidelines were violated, further undermining the legitimacy of the CCC process.**

✔ **Pretextual justification for non-promotion continues to unravel with documented evidence.**

278. This **further reinforces the claim** that **Dr. Ross's decision-making was arbitrary, capricious, and retaliatory**, rather than **based on objective performance criteria**.

January, 2023

Demonstrated Leadership, Clinical Excellence
& Pretextual Non-Promotion

Exceptional Inpatient Performance & Recognition

279. In **January 2023**, Plaintiff **successfully completed his third inpatient rotation**, entering the month with a **high level of confidence and a firm commitment to excellence**. Throughout this **demanding service**, he was responsible for **a significant number of nighttime admissions**, a task he **took upon himself** to ensure continuity of patient care. His dedication was **questioned by Chief Resident, Dr. Oghenetega Nduka**, to which Plaintiff responded by explaining his

unwavering commitment to patient care despite the **unjust denial of his promotion to PGY-3**.

✔ **Outpatient Pharmacy Acknowledgment** – Greg A. Bauer, M.S., Pharm.D., DPLA, **recognized Plaintiff's outstanding commitment**, awarding him **the highest resident capture rate** for **utilizing outpatient pharmacy services across 54 patient discharges** in January 2023.

✔ **Co-Resident Recognition** – Internal Medicine **co-resident, Dr. Nayak**, provided a **reference letter commending Plaintiff's exceptional work ethic**, noting that his admissions workload **matched that of a chief resident with additional support**.

Refer to Exhibit #54: Appreciation Letter from **Outpatient Pharmacy** for January Inpatient Service.

Refer to Exhibit #55: Evaluation of Work in January by Internal Medicine Co-Resident, **Dr. Nayak**.

Leadership, Teamwork & Multitasking

280. During this inpatient rotation, Plaintiff **exhibited exceptional leadership and multitasking skills**, working closely with his team:

✔ **Intern:** Dr. Christopher McLeod (PGY-1)

✔ **Medical Students:** Jasmine Worley, MS, & Urenna Onwuanaibe, MS (ROSS University)

✓ **Led & Mentored Team Members** – Plaintiff effectively **coordinated care, supervised his intern, and provided hands-on teaching** to medical students.

✓ **Maintained High-Quality Documentation** – Notes were **consistently completed on time**, meeting **hospital and ACGME documentation standards**.

✓ **Adapted to Hospital Policy Changes** – This month, **hospital administration eliminated the Medical Admitting Officer (MAO) role**, which had previously been **a major burden** on residents. Plaintiff successfully **navigated this transition**, further proving **his ability to handle dynamic inpatient environments**.

Case Study: Strong Clinical Judgment in Managing

a Diabetic Ketoacidosis (DKA) Patient

281. While **perfection is unattainable**, residency training involves **high patient volumes and complex cases** that serve as learning opportunities. A **notable case** in January **exemplifies Plaintiff's clinical expertise and adherence to ACGME core competencies**:

282. **Case Summary:**

1. **A patient presenting with Diabetic Ketoacidosis (DKA)** was **initially admitted to the Family Medicine Service** overnight by Plaintiff's co-resident, **Dr. Amanulla Siddiqui (PGY-2)**.
2. Upon **Plaintiff's arrival for the morning shift**, he **promptly evaluated the patient with Dr. McLeod (intern)** and **recognized the need for immediate intervention**.
3. Plaintiff **directed Dr. McLeod to initiate the appropriate DKA management protocol**, including:

✔ **IV Normal Saline for fluid resuscitation**

✔ **Potassium repletion**

✔ **Insulin drip initiation**

✔ **Immediate ICU consultation**

4. **Plaintiff demonstrated ACGME Core Competencies:**

✔ **Patient Care:** Recognized DKA and provided **immediate, evidence-based intervention**.

✔ **Medical Knowledge:** Correctly initiated **standard DKA protocol** in line with national guidelines.

✔ **Practice-Based Learning & Improvement:** Collaborated with intern and students, ensuring **real-time medical education**.

✔ **Interpersonal & Communication Skills:** Communicated effectively **with ICU team and hospital administration**.

✔ **Professionalism:** Advocated for patient safety, ensuring **proper escalation of care**.

✔ **Systems-Based Practice:** Navigated **hospital policies & protocols** effectively, reporting misallocated admission.

5. **Hospital System Flaw Identified:**

- ✓ The **Emergency Department (ED) and the MAO incorrectly assigned the DKA patient** to the Family Medicine Service, leading to **an inappropriate service placement**.
- ✓ **Dr. Chawla (attending physician)** initially expressed frustration over the admission but later **acknowledged the ED's mistake**.
- ✓ **Dr. McLeod (intern) filed an official incident report** with **Dr. Botwie, the Hospital Safety Officer**, documenting the **systemic issue** of improper patient allocation.

Conclusion: Continued Evidence of Plaintiff's Competence & Program's Bad Faith Actions

✔ **Strong inpatient leadership & teaching skills demonstrated.**

✔ **Pharmacy & co-resident recognition affirm Plaintiff's work ethic & dedication.**

✔ **ACGME core competency-based excellence is evident in DKA case management.**

✔ **Hospital policy changes were navigated efficiently, proving adaptability & professionalism.**

283. **These findings further invalidate the program's claims of deficiencies** and reinforce that the **decision to deny Plaintiff's promotion was arbitrary, capricious, and retaliatory rather than merit-based.**

February 2023

Escalated Scrutiny & Baseless Allegations of Insubordination

Dr. Ibe's False Accusations Despite Plaintiff's Adherence to Instructions

284. On **February 4, 2023**, Plaintiff was on a **24-hour inpatient call** under **Dr. Ibe, the on-call attending physician**. As part of his duties, Plaintiff followed **explicit instructions from Dr. Ibe** to admit a **71-year-old male patient with severe anemia, unstable vitals, and a supratherapeutic INR of 6.8**.

✔ **Following ICU Consultation & Stabilization:** Before the **Medical Admitting Officer (MAO) assigned the patient to family medicine**, the **ED attending and surgical team deemed the patient stable** following a **2-unit PRBC transfusion** and **IV protamine sulfate**, bringing the **INR down to 1.3**.

✔ **Plaintiff Executed Dr. Ibe's Orders Precisely:** Per **Dr. Ibe's directive**, Plaintiff **consulted ICU** and coordinated **a thorough evaluation** by **ICU attending Dr. Cynthia Shen**, who **did not recommend ICU admission**.

✔ **Medical Records Confirm Proper Decision-Making:** Plaintiff's **clinical decisions were appropriate, justified, and well-documented**.

Refer to Exhibit #55-A: February 4, 24-Hour Call with **Dr. Ibe – False Allegations of Insubordination**

Contradictory Actions:

Praise for Leadership Followed by an Unfounded Allegation

285. Despite Plaintiff **executing Dr. Ibe's instructions verbatim**, **Dr. Ibe falsely accused him of insubordination**, threatening to **report him to Program Director Dr. Ross**. However, **she never provided a formal letter, constructive feedback, or a valid reason** for this accusation.

✔ **Notably, the patient's safety was never at risk** – He was discharged home safely after a **medical-surgical floor stay**, as confirmed by **hospital records**.

✔ **Contradictory Praise Before the Allegation:** Earlier that day, **during rounds**, Dr. Ibe **praised Plaintiff's progress**, noting **his leadership skills, confidence, and patient presentation abilities had significantly improved** from their last rotation together in **March 2022**.

✔ **Plaintiff & Intern Had Completed All Progress Notes Before Rounds:** Unlike **March 2022**, when an **Individualized Learning Plan (ILP) was first suggested**, by **February 2023**, Plaintiff's performance was **markedly superior**, demonstrating his **continued growth and competency**.

Baseless Accusation & Anonymous Retaliatory Actions

286. The **sequence of events exposes a concerning inconsistency** in Dr. Ibe's **actions and motives**:

✔ **She never discussed her concerns directly with Plaintiff**.

✔ **She left an anonymous, negative evaluation on Plaintiff's New Innovations account**.

✔ **Despite her written accusation of "insubordination," she formally attested that she "fully agrees" with Plaintiff's H&P assessment and plan** in the patient's chart.

287. **Dr. Ibe's Anonymous Comment Had Severe Consequences:** Her **negatively worded "anonymous" evaluation** unfairly **damaged Plaintiff's reputation within the program** and **triggered a remediation period**—despite the **lack of any concrete basis** for her allegations.

288. **Sudden Change in Attitude Raises Concerns: Just hours before filing this anonymous evaluation,** she had **verbally commended Plaintiff for his progress**, which further **exposes the retaliatory nature of her later actions**.

Contradictions & Questionable Bias in Evaluations

289. **Three months later, in April/May 2023**, Plaintiff encountered **a returning patient** during an **outpatient visit at New Carrollton Office**. The patient, a woman in her **60s with multiple comorbidities (hypertension, diabetes, hypercholesterolemia, and chronic hip pain)**, required **medication refills and follow-up care**.

✔ **Plaintiff Provided Comprehensive Care:** He **refilled her medications, addressed all medical concerns, and reviewed her case with Dr. Ibe** before seeing the patient.

✔ **Patient Expressed Immense Satisfaction with Plaintiff's Care:** She **praised Plaintiff's thorough, detailed, and compassionate approach in front of Dr. Ibe**, acknowledging that **her needs were efficiently met in a single visit**.

✔ **Dr. Ibe's Reaction: She appeared visibly surprised** and even reminisced about her own experience with the patient during her own residency—**questioning whether she had ever received such gratitude**.

290. **Notably, despite witnessing this clear evidence of Plaintiff's competency, Dr. Ibe did not update his New Innovations evaluation with any corresponding positive feedback**.

Violations of GME & ACGME Standards

291. **Dr. Ibe's retaliatory and inconsistent actions directly violate:**

✔ **GME Policy 122 UMCRH – General Policy on Professionalism:**

Requires a professional, equitable, and civil learning environment free from mistreatment, abuse, and coercion.

✔ **GME Policy 104 UMCRH – Resident Evaluation Standards:**

Mandates that resident evaluations be objective, accurate, and constructive—Dr. Ibe's **anonymous and unfounded negative comment directly violated this policy**.

✔ **ACGME Institutional & Clinical Competency Standards:**

ACGME mandates that faculty evaluations be fair, transparent, and constructive. Retaliatory comments and personal biases have no place in competency-based medical training.

Refer to Exhibit #58: GME Policy 122 – **General Policy on Professionalism**

Refer to Exhibit #59: GME Policy 104 – **General Policy on Resident Evaluation**

Conclusion: Further Evidence of Arbitrary, Retaliatory, and Unjust Actions

✔ **Plaintiff followed all instructions and made clinically sound decisions.**

✔ **Dr. Ibe's allegations were inconsistent with her own documented approvals.**

✔ **Anonymous negative comments without direct feedback undermined professional integrity.**

✔ **Failure to acknowledge Plaintiff's progress in evaluations further underscores bias.**

✔ **Program's unjustified remedial actions based on unfounded accusations reinforce the pattern of arbitrary decision-making.**

292. **These findings further reinforce that the non-promotion decision and subsequent remedial actions against Plaintiff were neither competency-based nor legitimate but rather rooted in retaliation, bias, and procedural violations.**

Dr. Kaysin's False Claims about Leadership

& Patient Safety in Circumcision Procedures

Baseless Criticism of Leadership & Communication Practices

293. On **February 13, 2023**, following Plaintiff's nursery rotation with **Dr. Kaysin**, Plaintiff received feedback containing **mischaracterizations regarding note-taking responsibilities and leadership efforts**.

✔ **Leadership in Managing Intern Workload:**

As a **senior resident**, Plaintiff **proactively assisted interns** by handling **discharge summaries**, ensuring they completed their duties **efficiently** on their **designated office days at New Carrollton**. Despite his **commitment to teamwork and leadership**, **Dr. Kaysin misinterpreted this as an issue**—despite **discharge summaries being a required task** for **patient discharges**.

✔ **Military Service Conversation Misconstrued as a Concern:**

1. A casual discussion between Plaintiff and a patient regarding their shared military background—conducted professionally and without disrupting rounds—was later mischaracterized by Dr. Kaysin as a professional concern. This issue was subsequently raised again four months later, in June 2023, during a meeting with Dr. Prill and Dr. Ross, where Plaintiff was **advised against discussing military service with patients**, despite the complete absence of **any patient complaints, disruptions, or breaches of professionalism**.

2. Dr. Kaysin's remarks were nothing more than a **pretextual effort to manufacture a disciplinary issue**, serving **no legitimate educational or professional purpose**. Rather, these comments reflect **a pattern of retaliatory conduct aimed at discrediting Plaintiff's professional standing**. The intentional mischaracterization of an innocuous patient interaction suggests **a bad-faith effort to "dig up dirt"** on Plaintiff, further illustrating the broader campaign of **unwarranted scrutiny, professional demonization, and retaliatory action** taken against him.

Refer to Exhibit #57: Dr. Kaysin's Feedback on Nursery Rotation

Refer to Exhibit #58: Plaintiff's February 2023 Schedule

Questionable Allegations on Patient Safety & Surgical Competency in Circumcision Procedures

294. **Dr. Kaysin raised unfounded concerns about Plaintiff's circumcision skills**, alleging a **"potential safety risk"** despite:

✔ **Plaintiff's extensive prior experience** in performing neonatal circumcisions, including at **Blackfeet Community Hospital**.

✔ **No complications or patient complaints** following any of Plaintiff's **31 successfully completed circumcisions** during residency.

✔ **No formal recommendations or corrective guidance from any attending physician** regarding a preferred surgical technique.

Refer to Exhibit #59: Logged Circumcision Procedures – 31 Successfully Completed with Zero Complications

Inappropriate Comments Regarding

Cultural Background & English Proficiency

295. Beyond surgical performance, **Dr. Kaysin uniquely questioned Plaintiff's cultural background and English proficiency**—concerns that:

✔ Were never raised by any other faculty members or evaluators.

✔ Have no bearing on Plaintiff's clinical competency, patient care, or professional performance.

✔ Were accompanied by a cautionary statement about Plaintiff's potential "dismissal" from the program, suggesting a **preconceived bias** rather than an objective evaluation.

Violation of ACGME & GME Standards

✔ ACGME Program Requirements: Mandate that faculty evaluations be objective, competency-based, and free from personal bias or discrimination.

✔ GME Policy 122 UMCRH – General Policy on Professionalism: Prohibits discriminatory or biased treatment of residents.

✔ GME Policy 104 UMCRH – General Policy on Evaluation of Residents: Mandates fairness, accuracy, and objectivity in performance evaluations.

Refer to Exhibit #60: GME Policy 122 – General Policy on Professionalism

Refer to Exhibit #61: GME Policy 104 – General Policy on Evaluation of Residents

Conclusion: Another Instance of Bias & Retaliatory Targeting

✔ **Plaintiff's leadership, communication, and patient care were wrongly mischaracterized.**

✔ **No evidence substantiates concerns about circumcision safety—Plaintiff successfully completed 31 circumcisions without any complications.**

✔ **Dr. Kaysin's comments about Plaintiff's background and English proficiency reflect personal bias, not objective assessment.**

✔ **Warnings about "dismissal" further expose a premeditated agenda rather than competency-based evaluation.**

296. These findings further **solidify the pattern of biased, arbitrary, and retaliatory actions** within the program, reinforcing the lack of **due process** and **professional integrity** in Plaintiff's evaluations.

Unsubstantiated HIPAA Violation Allegations & Retaliatory Scrutiny

Escalated Scrutiny and Allegations Against Plaintiff

297. In **February 2023**, the Plaintiff experienced an **escalation in targeted scrutiny**, with faculty members actively seeking **any pretext to question his professionalism and compliance with regulations**. This included an **unwarranted intrusion into his family's medical care**, leading to a **baseless allegation of a HIPAA violation**.

✔ Plaintiff's pregnant wife had been receiving **routine prenatal care** at the **New Carrollton office**.

✔ Plaintiff **recommended magnesium oxide (MgO) tablets** for her nighttime leg cramps—

a **common over-the-counter supplement used in pregnancy**.

✔ This **recommendation was properly documented in her chart** and **discussed with her primary care physician, Dr. Rehman**.

✔ Despite **full transparency and adherence to ethical documentation standards**, this action was **misconstrued as a HIPAA violation** by **Dr. Kaysin**, who reported it to Human Resources (HR).

Refer to Exhibit #61: HR Investigation Report Concluding No HIPAA Violation

AMA Ethical Standards & Compliance with Medical Ethics

298. **The AMA Code of Medical Ethics** (Opinion 1.2.1 – **Treating Self and Family**) provides **clear guidelines** on when physicians **may treat family members**, stating that treatment is permissible under the following conditions:

✔ **In emergency or isolated settings where no other qualified physician is available** – Physicians should provide **necessary care until another provider can take over**.

✔ **For short-term, minor problems** – Physicians may prescribe or recommend treatment for **minor, non-urgent conditions**, provided they **properly document** and communicate with the patient's primary care physician.

✓ **Plaintiff followed these ethical principles precisely**:

✔ **Documented the magnesium oxide recommendation** in his wife's medical chart.

✔ **Consulted her primary care physician (Dr. Rehman)**, ensuring transparency and medical oversight.

✔ **Did not prescribe or administer any restricted medication**—only suggested an over-the-counter supplement.

Refer to Exhibit #60: AMA Code of Medical Ethics – Treating Self or Family

Violation of Professionalism Standards by Faculty

299. The **GME resident contract, ACGME program requirements, and institutional GME policies** do not prohibit **a resident from advising a family member on over-the-counter treatments**. The **only applicable standard** is the **AMA Code of Medical Ethics**, which **Plaintiff fully adhered to**.

✔ **University of Maryland Medical System's own HR investigation concluded there was no HIPAA violation.**

✔ The **faculty's excessive scrutiny and baseless reporting to HR were acts of bad faith and retaliation**.

✔ **GME Policy 122 (Professionalism)** explicitly **prohibits resident maltreatment, discrimination, and harassment**, making this incident a **clear violation of professionalism standards**.

Refer to Exhibit #62: GME Policy 122 – Professionalism and Resident Rights

Plaintiff's Good Faith Efforts to Address the Situation

✔ Following the **HR inquiry**, Plaintiff met with **Benjamin Carter, HR Director**, to **clarify hospital policies regarding access to family medical records**.

✔ Mr. Carter advised that while **Plaintiff had the right to view his wife's records**, it should be done through **her patient portal** rather than through **Plaintiff's physician access in EPIC**.

✔ Plaintiff **immediately complied**, setting up a **patient portal** and **transferring prenatal care from New Carrollton to the Largo Midwife Office**.

✔ This demonstrated Plaintiff's **willingness to accept constructive feedback and comply with best practices**.

Refer to Exhibit #61: Email Correspondence with HR Regarding Resolution of Issue

Legal Implications and Retaliatory Allegations by UM Counsel

300. During the **internal appeal**, Plaintiff cited the **AMA Code of Medical Ethics**, emphasizing that:

✔ His **actions were entirely ethical and within the guidelines set by the AMA**.

✔ The **HR investigation exonerated him**, confirming **no HIPAA violation occurred**.

✔ The **program's reporting of this matter was retaliatory and intended to create a pretext for further punitive action**.

301. Despite these facts, **UM's legal counsel falsely alleged during the appeal that Plaintiff had continued prescribing medication to family members**, a **claim unsupported by any evidence**.

✔ Plaintiff **challenged this assertion**, demanding that UM's attorneys provide **any documented evidence of a prescription written after February 2023**.

✔ **No such prescription exists**, making their claim **demonstrably false** and potentially undermining their credibility in the upcoming jury trial.

302. **This misrepresentation by UM's legal counsel underscores the bad-faith nature of these allegations, further evidencing the Plaintiff's wrongful treatment within the program.**

Conclusion: Retaliation, Resident Maltreatment, and Due Process Violations

✔ **No HIPAA violation occurred, as confirmed by the University of Maryland Medical System's HR investigation.**

✔ **Plaintiff complied fully with AMA medical ethics guidelines.**

✔ **The faculty's reporting of this incident was retaliatory, excessive, and rooted in bias.**

✔ **UM's legal counsel knowingly misrepresented the facts during the internal appeal, further undermining the legitimacy of their claims.**

✔ **This incident exemplifies the Plaintiff's ongoing mistreatment, the program's clear disregard for due process, and repeated violations of professional conduct standards under GME Policy 122.**

303. The Plaintiff will present these findings before the **jury to demonstrate a systemic pattern of retaliation** and **unjustified professional attacks,** further solidifying the case for **breach of contract and due process violations.**

Dr. Ross's Fabricated Allegations:

False Claims of Unsupervised Circumcisions, Non-Standard Treatment, and Hospital Risk

Baseless Allegations Against Plaintiff's Circumcision Procedures

304. On **February 15, 2023**, as Plaintiff transitioned from the **nursery rotation to outpatient pediatrics with Dr. Corder**, he continued assisting in **neonatal circumcisions** under the **direct supervision of Dr. Stephen Proctor, an attending OBGYN**.

✔ Plaintiff had previously **expressed interest in an OBGYN Family Medicine Fellowship**, prompting early involvement in **OBGYN rounds**.

✔ Plaintiff's **circumcisions were properly supervised and had no complications**—patients' parents **expressed satisfaction** with the care provided.

✔ Some of these patients later **transferred their primary care to Plaintiff at the Family Medicine New Carrollton office**, reflecting **high-quality care and trust**.

Refer to Exhibit #62 – Letter of Support from Dr. Proctor Confirming Supervised Circumcisions

Dr. Ross's Fabricated Allegations & Retaliatory Actions

305. When **Dr. Ross learned Plaintiff was performing circumcisions**, she **falsely accused him** of:

✔ **Performing circumcisions unsupervised**

✔ **Placing the hospital at risk**

✔ **Using non-standard treatment**

306. **These allegations were demonstrably false:**

✔ **Hospital policies prohibit residents from performing circumcisions without attending supervision**, making Dr. Ross's claims impossible.

✔ **Dr. Proctor directly supervised the Plaintiff's procedures**, confirming compliance with GME policies and ACGME training standards.

✔ **Dr. Corder, another attending, was fully aware of Plaintiff's participation** and had **no objections** to his involvement in these procedures.

Refer to Exhibit #63 – GME Policy 102: Graduate Medical Education Guidelines

Refer to Exhibit #64 – GME Policy 113: Resident Supervision

Supervision Policies & Clear Compliance by Plaintiff

307. **GME Policy 113 UMCRH** explicitly defines levels of supervision for residents:

1. **Direct Supervision: Attending physician is physically present**
2. **Indirect Supervision: Attending is immediately available for consultation**
3. **Oversight: Attending reviews procedures post-care**

✓ **Plaintiff's circumcisions were performed under direct supervision**, aligning fully with **GME policies and ACGME standards**.

✓ **Dr. Ross ignored these clear supervision guidelines**, choosing instead to fabricate allegations **without conducting any factual investigation**.

Refer to Exhibit #65 – GME Policy 104: Evaluation of Residents & Competency-Based Supervision Standards

Retaliatory Treatment: Double Standards in Resident Evaluations

308. **In stark contrast to her treatment of Plaintiff**, Dr. Ross handled a **serious circumcision complication by another resident, Dr. Nduka, entirely differently.**

✔ **November 2022: Dr. Nduka performed a circumcision under Dr. Ibe's supervision** that resulted in **severe complications**—

✔ **Excessive post-operative bleeding led to NICU admission**, a **blood transfusion**, and **surgical intervention** at Children's National Hospital.

✔ **Dr. Ross did not discipline Dr. Nduka**, nor did she initiate **remediation or termination** procedures.

✔ **Instead, Plaintiff—who had zero complications performing circumcisions—was targeted** for alleged unsupervised procedures **that never occurred**.

Refer to Exhibit #66 – serves as evidence that Dr. Ross sent secure emails to **CCC in an attempt to fabricate a case against** the **plaintiff and malign his professional standing.**

Contradictory Accusations of "Non-Standard Treatment"

309. **Following the severe circumcision complication, Plaintiff suggested using a silver nitrate stick to stop excessive bleeding**—a standard method used in circumcision care.

✔ **Dr. Ross initially agreed** and personally **applied silver nitrate**, achieving hemostasis.

✔ The patient was subsequently **discharged by Dr. Ross herself**.

✔ **Days later, Dr. Ross falsely claimed silver nitrate was a "non-standard treatment," blaming Plaintiff for its use**—despite **her own decision to apply it.**

Refer to Exhibit #68 – Pediatric Urology Guidelines Confirming Silver Nitrate as a Standard Treatment for Post-Circumcision Bleeding

310. **This blatant contradiction demonstrates a clear effort by Dr. Ross to retroactively frame Plaintiff for actions she herself approved.**

Final Evidence of Retaliation & Due Process Violations

311. **Dr. Ross's deliberate mischaracterization of events—while protecting other residents with actual procedural complications—reveals a pattern of targeted retaliation.**

✔ Plaintiff **followed all supervision guidelines** and performed procedures under attending oversight.

✔ Plaintiff **had zero procedural complications**, yet faced **false allegations and threats of termination**.

✔ Meanwhile, **residents with actual patient harm cases faced no disciplinary consequences**.

312. **These retaliatory actions violate**:

✔ **GME Policy 122 – Professionalism Standards**

✔ **GME Policy 113 – Resident Supervision Guidelines**

✔ **ACGME Clinical Competency Requirements**

✔ **ACGME Institutional Due Process Protections**

Conclusion: Clear Evidence of Retaliatory Targeting & Breach of Due Process

✔ **Dr. Ross's accusations were fabricated and unsupported by facts.**

✔ **Plaintiff's actions were fully compliant with supervision policies and hospital regulations.**

✔ **No patient safety risk was ever present—Plaintiff had zero complications performing circumcisions.**

✔ **Dr. Ross's selective targeting of Plaintiff, while ignoring serious complications from other residents, demonstrates bad faith and retaliatory intent.**

313. This evidence will be presented before the **jury** to establish a **clear case of unfair treatment, due process violations,** and **breach of contractual obligations** under the **Plaintiff's residency agreement.**

Dr. Ross's False Allegations of Insubordination & Retaliatory Evaluations

False Accusations & Mischaracterization of Clinical Decision-Making

Clinically Appropriate Blood Transfusion Order & Standard Communication Protocols

314. In February 2023, **Dr. Ross falsely accused Plaintiff of insubordination** for executing a **medically sound, evidence-based decision** regarding a **critically anemic patient**:

✔ **Patient Profile:** Established diagnosis of **anemia secondary to fibroids**, presenting for routine follow-up.

✔ **Lab Results:** Critically low **hemoglobin of 5.8**, yet the patient remained **clinically stable and asymptomatic**.

✔ **Medical Decision:** Following **standard treatment guidelines**, Plaintiff appropriately coordinated an **outpatient blood transfusion** at **UMCRH's Infusion Center** for the following day.

✔ **Communication Attempt:** Plaintiff attempted to **contact Dr. Ross by phone**, but she was **absent from the New Carrollton Office** and **unreachable**.

✔ **Proper Documentation:** Plaintiff **documented the medical decision** and **sent a Tiger Connect message** outlining the rationale for the transfusion order.

✔ **Informed Consent:** Plaintiff **directly discussed the treatment plan with the patient**, ensuring **understanding and agreement**.

Dr. Ross's Retaliatory Actions & Fabricated Allegations

315. Despite Plaintiff's **strict adherence to standard communication protocols**, **Dr. Ross retaliated** by **falsely alleging insubordination**:

✔ **Delayed Response: Four to five hours** after receiving **Plaintiff's Tiger Connect message**, Dr. Ross **called Plaintiff during a didactic lecture**.

✔ **Hostile Accusation:** Instead of a **professional discussion**, Dr. Ross **aggressively accused Plaintiff of insubordination** for **ordering the transfusion**.

✔ **Plaintiff's Justification:**

1. **The patient was stable**, and an **outpatient transfusion was appropriate**.
2. **Plaintiff made every effort** to **communicate with Dr. Ross beforehand**.
3. **Plaintiff was willing** to modify the order if Dr. Ross had **an alternative plan**.

✔ **Dr. Ross's Failure:** She **offered no clinical alternative**, instead **escalating hostility** without medical justification.

✔ **Toxic Environment:** Plaintiff pointed out that **Dr. Ross's conduct fostered intimidation** rather than a **supportive learning environment**.

Refer to Exhibit #69 - February 22, 2023 - Interim Evaluations, Orchestrated by Dr. Ross

✔ **Following this interaction, Dr. Ross retaliated further, orchestrating a Clinical Competency Committee (CCC) meeting to fabricate negative evaluations.**

Dr. Ross's Non-Standard ACGME Assessments

316. Dr. Ross **misused the CCC process** to manufacture **an unjustified and biased interim evaluation**:

✔ **Arbitrary Questions:** The CCC **evaluation criteria did not align with ACGME Six-Core Competencies** and instead included **subjective, non-standard inquiries**:

1. **Leadership ability** on the inpatient team
2. **Organizational skills** in leading the team
3. **Multitasking ability**
4. **Note-editing and presentation skills**
5. **Adherence to faculty instructions**
6. **Patient encounter volume**

Refer to Exhibit #121 - ACGME Six-Core Competency Questionnaires

✔ **Deviation from ACGME Standards:** The evaluation ignored the **ACGME's six-core competencies**, which focus on:

1. **Patient Care**
2. **Medical Knowledge**
3. **Practice-Based Learning & Improvement**
4. **Interpersonal & Communication Skills**
5. **Professionalism**
6. **System-Based Practice**

✔ **Use of Invalid Assessment Tools:** Dr. Ross improperly **re-used the Individualized Education Plan (IEP) questionnaire** from **April 18, 2022**, which is **not an ACGME-approved evaluation tool** and **was never intended for competency-based assessments.**

Refer to Exhibit #71 – Non-ACGME Standard Assessments, Including ILP-Related Questionnaires and Arbitrary Evaluations Conducted Between February 22-24, 2023

Fabrication of a "Significant Incident" &

Violation of ACGME Evaluation Standards

317. Dr. Ross **falsely labeled Plaintiff's clinically appropriate blood transfusion order** as a **"Significant Incident,"** claiming **it placed the hospital at risk**:

✔ **Fabricated Justification:** Used this **false claim** to **push for a CCC interim evaluation**.

✔ **Bias in CCC Proceedings:**

1. Improperly restricted evaluation to **Family Medicine faculty only**, **excluding** peer, patient, and non-faculty input.
2. Violated **GME Policy 104** & **ACGME Standard Six-Core Competency Evaluations**.

Refer to Exhibit #121 – ACGME Standard Six-Core Competency Evaluations

✔ **Deliberate Manipulation:** Dr. Ross **intentionally excluded impartial evaluators** to **ensure a biased outcome**.

Recycling of the Invalid IEP for Remediation

& Further ACGME Violations

318. On **February 24, 2023**, the program **conducted an "Interval Review of Continued Monitoring"**, unjustifiably classifying **Plaintiff's PGY-2 contract extension as an "Action Plan."**

✔ **Reused the Invalid IEP:** Dr. Ross **again weaponized the April 18, 2022, IEP questionnaire**, despite it being **explicitly prohibited** as an evaluation tool by ACGME.

✔ **Predetermined CCC Ruling:**

1. **Used biased evaluations** to fabricate grounds for negative findings.
2. **Violated ACGME Program Requirement V.A.3.a).(1)** by **assuming an adversarial role instead of an advisory one**.

Refer to **Exhibit #70 - Email from Dr. Ross to Dr. Prill**

✔ **Unwarranted Consequences:**

1. **Plaintiff's non-promotion in October 2022**
2. **Arbitrary "remediation" actions in February 2023**

Refer to Exhibit #73 - Interval Review Memorandum - February 24, 2023

✔ **Retaliatory Reassignments:**

1. **Unilateral cancellation** of:

   ✕ **Emergency Department rotation at Children's National Hospital (March 2023)**

   ✕ **Family Medicine Inpatient Service rotation (April 2023)**

   ✕ **Sports Medicine rotation (May 2023)**

2. **Forced reassignment** to the **Family Medicine Outpatient Clinic at New Carrollton**, ensuring **heightened faculty surveillance and scrutiny**.

Conclusion: Dr. Ross's Retaliatory Tactics,

Due Process Violations & ACGME Noncompliance

✔ **Dr. Ross's allegations of insubordination were demonstrably false**—Plaintiff **followed all proper communication protocols and exercised sound medical judgment**.

✔ **She re-initiated improper and unnecessary evaluations** solely **to target Plaintiff**, violating **GME Policy 104** and **ACGME CCC evaluation guidelines**.

✔ **She falsely classified a standard medical decision as a "Significant Incident"** to justify fabricated disciplinary measures.

✔ **She weaponized an invalid IEP questionnaire**, despite **explicit prohibitions** against its use.

✔ **She manipulated the evaluation process** by **excluding non-faculty input**, violating **ACGME's standard Six-Core Competency Evaluation framework**.

✔ **She unilaterally canceled Plaintiff's rotations** and **forced punitive reassignments**, further exposing **her pattern of retaliation**.

✔ **She deprived Plaintiff of due process**, withholding evaluations and **denying him his right to appeal remediation**, in direct **violation of GME and ACGME requirements**.

319. **Dr. Ross's actions were a blatant abuse of power, a due process violation, and a direct breach of Plaintiff's residency contract under GME policies and ACGME requirements.**

320. **All of these violations will be presented before the jury, reinforcing Plaintiff's claims of retaliatory treatment, bad faith decision-making, and procedural noncompliance.**

Violation of Due Process Rights

321. Plaintiff's **GME Resident Agreement, Section 2.6** explicitly guarantees **due process rights** when the **sponsoring institution** or **residency program** contemplates actions that may:

✔ **Result in dismissal, non-promotion, or non-renewal of contract**

✔ **Significantly threaten the resident's intended career development**, including:

1. **Extension of the residency program**
2. **Denial of credit for completed training/experience**
3. **Denial of promotion**
4. **Termination**

322. **Under GME Policy 103 – Due Process & Corrective/Discipline Process**, the **sponsoring institution must afford the resident the opportunity to appeal** any action that adversely affects their training or career trajectory.

University of Maryland Capital Region Health's

Promise of Pre-Action Appeal Rights

323. Through **GME Policies 102, 103, and 104**, **University of Maryland Capital Region Health (UMCRH) explicitly commits to affording residents due process and appeal rights before taking adverse actions.**

✔ **GME Policy 104 – Resident Evaluation**, under the section **"Request for Reconsideration,"** imposes a clear obligation:

The program director must advise the resident that they are entitled to appeal any adverse action by UMCRH that could result in:

1. **Dismissal**
2. **Non-renewal of contract**

3. **Any action that significantly threatens the resident's intended career development**

Blatant Due Process Violations

& Retaliatory Actions

324. Despite these **contractual and policy-based obligations**, UMCRH **egregiously violated** Plaintiff's due process rights by:

✔ Unilaterally initiating a formal remediation plan without affording Plaintiff an appeal opportunity.

✔ Canceling Plaintiff's already scheduled rotations at Children's National Hospital Emergency Department (March 2023), inpatient service rotations (April 2023), and sports medicine rotations (May 2023).

✔ Failing to notify Plaintiff of these adverse actions or allowing for due process review.

✔ Keeping fabricated evaluations hidden from Plaintiff, ensuring they could not contest the findings.

325. The **February 24, 2023, remediation document** was **deliberately withheld** from the Plaintiff for **two months** and was only presented on **May 9, 2023**, for **backdated signing**—further proving that **former Program Director Dr. Stacy Ross engaged in procedural manipulation and document falsification.**

Refer to Exhibit #174 – Direct Evidence of Dr. Ross's Practice of Backdating Documents February 24, 2023, Remediation Plan was retroactively signed on May 9, 2023—further exposing UMCRH's fraudulent attempt to manufacture compliance.

Conclusion: Systematic Violations of GME Resident Agreement

& ACGME Due Process Standards

✔ UMCRH's failure to afford Plaintiff due process rights prior to adverse actions directly violates:

1. **GME Resident Agreement, Section 2.6**
2. **GME Policy 103 – Due Process & Corrective/Discipline Process**
3. **GME Policy 104 – Request for Reconsideration**
4. **Broader ACGME Program Requirements & Institutional Standards**

✔ The deliberate concealment of fabricated evaluations and backdating of disciplinary documents underscores a clear pattern of arbitrary and capricious decision-making.

✔ UMCRH's actions constitute a material breach of contract and due process violations, demonstrating malicious intent, procedural noncompliance, and bad-faith retaliation.

326. **All of these violations will be presented before the jury, reinforcing Plaintiff's claims of retaliatory treatment, procedural misconduct, and systemic violations of due process protections.**

Graduate Medical Education Compliance Project (GMECP) Review

Expert Testimony

327. The **February Events** underwent independent review by the **Graduate Medical Education Compliance Project (GMECP)**, a nationally recognized initiative committed to promoting **awareness, transparency, and advocacy for resident physicians** across the United States.

✔ **Dr. Todd Rice, MD, MBA**, an **anesthesiologist** and **founder of GMECP**, provided the following expert commentary on the matter:

> "These situations are always challenging. Unfortunately, after speaking with over **100 residents in the past five years,** I have observed **recurring patterns in cases where no actual offense was committed by the resident.** Often, the resident has fallen out of **favor with a powerful attending,** who then **covertly orchestrates negative evaluations from other faculty members.** A case is then constructed against the resident using minor infractions—common among all residents—**to justify probation, suspension, and, ultimately, termination.**"

328. Dr. Rice's statement directly aligns with the **circumstances of the February Events** and **substantiates Plaintiff's claims**.

✔ **No substantive infraction** was committed by Plaintiff.

✔ Instead, the **February Events** were a **calculated maneuver** by **Dr. Stacy Ross**, the former program director and principal defendant in this case.

✔ **Dr. Ross fabricated a pretext for terminating Plaintiff's residency training** by leveraging minor, non-disciplinary incidents, orchestrating biased faculty evaluations, and manufacturing allegations of insubordination.

329. **Dr. Rice has provided an Amicus Statement on behalf of GMECP, which has been submitted as Exhibit 124.**

✔ As an **expert with extensive experience in graduate medical education compliance**, Dr. Rice's testimony will:

1. **Expose systemic misuse of faculty authority** to unjustly terminate residents.
2. **Demonstrate violations of due process and accreditation standards.**
3. **Provide critical insights to the jury regarding procedural failures and retaliatory faculty conduct.**

330. **Dr. Rice will testify as an expert witness in the upcoming jury trial, further reinforcing Plaintiff's claims of retaliatory treatment, due process violations, and systemic noncompliance with ACGME accreditation standards.**

Plaintiff's Proactive Patient Advocacy

& Unjustified Withholding of Evidence

331. In February 2023, **Plaintiff acted in the best interest of his patient**, demonstrating **proactive advocacy and resourcefulness** in ensuring access to essential medications for an **uninsured, Spanish-speaking patient** at the **New Carrollton Office**:

✔ **Patient Hardship:** The patient was **unable to afford** essential medications, including **insulin and blood pressure medications**, due to excessive costs.

✔ **Plaintiff's Advocacy:** Recognizing the patient's financial burden, Plaintiff **engaged with the UMCRH Outpatient Pharmacy** to explore cost-reduction options.

✔ **Successful Cost Reduction:** Through **Plaintiff's direct intervention**, the pharmacist **reduced the cost from approximately $450 to $40** by utilizing **various coupons and promotions**.

✔ **Faculty Awareness & Commendation: Dr. Laura Bradford**, the **attending preceptor** overseeing the patient's care at the **New Carrollton Office**, was **fully aware** of the patient's **self-pay and uninsured status**.

✔ **Official Acknowledgment: Dr. Bradford publicly recognized Plaintiff's efforts**, sending a **faculty-wide "appreciation kudos email"** commending his **initiative and dedication to patient care**.

Unjustified Withholding of Evidence

& Adverse Inference

332. During **internal appeal proceedings**, Plaintiff formally **requested access to this "appreciation kudos email"** to substantiate his case:

✔ **Plaintiff's Due Diligence:** Plaintiff **submitted a formal letter request** to **Dr. Bradford** seeking access to this documentation.

✔ **Faculty's Failure to Respond: Dr. Bradford failed to acknowledge or respond** to Plaintiff's request.

✔ **Legal Inference:** Since **the program has not denied the existence of this email**, its **withholding constitutes a tacit admission** under **well-established legal principles** of **adverse inference**.

✔ **Request for Judicial Recognition:** This **Honorable Court should recognize** the **program's silence as an admission** in favor of Plaintiff, acknowledging the existence and substance of Dr. Bradford's email as **material evidence of Plaintiff's commendable conduct and faculty support**.

Refer to Exhibit #72: Plaintiff's Letter Request to Dr. Bradford.

Conclusion: Evidence Suppression

as a Continuation of Retaliatory Tactics

✔ Plaintiff's proactive actions directly benefited an underserved, uninsured patient, embodying the principles of patient-centered care.

✔ Faculty recognition of Plaintiff's efforts further contradicts the negative narrative orchestrated by Dr. Ross.

✔ The program's failure to disclose a faculty-wide email evidencing Plaintiff's commendable conduct constitutes suppression of exculpatory evidence.

✔ This Honorable Court should draw an adverse inference against the program, treating the silence as an admission in favor of Plaintiff.

333. **This act of evidence suppression further supports Plaintiff's claims of retaliatory treatment, procedural misconduct, and the program's deliberate attempt to manufacture a misleading record.**

March, 2023

Plaintiff's Efforts to Seek Guidance

Failure to Provide Due Notice of Remediation & Sudden Rotation Cancellation

334. The program **failed to formally notify Plaintiff of his placement on remediation** as required by the **February 24, 2023, document**. Instead, Plaintiff **only became aware of this decision days before its implementation**, when he received an **unexpected email from the rotation coordinator at Children's National Hospital**:

✔ Plaintiff was scheduled to begin a **pediatric emergency department rotation** on **March 1, 2023**.
✔ Instead of receiving program notice, Plaintiff learned **through external sources** that his participation had been **abruptly revoked**.
✔ **This unilateral cancellation, without prior notice or opportunity for appeal, violated due process rights** under the GME resident contract.

Refer to Exhibit #67 - March Schedule: ED Rotation at Children's National Hospital (Cancelled).

Plaintiff's Efforts to Seek Guidance &

Program's Lack of Transparency

335. Following the unexpected cancellation, Plaintiff sought **clarification from program leadership**, but received **no substantive explanation**:

✔ Plaintiff attempted to **contact Dr. Ross and Dr. Prill**, but both failed to respond.

✔ **Dr. Ibe, upon inquiry, confirmed that the program unilaterally altered Plaintiff's schedule**, citing **"deficiencies"** as justification for remediation.

✔ The decision to **modify Plaintiff's schedule and impose remediation was made without affording him any opportunity to dispute the allegations**, violating fundamental **due process protections**.

✔ Plaintiff had already **obtained a Washington, D.C., physician trainee license** in anticipation of this rotation, demonstrating **his commitment to meeting program requirements**.

336. **The initiation of remediation and sudden schedule change—without notice, justification, or appeal rights—constituted a direct violation of Plaintiff's contractual and procedural safeguards under the GME resident agreement.**

Unwarranted Scrutiny Despite Flawless

Performance During Remediation

337. Despite being placed under **intensified faculty oversight**, Plaintiff **successfully completed his outpatient family medicine rotation** in **March and April 2023**, demonstrating **unblemished performance**:

✔ Plaintiff managed **approximately 250 outpatient encounters** under **direct faculty supervision**.

✔ No **deficiencies**—previously alleged as justification for remediation—were observed.

✔ **Despite adhering to all program requirements, Plaintiff remained subjected to arbitrary scrutiny.**

Refer to Exhibit #74 – April Schedule: Outpatient Medicine.

March 2023: Dr. Ross's Hostile Conduct & Retaliatory Behavior

338. In early **March 2023**, Plaintiff **personally met with Dr. Ross** at the **New Carrollton Office after hours** to discuss:

✔ The **sudden changes** to his schedule, and

✔ The **remediation process** initiated without prior notice.

339. Instead of engaging in constructive dialogue, **Dr. Ross used the meeting to berate Plaintiff**, making unsubstantiated claims regarding his performance:

✔ She **unjustifiably criticized Plaintiff's SOAP notes**, alleging they lacked clarity—without citing specific deficiencies.

✔ She **questioned Plaintiff's study habits outside of work**, an irrelevant and personal attack.

✔ She **belittled Plaintiff's clinical skills**, making disparaging remarks such as:

1. *"Medical students write better SOAP notes than you."*

2. *"You don't study enough to be board-certified."*

340. **Dr. Ross's conduct was not educational but retaliatory, aiming to humiliate Plaintiff rather than offer constructive feedback.**

Plaintiff's Rebuttal &

Dr. Ross's Escalation of Threats

341. When Plaintiff **challenged these baseless criticisms**, Dr. Ross **escalated the conversation**:

✔ She **raised her voice**, repeatedly **mentioning termination** as an imminent possibility.

✔ The meeting ended **without resolution**, reinforcing **Dr. Ross's pattern of intimidation and bad faith conduct.**

342. The following **Monday morning**, Plaintiff **revisited Dr. Ross's office** seeking clarification:

✔ **Dr. Ross reiterated her intent to dismiss Plaintiff**, declaring:

1. *"You must change your belief system."*
2. *"You can't be board-certified."*

✔ She **mocked Plaintiff's past medical experience**, stating:

1. *"I don't know what you did in your Indian reservation."*

✔ Plaintiff **perceived these remarks as discriminatory and dismissive** of his **prior role as**

a hospitalist at Blackfeet Community Hospital, Indian Health Services, in Browning, Montana.

343. **Dr. Ross's statements, laced with hostility and personal bias, directly contradicted principles of professionalism and fairness required under GME Policy 122.**

Plaintiff Seeks Support from Faculty

& Chief Resident

344. In response to **Dr. Ross's threats**, Plaintiff **sought urgent guidance from Chief Resident, Dr. Nduka**:

✔ **Dr. Nduka expressed shock** upon learning about the **discussions surrounding Plaintiff's termination**.

✔ He pledged to **speak directly with Dr. Ross** to assess the situation.

345. A few days later, **Dr. Nduka reported back**:

✔ *"You know how Dr. Ross can be—sometimes she gets upset."*

✔ He reassured Plaintiff, stating:

- *"She just wants to discipline you, not terminate you."*

  ✔ She advised Plaintiff to **avoid confrontation with Dr. Ross**, indicating **a lack of transparency from the program director regarding her true intentions.**

346. **This vague and inconsistent messaging further demonstrated the arbitrary and retaliatory nature of the actions taken against Plaintiff.**

Plaintiff's Consultation with Dr. Ibe

347. Plaintiff **engaged in a three-hour discussion with Dr. Ibe**, where she:

✔ Listened attentively to Plaintiff's concerns.

✔ **Advised against exceptional efforts that might provoke faculty scrutiny**, referencing her own experiences during residency.

✔ Noted that **Dr. Ross's treatment of Plaintiff was excessive**, suggesting **a personal vendetta rather than genuine concerns about performance.**

✔ At the conclusion of their conversation, **Dr. Ibe expressed solidarity and support**, embracing Plaintiff and assuring him of her prayers.

348. **Despite empathy from faculty, no concrete solutions were offered to address the program's clear violations of due process.**

Conflicted Faculty Advisors

& Institutional Hierarchy

349. **Dr. Prill**, as **both Plaintiff's faculty advisor and CCC Chair**, acknowledged the **conflict of interest** in her role:

✔ She admitted to Plaintiff:

1. *"You have been in the military—you know there's a hierarchy."*
2. *"I must listen to my boss, and you must subjugate yourself to this program."*

350. **This admission confirmed that faculty were aware of the power imbalance but unwilling or unable to challenge Dr. Ross's authority.**

Department Chair's Acknowledgment

of Unfair Treatment

351. Plaintiff also consulted **Dr. Tavakoli**, **Chair of the Family Medicine Department**:

✔ Dr. Tavakoli acknowledged **voting in favor of Plaintiff** in faculty discussions.

✔ He cautioned Plaintiff:

- *"Just be careful and do what the faculty says."*
- *"Don't confront Dr. Ross, and you'll be fine."*

352. **Dr. Tavakoli's advice further underscored the program's toxic power dynamics, where survival depended on compliance rather than merit.**

Conclusion: Systemic Failure to Provide

Due Process & Meaningful Support

353. Despite extensive **consultations with faculty members and the Chief Resident**, Plaintiff was:

✔ **Given no opportunity to formally appeal remediation.**

✔ **Provided no GME policy guidance on his due process rights.**

✔ **Repeatedly advised to "stay quiet" and avoid challenging faculty decisions.**

✔ **Offered no tangible solutions to resolve conflicts with Dr. Ross.**

354. **This systemic failure to uphold fairness and due process further demonstrates the retaliatory, arbitrary, and punitive nature of the actions taken against Plaintiff.**

355. **All evidence of procedural violations, faculty complicity, and Dr. Ross's abuse of authority will be presented before the jury, reinforcing Plaintiff's claims of retaliation, bad faith decision-making, and violation of due process rights.**

Recognition for Academic Excellence &

Leadership in Residency Research

356. Despite ongoing scrutiny and retaliatory actions by the program, Plaintiff remained committed to academic excellence, **actively participating in the Resident Research Project** in **March 2023**:

✔ Plaintiff delivered a **scholarly presentation** on a case report titled **"Anti-Synthetase Syndrome."**

✔ His **outstanding contributions** earned him the **Family Medicine Resident Award for Scholarship**, a distinction conferred by the **Association of Family Medicine Residency Directors (AFMRD) and NAPCRG.**

✔ Plaintiff **submitted a copy of the award certificate along with photographs from Resident Research Day** to document his achievements.

✔ Participation in the **research project was highly selective**, restricted to a **small group of distinguished family medicine residents**, underscoring:

1. **Plaintiff's dedication to medical education**
2. **Commitment to advancing clinical knowledge**
3. **Demonstrated leadership in research and scholarly activity**

357. **Refer to Exhibit #75 – Resident Research Day: Presentation Materials & Award Documentation.**

358. **This achievement stands in stark contrast to the program's baseless allegations of clinical and academic deficiencies, further reinforcing Plaintiff's exemplary performance and unjustified remediation.**

Remediation Phase: Procedural Irregularities & Pretext for Non-Promotion

Failure to Adhere to the Remediation Phase Monitoring Plan

359. The **February 24, 2023, Remediation Phase Monitoring Plan** required **evaluations in March, late April, and May 2023.** However, **records indicate that only the March 31, 2023, evaluation was completed,** with no evaluations conducted in April 2023.

✔ **Questions posed in the March 31, 2023, evaluation:**

1. Has the resident been diligent in attendance and work completion in the office?
2. Has the resident been presenting well with a strong assessment and plan?
3. Is the resident able to multitask or listen while working on something else?

4. Does the resident sufficiently edit the information he gathers about the patient in his notes and presentations?
5. Does the resident follow direct instructions given by faculty?
6. Has the resident had sufficient daily new patient and follow-up visits?

Refer to Exhibit #76 – Remediation Phase Evaluations: March 2023.

Use of Outdated & Non-ACGME

Compliant Evaluation Criteria

360. The **evaluation framework continued to incorporate flawed assertions** from the **2022 Individualized Education Plan (IEP),** which had been **previously discredited:**

✔ The **IEP's outdated and erroneous claims**—that Plaintiff lacked multitasking ability or failed to edit notes properly—were **wrongfully perpetuated.**

✔ These questions **did not conform** to:

1. The **Graduate Medical Education (GME) resident contract.**
2. **GME policies governing ACGME-compliant evaluations.**
3. **ACGME's Six-Core Competency Assessment framework.**

✔ The **questions notably diverged from those used in February 2023**, further **highlighting the arbitrary nature of the evaluation process.**

361. **These inconsistencies raise serious concerns regarding the legitimacy and fairness of the evaluation process, reinforcing Plaintiff's claims of procedural bias and bad faith.**

Resolution of Alleged Deficiencies Contradicts

Justification for Continued Scrutiny

362. The **March 31, 2023, evaluation failed to include any questions on leadership skills**—despite this being the **primary justification for remediation.**

✔ By **March 31, 2023,** all concerns regarding **insubordination and compliance had been fully resolved,** as evidenced by the program's own evaluation.

✔ However, despite this **complete resolution, no further evaluations were conducted in April 2023** as initially planned.

✔ The **remediation plan itself failed to outline any clear path for Plaintiff's progression,** instead creating a **pretext for continued punitive action.**

363. **This lack of follow-through demonstrates the program's failure to adhere to its own remediation framework, further supporting Plaintiff's claims of arbitrary decision-making.**

Pretext for Non-Promotion to PGY-3

& Probation Setup

364. The **remediation plan deliberately omitted provisions for Plaintiff's progression,** effectively ensuring failure and setting the stage for probation.

✔ Plaintiff was **contractually entitled to PGY-3 promotion by April 30, 2023,** per the **extension contract signed on November 15, 2022.**

✔ By **March 31, 2023,** faculty evaluations confirmed **complete resolution of previously cited concerns** regarding:

1. **Insubordination**
2. **Leadership**
3. **Time management**
4. **Multitasking**
5. **Organizational skills**
6. **Note editing**

✔ **Despite these verified improvements, Plaintiff was denied PGY-3 promotion without justification.**

365. **The program's actions clearly demonstrate that remediation was never intended to facilitate improvement but rather to serve as a pretext for unjustified probation and eventual termination.**

April, 2023

Breach of GME Policies &

Denial of Due Process in Non-Promotion to PGY-3

Unjustified Non-Promotion &

Breach of GME Policies

366. Despite **positive faculty evaluations in March 2023**, Defendant **Dr. Ross refused to advance Plaintiff to PGY-3 status** on **April 30, 2023,** constituting a **third breach** of the **GME resident contract, GME policies, and ACGME institutional requirements.**

✔ **Resident promotions must be based on a summative evaluation** assessing competency over the **entire training period**—in Plaintiff's case, **18 months within the program.**

✔ The **March 31, 2023, evaluation documented improvements** in all previously cited concerns.

✔ The **absence of a required semi-annual evaluation in April 2023** violated ACGME mandates for **objective competency-based assessment.**

✔ **No justification** was provided for the decision to withhold Plaintiff's promotion.

✔ This action violated ACGME's **Six-Core Competency framework**, which requires:

1. **Patient Care**
2. **Medical Knowledge**
3. **Practice-Based Learning & Improvement**
4. **Interpersonal & Communication Skills**
5. **Professionalism**
6. **Systems-Based Practice**

367. **By failing to conduct a formal April 2023 summative evaluation and by disregarding Plaintiff's due process rights, Defendant Dr. Ross violated fundamental principles of Graduate Medical Education (GME).**

Refer to Exhibit #77 – Excerpt from GME Policy 103 on the Remediation Period.

Violation of GME Policy 105 – Resident Advancement

368. Defendant **Dr. Ross's refusal to promote Plaintiff to PGY-3 directly contravened** the provisions outlined in **GME Policy 105 – General Policy Resident Advancement.**

✔ **No clinical rotations were deemed unsatisfactory.**

✔ **Plaintiff met all required competencies for promotion.**

✔ **GME Policy 103 explicitly states** that if a resident **corrects deficiencies and maintains satisfactory performance, no further corrective action is warranted.**

✔ Despite **marked improvements** as documented in **March 2023 evaluations,** Dr. Ross **arbitrarily imposed another non-promotion**—the **second instance of this unjustified action.**

369. **This decision was not based on merit or performance but was a continuation of a pattern of targeted retaliation.**

Refer to Exhibit #78 – Contract Non-Renewal Under GME Policy 103 UMCRH.

Refer to Exhibit #79 – Request for Reconsideration Under GME Policy 104 UMCRH.

Denial of Due Process &

Systemic Violations of ACGME Standards

370. Defendant Dr. Ross **deliberately failed to notify Plaintiff of his right to appeal the non-promotion decision, violating:**

✔ **GME Policy 105 – General Policy Resident Advancement**, which grants residents the right to **invoke grievance procedures upon notification of non-renewal.**

✔ **GME Policy 104 – General Policy Evaluation of Residents**, which mandates that the

program director must inform residents of their right to appeal non-renewal or non-promotion decisions.

371. **Dr. Ross's failure to adhere to these policies deprived Plaintiff of the opportunity to challenge an adverse and unjustified career-altering decision.**

Summary of Violations Committed by Defendant Dr. Ross

372. The **second instance of non-promotion** under Dr. Ross's leadership not only constituted a breach of Plaintiff's **GME contract and academic due process rights** but also represented **a systemic violation of ACGME institutional standards.**

✔ **(1) Breach of Resident Contract:**

- The **arbitrary non-promotion of Plaintiff**, despite documented competency and performance improvement, **violated GME Policy 102 UMCRH** (Fair Institutional Policies & Due Process), **GME Policy 103** (Corrective Action Process), and **GME Policy 105** (Resident Advancement).

✔ **(2) Denial of Academic Due Process Rights:**

- Plaintiff was **not informed of deficiencies, was not given a chance to contest non-promotion, and was denied a formal appeal process**, all of which are **mandatory elements of academic due process.**

✔ **(3) Violation of ACGME Program & Institutional Requirements:**

- Defendant **Dr. Ross disregarded ACGME guidelines** requiring **fair, competency-based, and transparent evaluations.**
- **Violations include:**
    - **ACGME II. Policies A. Program Director (Page 9)** – Failure to fulfill duties of fair evaluation.
    - **ACGME V. Evaluation (Pages 26-29)** – Inadequate performance assessment and feedback.
    - **Failure to adhere to GME Institutional Requirements, including:**
        - **IV. GME Policies Adherence** – Program failed to uphold fair due process policies.
        - **IV.B.1. Recruitment & Selection Policies** – Unfair treatment of Plaintiff as a resident.
        - **IV.C. Appointment Agreements** – Breach of contract terms.
        - **IV.E. & IV.I.3. Grievance & Harassment Policies** – Failure to ensure procedural fairness.

✔ **(4) Breach of Accreditation Contract with ACGME:**

- The program's **repeated failure to adhere to ACGME standards** constitutes a **violation of its accreditation contract,** potentially jeopardizing its **accreditation status.**

373. **These systemic violations confirm that Dr. Ross's actions were retaliatory, unlawful, and in direct breach of residency training standards.**

Meeting with GME Director & Institutional Negligence

374. Following the **April 2023 non-promotion,** Plaintiff **emailed the GME Director requesting a meeting** to address his concerns regarding his relationship with **Defendant Dr. Ross.**

✔ **The meeting took place at the GME office (4th floor) and included:**

1. Former **GME Director Mr. Hunter Tyrece**
2. Former **CCC Chair & Defendant Dr. Prill**
3. **Plaintiff**

✔ **Key takeaways from the meeting:**

- Mr. Hunter, representing the **GME office, assured Plaintiff of their support** and projected a **positive resolution.**
- **However, he failed to reference GME policies or Plaintiff's due process rights.**
- No official documentation was provided to Plaintiff regarding the meeting's outcome.
- Plaintiff's **email correspondence regarding this meeting is unavailable** due to his institutional **email being deactivated post-dismissal.**
- Both **Mr. Hunter and Dr. Prill have since left the institution.**

375. **The GME office's failure to take corrective action further demonstrates a systemic culture of disregard for resident rights and due process.**

Conclusion: Systemic Failure to Ensure

Fair Resident Advancement

✔ **Defendant Dr. Ross engaged in targeted retaliation** by **denying Plaintiff promotion to PGY-3 despite competency improvements and positive evaluations.**

✔ The **GME office failed to enforce policies ensuring due process, transparency, and fair promotion criteria.**

✔ The **non-promotion violated GME Resident Agreement, multiple GME policies and ACGME accreditation requirements.**

✔ The **institution's leadership failed to intervene, reinforcing an environment of procedural abuse and academic retaliation.**

✔ **Plaintiff was denied the opportunity to appeal non-promotion, a clear violation of contractual and institutional obligations.**

376. **These violations will be presented before the jury to substantiate Plaintiff's claims of retaliatory actions, due process violations, and deliberate career sabotage.**

FOURTH, INCOMPLETE SEMIANNUAL PERIOD

May, 2023

Arbitrary & Capricious Strike System: A Pretext for Probation

Introduction of the Strike System & False Promises of Fairness

377. On **April 28, 2023**, following the **denial of Plaintiff's promotion to PGY-3**, **Defendant Dr. Prill, in her capacity as CCC Chair, introduced a "strike system" as part of the May 2023 remediation plan.**

✔ The **Clinical Competency Committee (CCC) assured Plaintiff that as long as he did not accumulate three strikes, he would not be placed on probation.**

✔ This **remediation framework was presented as an objective, structured approach** to addressing concerns, but in reality, it served as a **pretext for placing Plaintiff on probation, regardless of compliance.**

Refer to Exhibit #82 – Strike System Implemented by CCC Chair Dr. Prill.

Arbitrary Criteria for "Strikes"

& Lack of Due Process

378. The **strike system purportedly established clear performance benchmarks**, stating that **three strikes would result in failure of remediation and probation.**

✔ The **criteria for receiving a "strike"** included:

1. **Failure to complete assigned leadership tasks or Diversity, Equity, and Inclusion (DEI) packet.**
2. **Failure to follow attending physician recommendations.**
3. **Failure to address patient safety concerns.**
4. **HIPAA violations (despite no prior infractions).**
5. **Managing patients without direct supervision.**

6. **Failure to consult a senior resident or attending before altering patient orders.**

✔ The **CCC assured Plaintiff that if he adhered to these conditions and avoided three strikes, he would not be placed on probation.**

379. **Despite fully complying with the strike system and receiving zero strikes, Plaintiff was still placed on probation, demonstrating the arbitrary and retaliatory nature of the remediation process.**

Refer to Exhibit #82, 83 – Strike System Terms & Plaintiff's Compliance Records.

Punitive & Non-Medical "Leadership Training"

as a Retaliatory Measure

380. As part of the **strike system remediation plan**, Defendant **Dr. Prill imposed a non-medical leadership training requirement**, which included a **mandatory reading assignment of three business and self-improvement books:**

✔ **"Developing the Leader Within You 2.0" (John C. Maxwell, 2018)** – General leadership principles.

✔ **"The Future Leader" (Jacob Morgan, 2020)** – Business & economics-oriented leadership.

✔ **"Discover Your Clifton Strengths" (Don Clifton, 2017)** – Personal development & motivational coaching.

381. **These books were unrelated to ACGME educational standards and had no relevance to Plaintiff's competency as a physician.**

✔ **Plaintiff was further required to prepare and deliver a leadership lecture** based on these books, rather than medical case presentations or research topics.

✔ **When Plaintiff requested to focus on clinical cases instead, Dr. Prill refused**, insisting on non-medical leadership themes.

Breach of ACGME Standards &

Evidence of Resident Maltreatment

382. The **forced leadership presentation** and unrelated reading assignments were not only **outside the scope of medical training** but also **constituted professional mistreatment.**

✔ The **Council on Ethical and Judicial Affairs of the American Medical Association**[4] **(AMA) explicitly categorizes** the assignment of unrelated, non-clinical tasks **as a form of professional retaliation and abuse.**

✔ The **AMA's Principles of Medical Ethics (Principles II, III, & VII) prohibit punitive assignments** that do not contribute to clinical education.

✔ A **survey of 581 senior medical students across ten medical schools found that 36.7% reported being assigned tasks as punishment.**

Plaintiff was subjected to targeted mistreatment inconsistent with ethical medical training practices.

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[4] Council on Ethical and Judicial Affairs Report 1—I-93 "Disputes Between Medical Supervisors and Trainees," American Medical Association (1994).

Refer to AMA Ethical Reports – Disputes Between Medical Supervisors & Trainees.[5]

DEI Packet Requirement:

Arbitrary & Retaliatory Shifts in Expectations

258. Under the **strike system**, Plaintiff was given **two options**:

✔ **Complete a Diversity, Equity, and Inclusion (DEI) packet, or**

✔ **Deliver a leadership lecture**

✔ **Plaintiff chose to complete the DEI packet**, believing it to be a **more efficient use of time** given the demands of residency.

✔ **Upon submission, Dr. Pruitt (faculty member) informed Plaintiff that the packet was no longer required**, following consultation with **Defendant Dr. Prill.**

383. **The sudden change in expectations demonstrates the arbitrary and shifting nature of the remediation process, further confirming that Plaintiff was set up for failure.**

Refer to Exhibit #85 – Text Correspondence with Dr. Pruitt Regarding DEI Packet.

[5] chrome-extension://kdpelmjpfafjppnhbloffcjpeomlnpah/https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.2.4%20Disputes%20between%20medical%20supervisors%20%26%20trainees%20--%20background%20reports.pdf

Despite Full Compliance, Plaintiff Was Placed

on Probation Without Justification

384. **Despite adhering to all remediation requirements, Plaintiff was placed on probation without ever receiving a single strike.**

✔ Plaintiff **fully complied with the strike system, avoided all violations, and met all imposed requirements.**

✔ The **CCC falsely promised that compliance would prevent probation, yet probation was imposed anyway.**

✔ This **demonstrates a deliberate breach of due process**, exposing the **arbitrary and capricious nature of the program's disciplinary measures.**

Refer to Exhibit #82 & 85 – Plaintiff's Compliance Records vs. Probation Decision.

Conclusion:

Arbitrary, Retaliatory, and Bad Faith Actions

✔ The "Strike System" was implemented under false pretenses to appear as an objective remediation process but was instead used as a pretext for probation.

✔ Despite Plaintiff receiving zero strikes, the program still placed him on probation, demonstrating an intentional act of bad faith.

✔ The non-clinical leadership lecture and assigned books had no relation to medical competency and were imposed as punitive measures.

✔ **The DEI packet requirement was suddenly rescinded after Plaintiff completed it, further exposing the arbitrary nature of the remediation process.**

✔ **AMA Ethical Guidelines confirm that assigning unrelated, non-medical tasks as "punishment" constitutes professional mistreatment.**

✔ **ACGME correspondence confirmed that these actions did not align with accredited residency training requirements.**

✔ **By failing to follow their own strike system terms, Defendants demonstrated a blatant disregard for Plaintiff's rights, due process, and fair treatment.**

385. These violations will be presented before the **jury** as clear evidence of the program's **retaliation, procedural abuse,** and **intentional sabotage** of Plaintiff's **residency training.**

Plaintiff's Proactive Renewal

of Required Certifications

386. In **May 2023**, **Plaintiff took proactive steps to renew all essential medical certifications**—Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS)—before their expiration.

✔ **Plaintiff anticipated potential retaliation** if certifications lapsed, as past incidents demonstrated that **residents had been penalized for failing to renew on time.**

✔ Understanding the **critical importance of maintaining active certifications**, Plaintiff **dedicated over 100 hours** to reviewing official manuals, attending online workshops, and fulfilling all renewal requirements.

✔ **By May 19, 2023, Plaintiff had successfully renewed all certifications, ensuring continued compliance with**:

1. **GME Policy 105 UMCRH – General Policy on Resident Advancement**, which mandates that residents maintain active certification.
2. **Hospital requirements for inpatient privileges and clinical responsibilities.**

Refer to Exhibit #80 – BLS, ACLS, PALS Certifications & Training Completion Records (May 2023).

Refer to Exhibit #81 – May 2023 Resident Schedule.

Certification Renewal Eliminated Any Justification

for Program's Retaliatory Actions

✔ **Plaintiff's renewal of these certifications preemptively removed any justification for program leadership to terminate inpatient privileges** or further delay promotion.

✔ **Despite full compliance, Defendants failed to acknowledge the Plaintiff's diligence, further proving the bad faith nature of the program's disciplinary actions.**

387. **This further underscores the program's pattern of arbitrary and retaliatory decision-making—where compliance with stated requirements did not prevent unjustified punitive measures.**

388. **These actions will be presented before the jury as additional evidence of the program's deliberate efforts to undermine Plaintiff's career and residency training.**

Arbitrary and Capricious Dismissal

Despite Compliance with Strike System

389. **Plaintiff's Compliance with Strike System & Unjustified Focus on Leadership Talk:**

✔ During the **internal appeal**, UM's legal counsel, **Mrs. Dena Terra, Esq.**, **questioned Plaintiff's failure to deliver a "leadership talk."**

✔ **Plaintiff rebutted this claim**, emphasizing that the program was not genuinely evaluating his performance, but rather **seeking pretexts for non-achievement.**

✔ Plaintiff underscored that **his role as a physician prioritizes medical knowledge and patient care**, not public speaking skills.

✔ **The expectation to engage in motivational speaking is irrelevant to ACGME competency assessments**, as the **primary measure of a physician's capabilities is their clinical performance, not leadership presentations.**

390. **Dismissal Based on Extraneous & Non-ACGME Factors:**

✔ **UM's legal counsel endorsed Plaintiff's dismissal based on the absence of a leadership talk— a requirement unrelated to medical competency.**

✔ This **directly contradicts the "Strike System Agreement"**, under which Plaintiff **incurred no strikes.**

✔ **Despite adhering to all remediation terms, Plaintiff was still placed on probation, demonstrating a deliberate disregard for due process.**

✔ The emphasis on **three non-ACGME mandated leadership books**—which **bore no relevance to clinical training**—further reveals the program's **bad faith attempts to justify Plaintiff's dismissal based on non-medical criteria.**

391. **This underscores the UM legal counsel's strategy of defending the program's retaliatory actions rather than ensuring an equitable and objective review of Plaintiff's performance.**

392. **Plaintiff Fully Complied with Remediation, Yet Was Arbitrarily Placed on Probation:**

✔ **Plaintiff met every condition set by the CCC's final remediation plan and adhered to all requirements under the strike system.**

✔ **Despite this, Dr. Ross unilaterally disregarded the strike system's outcome and placed Plaintiff on probation**—a decision that was both **arbitrary and capricious.**

✔ **This directly contradicts the original CCC agreement**, which stipulated that **accumulating three strikes would be the only basis for failure.**

✔ **Plaintiff had no strikes. Yet, he was still placed on probation.**

✔ **The decision was not based on any objective performance metric** but was instead a **personal and retaliatory action by Dr. Ross.**

393. **Dr. Ross Overrode the CCC Chair's Authority, Abusing Power & Ignoring Due Process:**

✔ **Dr. Ross disregarded the professional judgment of CCC Chair, Dr. Prill**, who had opposed her **vague leadership-based objectives** and sought to **protect Plaintiff from unjust scrutiny.**

✔ **The strike system was specifically implemented to ensure an objective remediation process**, **eliminating the possibility of arbitrary decisions by Dr. Ross.**

✔ **Despite this, Dr. Ross systematically overrode the system's outcome**, reinforcing her pattern of **bad faith, bias, and retaliatory decision-making.**

✔ **As a figure of authority, Dr. Ross abused her power to manipulate faculty decisions**, ensuring an outcome that served her personal agenda rather than an **objective assessment of Plaintiff's qualifications.**

394. **These violations will be presented before the jury as further evidence of the program's systematic disregard for due process, fairness, and adherence to Graduate Medical Education (GME) policies.**

Nursery Rotation with Former

Program Director Dr. Ross

395. From **May 22 to May 31, 2023,** the Plaintiff was assigned to the **nursery rotation under Dr. Ross's supervision.** Despite fulfilling all clinical responsibilities, Dr. Ross engaged in public reprimands during patient care interactions, often in front of interns and nursing staff. The Plaintiff maintained professionalism and ensured clear communication with patients. Dr. Ross,

however, continued to act in a confrontational and demeaning manner. The Plaintiff formally requested that Dr. Ross afford him the professional respect due to a physician.

396. **Following this exchange,** Dr. Ross abruptly exited the clinical floor and later issued a negative evaluation of the Plaintiff. The Plaintiff, however, remained on duty, underscoring his commitment to patient care. Dr. Ross's decision to leave, rather than directing the Plaintiff to do so, contradicts her claims of the Plaintiff's alleged misconduct.

Refer to Exhibit #88 – Dr. Ross's negative and erroneous evaluation.

397. Dr. Ross falsely alleged that the Plaintiff failed to report neonatal hypoglycemia. During the internal appeal, UM attorney Ms. Dena Terra, Esq., lacking a medical background, questioned the Plaintiff on this matter. The Plaintiff detailed **the hospital's neonatal hypoglycemia management protocols,** confirming that the incident occurred at 2:00 AM and was fully resolved by the overnight team before his shift began at 6:30 AM. Dr. Ross's claim was **unfounded and clearly intended to manufacture deficiencies.**

398. Despite her negative evaluation, Dr. Ross requested that the Plaintiff remain on nursery service instead of delegating responsibilities to interns. This request, coordinated through **Jacqueline Jone, the New Carrollton Office scheduler,** directly contradicts her claims of inadequate performance. Dr. Ross also acknowledged the **Plaintiff's punctuality and thorough documentation,** further exposing the inconsistencies in her assessment.

399. A **critical event occurred when a neonate required urgent phototherapy** due to escalating bilirubin levels. The Plaintiff attempted to contact Dr. Ross around 7:00 PM for approval but received no response. Given the urgency, the Plaintiff consulted on-call neonatologist Dr. Skelton, who reviewed and **approved the intervention.** The order was documented, and intern Dr. Luo was present.

400. Dr. Ross remained unavailable until the following morning and made no comments on the Plaintiff's decision, effectively conceding the necessity of the intervention. This incident highlights the Plaintiff's ability to manage urgent clinical decisions independently and demonstrates leadership in a high-pressure setting.

401. Dr. Ross falsely alleged that the Plaintiff **deprived an intern of a circumcision opportunity.** However, records confirm that only one circumcision case occurred during the May 2023 nursery rotation, and the Plaintiff did not perform the procedure. Having ceased circumcision procedures since February 2023 in direct response to Dr. Ross's prior criticisms, the Plaintiff facilitated intern Dr. Luo's training, with **supervision provided by OBGYN attending Dr. Medlock.** These facts are documented in the medical records, disproving Dr. Ross's allegations.

Refer to Exhibit #86 & Exhibit #87 – Unanswered requests to Dr. Medlock and Dr. Luo, constituting an admission by UM.

402. In violation of ACGME standards on transparency and professionalism, Dr. Ross posted anonymous negative notes on the Plaintiff's **New Innovations** account. Such conduct constitutes

professional retaliation and is explicitly condemned by the **Council on Ethical and Judicial Affairs Report** as an abuse of power within medical education.

Refer to Exhibit #89 – Documentation of Dr. Ross's anonymous notes.

403. Under ACGME guidelines, residents are entitled to appeal performance evaluations. The Plaintiff exercised this right by submitting a formal written testimony disputing Dr. Ross's claims and providing an account of the events that transpired during the nursery rotation.

Refer to Exhibit #90 – Plaintiff's testimony disputing Dr. Ross's claims in **Exhibit #88**.

Summary of Dr. Ross's Retaliatory

Actions During Nursery Rotation

✔ **Public reprimands and unprofessional behavior** – Dr. Ross deliberately targeted the Plaintiff in front of interns and nursing staff.

✔ **Fabricated claims of medical negligence** – Wrongfully accused the Plaintiff of failing to report neonatal hypoglycemia.

✔ **Contradictory assessment** – Requested the Plaintiff remain on nursery service while simultaneously labeling his performance inadequate.

✔ **Unjustified negative evaluation** – Issued erroneous feedback despite the Plaintiff's demonstrated clinical competence.

✔ **Professional retaliation through anonymous notes** – Secretly documented negative

assessments without direct discussion.

✔ **Failure to acknowledge Plaintiff's independent decision-making** – Did not challenge the bilirubin management decision, implicitly admitting fault.

✔ **Baseless circumcision training allegations** – Wrongly claimed the Plaintiff deprived an intern of a learning opportunity, despite records proving otherwise.

404. **Dr. Ross's actions constitute clear violations of GME and ACGME policies, evidencing targeted retaliation, professional misconduct, and procedural violations.**

Coercive Practices by Dr. Ross & Complete Failure of Professional Conduct

405. **On May 31, 2023, Dr. Ross** convened a meeting with the Plaintiff in **the small conference room of the GME office.** Initially scheduled for 3:30 PM, the meeting was delayed until after 4:00 PM, pending Dr. Prill's arrival. **The Plaintiff entered expecting confirmation of his promotion to PGY-3, having completed remediation without incurring any strikes.** Dr. Ross, notably carrying a yellow envelope—often associated with formal documentation—set the tone for an unexpected turn of events.

406. During the meeting, Dr. Ross suddenly expressed dissatisfaction with the Plaintiff's nursery rotation, declaring him **"incompetent."** She coerced the Plaintiff to repeat self-incriminating statements, including: **"You are an incompetent physician,"** and, **"Your training is akin to a ventilator, I will turn it off, and you have no rights to appeal."** The Plaintiff refused to comply and demanded specific instances of patient care deficiencies. Dr. Ross responded, **"You**

cannot argue with us," while Dr. Prill interjected, **"You cannot even pronounce what we told you to say." Both escalated their coercion,** threatening **termination unless the Plaintiff verbally admitted incompetence.** The meeting became **confrontational, with Dr. Ross raising her voice in an openly hostile manner.** The Plaintiff, in visible distress, attempted to remain in the room to regain composure, but Dr. Ross forcibly dismissed him.

407. During cross-examination by the Plaintiff's attorney, **Michael Herman, Esq.,** on November 9, 2023, Dr. Prill acknowledged hearing Dr. Ross instruct the Plaintiff to declare himself **"an incompetent doctor."** Initially, Dr. Prill did not recall the ventilator remark, but under persistent questioning, she conceded, **"I think she said something that she shouldn't have said in that context."** This admission is documented **in the official deposition transcript,** available through **Veritext Legal Solutions** (David Corbin, RPR). **Exhibit 154, November 9, 2023 Hearing.**

408. Dr. Prill's claim that the meeting lasted **2 hours and 15 minutes** contradicts the Plaintiff's detailed recollection of being on the **7th floor by 5:00 PM** for sign-out, indicating a significantly **shorter meeting duration.** This inconsistency calls into **question the credibility of her account.** While Dr. Prill later admitted Dr. Ross's behavior was **"unprofessional" and "inappropriate,"** her **active participation in the coercion reinforces** a pattern of **administrative misconduct.**

Coercion, Duress, & Violation of Due Process

409. **Coercion** is legally defined as the use of intimidation, threats of violence, or adverse professional consequences to force an individual to act against their will. **Black's Law Dictionary** defines **duress** as **"any unlawful threat or coercion used to induce another to act (or refrain from acting) in a manner they otherwise would not (or would)."** Dr. Ross's conduct meets this legal threshold, as she attempted to extract a false admission under explicit threats of termination.

410. By compelling the Plaintiff to declare himself incompetent and stripping him of appeal rights, Dr. Ross and Dr. Prill engaged in coercive practices that directly violate:

- ✔ **GME Policy 103 – Due Process & Corrective Action**
- ✔ **GME Policy 122 – Professionalism & Ethical Conduct**
- ✔ **ACGME Institutional Requirements – Resident Due Process Protections**

411. **These actions constitute egregious professional misconduct, subject to legal scrutiny and institutional sanctions.**

Ethical & Professional Violations in Medical Training

412. The ventilator metaphor—**"Your training is like you are intubated on mechanical ventilation, and I will turn it off"**—is a direct affront to the medical profession. Physicians are trained to **preserve life and provide ethical patient care**, making such rhetoric profoundly inappropriate.

✔ **Violates the Canons of Medical Ethics** – Physicians are bound to uphold **"primum non nocere"** (first, do no harm).

✔ **Contradicts the Hippocratic Oath** – The invocation of life-support imagery as a punitive measure **undermines the fundamental ethos of medicine.**

✔ **Demonstrates gross professional incompetence** – A program director entrusted with the training of physicians should **never** use medical procedures as an analogy for control, coercion, or punishment.

Dr. Ross's Attempt to Unilaterally Place Plaintiff on Probation

413. The yellow envelope contained a faculty memorandum, dated **May 30, 2023,** falsely stating that the Plaintiff **failed to complete remediation** and was being placed on probation. However, due to the chaotic nature of the meeting, Dr. Ross never presented the document for signature. Instead, the probation order—already signed by Dr. Ross and Dr. Prill—was electronically transmitted via **DocuSign** by program coordinator **Mrs. June Taylor.**

414. This **violates** the Plaintiff's GME contract, contradicts the **strike system agreement,** and exemplifies the **arbitrary and capricious** nature of Dr. Ross's actions:

✔ **No Strikes Were Issued** – The Plaintiff successfully completed remediation with no recorded infractions.

✔ **Violates CCC Strike System Agreement** – The Clinical Competency Committee (CCC) established that probation would only be enacted **if the Plaintiff accumulated three strikes.**

✔ **Directly Contradicts the May 2023 Faculty Evaluations** – The Plaintiff **met or exceeded** all remediation requirements.

415. **Despite full compliance, Dr. Ross unilaterally placed the Plaintiff on probation, exposing the retaliatory nature of the decision.**

Dr. Ross's Systematic Breach of GME Policies & Professional Standards

416. Under **GME Policy 122 – General Policy on Professionalism**, the program director is required to:

✔ **Model professionalism, educational excellence, and high-quality patient care.**

✔ **Foster an environment where respectful discussion is welcomed.**

417. Instead, Dr. Ross:

✖ **Engaged in coercion, threats, and professional misconduct.**

✖ **Orchestrated a fraudulent probationary order despite the Plaintiff's compliance.**

✖ **Created an environment of hostility, fear, and professional retaliation.**

418. The **ACGME Institutional Requirements** mandate that residency programs provide:

✔ **A professional, equitable, and civil learning environment.**

✔ **A structured appeal process for residents facing adverse actions.**

419. Dr. Ross's actions **completely disregarded** these fundamental principles.

Refer to Exhibit #101 – GME Policy 122 UMCRH – "General Policy on Professionalism."

Final Summary of Coercion & Retaliatory Actions by Dr. Ross

- ✔ **Coerced the Plaintiff into falsely admitting incompetence.**
- ✔ **Used threats of termination as a weapon to enforce compliance.**
- ✔ **Unilaterally overruled the CCC Strike System despite no strikes.**
- ✔ **Issued a fraudulent probationary order without procedural basis.**
- ✔ **Failed to uphold her responsibilities as program director.**
- ✔ **Violated multiple GME, ACGME, and institutional policies.**
- ✔ **Created a toxic learning environment detrimental to medical education.**

420. **Dr. Ross's conduct represents a clear abuse of power, warranting institutional investigation and legal consequences.**

Systematic Abuse & Maltreatment of Resident Physicians

421. The UM Capital Region Health Family Medicine Program has a documented history of **resident mistreatment, intimidation, and systemic deficiencies** that have persisted for years. This pattern is evidenced by:

✔ **Written testimonies** from former Chief Resident **Dr. Parvin Zafarani** and resigned resident **Dr. Brenda Figueroa**, which have been submitted as court exhibits.

✔ **ACGME citations** since **2019** for failure to meet core program requirements.

✔ **Multiple accounts of unjust treatment** from affected residents, including **Dr. Alexander Melkuev, Dr. Isra Amjed, Dr. Brenda Figueroa, and the Plaintiff.**

422. **The impact of these systemic failures has been devastating:**

✔ Residents have been unfairly placed on probation, denied promotions, or **forced out of medicine altogether.**

✔ Several **struggled to secure another residency position** due to the lasting effects of their mistreatment within the program.

✔ The toxic environment and **retaliatory actions by leadership** have irreparably damaged careers and professional aspirations.

Refer to:

Exhibit #102 – Letter of Dr. Parvin Zafarani

Exhibit #103 – Written Testimony by Dr. Brenda Figueroa

423. **The preponderance of evidence unequivocally demonstrates a pattern of systematic abuse and administrative misconduct within the residency program.**

Probationary Status as a Weapon of Retaliation

424. The program has historically **weaponized probationary statuses** as a means of control, coercion, and retaliation. Several residents have been subjected to:

✔ **Unjustified probation and suspension** despite fulfilling all clinical and academic requirements.

✔ **Threats and intimidation** from faculty and program leadership.

✔ **Career-ending repercussions** based on **arbitrary and capricious** decisions.

425. **Notable cases include:**

✔ **Dr. Christopher Johnson** – Placed on probation but **successfully completed residency in 2019** despite undue scrutiny.

✔ **Dr. Sonia Haidar** –

1. **Removed from scheduled rotations & suspended** for missing a **night call due to legitimate health concerns.**
2. **Issued a formal reprimand** by **Dr. Kaysin** and required to **complete a "Professionalism" lecture** as punishment.
3. **Ultimately completed her training & graduated in June 2023.**

Dr. Prill's Admission of Wrongdoing at Graduation

426. Despite subjecting residents to unjustified disciplinary actions, faculty members have later **admitted fault**, yet these admissions came too late to undo the damage caused.

427. **At the June 2023 graduation dinner, Dr. Prill acknowledged Dr. Haidar's mistreatment, stating:**

"I am sorry you had a hard time in our program."

✔ **Dr. Haidar's experience mirrored the Plaintiff's own struggles**—both faced targeted mistreatment, but while others were **promoted to PGY-3**, the Plaintiff was denied advancement.

✔ When approached by the Plaintiff to discuss her experience, **Dr. Haidar declined out of fear of retaliation**, particularly as a **non-U.S. citizen on a visa**, further highlighting the program's hostile environment.

428. **These admissions underscore the deeply ingrained culture of maltreatment within the residency program.**

Mass Faculty Turnover & ACGME Compliance Failures

429. The program has been plagued by **mass faculty turnover, leadership instability, and a deteriorating educational environment**, raising serious concerns about its ability to meet **ACGME accreditation standards.**

430. **Key departures from 2019–2023 include:**

✔ **2019–2021: Multiple faculty physicians resigned**, destabilizing resident education.

✔ **2021: Dr. Mapp was terminated for professionalism concerns.**

✔ **June 2023: Dr. Ross resigned as program director**, citing dissatisfaction with the role and institution.

✔ **July 2023: GME Office Director Tyrece Hunter resigned.**

✔ **December 2023: Associate Program Director Dr. Prill resigned.**

✔ **2023: Sponsoring Institution intervened** and appointed a **new program director.**

431. **Four resident terminations within four years, numerous probations, and complete leadership turnover** are irrefutable indicators of **gross program mismanagement and failure to maintain ACGME compliance.**

432. **The Plaintiff's career was directly impacted by these administrative failures, resulting in the loss of his training and professional future.**

Summary of Systemic Violations & Institutional Negligence

✔ **ACGME citation** confirms failures to meet program requirements.

✔ **Resident mistreatment & retaliation** have led to **career-ending consequences.**

✔ **Leadership instability & mass faculty resignations** signal **deep-rooted dysfunction** within the program.

✔ **ACGME accreditation remains at risk** due to the program's continued failure to uphold professionalism and due process.

433. **The Plaintiff's case is not an isolated incident—it is part of a larger pattern of systemic abuse that demands immediate institutional accountability.**

Integrity Breach:

The Impact of Falsifying ACGME Surveys

434. The **Accreditation Council for Graduate Medical Education (ACGME) annual surveys** serve as a critical tool for evaluating residency programs, ensuring compliance with **accreditation standards** while providing **anonymous** and **independent** feedback from residents and faculty. These surveys are designed to promote transparency and accountability, allowing participants to provide honest insights **without fear of retaliation.**

435. However, under the tenure of former **Program Director Dr. Ross** and former **Associate Program Director Dr. Prill**, **ACGME survey manipulation** became a systematic practice within the **UM Capital Region Family Medicine Program.**

✔ Residents were **instructed on how to respond** to survey questions, ensuring that answers aligned with leadership's desired outcome.

✔ The program convened **mandatory pre-survey meetings**, during which **"correct" responses** were explicitly dictated.

✔ This manipulation directly **undermined the survey's purpose** of evaluating resident and faculty experiences **objectively.**

436. **Key Evidence:**

Exhibit #104 – Email from Dr. Ross instructing chief residents to organize a pre-survey meeting.

437. **By falsifying ACGME surveys, the program deliberately misled accrediting bodies, concealing a toxic environment plagued by faculty resignations, resident terminations, and widespread policy violations.**

Systemic Cover-Up &

Institutional Failure

438. Despite appearing outwardly **compliant with ACGME standards**, the program was deteriorating internally:

- ✔ High faculty turnover and resignations created **instability in leadership.**
- ✔ Multiple resident terminations reflected a **pattern of punitive, retaliatory measures.**
- ✔ The **transition from Dimensions Health to the University of Maryland Medical System** in 2021 triggered institutional oversight aimed at **rectifying systemic failures.**

439. **The program's leadership knowingly falsified survey data to evade scrutiny and maintain accreditation despite internal dysfunction.**

440. The **ACGME relies on honest survey responses** to:

✔ Identify **deficiencies in residency programs** and improve educational quality.

✔ Ensure programs meet **ethical, educational, and patient safety standards.**

✔ Protect **residents from mistreatment and systemic failures.**

441. **The UM Capital Region Family Medicine Program's survey manipulation fundamentally compromised this process, preventing the ACGME from addressing real issues within the program.**

Falsification of ACGME Surveys:

A Violation of Medical Integrity

442. The falsification of ACGME surveys constitutes a **critical breach of professional integrity** and a **violation of medical ethics.**

✔ **Accreditation standards exist to safeguard patient care and medical education.**

✔ **Survey falsifications distort reality**, preventing residents from receiving necessary institutional support.

✔ **Compromised data undermines accreditation efforts**, leaving systemic failures unchecked.

443. **By manipulating survey responses, the program leadership actively contributed to an environment of deception, preventing necessary reforms and fostering a culture of retaliation.**

Erosion of Trust & Institutional Integrity

444. **Trust is a cornerstone of medical education.** The integrity of the ACGME survey process depends on:

- ✔ **Transparency & accountability** in reporting resident experiences.
- ✔ **Anonymity & protection from retaliation** to ensure honest feedback.
- ✔ **Institutional commitment to improvement**, rather than concealment.

445. **When survey data is manipulated, residents are effectively silenced, and the ACGME is misled into believing a dysfunctional program is meeting standards.**

446. The consequences extend beyond accreditation:

- ✔ **Residents lose faith in the program's leadership**, knowing that **concerns are suppressed.**
- ✔ **The medical community's confidence in accreditation standards diminishes.**
- ✔ **Future patient care is jeopardized** as systemic failures remain **unaddressed.**

447. **Falsified surveys do not just protect failing programs—they actively harm residents, faculty, and, ultimately, patient safety.**

Legal & Ethical Ramifications

448. The **ACGME's accreditation process is only as reliable as the honesty of participating programs.** The UM Capital Region Family Medicine Program's actions:

- ✔ **Violated ACGME institutional requirements** for ethical compliance.
- ✔ **Compromised the credibility of residency training evaluations.**
- ✔ **Undermined patient care and resident well-being** through systematic deception.

449. **Addressing survey falsifications is essential** for maintaining the credibility of medical education. The ACGME must:

- ✔ Conduct a **full investigation** into the program's survey practices.
- ✔ Impose **sanctions or corrective measures** to uphold accreditation integrity.
- ✔ Ensure **future safeguards** against similar fraudulent conduct.

450. **Upholding the principles of honesty and transparency in ACGME surveys is not just a regulatory requirement—it is a fundamental duty to medical trainees, patients, and the integrity of the healthcare system.**

Final Remediation Review &

Systemic Violations of Due Process

451. Between **April and June 2023,** the Plaintiff met with **GME Director Mr. Tyrece Hunter** at least five times to discuss his remediation status and program concerns. In one meeting, attended by **Dr. Prill (CCC Chair),** Mr. Hunter reassured the Plaintiff:

✔ "I don't see a problem with your performance; the issue seems to be a personality mismatch between you and Dr. Ross."

✔ "Be patient—Dr. Ross is leaving this summer, and new leadership will take over."

✔ "We are here to support you and want to see you graduate successfully."

452. **Based on these assurances, the Plaintiff refrained from filing a formal grievance, a decision that was neither advised nor encouraged by the GME office.**

Manipulated Final Remediation Review

& Probation Scheme

453. On **May 30, 2023,** the program issued a **Final Remediation Review**, prepared by **Dr. Ross**, as a **pretext for probation and termination.** This document:

✔ Contradicted **March 31, 2023,** CCC evaluations, which confirmed **all initial concerns were resolved.**

✔ Ignored the Plaintiff's **positive participation** in:

1. **Resident Research Day** (Case report presentation)
2. **Strike System compliance** (No strikes recorded)
3. **Successful renewal of BLS, ACLS, and PALS certifications**

454. **Despite documented performance improvement, Dr. Ross arbitrarily determined that the Plaintiff had failed remediation, setting the stage for probation.**

455. The program's **remediation assessments lacked objective benchmarks** and instead provided vague statements such as:

- ✔ "Some improvement" but "still lacking in certain areas"
- ✔ No defined **standards of sufficiency** for successful completion
- ✔ **No regression or failure in performance was documented**

456. **These subjective, non-standardized assessments ensured that no matter how the Plaintiff performed, a negative outcome was pre-determined.**

Fabricated Allegations & Lack of Evidence

457. The **May 30, 2023, letter**, likely drafted by Dr. Ross, falsely accused the Plaintiff of:

- ✔ **Lack of leadership & organizational skills**
- ✔ **Difficulty multitasking & editing patient notes**
- ✔ **Failure to instruct an intern (Dr. Luo) in neonatal circumcisions**

458. **Key Evidence Contradicting These Claims:**

- ✔ **CCC had already cleared the Plaintiff of leadership deficiencies.**
- ✔ **Plaintiff only worked inpatient on May 9–11, 2023, under Dr. Chowdhury**, who confirmed:

1. He was **never asked** to evaluate the Plaintiff.

2. He had **no complaints or concerns** about the Plaintiff's performance.

✔ **Dr. Medlock (OBGYN attending) confirmed that the Plaintiff instructed Dr. Luo** in the only circumcision case that occurred during the rotation.

Exhibit #84: Communication with Dr. Chowdhury confirming he never completed an evaluation.

Exhibit #86: Plaintiff's rebuttal to circumcision allegations, supported by Dr. Medlock's confirmation.

Unlawful Probation Decision

Based on False Premises

459. On **May 30, 2023**, the program issued a memorandum imposing **probation** due to "continuation of areas of concern without noticeable improvement." This claim was:

✔ **Not supported by CCC evaluations** (which showed resolution of all concerns in March 2023).

✔ **Based on prior IEP reports** from **May 2022, August 2022, and February 2023**, despite:

1. No documented performance failures.
2. No recorded infractions under the **Strike System** (which the Plaintiff fully complied with).

460. **The Plaintiff was placed on probation without justification, violating due process and ACGME guidelines.**

Biased & Selective Faculty Evaluations

461. The program relied exclusively on **four Family Medicine faculty members** to determine probation:

Faculty Member	Support for Plaintiff	Support for Dr. Ross's Allegations
Dr. Tavakoli (Dept. Chair)	100% opposed allegations	0%
Dr. Prill (CCC Chair)	86% opposed allegations	14%
Dr. Kaysin	72% opposed allegations	28%
Dr. Ross	28% opposed allegations	72%

462. **No non-Family Medicine attendings, no self-assessments, no peer, patient, or non-faculty evaluations were included—blatantly violating GME Policy 104 and ACGME requirements.**

Exhibit #90-A: Biased evaluations used to justify probation.

Unilateral Change in Probation Terms by Dr. Ross

463. Despite the CCC recommending a **3-month probationary plan** (June-August 2023), Dr. Ross unilaterally:

✔ Shortened the **probation to one month**

✔ **Modified it to end in termination**

✔ Ensured probation aligned with **her departure from the program**

Exhibit #122 & #123: Comparison of CCC probation memo vs. Dr. Ross's altered version.

Dr. Ross manipulated the process to execute the Plaintiff's termination before leaving her role.

Systematic Violations of GME & ACGME Policies

464. **GME Policy Violations:**

1. **GME Policy 102 – Complaints & Grievance** (Denial of fair procedures)
2. **GME Policy 103 – Due Process & Discipline** (Failure to follow corrective action guidelines)
3. **GME Policy 104 – Resident Evaluations** (No objective, multi-source assessments)
4. **GME Policy 105 – Resident Advancement** (Arbitrary non-promotion)
5. **GME Policy 112 – Resident Agreements** (Breach of contract terms)
6. **GME Policy 115 – Program Director Responsibilities** (Failure to act as an advocate for residents)
7. **GME Policy 122 – Professionalism** (Retaliation & coercion)

465. **ACGME Common Program Requirement Violations:**

1. **Program Director Responsibilities** (Failure to provide fair leadership)
2. **Faculty Qualifications** (Unqualified leadership roles)
3. **Resident Evaluation & Feedback** (Lack of objective assessments)

466. **ACGME Institutional Requirement Violations:**

1. **Non-compliance with policies & procedures**
2. **Failure to provide due process for promotion & dismissal**
3. **Deficient grievance procedures**

467. **The program's actions systematically violated both contractual and accreditation standards, warranting legal action and regulatory scrutiny.**

Denial of Due Process & Legal Implications

468. **GME Policy 104 – "Request for Reconsideration"** grants residents the legal right to **appeal any decision** regarding:

- ✔ **Dismissal**
- ✔ **Non-renewal of contract**
- ✔ **Actions impeding career progression**

469. **The Plaintiff was never informed of these rights, constituting a breach of contract and deprivation of due process.**

470. **GME Policy 103 – "Due Process & Corrective Action"** mandates:

- ✔ **Written warning before probation**
- ✔ **Consultation with the Designated Institutional Official (DIO) before probation**
- ✔ **A formal appeals process**

471. **Dr. Ross failed to consult the DIO and violated procedural safeguards, making the probation decision illegitimate.**

Exhibit #91: Medical student Ryan Jeffries' 360-degree evaluation refuting program claims.

Conclusion: Systematic Misconduct

& Termination Pretext

472. The Plaintiff was placed on **probation despite:**

- ✔ **Successfully completing remediation**
- ✔ **Receiving no strikes under the Strike System**
- ✔ **Demonstrating documented improvements in all performance areas**

473. **Probation was arbitrarily imposed as a retaliatory measure, with Dr. Ross ensuring termination before her departure.**

474. **The program's failure to uphold due process, legal obligations, and ACGME compliance standards renders its actions both unlawful and unethical.**

475. **This final remediation review reaffirms the Plaintiff's right to seek full legal redress against wrongful termination and professional damages.**

June, 2023

Probationary Period

Unjust & Predetermined Terms of Probation

476. On **June 1, 2023**, the Plaintiff commenced an **inpatient family medicine rotation** under a **probationary period** with rigid, **pretextual conditions** designed to justify termination. The terms outlined:

✔ **Failure to show "improvement"** in leadership, organization, multitasking, note editing, and compliance with faculty directives would result in termination.

✔ **Ambiguous and unattainable criteria** for evaluating "lack of improvement," violating **GME Policy 104**, which mandates objective, evidence-based assessments.

✔ **No clear standards or measurable benchmarks** were established for probation success, ensuring an **impossible standard** for the Plaintiff.

477. **This probation was a continuation of the Plaintiff's systematic denial of due process and followed a predetermined path toward termination, ignoring all procedural safeguards.**

Probation as a Pretext for Termination

478. The Plaintiff's probation was neither remedial nor developmental—it was an **orchestrated removal process** driven by **Dr. Ross's personal agenda** before her departure from the program. Key violations include:

✔ **GME Policy 104 – Evaluation Standards:** Failed to include diverse evaluators or objective performance metrics.

✔ **ACGME Six-Core Competency Standards:** No genuine attempt to assess competency based on patient care, medical knowledge, professionalism, or interpersonal communication.

✔ **Denial of Due Process:** Plaintiff was given **no opportunity** to dispute the legitimacy of the probation decision.

479. **Dr. Ross's sole objective was to ensure the Plaintiff's removal before the end of June 2023, further demonstrating her disregard for institutional policies, ACGME guidelines, and basic fairness.**

Exhibit #85: Probation Terms – June 2023, documenting subjective and unattainable criteria.

Conclusion: Weaponized Probation & Due Process Violations

✔ **Probation was imposed arbitrarily, ignoring Plaintiff's compliance with all remediation terms.**

✔ **Performance expectations were deliberately vague to ensure failure.**

✔ **GME and ACGME policies were violated at every stage of disciplinary action.**

✔ **Plaintiff was denied a fair assessment and an opportunity to contest probationary terms.**

480. **This probation period was a fabricated mechanism to justify wrongful termination, further substantiating Plaintiff's claims of retaliatory treatment and procedural noncompliance.**

Probation Period Evaluation – June 2023

Faculty & Peer Evaluations During Probation

481. During the Plaintiff's inpatient service rotation in **June 2023**, he was supervised by **Dr. Chawla and Dr. Cheema**, with **Dr. Christopher McLeod** serving as the intern and **Shadi Ramirez** as the medical student. The Plaintiff underwent **weekly evaluations** as part of the probationary process.

✔ **Evaluations were conducted in both inpatient and outpatient settings**, with Dr. Chawla overseeing inpatient assessments and **Dr. Prill and Dr. Bradford** responsible for

outpatient reviews.

✔ **Probationary meetings** were convened by **Dr. Ross, Dr. Prill, and Dr. Kaysin**, often beginning with **unwarranted critiques** about the Plaintiff's study habits.

✔ **Discussions about the Plaintiff's military background**, previously mentioned in **February 2023**, were repeatedly raised without relevance.

✔ The Plaintiff perceived **disrespectful and biased treatment**, though **Dr. Prill maintained a more neutral stance** and occasionally advocated for fairness.

Exhibit #92: Evaluation by Dr. Chawla, including his letter of support from the internal appeal.

Exhibit #93: Evaluations completed by Dr. Prill.

Exhibit #94: Evaluation by Dr. Bradford.

Exhibit #95: Summary of June 2023 Evaluations by attending physicians.

Documented Improvement &

Dr. Ross's Absence from the Evaluation Process

327. Throughout probation, the Plaintiff was evaluated on the following competencies:

✔ **Timeliness & attendance**

✔ **Task completion**

✔ **Patient evaluation & clinical planning**

✔ **Multitasking ability**

✔ **Accuracy in medical documentation**

✔ **Adherence to hierarchy & faculty directives**

✔ **Collegiality & teamwork**

✔ **Organizational & leadership skills**

482. **Dr. Ross, approaching her departure, was entirely removed from the evaluation process.**

Exhibit #97, #98, and #99: Peer evaluations from **Dr. Omar Merchant (PGY-2), Dr. Amanulla Siddiqui (PGY-2), and Dr. Christopher McLeod (PGY-1)**—none of whom reported concerns regarding the Plaintiff's performance.

Post-Dr. Ross's Departure:

Marked Performance Improvement

483. The **removal of Dr. Ross from the evaluation process directly correlated with improved evaluations** of the Plaintiff. This shift serves as **indisputable evidence** that previous assessments were influenced by her **bias** and undue influence over faculty.

✔ **Prior faculty assessments reflected systematic undervaluation of the Plaintiff's professional skills.**

✔ **Evaluations improved significantly after Dr. Ross was no longer involved.**

✔ **This demonstrates that prior negative evaluations were tainted by bias rather than objective performance deficiencies.**

484. **Dr. Ross's departure from the evaluation process confirms the Plaintiff was subjected to a pretextual, retaliatory probationary period rather than a fair performance assessment.**

Exhibit #95: Summary of June Evaluations – showing improvements after Dr. Ross's absence.

Failure to Provide Timely Feedback & ACGME Violations

485. **None of the Plaintiff's June evaluations were disclosed to him in real-time.** Instead, they were **withheld until after his dismissal**, in direct violation of ACGME standards requiring:

- ✔ **Transparent and timely evaluations**
- ✔ **Open feedback mechanisms to allow residents to improve**
- ✔ **Adherence to due process protections for residents on probation**

486. **Withholding evaluations further demonstrates the program's retaliatory intent and procedural noncompliance.**

Medical Student Evaluation: An Impartial Perspective

487. Medical Student **Shadi Ramirez**, who worked under the Plaintiff in June 2023, conducted an independent **360-degree evaluation** of his performance.

✔ **Her evaluation categorically refutes the program's allegations.**

✔ **As a non-faculty evaluator, her assessment provides an impartial viewpoint free from faculty influence.**

✔ **Her testimony further supports the Plaintiff's assertion that his probation was retaliatory rather than performance-based.**

Exhibit #100: Evaluation by **Medical Student Shadi Ramirez**—affirming the Plaintiff's professionalism and leadership.

Conclusion: Probation Evaluation Further Exposes Bias

& Procedural Violations

✔ **Evaluations improved significantly following Dr. Ross's removal from the process.**

✔ **No faculty or peer evaluations indicated performance deficiencies warranting termination.**

✔ **All evaluations were improperly withheld, violating ACGME transparency standards.**

✔ **Medical student feedback further refutes the program's allegations.**

488. **The evidence overwhelmingly demonstrates that the Plaintiff's probation was a retaliatory measure rather than a legitimate performance assessment, further solidifying claims of systematic mistreatment and procedural violations.**

Plaintiff's Leadership and ACGME 6 Core Competency Highlights – June 2023

Demonstration of Leadership & Professionalism in Clinical Practice

489. During his **June 2023 inpatient service rotation**, the Plaintiff consistently exhibited **leadership, professionalism, teamwork, and clinical reasoning** in managing patient care. His approach reflected a strong commitment to **educational integrity and mentorship**, particularly in guiding his intern, **Dr. Christopher McLeod (PGY-1)**, through inevitable learning errors within the medical setting.

Medication Error & Leadership Response

490. During patient rounds, **Dr. McLeod mistakenly prescribed lubricant eye drops to a diabetic foot ulcer patient** instead of the intended **sickle cell crisis patient** suffering from dry eyes. The **pharmacy delivered the incorrect medication**, prompting the patient to question the order.

✔ **Plaintiff immediately intervened**, ensuring the sickle cell patient received the correct prescription.

✔ **At the bedside, he reassured the affected patient**, presenting the situation as a **system error rather than an individual mistake**.

✔ **He upheld team integrity by not publicly attributing the error to Dr. McLeod**, reinforcing a **constructive learning approach.**

491. The Plaintiff emphasized that medical training should allow for **educational growth without punitive repercussions**. Rather than penalizing his intern, he turned the mistake into a **teaching moment**, fostering an environment where **errors are recognized as part of the learning process**.

Serious Diagnostic Test Error & Constructive Handling

492. During a morning bedside round, the Plaintiff directed **Dr. McLeod to order a Urea breath test for a patient with suspected H. Pylori infection**. However, due to an **inattention error**, Dr. McLeod **erroneously ordered a nuclear scan gastric emptying study**—an expensive and unnecessary test.

493. **Consequences:**

✔ **The patient fasted unnecessarily** and was transported for an incorrect procedure.

✔ **The hospital incurred a significant financial burden**, with the ordered test costing over **$1,000**, compared to the **$100 Urea breath test.**

494. After **Dr. McLeod admitted his mistake**, the Plaintiff escalated the issue to **Chief Resident Dr. Omar Merchant**, recognizing the **program's harsh stance on errors**.

✔ **To prevent unnecessary disciplinary action**, the Plaintiff, along with his peers, **resolved the issue internally** rather than reporting it to faculty.

✔ **He declined to submit an "anonymous negative note"** against Dr. McLeod, a retaliatory practice faculty members had previously used against him.

✔ **Instead, he reinforced constructive feedback and education**, ensuring Dr. McLeod learned from the mistake without damaging his professional record.

Handling of an Expensive Medication Prescribing Error

495. Another case involved a **44-year-old male patient with right-sided heart failure**, likely linked to **alcohol use and obstructive sleep apnea**.

✔ **Dr. McLeod prescribed Entresto® (Sacubitril-Valsartan)**—a costly CHF medication without **insurance approval or cardiology consultation**.

✔ **Entresto's retail price exceeds $896.51 per month**, making it financially unfeasible for an uninsured patient.

496. Upon pharmacy notification that **the patient could not afford Entresto**, the Plaintiff took the following corrective steps:

✔ **Reviewed alternative CHF management options.**

✔ **Counseled the patient** on lifestyle modifications as critical to treatment.

✔ **Consulted with two cardiologists**—Dr. **Dakak** and Dr. **Bulent Zaim**—to determine an appropriate alternative.

✔ **Documented the entire clinical reasoning process** in the medical record.

✔ **Switched the patient to Losartan 40mg ($7/month at Walgreens)**—a cost-effective alternative with **similar efficacy**

497. **Dr. Prill's Baseless Accusations:**

498. Despite the **rational correction of the prescribing error**, **Dr. Prill falsely accused the Plaintiff of insubordination**, **citing his failure to acknowledge a text message** regarding the CHF pathway. This **administrative protocol had no impact on the quality of patient care**, demonstrating **faculty misuse of arbitrary disciplinary claims.**

✔ **Dr. Chawla, the attending hospitalist, expressed frustration with Dr. Prill's interference**, emphasizing her **unnecessary micromanagement.**

Exhibit #95: Supporting evaluations demonstrating Plaintiff's leadership in managing patient safety.

Demonstrated Leadership &

ACGME 6 Core Competency Compliance

499. The Plaintiff's **management of clinical errors, patient safety, and interdisciplinary communication** directly aligns with the **ACGME's six core competencies:**

✔ **Patient Care:** Demonstrated by correcting medication errors, **ensuring accurate prescriptions, and facilitating cost-effective alternatives.**

✔ **Medical Knowledge:** Proper **assessment, escalation, and correction** of errors in real time, **consulting specialists when appropriate.**

✔ **Professionalism:** Maintained **composure, integrity, and mentorship**, **refraining from**

punitive actions against his intern.

✔ **Interpersonal & Communication Skills:** Effectively counseled **patients, peers, and consulting physicians** on treatment plans.

✔ **Practice-Based Learning & Improvement:** Utilized **errors as teaching moments** rather than opportunities for faculty retaliation.

✔ **Systems-Based Practice:** Advocated for **cost-effective care** while ensuring adherence to hospital and insurance guidelines.

Exhibit #100: Medical student **Shadi Ramirez's** evaluation corroborating Plaintiff's leadership and professionalism.

Termination Decision Lacks Factual Basis

& Violates Due Process

500. On **July 24, 2023**, the **interim program director, Dr. Tavakoli, issued a termination letter**, falsely alleging that the Plaintiff:

❌ **Failed to meet ACGME core competencies.**

❌ **Lacked leadership skills and professionalism.**

❌ **Did not adhere to faculty directives.**

501. **However, the record reflects the opposite:**

✔ **Every peer, attending, and medical student evaluation from June 2023 refutes these allegations.**

✔ **No documented incidents of patient safety violations, unprofessional conduct, or**

insubordination.

✔ **Plaintiff completed all probationary requirements without infractions.**

502. The Plaintiff formally requested **clarification and supporting evidence** for the program's allegations—yet none were provided.

Exhibit #122 & #123: Contradictory faculty memos from May 30, 2023, revealing **Dr. Ross's influence in modifying Plaintiff's evaluations** before her departure.

Conclusion: Plaintiff's Leadership Was Unfairly Undermined

✔ **Faculty deliberately mischaracterized his leadership and professional conduct.**

✔ **He effectively led his intern and medical students, mitigating patient safety risks.**

✔ **ACGME core competencies were objectively met, contradicting termination claims.**

✔ **The program violated due process by failing to substantiate claims of noncompliance.**

503. **The Plaintiff's termination was arbitrary, retaliatory, and unsupported by factual evidence.**

Night Call - June 26-27, 2023

Plaintiff's Vigilance and Clinical Expertise

Overview of Night Call Duties

504. On the night of **June 26, 2023**, transitioning into **June 27, 2023**, the Plaintiff assumed **night call duties covering both adult and nursery services** following sign-out from **Dr. Omar Merchant (PGY-2)**. The Plaintiff's shift spanned **8:30 PM to 6:30 AM**, during which he meticulously documented all **significant clinical events, patient management decisions, and interventions**, adhering to professional standards of **accountability and accuracy in medical documentation**.

Adult Service Cases

Case #1: Preventing Unnecessary Heparin Drip & Correcting Cardiac Monitor Error

505. A **68-year-old male patient** (identified by MRN, per HIPAA policy) with a history of **Coronary Artery Disease (CAD), prior open-heart surgery, and recent left heart catheterization (6/26/23)** was **signed out to receive a heparin drip** per **Dr. Merchant's handover**.

506. **Key Clinical Findings & Intervention:**

✔ **Review of orders & cardiology notes revealed no active heparin drip orders.**

✔ **Day resident confirmed incorrect sign-out after Plaintiff sought clarification.**

✔ **On-call cardiologist confirmed heparin drip was NOT required.**

507. **In a separate issue, the patient's cardiac monitor displayed a pacemaker rhythm**, but the patient denied having a pacemaker. **Upon physical examination, no pacemaker was found.**

✔ **Nursing staff discovered an MRN input error**, linking the monitor to another patient.

✔ **Plaintiff stayed at the bedside until the monitor error was corrected, ensuring patient safety.**

508. **Key Takeaway: Plaintiff's diligence prevented an unnecessary heparin drip and corrected a critical monitoring error, demonstrating clinical vigilance, independent decision-making, and leadership in patient safety.**

Case #2: Preventing Mismanagement of a 93-Year-Old Patient with Atrial Fibrillation & Hemodynamic Instability

509. A **93-year-old cachectic female patient** presented with **atrial fibrillation with rapid ventricular response (RVR), altered mental status, and possible stroke**. The **handover incorrectly recommended IV fluid boluses for hypotension.**

510. **Key Clinical Findings & Intervention:**

✔ **Plaintiff identified a BP cuff size error leading to falsely low BP readings.**

✔ **Correcting the cuff size revealed normal mean arterial pressure (MAP), preventing unnecessary fluid boluses.**

✔ **Day team had administered fluid boluses all day based on false BP readings.**

511. Later in the night, the patient's **heart rate spiked to 224 BPM**, prompting an urgent bedside **ICU consult with Dr. Ghandi, MD**.

✔ **Plaintiff recommended IV metoprolol, which the attending approved.**

✔ **Heart rate reduced from 221 to 81 BPM within one hour, avoiding cardioversion.**

✔ **Meticulous documentation ensured a clear medical record of events.**

512. **Key Takeaway: Plaintiff's intervention prevented both unnecessary fluid administration and escalated cardiac treatment, demonstrating strong clinical reasoning, patient advocacy, and leadership.**

Case #3: Managing a Drug-Seeking Patient & Preventing an AMA Discharge

513. A **22-year-old female patient** with a history of **alcohol use, endometriosis, anemia, and asthma** was admitted for **abdominal pain after excessive alcohol consumption and cannabis use.**

514. **Key Clinical Findings & Intervention:**

✔ **Handover noted frequent morphine requests, raising suspicion of drug-seeking behavior.**

✔ **At midnight, the patient threatened to leave AMA unless given morphine.**

✔ **Plaintiff persuaded her to stay, offering IM Ativan for anxiety instead.**

✔ **Coordinated with the ED charge nurse to ensure proper nursing assignment.**

✔ **Ultimately, the patient agreed to stay, allowing further evaluation by the day team.**

515. **Key Takeaway: Plaintiff successfully de-escalated a high-risk AMA discharge scenario through negotiation and patient-centered care, directly contradicting allegations of poor leadership skills.**

Case #4: Preventing Hypoglycemia in a 95-Year-Old TIA Patient

516. A **95-year-old female patient** with **a history of CHF, diabetes, and CKD stage III** was admitted for **suspected Transient Ischemic Attack (TIA)**.

517. **Key Clinical Findings & Intervention:**

✔ Nurse requested 10 units of insulin glargine per family's report.

✔ Plaintiff reviewed the chart and noted NO recorded blood glucose readings in the past 12 hours.

✔ Ordered POC glucose check before administration—level was 208 mg/dL.

✔ Instead of blindly following the 10-unit request, Plaintiff started a sliding-scale insulin regimen.

✔ Only 1 unit of insulin was necessary, avoiding a dangerous hypoglycemic episode.

518. **Key Takeaway: Plaintiff prevented potential insulin-induced hypoglycemia in a frail geriatric patient, demonstrating sound clinical judgment, independent decision-making, and adherence to patient safety protocols.**

Refuting Baseless Allegations Against Plaintiff's Leadership

519. The clinical cases above demonstrate that Plaintiff exhibited:

- ✔ **Superior leadership in patient safety and clinical oversight.**
- ✔ **Competency in decision-making under pressure.**
- ✔ **Adherence to ACGME's six core competencies:**

Exhibit #95 – June Evaluations confirm that **attendings and colleagues reported no concerns** regarding Plaintiff's leadership or professionalism.

Exhibit #100 – Medical Student Evaluation corroborates Plaintiff's effectiveness as a **mentor and supervisor.**

Contradictions in Faculty Evaluations & Plaintiff's Termination

520. Despite **clear and documented evidence** of Plaintiff's **clinical competence, leadership, and professional conduct**, the termination letter issued by **Interim Program Director Dr. Tavakoli on July 24, 2023**, was neither an **independent nor an objective decision**, but rather a **preordained retaliatory action** orchestrated **in bad faith**. During the discovery phase of this litigation, on **March 6, 2025**, Dr. Tavakoli, **testifying under oath and subject to the penalties of perjury**, unequivocally admitted that the **final termination letter was personally drafted by former Program Director Dr. Stacy Ross prior to her resignation in June 2023**.

521. Dr. Tavakoli **merely served an administrative function by signing the letter**, further confirming that he exercised **no substantive discretion in Plaintiff's dismissal**. This admission underscores a **flagrant violation of due process**, as Plaintiff's termination was not based on **any legitimate or independent assessment** but rather on a **predetermined and malicious effort** to unjustly remove him from the program. The termination letter's claim that Plaintiff failed to meet **ACGME core competencies** was not only **factually baseless but also demonstrably false**, serving as a mere pretext to justify an unjust decision driven by **personal animus and institutional retaliation**.

✔ **Plaintiff formally requested evidence substantiating these claims—none was provided.**

✔ **Dr. Prill, under cross-examination, admitted Plaintiff was a dedicated, competent physician.**

522. **Transcript (11/9/23) – Dr. Prill Testimony (Page 65)**

"He has a lot of good qualities and he is a good doctor. He cares about his patients, he would go above and beyond. He would cover for his colleagues. He has a lot of good qualities."

Conclusion: Plaintiff's Termination Was Retaliatory & Unsupported by Evidence

523. **Critical Findings:**

✔ **All documented patient encounters demonstrate Plaintiff's clinical competence and adherence to ACGME standards.**

✔ **Plaintiff's evaluations from faculty and medical students consistently contradict**

faculty allegations.

✔ **Termination decision was arbitrary, retaliatory, and lacked factual support.**

Exhibit #122 & #123 – Contradictory Faculty Memos reveal **Dr. Ross's influence in fabricating negative evaluations before her departure.**

Exhibit #95 – Summary of June Evaluations further disproves claims of incompetence.

Final Argument

524. The Plaintiff's management of multiple **high-risk cases on June 26-27, 2023, demonstrates unequivocal adherence to ACGME standards, clinical competency, and leadership.**

✔ **Each case directly refutes allegations of mismanagement or incompetence.**

✔ **The Plaintiff actively protected patient safety, corrected errors, and executed independent medical decision-making.**

✔ **His unjust termination lacks any substantive legal or medical justification.**

525. **The program's failure to provide any documented evidence supporting termination raises significant legal and ethical concerns regarding due process violations.**

Nursery Night Call (June 26-27, 2023):

Plaintiff's Vigilance and Clinical Judgment

526. After completing rounds on adult patients, the Plaintiff proceeded to the **designated call rooms for Family Medicine residents on the second floor**, formerly the **observation unit**, where he could be **easily located if necessary**. The Plaintiff then worked on **office notes using Dragon dictation software**, which required **muting his phone** to optimize speech recognition. At approximately **12:30 AM**, the Plaintiff conducted a routine **nursery check-in**, confirming that **no urgent concerns required immediate intervention**. Experiencing **significant fatigue** from **two consecutive weeks of night calls**, compounded by **daytime office duties**, the Plaintiff took a brief rest. However, **due to technological failure, human error, or inadvertent oversight**, the Plaintiff **did not unmute his phone**, leading to **missed calls from Nurse Corrie Welch, RN, and Dr. Kaysin at approximately 2:00 AM** regarding a neonate's respiratory rate.

527. The Plaintiff acknowledges this **unintentional lapse** but emphasizes that it was a **result of cumulative fatigue, not negligence or irresponsibility**. The **failure to respond was not a willful disregard of duty** but an unintended consequence of **systemic overwork and exhaustion**. **The incident should be assessed fairly, with full recognition of the documented effects of sleep deprivation on physicians.**

528. **New Evidence from Discovery (March 3 & 6, 2025 Depositions):**

✔ Nurse Welch, **testifying under oath and subject to the penalties of perjury**, unequivocally stated that she **never requested security personnel to locate Plaintiff**, directly contradicting the program's **false assertion** that Plaintiff was "unreachable for hours" or that "no one could locate him in the hospital."

✔ **No overhead pages were requested**, refuting the claim in the **June 27, 2023, termination memorandum** that such pages were issued.

✔ **Nurse Welch only contacted Dr. Kaysin once (around 2:00 AM)** regarding the neonate's respiratory rate.

✔ **Dr. Kaysin did not contact the NICU attending, Dr. Daniel Brewer, nor did he check on the patient at any time during the night.**

✔ **No faculty member—including Dr. Ross, Dr. Prill, or Dr. Tavakoli—ever contacted Nurse Welch for direct information before making termination decisions.**

Medical & Scientific Context of Sleep Deprivation in Physicians

529. **Acute sleep deprivation severely impairs physician alertness, cognition, and decision-making.** Studies, including research by **Siraj O. Wali et al.**, published in the **National Library of Medicine**, confirm that **87% of post-call physicians experience decreased alertness and an increased risk of cognitive lapses,** *see Wali et al.,* "Effect of on-call-related sleep deprivation on physicians' mood and alertness," NCBI[6]

530. **Legal Precedent Supporting the Plaintiff's Position:**

✔ The **United States Supreme Court has explicitly recognized that medical residents are not mere students but skilled professionals who work long hours and face significant employment demands.** In **Mayo Foundation for Medical Education & Research v. United States, 562 U.S. 44, 60 (2011)**, the Court rejected the notion that residents are still in training and not part of the workforce, finding instead that they are **"highly skilled professionals" who "typically share some or all of the terms of employment of career employees."** This precedent was reaffirmed in **Khoiny v. Dignity Health, 76 Cal.App.5th**

[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC3573553/

390, 400 (Cal. Ct. App. 2022), where the California Court of Appeal further recognized the **labor-intensive nature of residency, the long hours, and the extensive responsibilities borne by resident physicians**.

✔ **The Plaintiff's inability to wake up immediately was an expected physiological response, not an act of negligence.**

Additional Supporting Evidence:

✔ **The Plaintiff was granted only four weeks of vacation instead of six, exacerbating his chronic exhaustion.**

See Exhibit #125 – Vacation Record (Documenting Plaintiff's Reduced Leave).

Institutional Failures in Backup Coverage

& Fatigue Mitigation

531. **GME Policy 102 – Graduate Medical Education Standards at UMCRH mandates:**

✔ **Reasonable and non-excessive resident work hours.**

✔ **Guaranteed adequate supervision.**

✔ **Sufficient backup support.**

✔ **Backup Resident System Failed:** The **legitimate backup system was in place**—as confirmed under oath by **Dr. Tavakoli on March 6, 2025**—yet it **was deliberately not used by faculty** to cover for the Plaintiff.

532. It is important to note that **GME Policy 116 on Fatigue Mitigation and Wellness** explicitly states that it is **the program's responsibility** to **encourage and facilitate fatigue mitigation measures**, such as **strategic napping or turnover of care via backup schedules**, to prevent potential **negative consequences on patient care and learning**. The policy itself mandates that **during night calls, residents should remain in the designated call room and sleep** as part of standard fatigue management. This was not only **common practice** but was followed by **all residents and attending physicians throughout the residency program**, including Plaintiff's peers. The issue at hand was merely one of **communication and phone accessibility**, not a case of **negligence**, nor did it involve **leaving the hospital while on call**. Moreover, this was **an isolated instance**, not a pattern of conduct, as Plaintiff successfully completed **hundreds of night calls** without any prior incidents of inaccessibility.

533. Notably, during **cross-examination on September 27, 2023**, **University of Maryland Capital Region Health NICU Attending Physician, Dr. Daniel Brewer**, provided an example where he was **temporarily unreachable due to a phone update during a night shift**, yet **staff simply contacted hospital security**, who promptly located him in the designated call room. If **Nurse Welch, RN, or Dr. Kaysin, the attending physician, had exercised due diligence** by following this **established protocol** and notifying hospital security, Plaintiff **could have easily been found in his designated call room** without any unjustified escalation or mischaracterization of events. The program's attempt to frame this incident as misconduct is **not only inconsistent with institutional policy and established practice but further underscores the retaliatory nature of the claims against Plaintiff**.

See Exhibit #106 – GME Policy 116 (Fatigue Mitigation & Wellness).

Negligence by Faculty:

Systemic Breakdown, Not Plaintiff's Failure

534.If a primary resident is unreachable, the backup protocol mandates:

✔ **The second-call resident (Dr. Omar Merchant) must step in.**

✔ **The on-call attending (Dr. Kaysin) must assess the patient.**

Critical Discovery Findings:

✔ **Dr. Kaysin was informed at 2:00 AM but chose not to check on the neonate or call Dr. Brewer.**

✔ **Nurse Welch, RN, under oath, testified that had she seen clinical signs of deterioration, she would have closely monitored the neonate—but she did not.**

See Exhibit #109 – NICU Attending Dr. Brewer's Written Testimony Confirming Non-Emergent Status.

Plaintiff's Immediate Response & Clinical Judgment

535.Upon awakening at **4:45 AM**, the Plaintiff **immediately contacted Nurse Welch**, who assuredhim, **"Everything is fine; the neonatologist saw the patient; we are just monitoring."**

✔ **Plaintiff promptly reported to the nursery by 5:00 AM.**

✔ **Performed a thorough neonatal examination.**

✔ Observed mild tachypnea and subcostal retractions, indicating the need for NICU monitoring.

✔ Contacted Dr. Brewer at 5:33 AM, confirming NICU transfer.

See Exhibit #108 – NICU Transfer Note (Documenting Plaintiff's Medical Assessment).

False Allegations & Fabricated Narrative

in the June 27, 2023, Termination Memorandum

536. **On June 27, 2023, a WebEx meeting was convened by Dr. Ross, Dr. Prill, and Dr. Kaysin.**

New Discovery Evidence Contradicting Their Allegations:

✔ No overhead pages were made (contradicting the termination memorandum).

✔ No faculty member verified the facts with Nurse Welch before writing the report.

✔ Dr. Brewer was never contacted by faculty before they issued their termination decision.

See Exhibit #110 – Dr. Brewer's Testimony Debunking False Claims.

Retaliatory Intent: Faculty's Misuse of Incident to Justify Termination

537. The **June 27, 2023, Probation Review Letter** contained **deliberately false and misleading claims**, crafted **in bad faith** to justify the Plaintiff's termination. The faculty's **retaliatory intent** is evident in the following **fabrications:**

✔ **False Claim:** *"No one could locate the Plaintiff."*

✔ **Fact:** The Plaintiff was **asleep in the designated call room for family medicine residents** due to fatigue from consecutive night shifts. His **temporary unavailability was not due to negligence.**

✔ **Fact:** No **overhead pages** were made to locate the Plaintiff—**both Nurse Welch and Dr. Brewer confirmed this fact.**

✔ **Fact:** Security personnel were never contacted for assistance in locating the Plaintiff.

✔ **False Claim:** *"Dr. Kaysin reached out to Dr. Brewer about the neonate."*

✔ **Fact: Dr. Kaysin never contacted Dr. Brewer** regarding the neonate's condition, despite being the on-call attending. **This fabricated statement was likely drafted by Dr. Ross in bad faith and malice.**

✔ **False Claim:** *"Multiple neonates were left unattended."*

✔ **Fact:** Nurse Welch, **who was assigned to postpartum, not the NICU,** confirmed she never covered multiple neonates. **This assertion was entirely false.**

✔ **False Claim:** *"Faculty conducted an investigation before termination."*

✔ **Fact:** None of the decision-makers—**Dr. Ross, Dr. Prill, Dr. Kaysin, or Dr. Tavakoli**—spoke with **Nurse Welch or Dr. Brewer before drafting the termination letter.**

See Exhibit #114 – Probation Review Letter Signed by Dr. Ross & Dr. Prill, confirming the falsified allegations.

538. **The termination decision was not based on clinical judgment but was a pretext for retaliation, deliberately misrepresenting facts to remove the Plaintiff from the program.**

Conclusion: Retaliation, Not Legitimate Probation Review

539. **Critical Findings from Discovery Depositions:**

✔ Dr. Tavakoli admitted that a backup call system existed, yet faculty chose not to use it.

✔ Dr. Kaysin and Dr. Merchant, despite being reached, failed to assess the neonate.

✔ No rapid response was called, no incident report was filed, and no parental grievance was submitted.

✔ The Plaintiff was targeted over a single, non-emergent incident—while faculty who made conscious choices not to respond faced no scrutiny.

540. **Final Argument:**

✔ Plaintiff's clinical response was sound, timely, and well-documented.

✔ The probation review was a pretext for wrongful termination, executed in bad faith.

✔ Faculty, particularly Dr. Ross, fabricated allegations to push for Plaintiff's removal before her departure.

✔ GME & ACGME policies were systematically violated to justify a retaliatory dismissal.

June 27, 2023: Faculty Review and False Statements

541. On **June 27, 2023, at 4:00 PM**, a WebEx meeting was convened with **Dr. Ross, Dr. Prill, and Dr. Kaysin.** The Plaintiff, having rested at home, was preparing to return for his scheduled night shift at 6:30 PM. This meeting, expected to serve as the final probationary review, **failed to**

address the Plaintiff's overall performance during the probation period. Instead, it **immediately fixated on the previous night's nursery incident.**

542. The Plaintiff **provided a detailed, fact-based account** of the events, acknowledging the situation as a **result of human error induced by excessive fatigue from consecutive night shifts.** He **outlined the extensive measures he took** to ensure proper adult and nursery patient care. However, **Dr. Ross dismissed the Plaintiff's explanations, branding them as a lack of insight.** Her **rigid preconceptions and documented bias** against the Plaintiff rendered any discussion **a mere formality, rather than a genuine evaluation of facts.**

Please refer to Exhibit #112: Email from Dr. Ross to the Plaintiff, time-stamped and received.

543. **The decision to remove the Plaintiff from his night call duties had been premeditated by Dr. Ross before the meeting even took place.** Earlier that day, Dr. Ross **unilaterally arranged coverage for the Plaintiff's shift, effectively sidelining him without allowing him to be heard.**

544. On the same day, **Dr. Ross, Dr. Prill, and Dr. Kaysin drafted the June 27, 2023, Probation Review Letter**, falsely stating that **Drs. Ibe, Bradford, and Pruitt** participated in the decision. **Contrary to these claims, none of these faculty members were present in the meeting.** Dr. Ross's **habitual inclusion of multiple faculty names in official documents served to fabricate the illusion of a collective decision, when in reality, these discussions occurred within an exclusive, narrow circle.**

Please refer to Exhibit #114: Probation Review for the Plaintiff, signed only by the former program director and former associate program director.

545. By **June 27, 2023, Dr. Ross's tenure as program director was effectively over.** Her **clinical duties had ended on May 31, 2023**, and **she was set to conclude her administrative role by mid-June 2023.** Nevertheless, she remained **determined to orchestrate the Plaintiff's termination before her departure, prioritizing personal retaliation over procedural integrity.**

546. **Clear Evidence of Bias & Misconduct:**

- ✔ **Dr. Ross ignored due process.**
- ✔ **She disregarded procedural fairness and neutrality.**
- ✔ **She fabricated and distorted events to justify termination.**

547. Her actions were **arbitrary, capricious, and a clear abuse of authority.**

548. The **June 27, 2023, Probation Review Letter** contained **deliberately false statements** regarding the nursery incident. It **wrongly alleged** that:

> "...his phone was silenced, he did not hear overhead pages, nor had he reserved a call room per the hospital guidelines so no one could find where he was. This resulted in his unavailability for several

hours when an inpatient newborn had become unstable. The attending, despite numerous attempts to locate him, was compelled to request the neonatologist's intervention, leading to the newborn being closely observed and eventually transferred to the special care nursery."

549. **False Allegations Debunked by Discovery Evidence:**

1. **Overhead pages never occurred.**

   ✔ On **March 3, 2025, during sworn testimony in discovery, Nurse Corrie Welch, RN, confirmed she never initiated any overhead pages, contradicting the faculty's claim.**

2. **Security was never contacted to locate the Plaintiff.**

   ✔ **Nurse Welch testified under oath that she never requested hospital security to search for the Plaintiff.**

3. **The attending physician (Dr. Kaysin) never escalated the case.**

   ✔ Nurse Welch testified that she **only called Dr. Kaysin once around 2:00 AM.**

   ✔ **Dr. Kaysin merely instructed continued monitoring—he never followed up, never contacted the NICU attending (Dr. Daniel Brewer, DNP), and never made an effort to assess the neonate himself.**

   ✔ **Contrary to faculty claims, Dr. Kaysin only spoke with Nurse Welch in person at the end of the shift—long after the matter was resolved.**

4. **There were no multiple unattended neonates.**

   ✔ **Nurse Welch confirmed she was assigned to the postpartum nursery only, not the NICU, refuting the claim that multiple neonates were neglected.**

5. **No formal patient safety concerns or malpractice reports exist.**

   ✔ No **grievance letter from parents.**

   ✔ No **malpractice complaint.**

   ✔ No **"near miss" report filed.**

   ✔ No **incident report submitted by nursing or faculty.**

Please refer to Exhibit #110: Additional Letter of Support from NICU Attending Dr. Daniel Brewer, DNP, disproving these faculty allegations.

550. **Faculty Members Failed to Verify Facts Before Termination Decision:**

✔ Drs. Ross, Prill, Kaysin, and Tavakoli never sought testimony from Nurse Welch before issuing their termination letter.

✔ Drs. Ross, Prill, and Kaysin never spoke to NICU attending Dr. Brewer.

✔ Dr. Tavakoli testified under oath on March 6, 2025, that he never consulted Nurse Welch or Dr. Brewer.

✔ The program's reliance on a single, non-verified incident as the basis for termination demonstrates clear pretext and bad faith.

551. **Major Institutional Failure in Backup Coverage:**

✔ The Plaintiff, **exhausted from consecutive night shifts**, was temporarily unreachable due to his phone settings.

✔ The designated second backup resident, Dr. Omar Merchant, PGY-2, was successfully reached—but did not escalate concerns or report to the nursery.

✔ Dr. Kaysin, the on-call attending, deliberately chose not to attend to the patient.

552. **March 6, 2025: In sworn testimony, Dr. Tavakoli admitted that a backup call system existed, proving the institution's failure to follow its own policy.**

553. **Critical Question for Reasonable Minds:**

Who bears greater responsibility—**the Plaintiff, who was temporarily unavailable due to exhaustion, or the backup resident and attending physician, who were available but made a conscious decision not to report to the bedside?**

554. **Dr. Kaysin Engaged in Retaliatory, Unprofessional Conduct**

✔ After failing to respond in real time, Dr. Kaysin left an anonymous, negative "innovation note" against the Plaintiff, instead of addressing concerns directly.

✔ This conduct violates GME Policy 122 (Professionalism), which mandates transparent, constructive feedback.

✔ Rather than fostering communication, faculty members resorted to "stabbing from the back" through anonymous, inaccurate statements.

Please refer to Exhibit #105: Anonymous Negative Note Left by Dr. Kaysin.

Please refer to Exhibit #107: Nursery Night Events from the Plaintiff's Perspective.

555. **Final Evidence of Fabrication in Faculty Documentation**

✔ Dr. Ross falsely claimed in the June 27, 2023, Probation Review Letter that the Plaintiff arrived "after the transfer process was already initiated."

✔ Dr. Brewer's testimony and the NICU transfer records confirm that the Plaintiff

conducted a full assessment, documented clinical findings, and independently determined the need for NICU transfer.

✔ The Plaintiff's actions were in strict adherence to ACGME core competencies—contrary to false faculty allegations.

Please refer to Exhibit #108: NICU Transfer Note, authored by the Plaintiff, confirming his leadership in the case.

Please refer to Exhibit #109: Dr. Brewer's Written Testimony, affirming Plaintiff's medical judgment.

Conclusion:

556. The June 27, 2023, termination recommendation **was not a legitimate clinical judgment but a clear act of retaliation, executed in bad faith,** and **unsupported by evidence.**

557. All reasonable minds must conclude: **this was an orchestrated, improper, and illegal termination.**

July, 2023

Rejected Opportunity to Cure &

Dr. Ross's Continued Unprofessional Conduct

558. Following the **Web Ex meeting and the Plaintiff's exclusion from night call responsibilities**, he sought to understand the **faculty's rationale** behind their decision. On **July 28, 2023**, the

Plaintiff drafted a **detailed recounting of the night call events**, documenting both adult cases and the **nursery event in question**. However, **the Probation Review Letter had already been drafted on July 27, 2023**, indicating a **preconceived and retaliatory decision** by Dr. Ross, made **without considering the Plaintiff's full explanation**. Additionally, **Dr. Brewer (NICU attending) confirmed that no faculty members consulted neonatology regarding the incident**, further demonstrating the **lack of due process or a legitimate investigative effort.**

See Exhibit #113 – Full Explanation of Night Call Events by the Plaintiff (July 28, 2023).

559. It is significant that **by June 30, 2023, just three days after the incident, the neonate was safely discharged home** and is now presumably a **healthy 20-month-old toddler**. Transfers **between NICU/MICU and other hospital units are standard practice** in medical settings, reflecting routine patient management **based on clinical needs, not an adverse event**. Importantly, this transfer was conducted **without any formal incident report, rapid response activation, or blue code emergency.** The Plaintiff's **thorough and timely evaluation of the neonate ensured that no emergency intervention was required.**

560. Despite these **clear facts**, the **termination letter misrepresented the incident as a "dramatic professional failure,"** demonstrating a **flagrant mischaracterization** of events, **devoid of fairness, accuracy, or justice.**

Faculty's Concealment of Termination Decision

561. On **June 29, 2023,** the Plaintiff raised concerns about this **deliberate mischaracterization** to his faculty advisor, **Dr. Prill**. At that time, **Dr. Prill admitted to reading the Plaintiff's written account** (July 28, 2023) but **acknowledged that she was not informed of any decision regarding the Plaintiff's termination—again exposing the faculty's continued concealment of critical information.** Dr. Prill merely stated that any decision **about the Plaintiff's reinstatement to regular duties rested with the program director and the DIO.**

562. When discussing **nursery backup coverage, Dr. Prill confirmed** that **if both the first and second backup calls failed, the attending physician was responsible for bedside patient care.** Acknowledging the **importance of patient safety**, she **personally stated that she would have gone to the bedside under similar circumstances**, a stark contrast to **Dr. Kaysin's failure to do so**. Several **senior faculty members similarly criticized Dr. Kaysin for his negligence** in failing to respond, reinforcing the Plaintiff's argument that **his probationary status was selectively enforced while the attending physician's responsibilities were disregarded.**

Denial of Opportunity to Cure & Dr. Ross's Personal Malice

563. After **Dr. Prill declined the Plaintiff's request to resume night call duties** (a procedural safeguard often termed as an **"opportunity to cure" in academic and legal settings**), the Plaintiff directly **approached Dr. Kaysin on June 30, 2023**. During a **phone conversation**, Dr. Kaysin **deflected responsibility**, stating that **only Dr. Ross had the authority to reinstate night shifts**, despite **her official departure as program director.**

564. Seeking a **fair resolution**, the Plaintiff **contacted Dr. Ross directly multiple times**, acknowledging **his fatigue-related lapse** and requesting an opportunity to **demonstrate his continued commitment to the program**. **Dr. Ross refused outright, without offering any professional justification.** Instead, she **expressed personal malice, telling the Plaintiff, 'You must suffer.'**

See Exhibit #116 – Dr. Ross's Personal Animosity Towards the Plaintiff: 'You Must Suffer'.

Dr. Ross's Pattern of Unprofessional

& Retaliatory Conduct

565. Throughout the Plaintiff's residency, **Dr. Ross repeatedly demonstrated unprofessionalism, retaliatory intent, and a blatant disregard for GME Policy 122 on Professionalism.** Her **pattern of misconduct** included:

✔ **Frequent verbal and written misrepresentations** of the Plaintiff's performance.

✔ **Consistently bypassing institutional safeguards** meant to ensure fair evaluations.

✔ **Drafting faculty memos with pretextual allegations** to justify termination without due process.

566. Notably, her conduct **violated contractual obligations** under the Plaintiff's **legally enforceable GME agreement**, reinforcing the **bad faith** behind the Plaintiff's dismissal.

See Exhibit #101 – GME Policy 122 UMCRH: General Policy on Professionalism.

567. **Conclusion:** The faculty, led by Dr. Ross, had predetermined the Plaintiff's termination and deliberately ignored exculpatory evidence, denying him both due process and an opportunity to remediate. Dr. Ross's refusal to consider his request for reinstatement further proves her intent was **not to ensure patient safety or professional competency, but to retaliate against the Plaintiff in bad faith.**

Arbitrary and Capricious:

Retaliatory Termination in Violation of Due Process

Definition and Legal Standard

568. In legal terms, **"arbitrary and capricious"** is a **standard of judicial review** used by courts to assess **whether an administrative agency's decision was based on careful consideration of the facts and a rational connection between the findings and the final decision**. A decision is deemed **arbitrary and capricious** when it:

✔ **Lacks a Rational Basis:** The decision is not supported by reason, logic, or an objective understanding of the situation.

✔ **Is Made in Bad Faith:** The decision is made with **dishonest intent or retaliatory motives** rather than legitimate concerns.

✔ **Constitutes Disparate Treatment:** It subjects a person to different treatment **without a legitimate reason**, especially when others in **identical circumstances** were not disciplined.

✔ **Is Based on Unlawful Discrimination:** The decision is influenced by **bias**, whether personal, professional, or institutional, in violation of due process.

✔ **Is Unreasonably Disproportionate:** The **severity of the punishment exceeds** the gravity

of the alleged infraction.

✔ **Lacks Factual Support:** No credible evidence supports the allegations, or the findings **omit exculpatory evidence** that would exonerate the accused.

✔ **Fails to Consider Important Aspects of the Issue:** The decision **overlooks key facts** that should have been carefully evaluated before issuing a final determination.

569. **Legal Precedent:** The **Accreditation Council for Graduate Medical Education (ACGME)** mandates that disciplinary actions against residents **must be reasonable, fair, and non-retaliatory**. Any decision to suspend, terminate, or discipline a resident **must be supported by clear evidence**, ensuring **objectivity and adherence to due process protections.**

570. The **arbitrary and capricious standard** prevents **unjustified, retaliatory, or reckless decision-making**, ensuring that **graduate medical education programs adhere to fairness, legality, and institutional accountability.** The actions taken against the **Plaintiff starkly violate these principles**, as demonstrated below.

GME Policy 103 UMCRH – Due Process Violations

571. The **University of Maryland Capital Region Health (UMCRH)** General Policy on **Due Process and Corrective/Discipline Actions** outlines **several mandatory considerations** when determining whether a resident should be disciplined or terminated. The program **failed to follow its own policies**, as demonstrated below:

1. **Severity & Frequency of the Alleged Offense:**

   Fact: The **nursery incident was a first-time event**, caused by **fatigue, not negligence or malice**.

   Violation: The termination was **grossly disproportionate** to the alleged failure, violating due process.

2. **Assessment of Individual Incidents:**

   Fact: The **Plaintiff has never previously failed to answer a night call**. This was an **isolated event**.

   Violation: The decision disregarded **past performance** and **favorable evaluations** from multiple attending physicians.

3. **History of Corrective Actions:**

   Fact: The **Plaintiff had no prior disciplinary actions for unresponsiveness**.

   Violation: The faculty **skipped progressive discipline** and **went straight to termination**, a violation of **ACGME disciplinary guidelines**.

See Exhibit #111 – GME Policy 103 UMCRH on Corrective/Disciplinary Process.

Failure to Follow Probation Terms &

Fabrication of Justification for Termination

572. The **faculty memorandum dated May 30, 2023**, explicitly delineated the terms of Plaintiff's probation, stating that termination would be warranted **only** if Plaintiff failed to meet the established improvement criteria. However, **evaluations conducted in June 2023** confirmed that Plaintiff had fully satisfied the **required and agreed-upon probationary conditions**.

Despite this, Plaintiff was still **subjected to termination,** underscoring the **arbitrary and capricious** nature of Defendant's decision. This sequence of events further evidences that the termination was not based **on merit** or **compliance with probationary terms,** but rather on **pretextual and unjustified grounds**.

See Exhibit #95 – June 2023 Evaluations from Multiple Attendings Confirming Satisfactory Performance.

Retaliatory & Malicious Termination

573. The **Plaintiff's termination was based not on performance issues, but on personal bias and retaliation** by Dr. Ross, who sought to **expel him before her departure**. This is evidenced by:

✔ **Fabrication of Overhead Pages:** Nurse Welch **confirmed that no overhead pages were made, contradicting the June 27, 2023 Probation Review Letter.**

✔ **Failure to Contact NICU Attending: Dr. Kaysin never contacted Dr. Daniel Brewer** before the Plaintiff's termination.

✔ **False Claim of Multiple Unattended Neonates:** Nurse Welch **only covered postpartum, not NICU, refuting this allegation.**

See Exhibit #114 – Probation Review Letter Signed by Dr. Ross & Dr. Prill.

Legal Precedent: Academic Due Process Violations

574. In *Board of Curators of the University of Missouri v. Horowitz*, **435 U.S. 78 (1978),** the Supreme Court held that **academic dismissals require:**

✔ **(1) Notice of Performance Issues.**

✔ **(2) An Opportunity to Cure.**

✔ **(3) A Fair and Reasonable Decision-Making Process.**

1. **Citation:** *Missouri v. Horowitz*, **435 U.S. 78 (1978)**

   ACGME Legal Issues Guide

575. **The Plaintiff was denied an opportunity to cure** and was instead met with **retaliatory personal hostility** from Dr. Ross, who told him, **"You must suffer."** This represents a **gross abuse of power** and **malicious intent** in terminating the Plaintiff.

See Exhibit #116 – Dr. Ross's Malicious Statement to the Plaintiff: 'You Must Suffer'.

Final Conclusion: The Termination Was Arbitrary, Capricious, and Unlawful

576. The program's **failure to follow due process, refusal to allow remediation, and reliance on demonstrably false justifications** render the Plaintiff's termination **arbitrary and capricious**. These actions **violated multiple GME policies, ACGME requirements, and Supreme Court precedent** protecting academic due process.

See Exhibit #126 – Summary of Procedural Deficiencies and Violated GME Policies.

577. **The termination was not a lawful academic decision—it was a pretextual, bad-faith act of retaliation, executed in violation of ACGME standards, legal precedent, and the Plaintiff's contractual rights.**

Final Communications with

GME Office and Human Resources

578. Around **July 14, 2023**, the Plaintiff reached out to **Mr. Hunter Tyrece**, the then **GME Director**, expressing concerns regarding **obstruction of outpatient office hours**, which raised suspicions about **deliberate efforts to marginalize him** within the residency program. Mr. Tyrece responded via text, stating, **"Let me check, and I will get back to you."** However, **no follow-up was ever provided**, and the Plaintiff was left without clarification. This **lack of response from the GME leadership** is particularly significant, as it underscores a pattern of **systematic institutional neglect** and refusal to **engage in meaningful discussions to address the Plaintiff's concerns**.

Ignored Requests for Transparency

579. Around the same period in **July 2023**, the Plaintiff attempted to obtain access to his **resident file documents** by formally emailing **Program Coordinator Mr. June Taylor** to request permission for an inspection. Despite the **legitimate basis** for this request, **no response was received**, reinforcing the Plaintiff's perception that **key information regarding his status was being withheld**.

580. During this same time, the Plaintiff also made **multiple attempts** to communicate with **Dr. Nader Tavakoli**, who had recently assumed the position of **Interim Program Director**, in an effort to clarify **the reasons for his exclusion from clinical duties** and obtain **an explanation for the secrecy surrounding his status**. However, **Dr. Tavakoli repeatedly deflected responsibility**, **referring the Plaintiff to the GME office**, and **avoided direct discussions**. While he acknowledged that **the actions taken against the Plaintiff had been initiated before his tenure**, he **failed to provide any assurances** that he would rectify the matter or review it independently. This evasive behavior further **demonstrates the lack of transparency and procedural fairness** in handling the Plaintiff's case.

Plaintiff's Outreach to Human Resources

581. In light of the **GME office's failure to provide clarity**, the Plaintiff **directly contacted Mr. Benjamin Carter**, **Human Resources Director at UMCRH**, on **July 15, 2023**, seeking an **impartial review** of his situation. In response, Mr. Carter **expressed a willingness to discuss the issues** and scheduled a **phone conversation that lasted approximately two hours**. During this conversation, the Plaintiff **provided a detailed account** of the unfair treatment he had experienced within the program.

582. Mr. Carter **acknowledged the severity** of the Plaintiff's concerns, **took notes**, and assured the Plaintiff that he would **carefully consider the information** and the **request for "fundamental justice."** His response suggested a level of **understanding** and indicated **potential steps toward resolving the issue**.

The Formal Grievance Letter

583. Following the conversation with Mr. Carter, the Plaintiff **submitted a comprehensive 10-page grievance letter** on **July 19, 2023**, formally detailing his **concerns about due process violations, program misconduct, and retaliatory actions against him**. This document was sent to:

- ✔ **Mr. Benjamin Carter (HR Director)**
- ✔ **Dr. Nader Tavakoli (Interim Program Director)**
- ✔ **Dr. Archinard (Designated Institutional Officer - DIO)**

Exhibit #117: Letter Written to HR Director, CC-ed to Dr. Tavakoli and Dr. Archinard

584. In the letter, the Plaintiff explicitly **requested that all decisions related to his status be made in accordance with academic due process**. He urged the institution to **avoid inconsistent disciplinary actions** and **conduct a fair and objective evaluation**.

Systematic Institutional Neglect & Due Process Violations

585. **Despite the formal submission of the grievance letter, the Plaintiff received no response from any of the officials.** His **entitlement to due process under his contract was blatantly disregarded**.

✔ **Human Resources Director Mr. Benjamin Carter failed to follow up on his assurances.**

✔ **Dr. Archinard, as DIO, failed to intervene or ensure a fair review process.**

✔ **GME leadership took no steps to meaningfully investigate the Plaintiff's concerns.**

586. By proceeding with **termination without addressing the Plaintiff's request for due process**, **institutional officials engaged in willful neglect**, further **demonstrating that the decision to terminate was premeditated, retaliatory, and conducted in bad faith.**

Attempt to Meet with Designated Institutional Officer

587. Around the same time, the Plaintiff attempted to **schedule an in-person meeting with Dr. Archinard, the DIO**. A secretary **set the appointment for July 28, 2023**, due to **Dr. Archinard's full schedule**, indicating that no earlier availability was possible.

588. However, **this meeting never took place** because the Plaintiff was **suddenly terminated on July 24, 2023**, **four days before the scheduled discussion.** The **timing of the termination** effectively **deprived the Plaintiff of an opportunity to present his case to the highest institutional authority**—a further **violation of due process and fair institutional practices.**

Final Private Conversation with Dr. Kaysin

589. On **July 21, 2023**, before departing from **New Carrollton**, the Plaintiff engaged in **a private lunch discussion with Dr. Kaysin**, seeking insight into the faculty's internal conflicts. The conversation began **cordially**, with discussions about the Plaintiff's **pregnant wife and children**, before shifting to **the Plaintiff's precarious standing within the program**.

✔ **Dr. Kaysin suggested that faculty members "cared about the Plaintiff,"** but his words lacked any substantive assurance.

✔ **He revealed that faculty disputes were ongoing**, mentioning that he had recently filed a **formal complaint against Dr. Prill**, which had been submitted to **Dr. Archinard, the DIO**.

✔ **He confirmed the presence of internal faculty power struggles**, including **Dr. Prill's repeated overreach and interference in decision-making**.

590. The Plaintiff **expressed gratitude** for the conversation, though he remained **deeply anxious about the upcoming meeting with HR on July 24, 2023.**

The Unexpected Termination Meeting

591. On **July 24, 2023**, the Plaintiff **arrived at the hospital early at 6:30 AM**, prepared for his scheduled **meeting with Mr. Carter**, hoping for a **resolution** to the **ongoing uncertainties.**

592. However, upon arrival, the Plaintiff was met **not only by Mr. Carter but also by Dr. Tavakoli**, who **was wearing his white coat and carrying a yellow envelope**, signaling **an abrupt shift in the meeting's purpose.**

✔ **The Plaintiff initially expected a fair discussion.**

✔ **The unexpected presence of Dr. Tavakoli suggested otherwise.**

✔ **The atmosphere became uneasy and tense.**

A Predetermined Verdict: Immediate Termination

593. **At 7:15 AM, Dr. Prill arrived late, and Dr. Tavakoli immediately announced the Plaintiff's termination.**

✔ **The Plaintiff was in shock, struggling to process the words: "Your residency is terminated effective immediately."**

✔ **The decision had already been made before the Plaintiff even had an opportunity to defend himself.**

✔ **Despite the existence of a scheduled meeting with the DIO, the Plaintiff was terminated before that discussion could take place.**

Exhibit #120: Termination Letter Handed to Plaintiff on July 24, 2023.

594. As previously established, the **termination letter dated July 24, 2023, was personally drafted by Dr. Stacy Ross** before her resignation from the **University of Maryland Capital Region Health Family Medicine Program**, which she **misleadingly framed as "retirement."** During discovery on **March 6, 2025**, **Dr. Tavakoli, testifying under oath and subject to the penalties of perjury, unequivocally confirmed** that when he assumed the role of **Interim Program Director**, the **decision to terminate Plaintiff had already been made**, and he was merely expected to **sign the pre-drafted letter orchestrated by Dr. Ross.** This admission **exposes the**

retaliatory and bad-faith nature of Plaintiff's dismissal, which was executed **not based on legitimate academic or clinical concerns**, but out of **malice, personal animus, and Dr. Ross's own self-serving interests.**

595. During the meeting, **Mr. Carter inquired whether the Plaintiff possessed a copy of the GME Resident Manual. Dr. Prill responded that it was available on "our website,"** marking the **first acknowledgment of its existence.** This **underscored the program's failure to provide essential procedural information to the Plaintiff during his probation and subsequent termination.**

596. Throughout Plaintiff's residency, **Dr. Ross operated with a singular objective: to retaliate, fabricate grounds for termination, or, in the absence of actual cause, manufacture one.** The evidence strongly suggests that she **authored the June 27, 2023, recommendation letter advocating for Plaintiff's termination**, followed by the **final termination letter itself**, further **solidifying a pattern of premeditated retaliatory conduct.** While **Dr. Tavakoli acknowledges signing the termination letter**, his testimony makes clear that he did so **under the direct guidance and influence of University of Maryland Capital Region Health's Legal Department**, confirming that the process was **neither fair nor impartial**, but rather a **coordinated institutional effort to manufacture justification for an already predetermined outcome.** In doing so, **Defendants acted in blatant disregard of the Plaintiff's GME Resident Agreement and their legally enforceable contractual obligations**, further **compounding their liability for bad-faith conduct and due process violations.**

POST-TERMINATION

Post-Termination Developments and Interactions with GME Leadership

Delayed Notification of Appeal Rights and GME Policies

597. **On the day of termination, July 24, 2023, the HR Director, Mr. Benjamin Carter, for the first time, mentioned the existence of the GME resident manual and the appeal process available to the Plaintiff.**

✔ This information was deliberately concealed from the Plaintiff for the entire 21-month duration of his residency.

✔ The Plaintiff was never informed of his contractual rights under GME policies before being terminated.

✔ The program leadership either neglected, refused, or intentionally suppressed the existence of these policies.

Plaintiff's Formal Request for an Appeal Hearing

598. **On July 25, 2023, the Plaintiff formally requested an appeal hearing under GME Policy 103 UMCRH - Due Process**, specifically invoking the section **"Initiation of Hearing."**

✔ This request forced the institution to acknowledge that the Plaintiff had contractual rights under the GME policies.

✔ Under the "Pre-hearing Discovery" section, the Plaintiff sought to compile witness

testimonies, character references, letters of support, and 360 evaluations to counteract the program's false allegations.

✔ **The Plaintiff's residency was a legally protected property interest, and the institution had systematically denied him due process throughout his training.**

Plaintiff's Unanswered Inquiry to Former GME Director, Mr. Hunter Tyrece

599. On **September 6, 2023**, the Plaintiff, through **University of Maryland lawyer, Dena Terra, Esq.**, sent a **letter to former GME Director, Mr. Tyrece Hunter**, requesting his perspective on **GME due process violations** and seeking insight into the **wrongful termination decision**.

✔ **In a legal setting, this request functions as a formal discovery mechanism, similar to a written deposition.**

✔ **Mr. Hunter's role as GME Director during the relevant period makes him a crucial figure in understanding the mismanagement of GME policies.**

✔ **However, no response was ever received.**

Exhibit #118: Plaintiff's Letter to Former GME Director, Mr. Tyrece Hunter

600. As part of **ongoing legal discovery**, the Plaintiff issued a **subpoena for a written deposition** to **Mr. Tyrece Hunter** in accordance with **Maryland Rules of Civil Procedure Rule 2-510**.

✔ **The subpoena was duly endorsed by the Clerk's Office and bore the Seal of the Prince George's County Court.**

✔ **Mr. Hunter was properly served under Rule 2-121, establishing February 14, 2024,**

as the deadline for response.

✔ Despite being legally compelled to respond, Mr. Hunter has refused to comply, further emphasizing institutional resistance to transparency.

Ignored Requests for Clarity from Interim Program Director, Dr. Tavakoli

601. On **September 12, 2023**, the Plaintiff attempted to **obtain information from Dr. Nader Tavakoli**, who served as **Interim Program Director (IPD)** and **oversaw the termination process initiated by Dr. Ross**.

✔ This action, in a legal proceeding, is analogous to interrogatories during discovery.

✔ The Plaintiff submitted a grievance to Dr. Tavakoli on July 19, 2023, but received no response.

✔ Despite knowing the strained relationship between the Plaintiff and Dr. Ross, Dr. Tavakoli avoided directly addressing the matter.

Exhibit #119: Plaintiff's Letter to Interim Program Director, Dr. Tavakoli

Evidence of GME Leadership's Lack of Due Process

602. The **pattern of institutional neglect** and **refusal to engage with the Plaintiff's legitimate concerns** demonstrates:

✔ Failure to follow due process as required by GME Policy 103.

✔ Obstruction of discovery efforts by former and current GME leadership.

✔ **A coordinated attempt to prevent transparency and accountability in the Plaintiff's wrongful termination.**

603. These developments **further solidify the retaliatory nature of the Plaintiff's termination**, revealing an **intentional effort by faculty and institutional leadership to suppress evidence, avoid scrutiny, and deny the Plaintiff a fair appeal.**

Institutional Changes in GME Leadership

Resignations and Restructuring Following the Plaintiff's Termination

604. The **termination of the Plaintiff on July 24, 2023**, was swiftly followed by **a significant shakeup in the leadership of the Graduate Medical Education (GME) Office** at **University of Maryland Capital Region Health (UMCRH).** These abrupt changes **underscore concerns about mismanagement, lack of due process, and institutional instability** during and after the Plaintiff's dismissal.

Key Leadership Departures & Replacements

605. **Mr. Hunter Tyrece**, who served as the **Director of Graduate Medical Education (GME)** throughout the Plaintiff's **residency and termination**, **resigned effective July 30, 2023**—just **six days after the Plaintiff's dismissal.**

1. His **abrupt departure raises serious questions** about **the failure of due process, the mishandling of GME policies, and the program's overall governance.**

2. The timing suggests an effort to **distance himself from the Plaintiff's termination and the ensuing controversy.**
3. The **institution has refused to provide any statements** regarding whether his resignation was voluntary or influenced by internal administrative conflicts.

606. **Dr. Nader Tavakoli** was **immediately appointed as Interim Program Director (IPD) from July to September 2023**, following **the resignation of former program director Dr. Stacy Ross.**

1. Dr. Tavakoli **oversaw the finalization of the Plaintiff's termination, yet failed to conduct any independent review or reconsideration of the decision.**
2. He **deferred all responsibility to the GME office and previous leadership**, indicating a **lack of true authority over program decisions.**

607. **Former Associate Program Director, Dr. Donna Prill, applied for Dr. Ross's position** to become the **new permanent Program Director**.

1. **However, University of Maryland Capital Region Health denied her candidacy**, citing **ongoing faculty conflicts and internal concerns about leadership mismanagement.**
2. This denial suggests that **even within the institution, Dr. Prill was not considered a suitable candidate for the leadership role**, raising further credibility issues regarding her involvement in the Plaintiff's termination.
3. Instead, the institution **opted to hire an entirely new individual, Dr. Bultman, as the new Program Director**, signaling an effort to **completely restructure the program and distance itself from prior leadership.**

608. **Following the Plaintiff's lawsuit initiation on December 14, 2023, Dr. Prill resigned from the program and relocated to Chambersburg, Pennsylvania.**

1. **Dr. Prill's sudden departure after being denied the Program Director position, coupled with the timing of the Plaintiff's lawsuit, suggests potential concerns about her role in previous adverse decisions made against the Plaintiff.**
2. Her **resignation further reinforces the argument that the former faculty leadership—including Dr. Ross, Dr. Prill, and others—was unstable, contentious, and lacked proper governance.**

Legal & Institutional Implications of Leadership Changes

609. These leadership resignations and denials of promotion raise **severe concerns about the legitimacy of the decision-making process in the Plaintiff's termination.**

✔ **Multiple high-ranking GME officials and faculty members resigned within months of the Plaintiff's dismissal.**

✔ The **denial of Dr. Prill's promotion suggests internal recognition of faculty mismanagement.**

✔ The **complete restructuring of the Family Medicine Program's leadership raises serious doubts about the fairness and integrity of decisions made under the previous administration.**

✔ The **University's failure to provide transparency regarding these leadership changes further suggests attempts to avoid scrutiny.**

Conclusion

610. The **institution's instability, high turnover, and faculty resignations following the Plaintiff's termination** raise **serious questions about due process violations, leadership misconduct, and retaliatory actions.**

611. The **denial of Dr. Prill's promotion suggests that the same individuals responsible for the Plaintiff's termination lacked credibility within the institution itself.**

612. These **facts strengthen the argument that the Plaintiff's termination was not a fair or justified academic decision, but rather a product of internal faculty conflicts and institutional dysfunction.**

ACGME Ombudsperson Inquiry & Institutional Non-Compliance

ACGME Standards and the Program's Failure to Adhere to Required Evaluations

613. On **September 15, 2023**, the Plaintiff formally **contacted the ACGME Ombudsman and the ACGME Office of Compliance** to inquire about the proper **implementation of the ACGME's Six Core Competencies, Milestones, and accepted evaluation standards** within a residency training program.

614. The Plaintiff was directed to publicly available **ACGME resources**, including:

1. **The Milestone Guidebook for Residents and Fellows**, which outlines the **progression of competency expectations during residency.**

   ACGME Milestone Guidebook

2. **The ACGME Standard Six-Core Competency Evaluation Form**, which **programs are required to use** for evaluating resident physicians in compliance with **GME Policy 104 - Resident Evaluation**.

   ACGME Six-Core Competency Evaluation Form

3. Upon review of these materials, **it becomes evident that the program failed to conduct a single competency-based evaluation in compliance with ACGME accreditation requirements**.

4. The **program did not utilize an Individualized Education Plan (IEP)** as required under **ACGME Clinical Competency Committee (CCC) guidelines**, nor did it follow the standardized approach for assessing deficiencies before initiating probation or termination.

Exhibit #121: The ACGME Six-Core Competency Standard Evaluation Form

615. This document, which the University of Maryland Capital Region Health residency program was obligated to **utilize per ACGME accreditation guidelines**, was never used to **assess the Plaintiff before or during probation.**

Failure of the University of Maryland Capital Region Health

to Respond to the ACGME Ombudsperson

616. Following the Plaintiff's inquiry, the **ACGME Ombudsperson attempted to contact the University of Maryland Capital Region Health to seek clarification on the Plaintiff's concerns.**

✔ **The institution failed to provide any formal written response to the ACGME Ombudsperson inquiry.**

✔ **The ACGME Ombudsperson never received a reply from University of Maryland Capital Region Health, demonstrating a clear pattern of institutional non-compliance and avoidance of accountability.**

617. This silence is particularly significant **given that ACGME accreditation guidelines require institutions to respond to compliance-related inquiries.**

Exhibit #122: ACGME Ombudsperson Inquiry and University of Maryland Capital Region Health's Failure to Respond

Pattern of Non-Compliance Extends to State

& Federal Civil Rights Agencies

618. This institutional pattern of **ignoring regulatory oversight and due process obligations** is not isolated to ACGME inquiries. The **University of Maryland Capital Region Health similarly failed to respond to multiple external oversight agencies**, including:

✔ **The Maryland Commission on Civil Rights (MCCR)**

✔ **The U.S. Equal Employment Opportunity Commission (EEOC)**

619. Despite **multiple inquiries from these agencies regarding the Plaintiff's discrimination and wrongful termination complaints**, the institution **never provided any substantive response or defense**, leading to a **default ruling in favor of the Plaintiff.**

✔ As a result, **both the Maryland Human Rights Commission and the EEOC issued a "Right to Sue" letter**, confirming that the institution's **failure to respond effectively waives its right to contest the Plaintiff's claims at the administrative level.**

Exhibit #132 and 179: "Right to Sue" Letter Issued by the EEOC & Maryland Human Rights Commission Due to the Institution's Failure to Respond

Institutional Pattern of Silence and Avoidance of Due Process

620. The institution's consistent failure to **respond to inquiries from**:

✔ The **ACGME Ombudsperson**

✔ The **Maryland Commission on Civil Rights**

✔ The **U.S. Equal Employment Opportunity Commission**

constitutes a deliberate and systematic evasion of accountability.

✔ The **Plaintiff was denied procedural fairness at every stage of his training, disciplinary actions, and termination.**

✔ The **institution's refusal to engage with external oversight agencies further underscores its bad faith and retaliatory intent.**

Legal and Accreditation Consequences

621. Under ACGME Common Program Requirements (V.A.1 & V.A.2), accredited institutions must ensure an evaluation system that is objective, transparent, and compliant with ACGME accreditation standards.

✔ The University of Maryland Capital Region Health's **failure to conduct ACGME-mandated evaluations before imposing probation and termination constitutes a serious breach of its accreditation obligations.**

✔ The **failure to respond to oversight agencies suggests an awareness of misconduct and an effort to evade accountability.**

✔ The **issuance of a Right to Sue letter by both state and federal agencies indicates that the Plaintiff's claims have sufficient legal merit to proceed in court.**

Conclusion

✔ The **Plaintiff's termination was executed without following ACGME-mandated competency evaluations.**

✔ **No written response was ever provided by the institution to the ACGME Ombudsperson or compliance inquiries.**

✔ **The institution also failed to respond to state and federal human rights agencies, leading to a "Right to Sue" ruling in the Plaintiff's favor.**

622. These actions **demonstrate an intentional pattern of due process violations, regulatory non-compliance, and institutional bad faith.**

Assessing Plaintiff's Contributions as a Hospital Employee

Objective Performance Metrics:

EPIC Signal Data & Comparative Analysis

623. Residency training programs, particularly those accredited by the **Accreditation Council for Graduate Medical Education (ACGME),** recognize residents **not only** as trainees **but also** as full-time employees of their respective institutions. This **dual status**—as both **physicians in training and employees**—entitles residents to **employment protections, performance assessments based on objective metrics, and fair labor standards.**

✔ The **Plaintiff's performance as an employee of UMCRH** can be **quantitatively assessed** using **Epic Signal Data**, a benchmarking tool that allows **comparative performance analysis among UMRCH Family Medicine Residents.**

✔ **Epic Signal Data** provides **objective, system-generated metrics** on physician performance, including:

1. **In Basket Management:** Timeliness in responding to staff and patient communications.
2. **Orders:** Frequency and accuracy of placing medical orders.
3. **Notes and Letters:** Completeness and thoroughness of medical documentation.
4. **Clinical Review:** Efficiency and accuracy in reviewing patient records.

✔ **Despite the Plaintiff consistently surpassing the average performance of his peer residents in key metrics**, he was nonetheless **terminated from the residency program** under claims that he lacked organizational skills, efficiency, and time management abilities. The **objective Epic Signal Data directly contradicts these baseless allegations.**

Exhibit #127: EPIC SIGNAL DATA - **Physician Performance Peer Comparison.**

Objective Clinical Performance

Data Refutes Allegations

624. The **analysis of Epic Signal Data by UMCRH** provides an **empirical, unbiased measure of physician competency, communication skills, and efficiency.** This data refutes any unsubstantiated claims that the Plaintiff was deficient in **organizational skills, clinical workflow efficiency, or medical note documentation.**

✔ **Key insights from Epic Signal Data include:**

1. The Plaintiff consistently **cleared patient messages and In Basket communications faster than his peers.**
2. The Plaintiff **placed accurate and timely orders**, demonstrating **proficiency in clinical decision-making.**
3. His **documentation exceeded the department's average quality standards**, directly refuting claims that he was incapable of properly editing or managing medical notes.
4. The Plaintiff **handled complex patient encounters effectively,** demonstrated through the **depth of documentation and clinical review time, which met or exceeded benchmarks.**

Exhibit #127: EPIC SIGNAL DATA - **Comparison of Plaintiff's Clinical Performance Against Peer Residents.**

625. The **objective Epic Signal Data** contradicts the subjective and **retaliatory** nature of faculty criticisms against the Plaintiff, further establishing that the **termination decision was not based on any genuine performance deficiencies but rather on bad faith, malice, and institutional bias.**

Independent Expert Testimony:

Ambulatory Informatics Specialist Discredits Faculty Allegations

626. The **expert judgment of Ms. Kendra Johnson, MSN, RN,** a senior specialist in **Ambulatory Informatics at the University of Maryland Medical Systems**, provides an **independent assessment of medical documentation practices within the EPIC system.**

✔ Ms. Johnson, an expert in **clinical documentation compliance and electronic medical records (EMR) optimization**, **reviewed the Plaintiff's documentation performance** and concluded that:

1. The **Plaintiff's documentation was thorough, well-structured, and in compliance with EPIC best practices.**
2. The **claims made by former program director Dr. Ross regarding the Plaintiff's inability to edit notes or document efficiently were entirely without merit.**

3. The **Plaintiff's documentation proficiency met or exceeded the program's expected standards,** reinforcing that the **program director's criticisms were pretextual and retaliatory rather than based on legitimate concerns.**

   Exhibit #128: Expert Testimony from Kendra Johnson, MSN, RN, refuting Dr. Ross's fabricated allegations.

627. **The Plaintiff's medical documentation and clinical efficiency were never genuine concerns but were instead weaponized by faculty leadership to construct a pretext for termination.** The **independent expert testimony from an EPIC informatics specialist further exposes the Plaintiff's wrongful dismissal as lacking factual basis.**

Conclusion

✔ The **Plaintiff's clinical performance, as verified by objective data from EPIC Signal, demonstrates competency and efficiency, directly contradicting faculty claims of deficiencies.**

✔ The **Plaintiff outperformed peer residents in critical areas such as documentation, order management, and communication efficiency.**

✔ The **expert testimony of a UMMS Ambulatory Informatics specialist debunks faculty allegations, reinforcing that the Plaintiff's termination was based on fabricated criticisms rather than actual performance issues.**

✔ The **Plaintiff's termination was not a product of academic failure but an act of bad faith, retaliation, and deliberate institutional bias.**

Exhibit #127: EPIC SIGNAL DATA - **Plaintiff's Clinical Performance Metrics.**

Exhibit #128: Expert Testimony from Kendra Johnson, MSN, RN, refuting Dr. Ross's allegations.

Comprehensive Evaluations and Advocacy for Reinstatement

Objective Evaluations and Due Process Violations

628. Several esteemed staff members from **UMCRH Medical Center** submitted **letters of reference** to the **physician panel**, advocating for **the reversal of the Plaintiff's wrongful termination** and restoration of his residency training.

✔ **GME Policy 104 UMCRH** mandates **evaluations from multiple sources**, commonly referred to as **360-degree evaluations**, to ensure fairness and prevent **arbitrary and capricious** decisions regarding **non-promotion, denial of credit, remediation, or termination.**

✔ The **Accreditation Council for Graduate Medical Education (ACGME)** explicitly **requires that residents be assessed within the broader context of their overall performance** rather than isolated incidents.

✔ **Despite these policies, the Plaintiff's performance evaluations were selectively ignored** while fabricated claims were used to justify termination, violating established due process rights.

Expert Endorsements by Faculty Physicians

629. **Dr. Nader Dakak, Chief of Cardiology, UMCRH**, a **board-certified cardiologist** and leading educator at the **George Washington University School of Medicine**, submitted a reference in **strong support of the Plaintiff.**

✔ Dr. Dakak, who has published over **50 peer-reviewed studies** and trains **cardiology fellows**, **personally testified before the physician panel on September 27, 2023,** asserting that the Plaintiff's termination was **a grave injustice that jeopardized his career.**

✔ His testimony is **officially recorded in the court transcript** by **David Corbin, RPR, Veritext Legal Solutions, 202-803-8830**, **starting from page 10.**

Exhibit #133: Testimony of Dr. Nader Dakak – Chief of Cardiology, UMCRH.

630. **Dr. Patricia Skripko, a board-certified neurologist at UMCRH**, provided an **independent evaluation** of the Plaintiff's performance during his **neurology rotation.**

✔ Dr. Skripko's evaluation **directly refutes faculty claims** regarding the Plaintiff's **documentation skills, professionalism, and ability to follow clinical protocols.**

✔ She **affirmed the Plaintiff's clinical competence**, contradicting the fabricated allegations that formed the basis of his termination.

Exhibit #134: Testimony of Dr. Patricia Skripko – Neurology, UMCRH.

Resident and Peer Support for Reinstatement

631. The **Plaintiff's co-residents from the Internal Medicine program** formally submitted a **petition letter** to the physician panel, advocating for **his reinstatement.**

✔ **This letter was co-signed by twenty-two physicians, including three chief residents and a GME Resident Representative.**

✔ The letter **unequivocally contradicts** the program's fabricated allegations and provides **firsthand testimony of the Plaintiff's professional competence, leadership, and patient care.**

✔ The **petition further highlights the pattern of biased faculty actions** and confirms that the Plaintiff's performance was **consistent with, or exceeded, peer expectations.**

Exhibit #135: Petition Letter from Internal Medicine Residents.

Colleague Testimonies from Faculty Physicians

632. **Dr. Oyinkansola Awodiya, MD,** a faculty physician in **Family Medicine in Tulsa, Oklahoma**, provided a **written reference** disputing the allegations against the Plaintiff.

✔ Dr. Awodiya **worked alongside the Plaintiff during multiple cross-rotations** and emphasized that his documentation was **meticulous, complete, and well-organized.**

✔ She described his notes as **"a testament to his thoroughness, listing each diagnosis and creating comprehensive care plans."**

✔ **Dr. Awodiya explicitly urged the panel for the Plaintiff's reinstatement.**

Exhibit #136: Written testimony of Dr. Oyinkansola Awodiya, MD.

Ancillary Medical Staff & Informatics Evaluations

633. **Lizzy Katz, RD, CDCES, Diabetes Program Coordinator at UMCRH**, submitted **an independent evaluation** based on extensive interactions with the Plaintiff during **inpatient and outpatient rotations.**

✔ Katz's **360-degree evaluation** noted:

1. The Plaintiff **"utilized correct English in written and verbal communication."**
2. He **"recognized diabetes team members by name" and "responded attentively and promptly when needed."**
3. **"From patient charts we collaborated on, all work was completed in a timely, accurate, and efficient manner."**

634. **Katz's assessment refutes faculty claims** regarding **organizational skills, leadership, and documentation deficiencies.**

Exhibit #137: Written testimony of Lizzy Katz, RD, CDCES.

635. **Ms. Kendra Johnson, RN, MSN,** a senior **Epic Informatics Specialist at UMCRH**, provided a **comprehensive 360-degree evaluation** on the Plaintiff's **electronic medical record (EMR) competency.**

✔ Johnson's independent review noted:

- The Plaintiff **"used Smart Tools efficiently in notes and letters."**
- He **"promptly followed up on patient inquiries and concerns."**

- He **"collaborated with the informatics team to improve clinical workflows and documentation efficiency."**

636. **Johnson's expert evaluation refutes faculty allegations** regarding the Plaintiff's **documentation skills, leadership, and multitasking ability.**

Exhibit #138: 360-degree evaluation and written testimony from Kendra Johnson, MSN, RN.

Firsthand Testimony from Clinical Staff

637. **Mrs. Stephanie Allen, MA,** a **Medical Assistant at the Cheverly and New Carrollton outpatient offices,** provided a **firsthand account** of the Plaintiff's clinical performance.

✔ Allen described the Plaintiff as **"a great doctor who cares deeply about his patients and ensures that no detail is missed."**

✔ She further criticized the **program's flawed evaluation process**, highlighting that **faculty preceptors rarely observed residents directly, leading to biased and incomplete assessments.**

Exhibit #139: Written testimony of Stephanie Allen, MA.

638. **Mrs. Yolanda Johnson, a UMCRH Outpatient Pharmacy staff member,** worked directly with the Plaintiff **during his nursery rotation in May 2023.**

✔ She provided **direct testimony** regarding the Plaintiff's **communication skills, professionalism, and ability to coordinate care.**

✔ Johnson emphasized that the Plaintiff **"consistently ensured timely medication delivery**

to newborns," "communicated effectively," and "contributed significantly to the team's success."

✔ Her testimony directly refutes allegations regarding the Plaintiff's nursery performance.

Exhibit #140: Written testimony from Yolanda Johnson, UMCRH Outpatient Pharmacy.

Conclusion

✔ Multiple independent evaluations from faculty physicians, peers, and ancillary medical staff refute the baseless allegations used to justify the Plaintiff's termination.

✔ The Plaintiff received outstanding evaluations in leadership, communication, medical documentation, and patient care.

✔ These 360-degree evaluations were deliberately disregarded by the program in violation of GME Policy 104 and ACGME requirements.

✔ The decision to terminate the Plaintiff was not based on legitimate concerns but was instead an act of institutional retaliation and bad faith.

Exhibit #133–140: Comprehensive Evaluations & Testimonies Supporting Reinstatement.

Analysis of Termination Letter: False Statements

Contractual Violations & Procedural Irregularities

639. The **termination letter issued on July 24, 2023**, contains **numerous misrepresentations, procedural irregularities, and factual inaccuracies**, closely mirroring concerns previously

raised in **faculty memoranda.**

Exhibit #120: Termination Letter signed by Interim Program Director Dr. Nader Tavakoli, dated July 24, 2023.

Factual Discrepancies in Remediation History

640. The termination letter **falsely claims that the Plaintiff underwent two remediation periods.**

✔ However, **faculty records and official documentation confirm only one remediation period, from March 1, 2023, to May 31, 2023.**

✔ This **fabricated claim introduces a substantial inconsistency**, **undermining the legitimacy of the rationale for termination.**

641. The **deliberate misrepresentation** of the Plaintiff's remediation history **directly contradicts documented records** and **raises significant concerns regarding procedural fairness and due process.**

✔ **GME Policy 103 UMCRH** mandates that disciplinary actions, including termination, **must be based on factual evidence and procedural consistency.**

✔ The **lack of accurate documentation** suggests an **arbitrary and capricious** decision-making process.

Failure to Follow ACGME-Mandated Evaluations

642. Throughout Plaintiff's residency, **performance was consistently assessed** based on **leadership, organizational skills, multitasking, note-taking proficiency, and purported allegations of insubordination**—metrics routinely used within the program to evaluate residents.

✔ **Despite these established evaluation criteria, the termination letter abruptly alleges deficiencies across all six ACGME core competencies, even though the Clinical Competency Committee (CCC) never conducted any formal, ACGME-compliant evaluation in the following areas. This further underscores the arbitrary and capricious nature of the decision-making process:**

1. **Patient Care**
2. **Interpersonal and Communication Skills**
3. **Medical Knowledge**
4. **Professionalism**
5. **Systems-Based Practice**
6. **Practice-Based Learning and Improvement**

Exhibit #121: ACGME Six-Core Competency Standard Evaluation Form.

Inconsistent Justifications & Lack of Documented Evidence

643. The **abrupt shift in evaluation criteria** within the termination letter **deviates from established residency assessment protocols,** violating:

✔ **ACGME Milestone Evaluation Standards.**

✔ **GME Policy 104 – Resident Evaluation Criteria.**

✔ **Basic Due Process Requirements in Resident Performance Assessment.**

✔ This **inconsistency further invalidates the legitimacy** of the termination, as **no documented evidence supports the new claims.**

✔ The program **failed to conduct a single evaluation aligned with ACGME-mandated assessment methods.**

Misuse of Individualized Learning Plan (ILP)

& Failure to Document Deficiencies

644. The **termination letter misleadingly references** an **Individualized Learning Plan (ILP)**, falsely suggesting it was a **disciplinary measure** rather than a **developmental tool.**

✔ **According to Dr. Donna Prill, CCC Chair,** during cross-examination by **Plaintiff's attorney Michael Herman, Esq.,** an **ILP is neither punitive nor disciplinary.**

✔ **Deposition transcripts from November 9, 2023, confirm that the ILP was successfully completed** in **May 2022**, and **no deficiencies were documented.**

✔ The **Plaintiff never received written notice of any ILP extension,** making any post hoc allegations of failure **factually unsubstantiated.**

Exhibit #154: Deposition Transcript of Dr. Donna Prill, Veritext Legal Solutions, Pages 12, 18, and 35.

Unsubstantiated Non-Promotion & Due Process Failures

645. The **August 26, 2022, memo declining the Plaintiff's promotion to PGY-3** vaguely cites **"concerns from the CCC, faculty, and colleagues"** but **lacks documented performance deficiencies.**

✔ During **internal appeal proceedings, no verifiable evidence** was provided to justify non-promotion.

✔ Any **post-hoc fabrication of records constitutes fraudulent documentation.**

646. Under **Maryland contract law,** failure to provide documentation **prior to a non-promotion decision constitutes a due process violation.**

✔ **The Program must legally justify** its decision with **documented, contemporaneous evidence,** which it **has failed to provide.**

Exhibit #42: Non-Promotion Memo, Dated August 26, 2022.

Fabricated Claims of "Multiple Incidents"

647. The **remediation period initiated by Dr. Ross in February 2023** was based on **unfounded allegations**, including:

✔ **An alleged "unsupervised circumcision"—which, upon investigation, was deemed unsubstantiated.**

✔ **Baseless claims of "insubordination" by Dr. Ibe.**

✔ **HIPAA violations that were never corroborated.**

✔ **The initiation of remediation was clearly retaliatory,** as it **coincided with the Plaintiff's protected discussions regarding patient care.**

Violations of Due Process in Probation & Termination

648. On **May 30, 2023,** Dr. Ross **attempted to coerce the Plaintiff into signing a probation document** without affording:

- ✔ **Any opportunity to contest the decision.**
- ✔ **Any formal due process hearing.**
- ✔ **Any GME Policy-mandated appeal process.**

✔ The **Plaintiff's refusal to sign the probation document** led Dr. Ross to direct the **program coordinator to repeatedly send unsigned DocuSign requests.**

✔ **This action constitutes procedural coercion and a direct violation of contract rights.**

Retaliatory Nature of Termination

& Lack of Patient Harm

649. The **termination letter falsely characterizes** the Plaintiff's **nursery incident as a "dramatic professional failure,"** despite:

- ✔ **No documented harm to the neonate.**
- ✔ **No hospital safety escalation.**

✔ **No recorded "near-miss" reports or incident reports.**

✔ **The neonate being safely transferred to the NICU and later discharged home without complications.**

✔ **No reasonable hospital or training program would equate a single phone-related issue with termination, particularly given the documented fatigue and staffing failures.**

Final Rejection of Severance & Legal Implications

650. Immediately following Plaintiff's **wrongful termination**, **University of Maryland Capital Region Health's Human Resources Director, Benjamin Carter**, attempted to **induce Plaintiff into signing a severance agreement**. The agreement **offered an additional $2,000 per month for three months** in exchange for **a complete waiver of Plaintiff's legal rights to sue the institution**. This maneuver—**devised by Human Resources in coordination with the Legal Department**—was strategically presented **only after Plaintiff had retained legal counsel in July 2023**, evidencing a **deliberate attempt to circumvent legal accountability**.

651. Recognizing the **coercive and pretextual nature** of this offer, Plaintiff **unequivocally refused to sign the severance agreement**, thereby preserving his right to pursue **lawful remedies for contractual breaches and wrongful termination** through judicial proceedings. A **true and authentic copy of the severance agreement** was **submitted to this Court as Exhibit 178 on August 27, 2024.**

Conclusion

✔ The **termination letter contains multiple falsehoods, procedural violations, and misrepresentations.**

✔ **Key due process protections were deliberately ignored,** exposing the **retaliatory intent behind the termination.**

✔ The **program failed to document any legitimate grounds** for non-promotion, remediation, probation, or termination.

✔ The **Plaintiff's rejection of severance and refusal to concede** demonstrates a **clear commitment to justice and accountability.**

Exhibit #120–125: Legal & Procedural Violations in Termination Letter.

SHAM INTERNAL APPEAL PROCESS

Due Process Violations & Delayed Hearings

652. The **University of Maryland Capital Region Health failed to uphold its contractual obligations** under the **GME Resident Agreement** and explicitly violated **GME Policies 102, 103, and 104,** which govern **due process rights and disciplinary actions.** These policies **clearly mandate** that **due process rights must be provided before a final decision** on dismissal, non-renewal of contract, denial of credit, or any other action that could significantly

jeopardize a resident physician's career. The language of these policies is unambiguous—the University was obligated to provide due process protections **before** taking any adverse action.

✔ **GME Policy 103** specifically **requires the Program Director to notify residents of their due process rights before imposing disciplinary actions, including termination.**

✔ **The Plaintiff was not afforded an opportunity to appeal before adverse actions were taken, constituting a direct violation of fundamental due process protections.**

✔ **GME Policy 103 further mandates expedited hearings to minimize training disruptions.**

653. **The University of Maryland Capital Region Health deliberately delayed the process** by scheduling hearings on **September 27, October 30, November 9, and November 15, 2023,** in **blatant disregard** of the policy's requirement for **prompt resolution.**

Exhibits #152–155: Court transcripts for hearings on **September 27, October 30, November 9, and November 15, 2023.**

Bias & Procedural Manipulation

by Presiding Officer

654. Throughout these hearings, the **impartiality of Mr. Michael Baxter, Esq.,** the presiding officer paid by the institution, was **repeatedly called into question.**

✔ Plaintiff's attorney, **Michael Herman, Esq.,** raised **critical inquiries** during faculty cross-examinations regarding:

1. **Peer comparisons.**
2. **Decision-making inconsistencies.**
3. **Compliance with ACGME and GME standards.**

✔ The **University's attorney, Mrs. Dena Terra, Esq., repeatedly objected**, with Mr. Baxter **sustaining these objections, obstructing material evidence from the record.**

655. **Dr. Ross, the former Program Director, failed to appear for cross-examination,** depriving the Plaintiff of a fundamental opportunity to challenge her allegations.

✔ **Interim Program Director Dr. Nader Tavakoli distanced himself from prior decisions**, stating he was merely faculty at the time.

✔ Dr. Tavakoli also:

1. **Failed to consult Dr. Brewer, the neonatologist.**
2. **Neglected to seek input from Dr. Jacqueline Skelton, NICU attending.**
3. **Did not attempt to hear the Plaintiff's perspective**, violating **academic due process principles of a fair and deliberate decision-making process.**

Exhibits #152 & 154: Deposition Transcripts of Dr. Tavakoli & Dr. Brewer.

Fabrication of Evidence &

Lack of Legitimate Investigation

656. The **omission of a thorough investigation** and the **deliberate falsification of facts regarding the nursery incident** constitute **gross procedural misconduct.**

✔ **Falsified documentation or manipulated records constitute fraud, a serious legal violation.**

✔ The **lack of an impartial, evidence-based review** directly **undermines the legitimacy of the termination decision.**

657. The **internal appeal panel had access to all faculty evaluations**, including:

✔ **Written evaluations from non-faculty attending physicians, resident peers, and ancillary staff**—all signed and authenticated.

✔ These **testimonies overwhelmingly contradicted the accusations** levied by Dr. Ross, Dr. Kaysin, and, to some extent, Dr. Ibe.

✔ Notably, **Dr. Prill and Dr. Tavakoli remained neutral**, **not fully endorsing** the allegations.

✔ Despite **conflicting faculty opinions**, the **final decision to dismiss was unanimously fabricated**, falsely **presented as a "collective vote" to shield the institution from liability.**

Fabrication of a "Unanimous Vote"

658. The claim of a **unanimous faculty vote for dismissal was deliberately fabricated** following consultations with the **University's legal team.**

✔ **ACGME regulations explicitly prohibit dismissing a resident based solely on a vote,** requiring a **deliberate, evidence-based decision-making process.**

✔ The **institution's failure to adhere to ACGME requirements** demonstrates **blatant disregard for due process.**

Statistical Discrepancy in Evaluations

659. A **side-by-side analysis of evaluations** reveals significant disparities:

Evaluator	Assessment of Plaintiff
Dr. Ross	Overwhelmingly negative; excessively critical.
Dr. Kaysin	Mixed; positive and negative, but omitted key details.
Dr. Ibe	Contradictory feedback lacking logical coherence.
Dr. Prill	Neutral; balanced commentary.
Dr. Tavakoli	No negative comments; previously supported Plaintiff's continuation in the program.

✔ In **stark contrast**, **evaluations from 54 physicians, residents, and ancillary staff overwhelmingly endorsed the Plaintiff's competence.**

✔ The **ratio of negative to positive evaluations was 3:54 (5% negative vs. 95% positive),** highlighting **blatant inconsistencies in faculty assessments.**

Burden of Proof & Preponderance of Evidence Standard

660. **Under GME Policy 103 UMCRH**, the **burden of proof** rests on the **initiating party** (the institution) to **demonstrate that termination was neither arbitrary nor capricious.**

✔ **The Plaintiff submitted over 200 exhibits**, providing substantial **documented evidence contradicting faculty allegations.**

✔ Despite this, the **panel disregarded clear evidence**, undermining the **integrity of the judicial process.**

Exhibit #147: GME Policy 103—Burden of Proof & Due Process Guidelines.

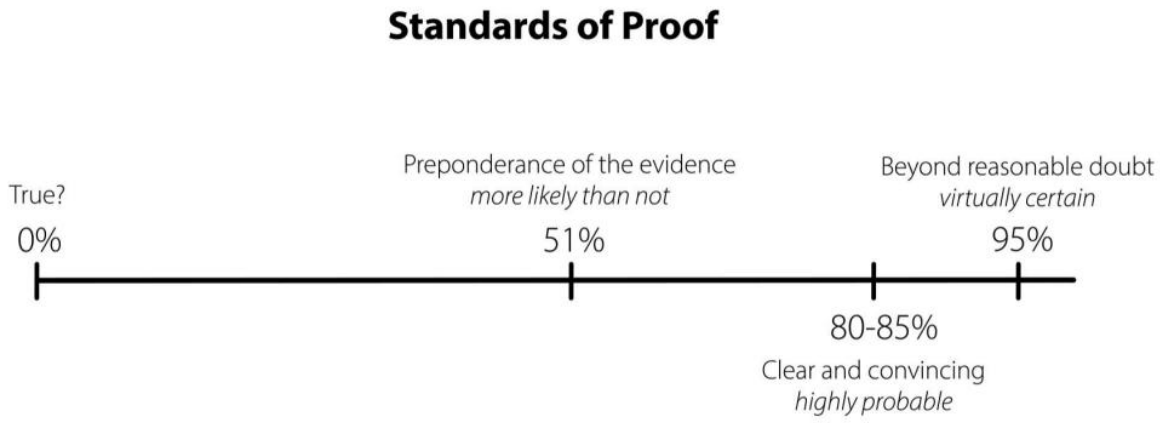
Statistical Evidence Contradicting Termination Decision

661. Applying **legal standards of evidentiary weight:**

✔ **Preponderance of evidence (51% threshold)** – Plaintiff's **95% positive evaluations far exceed this requirement.**

✔ **Clear and convincing evidence (80–85% threshold)** – Plaintiff's evaluations meet and exceed this standard.

✔ **Beyond a reasonable doubt (95% threshold)** – The **statistical weight of evidence confirms the decision was arbitrary and capricious.**



662. **The panel's reliance on obstructed cross-examination, technical difficulties, and procedural delays significantly eroded due process protections.**

✔ The **University's legal counsel (Mrs. Dena Terra, Esq., and Sandra H. Benzer, Esq.) exerted undue influence**, further **compromising the fairness of the process.**

✔ **Despite overwhelming evidence (95% certainty of wrongful termination),** the panel **failed to apply even the basic preponderance of evidence standard.**

663. **Conclusion: Grounds for Legal Action**

✔ **Multiple procedural violations**, including **fabricated evidence, manipulated faculty votes, and failure to meet the burden of proof**, have fundamentally compromised the integrity of the appeal process.

✔ **University officials disregarded** the **GME Resident Agreement, GME policies, and ACGME program and institutional standards**, rendering their decision **legally indefensible**.

✔ Given the **egregious nature of these violations**, **pursuing legal action is both warranted and imperative** to hold the institution accountable and seek appropriate remedies.

January 10, 2024

Fraudulent Formative and Summative Evaluations:

Fabricated Post-Termination Documents

664. **On January 10, 2024, Ms. Dena Terra, Esq., counsel for the University of Maryland, produced a purportedly legitimate but fundamentally fraudulent document following the initiation of this lawsuit.** This document contradicts all prior records issued before and after the Plaintiff's termination, raising serious concerns about its authenticity. The creation of this document appears to be a **strategic attempt by the University of Maryland's legal team to manufacture a retroactive justification for the Plaintiff's wrongful termination,** providing a misleading record for future litigation.

Refer to Exhibit #159: Final Formative and Summative Evaluation.

665. The **termination letter dated July 24, 2023, conspicuously lacked any prior ACGME-standard 6-core competency evaluations** conducted by the program. Yet, in a blatant contradiction, it falsely declared that the Plaintiff had **failed all six ACGME core competencies**, without following proper evaluative procedures. This reckless assertion is **a clear deviation from standard ACGME evaluation protocols** and serves as an *ex post facto* justification for an otherwise baseless decision.

Refer to Exhibit #120: The Final Termination Letter signed by Dr. Tavakoli.

Misuse of Individualized Learning Plan (ILP)

666. Throughout the Plaintiff's residency, **all evaluations were derived from an outdated Individualized Learning Plan (ILP), initiated on April 18, 2022.** Despite the ILP being originally designed to prepare the Plaintiff for the Medical Admitting Officer (MAO) role—a role that was discontinued by UM Cap Reg Health in July 2022—the program **continued to improperly use the ILP as the basis for critical decisions regarding non-promotion, remediation, probation, and ultimately termination.** This **gross misapplication of the ILP** suggests that the program fundamentally misunderstood or misused its intended function.

667. **The ILP was not an evaluative tool and should not have been used for determining the Plaintiff's performance status.**

668. In direct violation of the **GME Resident Agreement**, which mandates **substantial compliance with GME policies, ACGME program requirements, institutional standards, and ACGME CCC guidelines**, the **ILP was manipulated at the discretion of former Program Director Dr. Ross** to fabricate justification for adverse actions against the Plaintiff. The **termination letter improperly repackaged areas for improvement outlined in the ILP** as purported **failures in the ACGME six core competencies**, exposing a **fundamental inconsistency in the program's evaluative approach** and further demonstrating procedural misconduct.

Refer to Exhibit #121: ACGME Six-Core Competency Standard Evaluation Form, which defines the core competencies as:

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement

4. Interpersonal and Communication Skills

5. Professionalism

6. Systems-Based Practice

Contradictory and Fraudulent

Post-Termination Evaluations

669. **On November 27, 2023, during the internal appeal process, the Panel—under the influence of University of Maryland's legal counsel—introduced new evaluation criteria** including **practice-based learning, professionalism, ethical behavior, accountability, conscientiousness, self-awareness, and help-seeking behavior.** None of these criteria had previously been cited as deficiencies in the faculty memos used to justify his non-promotion, remediation, probation, and termination.

670. A blatant contradiction emerged between the **July 24, 2023, termination letter**, the **November 27, 2023, Panel decision-related document**, and the **January 10, 2024, Final Formative and Summative Evaluation**:

1. The **July 24, 2023, termination letter falsely stated** that the Plaintiff had **failed all six ACGME core competencies**, despite the program **never having conducted an ACGME-standard evaluation properly assessing these competencies** to reach such a conclusion.

2. The **November 27, 2023, Panel decision** contradicted this claim, citing deficiencies only in **"Practice-Based Learning" and "Professionalism"**, while finding the remaining competencies satisfactory.

3. On **January 10, 2024, a third contradictory evaluation document** was produced, further altering the alleged basis for termination. This time, **Ms. Dena Terra, Esq., arbitrarily introduced "Interpersonal and Communication Skills"** as a newly failed competency, despite **no prior documentation or assessment substantiating this claim**.

671. These clear inconsistencies **expose the fabricated and pretextual nature** of the program's decision-making process, further demonstrating **procedural manipulation and a lack of good faith**.

Defamation

672. On **January 10, 2024**, the **University of Maryland Capital Region Health's Legal Department arbitrarily composed a final formative and summative evaluation**, containing **defamatory and false statements** aimed at **permanently tarnishing Plaintiff's professional reputation.** This document, intended to be **maintained indefinitely for future residency program and employment references**, was not an objective assessment but rather a **malicious effort to justify Plaintiff's wrongful termination** through fabricated claims.

673. The **evaluation falsely alleges** that throughout Plaintiff's residency, he **exhibited inappropriate behavior, engaged in illicit substance use, and required ongoing counseling regarding professional interactions with medical students.** These **absurd and baseless accusations** were **never raised during Plaintiff's active training** and were introduced **only after Plaintiff initiated legal action against the University**, demonstrating **a clear retaliatory motive.**

674. The **University was compelled** to **retroactively fabricate justifications** for its **arbitrary and capricious termination decision** and **deliberately inserted nonessential and defamatory claims** into an official document with the intent to **irreparably harm Plaintiff's professional standing**. As a direct result, Plaintiff **filed defamation per se claims** in this litigation, holding Defendants accountable for **knowingly publishing false and damaging statements** that **attacked his professional competence, character, and future career prospects.**

Excerpt from the document dated January 10, 2024:

Professionalism (check the appropriate box):

☐ During the dates of training, the resident did not show any signs of inappropriate behavior, or substance use.

☒ During the dates of training, the resident did show signs inappropriate behavior, or substance use. An explanation is attached.

Denial of ACGME Credits

675. The **January 10, 2024, document** falsely stated **19 months** of completed training, despite the Plaintiff having **spent 21 months in the program**:

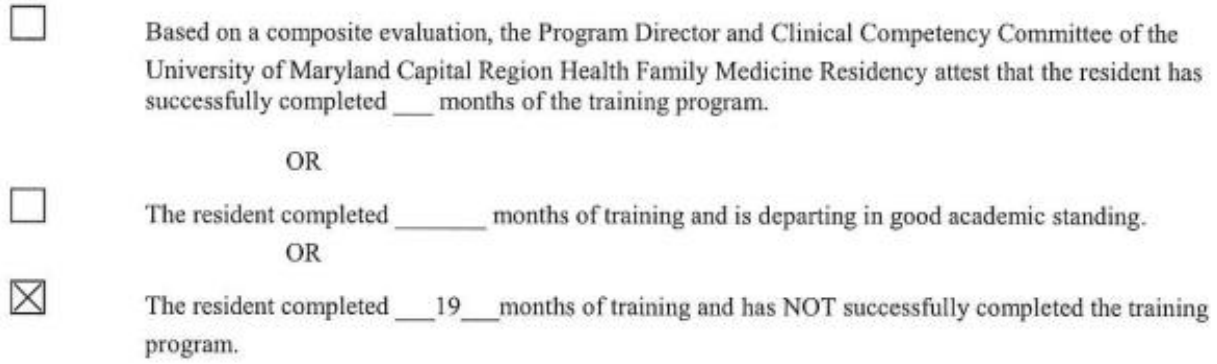
676. The **Plaintiff completed 21 months** of training with **no formal indication of failure for any rotation**. However, the **Final Summative Evaluation incorrectly reflects only 19 months**, despite the actual training period spanning **November 1, 2021, to July 24, 2023 (20 months and 23 days)**. When accounting for **two weeks of denied vacation**, the total training time is **a full 21 months**.

677. The program **previously reported 12 months of completed training** to the **American Board of Family Medicine (ABFM)** for the period **November 1, 2021, to October 31, 2022**. However, the program **later altered internal records**, first changing the completion date to **April 30, 2023**, then again to **June 27, 2023**, and ultimately **denying ACGME credits for the period between November 1, 2022, and July 24, 2023—effectively erasing 9 months of training**.

678. **Per the GME Resident Agreement, GME policies, and broader ACGME standards**, any **denial of training credit toward licensing is subject to due process rights**, meaning each denied month should have been **properly documented**, with **appeal rights offered and exercised**. However, **no such documentation exists**, further underscoring the program's **arbitrary and capricious decisions, denial of due process rights, and ultimate breach of the GME Resident Agreement**.

679. As the **GME Resident Agreement explicitly states**, the **University of Maryland Capital Region Health, as the sponsoring institution, is required to provide substantial compliance with ACGME program requirements** to maintain its **accreditation status**, which **allows the University to receive federal and state funding**. The program's actions—**failing to document denied training months, withholding due process, and manipulating training records—represent a direct breach of contract and noncompliance with ACGME accreditation standards.**

✔ Refer to Exhibit #162: ABFM Records Confirming the Plaintiff's Awarded ACGME Credits.



☐ Based on a composite evaluation, the Program Director and Clinical Competency Committee of the University of Maryland Capital Region Health Family Medicine Residency attest that the resident has successfully completed ___ months of the training program.

OR

☐ The resident completed _____ months of training and is departing in good academic standing.

OR

☒ The resident completed ___19___months of training and has NOT successfully completed the training program.

Residency Training

Details about your participation in a full 36 calendar month curriculum in an ACGME accredited family medicine residency program are provided annually by your Program Director.

YEAR	RESIDENCY	CREDITS
PGY1 (A/P)	Wayne State University Program	12
Start Date: **07/01/2017**	End Date: **06/30/2018**	
	Advanced placement confirmed: 10/15/2021	
PGY2	Prince George's Hospital Center Program	12
Start Date: **11/01/2021**	End Date: **04/30/2023**	

Residency Training

Details about your participation in a full 36 calendar month curriculum in an ACGME accredited family medicine residency program are provided annually by your Program Director.

YEAR	RESIDENCY	CREDITS
PGY1 (A/P)	Wayne State University Program	12
Start Date: **07/01/2017**	End Date: **06/30/2018**	
	Advanced placement confirmed: 10/15/2021	
PGY2	University of Maryland Capital Region Health Progr...	12
Start Date: **11/01/2021**	End Date: **06/27/2023**	

Please contact your Residency Program Coordinator if you feel there is a discrepancy in the provided information.

CONTRACTUAL RELATIONSHIP AND GOVERNING DOCUMENTS

680. Plaintiff's **contractual relationship** with **University of Maryland Capital Region Health** and the claims asserted in this litigation are **firmly grounded in the following governing documents**, which establish the **binding obligations, due process protections, and regulatory standards applicable to Plaintiff's residency training:**

✔ **Exhibit #141** – **GME Resident Contract** between Plaintiff and the Sponsoring Institution, outlining the contractual rights and obligations governing the residency training relationship.

✔ **Exhibit #147** – **GME Resident Manual**, formally endorsed by **VP of HR Veronica Ford on May 5, 2021**, setting forth policies and procedures affecting Plaintiff's training and due process rights.

✔ **Exhibit #148** – **ACGME Common Program Requirements (Residency), interim revision dated September 17, 2022, effective July 1, 2023**, which define **the minimum accreditation standards** that the Sponsoring Institution was required to uphold.

✔ **Exhibit #149** – **Milestones Guidebook for Residents and Fellows**, providing the **ACGME's competency-based framework** for assessing resident progression and performance.

✔ **Exhibit #150** – **ACGME Guidebook for Programs – Clinical Competency Committees, 3rd Edition**, detailing the **standardized process for evaluating resident performance and ensuring procedural integrity** in decision-making.

✔ **Exhibit #160 – ACGME Institutional Requirements**, which **govern the responsibilities of the Sponsoring Institution** in maintaining a compliant and fair training environment.

681. The **GME Resident Agreement** is not merely a program guideline—it is a **legally enforceable contract** between Plaintiff and **University of Maryland Capital Region Health**, explicitly governed by **Maryland law**, as stated in **Section 5.6 of the Agreement**, which provides:

> "This Agreement shall be governed by and construed in accordance with the applicable laws of the State of Maryland."

682. Accordingly, Plaintiff's **contractual and due process claims** are not only supported by the **explicit terms of the GME Resident Agreement** but also by **all other applicable Maryland contractual laws, regulations, and judicial precedents.** In addition, the **Maryland State Constitution, particularly Articles 19, 23, and 24**, along with the **Fourteenth Amendment to the United States Constitution**, provide Plaintiff with **fundamental rights to due process, judicial access, and protection against arbitrary deprivation of property and liberty interests.**

683. Defendants' actions—including **arbitrary termination, failure to adhere to due process protections, procedural deficiencies, and post-termination defamatory statements—constitute clear violations of both contract law and constitutional guarantees.** The **University's failure to comply with the GME Resident Agreement, ACGME-mandated due process protections, and Maryland statutory and constitutional requirements** further

reinforces **the unlawfulness of Plaintiff's termination** and underscores the necessity of legal redress.

LEGAL CLAIMS

COUNT I

BREACH OF CONTRACT

684. **Plaintiff incorporates by reference all preceding paragraphs as if fully set forth herein.**

685. Plaintiff, Dr. Otabek Elmurodov, entered into a legally enforceable **Graduate Medical Education (GME) Resident Agreement** (the "Contract") with Defendant, **University of Maryland Capital Region Health** (the "Defendant"), which governed the terms and conditions of his residency training.

686. The Contract, executed by both parties, expressly states that it is **"intended to be legally binding,"** thereby meeting the requirements of a valid and enforceable contract under **Maryland law**. Furthermore, **Section 5.6** of the GME Resident Agreement explicitly states that **"this agreement shall be governed by and construed in accordance with the laws of the State of Maryland."**

687. The Contract incorporated by reference **Exhibit A**, which consists of **27 GME policies** approved by **University of Maryland Capital Region Health Vice President Veronica Ford**. Additionally, **Section 3.1** of the Contract obligates the **Sponsoring Institution** to provide a **suitable environment and educational program** that meets **ACGME Institutional Requirements**, requiring **substantial compliance with ACGME Program and Institutional Requirements**, thereby incorporating **Accreditation Council for Graduate Medical Education (ACGME) standards** and **Clinical Competency Committee (CCC) guidelines**. These provisions establish clear standards governing **resident physician evaluations, training advancement, grievances, disciplinary procedures, and due process rights.**

688. Defendant **does not dispute** that the **GME Resident Agreement constitutes a legally enforceable contract**. In its **pleading responses, answers to Plaintiff's Complaint, and through limited discovery,** Defendant **does not deny** the enforceability of the Contract, its **incorporation of GME Policies (Exhibit A), its obligations to maintain substantial compliance with ACGME Program and Institutional Requirements,** or its duty to adhere to **ACGME Clinical Competency Committee guidelines.** Specifically, **Section 3.7** of the Contract mandates that **"University of Maryland Capital Region Health will maintain policies and procedures applicable to residents, the program, and the sponsoring institution to comply with all applicable laws, regulations, and standards of ACGME, the Joint Commission, and other applicable accrediting bodies and governmental authorities."** Defendant has not contested the governing documents of this contract, including:

Exhibit 141 – GME Resident Agreement

Exhibit 147 – GME Resident Manual (GME Policies)

Exhibit 148 – ACGME Common Program Requirements

Exhibit 149 – Milestones Guidebook for Residents and Fellows

Exhibit 150 – ACGME Clinical Competency Committee Guidelines

Exhibit 160 – ACGME Institutional and Program Requirements

689. Defendant **does not deny** its **full accreditation status with ACGME** nor its **obligation to remain in substantial compliance** with **ACGME Program and Institutional Requirements** as a condition of receiving **significant federal and state funding**. Defendant's accreditation **directly enables it to receive substantial financial resources**, including **Medicare Graduate Medical Education (GME) payments**, which are **funded by U.S. taxpayers to support the training of physicians in accordance with ACGME's quality education standards.**

690. These **federal and state funds** have been **calculated to reach approximately $3.2 million annually** solely for the **training of 12 Family Medicine resident physicians per year**, underscoring the **significant financial incentives** tied to **Defendant's compliance with ACGME-mandated residency training standards.** The **allocation of these taxpayer-funded resources** is **not merely discretionary support**, but an **investment by the federal and state governments** in ensuring that residency programs **meet the highest educational, ethical, and procedural standards** established by ACGME.

691. The **nation's return on investment** in funding these programs is premised on **ACGME-accredited institutions upholding the highest standards of medical education, fair evaluation processes, and due process protections for resident physicians.**

692. ACGME itself **affirmed this direct financial connection** in its **Motion to Quash Defendant's Subpoena**, filed in the **Circuit Court of Cook County, Chicago, Illinois, on March 12, 2025**, explicitly stating:

> "By law, the **Centers for Medicare & Medicaid Services makes Medicare graduate medical education payments to institutions sponsoring residency programs** that are accredited by ACGME."

693. **Defendant does not deny receiving these funds.** However, while **reaping the financial benefits of ACGME accreditation**, Defendant has **flagrantly disregarded its obligations** under ACGME standards by engaging in **retaliatory misconduct, violating due process protections, and failing to uphold the contractual and regulatory commitments that justify its receipt of public funds.** Defendant's continued **failure to comply with ACGME standards not only constitutes a breach of its contractual obligations to residents but also raises serious concerns regarding its entitlement to continued public funding.**

694. Resident physician **dismissal is an extremely rare national phenomenon**, with **average dismissal rates across all specialties remaining below 1% nationwide** for the period spanning **2010–2020**. While dismissal rates naturally **vary by specialty**, they remain **statistically uncommon** across accredited residency programs in the United States.

695. However, in stark contrast to national norms, the **University of Maryland Capital Region Health Family Medicine Program exhibited an alarmingly high dismissal rate**, ranging between **25–50% annually from 2019 to 2023.** Defendant **does not deny** publicly available

ACGME citations for noncompliance nor does it dispute the **prior dismissals of multiple resident physicians**, including:

✔ **Dr. Alexander Melkuev**

✔ **Dr. Isra Amjed**

✔ **Dr. Brenda Figueroa** *(all dismissed from the Family Medicine Program prior to Plaintiff)*

✔ **Dr. Fariba Yazdanpanah**, *(dismissed in June 2023 from the parallel Internal Medicine Program)*

696. These dismissals **strongly indicate a systemic issue** within the **University of Maryland Capital Region Health Family Medicine Program and its GME office**, reflecting **a pattern of noncompliance, arbitrary terminations, and institutional failures in upholding due process and resident protections.**

697. ***See*** *Khoiny v. Dignity Health*, 76 Cal.App.5th 390, 402 (Cal. Ct. App. 2022) ("All the cases discussed above involve residency programs not before this court. Nevertheless, they have general application to our analysis of respondent's programs, **because all residency programs are expected to follow ACGME guidelines.** While it is not determinative of our analysis, we note that the **specific residency program at SMMC was not in compliance with ACGME's guidelines concerning the academic aspects of its program.** ACGME placed SMMC's residency program **on probation as of January 2014 for problems dating back to 2012.** ")

698. Further reinforcing this **chronic pattern of wrongful termination and employment law violations**, an **ongoing parallel lawsuit**—***Felicia Hendrix-Bennett v. University of Maryland***

Medical Center, LLC, et al. **(Case No. C-16-CV-24-005012, Prince George's Circuit Court)**—demonstrates that these **violations extend beyond the residency program** to broader **institutional misconduct in employment practices.**

699. Defendant's **repeated and unjustified terminations** of resident physicians, combined with its **ongoing employment-related legal disputes, ACGME citations, and noncompliance issues**, strongly suggest **a deeply ingrained, systematic failure within the institution, warranting heightened legal and regulatory scrutiny.**

700. Under **Maryland contract law**, the **GME Resident Agreement** satisfies **all essential elements of a valid and legally enforceable contract**, including **offer, acceptance, consideration, mutual assent, legal purpose, and capacity**:

1. **Offer** – Defendant **offered a residency position** with specific terms outlined in the **GME Resident Agreement**, including **its incorporated Exhibit A**, which **detailed the obligations, policies, and due process protections** governing Plaintiff's residency training.

2. **Acceptance** – Plaintiff **accepted the contract** by **signing the agreement** and **fulfilling all residency obligations**, including **completing clinical rotations, providing patient care, and complying with ACGME competency evaluations**, as explicitly required under the contract.

3. **Consideration (Exchange of Value)** – Plaintiff **provided medical services, actively participated in training, and fulfilled all contractual obligations** with the **reasonable**

expectation of obtaining a Certificate of Completion and achieving Board Eligibility in Family Medicine. In exchange:

- **Defendant received substantial federal and state funding** from the **Centers for Medicare & Medicaid Services (CMS)** for Plaintiff's training.
- **Defendant's receipt of these funds** was **conditioned upon its obligation to provide ACGME-compliant medical education and training.**

Further illustrating **Defendant's financial interest and contractual obligations**, after **dismissing Dr. Brenda Figueroa**, the **University of Maryland Capital Region Health Family Medicine Program actively sought to recruit another resident physician** to fill the **vacant PGY-2 slot**—not merely for programmatic continuity, but **to maintain CMS funding.** If **Defendant failed to recruit a replacement after dismissing a resident**, it **risked losing a portion of its Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments.** This **financial dependency on residency slots** underscores **why Defendant entered into a contractual relationship with Plaintiff**, making **explicit assurances to honor the terms and conditions of the agreement.**

4. **Mutual Assent** – Both parties **explicitly agreed** to the terms of the **GME Resident Agreement, ACGME compliance, and other employment conditions**, as detailed in the contract, thereby demonstrating a **meeting of the minds** regarding the contractual obligations and rights of both parties.

5. **Legal Purpose & Capacity** – The **contract is lawful**, as it pertains to **graduate medical education and training**, and **both parties were legally competent to enter into the agreement.**

701. By satisfying **each of these essential contract elements**, the **GME Resident Agreement constitutes a legally enforceable contract under Maryland law.** Defendant's **breach of contract** through **wrongful termination, procedural violations, and retaliatory misconduct** constitutes **a material failure to uphold its contractual obligations**, thereby **entitling Plaintiff to seek legal redress.**

702. **Prince George's County Circuit Court has formally recognized the existence of this legally enforceable contract**. On **December 9, 2024,** the Honorable **Judge Krystal Alves denied Defendant's Motion to Dismiss or, in the Alternative, Motion for Summary Judgment** as to **Plaintiff's breach of contract claim under Count One**, thereby reaffirming the **legally enforceable contractual obligations of Defendant.**

703. **Maryland contract law establishes that contract interpretation is a question of law**. Where contract terms are **unambiguous, they are enforced as written**. If ambiguous, **they are construed against the drafter**—here, **Defendant University of Maryland Capital Region Health**.

704. **See** *Kiley v. First Nat'l Bank*, 102 Md. App. 317, 333 (Md. Ct. Spec. App. 1994) ("**A contract is defined as "a promise or set of promises for breach of which the law gives a remedy, or the**

performance of which the law in some way recognizes as a duty." Richard A. Lord, 1 *Williston on Contracts* § 1:1, at 2-3 (4th ed. 1990) (hereinafter " *Williston*"). *Accord, Restatement (Second) Contracts* § 1, at 5 (1981). **Mutual assent is an integral component of every contract.** *Md. Supreme Corp. v. Blake Co.,* 279 Md. 531, 539, 369 A.2d 1017 (1977).")

705. **See** *Rice v. St. Louis Univ.*, No. 4:19-cv-03166 SEP, at *5 (E.D. Mo. June 4, 2020) ("**Contract interpretation is a question of law.** *Theroff v. Dollar Tree Stores, Inc.*, 591 S.W.3d 432, 436 (Mo. banc 2020). **"The cardinal principle for contract interpretation is to ascertain the intention of the parties and to give effect to that intent."** *Intertel, Inc. v. Sedgwick Claims Mgmt. Servs., Inc.*, 204 S.W.3d 183, 196 (Mo. Ct. App. 2006) (citing *Butler v. Mitchell-Hugeback, Inc.*, 895 S.W.2d 15, 21 (Mo. banc 1995)). "**If the contract is unambiguous, it will be enforced according to its terms. If ambiguous, it will be construed against the drafter . . . .**" *Triarch Indus., Inc. v. Crabtree*, 158 S.W.3d 772, 776 (Mo. banc 2005). ")

706. **See** *Kiley v. First Nat'l Bank*, 102 Md. App. 317, 336 (Md. Ct. Spec. App. 1994) ("**In applying the objective test to interpret a contract,** the Court of Appeals has said: **"`The true test of what is meant is not what the parties to the contract intended it to mean, but what a reasonable person in the position of the parties would have thought it meant.'"** *Cloverland Farms Dairy, Inc. v. Fry,* 322 Md. 367, 373, 587 A.2d 527 (1991) (quoting *Kasten Constr. v. Rod Enterprises,* 268 Md. 318, 329, 301 A.2d 12 (1973)).

707. Plaintiff **fully performed all obligations** under the **GME Resident Agreement**, demonstrating **unwavering compliance with the terms of the contract** and **exceeding the program's performance expectations**, as evidenced by the following:

1. **Provision of Medical Services as a Licensed Physician** – Throughout his residency training, Plaintiff served as a **physician in good standing** without a single **patient grievance, malpractice claim, or tort liability** arising from his clinical practice. Plaintiff **never subjected** the **University of Maryland Capital Region Health** to **any reputational harm**, instead delivering **high-quality physician services** that directly benefited the institution. Defendant **received and retained full payments** for services Plaintiff provided as a physician, further **profiting from Plaintiff's clinical contributions**. Plaintiff's **National Practitioner Data Bank (NPDB) record remains clean**, affirming his **unblemished professional standing**.

2. **Exceeding Performance Metrics Among Resident Physicians** – As **substantiated through Exhibit #127**, **EPIC Signal Data**—a proprietary system measuring **physician efficiency, clinical workload, and documentation proficiency**—demonstrates that Plaintiff **consistently outperformed his peers** in **clinical productivity and patient care delivery**.

3. **Compliance with Billing and Documentation Standards** – Plaintiff **never received any citation or notification** from the **University of Maryland Capital Region Health Medical Billing Department** regarding any **deficiency, noncompliance, or insufficiency** in his medical documentation. All **notes and charts created by Plaintiff were fully compliant and billable**,

ensuring **proper reimbursement for physician services** rendered through **insurance providers, including Medicare and Medicaid.**

4. **Unblemished Character and Professional Conduct** – Plaintiff **maintained good moral character throughout his residency**, with **no history of legal issues, professional misconduct, or disciplinary actions**. Specifically:

    1. **Never faced any legal infractions or issues with the laws of the State of Maryland.**
    2. **Never been subject to any impairment, psychiatric treatment, or psychiatric evaluation.**
    3. **Never engaged in drug use, substance abuse, sexual harassment, or physical altercations** with **any staff member, faculty, or medical student.**

5. **Meeting All Residency Training Requirements** – Plaintiff was a **full participant in the residency program**, with an **impeccable attendance record**, demonstrating **commitment beyond the baseline requirements**:

    1. **Never called in sick or missed a single day of training.**
    2. **Consistently demonstrated teamwork, covering sick calls for peer residents**, as **admitted by Dr. Donna Prill's testimony on November 9, 2023, during cross-examination.**
    3. **Regularly exceeded duty hour expectations, often overworked without receiving his legally promised vacation time in comparison to his peers.**
    4. **Actively contributed to resident research and scholarly activities, fulfilling ACGME-mandated requirements.**
    5. **Maintained continuous certification in BLS, ACLS, PALS, and ALSO throughout residency training.**

6. **Duly participated in Family Medicine board exams without scoring lower than his peers.**

6. **Maintaining Good Standing Among Faculty, Peers, and Hospital Staff** – By **preponderance of the evidence**, Plaintiff's **performance evaluations, written character references, and letters of support** from **impartial attending physicians, co-residents, ancillary staff, and medical students** confirm that **Plaintiff remained in good standing throughout his tenure in the program**.

7. **Defendant Failed to Cite Any Specific Contractual Violation** – At no point did Defendant **allege or substantiate that Plaintiff violated any explicit contractual obligation** within the **GME Resident Agreement or its incorporated 27 GME Policies (Exhibit A)**. **Defendant's failure to identify a specific breach of contract** further **reinforces the arbitrary, capricious, and retaliatory nature of Plaintiff's termination**.

708. By **fulfilling all contractual obligations**, **maintaining superior clinical performance**, and **remaining in good standing with no documented deficiencies**, **Plaintiff's wrongful termination constitutes a material breach of contract by Defendant**, thereby **entitling Plaintiff to full legal redress for the damages incurred**.

709. Defendant **materially breached** the **GME Resident Agreement** by **failing to uphold its contractual obligations**, including the following violations:

1. Violation of GME Resident Agreement & GME Policies: Defendant **disregarded multiple provisions** of the **GME Resident Agreement** and **GME Policies 102, 103, 104, and 105**, which govern **resident physician evaluations, advancement, due process rights, and disciplinary procedures.**

2. Noncompliance with ACGME Program & Institutional Requirements: Defendant **failed to adhere** to **ACGME-mandated standards** governing **resident training, evaluations, and disciplinary actions**, thereby violating **contractual and accreditation obligations.**

3. Unethical and Retaliatory Conduct by Former Program Director, Dr. Stacy Ross:

1. **Dr. Ross repeatedly violated professional and ethical obligations** under **GME Policy 122 (Professionalism)** and **acted in bad faith, with personal animus and malice toward Plaintiff.**
2. **By preponderance of the evidence,** multiple examples in the **Statement of Facts** demonstrate **Dr. Ross's misconduct, coercion, and maltreatment of Plaintiff**, including **retaliatory actions and procedural irregularities** leading to Plaintiff's wrongful termination.
3. **Dr. Ross evaded cross-examination** during the **internal appeal hearing on November 9, 2023,** when Plaintiff was represented by **attorney Michael Herman, Esq.**
4. **Dr. Ross further failed to comply with a lawfully issued writ of summons** from this Court, **evading in-person deposition on March 7, 2025,** under **unsubstantiated "safety concerns,"** despite offering to appear remotely.
5. When Plaintiff agreed to a remote deposition, **Defendant Dr. Ross's counsel willfully obstructed the process** by **refusing to comply with Maryland public notary laws governing deponent identification.** Under Maryland law, a **commissioned public notary must verify the deponent's identity before administering the oath**, a **mandatory**

prerequisite for a **legally valid deposition. Due to defense counsel's refusal to facilitate proper identification, the commissioned notary for Prince George's County was legally precluded from administering the oath and proceeding with the deposition.**

6. The **University of Maryland Capital Region Health refused to provide legal representation for Dr. Ross**, confirming that **she did not leave the institution on unfavorable terms**.
7. **Dr. Ross actively participated in litigation as a separate defendant until December 9, 2024, and then as a non-party.**
8. **Dr. Ross's misconduct and failure to comply with the GME Resident Agreement and broader ACGME standards** subjected the institution to **this lawsuit.**

3. <u>Failure to Follow ACGME Clinical Competency Committee (CCC) Guidelines:</u> Defendant **disregarded ACGME-mandated procedures** regarding **non-promotion, denial of credit, non-renewal of contract, and dismissal decisions,** rendering **Plaintiff's termination arbitrary and noncompliant with accreditation standards.**

5. <u>GME Office's Failure to Enforce Due Process Protections:</u> Former GME Director Tyrece Hunter failed to uphold GME policies and **ACGME standards,** despite being responsible for **graduate medical education compliance.**

1. **The University's pattern of instability**, reflected in **multiple leadership resignations,** further underscores the **systemic failures in enforcing due process**:
    - **Dr. Donna Prill's application for Program Director was denied, leading to her resignation.**
    - **Dr. Stacy Ross resigned in June 2023.**

- **Tyrece Hunter resigned following Dr. Ross's departure.**

6. Failure to Conduct an Independent Investigation: The **University of Maryland Capital Region Health failed to conduct any independent investigation** into the **June 27, 2023, night call incident.**

1. **Neither Dr. Donna Prill, Dr. Stacy Ross, nor Dr. Nader Tavakoli, nor any hospital official interviewed first-hand witnesses,** including **Nurse Corrie Welch, RN, or NICU Attending Physician Dr. Daniel Brewer.**

7. Denial of Due Process Prior to Termination: Defendant **failed to provide Plaintiff with due process** before terminating his contract on **July 24, 2023,** despite:

1. Plaintiff submitting **written grievances** to **HR Director Benjamin Carter, Interim Program Director Dr. Tavakoli, and Designated Institutional Official (DIO) Dr. Archinard**, requesting his **due process rights.**
2. Defendant **unilaterally terminating Plaintiff** without offering the **contractual due process protections** guaranteed by the **GME Resident Agreement.**

8. Coercive Severance Agreement Attempt: Defendant's HR department **attempted to pressure Plaintiff into signing a severance agreement** in exchange for **a small monetary payment.**

1. **The severance agreement was designed to waive Plaintiff's right to litigation, shielding Defendant and its agents from legal accountability.**

9. Retaliatory and Unlawful Administrative Appeal Process: Only after Plaintiff secured legal counsel did Defendant agree to proceed with an administrative hearing.

1. **Defendant hired Michael Baxter, Esq., to preside over the hearing, ensuring a biased process.**
2. **The hearing panel was comprised entirely of Defendant's employees, acting as an "impartial jury."**
3. **Defendant failed to apply Maryland law or the preponderance of evidence standard required in such proceedings.**

10. Failure to Cooperate with State & Federal Equal Employment Investigations:

1. Defendant **failed to respond to official inquiries** made by the **Maryland Commission on Civil Rights (MCCR) and the U.S. Equal Employment Opportunity Commission (EEOC).**
2. **Due to Defendant's failure to respond, Plaintiff was issued a Right to Sue Letter by default.**

11. Failure to Respond to ACGME Ombudsperson Inquiry:

1. Defendant **never submitted a formal response** to the **ACGME Ombudsperson's inquiry regarding Plaintiff's complaint.**
2. **There is no record of any official documentation** from the **University of Maryland Capital Region Health** addressing **Plaintiff's concerns with ACGME.**

12. Interference with Plaintiff's Medical Licensure:

1. **Defendant deliberately delayed post-graduate education verification forms** required by the **Maryland Board of Physicians.**
2. **Defendant initially refused to grant ACGME-earned credits necessary for Plaintiff's licensing process.**
3. **Only after the Maryland Board of Physicians issued a subpoena did Defendant agree to complete the verification forms.**
4. **In retaliation for this lawsuit,** Defendant issued **defamatory statements falsely alleging Plaintiff exhibited "inappropriate behavior, substance abuse, or required continuous counseling regarding professional interactions with medical students".** These defamatory statements were made **to harm Plaintiff's reputation and future employment prospects.**

13. Unjustified Termination & Failure to Defend Claim with Maryland Department of Labor:

1. **Defendant failed to justify Plaintiff's termination** before the **Maryland Department of Labor.**
2. **As a result, Plaintiff was awarded unemployment benefits,** further confirming the **arbitrary and capricious nature of his termination.**

14. Defendant's Discovery Misconduct & Obstruction of Depositions:

1. Defendant **provided legal services to non-party witnesses** while **prejudicing Plaintiff, creating a clear conflict of interest.**
2. Defendant **filed multiple frivolous motions for protective orders to avoid participation in depositions.**

3. Defendant **refused to comply with a lawfully issued writ of summons for in-person depositions on March 7, 2025,** agreeing only to **remote depositions** but then **obstructing the process by failing to comply with Maryland's remote notarial requirements.**
4. Defendant **completely declined participation** in any **depositions in violation of its discovery obligations.**
5. **Plaintiff's motion for contempt of court is pending, with Plaintiff having already submitted his reply in support.**

710. **Defendant's Breaches Constitute Material Violations of the Contract**

711. Defendant's **repeated violations of the GME Resident Agreement, ACGME-mandated due process standards, and Maryland employment protections** amount to **a material breach of contract.** These violations **demonstrate a systemic failure to uphold its obligations, entitling Plaintiff to full legal redress for the damages incurred.**

712. Under **Maryland law**, **MD Code, Commercial Law § 22-701** defines a **breach of contract** as a party's failure to fulfill its contractual obligations **without a reasonable legal excuse**, and a **material breach** occurs when such failure substantially deprives the aggrieved party of an essential benefit reasonably expected under the contract. Defendant **has no legal excuse** for its breach.

713. Throughout Plaintiff's residency, Defendant maintained **valid ACGME accreditation, received federal funding designated for training resident physicians, and applied ACGME standards to other residents while subjecting Plaintiff to disparate treatment.** Despite these

obligations, Defendant **failed to follow the due process protections, evaluation standards, and disciplinary procedures required under the GME Resident Agreement and ACGME regulations.**

714. Defendant's breach **substantially harmed Plaintiff** by unlawfully terminating his contract and **depriving him of a Certificate of Completion, board eligibility, and ultimately the opportunity to achieve board certification—fundamental benefits of residency training.** Plaintiff lost **two years of his career, financial earning potential, and the ability to practice as a board-certified family physician.**

715. As **§ 22-701 expressly states, a breach entitles the aggrieved party to its remedies**, and the **severity of this breach meets the statutory threshold for material breach** given the **substantial financial loss, professional harm, and irreversible career consequences inflicted upon Plaintiff.** Defendant's repeated failures to comply with contractual and industry standards, coupled with procedural misconduct and retaliation, **make clear that Plaintiff is entitled to full legal redress, including damages and any other remedies available under Maryland law.**

716. ***See*** *Taylor v. Nationsbank*, 365 Md. 166, 175 (Md. 2001) (**"To prevail in an action for breach of contract, a plaintiff must prove that the defendant owed the plaintiff a contractual obligation and that the defendant breached that obligation.** See *Continental Masonry Co., Inc. v. Verdel Const. Co., Inc.,* 279 Md. 476, 480, 369 A.2d 566, 569 (1977). **It is not necessary that the plaintiff prove damages resulting from the breach, for it is well settled that where a breach of contract occurs, one may recover nominal damages even though he has failed**

to prove actual damages. *Hooton v. Kenneth B. Mumaw Plumbing Heating Co., Inc.,* 271 Md. 565, 572-73, 318 A.2d 514, 518 *(1974); Asibem Assoc., Ltd. v. Rill,* 264 Md. 272, 276, 286 A.2d 160, 162 *(1972); Rotwein v. Bogart,* 227 Md. 434, 438, 177 A.2d 258, 260 *(1962); Gilbert Const. Co. v. Gross,* 212 Md. 402, 412, 129 A.2d 518, 523 *(1956); Envelope Co. v. Balto. Post Co.,* 163 Md. 596, 606, 163 A. 688, 692 *(1933); see Mallis v. Faraclas,* 235 Md. 109, 116, 200 A.2d 676, 680 (1964).")

717. Throughout their **dismissive motions and answer pleadings,** Defendant **University of Maryland Capital Region Health** has repeatedly argued before this **Honorable Court** that the **judicial system should not interfere with the internal academic affairs of institutions,** using this argument as a shield to justify their **arbitrary and capricious decisions** regarding Plaintiff's **non-promotion, denial of credit, non-renewal of contract, unjustified remediation and probation, and ultimately, wrongful termination.**

718. However, **well-established legal precedent** confirms that **courts across the nation have intervened in university dismissal cases when institutions fail to follow their own established procedures and protocols.** Judicial review is particularly warranted when **a university's decision is not based on sound academic judgment but rather on arbitrary, retaliatory, or discriminatory actions that violate contractual and procedural safeguards.** Defendant's invocation of academic non-intervention **cannot insulate them from liability when their own misconduct and failure to adhere to governing policies resulted in material harm to Plaintiff's career and due process rights.**

719. **See** *Gurbani v. Johns Hopkins Health Sys. Corp.*, 237 Md. App. 261, 307 (Md. Ct. Spec. App. 2018) (“"**Educational discretion is ... not limitless**[,]" and "in exercising its professional judgment, an **educational institution does not have license to act arbitrarily, capriciously, or in bad faith.**" *Gupta v. New Britain Gen. Hosp.* , 687 A.2d at 121.”) (“Bad faith " ‘is not simply bad judgment or negligence, but **implies a dishonest purpose or some moral obliquity and a conscious doing of wrong.’ "** *Rite Aid Corp. v. Hagley* , 374 Md. 665, 681, 824 A.2d 107 (2003) (quoting *Catterton v. Coale* , 84 Md. App. 337, 342, 579 A.2d 781 (1990)).”)

720. **See** Cf. *Susan M. v. N.Y. Law School*, 149 A.D.2d 69, 72 (N.Y. App. Div. 1989) (“… "the highly discretionary, professional, and inevitably subjective process of actually grading law school exams" is beyond judicial review. **We disagree. As seldom and reluctantly as the principle has been applied to actually override a determination, a school's academic evaluation of a student is not "completely immune from judicial scrutiny"** *(Matter of Olsson v. Board of Higher Educ.*, 49 N.Y.2d 408, 413). **If a school exercises its discretion to dismiss a student for academic reasons in an arbitrary or irrational fashion, the courts will intervene** *(supra*, at 414).”)

721. **See** also *Denterlein v. Gamp,* A144516, at *8-9 (Cal. Ct. App. Dec. 20, 2017) (“ Our high court has explained that "[t]here is a widely accepted rule of judicial nonintervention into the academic affairs of schools." (*Paulsen v. Golden Gate University* (1979) 25 Cal.3d 803, 808 (*Paulsen*).) Under this rule, **we may overturn a university's decision only "if we find it tobe arbitrary and capricious, not based upon academic criteria, and the result of irrelevant or discriminatory factors."** (*Banks*, at p. 1551, citing *Paulsen*, at pp. 808-809 and *Wong v. Regents of University of California* (1971) 15 Cal.App.3d 823, 830 (*Wong*).) "We must uphold the university's decision '**unless it is such a substantial departure from accepted academic**

norms as to demonstrate that the person or committee responsible did not actually exercise professional judgment.' " (*Banks*, at p. 1551, quoting *Regents of University of Michigan v. Ewing* (1985) 474 U.S. 214, 225.) "An essential element of all claims such as appellant's, which seek to challenge an academic decision of a private university, **is proof that the decision was arbitrary and capricious, because it was not based upon any discernible legitimate, rational basis.**" (*Banks*, at p. 1553.)")

722. Another **meritless argument** advanced by **University of Maryland Capital Region Health** is that, for judicial purposes, **Plaintiff should be treated as a "medical student."** This argument is **unsupported by the GME Resident Agreement, contradicts well-established legal principles, and fails under both contractual and factual analysis.**

723. Defendant is **fully aware of the fundamental legal and professional distinction** between a **medical student** and a **physician in training (resident physician).** Unlike medical students, **Plaintiff was an employee of the hospital, serving as a physician in training,** receiving **a salary, paid vacation time, health benefits, and other employment entitlements.** Plaintiff **filed a W-2 form with the IRS, paid federal, state, and Social Security taxes as an employee,** and was contractually bound by the **GME Resident Agreement, not a medical school enrollment agreement.**

724. Additionally, **medical students at University of Maryland Capital Region Health do not receive compensation; rather, they pay tuition to the institution for their training.** Medical students **do not provide billable physician services, cannot place independent orders, prescribe medications, or act as licensed healthcare providers.** In contrast, **resident**

physicians provide direct, legally recognized patient care, write billable notes, and perform physician duties under supervision.

725. The **United States Supreme Court has recognized the right and logic of treating resident physicians as employees rather than students.** In *Mayo Foundation for Medical Education and Research v. United States,* 562 U.S. 44 (2011), the Supreme Court held that **resident physicians are employees for federal tax purposes**, further reinforcing that **they are not mere students, but compensated professionals engaged in the practice of medicine under structured training.** Defendant's attempt to **misclassify Plaintiff as a medical student** is a **transparent effort to evade liability for its breach of contract and failure to adhere to due process, employment protections, and ACGME-mandated training obligations.**

726. **See** *Khoiny v. Dignity Health*, 76 Cal.App.5th 390, 400 (Cal. Ct. App. 2022) ("Generally, medical residents have been found **to spend 75 percent to 80 percent of their time providing services to the medical centers or hospitals where their residency programs are located.** (*Regents of University of California v. Public Employment Relations Bd.* (1986) 41 Cal.3d 601, 619, 224 Cal.Rptr. 631, 715 P.2d 590 (*PERB*); *Boston Med. Center Corp., supra,* 330 NLRB at p. 160.) Significantly, **"the patient care services performed by housestaff [are] an important part of the hospital's overall service delivery."** (*PERB* , at p. 618, 224 Cal.Rptr. 631, 715 P.2d 590 [housestaff refers to interns, medical residents and fellows].) **The United States Supreme Court** has rejected **an argument** that residents are **not fully trained and have yet to begin their working lives, finding instead that these doctors " 'who work long hours, serve as highly skilled professionals, and typically share some or all of the terms of employment of career employees' "** are in fact workers, even if they are also "students of their craft." (*Mayo*

Found. for Med. Educ. & Research v. United States (2011) 562 U.S. 44, 60, 131 S.Ct. 704, 178 L.Ed.2d 588 (*Mayo*).)")

727. Maryland case law **unequivocally supports** the principle that in **breach of contract cases, the non-breaching party is entitled to an appropriate remedy under the law.** Plaintiff is **not failing to state a claim**; rather, his **claim for reinstatement is explicitly grounded in the GME Resident Agreement and institutional policy.**

728. **Policy 103 on Due Process, under the section "Burden of Proof,"** provides that if a resident **demonstrates by a preponderance of the evidence** that an adverse decision was **arbitrary and capricious, the resident is entitled to a remedy**—in this case, **reinstatement and continuation of training.** Defendant's **failure to adhere to its own established policies and due process protections** substantiates **Plaintiff's claim for reinstatement as an appropriate contractual remedy.**

729. Furthermore, **Maryland law explicitly guarantees the right to relief upon breach of contract. MD Code, Commercial Law § 22-701** states: *"A breach, whether or not material, entitles the aggrieved party to its remedies."* This statutory provision, **reinforced by Maryland case law**, affirms **Plaintiff's legal entitlement to reinstatement and continuation of training**, as the contract itself **expressly provides for such relief when due process violations and arbitrary decision-making are established.**

730. **See** *WSC/2005 LLC v. Trio Ventures Assocs.*, 460 Md. 244, 268 (Md. 2018) ("**In an action for breach of contract, courts attempt to put the injured party in as good a position as it would have occupied had the contract been fully performed by the breaching party.** *See Beard v. S/E Joint Venture* , 321 Md. 126, 133, 581 A.2d 1275 (1990) ("Damages for breach of a contract ordinarily are that sum which **would place the plaintiff in as good a position as that in which the plaintiff would have been, had the contract been performed.**").")

731. **See** *CR-RSC Tower I, LLC v. RSC Tower I, LLC*, Nos. 280 2535, September Term, 2010, at *31 (Md. Ct. Spec. App. Oct. 26, 2011) (" The Court stated that a court can consider post-breach evidence **"in order to place the non-breaching party in as good a position as he would have been had the contract been performed."** *Id.* at 1370 (quoting *Fifth Third Bank v. United States,* 518 F.3d 1368, 1377 (Fed. Cir. 2008)).")

732. **See** *Casualty Ins. Co. v. Messenger*, 181 Md. 295, 301-02 (Md. 1943) ("**The court should endeavor to place the injured person, as far as possible by monetary award, in the position in which he would have been, if the contract had been properly performed.** *Chamberlain v. Baltimore Ohio R. Co.,* 66 Md. 518, 529, 18 A. 267; *United States v. Behan,* 110 U.S. 338, 4 S.Ct. 81, 28 *L.Ed.* 168.")

733. U.S. jurisprudence has **properly recognized that a resident physician's claim to residency training constitutes a legally protected property interest and liberty right.** Courts have acknowledged that residency training is not merely an academic privilege but a **career-defining professional entitlement, subject to due process protections when adverse actions are taken against a resident.**

734. The **Maryland Declaration of Rights** further safeguards Plaintiff's rights under multiple provisions:

1. **Article 19** guarantees that **every individual is entitled to a legal remedy for injuries done to their person or property** and that justice must be **freely provided, without sale, fully without denial, and speedily without delay, according to the law of the land.** Defendant's **arbitrary and capricious termination** deprived Plaintiff of his **contractual and professional rights**, warranting judicial intervention and appropriate relief.
2. **Article 23** preserves **Plaintiff's constitutional right to a jury trial** in civil proceedings where the amount in controversy exceeds $15,000. Defendant's attempt to evade **judicial review of its wrongful actions** contradicts this fundamental right, reinforcing the necessity of jury adjudication in this matter.

3. **Article 24** provides that **no person may be deprived of life, liberty, or property without due process of law.** Residency training, as a **property interest and liberty right**, cannot be **arbitrarily revoked without affording the resident procedural protections and substantive fairness.** Defendant's **failure to adhere to due process, its retaliatory conduct, and its procedural violations** directly infringe upon these constitutional protections.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court grant the following relief:

1. **Issue an order for specific performance, compelling Defendant to reinstate Plaintiff into the residency program, certify his completion of 21 months of ACGME-accredited training, and provide an additional three months necessary for graduation and board**

eligibility. Given the unique and irreplaceable nature of residency training, monetary damages are insufficient to remedy the harm suffered. Accordingly, specific performance is the only appropriate remedy to enforce Defendant's contractual obligations under the GME Resident Agreement and restore Plaintiff to the position he was rightfully entitled to before Defendant's wrongful termination.

2. **Award compensatory damages for lost wages, lost earning capacity, lost career opportunities, and reputational harm.**
3. **Grant such other and further relief as this Court deems just and proper.**

COUNT II

BREACH OF THE COVENANT OF

GOOD FAITH AND FAIR DEALING

735. Plaintiff incorporates by reference **all preceding paragraphs** of this Complaint as if fully set forth herein and states the following:

736. Under **Maryland law**, every contract carries an **implied duty of good faith and fair dealing**, obligating both parties to **act honestly and fairly to uphold the reasonable expectations and benefits of the contract.** This principle is codified under **MD Code, Commercial Law § 23-**

105(a), which explicitly states that the **covenant of good faith and fair dealing is inherently implied in an operating agreement unless expressly disclaimed.**

737. The **GME Resident Agreement** contains **no provision disclaiming this duty.** Instead, the contract reinforces its **binding nature under Maryland law** in **Section 5.6**, which states:

> "This agreement shall be governed by and construed in accordance with the laws of the State of Maryland."

738. Additionally, **Section 5.7** affirms that any **modifications to the agreement require mutual written consent** with **advance notice of ten (10) days**, further underscoring that **Defendant was contractually bound to adhere to the agreement's terms in good faith.**

739. **Defendant University of Maryland Capital Region Health** did not possess **unlimited academic discretion** under the **GME Resident Agreement.** Instead, it was **explicitly bound** by the **terms and conditions of the agreement** and its incorporated **Exhibit A—27 GME Policies—formally approved by Vice President Veronica Ford.** Additionally, as an **ACGME-accredited institution,** Defendant was required to comply with **ACGME program and institutional requirements**, as well as **ACGME Clinical Competency Committee (CCC) guidelines** governing resident evaluations, due process, and disciplinary actions.

740. **Defendant failed to adhere to these obligations and engaged in bad-faith conduct by:**

1. **Failing to provide ACGME-mandated semiannual evaluations** based on the **six-core competency framework**, depriving Plaintiff of a fair and transparent assessment process.

2. **Failing to issue an ACGME-required annual summative evaluation** before making **decisions regarding non-promotion or nonrenewal of contract**, violating both ACGME guidelines and the contractual terms of the residency agreement.

3. **Misapplying Individualized Learning Plans (ILP) as a form of evaluation**, despite **ACGME guidelines explicitly stating** that ILPs **should not be used as evaluation tools.** ACGME mandates ILPs for **all residents**, from **low-performing to high-performing ("superstar") residents**, as a **developmental tool**, not as a **basis for adverse actions such as termination.**

4. **Failing to apply due process protections**—All **adverse actions**, including **denial of promotion, denial of credit, and nonrenewal of contract**, were subject to **due process rights** under **Section 2.6 of the GME Resident Agreement and applicable GME policies.** Instead of **following these protections**, Defendant and its **family medicine program leadership** acted **arbitrarily, capriciously, and in a retaliatory manner** against Plaintiff.

5. **Fabricating pretextual reasons for termination**—Defendant **misrepresented the events of June 27, 2023,** despite **clear evidence** showing that **Plaintiff properly evaluated the**

neonate, documented the transfer of care in the NICU, and was supported by transfer notes and first-hand testimony from NICU Attending Dr. Daniel Brewer.

6. **Denying Plaintiff pre-termination due process rights**—Despite **Plaintiff's formal grievance letter submitted on July 19, 2023**, **explicitly requesting due process protections**, Defendant **never responded** and proceeded with **termination on July 24, 2023, without affording Plaintiff a hearing or procedural review**, in direct violation of **contractual and legal due process requirements.**

7. **Conducting a biased and pre-scripted internal appeal process**—Despite **Plaintiff presenting a preponderance of evidence**, including **collected letters, evaluations, and strong advocacy** from **attending physicians, residents, medical students,** and **ancillary staff,** Defendant **did not act in good faith** during the **internal appeal process.** Instead, Defendant hired **Michael Baxter, Esq., to preside over the hearing in a judge-like role, while the "jury" was composed entirely of Defendant's own employees** following a script prepared by its **legal department.** The panel members **did not attend in person** but **participated remotely via Zoom, where their screens frequently disappeared**, and they **refused to engage in any clarification of critical details.** The **hired "judge" and panel exclusively pursued Defendant's interests** to protect its **reputation**, rather than **honoring their contractual obligations and conducting a fair review.**

741. **Maryland case law unequivocally recognizes an implied duty of good faith and fair dealing as applied to the performance and enforcement of a contract.** This **covenant of good faith and fair dealing** is a **well-established legal principle** in Maryland contract law, ensuring that

neither party to a contract acts in a way that **prevents the other from receiving the benefits of their agreement.** This principle is supported by the following case law:

742. **See** *University of Baltimore v. Iz*, 123 Md. App. 135, 175 (Md. Ct. Spec. App. 1998) ("[I]f an employer has contracted to do something that requires it to **exercise its discretion, then it must exercise that discretion in good faith."** *Elliott v. Board of Trustees,* 104 Md. App. 93, 108, 655 A.2d 46, *cert. denied,* 339 Md. 354, 663 A.2d 72 (1995).") ("…. [t]he court addressed the breach of contract count. It said: "**The College's obligation to act in good faith extends only to the performance of those contractual duties** it has chosen to assume." *Id*. 504 A.2d at 256. Nevertheless, the court recognized that once "**the College undertook to evaluate Baker, the evaluation and review process must be honest and meaningful, not a sham formality designed to ratify an arbitrary decision already made."** *Id*. 504 A.2d at 255.")

743. *See Lipitz v. Hurwitz*, 207 Md. App. 206, 231 (Md. Ct. Spec. App. 2012) (""Maryland law recognizes an **implied duty of good faith and fair dealing as applied to the 'performance and enforcement' of the contract itself."** *Polek v. J.P. Morgan Chase Bank, N.A.,* 424 Md. 333, 362, 36 A.3d 399 (2012). This duty has been summarized as **"simply prohibiting one party to a contract from acting in such a manner as to prevent the other party from performing his obligations under the contract."** *Id.* A

744. ***See*** *Himes v. Anderson*, 178 Md. App. 504, 538 (Md. Ct. Spec. App. 2008) (""**[I]n the just cause employment context,** a [fact-finder's] role is to determine the **objective reasonableness** of the employer's **decision to discharge,** which means that the **employer act in objective good**

faith and base its decision on a reasoned conclusion and facts reasonably believed to be true by the employer." *Id.* at 91, 862 A.2d 941

745. Notably, on **December 9, 2024,** the **Prince George's County Circuit Court, under Hon. Judge Krystal Alves, denied Defendant's motion to dismiss or for summary judgment on Count II—Breach of the Covenant of Good Faith and Fair Dealing.** The Court found that the **GME Resident Agreement constitutes a legally enforceable contract** and that the **covenant of good faith and fair dealing unequivocally applies** under **MD Code, Commercial Law § 23-105.**

746. This ruling **recognizes Plaintiff's viable legal claim under Maryland law**, affirming that **Defendant was contractually obligated to act in good faith in the performance and enforcement of the GME Resident Agreement.** Defendant's failure to uphold this duty, coupled with its retaliatory and bad-faith actions, warrants judicial intervention to provide full redress for Plaintiff's contractual and professional damages.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court grant the following relief:

1. **Issue an order for specific performance, compelling Defendant to reinstate Plaintiff into the residency program, certify his completion of 21 months of ACGME-accredited training, and provide an additional three months necessary for graduation and board eligibility. Given the unique and irreplaceable nature of residency training, monetary damages are insufficient to remedy the harm suffered. Accordingly, specific performance is the only appropriate remedy to enforce Defendant's contractual obligations under the GME Resident Agreement and**

restore Plaintiff to the position he was rightfully entitled to before Defendant's wrongful termination.

2. **Award compensatory damages for economic losses resulting from Defendant's bad faith conduct, including lost wages, lost earning capacity, and reputational harm.**
3. **Grant such further relief as this Court deems just and proper.**

COUNT III

DEPRIVATION OF PROPERTY AND LIBERTY INTERESTS

WITHOUT DUE PROCESS

(*Violation Of Maryland Constitution, Article 24*);

747. Plaintiff incorporates by reference all preceding paragraphs as if fully stated herein.

748. On **December 9, 2024,** the Prince George's County Circuit Court dismissed Plaintiff's **original academic due process claim,** stating that **"Maryland law does not recognize this cause of action."** However, the dismissal was **neither with prejudice nor designated as a final judgment under** *Maryland Rule 2-602(b)*, thereby **preserving Plaintiff's right to amend the claim pursuant to** *Maryland Rule 2-341* without leave of court, provided the amendment is **filed within the timeframe established in the scheduling order** issued on January 30, 2025, in

preparation for the upcoming jury trial, and to **assert his constitutional protections under** *Article 24 of the Maryland Declaration of Rights*.

749. United States jurisprudence has long recognized that **a resident physician's claim to their training is a constitutionally protected property and liberty interest** under the **Fourteenth Amendment** of the **United States Constitution**. Residency training is not an arbitrary academic experience but a structured professional employment arrangement, where resident physicians serve as employees, receive wages, pay taxes, and deliver critical physician services. It is precisely for this reason that **federal and state law recognize a resident physician's vested interest in completing training, obtaining board eligibility, and ultimately achieving board certification**—all of which are essential to practicing medicine and serving the public interest.

750. In *Stretten v. Wadsworth Veterans Hospital*, the Ninth Circuit found that a physician's claim to his residency at a **federal medical facility constituted a property interest such that he was entitled to due process prior to removal from that program.** 537 F.2d 361, 367 (9th Cir. 1976). In addition, other circuits **have found property interests** in higher education **"'sufficiently important to warrant protection'"** where **state law has provided an anchor for that right.** *Doe*, 2018 WL 1474531 at *11 (quoting *Barnes v. Zaccari*, 669 F.3d 1295, 1305 (11th Cir. 2012)

751. ***See*** *Tate v. State,* 356 P.3d 506, 511 n.3 (Nev. 2015) ["It is well-established that **a fundamental right** may not be **impaired without due process of law.** *Chudacoff v. Univ. Med. Ctr. of S. Nev.,* 609 F.Supp.2d 1163, 1172–73 (D.Nev.2009); *Maiola v. State,* 120 Nev. 671, 674–75, 99 P.3d 227, 229 (2004). Moreover, we have recognized that a **physician's interest in practicing medicine is a property right that must be afforded due process.** *Minton v. Bd. of Med. Exam'rs,* 110 Nev. 1060, 1082, 881 P.2d 1339, 1354 (1994)"]

752. ***See*** *Stretten v. Wadsworth Veterans Hospital*, 537 F.2d 361, 366 (9th Cir. 1976) ("The **"liberty interest"** is **the interest an individual has in being free to move about, live, and practice his profession without the burden of an unjustified label of infamy.** *Board of Regents v. Roth,* 408 U.S. at 572, 92 S.Ct. at 2706, 33 L.Ed.2d at 557. ")

753. By offering the **PGY-2 position** and executing the **GME Resident Agreement,** University of Maryland Capital Region Health entered into a **legally binding employment contract** with Plaintiff, thereby conferring a **constitutionally protected property and liberty interest** in his continued participation in the family medicine residency program. Under established Maryland law, **a professional has a liberty interest in the pursuit of their chosen profession and a property interest in the right to practice that profession**. *Greenberg v. Md. State Bd. of Physicians*, No. 1465-2020, at *15* (Md. Ct. Spec. App. Dec. 1, 2021); *Comm'n on Med. Discipline v. Stillman*, 291 Md. 390, 405 (1981). Accordingly, Plaintiff possesses a **liberty interest in his chosen profession as a family medicine physician** and a **property interest in the right to practice that profession**.

754. To **lawfully and freely** engage in the practice of medicine **without undue infamy** or professional obstruction, Plaintiff requires **board eligibility and board certification**, which are essential for his **career advancement, professional growth, and ability to secure future employment opportunities**. Depriving Plaintiff of these credentials—**without affording him constitutionally mandated due process**—would effectively **bar him from practicing medicine**, **irreparably damage his professional reputation**, and **terminate his career prospects**. As the *Supreme Court* recognized, "**[d]ue process requires** a hearing **before** a

person is deprived of a protected property interest." *Greene v. McElroy*, 360 U.S. 474, 492 (1959); *City of Annapolis v. Rowe*, 123 Md. App. 267, 276 (1998).

755. ***See*** *Greenberg v. Md. State Bd. of Physicians*, No. 1465-2020, at *15 (Md. Ct. Spec. App. Dec. 1, 2021) ("**Constitutional due process** requires a hearing **before** a person is **"deprived of a protected property interest."** *City of Annapolis v. Rowe*, 123 Md.App. 267, 276 (1998). A professional has a **liberty interest in the pursuit of their chosen profession and a property interest in the right to practice that profession.** *Greene v. McElroy*, 360 U.S. 474, 492 (1959); *Comm'n on Med. Discipline v. Stillman*, 291 Md. 390, 405 (1981) **(Physician has property interest in right to practice medicine). ")**

756. The Defendant filled a **PGY-2 vacancy** by appointing Plaintiff **after dismissing a prior resident**, thereby **securing continued federal and state funding** through Graduate Medical Education (GME) payments from **Medicare and Medicaid**. Having accepted taxpayer dollars to train resident physicians, Defendant **cannot arbitrarily terminate Plaintiff without adhering to constitutionally mandated due process protections** before depriving him of his vested **property and liberty interests**. **A university's decision may be arbitrary if it violates its own established procedures.** *Tatro v. Univ. of Minn.*, 800 N.W.2d 811, 816 (Minn. Ct. App. 2011), aff'd on other grounds, 816 N.W.2d 509 (Minn. 2012). Here, Defendant's failure to follow its own policies and procedural safeguards in the termination process **constitutes arbitrary and capricious action**, rendering its decision **legally infirm**. Such actions not only violate Plaintiff's fundamental rights but also establish a **dangerous precedent** whereby **private institutions benefiting from public funds** can **terminate physicians-in-training without accountability,**

disrupt careers, deny employment rights, and deprive citizens of this State of essential legal protections.

757. See *Olson v. Macalester Coll.*, 21-cv-1576 (ECT/DJF), at *73-74 (D. Minn. July 5, 2023) (“ “The Minnesota Supreme Court has long held that an ‘**action is arbitrary, oppressive, and unreasonable** so that it represents [the agency's] will and not [its] judgment.'” *Id.* (quoting *Webster v. Marshall*, 133 N.W.2d 533, 535 (Minn. 1965)). **A disciplinary decision is arbitrary and capricious** if, for example, it is tainted by **“actual bias, such as personal animosity, illegal prejudice, or a personal** or financial stake in the outcome.” *Id.* at 1019 (quoting *Richmond v. Fowlkes*, 228 F.3d 854, 858 (8th Cir. 2000)). “**A university's decision may be arbitrary if the university violates its own procedures.”** *Id.* (quoting *Tatro v. Univ. of Minn.*, 800 N.W.2d 811, 816 (Minn.Ct.App. 2011), *aff'd on other grounds*, 816 N.W.2d 509 (Minn. 2012)).

758. Plaintiff establishes a **prima facie claim** for **violation of Maryland Constitution, Article 24** by demonstrating:

1. **Existence of a Protected Interest** – Plaintiff held a **legitimate property and liberty interest** in his continued residency training, employment, and right to pursue his medical career.
2. **Deprivation of That Interest** – Defendant deprived Plaintiff of his **employment, professional standing, and future opportunities** by terminating him **without due process.**
3. **Lack of Due Process** – Defendant **failed to provide pre-termination procedural protections**, including a **fair hearing, independent review, or meaningful appeal**, thereby violating Plaintiff’s constitutional rights.

759.***See*** *Samuels v. Tschechtelin*, 135 Md. App. 483, 523-24 (Md. Ct. Spec. App. 2000) ("**To be successful in an action alleging denial of procedural due process** in violation of a **property interest,** a plaintiff must demonstrate that he had a **protected property interest,** that he was **deprived of that interest,** and that he was **afforded less process than was due.** *See Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 538-41, 105 S.Ct. 1487, 84 L.Ed.2d 494 (1985); *Rowe*, 123 Md. App. at 275-76, 717 A.2d 976. In *Board of Regents v. Roth*, 408 U.S. 564, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972)")

760.***See*** *Christian v. Dep't of Health & Human Servs.,* 258 N.C. App. 581, 585-86 (N.C. Ct. App. 2018) ("As **we have stated, "[w]ithout question**, procedural **due process requires** that an individual receive **adequate notice** and a **meaningful opportunity** to be heard **before [s]he is deprived of life, liberty, or property.** Moreover, **a professional license [ ] is a property interest, and is thus protected by due process.** " *Herron v. N.C. Bd. of Exam'rs for Engin'rs & Surveyors* , N.C. App., 790 S.E.2d 321, 327 (2016) (internal citation and marks omitted)

761.Plaintiff's claim is rooted in **Article 24 of the Maryland Declaration of Rights**, which provides:

> **Art. 24.** That **no man ought to be taken** or imprisoned or **disseized of his freehold, liberties, or privileges,** or outlawed, or exiled, or, in any manner, destroyed, or **deprived of his life, liberty, or property, but by the judgment of his peers,** or by the **Law of the land.**

762. Defendant's **unilateral and arbitrary decision** to terminate Plaintiff **without affording pre-termination due process** constitutes a direct violation of **constitutional protections**. Established legal precedent mandates that **due process requires a hearing ***before*** an individual is deprived of a protected property interest**. *Greenberg v. Md. State Bd. of Physicians*, No. 1465-2020, at *15* (Md. Ct. Spec. App. Dec. 1, 2021) (citing *City of Annapolis v. Rowe*, 123 Md. App. 267, 276 (1998)). Likewise, procedural due process **demands that an individual receive adequate notice and a meaningful opportunity to be heard ***before*** being deprived of life, liberty, or property**. *Christian v. Dep't of Health & Human Servs.*, 258 N.C. App. 581, 585-86 (N.C. Ct. App. 2018).

763. The **United States Supreme Court** has made clear that **pre-termination procedural protections are not optional but constitutionally required**. In *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985), the Court held that a **public employee with a protected property interest in their employment must receive at least "some kind of hearing" before termination**. This includes **(1) oral or written notice of the charges, (2) an explanation of the employer's evidence, and (3) an opportunity to present a response prior to termination**. *Id.* at 545-46. The pre-termination hearing serves as an **initial check against mistaken or arbitrary decisions** and does not need to be a full evidentiary proceeding, but it must provide **a meaningful opportunity to be heard before deprivation occurs**.

764. In Plaintiff's case, the **recommendation for termination was predetermined without affording him any opportunity to respond**. The **Clinical Competency Committee memorandum recommending Plaintiff's termination was drafted on June 27, 2023—immediately following a night call shift—before Plaintiff had any opportunity to submit his**

side of the story in writing. This **probation review memorandum, submitted to this Court as Exhibit 114, was deliberately withheld from Plaintiff** by former Program Director **Dr. Stacy Ross**, Clinical Competency Committee Chair **Dr. Donna Prill**, and Interim Program Director **Dr. Nader Tavakoli**.

765. When Plaintiff repeatedly inquired about the status of his residency and sought clarification, he was **met with vague, evasive, and misleading responses**. He was repeatedly reassured to **"just wait"** and **"don't worry"**, with explanations citing an ongoing **leadership transition following the resignation of the former Program Director**. These statements were not only **deceptive but designed to keep Plaintiff uninformed of critical decisions affecting his employment and training**, further underscoring the **arbitrary and constitutionally deficient nature of Defendant's actions**.

766. Plaintiff only **became aware of the June 27, 2023, termination recommendation during the "discovery phase" of the University of Maryland Capital Region Health's internal appeal process in August 2023**—when it was disclosed by **legal department employee Ms. Dena Terra**. This disclosure occurred **only after Plaintiff's attorney formally requested all documentation related to his termination**. The deliberate **concealment of this critical document throughout the initial process** further underscores the **arbitrary, procedurally deficient, and unconstitutional manner** in which Plaintiff was terminated.

767. Under **binding United States Supreme Court precedent**, Defendant's actions **fail to meet even the minimal requirements of procedural due process**. Plaintiff was **never provided oral or written notice of his termination before it was executed**, nor was he given **any**

explanation of the charges against him prior to termination. *See Cleveland Board of Education v. Loudermill*, 470 U.S. 532, 545-46 (1985) (holding that due process requires **pre-termination notice, an explanation of evidence, and an opportunity to respond**). Furthermore, Defendant **never afforded Plaintiff an opportunity to present his case before an impartial decision-maker prior to termination taking effect**, violating both **Maryland and federal constitutional protections**.

768. Had **University of Maryland Capital Region Health** followed **its own procedural policies in good faith**, it would have, at a minimum, **offered Plaintiff a period of paid or unpaid suspension before proceeding with termination**. The **GME Due Process Policy explicitly requires a structured disciplinary process—probation, then suspension, followed by termination—until pre-termination due process rights are honored**. Defendant's **failure to follow this required progression** constitutes a **clear deviation from its own established procedures, further rendering its decision arbitrary and legally untenable**.

769. This failure was further **exacerbated by the abrupt and procedurally deficient manner** in which Plaintiff was **summarily terminated on July 24, 2023, without any verbal, informal, or formal notice**. Plaintiff had a **scheduled in-person appointment with Designated Institutional Officer Dr. Tommeka Archinard on July 28, 2023**, which was **never honored or rescheduled**, as Plaintiff had already been **abruptly removed from the program without prior warning**.

770. On **July 19, 2023**, Plaintiff had **submitted a formal grievance letter regarding his treatment** and was called to meet with **HR Director Benjamin Carter** for further discussion. The meeting

was scheduled for **7:00 AM on Monday, July 24, 2023**, prior to Plaintiff's **8:00 AM clinic hours**, ensuring that the discussion would take place **before his patient responsibilities**. Upon arrival at the meeting room, **Benjamin Carter entered, accompanied by Dr. Nader Tavakoli**—a presence that was **never disclosed to Plaintiff in advance**. It later became evident that **Dr. Donna Prill was also expected to join**, a fact similarly withheld from Plaintiff. All three individuals then **waited in silence for Dr. Prill's arrival**, leaving Plaintiff unaware of the true nature of the meeting.

771. When Plaintiff inquired whether **Dr. Tavakoli or Benjamin Carter had reviewed his grievance**, both responded that they had been **away for the weekend, spending "family time."** Upon **Dr. Prill's arrival, Dr. Tavakoli retrieved a letter from a yellow envelope and, without prior discussion or explanation, immediately read aloud:** *"Effective immediately, your residency training is terminated."* The termination was so **abrupt and procedurally improper** that Plaintiff—who was **scheduled to see patients at the New Carrollton office that same day—had already prepared and reviewed patient charts**, entirely unaware that he had been removed from the program.

772. To further compound this **procedural irregularity**, **Plaintiff's email account, Epic access, and hospital badge credentials were immediately deactivated**—a measure **covertly executed** by **the University of Maryland Capital Region Health IT department**. This **immediate and deliberate revocation** not only **prevented Plaintiff from accessing his work-related records and patient documentation** but also **obstructed his ability to retrieve critical communications necessary to contest his termination**. Defendant's actions **directly hindered**

Plaintiff's ability to challenge his dismissal, reinforcing the **arbitrary and constitutionally deficient nature of the process**.

773. By **failing to provide even the most basic procedural review before terminating Plaintiff's residency**, Defendant **unlawfully deprived him of his constitutionally protected property and liberty interests through an arbitrary, procedurally defective, and fundamentally flawed process**.

774. Defendant's **post-termination internal appeal process does not cure its constitutional violation**. The law is clear: **due process protections must precede termination, not follow it**. *See Loudermill*, 470 U.S. at 542 **("The right to due process is not satisfied by a post-deprivation hearing alone.")**. Any process provided **after** the deprivation of Plaintiff's employment is legally meaningless because it **fails to prevent the harm caused by the unlawful termination itself**. A post-hoc review that merely **rubber-stamps an already executed decision** is nothing more than a **procedural façade, lacking any substantive due process value**.

775. Defendant's **failure to adhere to pre-termination procedural requirements** constitutes a **substantive due process violation under both Maryland and federal law**. By depriving Plaintiff of his **protected rights without the requisite procedural safeguards**, Defendant's actions were not only **arbitrary and unlawful** but also in direct contravention of **longstanding constitutional principles and binding legal precedent**.

776. **See** *Samuels v. Tschechtelin*, 135 Md. App. 483, 522-23 (Md. Ct. Spec. App. 2000) ("**Both Article 24 and the Due Process Clause of the Fourteenth Amendment protect an individual's interests in substantive and procedural due process.** *See Office of People's Counsel v. Maryland Pub. Serv. Comm'n*, 355 Md. 1, 26-27, 733 A.2d 996 (1999) (discussing substantive due process); *Roberts v. Total Health Care, Inc*., 349 Md. 499, 508-09, 709 A.2d 142 (1998) (discussing procedural due process). **Accordingly, our courts have long equated the Due Process Clause and Article 24.** *See Comm'n on Med. Discipline v. Stillman*, 291 Md. 390, 414 n. 9, 435 A.2d 747 (1981); *Pitsenberger v. Pitsenberger*, 287 Md. 20, 27, 410 A.2d 1052 (1980); *City of Annapolis v. Rowe*, 123 Md. App. 267, 270, 717 A.2d 976 (1998) (stating that Article 24 "`protects due process rights and is construed *in pari materia* with the federal Due Process Clause'" (citation omitted)). Consequently, Supreme Court decisions interpreting the Due Process Clause **"are practically direct authority for the meaning of the Maryland provision."** *Garnett v. State*, 332 Md. 571, 613 n. 20, 632 A.2d 797 (1993); *accord Owens v. State*, 352 Md. 663, 669 n. 3, 724 A.2d 43, *cert. denied*, 527 U.S. 1012, 119 S.Ct. 2354, 144 L.Ed.2d 250 (1999).")

777. The **GME Resident Agreement, Section 2.6**, along with **applicable GME policies 102, 103, and 104**, **explicitly require that due process rights be provided before the imposition of adverse actions** such as **dismissal or non-renewal**. The **contractual language is clear and unambiguous**—nowhere does it state that **due process rights may be granted only after** such actions have been executed. Rather, the language **unequivocally mandates pre-deprivation due process**, as it states that **"when actions are contemplated that could result"** in termination or non-renewal, procedural protections must be afforded. **A reasonable person would interpret this provision to mean that due process rights must be provided before, not after, the resident is dismissed or subjected to career-altering consequences**.

"When actions by the Sponsoring Institution or the institution where the Resident is primarily assigned are contemplated that could result in *dismissal, non-renewal*, or which *could significantly threaten the Resident's intended career development,* the Sponsoring Institution will provide the Resident with an opportunity to appeal such action in accordance with the Disciplinary Action Policy."

778. The **interpretation of contractual language is a question of law**. *See Rice v. St. Louis Univ.*, No. 4:19-cv-03166 SEP, at *5 (E.D. Mo. June 4, 2020)* (citing *Theroff v. Dollar Tree Stores, Inc.*, 591 S.W.3d 432, 436 (Mo. banc 2020)). The **cardinal principle of contract interpretation is to ascertain and effectuate the intent of the parties**, ensuring that contractual **obligations are honored as written.** *Intertel, Inc. v. Sedgwick Claims Mgmt. Servs., Inc.*, 204 S.W.3d 183, 196 (Mo. Ct. App. 2006) (citing *Butler v. Mitchell-Hugeback, Inc.*, 895 S.W.2d 15, 21 (Mo. banc 1995)). If a contract is **unambiguous, it must be enforced according to its express terms**. However, if ambiguity exists, **it is construed against the drafter**. *Triarch Indus., Inc. v. Crabtree*, 158 S.W.3d 772, 776 (Mo. banc 2005). The **GME Resident Agreement contains no ambiguity** regarding the **requirement that due process protections must be provided before termination**, and therefore, the contract **must be enforced as written**.

779. Plaintiff **exercised his right to due process** by submitting a **formal grievance letter on July 19, 2023**. This **ten-page document**, submitted to this Court as **Exhibit 117**, was addressed to **Benjamin Carter, Director of Human Resources at University of Maryland Capital Region**

Health, and **carbon copied to Interim Program Director Dr. Nader Tavakoli and Designated Institutional Officer Dr. Tommeka Archinard**.

780. In Defendant's **responsive pleading—Answer to Plaintiff's Second Amended Request for Jury Trial, filed on December 26, 2024—Defendant University of Maryland Capital Region Health does not deny receipt of Plaintiff's grievance letter nor the email communications related to its submission**. The grievance, formally titled **"Request for Fundamental Justice,"** was explicitly directed to Human Resources for review and resolution. However, instead of addressing the substantive concerns raised, Defendant **disregarded its own procedural safeguards and due process obligations**, rendering its decision **arbitrary, capricious, and unlawful**. The University of Maryland Capital Region Health's **failure to adhere to fundamental fairness and due process protections** not only **miscarried justice but directly contributed to this litigation**.

781. **Damages Resulting from Defendant's Violations:** As a **direct and proximate result** of Defendant's **unlawful deprivation** of Plaintiff's **property and liberty interests** without due process, Plaintiff has suffered **severe, ongoing, and irreparable professional and financial harm**, including but not limited to:

1. **Eleven months of unemployment following wrongful termination**—Defendant not only **arbitrarily and unlawfully terminated Plaintiff** but also **actively interfered with his licensure process before the Maryland Board of Physicians** by **deliberately refusing to provide the required ACGME training certification necessary for physician licensure in Maryland**.

2. **Nearly two years of professional derailment**, **effectively barring Plaintiff from securing further residency or employment opportunities**. If this **injustice is not rectified**, Plaintiff's **return to medical practice remains uncertain, if not entirely foreclosed**.

3. **The absence of board eligibility**, which has significantly **diminished Plaintiff's employment prospects, salary potential, and long-term earning capacity**.

4. **Severe restrictions on Plaintiff's ability to relocate or continue his medical career**, as Defendant's **wrongful termination and refusal to provide certification** have created **insurmountable barriers to professional advancement**. Despite **applying to alternative residency programs, Plaintiff has been categorically denied even interview opportunities**, further evidencing the **irreparable damage to his career trajectory**.

WHEREFORE, Plaintiff respectfully requests that this Honorable Court grant the following relief:

1. **Issue declaratory relief** affirming that Defendant's actions violated Plaintiff's **due process rights** under **Article 24 of the Maryland Declaration of Rights.**
2. **Issue an order for specific performance, compelling Defendant to reinstate Plaintiff into the residency program, certify his completion of 21 months of ACGME-accredited training, and provide an additional three months necessary for graduation and board eligibility. Given the unique and irreplaceable nature of residency training, monetary damages are**

insufficient to remedy the harm suffered. Accordingly, specific performance is the only appropriate remedy to enforce Defendant's contractual obligations under the GME Resident Agreement and restore Plaintiff to the position he was rightfully entitled to before Defendant's wrongful termination.

3. **Award compensatory damages for lost wages, lost earning capacity, lost career opportunities, reputational harm, and emotional distress caused by Defendant's unconstitutional actions.**
4. **Award punitive damages due to Defendant's reckless and deliberate violation of Plaintiff's due process rights.**
5. **Grant such other and further relief as this Court deems just and proper.**

COUNT IV

INTENTIONAL INTERFERENCE

WITH ECONOMIC RELATIONSHIPS

782. Plaintiff incorporates by reference **all preceding paragraphs** as if fully stated herein.

783. On **December 9, 2024**, the **Prince George's County Circuit Court** dismissed **Plaintiff's claim for Tortious Interference with Prospective Economic Relations**, stating that **Plaintiff had not sufficiently pleaded the necessary elements to sustain the cause of action** in his **Second Amended Complaint**. However, the dismissal was **neither with prejudice nor designated as a**

final judgment under Maryland Rule 2-602(b), thereby preserving **Plaintiff's right to amend the claim** pursuant to **Maryland Rule 2-341** without leave of court, provided the amendment is filed **within the timeframe set forth in the scheduling order issued on January 30, 2025, in preparation for the upcoming jury trial**.

784. Plaintiff now **exercises his right to amend** the claim, as permitted by law, and **replaces his prior claim for Tortious Interference with Prospective Economic Relations with the proper legal cause of action—Intentional Interference with Economic Relationships**. This amendment is necessary to accurately reflect **Defendant's deliberate obstruction of Plaintiff's timely receipt of his Maryland physician license**, which in turn **prevented Plaintiff from seeking physician employment opportunities and forced him to rely on unemployment benefits from the Maryland Department of Labor**.

785. Plaintiff explicitly clarifies that his **previous claim for Tortious Interference with Prospective Economic Relations is now amended and properly reclassified as Intentional Interference with Economic Relationships**, ensuring that the legal claim correctly aligns with **Defendant's wrongful conduct and the resulting economic harm suffered by Plaintiff**.

Factual Basis For Claim

786. Plaintiff applied for **a Maryland physician license on August 29, 2023**, after successfully completing **over 21 months of ACGME-accredited residency training**. As part of the licensing process, the **Maryland Board of Physicians required postgraduate verification forms** from **University of Maryland Capital Region Health** to confirm Plaintiff's training.

787. Under **ACGME accreditation policies and GME Policy 115**, **Defendant was required to complete Plaintiff's postgraduate verification within 30 days**. However, despite **Plaintiff's repeated formal requests during the internal appeal process**, Defendant **deliberately refused to verify Plaintiff's training** without providing any lawful justification.

788. Plaintiff was not the only party requesting verification—**the Federation of State Medical Boards (FSMB) also submitted multiple requests in September 2023**, seeking confirmation of Plaintiff's **postgraduate training and ACGME-accredited residency credits**. However, Defendant **ignored these requests as well and made no effort to comply with its obligations**, further obstructing Plaintiff's ability to obtain medical licensure.

789. Throughout the **internal appeal process**, Plaintiff, along with his attorney at the time, **Mr. Michael Herman, Esq.**, repeatedly communicated with **Dena Terra, the University of Maryland Capital Region Health staff attorney**, regarding **Defendant's ongoing failure to complete Plaintiff's postgraduate verification forms**. Despite **multiple requests made both in writing and during internal proceedings**, **Defendant knowingly refused to verify Plaintiff's training**, thereby **intentionally delaying the licensure process**.

790. As a direct result of Defendant's deliberate inaction, **Plaintiff was unable to obtain his medical license for 11 months**, which **completely prevented him from applying for physician employment opportunities**. Without a valid medical license, Plaintiff was also **ineligible to apply for essential professional credentials**, including a **DEA registration—an absolute**

prerequisite for prescribing controlled substances—further compounding his inability to practice medicine.

791. On **December 14, 2024, Plaintiff initiated this lawsuit against Defendant**. Immediately thereafter, **Defendant—under the pressure of litigation—began complying with verification requests it had previously ignored**. Prior to the lawsuit, Defendant had made **no effort to complete the required verification process** despite multiple formal requests from **Plaintiff, his attorney, the Maryland Board of Physicians, and FSMB**. Defendant's sudden cooperation after litigation commenced demonstrates **clear bad faith and a willful effort to deprive Plaintiff of economic opportunities**.

792. Following Plaintiff's **formal complaint to the Maryland Board of Physicians regarding Defendant's intentional obstruction**, the **Board's legal department issued a subpoena to University of Maryland Capital Region Health Family Medicine Program around March 2024**, compelling the program to complete the required verification. As a direct result of this legal intervention, the **Maryland Board of Physicians finally issued Plaintiff's medical license at the end of May 2024**.

793. Only upon obtaining his medical license was Plaintiff able to **apply for a DEA registration**, which is a **critical prerequisite for employment as a practicing physician**. **Defendant's prolonged and unjustified delay in completing verification not only obstructed Plaintiff's licensure but also directly delayed his ability to obtain the necessary DEA registration, further impeding his employability.**

794. With his medical license and DEA registration finally in place, **Plaintiff was able to begin seeking employment opportunities**. However, due to **Defendant's interference**, Plaintiff was left with **severely diminished job prospects**. The **absence of board eligibility and board certification**, a direct consequence of **Defendant's wrongful conduct**, forced Plaintiff to **accept a minimally compensated primary care physician position, significantly below his professional qualifications and earning potential**.

795. Defendant's **deliberate and prolonged withholding of Plaintiff's verification was not the result of mere administrative oversight but a calculated effort to deprive Plaintiff of economic opportunities**, forcing him into financial hardship with the **intent to pressure him into abandoning his legal claims**. The **timing of Defendant's compliance—only after litigation was filed—demonstrates its clear intent to obstruct Plaintiff's professional advancement for malicious purposes**.

796. **Refer to Exhibit 181,** previously filed in support of **Count VI – Tortious Interference with Prospective Economic Relations in Plaintiff's Second Amended Request for Jury Trial.** Exhibit 181 consists of **email communications between Plaintiff, the Federation of State Medical Boards (FSMB), and University of Maryland Capital Region Health**, documenting Defendant's failure to timely verify Plaintiff's postgraduate training.

797. As **Plaintiff now amends Count VI to assert a claim for Intentional Interference with Economic Relationships**, **Exhibit 181 is reintroduced in support of Count IV of Plaintiff's Third Amended Request for Jury Trial**.

798. For the sake of **judicial economy, Exhibit 181 is not refiled, as it remains part of the record, having been originally filed on September 4, 2024.**

Legal Standard For Intentional Interference

With Economic Relationships

799. Maryland courts recognize **Intentional Interference with Economic Relationships** as a valid cause of action when a defendant **wrongfully interferes with a plaintiff's ability to engage in lawful business or employment**, even in the absence of a formal contract.

800. To establish a claim for **Intentional Interference with Economic Relationships**, Plaintiff must demonstrate:

1. **Intentional and Willful Acts** – Defendant, through its agents, **intentionally refused to verify Plaintiff's residency training**, despite knowing it was a **mandatory requirement** for licensure.

2. **Conduct Calculated to Cause Damage** – Defendant's **deliberate failure** to complete the verification process **prevented Plaintiff from obtaining a Maryland physician license**, which in turn **barred him from applying for physician employment**.

3. **Acts Done with an Unlawful Purpose and Without Justifiable Cause** – Defendant's refusal to verify Plaintiff's training **violated accreditation and licensing policies**, and was executed **in bad faith and with malice**.

4. **Actual Damage and Economic Harm** – Plaintiff suffered:

    1. **11 months of lost income** due to delayed licensure.
    2. **Lost wages and diminished earning capacity** as he was unable to work as a physician.
    3. **Inability to apply for physician jobs** due to Defendant's obstruction.
    4. **Forced reliance on unemployment benefits from the Maryland Department of Labor**.

    Refer to Exhibit 166, which consists of unemployment benefit checks received from the Maryland Department of Labor, submitted and docketed with this Court on May 16, 2024.

Maryland Case Law

Supporting Plaintiff's Claim

801. Plaintiff's claim is **well-grounded in Maryland law**, as established in the following precedents:

1. *Alexander & Alexander Inc. v. B. Dixon Evander & Assocs., Inc.,* 650 A.2d 260, 269 (Md. 1994) – Establishing that **intentional interference with economic relationships** does not require a contract but requires:

    1. **Intentional and willful acts**;
    2. **Acts calculated to cause damage**;
    3. **Acts done with an unlawful purpose or without justifiable cause (malice)**; and
    4. **Actual damage and loss resulting from the interference**.

2. *Painter's Mill Grille, LLC v. Brown,* 716 F.3d 342, 353-54 (4th Cir. 2013) – Recognizing **Intentional Interference with Economic Relationships** as a **separate and distinct claim from contractual interference**, and affirming its applicability to cases where a **defendant wrongfully prevents a plaintiff from engaging in lawful business or employment**.

3. *Macklin v. Robert Logan Assocs.,* 639 A.2d 112, 119 (Md. 1994) – Holding that **both tortious intent and improper conduct** must be established, which is satisfied here by **Defendant's deliberate obstruction of licensing despite knowing Plaintiff's economic livelihood depended on it**.

4. *Steele v. Johns Hopkins Health Sys. Corp., *CIVIL No. JKB-19-3628, at 9-10 (D. Md. Aug. 4, 2020)* – Affirming that **deliberate interference with a physician's professional opportunities constitutes unlawful economic interference**.

Relief Requested

WHEREFORE, Plaintiff respectfully requests that this Honorable Court:

1. **Enter judgment in favor of Plaintiff** on Count VI – Intentional Interference with Economic Relationships;
2. **Award compensatory damages** for **lost wages, lost earning capacity, lost career opportunities, and reputational harm** caused by Defendant's wrongful conduct;
3. **Award punitive damages** to deter Defendant's **willful and malicious interference**;
4. **Award pre-judgment and post-judgment interest, attorneys' fees, and costs** as permitted by law;
5. **Grant such other and further relief as this Court deems just and proper**.

COUNT V

DEFAMATION PER SE

802. Plaintiff incorporates by reference **all preceding paragraphs as if fully stated** herein.

803. On December 9, 2024, the **Circuit Court denied Defendants' motion to dismiss this count,** finding that Plaintiff's claims were sufficiently pleaded. Accordingly, **this count remains pending for trial**

Factual Allegations

804. On **January 10, 2024**, Defendants published a **Final Summative Evaluation** that contained knowingly false and defamatory statements about Plaintiff, including but not limited to:

    1. Plaintiff **"required continuous counseling regarding his professional interactions with medical students."**
    2. Plaintiff **"exhibited signs of inappropriate behavior or substance use"** during his residency.

805. These statements, made without any factual basis, **were included in Plaintiff's permanent academic and professional record**, intended for d**issemination to licensing bodies, prospective employers,** and **medical institutions.**

806. Defendants **intentionally fabricated these allegations post-termination** as retaliation against Plaintiff for challenging his wrongful dismissal. Prior to his termination, there was **no disciplinary record, counseling requirement, or report of any inappropriate behavior or substance use** in Plaintiff's personnel file.

807. The **publication requirement for defamation** is satisfied, as **Defendants knowingly transmitted the defamatory Final Summative Evaluation to multiple third parties**, ensuring its **widespread dissemination and continuous reputational harm** to Plaintiff. These third parties include, but are not limited to:

1. **The Maryland Board of Physicians**, as part of Plaintiff's **licensure application process**, where the defamatory statements were reviewed in determining his eligibility for a medical license.
2. **The Georgia Composite Medical Board**, which also received and reviewed Plaintiff's credentials as part of its independent licensure evaluation.
3. **The Accreditation Council for Graduate Medical Education (ACGME),** the accrediting body overseeing Plaintiff's residency program, where Defendants had an obligation to report resident dismissals, thereby ensuring further circulation of the defamatory evaluation.
4. **The ACGME Annual Accreditation Data System (ADS) Reporting**, through which **Program Directors are required to report resident attrition, dismissals, or non-renewal of contracts**, ensuring that the defamatory record remains within ACGME's official accreditation system.
5. **The American Board of Family Medicine (ABFM),** the entity responsible for determining **Board Eligibility**, where Defendants' false statements directly impacted Plaintiff's ability to meet certification requirements.
6. **The Maryland Department of Labor,** where a dispute arose regarding whether UM Capital Region Health had lawfully terminated Plaintiff **to justify denial of unemployment benefits.** Ultimately, UM Capital Region Health failed to sustain its argument, and Plaintiff prevailed in securing benefits.
7. **Future residency programs and potential employers**, as the defamatory evaluation remains in Plaintiff's permanent residency records and is **subject to verification requests**, ensuring continued professional and economic damage.

808. Under Maryland law, **statements impugning one's professional competence, integrity, or fitness to perform their job constitute defamation per se.** See *Batson v. Shiflett*, 325 Md. 684, 723 (1992); *Samuels v. Tschechtelin*, 135 Md. App. 483, 550 (2000).

809. Because the statements falsely suggest that Plaintiff was unfit to practice medicine due to **alleged inappropriate conduct and substance use**, they are **actionable without proof of special damages** under *Piscatelli v. Smith*, 424 Md. 294, 307 (2012).

810. **Defendants acted with actual malice,** as evidenced by:

1. **The timing of the false allegations**—Defendants first introduced these defamatory statements **after Plaintiff's termination**, during the internal appeals process, despite the **complete absence of any legitimate record of professional misconduct, concerns regarding interactions with medical students, staff, or other personnel, or any history of impairment, alcoholism, or drug abuse prior to dismissal**. The **retroactive fabrication of these claims** underscores their retaliatory and pretextual nature.

2. **The lack of any supporting documentation**—UM Capital Region Health **failed to produce any evidence to substantiate these claims**, as **no prior reports, disciplinary actions, or documented concerns existed** before Plaintiff's termination. **Staff Attorney Dena Terra deliberately fabricated allegations** regarding "medical students," "behavioral issues," and **"substance abuse" as a post-factum justification** for what was otherwise an **arbitrary and wrongful dismissal**.

3. **Defendants' delayed compliance with credentialing requests**—Defendants **refused to verify Plaintiff's postgraduate training credentials** until after **this lawsuit was initiated**, further demonstrating **bad faith intent to obstruct Plaintiff's professional advancement** and **cause**

prolonged economic harm. Their **sudden compliance under legal pressure** reinforces the inference that their **prior refusal was not based on any legitimate rationale but rather on retaliatory motives.**

811. Defendants **knowingly and deliberately caused harm** to Plaintiff by placing these defamatory statements in his professional records, ensuring they would continue to impact his career indefinitely.

Elements of Defamation Per Se

Under Maryland Law

812. Plaintiff satisfies **all four elements** required under Maryland law for a **defamation per se** claim:

1. **Defamatory Statement:** Defendants made false statements that **negatively impact Plaintiff's reputation and professional standing**.
2. **Publication to a Third Party:** The **Final Summative Evaluation** was **disseminated to licensing boards, ACGME, ABFM and prospective employers**, satisfying the **publication requirement**.
3. **Falsity:** The statements are demonstrably **false and fabricated post-termination**, with no factual basis in Plaintiff's official residency records.
4. **Actual Malice or Negligence:** Defendants acted **with actual malice**, as the statements were intentionally introduced **after Plaintiff contested his termination**, suggesting a retaliatory motive.

Defendants' Defenses Lack Merit

813. Defendants' likely defenses fail under **well-established Maryland case law**:

1. **Common Interest Privilege Does Not Apply:**

- Defendants **acted with actual malice**, negating any claim to **qualified privilege** (*Seley-Radtke v. Hosmane*, 450 Md. 468, 482 (2016)).

2. **The Statements Were Not Opinion:**

- Maryland courts distinguish **between opinions and statements that imply undisclosed defamatory facts** (*Milkovich v. Lorain Journal Co.*, 497 U.S. 1, 18 (1990)).
- Defendants' **statements suggest undisclosed facts (i.e., improper conduct and substance use) that would reasonably be interpreted as factually verifiable claims.**

3. **Truth Is Not a Defense Because the Statements Are False:**

- **Defendants lack any evidence to substantiate their claims**, making **truth as a defense inapplicable** (*Batson v. Shiflett*, 325 Md. 684, 727 (1992)).

Damages Sustained by Plaintiff

814. As a **direct and proximate result** of Defendants' **false and defamatory statements**, Plaintiff has suffered the following **severe and ongoing harm**:

1. **Loss of professional reputation within the medical community** – The defamatory statements, including claims that Plaintiff **"required continuous counseling regarding his professional interactions with medical students"**, have severely damaged his standing among peers and prospective employers.

   - **Such language, by its very nature, creates the false and highly stigmatizing impression that Plaintiff engaged in sexual harassment or other serious boundary violations.**
   - In the **medical profession,** any suggestion of **"substance use" or "inappropriate behavior"** toward **students, staff, or patients is catastrophic,** often leading to permanent exclusion from the field. Even **without explicit allegations,** such **vague and damaging language inherently invites** the **most severe interpretation,** making Plaintiff unemployable in residency, fellowship, or any attending physician position.
   - Because these **false statements were included in Plaintiff's Final Summative Evaluation**, which remains **permanently documented in ACGME records**, no **potential employer or residency program** would reasonably offer Plaintiff a position after reading vague but devastating allegations regarding **"inappropriate behavior" or "substance use."**

2. **Employment rejections and loss of career opportunities** – The **defamatory records have been disclosed** to **licensing boards, credentialing bodies, and prospective employers**, causing direct harm to Plaintiff's career:

   - The **American Board of Family Medicine (ABFM)** may **deny Plaintiff's board eligibility** based on these defamatory statements, preventing him from obtaining certification in his specialty.
   - The **false statements may present obstacles** in obtaining **medical licensure in other states**, as state medical boards frequently review disciplinary records and Final Summative Evaluations.

- **No healthcare employer, hospital, or residency program** will consider hiring a physician with any documented history of alleged **"inappropriate behavior"** toward students or **"substance use."** Such allegations serve as an **automatic disqualifier, triggering immediate rejection** without further review. **Given the high ethical and professional standards required in medicine,** institutions prioritize protecting **patients, staff, and their reputations, making any record of such misconduct a permanent and insurmountable barrier to employment.**

3. **Economic harm, lost income, and professional derailment** – As a **direct result of Defendants' defamatory statements**, Plaintiff has faced **significant barriers to employment**, leading to **financial hardship** and loss of potential earnings.

- The **damage to Plaintiff's professional record has rendered him unemployable** in his intended specialty, affecting his **career trajectory, earning capacity, and financial stability**.
- **Defendants' intentional delay in credentialing verification prolonged Plaintiff's inability to work, directly contributing to economic distress.**

4. **Emotional distress and mental anguish** – Plaintiff has suffered **severe psychological distress** as a result of Defendants' actions. The defamatory statements, which falsely attack his **character and professional competence**, have placed his **entire medical career in jeopardy**, causing **emotional suffering, humiliation, and reputational injury**.

Relief Requested

WHEREFORE, Plaintiff respectfully requests that this Court:

1. **Enter judgment in favor of Plaintiff on Count V – Defamation Per Se.**
2. **Award compensatory damages** for **lost wages, lost career opportunities, emotional distress, and reputational harm** resulting from Defendants' wrongful conduct.
3. **Award punitive damages** due to **Defendants' malicious intent in publishing knowingly false and defamatory statements**.
4. **Issue an injunction ordering the expungement of all defamatory records**, preventing further dissemination of these false statements.
5. **Award pre-judgment and post-judgment interest, litigation costs, and any other relief this Court deems just and proper.**

GENERAL PRAYER FOR RELIEF:

WHEREFORE, Plaintiff respectfully requests that this Honorable Court enter judgment in his favor on all counts asserted herein and grant such relief as requested, including but not limited to:

1. **Declaratory Relief** – Affirming that Defendant's actions violated Plaintiff's contractual rights, the covenant of good faith and fair dealing, and Plaintiff's constitutionally protected property and liberty interests under Article 24 of the Maryland Constitution.
2. **Specific Performance** – Ordering Defendant to reinstate Plaintiff into the residency program, certify his completion of 21 months of ACGME-accredited training, and provide

an additional three months of training necessary for graduation and board eligibility, as monetary damages alone are inadequate to remedy the harm suffered.

3. **Compensatory Damages** – Awarding Plaintiff damages for lost wages, lost earning capacity, lost career opportunities, and reputational harm caused by Defendant's wrongful conduct.
4. **Punitive Damages** – Awarding punitive damages to deter Defendant and similarly situated institutions from engaging in arbitrary, capricious, and retaliatory actions that interfere with due process and economic opportunities.
5. **Pre- and Post-Judgment Interest, Costs, and Any Other Relief** – Awarding pre- and post-judgment interest, litigation costs, and such other relief as this Court deems just and proper to fully redress Plaintiff's harm.

Plaintiff further demands a trial by jury on all triable issues.

Respecfully Submitted,

Otabek Elmurodov MD

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Largo, MD 20774
Cell: 206-335-0684
Email: otab.elmur@gmail.com

Dated: March 14, 2025

Otabek Elmurodov MD

CERTIFICATE OF SERVICE

I hereby certify that on March 14, 2025, I electronically served a true and correct copy of the foregoing document via the Maryland Electronic Courts (MDEC) system, in compliance with Maryland Rule 1-323 of the Maryland Rules of Civil Procedure. This service was effected upon all opposing counsel of record in this case.

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Dated: March 14, 2025

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CIRCUIT COURT FOR PRINCE GEORGE'S COUNTY, MARYLAND
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To: OTABEK ELMURODOV
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UPPER MARLBORO MD 20774

Case Number: **C-16-CV-23-005681**
Other Reference Number(s): **ACM-REG-1066-2024; ACM-REG-2067-2024**

OTABEK ELMURODOV VS. UNIVERSITY OF MARYLAND CAPITAL REGION HEALTH FAMILY MEDICINE PROGRAM

Date: 1/30/2025

SCHEDULING ORDER

This order is your notice of dates and required court appearances. It may not be modified except by order of court upon a showing of good cause. Stipulations between counsels are not effective to change any deadlines in this order. Failure to comply with all terms of this Order may result in the imposition of appropriate sanctions.

1/30/2025
Date

DaNeeka Varner Cotton
Administrative Judge DaNeeka Varner Cott

This case is assigned to Civil Track: Two
Try By Date: 06/14/2025

Date	Time	Type of Proceeding
05/13/2025	08:45AM	Trial - Jury
05/14/2025	09:00AM	Trial - Jury

ADR:
(*Required for motor torts and cases with an anticipated trial time exceeding 3 days*)

(UPON ARRIVING AT THE COURTHOUSE, CHECK MONITORS FOR THE ASSIGNED COURTROOM)

TRACK 2

Parties have 90 days from the date of this order to add/serve additional parties

90 days prior to trial, complete the following:

1. Notice of computer-generated evidence per Maryland Rule 2-504.3
2. If the parties agree to ADR, it must be scheduled utilizing ADR form
3. Plaintiff's Experts, if any, identified per Maryland Rule 2-402(g) or 2-504.2(9)

60 days prior to trial, complete the following:

1. Amendments to pleadings
2. All discovery
3. Motions to Bifurcate
4. Defense Experts, if any, identified per Maryland Rule 2-402(g) or 2-504.2(9)

30 days prior to trial, complete the following:

1. File dispositive motions
2. File Motions In Limine

10 days prior to trial, complete the following:

1. Secure resolution of any outstanding dispositive motions from the court per Maryland Rule 2-322 or 2-501
2. Provide an Exhibit list with exhibits arranged in the order the party anticipates they will be used. If there are more than **25** exhibits, Counsel shall contact the Courtroom Clerks' Office at 301-952-5016, to arrange a meeting for the purpose of pre-marking exhibits
3. If required, submit request for an Interpreter. The form to request an Interpreter can be found at https://princegeorgescourts.org/267/Interpreters.

Trial Continuance/Modification

Parties are permitted to request ONE automatic continuance of the trial. To request an automatic continuance, parties may submit a Consent Request for Modification of Trial form, which is located at https://princegeorgescourts.org/314/Online-Forms. Prior to submitting the form, the parties are required to clear new trial dates with Calendar Management at 301-952-2976. This form can also be used for parties to request additional days for trial.

Please note the request must be submitted at least 30 days prior to the original trial date and the proposed trial date cannot exceed sixty (60) days past the original court designated trial date.

Alternative Dispute Resolution (ADR)

Except for motor tort cases and cases lasting 3 or more days, cases on Track 2 do not require ADR attendance. **ADR attendance is required for all motor tort cases and cases lasting 3 or more days.**

As appropriate, it is encouraged to submit the controversy to non-binding arbitration, which includes mediation. To request an ADR date, parties must submit an Auto Request located at https://princegeorgescourts.org/314/Online-Forms. Please note the ADR date will need the consent of all parties and all ADR sessions must be completed approximately sixty (60) days prior to trial. All confidential mediation statements are due in the ADR Office no later than fifteen (15) days prior to the ADR Conference date. Please email the statements to pgccadrcoordinator@mdcourts.gov and contact the ADR office at 301-952-4173, with any questions.

Technology Training

The Circuit Court offers free training to attorneys, their staff, and pro se litigants on the Epson Projectors installed in every courtroom. **Training is mandatory for use of the equipment, and must be completed at least three (3) days prior to the scheduled court hearing.**

Please use the following link to contact the Information Technology Department and schedule your training: https://princegeorgescourts.org/civicalerts.aspx?aid=35.

Motions Protocol

The Administrative Judge, Honorable DaNeeka Varner Cotton will consider the following motions: Motions for admission of out-of-state attorneys (Pro Hac Vice), motions pursuant to Rule 2-327(d), and petitions for appointment of a conservator of attorney client matters.

The Civil Coordinating Judge (Snoddy) will consider the following motions: Disputes over track assignment, arbitration, or any provision of this Order, motions for continuance of trial beyond the try-by date or ADR, motions under 2-507, motions to stay, motions to consolidate, motions to transfer, motions to waive court costs and filing fees, motions to withdraw/strike appearance, motions to shield/unseal case, and writs of certiorari.

The Judges listed below will consider all other civil (non-family) equity and law motions including all discovery disputes, dispositive motions, and default motions; excluding foreclosure matters and specially assigned cases.

A party filing a motion or responding to a motion shall provide a courtesy copy to the Judge who is assigned to that motion. All motions must be accompanied by a proposed order. Your proposed order must be specific regarding relief to be granted. The court may decline to rule on your motion unless an appropriate order is submitted.

A hearing, where appropriate, will be set by the assigned Judge not later than thirty (30) days after the motion and response have been filed. **It is counsel's responsibility to follow-up with the assigned motions judges' chambers for a status on their motion.**

The assigned Judge for civil motions, except as noted above, is determined by the last digit in the case number:

1 – Steuart	6 – Weatherspoon
2 – Alves	7 – Bright
3 – Coderre	8 – Anderson
4 – Pearson	9 – Clark-Edwards
5 – Woodall	0 – Stewart Jones

*** Please bring this form with you to court ***

Possession and use of cell phones, computers, cameras, and other electronic devices may be limited or prohibited in designated areas of the courthouse. The use of any camera, cell phone, or any electronic device for taking, recording, or transmitting photographs, videos, or other visual images is prohibited in the courthouse at all times without express permission by the court.

In the case of inclement weather, visit the Circuit Court for Prince George's County website at www.princegeorgescourts.org or Instagram at princegeorgescty_circuitcourt

Notified:
Otabek Elmurodov
University Of Maryland Capital Region Health Family Medicine Program
Jennifer L Curry
Chaitra Gowda
Dr. Bai Lin Luo
Dr. Christopher Mcleod

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

UNIVERSITY of MARYLAND PRINCE GEORGE'S HOSPITAL CENTER

GME Resident Agreement

- **Resident Name:** Otabek Elmurodov,
- **Residency Program:** Family Medicine
- **Post Graduate Year:** PGY-2
- **Annual Salary:** $58,098.18
- **Appointment Dates:** 11/01/2021 to 10/31/2022

University of Maryland Prince George's Hospital Center (the "Sponsoring Institution") has offered a position in the Residency Program set forth above (the "Residency Program" or the "Program") to the above-named individual (the "Resident") for the above-captioned salary and Resident has agreed to accept the position on the terms and conditions above and as follows:

1.0 Resident's Responsibilities

1.1 **Duties & Responsibilities.** During the term of the Resident's appointment, the Resident shall carry out and be responsible for the following duties:

1.1.1 The Resident will follow and comply with all applicable policies and procedures including the policies and procedures of the Graduate Medical Education Program at the Sponsoring Institution as set forth in the Manual on Policies & Guidelines for Accredited Residency Programs (hereinafter referred to as the "Manual") and the applicable Resident Handbook.

1.1.2 With guidance from the teaching staff, the Resident will develop a personal program of self-study and professional growth.

1.1.3 Under the supervision of the teaching staff, the Resident will provide safe and appropriate care for patients, commensurate with his/her level of education, ability and experience as determined by the teaching staff.

1.1.4 The Resident will perform the duties prescribed by the Sponsoring Institution, the Program, an attending physician and/or the Department, in a competent, efficient, satisfactory, humanistic and courteous manner in strict accordance with the professional and ethical standards of the medical profession.

1.1.5 The Resident will participate fully in the educational and scholarly activities of his/her Program and, as authorized by the teaching staff and assume responsibility for teaching and supervising other residents and students.

1.1.6 The Resident will comply with practices, guidelines, procedures, and policies of the Sponsoring Institution, the Bylaws and Rules and Regulations of its Medical Staff, and all guidelines, policies, procedures, by-laws, rules and regulations of the Program and other institutions or clinical sites to which he/she is assigned; such policies shall include, but not be limited to, those concerning confidentiality of protected health information.

1.1.7 As directed by his/her Program Director, the Resident will provide services in all hospitals and clinics and participate in all activities to which the Resident is assigned as part of the Sponsoring Institution's Graduate Medical Education Program.

1.1.8 The Resident will comply with all applicable federal laws and the laws of the State of Maryland, including, but not limited to, those relating to the practice of medicine as appropriate.

1.1.9 If the Resident is a graduate of a foreign medical school, the Resident will provide the Sponsoring Institution with a copy of the certificate issued by the Educational Council for Foreign Medical Graduates prior to the commencement of his/her appointment. Failure to provide this certificate to the Sponsoring Institution will result in automatic and immediate revocation of the Resident's appointment.

1.1.10 The Resident shall satisfy all requirements for employment by the Sponsoring Institution. Resident shall satisfactorily complete all departmental requirements for promotion to the PG year noted at the beginning of this Agreement, if applicable (if the Resident is a resident at the Sponsoring Institution during the year immediately prior to the commencement of the appointment under this Agreement). The Resident shall present, no later than the commencement date of his/her appointment, evidence of his/her identity and authorization to work in the United States as required by federal law. Failure to provide this evidence will result in revocation of the Resident's appointment. If Resident's work authorization documents expire, he/she shall provide the Sponsoring Institution with current authorization documents prior to such expiration for reverification by the Sponsoring Institution. If Resident fails to provide such authorization documents, this Agreement may be terminated by the Sponsoring Institution immediately.

1.1.11 The Resident will provide, in a timely manner, all information requested for purposes of credentialing by the Sponsoring Institution and registration as an unlicensed medical practitioner by the Maryland Board of Physicians, if applicable. Failure to provide this information may result in revocation of the Resident's appointment. During the term of this Agreement, the Sponsoring Institution and

the Resident shall cooperate to maintain a current registration as an unlicensed medical practitioner with the Maryland Board of Physicians. Resident's failure to cooperate or to comply with applicable laws and regulations for current registration as an unlicensed medical practitioner with the Maryland Board of Physicians may result in disciplinary action as set forth in Section **3.0** below.

1.1.12 The Resident will satisfy all health requirements for employment by complying with all immunization, tuberculosis and drug testing requirements of the Sponsoring Institution, such screening to be completed by the Employee Health Department. The Resident understands that his/her employment is contingent upon successful completion of a pre-employment health assessment in accordance with the Pre-Placement Drug and Alcohol Testing/Physical Policy (Manual Section #4) and compliance with the Physician (Resident) Impairment Policy (Manual Section #20) and Resident Counseling Policy (Manual Section #22).

1.1.13 The Resident will participate in evaluations of the quality of education provided by the Program.

1.1.14 The Resident will develop an understanding of ethical, socioeconomic and medical/legal issues that affect Graduate Medical Education and of how to apply cost containment measures in the provision of patient care. The Resident will also participate in quality improvement activities related to his/her clinical service.

1.1.15 The Resident will participate in institutional committees and councils, especially those which relate to patient care review activities, as determined by the Department chief.

1.1.16 The Resident will participate in videotaping, photographing, filming, recording or other permanent preservation of mock drills, direct patient care, or other parts of his/her responsibilities under this Agreement and consents to use of this material for any purpose.

1.1.17 The Resident will attend and participate in Risk Management presentations and comply with the policies, procedures and guidelines, as directed by the Sponsoring Institution.

1.1.18 The Resident will participate in Infection Control education and comply with all health or safety requirements mandated by the Maryland Occupation Health & Safety Program, applicable state and federal law and the Sponsoring Institution.

1.1.19 The Resident will attend and participate in presentations about compliance, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA), and confidentiality of patient health information.

1.1.20 The Resident will maintain his/her personal appearance and conduct himself/herself in a manner consistent with the Sponsoring Institution's standards and all applicable personnel policies. The Resident understands that the Sponsoring Institution prohibits sexual or other harassment toward co-workers, subordinates, supervisors, students, patients or any other individual and the Resident shall not engage in such behavior and shall comply with the Disruptive Conduct Policy (Manual Section # 39).

1.1.21 The Resident will perform his/her duties under this Agreement during such hours as the Program Director may direct in accordance with the Sponsoring Institution's Duty Hours Policy as set forth in the Financial Support, Benefits and Conditions of Employment Policy (Manual Section # 8) and in the applicable Resident Handbook. Duty hours, although subject to modification and variation, depending on the clinical area of assignment and/or urgent circumstances, shall be subject to applicable state, federal, and the Accreditation Council on Graduate Medical Education ("ACGME") requirements. If a scheduled duty assignment is inconsistent with this Agreement or the Duty Hours Policy, the Resident shall bring that inconsistency first to the attention of the Program Director for resolution. If the Program Director does not resolve the inconsistency, it shall be the obligation of the Resident to notify the Director of the Sponsoring Institution's Graduate Medical Education office of the inconsistency, who working with the Graduate Medical Education Committee, shall take the necessary steps to address the inconsistency.

1.1.22 Resident acknowledges and agrees that any and all inventions, whether or not patentable, processes, trade secrets, data improvements, patents, and/or other intellectual property relating to Resident's employment or otherwise arising from his/her employment, conceived or first reduced to practice, as the case may be, during his/her employment ("Inventions"), without further remuneration shall be the property of the Sponsoring Institution. Resident agrees that all Inventions will be promptly and fully disclosed to the Sponsoring Institution, in writing and any and all legal interest in such Inventions assigned to the Sponsoring Institution. Resident agrees to cooperate with the Sponsoring Institution, at the Sponsoring Institution's expense, by promptly executing any documents or carrying out any acts that may be required to vest the rights in or to Inventions in the Sponsoring Institution and otherwise to enable the Sponsoring Institution fully to protect its intellectual property.

1.2 **Standards of Performance.** Resident shall professionally, ethically, diligently, and faithfully carry out his or her responsibilities hereunder in order to best serve the interests of the patients he or she serves, the Residency Program, and the Sponsoring Institution. Resident agrees that all responsibilities will be carried out promptly, efficiently, and in strict accordance with the ethical and professional standards for the provision of health care services applicable to residents of the Residency Program and those adopted by the Program and the Sponsoring Institution, the Joint Commission f/k/a the Joint Commission

on Accreditation of Health Care Organizations, and the Accreditation Council for Graduate Medical Education.

1.3 **Accountability.** Resident shall report to and be held accountable by the Designated Institutional Officer of the Sponsoring Institution and the Residency Program's Director or his designee regarding the performance of all duties and responsibilities hereunder and compliance with this Agreement.

1.4 **Release of Information.** The Resident consents to the Sponsoring Institution seeking independent verification of his/her graduation from medical, dental or pharmacy school and other residency or training programs. On request, the Resident will present evidence of his/her successful graduation from medical/dental/pharmacy school or successful completion of other residency or training programs. The Resident understands that the Sponsoring Institution will conduct an independent background check. If any negative information is identified, the Program Director will offer the Resident an opportunity to discuss the results of the background check before taking action. The Resident acknowledges and agrees that his/her participation in the Program and any contractual obligation to employ and train him/her are contingent upon Resident's satisfactory cooperation and successful completion of the credentialing process, including but not limited to the background check and verification of education and other training programs.

2.0 Duration of Appointment & Conditions for Reappointment.

2.1 **Term.** The term of this Agreement shall be the Duration of Appointment set forth in Section **1.0** above, subject to the termination provisions hereof.

2.2 **Conditions for Reappointment.** The Resident acknowledges and agrees that there is no guarantee of a position as a resident for any subsequent years of education and training regardless of the total length of the Program to which the Resident was appointed. Any reappointment of the Resident will be based on satisfactory performance evaluations completed at least semi-annually by the Program Director or his/her designee as set forth in the Sponsoring Institution's Criteria for Promotion Policy (Manual Section #27). Reappointment is not guaranteed.

2.3 **Required Written Notice of Intent.** The Sponsoring Institution shall provide written notice of intent as set forth in this Section **3.3**.

2.3.1 If the decision is made not to promote, a written notice of this intent will be provided to the Resident by the Program Director in accordance with the Sponsoring Institution's Criteria for Promotion Policy (Manual Section #27).

2.3.2 If the decision is made not to renew the Agreement, a written notice of intent not to renew a Resident's contract will be provided by the Program Director in accordance with the Sponsoring Institution's Criteria for Promotion Policy (Manual Section #27).

2.4 **Non-Renewal by Resident.** If the Resident decides not to seek renewal of this Agreement for a subsequent year of residency, the Resident shall provide the Program Director written notice of such decision no less than one hundred and twenty days (120) prior to the expiration of this Agreement.

2.5 **Suspension, Dismissal, or Termination of Agreement by Sponsoring Institution.**

2.5.1 The Sponsoring Institution may immediately suspend the Resident from his or her appointment in the Residency Program if the Sponsoring Institution has reasonable grounds to believe the health or safety of any patient or staff may be in imminent and serious danger as a result of Resident's continued participation and appointment in the Program or such other grounds as set forth in Section **3.5.2**. The Sponsoring Institution will suspend or reassign the Resident in accordance with the Sponsoring Institution's Immediate Reassignment or Suspension Policy (Manual Section #18).

2.5.2 The Sponsoring Institution reserves the right to terminate this Agreement or to take other action including, but not limited to, suspension of Resident's participation in the Program if:

a. the Resident breaches any term or condition of this Agreement;

b. it is discovered that material facts presented by Resident at the time of application or re-application are misleading or untrue;

c. Resident's employment is terminated, subject to the due process requirements;

d. Resident fails to meet the performance or conduct standards of the Residency Program or to make reasonable progress towards those standards;

e. Resident violates the rules, regulations, policies or procedures of the Sponsoring Institution, including but not limited to personnel policies;

f. Resident is convicted or enters a plea of guilty or nolo contendere to a felony or misdemeanor or any crime involving moral turpitude;

g. Resident places the welfare of any patient in jeopardy;

h. Resident's actions are not commensurate with good medical practice;

i. Resident fails to obtain and maintain applicable registrations, licenses or certifications or disciplinary action is imposed on Resident by a licensing board;

j. Resident displays conduct not commensurate with good moral standards including, but not limited to, unprofessional conduct;

k. it is believed that Resident's capacity is diminished by the use of drugs or alcohol;

l. Resident fails to fulfill residency responsibilities;

m. Resident fails to obtain and maintain professional liability insurance as set forth in Section **4.4** herein; or

n. Resident fails to keep charts, records and reports, accurate, current and signed, including discharge summaries.

2.5.3 If the Resident is suspended, the Resident's pay may be suspended for the duration of the suspension.

2.5.4 In the event that this Agreement is terminated by the Sponsoring Institution pursuant to this Section **3.5**, the Resident shall be entitled to appeal rights and procedures accorded to residents in accordance with the Due Process Hearing Procedure Policy as further specified in Section **3.6** below.

2.6 **Due Process.** When actions by the Sponsoring Institution or the institution where the Resident is primarily assigned are contemplated that could result in dismissal, non-promotion, non-renewal of a contract, or which could significantly threaten the Resident's intended career development (e.g., extension of program, denial of credit for training/experience, denial of promotion, termination), the Sponsoring Institution will provide the Resident with an opportunity to appeal such action in accordance with the Disciplinary Action Policy (Manual Section #15), the Notice of Disciplinary Action/Request for Hearing (Manual Section #16) and the Hearing Process (Manual Section #19).

Violated 7 times!

2.7 **Grievance Procedure.** The Grievance Procedure is also available to the Resident for the adjudication of Resident complaints and grievances related to work environment or issues related to the Program or faculty as set forth in the Grievance Procedure Policy (Manual Section #17). The grievance process is not available to contest issues underlying a resignation in lieu of termination.

2.8 **Residency Closure/Reduction.** In the event of a residency closure or reduction, it will be addressed as set forth in the Sponsoring Institution's Institutional Commitment Policy for entitled "Employees' Security" (Manual Section #30).

2.9 **Effect of Termination.** Upon termination of this Agreement, neither party shall have any further rights, duties or obligations under this Agreement, except to carry out the provisions that contemplate performance after termination or expiration and for rights, duties or obligations imposed by applicable law. The termination or expiration shall not affect any liability or other obligation of either party which accrued prior to termination or expiration.

3.0 Sponsoring Institution's Responsibilities

3.1 **Graduate Medical Education Program.** The Sponsoring Institution sponsors a Graduate Medical Education Program. The Sponsoring Institution provides a suitable environment and educational program that meets the institutional requirements of ACGME. The Sponsoring Institution's ACGME-accredited programs are in substantial compliance with the ACGME Program Requirements and the applicable Institutional Requirements. Sponsoring Institution will award a Certificate of Completion to the Resident upon successful completion of a multi-year program or part of a training program successfully completed at the Sponsoring Institution.

3.2 **Compensation.** In consideration for the Resident's participation in the Program in accordance with the terms and conditions of this Agreement, the Sponsoring Institution agrees to provide the Resident the compensation as set forth in Section **1.0**, subject to all applicable city, state, federal and other withholding taxes and such other deductions as Resident may authorize. The Sponsoring Institution will pay Resident on a biweekly basis. The parties agree that all amounts to be paid hereunder are reasonable and constitute fair market value for the services to be performed and are not related, directly or indirectly, to the volume or value of any referrals between the parties or to any hospital or other entity affiliated with either of them.

3.3 **Benefits.** The Sponsoring Institution will offer the Resident the option of participating in benefits as set forth in Exhibit B attached hereto and incorporated by reference herein.

3.4 **Professional Liability Insurance.** The Sponsoring Institution will provide the Resident with professional liability coverage for the authorized activities of the Resident under this Agreement. Coverage will include legal defense and protection against awards from claims report or filed either during the Resident's participation in the Residency Program or after the Resident's completion of the Residency Program if the alleged acts or omissions of the Resident are within the scope of his or her participation in the Program. This coverage is subject to such requirements, conditions and limitations as may exist from time to time. Upon the Resident's request, the Sponsoring Institution will provide official documentation of the details of liability coverage. Any moonlighting by the Resident is not covered through this professional liability coverage set forth in this Section **4.4**. This Section **4.4** will survive termination of this Agreement.

3.4.1 If applicable, the Resident shall cooperate in making application for any insurance policies applied for by the Sponsoring Institution on the Resident's behalf. Resident shall also satisfy the Sponsoring Institution's qualifications for insurability throughout the term of this Agreement.

3.4.2 In accordance with Section **3.6.1** herein, Resident agrees that upon receipt of a Notice of Claim for a malpractice claim or similar legal proceeding filed against the Resident before any court or arbitration board, the Resident will, within three (3) business days, deliver the original notice to the Sponsoring Institution so that appropriate defense of the claim is initiated.

3.4.3 If applicable, the Resident must provide written verification to the Sponsoring Institution that extended reporting period (tail) coverage for any and all exposures from his or her previous employment or practice has been obtained and is in place prior to the Effective Date of this Agreement.

3.5 **Facilities and Support.** The Sponsoring Institution shall furnish, provide for, or secure appropriate resources, including but not limited to facilities, non-physician personnel (including administrative, nursing, and other medical support) and support services that are reasonably needed by the Residency Program and necessary for Resident's professional medical training in accordance with ACGME standards as amended from time to time. In no event shall Resident use any facilities and/or support provided under this Section for his or her private benefit.

3.5.1 **Medical Records.** The Sponsoring Institution or other assigned sites will provide systems that document the patient's illness and treatment, and are adequate to support the Resident's education, participation in quality improvement activities, and provide a resource for appropriate scholarly activity. Resident is required to and will complete all medical records accurately, timely and in accordance with the policies and procedures of the Sponsoring Institution and of the respective institutions participating with the Sponsoring Institution in the Graduate Medical Education Program.

3.5.2 **On-Site Sleeping Quarters.** The Sponsoring Institution and other sites provide adequate on-site sleeping quarters as needed for the Resident when on-call.

3.5.3 **On-Call Food Services.** The Sponsoring Institution provides a cafeteria and food services during regular dining hours. During off-hours, food services and vending machines located throughout the Sponsoring Institution are available. Reimbursement or the use of meal tickets for food when the Resident is on-call is at the discretion of the clinical service.

3.5.4 **Uniforms and Laundry Service.** The Sponsoring Institution will provide adequate uniforms and laundry services for specified uniforms for the Resident. No personal laundry service for Resident or his/her family will be provided.

3.5.5 **Safe-Working Environment.** The Sponsoring Institution promotes a safe working environment through the departmental safety officer program, camera surveillance, and staff education concerning institutional and personal safety guidelines.

3.6 **Requests for Accommodations Related to Disabilities.** The Sponsoring Institution is an equal opportunity employer. Individuals with disabilities may request reasonable accommodations through the individual's Program, Graduate Medical Education Department, or the Sponsoring Institution's Department of Human Resources. Requests for accommodation will be evaluated in compliance with Federal and State laws. Additional information regarding the reasonable accommodation of disabilities, including the minimum essential functions of all resident positions at the Sponsoring Institution, are found in the Sponsoring Institution's Policy on Accommodations of Residents with Disabilities (Manual Section #35).

3.7 **Institutional Policies and Procedures.** The Sponsoring Institution will maintain policies and procedures applicable to the Residents, the Program, and the Sponsoring Institution to comply with all applicable laws, regulations, and standards of ACGME, the Joint Commission, and other applicable accrediting bodies and governmental authorities. The Sponsoring Institution may modify or amend at any time its personnel or Graduate Medical Education policies, including those referenced in this Agreement. The Sponsoring Institution shall ensure the Resident is oriented and has access to all applicable policies and procedures. Specifically, and in accordance with ACGME standards as amended, the Sponsoring Institution will maintain policies governing the Resident's duty hours and moonlighting during the term of this Agreement as further specified in this Section **4.7**.

3.7.1 **Duty Hours.** The Sponsoring Institution promotes patient safety and resident education through faculty availability and resident duty hour assignments that are developed by each individual service in accordance with the Sponsoring Institution's Duty Hours Policy as set forth in the Financial Support, Benefits and Conditions of Employment Policy (Manual Section # 8) and in the applicable Resident Handbook. The Sponsoring Institution's policy on duty hours will ensure effective oversight of institutional and program-level compliance with ACGME standards as amended from time to time. As determined by individual services, the Resident will receive reasonable notice of hours of duty, work assignments and on-call schedules.

3.7.2 **Moonlighting.** The Sponsoring Institution's policy on moonlighting will ensure institutional and program-level compliance with ACGME standards as amended from time to time. Resident shall comply with the Sponsoring Institution's Moonlighting Policy as set forth in the Off-Duty Employment Policy (Manual Section #12). The Resident's services shall be devoted solely to advancing the clinical and educational program. Moonlighting is prohibited, unless expressly approved in writing by the Resident's Program Director prior to the performance

of any moonlighting. All professional activity outside the educational programs is prohibited except in accordance with the Off-Duty Employment Policy (Manual Section #12). The Resident shall report all moonlighting activities and actual moonlighting hours worked to the Program Director at intervals (e.g., weekly) specified by the Program Director. The Sponsoring Institution provides no professional liability coverage for moonlighting.

3.7.3 **Vacation, Parental, Sick and Other Leave(s).** The Sponsoring Institution must maintain a policy for vacation and other leaves of absences as consistent with applicable laws for residents. Further, this policy is required to ensure each ACGME-accredited residency program of the Sponsoring Institution provides accurate information to its residents regarding the impact of an extended leave of absence upon: (1) the criteria for satisfactory completion of the program; and (2) the resident's eligibility to participate in examination by relevant certifying board(s). The Sponsoring Institution's Leave Policies (Manual Section #11) and Exhibit B shall govern the Resident's permitted leave.

3.8 **Evaluations.** The Resident's performance will be reviewed and evaluated by the Program's faculty at least semiannually. The Program Director, or the Director's designee, will review the Resident's overall progress toward the Resident's educational objectives. Written summary evaluations will be provided and maintained in the Graduate Medical Education Department of the Sponsoring Institution in accordance with the Sponsoring Institution's Performance Evaluation Policy (Manual Section #10). An unsatisfactory evaluation may result in required remedial activities, temporary suspension, non-promotion, non-renewal or termination from the Program as set forth in Section **3.0** above.

4.0 Representations and Warranties

4.1 **Authority.** Each party hereby represents and warrants that, as of the date of execution of this Agreement, it has the legal right to enter into this Agreement and perform the duties hereunder, and that it is not subject to or bound by any non-compete or other restrictive covenant that would impede or interfere in the performance of its duties hereunder.

4.2 **Accreditation.** The Sponsoring Institution represents and warrants that it and the Residency Program are accredited by the Accreditation Council for Graduate Medical Education and such other regulatory and accrediting bodies.

4.3 **Compliance with Laws.** The Resident represents and warrants that he or she is, and will remain, throughout the term of this Agreement, in compliance with all laws, rules and regulations that are now or hereafter promulgated by any governmental authority or agency that governs or applies to the practice of medicine, professional medical training in an ACGME-accredited residency program, and the provision of health care services within the scope of this Agreement.

4.4 **Exclusion from Federal Health Programs.** The Resident represents and warrants that he/she has never been (1) convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; or (2) excluded from participation in any federal health care program, including Medicare and Medicaid. The Resident shall notify the Sponsoring Institution immediately in the event that (1) Resident is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid, or another federal health program; or (2) Resident is excluded from participation in any federal health care program, including Medicare and Medicaid.

4.5 **Confidentiality of Business Information.** Resident may have access to business information of Dimensions Health Corporation, the Sponsoring Institution, and their affiliates, including but not limited to information related to the identity of patients, managed care contracts, third party payer arrangements, health care provider agreements, business plans, strategic plans, marketing strategies, and other information about the present or proposed conduct or activities. Resident shall hold in strict confidence all data and information obtained with respect to Dimensions Health Corporation's, the Sponsoring Institution's, and their affiliates' activities and businesses, and shall not use such data or information or disclose the same to others except for authorized disclosures in the normal course of his or her duties and except as required by law or expressly authorized by the Sponsoring Institution. The covenant to maintain the confidentiality of business information shall survive the termination of this Agreement.

4.6 **Required Notice to Sponsoring Institution.** Resident warrants and covenants to the Sponsoring Institution that as of the Effective Date and during the term of this Agreement that the Resident will promptly notify the Program and the Sponsoring Institution in writing in accordance with the notice requirements in this Agreement upon the occurrence of any of the following events:

4.6.1 **Legal or Disciplinary Proceeding or Investigation.** Resident will notify the Sponsoring Institution in writing within three (3) business days if Resident becomes the subject of a disciplinary proceeding or action or subject of any investigation, sanction or similar action by a medical review committee or peer review organization or the subject of any audit or similar proceeding by any federal, state, or local agency or any Medicare carrier or intermediary. This provision shall survive the term of this Agreement for all claims or allegations related to the acts or omissions of Resident while participating in the Residency Program and providing services hereunder, including any claims or allegations reported or proceedings or investigations initiated after the termination of this Agreement.

4.6.2 **Inability to Practice.** Resident will notify the Sponsoring Institution in writing within three (3) business days if an event occurs that substantially interrupts all or a portion of the Resident's training or that materially adversely affects the Resident's ability to carry out his or her responsibilities under this Agreement.

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

UNIVERSITY of MARYLAND PRINCE GEORGE'S HOSPITAL CENTER

5.0 Miscellaneous

5.1 **Nondiscrimination.** The Sponsoring Institution does not discriminate on the basis of race, color, religion, age, sex (including pregnancy), national origin, disability, marital status, familial status, veteran status, genetic information, occupation, political opinion, sexual orientation or any legally prohibited factor in the administration and provision of health care services, employment practices, or other related activities. The Resident, in the performance of his or her duties hereunder, shall not discriminate on the basis of race, color, religion, age, sex (including pregnancy), national origin, ancestry, disability, marital status, familial status, veteran status, political opinion, sexual orientation or any legally prohibited factor.

5.2 **Confidentiality.** Each party shall maintain the confidentiality of the existence and contents of this Agreement and only share with those individuals the party consults including but not limited to accountants, lawyers and other experts, and who need to know.

5.3 **Notices.** All notices, requests, demands and other communications required by or permitted hereunder shall be in writing and shall be deemed to have been duly given where received by the party to whom directed; provided, however, that notice shall be conclusively deemed given at the time of deposit of such notice in the United States mail when sent by certified or registered mail, postage prepaid, to the other party at the following addresses (or at addresses as shall be given in writing by either party to the other). Resident shall be required to inform the Sponsoring Institution promptly upon any change in his or her mailing address.

If to Sponsoring Institution:

Attention Designated Institutional Official

Graduate Medical Education

3001 Hospital Drive, Cheverly, MD 20785

5.4 **Beneficiaries.** This Agreement shall not confer any benefit or rights upon any persons other than the Sponsoring Institution and the Resident, and no other third parties shall be entitled to enforce any obligation, responsibility or claim of any party to this Agreement.

5.5 **Entire Agreement.** This Agreement contains the entire agreement of the parties hereto, and no other oral or written agreement shall be binding or obligating upon the parties hereto. This Agreement supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof.

5.6 **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the State of Maryland.

Important Point here

5.7 **Amendment.** This Agreement may not be amended or modified in any way except as provided in this Section **6.7**. This Agreement may be amended by mutual written agreement of the parties. In addition, the Sponsoring Institution may amend this Agreement upon ten (10) days advance notice to Resident and if Resident does not provide a written objection to the Graduate Medical Education office within such ten (10) day period, then the amendment shall be effective at the expiration of the ten (10) day period. If Resident does object to the amendment, then the Sponsoring Institution, in its discretion, may terminate this Agreement.

5.8 **Binding Effect.** This Agreement shall be binding upon the parties, their heirs, successors and assigns.

5.9 **Master List.** All contracts involving remuneration from Capital Medical Group to/from a physician, an immediate family member of the physician, or a group practice are listed on a master list of contracts that is maintained and updated centrally by the Legal Department and that is available for review by the Secretary of Health and Human Services upon request. At this time the master list and digital copies of the contracts are maintained by CMG's contract manager system.

5.10 **Severability.** If any provision of this Agreement or any portion thereof is found to be invalid, illegal or unenforceable, such provision or portion hereof shall be deemed omitted, and the validity, legality and enforceability of the remaining provisions shall not be in any way affected or impaired thereby.

5.11 **Headings.** The headings of the various sections and paragraphs of this Agreement are inserted merely for the purpose of convenience and do not expressly or by implication limit or define or extend the specific terms of the section or paragraph so designated.

5.12 **Survival.** The provisions of Sections **4.4**, **4.8**, **5.5**, and **5.6.1** shall survive any termination of this agreement.

6.0 Acknowledgement

The Resident acknowledges receipt of the Sponsoring Institution's Graduate Medical Education policies via the internet or the Graduate Medical Education office as set forth in Exhibit A attached hereto and incorporated herein and understands that he or she is required and responsible for reading and understanding such policies as a condition of entering into this Agreement. The Resident's signature below indicates that Resident has read and understands and agrees to abide by such policies.

INTENDING TO BE LEGALLY BOUND, the parties hereto have executed this Agreement the date first above-written.

SPONSORING INSTITUTION

Bradford Schwartz

Bradford Schwartz, MD (Signature)

Designated Institutional Official

UM Prince George's Hospital Center

Recommended by:

Stacy Ross

Stacy Ross

Program Director

Family Medicine Residency Program

UM Prince George's Hospital Center

RESIDENT

Otabek Elmurodov,

UNIVERSITY of MARYLAND CAPITAL REGION HEALTH

UNIVERSITY of MARYLAND PRINCE GEORGE'S HOSPITAL CENTER

EXHIBIT A

ACKNOWLEDGEMENT

OF

RECEIPT AND REVIEW OF

Graduate Medical Education Resident Manual

I, Otabek Elmurodov, PGY-2

acknowledge that I have received and have been informed that it is my responsibility to review the Policies and Guidelines of the Department of Medical Education and the Clinical Manual and am aware of the availability of these documents on the "WEB" as indicated above.

RESIDENT:

Otabek Elmurodov,

Signature Certificate

Document Ref.: PSZVN-XOCBP-RJHHQ-Y6PAY

Document signed by:

Otabek Elmurodov

Verified E-mail:
otabek.elmurodov@ihs.gov

IP: 98.127.230.232 Date: 18 Sep 2021 04:10:52 UTC

Bradford Schwartz

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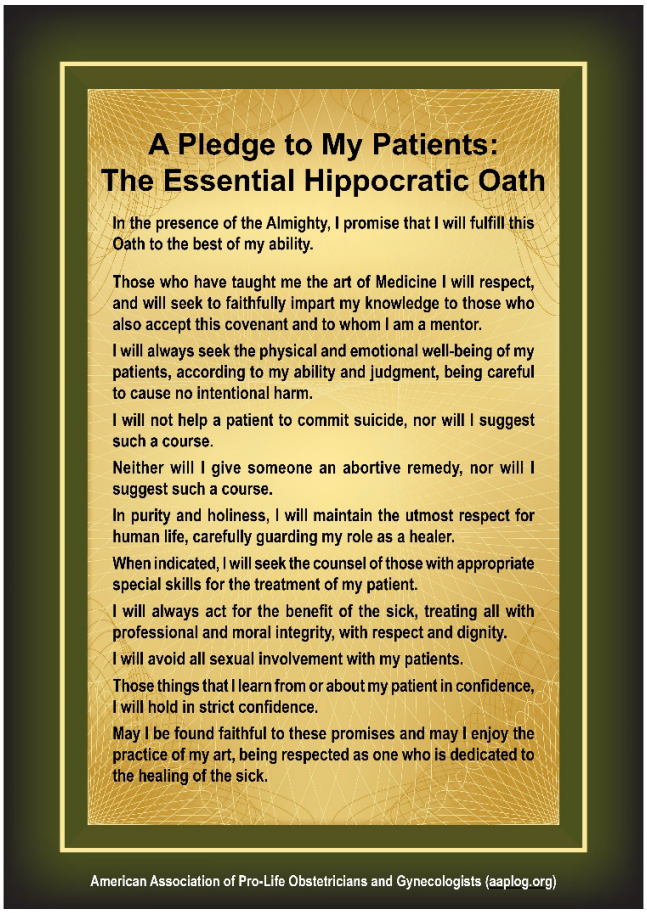
Document completed by all parties on:
28 Sep 2021 16:41:57 UTC

UNIVERSITY OF MARYLAND CAPITAL REGION HEALTH

2022-2023 GME Resident Manual

UNIVERSITY of MARYLAND
PRINCE GEORGE'S
HOSPITAL CENTER

Contents



A Pledge to My Patients: The Essential Hippocratic Oath

In the presence of the Almighty, I promise that I will fulfill this Oath to the best of my ability.

Those who have taught me the art of Medicine I will respect, and will seek to faithfully impart my knowledge to those who also accept this covenant and to whom I am a mentor.

I will always seek the physical and emotional well-being of my patients, according to my ability and judgment, being careful to cause no intentional harm.

I will not help a patient to commit suicide, nor will I suggest such a course.

Neither will I give someone an abortive remedy, nor will I suggest such a course.

In purity and holiness, I will maintain the utmost respect for human life, carefully guarding my role as a healer.

When indicated, I will seek the counsel of those with appropriate special skills for the treatment of my patient.

I will always act for the benefit of the sick, treating all with professional and moral integrity, with respect and dignity.

I will avoid all sexual involvement with my patients.

Those things that I learn from or about my patient in confidence, I will hold in strict confidence.

May I be found faithful to these promises and may I enjoy the practice of my art, being respected as one who is dedicated to the healing of the sick.

American Association of Pro-Life Obstetricians and Gynecologists (aaplog.org)

GME Policy 101 UMCRH – Policy for Accredited Residency Programs

The Graduate Medical Education Committee (GMEC) established these policies and guidelines of The University of Maryland Capital Region Health System as required by the Accreditation Council on Graduate Medical Education. The resident will be required to sign a receipt, which will become a part of the resident's official training file in the Department of Medical Education. Any significant additions, deletions, or revisions will be immediately distributed to the current resident staff.

The Graduate Medical Education Committee (GMEC)

The Graduate Medical Education Committee is s per ACGME guidelines. The Designated Institutional Official will report to the Executive Committee of the Medical Staff as needed. The Medical Education Committee's Chairman is the Designated Institutional Official (the operating medical director of the institution). Also, Program Directors, Associate Program Directors, Core Faculty Members, hospital administration representatives, and the Chief Residents will serve as Ex-Officio members. The responsibilities of the Graduate Medical Education Committee are:

- The establishment and implementation of institutional policies and procedures for graduate medical education for accredited and non-accredited programs.
- Establish and maintain appropriate oversight and liaison with residency directors and administrators of other institutions participating in programs sponsored by this institution.
- Regular review of all residency training programs to assess compliance with the relevant ACGME Residency Review Committees' institutional requirements and program requirements.
- Oversight of all financial aspects of residency programs, including revenue and expense budgeting, coordination of benefits among programs, e.g., books, travel, etc.
- Outcomes from each meeting will become an integral part of the files for reporting.

GME Policy 102 UMCRH – General Policy of Graduate Medical Education

General Policy of Graduate Medical Education

The Graduate Medical Education Committee will maintain an overview of each Program to assure that each of the residency programs complies with Institutional Requirements of the ACGME as well as other requirements of the Resident Review Committees: The committee will maintain an overview of the performance review, both of the residents and the faculty.

This general policy for Graduate Medical Education will outline a list of requirements that should be in place in this institution that serves as a sponsor for Graduate Medical Education Programs.

- Liability insurance: the institution will provide liability insurance to residents for the duration of the training. It will also provide legal defense and protection from claims reported or filed against the residents after completing the Graduate Medical Education program if their alleged action or omissions were within the educational Program's scope. Coverage should be consistent with what the institution offers other medical practitioners.
- Residents are required to attend orientation, which includes information referencing liability coverage, risk management, harassment, and other policies, information referencing identification pictures, parking permits, computer passwords, pagers, immunizations, relationships to other affiliated hospitals, licensure and registration requirements, prescription writing ability, due process information, and financial and health benefits information.
- A Graduate Medical Education Manual will be reviewed regularly by the GMEC. This handbook will outline requirements for moonlighting, supervision, and duty hours.
- The Graduate Medical Education Committee will encourage obtaining autopsies in appropriate circumstances. A sufficient number of autopsies representing an adequate diverse spectrum of diseases should be performed to enhance patient care and the educational experience. Residents should promptly receive autopsy reports on the patients under their care.
- The Graduate Medical Education Committee will also develop a policy for visiting Residents and medical students.
- The use of dependable measures to assess Residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice as defined in Section 111.E. of the ACGME Institutional Requirements, and the Program Requirements.
- Each Program's effectiveness in implementing a process that links educational outcomes with program improvement is an integral part of each Program's annual program evaluation.
- Each Program will maintain a Resident and program database to track all necessary information about the Resident and Program, including but not restricted to forwarding address of Residents, membership, rotation schedules, licensure, and certificate.
- Each Program requires a supervision policy to assure that a Resident is only allowed to perform at their current level of competence.
- The GMEC will also assure and monitor the core curriculum of each Program.
    - It should include ethical, social, economic, medical, legal, high cost-conscious care issues, communication skills, research design, statistics, and critical review of the literature and scholarly activities.

- An evaluation system for residents is required per ACGME requirements by the program director whereby the resident evaluates: the faculty, support services, their educational experiences and the Program at least on an annual basis.
- This review shall be a part of the Annual Program Evaluation to the Graduate Medical Education Committee. If there is a concern about the program director, Residents are encouraged to report their concern to the Designated Institutional Official. These reports are confidential.
- Institutional officials, administrators of graduate medical education, program directors, faculty, and Residents will have access to adequate communication technologies and technological support to include at least computers and access to the Internet.
- Resident Work Hours and on-call schedules vary from Program to program. However, the Graduate Medical Education Committee has the responsibility to be sure the Program complies with the requirements of the Resident Review Committee of the ACGME.
- Resident Work Hours will not be excessive. However, duty hours will reflect the responsibilities of continuing patient care.
- Adequate supervision of residents is assured.
- The level of supervision will be proportional to the level of responsibility. Increasing responsibilities of residents are by the level of education, ability, and experience.
- There will be adequate backup support for the residents.

Complaints and Grievances

The residents' Program Director will query the Residents, at least annually, for comments and recommendations regarding the faculty, curriculum, facilities, and any other issues that may impact their education and make an appropriate response.

If the above mechanism cannot address complaints or grievances, they should submit their concerns in writing to the Program Director, anonymously if desired, for immediate review.

Upon receipt of the written complaint or grievance, the Program Director will initiate an investigation. After the said investigation, a written report including the nature of the complaint, the investigation results, and the action plan, will be made by the Program Director to the involved individuals.

A copy of the report will reside in the archives of GME and the department. The GMEC will review the complaint and action plan for recommendations. Proper measures are in place to maintain the confidentiality of the complainant.

The Graduate Medical Education Committee will review all submitted reports and further investigate or take supplementary action if deemed appropriate.

Due Process

The Graduate Medical Education Committee will formulate a policy that deals with due process for the Resident. Each Program will have formal written criteria and processes for the selection, evaluation, promotion, and dismissal of residents. Each Program will have assurances of an educational environment in which the residents may raise and resolve issues fairly and reasonably without fear of intimidation or retaliation that includes:

- A Resident organization or forum to address issues related to working conditions and education of residency programs.
- It might take the form of an official ombudsman.
- A process for Residents to address issues in a confidential and protected manner.

- Fair institutional policies and procedures that address academic and other disciplinary actions taken against the resident could result in dismissal, non-renewal of a Resident agreement of appointment, or actions that could significantly weaken a Residents' intended career development.
- Fair institutional policies and procedures that address the resident's complaints and grievances related to the work environment or issues related to the Program or faculty.

Recruitment

As needed, each Program will review the need to market its Program actively on an annual basis. All applicants must utilize the ERAS MATCH System for consideration for all ACGME residency programs.

Documentation of minimum salary and benefits is available to each interviewee for a position within the Program.

All residency programs have current websites with minimum requirements for interviews, the current curriculum, current residents, faculty, and staff.

Resident Participation at Committee Meetings

Resident participation in committee meetings will enhance resident education and hospital operations by promoting communication between the residents, the medical staff, and hospital management. The committee allows direct input from the residents that will affect their education and ability to treat patients.

This policy intends that each Program's resident staff meet at least quarterly to discuss common issues and bring these to their respective program director and the committees' attention through their representatives.

It is the policy of the Hospital that residents participate on the Patient Care and Quality Committee, Pharmacy, and Therapeutics Committee, Infection Control Committee, Critical Care Committee, Ethics, and the Graduate Medical Education Committee.

This policy aims to promote better communication and better flow of ideas, policies, and information to enhance the residents and improve the quality of care at Prince George's Hospital Center.

Residents shall recommend resident physicians to serve the Hospital for the committees. If more than one resident is recommended to serve on a committee, the Designated Institutional Official will make the final selection. The requirement that there will be one resident committee member to serve on the Ethics Committee, Patient Care Policy Committee and Pharmacy and Therapeutic Committee. There will be at least one resident from each Program appointed to the Graduate Medical Education Committee.

The resident representative's responsibility is to attend each meeting and bring questions, comments, concerns, and information from residents to the committee members. The resident representative should actively participate as a voting member of the committee and communicate back to the other residents.

GME Policy 103 UMCRH – General Policy Due Process, Corrective/Discipline Process

Purpose

As the sponsoring institution, the University of Maryland Capital Region Health System desires to have residency training programs in an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation, which includes:

- Establishment of fair and reasonable, and readily available policies and procedures for adjudication of resident's complaints and grievances related to the work environment or issues related to the Program or faculty
- Implementation of fair and reasonable policies and procedures for academic or disciplinary action related to a resident or fellow taken against residents that could result in dismissal, non-renewal of a resident's agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident's intended career development

Scope

- This policy applies to all residents in the University of Maryland Capital Region Health System sponsored programs.

Responsibility

- It is the responsibility of all residents, program directors, faculty, and staff to comply with this policy.

Grievance

- **Definition: A grievance is defined as follows:**
    - A any controversy, complaint, misunderstanding, or dispute concerning the meaning, interpretation, or application of Prince George's Hospital Center, department, or residency program personnel policies directly and adversely affects the grieving resident. Corrective/disciplinary actions and evaluations, as based on resident performance and evaluations, are defined below.
    - Any claim of discrimination in the grieving resident's employment based on race, color, religion, sex, national origin, physical or mental handicap, age, veteran's status, or sexual orientation.
    - A resident who claims that he/she is the object of sexual harassment is grieved under the University of Maryland Capital Region Health Sexual Harassment Policy (specifically: Personnel Policy).
- **Informal Procedure**
    - This grievance policy is designed to supplement, not replace, informal ways to resolve problems. A resident is encouraged to resolve problems by raising them with his/her Program Director. If the grievance cannot be resolved in this manner, the Resident may use the Due Process procedure as described in Section 6 below.
- **Causes for Corrective/Disciplinary Action**
    - Corrective/disciplinary action may be taken for cause as determined in the discretion of the Program Director, including but not limited to any of the following:
        - Failure to satisfy the academic or clinical requirements of the residency program;

- Professional incompetence, misconduct, or conduct that might be inconsistent with or harmful to patient care or safety;
- Conducts detrimental to the reputation or standing of the Hospital;
- Conduct which calls into question the professional qualifications, integrity, ethics, or judgment of the resident, or which could prove detrimental to the Hospital's patients, employees, staff, volunteers, visitors, or operations;
- Violation of the bylaws, rules and regulations, policies, or procedures of the Medical Staff, the Hospital, applicable department or residency program;
- Misconduct in science or research;
- Failure to perform duties or conduct that fails to meet the goals of the Program

- **Informal Resolution**
  - To the extent reasonably possible, the Hospital encourages the use of informal efforts by the Program Director or his/her designee to deal with minor and incidental instances of poor performance or misconduct. These efforts may include issuing an oral warning by the Program Director, from which there is no appeal. In situations where these informal efforts are unsuccessful or in circumstances in which the Program Director, in his/her discretion, deems an informal resolution to be inappropriate, formal corrective/disciplinary action may be initiated.
- **Formal Corrective/Disciplinary Action**
  - For this policy, formal corrective/disciplinary action may include but is not limited to written warning, probation, suspension, or termination of the resident from the residency program. The factors to be considered in determining the action(s) to be taken are:
    - the severity and frequency of the offense, documented history of prior informal or formal corrective/disciplinary actions, and the resident's overall performance and conduct.
    - Except under circumstances which, in the discretion of the Program Director, require immediate imposition of corrective/disciplinary action to preserve acceptable standards of care, safety, integrity, or ethics at the Hospital or at any other hospital(s) where the resident may be on temporary rotation or assignment, the following procedures will be followed before the imposition of the corrective/disciplinary action.
    - In circumstances in which immediate imposition of corrective/disciplinary action is taken, the following procedures will be followed after the corrective/disciplinary action's imposition.
    - The order of recommended actions below is provided for purposes of general guidance only. Each incident or problem will be considered separately, and action may be taken, which deviates from the order below. That is, the most severe action may be taken without taking less severe actions.

Written Warning

- The program director and faculty are responsible for providing residents in the University of Maryland Captial Region Health sponsored Program with frequent feedback through Semi-Annual Reviews that comply with the ACGME Institutional and Program Requirements. The assessment system includes, but is not limited to, verbal, written, formal, and informal feedback based on multiple assessment methodologies (e.g., rotation evaluations, in-service exam scores) and multiple raters (e.g., faculty, ancillary staff, peers, patients).
- The program director may issue a written warning to the resident. At a minimum, this warning should include:
  - The specific performance concerns that have been identified;
  - The expected level of performance/behavior required to address the deficiency;

  - A remediation plan including time frames for completion of specific actions;
  - Any future actions that may be taken if remediation is unsuccessful (e.g., elect not to promote; deny credit for training; non-renewal of the contract; extension of training; termination); and
  - The signature of the program director
- If the resident satisfactorily addresses the deficiencies in performance or behavior and maintains acceptable performance/behavior at expected levels, no further action is required.
- If the resident does not satisfactorily address the deficiencies in performance or behavior, the program director, after consulting with the DIO or designee, will communicate in writing details the next intended action. The communication will inform the resident that he/she is eligible to request a hearing under the Due Process Hearing procedure.

Probation

- A resident may be placed on probation following: a written warning, repeated incidents of deficient performance, inappropriate conduct of a minor nature, a single incident of deficient performance, inappropriate conduct of a severe nature for which the Program Director, in his/her discretion, deems it appropriate to place the resident on probation rather than issue a written warning.
- Generally, a resident will continue to fulfill residency program requirements while on probation subject to the specific terms of the probation.
- The Program Director shall notify the resident in writing of the probation, the reason{s) for the decision, and, if relevant, the required method and timetable for correction, the possible consequence(s) for failure to correct, and the date upon which the decision will be reevaluated.
- There is no appeal from a decision to place a resident on probation.

Suspension

- The Program Director may temporarily suspend a resident from residency program duties by placing him/her on a leave of absence, either paid or unpaid as determined at the Program Director's discretion, for seriously deficient performance or incredibly inappropriate conduct.
- The Program Director shall provide the resident with written notification of the reason(s) for the suspension, the required method and timetable for correction, the possible consequence(s) for failure to correct, and a date upon which the decision will be reevaluated. Written notification shall advise the resident of their right to request a review of the suspension under the procedures outlined below.

Involuntary Termination From the Program

- The Program Director may decide to terminate a resident from a residency program for cause, including but not limited to a failure to fulfill the residency program's requirements satisfactorily.
- Dismissal of a resident during an academic year shall constitute a termination.
- For purposes of the appeal rights under this policy, a decision not to certify the Program's successful completion shall be considered a termination.
- Written notice of a decision to terminate a resident, including reason(s) for the decision and the effective date, shall be provided by the Program Director to the resident.
- The notice shall also state that the resident may request a formal review of the termination following the procedures described below in Section 6

Due Process

- The University of Maryland Capital Region Health provides residents of the sponsored Program the opportunity to request a hearing to adjudicate a grievance or to appeal any action.
- A decision that could result in dismissal from the Program, non-renewal of a Resident Agreement (contract), non-promotion of a resident to the next level of training; or other corrective/disciplinary action could significantly threaten the resident's intended career development.

Initiation of Hearing

- If the resident elects to request a hearing, the resident must submit a formal written request for a hearing.
- This request shall be to the attention of the Designated Institutional Official.
- The formal request must be written, signed, dated and must include a complete factual description of the complaint or the action leading to the request for a hearing and any other information that may be relevant or helpful.

Time Limit for Requesting a Hearing

- The resident shall have 14 calendar days following the receipt of notice of an appealable action that has been or will be taken within which to request a hearing.
- If the resident does not request a hearing within this time frame and in the manner set forth above, he/she shall have waived his/her right to such hearing and have accepted the action involved, and such action shall thereupon become effective immediately.

Unappealable Actions

Voluntary resignation by the resident from a Prince George's Hospital Center GME program shall not constitute grounds for a hearing but shall take effect without hearing or appeal.

Notice of Hearing

- The Designated Institutional Official shall schedule the hearing and shall notify in writing, return receipt requested, to the resident of its' time, place, and date. The hearing shall begin as soon as practicable. The notice shall contain a statement of the reasons for the recommendation.

Hearing Panel

- Whenever a hearing is requested, the Designated Institutional Official shall appoint a Hearing Panel which shall be composed of not less than three members,
- Of whom shall be the DIO and two faculty member appointees who shall not have actively participated in considering the matter involved at any previous level.

Failure to Appear

Failure without good cause of the person requesting the hearing to appear and proceed at such a hearing shall constitute voluntary acceptance of the recommendations or actions pending, which shall become final and effective immediately.

Postponement

Postponements and extension of time beyond any time limit set forth herein may be requested by anyone but shall be permitted only by the Hearing Panel or its' Chairman on a showing of good cause.

Deliberations and Recommendation of the Hearing Panel

Within 20 days after the hearing's final adjournment, the panel shall conduct its' deliberations and shall render a recommendation accompanied by a report to the Designated Institutional Official.

Disposition of Hearing Panel Report

Upon its' receipt, the DIO shall send a copy of the report and recommendation, return receipt requested, to the person who requested the hearing. Additionally, a report will be sent to whoever made the original recommendation for action, to make whatever modification, if any, to the original recommendation.

Hearing Procedure

The person requesting the hearing shall be entitled to have an attorney present. He/she shall inform the Designated Institutional Official in writing of that person's name at least ten days before the date of the hearing. The Designated Institutional Official, acting for the Hospital, shall appoint a representative, an attorney, present the recommendation and reasons for the action, and examine and cross-examine witnesses.

Presiding Officer

The Designated Institutional Official may appoint an attorney at law as presiding officer. Such a presiding officer should not be legal counsel to the Hospital. He must not act as a prosecuting officer or as an advocate for the Hospital. He may participate in the Hearing Panel's private deliberations and be a legal advisor to it, but he shall not be entitled to vote on its' recommendations. If no presiding is appointed, the Chairman of the Hearing Panel shall be the presiding officer. The presiding officer shall ensure that all hearing participants have a reasonable opportunity to be heard and present all oral and documentary evidence that decorum displayed throughout the hearing and that no intimidation is permitted. He shall determine the order of procedure throughout the hearing. He shall have the authority and discretion to make rulings on all questions about procedural matters and the admissibility of evidence. Legal counsel may advise him to the Hospital. In all instances, he shall act so that the Hearing Panel considers all relevant information in formulating its recommendations. The presiding officer is acting to see that all relevant information is made available to the Hearing Panel for its' deliberations and recommendations to the Chief Executive Officer.

Record of Hearing

The Hearing Panel shall maintain a record of the hearing of the proceedings. The Hospital shall bear the cost of such a reporter. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

Rights of Both Sides

At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available, to introduce exhibits, to cross-examine any witnesses on any matter relevant to the issues, to rebut any evidence, and to submit a written statement at the close of the hearing. If the person requesting the hearing does not testify on his/her behalf, he/she may be called and examined as if under cross-examination.

Pre-Hearing Discovery

There is no right to discovery in connection with the hearing. The individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

- copies of, or reasonable access to, all patient medical records referred to in the Statement of reasons, at the individual's expense;
- reports of experts relied upon by the Hospital;
- redacted copies of relevant committee or department minutes (such provision does not constitute a waiver of the state peer-reviewed protection statute); and
- copies of any other documents relied upon by the Hospital.

Before the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the Hospital's witness list concerning the hearing's subject matter unless expressly agreed upon by counsel.

Admissibility of Evidence

The hearing will not reflect a proceeding according to law rules relating to examining witnesses or presenting evidence. The presiding officer shall admit any relevant evidence if it is the sort of evidence on which responsible persons are accustomed to relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

Burden of Proof

At any hearing, it shall be incumbent on the person who requested the hearing initially to come forward with evidence supporting his position. In all cases, after both sides have submitted all the evidence, the Hearing Panel shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation which prompted the hearing was made arbitrarily or capriciously; or the recommendation was not supported by substantial evidence.

Basis of Decision

The decision of the Hearing Panel shall reflect the evidence produced at the hearing. This evidence may consist of the following: oral testimony of witnesses, memorandum of points and authorities presented in connection with the hearing, any material contained in the Hospital's files regarding the person who requested the hearing so long as this material is admitted with evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it; any applications, references, and accompanying documents, all officially noticed matters; and any other evidence that is admitted.

Attendance by Panel Members

Recognizing all Hearing Panel members may not appear at all sessions of the panel, and it is necessary to conduct a hearing as soon as reasonable, the hearing shall continue even though individual members of the Hearing Panel are not present at all times. The fact that individual panel members were not physically present during the hearings will not disqualify them or invalidate the hearing. Consequently, no quorum of the Hearing Panel is required to continue the hearing. The vote shall be by the majority of those appointed to the Hearing Panel.

Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same at the participants' convenience without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Final Recommendation

The Hearing Panel's final recommendation shall be effective immediately and shall not be subject to further review. Provided, however, where the Hearing Panel refers to further action and recommendation, such recommendations will be submitted to the Designated Institutional Official. The continued review process and the report back to the Hearing Panel shall in no event exceed 30 days in duration except as the parties may otherwise stipulate.

Right to One Appeal Only

No individual is privy to more than one hearing on any single matter which may be the subject of an appeal.

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PRINCE GEORGE'S
HOSPITAL CENTER

GME Policy 104 UMCRH – General Policy Evaluation of Residents

Purpose

The University of Maryland Capital Region Health, as the sponsoring institution, assures that each Program has defined, per the ACGME Program Requirements, the specific knowledge, skills, and attitudes required of graduate-level trainees. Individual training programs must also provide educational experiences and an evaluation system to ensure that residents demonstrate competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Scope

This policy applies to all residency training programs sponsored for ACGME and equivalency accreditation by The University of Maryland Capital Region Health.

Responsibility

Completion of the resident evaluation is the responsibility of the Program Director, with input from the faculty.

The Graduate Medical Education Committee (GMEC) responsibility is working closely with the Designated Institutional Official (DIO) to oversee the process and ensure that relevant guidelines and requirements comply.

Cadence

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the Program and utilizing the results to improve resident performance. Each resident's performance must be evaluated formally and in writing no less frequently than every six months, or more, per ACGME Program Requirements. This evaluation is written and reflects an objective review of the trainee's progress in knowledge, skills, and professional growth.

Evaluation Plan

- Program Directors, working in conjunction with program faculty, must establish objective criteria and an evaluation plan for residents' advancement based on demonstrated readiness and competence. The plan must include:
    - The use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
    - Milestone Specific per the program requirements
    - Mechanisms for providing regular and timely performance feedback to residents that includes at least monthly
    - Written evaluation that is communicated to each resident in a timely manner no less frequently than semi-annually, or more frequently as required by specific ACGME Program Requirements
    - The maintenance of a record of evaluation for each resident that is accessible to the resident via the Residency Management Suite preferred by the GME Office/Institution
    - A process involving the use of assessment results to achieve progressive improvements in residents' competence and performance and which can include faculty, patient, peer, self, and other professional staff evaluative information
    - Documentation of Individual Learning Plans to assess the areas of weakness and improvement
    - Documentation of goals and objectives of each individual resident for plans

Final Evaluation

- The program director must provide a final evaluation for each resident who completes the Program. The evaluation must include:
    - A review of the resident's performance during the final period of education
    - Verification that the resident has demonstrated sufficient professional ability to practice competently and independently without supervision
    - The final evaluation must become part of the resident's permanent record maintained by the institution
- Transfers from other residency programs;
    - To determine the appropriate level of education for a resident who is transferring from another residency program, the program director must receive written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident,
- Transfer to another residency program;
    - The program director is required to verify residency education for any residents who may leave the Program before completion of their education

Request for reconsideration

The program director must advise residents that they are afforded the opportunity for an appeal any action by The University of Maryland Capital Region Health which could result in (a) their dismissal; (b) non-renewal of a contract; or (c) which could significantly threaten their intended career development, outlined in the Due Process Hearing Procedure detailed in this Manual.

GME Policy 105 UMCRH – General Policy Resident Adancement

- ## CRITERIA FOR PROMOTION

  Residents must, as a minimum, meet the following criteria to be eligible for promotion to the next level, or to receive a satisfactory completion for the year:

  - Successful completion of all required rotations for the academic year at the time of the clinical competency committee meeting (Maximum of one failure of a rotation per academic year allowed with satisfactory completion of same rotation within the academic year)
  - Satisfactory attendance for the morning report and noon conferences greater than 60% attendance.
  - No unsatisfactory correspondence in the file.
  - Residents shall pass USMLE Step III by the end of PGYII year and provide the Program with a copy of the score report.

  If any of the above criteria are not met then the Clinical Competence Committee will review the circumstances on an individual case basis and make a decision regarding promotion. Any disciplinary actions in a resident's file during the academic year will be reviewed and discussed.

  A written notice of the intent not to renew a resident' contract will be issued not later than four (4) months prior to the end of the resident's current contract period. However, if the primary reasons(s) for non-renewal occur(s) within the four months prior to the end of the contract period, the resident will be given as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the current contract period. Residents will be allowed to implement the grievance procedures, when they receive a written notice of intent not to renew their contracts.

  Those residents judged by a program to have completed satisfactorily the requirements for a specific level of training will be promoted to the next higher level of responsibility unless the resident specifically is enrolled in a training track of limited duration, not designed to achieve full certification (e.g., a one-year preliminary position).

  Except for shared residency positions, no resident may remain at the same level of training for more than 24 months, exclusive of leave. A resident whose performance is judged to be satisfactory will advance until the completion of the program/certification requirements. Promotion decisions require approval by both the Program Director and the CCC.

  Residents are required to take their step 3 USMLE exam in PGY1 and must pass Step 3 by the completion PGY2 year. Residents who do not pass their exam by the end of PGY 2 may not be promoted to the PGY 3 level.

- ## IN-TRAINING EXAM

  - Residents are expected to take the In-Training Exam for their program every year. Residents on vacation and on an elective outside the metropolitan area may be excused at the director's option, although they should make an effort to be present for the exam. Any resident not excused from the exam as above, who will not be present, should submit a written explanation for their absence to their Program Director.

- ## BLS/ACLS CERTIFICATION

  - Residents are responsible for maintaining their certification in BLS and ACLS. Arrangements will be made for the initial training either during the orientation schedule or as soon as possible after the beginning of the academic year. Thereafter, notices will be posted

regarding dates for recertification classes in CPR and it will be the residents' responsibility to enroll and attend these classes as necessary. Each resident will provide the Department of Medical Education with copies of their current BLS and ACLS certification verifications for inclusion in their official training folders.

GME Policy 106 UMCRH – General Policy Support in the Event of Disaster or Interruption

Purpose

As the institutional sponsor, The University of Maryland Capital Region Health is committed to assisting in reconstituting and restructuring residents' educational experiences as quickly as possible after a disaster and/or interruption in patient care.

Scope

This policy applies to all graduate medical education programs sponsored by The University of Maryland Capital Region Health.

Responsibility

It is the responsibility of the directors of each residency ("Program Directors"), The University of Maryland Capital Region Health r management, and The University of Maryland Capital Region Health Graduate Medical Education Committee (GMEC)) to comply with this policy.

Definitions

Disaster is defined as an event or set of events causing significant alteration to the residency experience at The University of Maryland Capital Region Health and which has been declared as a disaster on the ACGME website.

Resident Transfers and Program Reconfigurations

If The University of Maryland Capital Region Health as sponsor of the ACGME-accredited programs determines it cannot provide an adequate educational experience for each of its residents because of a disaster, it will take one of the following actions:

- Arrange a temporary transfer to other programs and institutions until such time as the The University of Maryland Capital Region Health sponsored program can provide adequate experience or assist the residents in permanent transfers to other ACGME accredited programs or approved institutions where they may continue their education. If more than one program is available for a temporary or permanent transfer of a particular resident, the transfer preferences of the resident will be considered by The University of Maryland Capital Region Health and its affected program. The transfer decision will be handled expeditiously so as to maximize the likelihood that each resident will complete the training year in a timely manner.
- Within ten days after the declaration of disaster, the DIO of The University of Maryland Capital Region Health or designee with one or more disaster affected programs will contact the ACGME to discuss due dates that ACGME will establish for the affected programs timeframe for submission of the following information to the ACGME:
- Program reconfigurations necessary related to the disaster,
    - Notification to the affected programs' residents of the resident transfer decisions.

If the ACGME has not received communication from the D1O, the ACGME will attempt to establish contact to determine the severity of the disaster and its impact on the residents' educational programs. All information will be submitted to the ACGME no later than 30 days after the disaster unless other due dates are approved by the ACGME.

Communication with ACGME from Disaster Affected Institutions and Programs:

The DIO or designee will call or e-mail the Institutional Review Committee Executive Director with information and/or requests for information.

The affected Program Directors will call or e-mail the appropriate Residency Review Committee Executive Director with information and/or requests for information.

Residents may call or e-mail the appropriate Review Committee Executive Director with information and/or requests for information. On its website, the ACGME will provide instructions for changing resident e-mail information on the ACGME Web Accreditation Data System.

Acceptance of Transfers

- If The University of Maryland Capital Region Health DIO offers to accept temporary or permanent transfers from another program affected by a disaster The University of Maryland Capital Region Health will complete the appropriate paperwork found on the ACGME website and will provide this information to affected programs and residents upon request.
- The University of Maryland Capital Region Health and its programs will arrange temporary transfers to other programs or institutions until such time as the residency program can provide an adequate educational experience for each of its residents or will assist the residents in permanent transfers to other programs or institutions in which they can continue their education. Transferee preferences will be considered in those cases where more than one program or institution is available for temporary or permanent transfer of a particular resident.
- Transfer decisions will be made expeditiously so as to maximize the likelihood that each resident will be able to complete their training in a timely fashion.

UNIVERSITY of MARYLAND
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GME Policy 107 UMCRH – General Policy Moonlighting

Purpose

The University of Maryland Capital Region Health is committed to facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients and a strong commitment to the resident's educational program. This policy outlines the circumstances under and the procedure by which a resident may practice medicine after completing regular contractual patient care duties and educational activities, i.e. extracurricular employment (moonlighting).

Scope

This policy applies to all residents participating in training programs sponsored The University of Maryland Capital Region Health. Both extra sessions and external moonlighting are included in this policy. NOTE: Residents with J-1 visa sponsorship are not permitted to engage in moonlighting activities.

- **Internal Moonlighting (Extra Sessions)**
  - Extra sessions allow residents to perform extra amounts of work in the same venues and with the same activity as found in their regular curriculum. The residents are supervised by faculty, have prescribed duties and their performance is formally evaluated by faculty of their training program. The faculty is responsible for the residents' actions just as in the regular curriculum. Though there is extra compensation for this extra activity, the activity is considered supplementary to their formal training. It is not a substitute for the formal curriculum. The residency program keeps records of activity and supervision. This type of supplemental duty is approved and arranged by the Program Director, and in this function, the resident is not required to obtain supplemental malpractice insurance.
- **External Moonlighting**
  - External Moonlighting allows residents to perform extra amounts of work in and receive pay through venues unsupervised by The Prince George's Hospital Center faculty. For all moonlighting activities, the resident must obtain prior written approval from the Program Director, and copies of this written approval must be placed in the resident's folder. This activity is not considered adjunctive to the resident curriculum and the resident is acting as an "independent contractor." All residents engaged in moonlighting activities must be independently licensed for unsupervised medical practice, possess the appropriate training and skills for the moonlighting activity, and must obtain proper malpractice insurance with a minimum of $1M/3M.

Specific Restrictions on All Moonlighting Activities

- Moonlighting is limited to PGY 3 residents who scored at least 60% in percentile rank (compared to their peers nationally) on the most recent In-Training exam.
- Moonlighting must NOT exceed 24 hours per month and may be further limited at the Program Director's discretion.
- Residents engaged in moonlighting activities may only attempt procedures for which they have been deemed competent to perform independently.
- Moonlighting must NOT interfere with the ability of the resident to achieve the goals and objectives of the educational program. Residents are only allowed to moonlight if all dictations are completed, and they are on elective, rheumatology, endocrinology, geriatrics, or ambulatory block rotations. No overnight shifts are permitted during the week.
- Internal and external moonlighting is considered part of the 80-hour weekly limit on duty hours and all hours spent moonlighting must be documented on the duty hour log.

- PGY1 or Preliminary Year residents are not allowed to moonlight.

Responsibility

- The resident complies with the procedures for requesting and receiving approval for extra sessions and/or external moonlighting assignments as described in this policy. If the resident engages in external moonlighting, the resident's professional liability insurance is NOT covered by Maryland Medicine Comprehensive Insurance Program (MMCIP). For external moonlighting activities, the resident must obtain and provide proof of professional liability insurance coverage of $1M/3M, to the Program Director.
- Any extracurricular employment without knowledge and prior written approval of the Program Director is grounds for dismissal from the training program.
- The Program Director ensures that neither extra session nor external moonlighting activities exceed applicable Residency Review Committee (RRC) regulations or interfere with the resident's educational activities and patient care duties. The Program Director monitors resident performance to ensure that the policies relating to extra sessions and external moonlighting are enforced and that resident performance is not diminished because of these activities. The Program Director report of duty hours to the Graduate Medical Education Committee (GMEC) must count extra sessions and external moonlighting hours toward the sum total of working hours.
- It is not the responsibility The University of Maryland Capital Region Health to provide outside employment for residents.
- The University of Maryland Capital Region Health accepts no responsibility for the financial consequences to residents who engage in extra sessions if permission for that employment is

Procedures

- Moonlighting is discouraged, but if the resident wishes to engage in extra sessions or external moonlighting activities after completing regular contractual duties and educational activities, the resident must obtain the prior written approval of the resident's Program Director. A record of the written approval will be kept in the resident's permanent file.
- In situations in which the department permits extra sessions and/or external moonlighting the resident and Program Director must count extra sessions and external moonlighting hours toward the sum total of working hours and periods and must comply with the Resident Duty Hour policy.
- The Program Director may restrict extra sessions and external moonlighting activities if he/she believes it may interfere with the resident's ability to complete educational activities and/or to provide appropriately care for patients.
- Departmental policies regarding extra sessions and external moonlighting must comply with The University of Maryland Capital Region Health institutional policy and may contain additional restrictions or requirements.
- The specifics of off-duty and extracurricular employment of external moonlighting will be negotiated between residents and their employers.
- A resident may not provide coverage for individual physicians or groups of physicians by engaging in the private practice of medicine. A resident may not open a private practice office while in training.

Malpractice Insurance Coverage

- Professional liability coverage for a professional activity outside of the resident's training program is provided by the MMCIP only if the following criteria are met
    - the service is an "extra session" assignment which has been approved by the Program Director; and

- the request for professional liability coverage has been submitted in advance in writing to MMCIP and approved by MMCIP.

- If the resident engages in external moonlighting, the resident's professional liability insurance is NOT covered by MMCIP and the resident must obtain professional liability coverage either on his/her own or from the contracting employer for a minimum of $1M/3M. The resident must provide proof of coverage to MMCIP prior to the start of extracurricular employment. If coverage is provided on a "claims made" basis, the resident is obligated to obtain "tail coverage" upon completion of the extracurricular employment. Residents should require a 30-day cancellation notice of an individual policy.

Withdrawal of Extracurricular Employment Privileges

- Consent to perform extra sessions or external moonlighting will be withdrawn if the Program Director determines that the extracurricular employment (moonlighting) interferes with the resident's performance academically or the residents meeting of patient care obligations.
- Any extracurricular employment activity by a resident that appears to be detrimental to the reputation or well-being of The University of Maryland Capital Region Health may be halted by the respective Program Director.
- If the Program Director determines a resident's performance is below departmental standards, the resident will be immediately counseled, and a warning will be given that failure to correct deficiencies noted will result in withdrawal of permission for extracurricular employment.
- If the Program Director determines that there has not been adequate improvement in the resident's performance within the designated period of time, he/she will inform the resident of this decision and withdraw approval for the resident to perform extra sessions or external moonlighting.
- The University of Maryland Capital Region Health does not encourage nor require its residents to engage in extracurricular employment, including internal moonlighting.

GME Policy 108 UMCRH – General Policy Program Closure/Reduction

Purpose

To provide appropriate notification and reasonable transfer opportunities so that Residents might be able to complete their clinical training toward Board eligibility in case a Residency Program sponsored by Prince George's Hospital Center is forced to close or to reduce the number of positions for any reason.

Notification

When it is determined that a Residency Program will close or reduce its number of positions, all current and selected Residents will be notified expeditiously. Ideally, a minimum of one year's notice will be provided, if circumstances allow. It is recognized that only under the most extreme circumstances, would an appointment be terminated by closure/reduction within an academic appointment year.

Phasing

If circumstances allow, in the case of program closure or reduction, current Residents will be allowed to complete their training program, while no new Residents will be appointed. If current Residents will be impacted, then the most junior Residents will released first.

Transfers

In all situations, the Hospital and the Programs will take all reasonable efforts to assist the Residents impacted by any closure/reduction to transfer to a comparable program, preferably within Maryland and D.C.

GME Policy 109 UMCRH – General Policy Resident Clinical & Educational Work Hours

Accreditation Council for Graduate Medical Education (ACGME) Requirements

The following is a summary of the ACGME Common Program Requirements regarding resident clinical and educational work hours. Residency programs will be expected to meet the Common Program Requirements as well as any additional requirements described in the specialty-specific requirements for each specialty.

- **Clinical and Educational Work Hours**

Didactic and clinical education must have priority in the allotment of residents' time and energies. Work hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

- Clinical and educational work hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Clinical and educational work hours do not include reading and preparation time spent away from the clinical site.
    - Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. A Review Committee may grant rotation-specific exceptions for up to 10% or a maximum of 88 clinical and educational work hours to individual programs, based on a sound educational rationale. The 88-hour exception is not allowed for PGY1 residents.
- Residents should have eight hours off between scheduled clinical work and education periods.
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on those free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
- After 24 hours of continuous scheduled clinical assignments, residents may be allowed to remain on-site for up to four hours for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

- In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site to continue to provide care to a single severely ill or unstable patient, or humanistic attention to the needs of a patient or family, or to attend a unique educational event.

- Night Float is defined as rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus.
    - Night float must occur within the context of the 80-hour and one- day-off-in-seven requirements.
    - The maximum number of consecutive weeks of night float, and maximum number of months of night float per year, may be further specified by each Review Committee.
- In-House Call is defined as duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution. Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
- At-Home Call (also known as Pager Call) is defined as a call taken from outside the assigned site. Time in the hospital, exclusive of travel time, counts against the 80 hour per week limit but does not restart the clock for time off between scheduled in-house duty periods. At-Home Call may not be scheduled on the resident's one free day per week (averaged over four weeks).
    - The frequency of at-home call is not subject to the every-third- night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
    - At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    - Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour weekly maximum.

Oversight

- The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.
- Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment, including moonlighting, and to that end, must:
    - distribute these policies and procedures to the residents and faculty.
    - monitor resident clinical and educational work hours with a frequency sufficient to ensure compliance with ACGME requirements;
    - adjust schedules as necessary to mitigate excessive service demands and/or fatigue;
    - if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue;
    - monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.

Graduate Medical Education Requirements

- Program Directors will provide a written copy of their resident working hour policy to the Graduate Medical Education (GME) Office upon request by the office. The Office of GME will provide a summary of individual program policies to the Graduate Medical Education (GMEC) on a periodic basis.
- All recommendations by programs for an increase in clinical and educational work hours must receive approval of the GMEC prior to being submitted to the ACGME, and must include the following documentation:

- Educational rationale for the request, stated in terms of the program's goals and objectives for the particular assignments, rotations, and levels of training for which the increase is requested.
- Information on how the program will monitor, evaluate, and ensure patient safety with the extended work hours.
- Specific information regarding the program's moonlighting policies.
- Specific information regarding resident call schedules during the times specified for the exception.
- Evidence of faculty development activities regarding the effects of resident fatigue and sleep deprivation.

- Residents must report their clinical and educational work hours, including clinical work done from home and all moonlighting, at least once per week in the residency management suite (New Innovations). The Program Director will monitor the compliance summary reports and will take necessary corrective action when compliance issues are reported.
- Program Special Reviews will include a survey of actual resident assignments to determine compliance with programmatic as well as ACGME requirements on working hours. Discrepancies will be reported to the GMEC for further action.
- The Office of GME will develop additional compliance measures as needed, including but not limited to auditing of call schedules and periodic surveys of residents. Discrepancies will be reported to the GMEC for further action

GME Policy 110 UMCRH – General Policy Accommodation of Disabilities/Technical Requirements

Purpose

It is the responsibility of the University of Maryland Capital Region Health residency Program Directors and faculty, to select individuals who are best qualified to complete the required residency program requirements and who are the most likely to become skilled, independent physicians. Applicants and residents must have the knowledge and skills to function in a broad variety of clinical situations and to render a wide spectrum of patient care.

the University of Maryland Capital Region Health, as the institutional sponsor for graduate medical education, acknowledges Section 504 of the 1973 Vocational Rehabilitation Act and PL 101-336, the American with Disabilities Act (ADA). However, the Medical Center maintains certain minimum technical standards that applicants and applicants must possess.

Scope

This policy applies to all Accreditation Council for Graduate Medical Education (ACGME) accredited graduate medical education programs sponsored by the Prince George's Hospital Center.

Responsibility

It is the responsibility of all program directors and the institution's Graduate Medical Education Committee to comply with this policy.

Technical Skills Eligibility Criteria

Graduate medical education programs must require applicants accepted into the program (Residents) to develop competence in six areas: Patient Care, Medical Knowledge, Practice based Learning, Systems Based Practice, Interpersonal Skills and Communication, and Professionalism.

Toward this end, GME programs in accordance with the Accreditation Council for Graduate Medical Education Institutional and Program Requirements define the specific knowledge, skills, and attitudes required and provide educational experiences needed in order for their Residents to demonstrate the competencies.

In order to achieve competency in these six areas, Residents and applicants accepted into a program, at a minimum, must have aptitude and abilities in the following areas: (1) observation;

(2) communication; (3) sensory and motor coordination and function; (4) conceptual, integrative abilities; and (5) behavioral and social attributes.

Observation requirements

Applicants and residents must be able to:

- observe demonstrations and participate in clinical care and in basic and clinical sciences determined essential by the respective faculties; and
- observe a patient accurately at a distance and at close hand, noting non-verbal as well as verbal signals.

Communication requirements Applicants must be able to:

- speak intelligibly, hear adequately, and observe patients closely in order to elicit and transmit information, describe changes in mood, activity and posture, and perceive non-verbal communications;
- communicate effectively and sensitively with patients;

- communicate effectively and efficiently in oral and written English with all members of the health care team;
- possess reading skills at a level sufficient to accomplish curricular requirements and provide clinical care for patients; and
- complete appropriate medical records and documents and plans according to protocol and in a complete and timely manner.

Sensory and Motor Coordination and Function Requirements Applicants and Residents must:

- Possess sufficient sensory and motor function to elicit information from patients by palpation, auscultation, percussion and other diagnostic maneuvers;
- be able to execute motor movements reasonably required to provide general care and emergency treatment to patients;
- have somatic sensation and the functional use of the senses of vision and hearing;
- Have sufficient exteroceptive sense (touch, pain and temperature), sufficient proprioceptive sense (position, pressure, movement, stereognosis and vibratory) and sufficient motor function to permit them to carry out required activities; and
- be able to consistently, quickly, and accurately integrate all information received by whatever senses are employed.

Intellectual, Conceptual, Integrative and Quantitative Abilities Applicants and Residents must:

- be able to identify significant findings from history, physical examination and laboratory data, provide a reasoned explanation for likely diagnoses, prescribe appropriate medications and therapy and retain and recall information in an efficient and timely manner;
- possess the ability to incorporate new information from peers, teachers, and the medical literature in formulating diagnoses and plans; and
- possess good judgment in patient assessment and in diagnostic and therapeutic planning is.

Behavioral and Social Attribute Requirements Applicants and Residents must:

- possess the emotional health required for full use of their intellectual abilities, the exercise of good judgment and the prompt completion of all responsibilities attendant to the diagnosis and care of patients;
- exhibit the development of mature, sensitive and effective relationships with patients, colleagues, clinical and administrative staff, and all others with whom the accepted applicant interacts in the professional or academic setting, regardless of their race, ethnicity, gender, religion, age or other attributes or affiliations that may differ from that of the applicant /Resident;
- tolerate physically taxing workloads and to function effectively when stressed;
- be able to adapt to changing environments, to display flexibility and to learn to function in the face of uncertainties inherent in the clinical problems of many patients; and
- be able to accept appropriate suggestions and criticism and, if necessary, respond by modification of behavior.

Applicants with Disabilities

State and federal law require that the the University of Maryland Capital Region Health provide reasonable accommodations for applicants and Residents with disabilities that are otherwise qualified to do the essential functions of the job. In the context of the Institutional and Program Requirements, for its sponsored programs, some disabilities cannot be accommodated, while others can be accommodated.

An applicant or Resident is not disqualified from consideration due to a disability and is not required to disclose the nature of their disability during the application and/or interview process. Applicants or Residents with questions about the Accreditation Council for Graduate Medical Education Institutional and Program Requirements in relation to their disability are encouraged to discuss the issue of reasonable accommodation with the Program Director.

Upon the request of an applicant or Resident, and provision of any requested information, academic adjustments and/or reasonable accommodations may be provided, if appropriate. For applicants and Residents, the Program Director working with sponsoring institutional representatives will determine whether requested accommodations are feasible and reasonable.

Some of the aptitudes, abilities, and skills described in the ACGME Requirements can be attained by some applicants or Residents with technological compensation or other reasonable accommodation. However, applicants or Residents using technological supports or other accommodations must be able to perform in a reasonably independent manner. The use of trained intermediaries to carry out functions described in the ACGME

Requirements will not be permitted by the Prince George's Hospital Center. Intermediaries, no matter how well trained, are applying their own powers of selection and observation, which could affect the judgment and performance of those to whom they are providing their intermediary services. Therefore, the Prince George's Hospital Center will not permit third parties to be used to assist a Resident in the clinical training area in accomplishing curriculum requirements. Other accommodations will be given due consideration, and reasonable accommodations will be made where consistent with curriculum objectives and legal requirements applicable to the Prince George's Hospital Center and/or its sponsored programs.

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GME Policy 111 UMCRH – General Policy Special Reviews

Purpose

To ensure excellence in the educational quality and demonstrate effective oversight and monitoring of underperforming programs through a Special Review process under the auspices of the Graduate Medical Education Committee (GMEC).

Policy

In accordance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements, the GMEC will develop a protocol that establishes the criteria for identifying program underperformance which triggers the Special Review process.

The Special Review must result in a report that describes the quality improvement goals, the corrective actions being taken, and the process for GMEC monitoring of outcomes. The Special Review process is an internal quality assurance evaluation and, as such, the reports are considered confidential and not shared with ACGME site visitors.

Procedure

Graduate Medical Education (GME) leadership and/or the Annual Oversight Committee (AOC) Subcommittee of the GMEC identifies underperformance through a wide range of mechanisms including:

- Program failure to meet established ACGME Specialty-specific requirements as evidenced by:
  - Multiple citations (new or extended); or,
  - A status of continued accreditation with warning or probation.
- An annual program evaluation review with deviations from expected results noted in standard performance indicators, as well as from the evaluation process itself.
- ACGME Resident and Faculty Surveys including:
  - significant downward category trends since last survey;
  - results at or below 80% in any category for two consecutive periods; and/or
  - results that necessitate review dependent upon severity.
- Program non-compliance with administrative duties, including failure to:
  - submit Milestones evaluations or other data required by the ACGME;
  - submit a complete annual program evaluation to GME; or,
  - address other institutional administrative issues.
- Complaints or problems brought forward to GME leadership, AOC, or Resident Work Environment Committee (RWEC) regarding learning and working environment issues from residents and/or faculty that have not been successfully addressed by the program.

Requests

- Requests for a Special Review can be generated by program administration.
- The Designated Institutional Official (DIO), at his or her discretion and based on underperforming data from a program, can request a comprehensive review.

Special Review

- When a program is deemed to have met the established criteria of an underperforming program, GME will schedule a Special Review within 60 days of its identification. (Note: Focused Special Reviews related to a specific area of concern may be scheduled.)

- When a program is deemed to have met the established criteria of an underperforming program, and is scheduled for an ACGME Self-Study or full Site Visit within 90 days of its identification, the program director may request an exemption from the DIO/GMEC.
- When a program is deemed to have met the established criteria of an underperforming program for a second consecutive year, GME will schedule a Focused Special Review within 60 days of its identification.

- The Special Review will be conducted by a team appointed by the DIO.
  - At minimum, the team will consist of the DIO or appropriate designee to function as lead reviewer, a program director or other faculty member, and a resident interviewer.
  - The resident interviewer is selected from departmental submissions as well as from volunteers solicited during learning and working environment audits.
  - Team members will be selected from within the Sponsoring Institution, but shall not be from the program being reviewed or, if applicable, from its affiliated subspecialty programs.
- GME Office staff provides support to the review team.
  - The lead reviewer of the Special Review team will determine the materials and data to be requested of the program. These materials are to be provided to the GME Office a minimum of two weeks in advance for distribution to and review by the Special Review team.
  - The Special Review team will conduct interviews with the program director, core faculty, a complement of residents from each level of training in the program, and other key identified individuals.
  - The Special Review team will prepare a written report to be presented to the Annual Oversight Committee subcommittee of the GMEC for review and approval. Prior to AOC review, the program director will have the opportunity to review the report and provide factual corrections and comments to the lead reviewer. The DIO will then review the report for placement on the agenda of the next available AOC meeting. At minimum, the report will contain proposed quality improvement goals and corrective actions to address identified concerns.

GMEC Monitoring

- The AOC will review the report, make final recommendations for the corrective action plan, and monitor the program's progress. The AOC will make at least a quarterly report to the GMEC regarding all ongoing oversight.
- The AOC and GMEC will monitor outcomes through all appropriate means including, but not limited to, progress reports, data collection, accreditation results, surveys, and annual program evaluations.
- The process and follow-up discussion(s) will be documented in AOC and GMEC minutes.

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GME Policy 112 UMCRH – General Policy Resident Agreements

Definition

The Resident Agreement, with attachments, is the written contract between The University of Maryland Capital Region Health ("Hospital") and the resident.

Issuance of Agreement

The Graduate Medical Education (GME) Office will prepare a written resident agreement, outlining the terms and conditions of the resident's appointment to a program The Resident Agreement will directly contain or provide a reference to the following items:

- resident responsibilities;
- duration of appointment;
- financial support for residents;
- conditions for reappointment and promotion to a subsequent PGY level;
- grievance and due process;
- professional liability insurance, including a summary of pertinent information regarding coverage;
- hospital and health insurance benefits for residents and their eligible dependents;
- disability insurance for residents;
- vacation, parental, sick, and other leave(s) for residents, compliant with applicable laws;
- timely notice of the effect of leave(s) on the ability of residents to satisfy requirements for program completion;
- information related to eligibility for specialty board examinations; and,
- institutional policies and procedures regarding resident clinical and educational work hours and moonlighting.

Execution of Agreement

The GME Office will issue all Resident Agreements and monitor the implementation of terms and conditions of appointment.

- The Resident Agreement is executed once all of the following signatures are obtained:
  - The Designated Institutional Official (DIO)
  - The Resident candidate
  - The Program Director

Matriculation

- Each resident will be considered as enrolled based on the starting date of the Resident Agreement.
- If a resident is unable to begin training on the date indicated in the Resident Agreement due to a failure to meet all the preconditions of the Resident Agreement, that Agreement will become null and void. If requested by the Program Director, a new Agreement will be issued when the resident has provided documentation that all the preconditions have been met.

- Current Residents: The Program Director may withdraw an offer based on a resident's performance (failure to meet the program standards or requirements) at any time prior to the new agreement date. If the Program Director withdraws an offer before the Agreement has been signed by all parties as described above, the Resident shall be entitled to due process as set forth in the Grievances and Appeals Policy.

Advancement

- The program director must determine the criteria for promotion and/or renewal of a resident's appointment.
- The program director must provide documentation to the GME Office that a resident on probation has fulfilled the requirements specified in the corrective action plan before he or she will be extended a resident agreement for advancement to the next level of training.

Resident Resignation

- Any resident wishing to resign must submit a written request for release from the remaining term of their agreement to their Program Director. The Program Director has the right to delay or specify the actual termination date to ensure coverage of services.
- The resident training will terminate on the date agreed to by the Program Director. The paycheck will be issued at the next regular payday, provided the resident has completed the human resources clearance process.

Declining to Sign the Resident Agreement

- A resident may choose to decline to renew an offered agreement for the following year by not signing and returning the Agreement. The resident will remain in good standing during the remainder of the current agreement without prejudice and will perform the usual Resident functions until the end of the term of the agreement.

Non-competition

- Neither the sponsoring institution nor any of its ACGME-accredited programs will require a resident to sign a non-competition guarantee or restrictive covenant.

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GME Policy 113 UMCRH – General Policy Resident Supervision

Purpose

This policy delineates the roles and responsibilities of the residents, program directors, faculty members, and Graduate Medical Education Committee (GMEC) to ensure that each resident participating in a University of Maryland Captial Region Health graduate medical education program is adequately supervised.

Responsibility for Supervision

- The program director must monitor resident supervision at all participating sites.
- In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is responsible and accountable for that patient's care

This information must be available to residents, faculty members, other members of the health care team, and patients.

Residents and faculty members must inform each patient of their respective roles in each patient's care when providing direct patient care.

For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

The program must demonstrate that the appropriate level of supervision is in place for all residents based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

The program must define when physical presence of a supervising physician is required.

Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision, and implement the supervision as described in the ACGME Common Program Requirements:

- Direct Supervision:
    - the supervising physician is physically present with the resident during the
- key portions of the patient interaction; or
        - PGY-1 residents must initially be supervised directly.
    - the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
- Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
- Oversight - the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Resident Progressive Authority and Conditional Independence

The program director and faculty members must assign the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident.

- The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
- Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.
- Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Program Guidelines

- Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
- Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
- Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.
- Each program will define in writing the expected competencies and degree of responsibility allowed for each level of residency.

GMEC Oversight

The GMEC may request written descriptions of program resident supervision policy at the Committee members' discretion.

GME Policy 114 UMCRH – General Policy Participating Sites & Affiliations

Participating Sites (Affiliates)

- The Accreditation Council for Graduate Medical Education (ACGME) defines a participating site as: An organization providing educational experiences or educational assignments/rotations for residents/fellows.
    - Examples of participating sites include: a university; a medical school; a teaching hospital, including its ambulatory clinics and related facilities; a private medical practice or group practice; a nursing home; a school of public health; a health department; a federally qualified health center; a public health agency; an organized health care delivery system; a health maintenance organization (HMO); a medical examiner's office; a consortium; or an educational foundation.
- While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. When utilizing such sites,
    - the program must:
        - ensure the quality of the educational experience; and,
        - monitor the clinical learning and working environment at all participating sites.
            - At each participating site there must be one faculty member, designated by the program director, who is accountable for resident/fellow education for that site, in collaboration with the program director.
    - the program director must:
        - receive approval from the DIO and/or GMEC prior to creating an agreement.
        - ensure that a current, fully executed agreement is in place and conforms with ACGME standards, prior to the start of the rotation; and,
        - submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one-month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).
    - the program coordinator must maintain an accurate and current block schedule to fulfill accreditation and financial standards/obligations.
        - For detailed information, review the GME Affiliate Billing Reconciliation Process policy within the New Innovations Resources/Policies section.
- Affiliation Agreement
- An affiliation is established when The University of Maryland Capital Region Health, as a sponsoring institution, formally affiliates with a participating site.
- All affiliations must be secured by an affiliation agreement that fulfills University regulation and policy, as well as ACGME standards.
- An affiliation agreement is an overarching document that describes the responsibilities between UMCRH and the participating site as it relates, but not limited, to:
    - general obligations (i.e. overall control over delivery and quality of patient care);
    - accreditation and licensing (i.e. Joint Commission accreditation);
    - research ownership;
    - space;
    - liability insurance;
    - indemnification (i.e. holding liable for negligent or wrongful acts);
    - affirmative action and equal opportunity language.

- Program Letter of Agreement (PLA)
- According to the ACGME a Program Letter of Agreement (PLA) addresses graduate medical education responsibilities between an individual accredited program and a site other than the Sponsoring Institution at which residents have educational experiences.
    - The PLA must be renewed at least every 10 years and be approved by the designated institutional official (DIO);
    - Elements to be considered in PLAs include (See New Innovations Resources section for PLA template):
        - identify the faculty members who will assume both educational and supervisory responsibilities for residents/fellows;
        - specify these faculty members' responsibilities for the teaching, supervision, and formal evaluation of residents/fellows;
        - specify the duration and content of the educational experience; and,
        - state the policies and procedures that will govern resident/fellow education during the assignment.
- For detailed information, review the Creating New Program Letters of Agreement
- policy within the New Innovations Resources/Policies section.
- Memorandum of Understanding (MoU)
- The MoU must include, but is not limited to:
    - the number of FTEs rotating to the participating site;
    - dates of the assignment;
    - reimbursement terms (e.g. the affiliate agrees to reimburse Hospital for X FTEs for the period established by the PLA);
    - certificate of malpractice coverage, if required.

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GME Policy 115 UMCRH – General Policy Program Director & Responsibilities

Definition

The program director is the administrative head designated with authority and accountability for the operation of the residency/fellowship program, as identified by an accrediting body or the Graduate Medical Education Committee (GMEC). The program director will be the authority most directly responsible for the successful implementation and operation of the graduate medical education (GME) program.

Qualifications of the Program Director

- The DIO is responsible for the program director and must ensure that he/she meets all specialty board and/or Accreditation Council and Graduate Medical Education (ACGME) Requirements prior to nomination.
- Each program director must obtain and maintain the following credentials:
  - specialty expertise and at least three years of documented educational and administrative experience.
  - current medical licensure to practice medicine in Maryland.
  - current certification in the specially for which they are program director or suitable equivalent qualifications.
  - ongoing clinical activity
  - be a member in good standing of the medical staff at The University of Maryland Capital Region Health.
- Program directors must communicate any changes in credentials that could adversely affect program accreditation to the Designated Institutional Official (DIO).

Responsibilities of Program Directors

The program director must:

- submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one-month full time equivalent (FTE) or more through the ACGME Accreditation Data System;
- have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.
- be a role model of professionalism;
- design and conduct the program in a fashion consistent with the needs of the
- administer and maintain a learning environment conducive to educating the residents in each of the ACGME competency domains;
- develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter;

- with collaboration with the DIO, have the authority to approve program faculty members for participation in the residency program education at all sites;
- with collaboration with the DIO, have the authority to remove program faculty members from participation in the residency program education at all sites;
- with collaboration with the DIO, have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program;

- submit accurate and complete information required and requested by the DIO, GMEC, and ACGME.
- provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s);
- provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;
- ensure the program's compliance with GME policies and procedures related to grievances and due process;
- ensure the program's compliance with the GME policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident;
- ensure the program's compliance with the University and GME policies and procedures on employment and non-discrimination;
- document verification of program completion for all graduating residents within 30 days;
- provide verification of an individual resident's completion upon the resident's request, within 30 days;
- obtain review and approval of the DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements;
- report circumstances when the presence of other learners has interfered with the residents' education to the DIO and GMEC;
- define and implement the goals and objectives of the training program;
    - Program goals will be at a minimum those defined by the specialty board of the program. Written objectives will be routinely provided to residents, fellows, and members of the teaching staff.
    - ensure that residents and fellows have access to counseling and psychological support for emotional and mental conditions resulting from training-related stress;
    - assist the GMEC in integrating the training program with the training programs of all other specialties to enable the University to provide an effective overall graduate medical educational program; and,
    - participate and assist in Special Reviews scheduled by the GMEC for the program.

Selection

The Designated Institutional Official is responsible for the GME program will nominate to the GMEC a proposed program director for each program.

- There must be a single program director with authority and accountability for the operation of the program.
- The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.
- The Department Head will notify the GME Office and the DIO of any appointments/terminations of program directors. The GMEC must approve a change in program director.
- For ACGME-accredited programs, final approval of the program director resides with the ACGME Review Committee.

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GME Policy 116 UMCRH – General Policy Fatigue Mitigation/Wellness

Purpose

This policy is required in accordance with the 2010 ACGME standards for resident well- being, based on recommendations by the Institute of Medicine (IOM). It is meant to set specific requirements for alertness management and fatigue mitigation to ensure continuity of patient care, patient safety, and resident safety.

Program Responsibilities

- Each program must:
  - Educate all faculty members, residents and fellows (hereinafter referred to as "residents") to recognize signs of fatigue and sleep deprivation. This must be done annually as part of the residents' curriculum and faculty development.
  - Educate all faculty members and residents about alertness management and fatigue mitigation processes.
  - Encourage residents to use fatigue mitigation processes such as strategic napping or turnover of care via back-up schedules, to manage the potential negative consequences on patient care and learning.
  - Ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care responsibilities due to fatigue.
  - Educate residents and faculty members about their professional responsibilities as physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.
  - Ensure that residents and faculty members demonstrate an understanding of their roles in the management of their time before, during, and after assignments; recognize impairment, including illness, fatigue, and substance abuse, in themselves, their peers; and other members of the health care team; and submit accurate clinical and educational work hour reports.
  - Monitor the demands of at-home call and adjust schedules to mitigate fatigue when applicable.

Institutional Responsibilities

Each sponsoring institution must provide, at a minimum, adequate sleep areas and/or safe transportation options for residents who may be too fatigued to safely return home.

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GME Policy 117 UMCRH – General Policy Transitions of Patient Care

Purpose

The purpose of this policy is to establish protocol and standards within the University of Maryland Capital Region, residency programs for the orderly transfer of responsibility for a patient's care from one physician to another, and to define a safe process to transfer important information, responsibility, and authority from one provider to another.

Definition

A "handoff ' or "transition of care" is defined as the communication of information to support the transfer of care and responsibility for a patient or a group of patients from one provider to another in the health care setting. This is best done as a face-to-face encounter between providers, but it can be conducted over the telephone so long as both parties have access to an electronic or printed version of the sign-off sheet or summary. The handoff/transition of care is an interactive communication process for passing specific, essential patient information from one caregiver to another. Throughout this policy, the term "handoff ' shall be used to indicate a handoff or transition of care.

Handoffs occur regularly in conjunction with (not limited to) the following conditions:

- Transfer of patient care related to shift change or rotation changes for residents/fellows (hereinafter referred to as "residents")
- Transfer of patient care temporarily or long-term for any reason (e.g., cross- coverage for didactics or during vacations)
- Changes in level of patient care, including admissions from the Emergency Room to inpatient, outpatient to inpatient admissions, or admissions from a procedural/diagnostic area
- Discharge to another institution, facility, care setting, or provider

Policy

All programs must have in place a standardized process that includes both verbal and written/electronic communication of patient care-related information that facilitates continuity of care and promotes patient safety. An essential element must be the opportunity for all parties involved to ask and respond to questions, and to clarify information during these transitions.

Procedure

Handoffs should be carried out in a consistent manner facilitated by a standardized handoff form. The form's content should be specific to the type of patient care being provided. The handoff process should include, at a minimum:

- Patient's name, date of birth, medical record number, and location
- Identification of the admitting and supervising physician, along with contact information
- Diagnosis, condition and level of acuity of the patient
- Hospital course of treatment and pertinent historical data
- Medication list and history of any known allergies

- Vitals and important or outstanding labs to be monitored during absence or transition
- Identification of any specific protocols/resources/treatments in place that need to be completed in the near future

- Description of anticipated care plan for next 24 hours of care
- Identification of any anticipated problems, or changes in patient's condition that may require intervention, along with suggested actions to be taken, if known
- Advanced Directives are documented in the medical record
- Any other clinical information that is considered integral to the provision of evidence-based, effective, and safe care

Programs and participating clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.

Each program must include handoffs as part of its curriculum. Residents should be shown how to organize and integrate the information listed above.

- into either the Situation Background Assessment Recommendation (SBAR) or Illness Severity, Patient Summary, Action List, Situation Awareness and Contingency Planning, Synthesis by Receiver (I-PASS) framework. The Program Director will determine which framework serves the program best.

Each program must ensure that its process includes opportunities to observe both the behavior of the receiving clinician and the reporting clinician, as each has a responsibility to the patient. There must be:

- a process facilitated by a supervising attending physician or, at a minimum, a senior resident, until such time as competency is determined for any individual resident
- an opportunity for verification of the received information through repeat back or read back as deemed appropriate for the situation
- an opportunity for the receiving clinician to ask pertinent questions and requisite information from the reporting physician
- an opportunity to observe and reinforce that the process is conducted discreetly so as to preserve confidentiality, and in a way that is free from distractions such as telephones, cell phones, hand-held electronic devices, or disruptive third-party conversations

Each program must ensure that residents demonstrate competency in performance of tasks related to handoffs. Some suggested methods include:

- direct observation of a handoff session, with use of a checklist by a supervising clinician skilled in this task, to provide feedback
- direct observation of a handoff session by a more senior supervising resident already certified as competent in performing the process
- evaluation of written handoff materials by either of the above supervisory chains of command
- use of case-based simulation OSCE
- mini-CEX for knowledge and skill assessments
- evaluation of adverse events and root cause analysis to define causational relationship to quality of handoff process (e.g., survey, reporting on MIDAS or hotline, trigger tool, chart review with stimulated recall)

Responsibilities

The transferring resident or attending must:

- comply with policy and procedures for handoffs
- resolve discrepancies and concerns in a timely manner

- remain in the hospital until an effective handoff has occurred with the attending or resident coming onto the service. Supervision as required must be in attendance

The receiving resident or attending must:

- review the handoff form or receive verbal handoff (free of distraction)
- resolve any questions with transferring resident or attending prior to acceptance of patient

The Program Director must:

- ensure that schedules and assignments minimize the number of transitions in caring for patients
- evaluate each resident for competency attainment in performing handoffs through direct observation and documentation in the resident's file
- ensure that a standardized process is in place and familiar to all residents and attending supervisors
- ensure that the learning environment has the requisite materials and infrastructure to support the process (e.g., forms, computers, telephones)
- ensure that all are familiar with HIPAA requirements and the need to preserve patient confidentiality and privacy
- ensure that a process is in place for any necessary remediation
- ensure continuity of patient care, consistent with the program's policies and procedures, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency

GME Policy 119 UMCRH – General Policy Resident Educational Support

Residents will be required to make education purchases and present the receipt for reimbursement. Reimbursement requests should be sent to the respective program coordinators, and they will be presented to GME for approval and to verify if the activity meets criteria.

Training Level	**Stipend or Educational Materials Provided**	**Additional Details**
PGY-1	Professional Membership (ACP or AAFP)	Departmental discretion for books provided
PGY-2	$500*	Reimbursed upon request
PGY-3	$1500*	Reimbursed upon request and program director approval**

** purchasing includes for books, journals, educational supplies, electronics, educational courses, and conferences. Registration for USMLE step 3 exams, license application, and board exam registration does not qualify.*

Educational stipend will be applied to all cost relating to conference presentation/travel request. Additional conference presentations will be reviewed/approved on a case by case basis upon request, particularly those structured towards presenting scholarly works (abstracts, poster presentations, etc.) For research manuscript support please discuss with the research department (Dr Gopakumar).

***Educational stipend for 3rd years is discretional to the program administration. Some component of the educational stipend is reserved for board review course reimbursement. Board review course(s) will be program specific and it is ultimately recommended to discuss this with your program administration as multiple factors (Step 3 scores, in service scores) will have influence.*

Please note: Original receipts must be presented. Credit cards statements will not be honored. All receipts must be submitted to your Program Coordinator for processing.

GME Policy 120 UMCRH – General Policy Annual Institutional Review (AIR)

Purpose

This policy provides a process by which the University of Maryland Capital Region Health, through its Graduate Medical Education Committee, assures effective institutional oversight of GME and demonstrates accountability to the Sponsoring Institution's Governing Body through an annual summary of the Annual Institutional Review (AIR).

Scope

This policy applies to the Graduate Medical Education Committee (GMEC), ACGME- accredited residency educational programs sponsored by the University of Maryland Capital Region Health.

Responsibility

It is the responsibility of the DIO and all members of the GMEC and the University of Maryland Capital Region Health officials to comply with this policy.

Procedure

An Annual Institutional Review (AIR) shall be conducted by the GMEC itself or by an Ad Hoc committee designated by the Chair of the GMEC. Such Ad Hoc Committee, if established, shall consist of at least the DIO as chair at three other members of the GMEC one of whom shall be a resident member. Other members may be appointed as deemed appropriate by the DIO along with adequate support personnel.

The GMEC thorough the annually AIR will document a formal, systematic evaluation of institutional performance indicators which will include:

- ACGME notification of institutional accreditation status
- Results of the most recent CLER visit
- Results of the most recent institutional self-study visit
- Aggregate results of ACGME surveys of resident/fellows and faculty, and
- Aggregate results of ACGME-accredited program performance indicators

Annual Institutional Review Report

A written report of each AIR shall be presented to the GMEC and must include monitoring procedures for action plans resulting from the review, if any, for approval by the GMEC. An executive summary of the AIR will be submitted annually to the Governing Body of the Sponsoring Institution.

Progress Reports

As appropriate, the GME Committee shall monitor the progress of implementing and the response to and any action recommendations.

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GME Policy 121 UMCRH – General Policy Program Evaluation

Purpose

- The annual program evaluation process is intended to promote a meaningful way for program leadership to review and analyze program data. The purpose of this policy and procedure is two-fold:
    - To establish a method for composition and responsibilities related to the requirement for individual Program Evaluation Committees (PEC); and,
    - To define the Graduate Medical Education Committee's (GMEC) responsibilities associated with oversight of Accreditation Council for Graduate Medical Education (ACGME)-accredited programs by establishing a formal, systematic process to annually evaluate the educational effectiveness and monitor improvements as mandated by the ACGME and recommended by the GMEC.

Policy

- In accordance with the ACGME Common Program Requirement V.C., Program Evaluation and Improvement, each ACGME-accredited program will establish a PEC. The PEC is required to meet a minimum of two (2) times per year.
- In accordance with the ACGME Institutional Requirement I.B.5, as well as its overall responsibility to maintain effective oversight, the GMEC will review all annual program evaluation and self-studies. This review will function as a component of the Annual Institutional Review (AIR).

Program Evaluation and Improvement

- The program director must appoint the Program Evaluation Committee (PEC) to conduct and document the annual program evaluation as part of the program's continuous improvement process.
    - The PEC:
        - must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident;
        - responsibilities must include:
            - acting as an advisor to the program director, through program oversight;
            - review of the program's self-determined goals and progress toward meeting them;
            - guiding ongoing program improvement, including development of new goals, based upon outcomes; and,
            - review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.
- The PEC should consider the following elements in its assessment of the program:
    - curriculum;
    - outcomes from prior Annual Program Evaluation(s);
    - ACGME letters of notification, including citations, Areas for Improvement, and comments;
    - quality and safety of patient care;
    - aggregate resident and faculty:
        - well-being;
        - recruitment and retention;
        - workforce diversity;
        - engagement in quality improvement and patient safety;
        - scholarly activity;
        - ACGME Resident and Faculty Surveys; and,
        - written evaluations of the program.
    - aggregate resident:

        - achievement of the Milestones;
        - in-training examinations (where applicable);
        - board pass and certification rates; and,
        - graduate performance;
    - aggregate faculty:
        - evaluation; and,
        - professional development.
- The PEC must evaluate the program's mission and aims, strengths, areas for improvement, and threats.
- The annual review, including the action plan, must:
    - be distributed to and discussed with the members of the teaching faculty and the residents; and,
    - be submitted to the Designated Institutional Official (DIO).

Procedure

- The annual program report and a written action plan for improvement must be completed and submitted to the Office of Graduate Medical Education by the last business day in August, or in compliance with an alternate date as established by the DIO.
- The GMEC and any officially designated subcommittees and/or representatives will review the annual program evaluations and corresponding action plans with respect to program performance and trending. The GMEC will, in addition, conduct an overview across programs.
- Summaries of the reviews and recommendations will be provided to the individual Program Directors and Department Heads and presented at the GMEC meetings.

GME Policy 122 UMCRH – General Policy Professionalism

Introduction

- In accordance with the ACGME Core Competency requirement for Professionalism, this policy is written to facilitate programs and their residents in meeting professionalism standards for the practice of medicine.

Institutional Responsibilities

- The Sponsoring Institution, in partnership with the program directors of its ACGME-accredited programs, must provide a culture of professionalism that supports patient safety and personal responsibility.
- The Sponsoring Institution, in partnership with its ACGME-accredited programs, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.
- The Sponsoring Institution must provide systems for education in and monitoring of:
    - residents' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits; and,
    - accurate completion of required documentation by residents.
- The Sponsoring Institution must ensure that its ACGME-accredited programs provide a professional, equitable, respectful and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse or coercion of residents, other learners, faculty members, and staff members.
    - The Sponsoring Institution, in partnership with its ACGME-accredited programs, must have a process for education of residents and faculty members regarding unprofessional behavior, and a confidential process for reporting, investigating, monitoring, and addressing such concerns.
- Each program must have a program-level policy that describes the manner in which the program provides professionalism education to the resident.
- Residents are required to fulfill all obligations that the University, GME Office, residency programs, and hospitals deem necessary to begin and continue duties as a resident, including but not limited to:
    - Attending orientations, receiving appropriate testing and follow-up, if necessary, for communicable diseases, fittings for appropriate safety equipment, necessary training, and obtaining of badges. Some of these activities may occur prior to the resident appointment start date.
    - Completing required assignments before established deadlines, including but not limited to: Safe Haven training, Ethics training, Learning Management Suite (LMS) modules, medical records, mandatory online curricula, mandatory surveys, resident work hour logs, procedural logs, or conference attendance.)

Program Responsibilities

- Each program must:
- Facilitate the development of habits of conduct that demonstrate sensitivity, compassion, integrity, respect, and trust, through the use of an organized curriculum.
- Emphasize the importance of maintaining the patient's dignity and confidentiality at all times.
- Emphasize the need for residents to commit to carrying out professional responsibilities and to adhere to ethical principles.

Program Director Responsibilities

- The program director must be a role model of professionalism.
- The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient

care, educational excellence, and a scholarly approach to work. The program director must create an environment where respectful discussion is welcomed, with the goal of continued improvement of the educational experience.

Expected Resident Behaviors

- Each resident must:
- Demonstrate a commitment to professionalism and an adherence to ethical principles;
- Demonstrate competence in:
    - compassion, integrity, and respect for others;
    - responsiveness to patient needs that supersedes self-interest;
    - respect for patient privacy and autonomy;
    - accountability to patients, society, and the profession;
    - respect and responsiveness to the diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;
    - ability to recognize and develop a plan for one's own personal and professional well-being; and,
    - appropriately disclosing and addressing conflict or duality of interest.
- Respect individual patient concerns and perceptions.
- Demonstrate respect for peers and other members of the health care team by maintaining open communication at all times.
- Respect the systems that are in place to provide and improve the quality and safety of patient care.
- Comply with all requirements as set forth in the GME Policy Manual, and all other University requirements.

GME Policy 123 UMCRH – General Policy Resident Work Environment

ACGME Requirements

- The Sponsoring Institution (The University of Maryland Capital Region Health) and each of its ACGME-accredited programs must provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback without intimidation or retaliation. Feedback should be provided in a format that ensures confidentiality as appropriate.
- UMCRH will provide support services and develop health care delivery systems to minimize the work of residents that is extraneous to their graduate medical education (GME) programs' educational goals and objectives. Programs must ensure that residents' educational experience is not compromised by excessive reliance on residents to fulfill non-physician service obligations. These services and systems must include:
    - Peripheral intravenous access placement, phlebotomy, laboratory, pathology and radiology services, and transportation services provided in a manner appropriate to and consistent with educational objectives and to support high quality and safe patient care.
    - Availability of medical records at all participating sites to support high quality and safe patient care, residents' education, quality improvement, and scholarly activities.
- The Institution, in partnership with its GME programs, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to return safely home.
    - Sleep facilities must be safe, quiet, and provide a modicum of privacy. Facilities must be available and accessible for residents to support education and safe patient care.
- The institution must ensure a healthy and safe clinical and educational environment that provides for:
    - access to food during clinical and educational assignments.
    - safety and security measures for residents appropriate to the participating site.

Resident Forum/Town Hall

- The Resident Forum is a mechanism for residents to communicate and exchange information on their educational and work environment, their programs, and other resident issues, in a confidential and protected manner. Resident forum meetings are held approximately quarterly. Resident members of the GMEC serve as facilitators of the meetings. Any and all residents are welcome to attend the meetings. The GME Office staff assists with meeting logistics, but
- does not attend the meetings unless invited. The Resident Forum meets the ACGME requirement for residents to have a pathway to discuss issues pertaining to the learning environment free of oversight by faculty and staff. The purpose of the meetings includes:
    - To help the GMEC resident members better represent the residents' concerns to the GMEC.
    - To improve communication among residents, between programs, and between departments.
    - To elicit resident feedback in a peer to peer environment.
    - To improve morale among residents and to provide a venue for effecting change.

- The resident facilitators of the Forum meetings use a standard form to record the date, time, and location of the meetings, the names of the facilitators, and the number of residents who attended the meetings. The form is also used to collect resident comments and concerns, which are reported to the GMEC and the GME Office for follow-up.

Resources for Residents

- There are several levels at which residents may address problems and issues. In ascending order, these include:
    - Chief Resident
    - Program Director

  - Director of Graduate Medical Education
  - Designated Institutional Official
- All Campus resources for students and employees are also open to residents. Information is available from the University's website or by contacting the GME Office.

Resident Activities

- Resident activities are designed to provide the optimal educational experience possible in an environment of clinical patient care. Resident involvement in patient care must be carefully supervised to ensure that the patient receives the highest quality of care. Any basic or routine technical or administrative work required of a resident must be part of the learning process and should only be related to a patient in whose care the resident is involved.

GME Policy 124 UMCRH – General Policy Resident Meal Allowance

Objective

The University of Maryland Capital Region Health/Prince George's Hospital Center provides financial assistance for on-call meals to all medical residents.

ACGME Institutional Requirement III.B.7. Well-Being;

- III.B.7.d) The Sponsoring Institution must ensure a healthy and safe clinical and educational environment that provides for: (Core)
- III.B.7.d).(1) access to food during clinical and educational assignments; and, (Core)
- III.B.7.d).(2) safety and security measures for residents/fellows appropriate to the participating site. (Core)

Distribution of Funds

A. Each resident receives a meal allowance of $500.00 per appointment year. This meal allowance is in addition to the salary that the resident receives as compensation for his/her residency appointment.

B. The meal allowance is distributed each fiscal/academic year as a lump sum payment via the residents' paychecks. These funds are taxed as income.

Reporting Requirement

C. There will be no requirement for reporting the use of funds.

- A current resident or fellow may not apply for medical staff privileges at any hospital without the resident's program director's written permission.

- A resident may not apply for attending privileges at any affiliated hospital for the specialty in which he/she is currently training. Privileges will be limited to the specialty in which the resident is already board certified or eligible.

    - Example: A fellow in a surgical subspecialty may apply for general surgery privileges, with the approval of his/her program director, assuming the fellow is board eligible in general surgery. The fellow cannot apply for privileges related to his/her current field of training.

Current Status: *Active* **PolicyStat ID:** *9294475*

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Owner:	*Veronica Ford: VP Human Resources*
Policy Area:	*Human Resources*
References:	
Applicability:	*UM Capital Region Health - Systemwide*

Drug Free Workplace

I. **POLICY**

A. **Purpose**

The University of Maryland Capital Region Health is committed to protecting the safety, health and well-being of its team members, patients and visitors. The purpose of this policy is to achieve and maintain a drug-free workplace through a program that balances the need to maintain a drug free workplace for the safety of our team members, patients and visitors with our respect for individuals.

B. **Scope**

This policy applies to all job applicants and team members of the University of Maryland Capital Region Health Campuses.

C. **Definitions**

Diversion	The removal or theft of any controlled substance or psycho-pharmacologic medication or substance from University of Maryland Capital Region Health for reasons that are not work-related.
Team Member Assistance Program (EAP)	A confidential counseling and referral service available to all University of Maryland Capital Region Health team members and their family members. The EAP is staffed by trained mental health professionals, and all EAP services are provided free of charge to team members. This program is separate from the health plan benefits provided by University of Maryland Capital Region Health.
Illegal Drug	Any drug, substance, or immediate precursor whose use or possession is controlled by federal law but that is not being used or possessed under the supervision of a licensed health care professional. (Controlled Substances are listed in Schedules I through V 21 C.F.R. Part 1308).
Non-Controlled Substance	Those substances approved for medicinal use in the United States not having a significant abuse potential and, thus, not classified as a controlled substance.
Refuse to Cooperate	Means to obstruct the collection or testing process; to submit an altered, adulterated or substitute sample; to fail to show up for a scheduled test; to refuse to complete the requested drug testing forms; or to fail to promptly provide specimen(s) for testing when directed to do so, without a valid medical basis for the failure.
Substance Use Disorder	The recurrent use of alcohol and/or drugs that causes clinically and

	functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. For the purposes of this policy, reference to the term "substance use disorder" shall be interpreted to include the "illegal use of drugs" as defined in the Americans with Disabilities Act, 42 USC §12111(6).
UM Capital Region Health Premises	Includes all buildings, offices, facilities, grounds, parking lots, lockers, places and vehicles owned, leased or managed by UM Capital Region Health or on any site in which UM Capital Region Health **is conducting business.**
Under the influence of alcohol	Means actions, appearance, speech or bodily odors that reasonably cause a supervisor to conclude that **an team member is impaired because of alcohol use.**
Under the influence of drugs	Means a confirmed positive test result for illegal drug use per this policy. In addition, it means the misuse of legal drugs (prescription or OTC) when there is not a valid prescription from a physician for the lawful use of a drug in the course of medical treatment or, in the case of OTC medication, when medication is taken in a manner inconsistent with its intended use.

Psycho-pharmacologic Medication or Substance	Any drug or substance that alters one's cognitive ability, judgment, thoughts, and behavior.

II. RESPONSIBILITY

All Staff	Responsible for maintaining a drug free workplace by complying with the terms of this policy.
Managers/ Supervisors	Responsible for communicating to the team members under their supervision the contents of this and related policies, and enforcing its provisions through corrective action, referral for a Fitness for Duty evaluation, or referral to the EAP when indicated.

III. WORK RULES

A. General

1. Whenever team members are working, are present on University of Maryland Capital Region Health premises, or are conducting company-related work off-site, they are prohibited from:

    a. Using, possessing, buying, selling, manufacturing or distributing an illegal drug (to include possession of drug paraphernalia) in the workplace.

    b. Being under the influence of alcohol or an illegal drug as defined in this policy.

    c. Possessing or consuming alcohol.

2. The presence of any detectable amount of any illegal drug or illegal controlled substance in an team member's body system, while performing company business or while in a company facility, is prohibited.

3. University of Maryland Capital Region Health does not allow team members to perform their duties while taking prescribed drugs if the prescription drug adversely affects the team member's ability to safely and effectively perform his/her job duties. team members taking a prescribed medication must

carry it in the container labeled by a licensed pharmacist or be prepared to produce it if asked.

A. Marijuana

Marijuana is a Schedule I drug, the possession and use of which remains illegal under federal law. For this reason, unless an individual is using marijuana subject to a valid prescription, the presence of any detectable amount of marijuana or its metabolites in a team member's body system is prohibited by this policy.

Individuals who are using marijuana as prescribed by a physician may be approved for an exception to this policy, provided that the individual is not under the influence of marijuana while on duty or on University of Maryland Capital Region Health premises and the individual's medical use of marijuana does not pose a threat to the safety of University of Maryland Capital Region Health's team members, patients and visitors, as determined in the sole discretion of University of Maryland Capital Region Health.

II. PROCEDURES

A. **New Hires**

After an employment offer has been made, but before the applicant begins working, the applicant will have a pre-placement health assessment, which includes testing for drugs. (*See* HR Policy *Pre-Placement Health Assessment*). If the test results demonstrate that the team member violates the drug-free workplace policy, the offer of employment will be withdrawn.

B. **Orientation for New Hires to Drug Free Workplace Policy**

At the time of employment, each newly hired team member will be required to sign an acknowledgement of their receipt of the University of Maryland Capital Region Health Drug Free Workplace Policy. This signed form will be placed in the team member's personnel file in the Department of Human Resources.

C. **Fitness for Duty (Reasonable Suspicion)/Corrective Action**

After employment begins, if the team member exhibits signs of being under the influence of drugs or alcohol, or self-discloses current drug or alcohol abuse, the supervisor shall refer the team member to team member Health Services (Employee Health) for further evaluation. Specific procedures for this referral can be found in the HR Policy *Fitness for Duty*.

University of Maryland Capital Region Health provides reasonable accommodations to qualified individuals with disabilities, including individuals who are undergoing treatment for SUD or have completed such a treatment program. team members remain responsible for meeting performance expectations. Nothing in this policy prohibits supervisors from continuing to use corrective action to address any specific performance issues of such an team member.

D. **team member Diversion of Psychopharmacologic Substances or Controlled Substances**

Any team member engaged in diversion will be terminated from employment. The supervisor is to contact their Human Resources Business Partner, who will activate the Substance Use Disorder Advisory Group/Task Force and Security to assist in this process. Team members may be subject to legal action through the appropriate authorities and will be reported to any appropriate licensing board and/or regulatory agency. University of Maryland Capital Region Health reserves the right to evaluate each diversion incident on a case-by case basis, and to make employment decisions based on all aggravating and mitigating factors.

E. **Reporting to Licensing Board and/or Regulatory Agency**

Licensed professional team members of University of Maryland Capital Region Health will be reported to any appropriate state licensing board or other regulatory agency in accordance with the procedures established by that board or agency.

A. **Drug and Alcohol Testing**

University of Maryland Capital Region Health shall conduct all drug and alcohol testing in the manner specified in the Pre-Placement Health Assessment Policy (*see* HR Policy *Pre-Placement Health Assessment*) and consistent withSection 17-214 of the Health General Article, Annotated Code of Maryland.

B. **Self-Reporting Alcohol and/or Drug Addiction**

Team members are encouraged to seek help for SUD voluntarily through the EAP. If a team members self-discloses active SUD to someone other than EAP, then his or her supervisor shall follow the fitness for duty process as outlined in HR Policy *Fitness for Duty*. A team member who self-reports is encouraged to also self-report to his or her licensing/ certifying board in accordance with the reporting requirements for that entity. Any team member who pleads guilty or is convicted of a criminal drug violation must notify Human Resources immediately (within five calendar days). Failure to do so may result in termination of employment. Human Resources will conduct an assessment to determine if the conviction is sufficiently related to the team member's role and position and will recommend an appropriate course of action up to and including termination of employment, if warranted.

C. **Controlled Substances Group**

The Controlled Substances Group is responsible for University of Maryland Capital Region Health's surveillance and monitoring of controlled substances. The Controlled Substance Group:

- Develops recommended policies regarding the purchase, dispensing, storage, transfer, and security of all controlled substances at University of Maryland Capital Region Health (including its clinics and pharmacies);
- Recommends practices, protocols and policies to prevent diversion; and
- Reviews cases of suspected diversion.

D. **The Substance Use Disorder Advisory Group/Task Force**

The Controlled Substance Group is comprised of representatives from Human Resources, Pharmacy, Patient Care Services leadership, Security, EAP, Legal, Compliance, and Employee Health.

Investigations of Diversion

The SUD Advisory Group/Task Force reviews all cases in which an team member discloses an active SUD but where the team member has not been found to be diverting medication. This group will review each case to document and gather information necessary to provide guidance to University of Maryland Capital Region Health leadership regarding reporting to regulatory agencies, if required, and to provide guidance on the individual's ability to safely return to work as described below

Membership

The SUD Advisory Group/Task Force is comprised of representatives from: Human Resources, Pharmacy, Patient Care Services leadership, EAP, and Employee Health Services (EHS). Ad hoc members of this group will include supervisors and other associated leaders from areas where the team member discussed has worked or will be working.

Support of Team Members Returning to Work After Treatment

The SUD Advisory Group/Task Force will review all cases of team members returning to work following SUD treatment and medical clearance from EHS. This group will provide recommendations to University of Maryland Capital Region Health leadership regarding appropriate work placement for individuals who are in recovery from SUD, and offer support to managers/supervisors in those areas in understanding the conditions of employment and/or monitoring agreements from licensing agencies for applicable team members.

J. **Licensing Board Liaison**
Each department with team members who are licensed or certified by a health professions licensing board will provide a contact person who will act as liaison to that government agency. In addition to managing relationships with the licensing board(s), this individual will provide support to departmental managers/ leadership in maintaining compliance with any stipulations placed on an individual who is engaged in an alternative-to-discipline program or placed on probation by the licensing agency.

K. **Confidentiality**

All information received by University of Maryland Capital Region Health under this policy is confidential, meaning that:

- Information is kept in a confidential record separate from the team member's personnel file;
- Supervisors are informed of drug test results only as-needed to address diversion or to accommodate a team member's return to work;
- Supervisors are not informed of other medical information that may be obtained through fitness for duty process, but may be advised of only that information necessary to support a reasonable accommodation; and
- Information gathered pursuant to this policy is not released externally without: (1) the written consent of the individual; (2) a valid subpoena that complies with the Maryland Confidentiality of Medical Records Act; or (3) other valid legal process (for example, a court order).

Attachments

No Attachments

Approval Signatures

Approver	Date
Veronica Ford: VP Human Resources	05/2021

Applicability

UM Bowie Health Center, UM Capital Region Health, UM Capital Region Medical Center, UM Laurel Medical Center, UMCR Surgery Center

Current Status: *Active* **PolicyStat ID:** *9303479*

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Last Reviewed:	*05/2021*
Review:	*05/2024*
Owner:	*Veronica Ford: VP Human Resources*
Policy Area:	*Human Resources*
References:	
Applicability:	*UM Capital Region Health - Systemwide*

Sexual Harassment, 230-605

PURPOSE:

The organization is committed to maintaining a work environment in which all individuals are free from harassment. The organization therefore has adopted this policy to prevent and promptly correct sexual harassment, as well as harassment on the basis of race, color, sex, religion, national origin, age, sexual orientation, gender identity and/or expression, disability, protected activity under the anti-discrimination laws, or any other status protected by federal, State or local law.

CANCELLATION:

This policy supercedes Policy No. 230-602, "Sexual Harassment", dated October 24, 1991.

POLICY:

This policy strictly prohibits sexual harassment or harassment on the basis of any protected status (race, color, sex, religion, national origin, age, sexual orientation, gender identity and/or expression, disability, protected activity under the anti-discrimination laws or any other status protected by federal, State or local law) in the workplace, provides a procedure for reporting harassment, and serves as a guideline for necessary actions to be taken after a complaint has been made.

PROCEDURE:

I. **Harassment Definitions**

A. Harassment: Unwanted or unwelcome verbal, written or physical conduct towards another person because of their race, color, sex, religion, national origin, age, sexual orientation, gender identity and/or expression, disability, protected activity under the anti-discrimination laws or any other status protected by federal, State or local law.

B. Harassment can include but is not limited to: intimidation, epithets, slurs, negative stereotyping, threatening, bullying, and/or the creation of a hostile or offensive work environment, which has the purpose or effect of unreasonably interfering with an individual's work performance or otherwise adversely affecting an individual’s employment opportunities.

C. Sexual Harassment: Unwelcomed or unwanted sexual advances, requests for sexual favors and other verbal or physical conduct when:

1. It is considered unacceptable by another individual;

2. Submission to such conduct is made either explicitly or implicitly as a term or condition of an individual's employment;

3. Submission to or rejection of such conduct is used as a basis for employment decisions affecting such individual;

4. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.

II. **Reporting Harassment**

A. Team member

1. A team member who feels he/she has been subjected to conduct that violates this policy, or a team member who witnesses conduct that violates this policy:

a. Is encouraged (but not required) to immediately tell the other person when his or her behavior is considered inappropriate and unwelcome and ask that the unwanted conduct stop. Persons should comply immediately with such requests and without retaliation.

b. Should immediately report the incident to his/her supervisor, any member of management, or to Human Resources.

c. Human Resources will conduct a prompt, thorough and impartial investigation to determine if prohibited harassment has occurred.

1. Complaints will remain confidential to the maximum extent possible, although some disclosure may be necessary to facilitate the investigation.

2. In appropriate circumstances, the individual accused of harassment may be suspended pending the conclusion of the investigation.

d. Prompt and appropriate action will be taken consistent with the results of the investigation.

e. There will be no retaliation against an individual who makes a report of harassment. An individual who feels that he/she has been subject to retaliation for reporting harassment should inform his/her supervisor, any member of management, or Human Resources. Any person found to have retaliated against another individual for reporting violations of this policy will be subject to disciplinary action up to and including termination of employment.

f. If the final resolution is not acceptable to the complaining individual, the team member may request a review of the issue by the President and CEO or designee. The resolution offered by the President and CEO or designee is final.

2. A team member who is found to have engaged in prohibited harassment will receive appropriate discipline up to and including termination of employment according to organizational policies and practice.

3. Reports of harassment by physicians will be reported immediately to the President of the Medical Staff Chief Medical Officer.

   See UM Capital Policy No. 230-602, "**Grievance Procedure-Non-Represented team members"** or the respective Collective Bargaining Agreement, for details.

B. Physician

1. A physician who feels he/she is being harassed should report the occurrence to his/her Medical Staff department chairperson or the Chief Medical Officer or Administrator on Call.

2. The Department Chair and President and CEO/designee will have joint responsibility for conducting an investigation to determine if harassment has occurred and the appropriate remedy. Human Resources will provide guidance.

C. Volunteer

1. A Volunteer who feels he/she is being harassed should report the occurrences to a member of management or Human Resources.

2. If reported to management, management will work with Human Resources to conduct an investigation to determine if harassment has occurred and the appropriate remedy.

Attachments

No Attachments

Approval Signatures

Approver	Date
Veronica Ford: VP Human Resources	05/2021

UNIVERSITY of MARYLAND
CAPITAL REGION
MEDICAL CENTER

Irman E. Siddiqi, MD, MBA, FACP, FCCP
Chairman, Department of Critical Care
UM Capital Region Health
901 Harry S Truman Drive North
Largo, MD 20774
PHONE: 240-677-0246

Dear Dr. Tavakoli,

Interim Program Director, Family Medicine Residency Program UMCRH
Sir,

Please consider this letter as my delayed evaluation for Dr. Otabek Elmurodov. I regret that I did not complete his formal evaluation at the time of his rotation. However, as a part of a 360 degree evaluation for any Resident Physician, I do believe that my following input is warranted. I will certainly fill out his formal evaluation if asked to do so by the Program. I currently do not have any access to it.

Dr. Elmurodov worked in our very high acuity ICU during his assigned rotation. I personally worked with him side-by-side for a few days while taking care of some of the sickest patients in our hospital.

I have worked with Resident Physicians for most of my clinical career and once in a while there are some compelling characteristics in a learner which makes me give a direct verbal feedback to the respective Program Director. I distinctly remember talking with Dr. Donna Prill who is the Associate Program Director of the Family Medicine Training Program about Dr. Elmurodov. My specific positive feedback was about my very pleasant surprise upon reading the clinical progress notes of Dr. Elmurodov. I found his clinical progress notes to be grounded in deep understanding and description of pathophysiology of our very sick patients. I usually do not see such a good understanding of pathophysiology amongst young Resident Physicians. It is for this reason I was very impressed by his narrative of clinical scenarios and pathophysiology. I made a point to verbally communicate this to his Associate Program Director.

In addition to this outstanding quality, I found Dr. Elmurodov to be highly professional during his rotation. I did not witness, nor did I receive any complaint about insubordination during his Critical Care rotation. I found him to be a keen learner who was deeply invested in his profession. He was consistently kind and compassionate. I found him to be very reliable and he followed all instructions effectively. I also found him to be hard-working team member because he was willing to stay late and go an extra mile to help out his colleagues. He was always collaborative with our large multidisciplinary ICU team of IM Residents, Attendings, Medical Students, APPS, Nurses, Respiratory Therapists, and Clinical Pharmacists.

I do formally and respectfully request that my above evaluation be considered a part of the 360-degree evaluation for this Resident Physician. As such I do request that this be presented as a part of his review that is currently underway.

I thank you for your time and consideration in this matter.

Respectfully submitted,

Imran Siddiqi, MD, MBA, FACP, FCCP
Chair, Department of Critical Care University of Maryland Capital Region Health
isiddiqi@som.umaryland.edu
Cell- 443-341-7853

MEADE, REYES & NAYAK P.A.

9811 Greenbelt Road, Suite 101 · Lanham, MD 20706 · Phone: (301) 477-2311 · Fax: (301) 477-2753

To the University of Maryland Capital Region Health Department of Graduate Medical Education,

I wish to express my strongest support for Dr. Otabek Elmurodov for his reinstatement in Family Medicine Residency. Although he was a relative newcomer to the institution, I unequivocally believe in his outstanding moral character, amiable professionalism, and unparalleled work ethic, that he consistently displayed during the overlapping year and half that we served as coresidents in the sister residency programs for University of Maryland Capital Region Medical Center.

During my final and chief year of Internal Medicine Residency, I had the pleasure of working alongside and interacting with Dr. Elmurodov on several occasions. While I was never his literal teammate, we directly collaborated on many complex patient cases, through the many consultation service rotations of my final year. We also found ourselves working on Night Call for our respective services concurrently, in the midst of the demanding winter season.

I was surprised to see that he was so often assigned as Senior Medical Resident of the Family Medicine Admitting Team, possibly because he was regularly covering for House Staff shortages. Nevertheless, it was a delight to work with him. We collaborated on several cases, whenever I was on duty for a consultation service, including Cardiology, Gastroenterology, Pulmonology, Nephrology, and Hematology/Oncology services.

Unlike most consultations we received, which were typically short, uninformative TigerText messages without any follow-up, Dr. Elmurodov always took the additional step to personally call and convey his clinical queries consistently whenever placing a consultation order. He enjoyed discussing with our team and learning the medical rationales. More importantly, he was quick to enact our recommendations for the care plan and followed up on any patient progress or changes in patient status. His meticulous attention to detail, his genuine care for his patients, his proactive communication, and his authentic desire to learn and improve his craft, make him a solid role other residents would model to medical interns and students. I could only wish that other residents would call and discuss their consultations even a fraction of how dependably Otabek did so.

In the month of January 2023, both Otabek and I worked on Night Call for the Family and Internal Medicine services respectively. While I had a team of interns, he was by himself. Despite this, he eagerly shared in the nocturnal admissions load. Quite uncharacteristic of most residents, Otabek seems to enjoy the work, and readily embraces the challenge. Even in the deep of the night, he actively sought admissions whenever his service had capacity. Together, we worked well to maintain pace and keep the patients safe.

He was reliably prompt to address the Rapid Responses and CODE Blue pages, while also tending to his Pediatric and Obstetric Ward duties. Whenever time permitted, he would check in on our team. We often discussed the admission cases, any opportunities to perform procedures, and planned ahead for the night. I trusted that we could handle anything we encountered, no matter how busy the night became, between our two services. His proactive work and sincere camaraderie were always welcome. He made for a genial and fun environment in the peak of otherwise wintery doldrums.

Dr. Elmurodov is a kind, collegial, professional, well-intentioned physician whose foremost priority is patient care. Tenacious and resilient, he remains polite and composed, and works exceedingly well under pressure. In all of our interactions, I have never seen him ever upset, nor uneasy, nor unable to perform his duties safely and efficiently. Even though a newcomer to our institution, he never once hesitated to reach out whether he needed help or if he could offer it. I am happy to write this letter offering my strongest support for my former coworker, Dr. Otabek Elmurodov. If I can be of any additional help, please do not hesitate to contact me.

Sincerely,

Raj Nayak, MD
UMCRH Internal Medicine Class of 2023
September 18, 2023

GREENWAY ENDOCRINOLOGY, PA
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Tel: 301-474-0400 • Fax: 301-474-2686

www.greenwayendo.com

July 26, 2023

RE: Dr. Otabek Elmurodov

Dear Members of the Appeals Panel,

I am writing this letter in strong support of Dr. Elmurodov, whom I had the pleasure of instructing during his Endocrine Rotation at my office in December 2022. From our first meeting, I was impressed by his polite, confident, and professional demeanor. Throughout his time in my office, he demonstrated an unwavering commitment to patient care and a genuine passion for family medicine.

I observed Dr. Elmurodov's resilience, determination, and dedication to self-improvement, all of which are vital qualities for a successful medical career and should be taken into consideration as the Appeals Panel reviews this case. Not once did I witness him disregarding recommendations or managing patients without supervision. He consistently followed instructions, expressed genuine interest in patient care, and actively sought to expand his knowledge through insightful questions.

While I understand that there may have been circumstances leading to his termination, I urge the Appeals Panel to consider the entirety of Dr. Elmurodov's record, including his exceptional clinical skills and unwavering dedication to patient care. I firmly believe in his potential to become a compassionate and proficient family medicine practitioner, and I wholeheartedly support his appeal for reinstatement into the residency program.

I also kindly request the Appeals Panel to carefully weigh the impact of their decision on Dr. Elmurodov's future career and the well-being of the community he aspires to serve. Allowing him to complete his training and become a practicing physician would undoubtedly benefit the greater good and the medical community at large.

I trust that your wisdom and sense of fairness will guide you toward a just resolution.

Thank you.

Sincerely,

Irfan A. Khan, MD

Letter of Support for Otabek Elmurodov, MD

To whom it may concern,

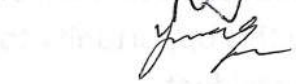
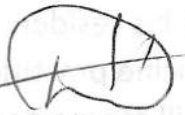
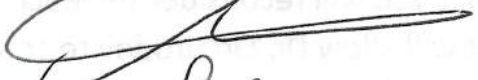
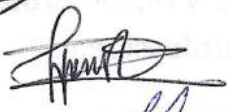
We, the residents at the University of Maryland Capital Region, are writing to express our support for Dr. Otabek Elmurodov, a resident in the Family Medicine Residency Program. We were saddened to learn of his termination from the program and would like to take this opportunity to highlight his outstanding qualities during his tenure as a resident.

Dr. Elmurodov always conducted himself in a highly professional and competent manner when it came to patient care. He showed dedication towards his patients and a genuine passion for the medical profession. His approachable demeanor and pleasant personality contributed to a positive and supportive atmosphere within the healthcare team. Patients under his care deeply admired his compassionate nature, empathy, and ability to communicate complex medical information in a clear and concise manner.

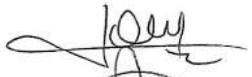
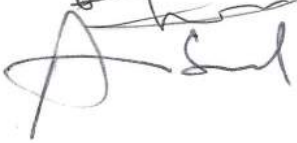
While we are not privy to the specific circumstances that led to his termination, we request that you take into consideration the exceptional qualities and potential he demonstrated during his residency. We firmly believe that he has the potential to excel as a family medicine practitioner with the appropriate guidance and support. We hope that you will reconsider the decision and explore alternative solutions that will allow Dr. Elmurodov to continue his journey towards becoming a successful medical professional.

We thank you for taking the time to review our support letter, and we hope that you will give Dr. Elmurodov a fair opportunity to showcase his capabilities and dedication to the medical field which is essentially what the UMCAP culture represents.

Sincerely,

NAME	SIGNATURE	DEPT/DATE
ARNAUD YANOGO		IM 8/4/23
Netsanet Belete		IM 8/4/23
Yemiyou Geleta		IM 8/4/23
[redacted]	[redacted]	[redacted]
Vinesh Kumar		IM 8/4/23.
Mamoon Al-Afun		IM 8/8/2023
GASHAW HASSEN		IM 8/9/2023
ASSal Shikaren		IM 8/9/2023
Saeed Shoar		IM 08/9/2023
Elham Ahmed		IM 08/9/23
Nemeen Kolta		IM 08/09/2
Tirsit Woldeyohanes		IM 08-11-2023
Eyoel Fantaye		IM 08-14-23
TESFAYE MOGES		IM 08-14-23
KENECHUKWU OKORO		IM 08/14/23
Marvi Ouobakhshani		IM 8/14/2023
Varinder Bangoo		IM 8/14/2023

Sincerely,

NAME	SIGNATURE	DEPT/DATE
FAIZAL OUEDRAOGO		IM 8/14/2023
Bethlehem TEKLU		IM 8/18/2023
Meron Moges Arega		IM 8/22/2023
Simachew Demelash		IM 8/28/2023
Dabafemi Adeniji		IM 8/28/2023
Amin Suad		IM 8/28/2023

August 1, 2023

Dear members of the appeal panel.

Ref: Dr. Otabek Elmurodov.

I am writing this letter in support of Dr Elmurodov, whom I have known for the last couple of years as a resident at the UM Capital Region Hospital. During the period I observed him as a cardiology attending, including a week of close supervision when he was rotating in cardiology while I was in charge. He is a very friendly resident, and it was a pleasure to have him around. He performed well. His knowledge in cardiology was average, but this is understandable as his background and previous training was in a different field. I have no reservations regarding his performance.

Regarding the concerns brought by my colleagues from family medicine: I went over the final remediation review; I have no specific knowledge about the claims. Yet, I find it very harsh to terminate a resident for these reasons.

I would like the panel to take into consideration the fact that Dr Elmurodov, he functioned as an attending in his home country, he also functioned as a hospitalist in this country. Hence his behavior and his conduct are not expected to be like a typical resident. Attendings will sometimes misunderstand the conduct and attitude, and this can reflect their evaluations. I respectfully ask the panel to take this into consideration. I personally enjoyed having Dr. Elmurodov in my team. I found him mature and helpful.

I have been teaching residents in this facility for more than twenty years, I am also a clinical associate professor at the George Washington University school of medicine. I feel it will not be fair to terminate the service of this resident. Termination will harm his career. Any plan that will allow him to finish his residency in this facility would be acceptable. I respectfully ask the panel to reinstate Dr. Elmurodov residency position. I am personally willing to participate in his supervision as I believe he will make an exceptionally good future family physician.

Respectfully yours

Nader Dakak, MD

Board certified in Cardiology and in Interventional Cardiology

Chief of Cardiology division, UM Capital Region

From:	Bradford, L. Latey
To:	Afshan Rehman; Ross, Stacy; Donna Prill; Kaysin, Alexander; Tavakoli, Nader; ULOMA IBE; Newman, Paul; June M Taylor; OGHENETEGA NDUKA; Sonia Haider; Elmurodov, Otabek; Merchant, Omar; Mirani, Manthan; Siddiqui, Amanullah; Nwogu, Ijeoma; Mirani, Zankhan; Miller, Derrick; Mcleod, Christopher; Luo, Bai Lin
Subject:	Resident Kudos!
Date:	Tuesday, November 22, 2022 4:57:24 PM

Hi Family Medicine Team,

All of you residents have been fantastic and it is my hope to make sure I let each of you know when a job is well done. But I wanted to specifically share a word of THANKS to one resident, in particular, who advocated for his patient in an outstanding way this week!

Dr. Elmurodov has been seeing a Spanish-speaking, uninsured patient in our practice on a weekly basis for the last several weeks following a recent hospitalization. It is clear that cost has been a major barrier to her being able to start on the medications which would most effectively treat her uncontrolled HTN and T2DM. Not only has Dr. Elmurodov called around to different pharmacies, researching medication costs on her behalf, but he linked up with our outpatient pharmacy here at the hospital and secured a relatively cheap and much more affordable solution for her home meds. Thank you Otabek for doing this!!

I have observed firsthand that so many of you really do go the extra mile for your patients and it does not go unnoticed. KUDOS to Dr. Elmurodov and a BIG THANKS to each of you for being sensitive to all to social determinants of health that impact the way we care for our patients and their ability to take care of themselves. Keep up the great work.

Happy Thanksgiving to all!

Best,

L. Latéy Bradford, MD, PhD
Core Faculty, Family Medicine Residency
Department of Family Medicine
University of Maryland Capital Region Health
www.umms.org/capital

A better state of care.
compassion | discovery | excellence | diversity | integrity

From: Bauer, Gregory
Sent: Wednesday, February 15, 2023 3:43 PM
To: Elmurodov, Otabek <Otabek.Elmurodov@umm.edu>
Cc: Hondroulis, Maria <Maria.Hondroulis@umm.edu>; Vranek, Kathy <kvranek@umm.edu>; Denford, Joshua <jdenford@umm.edu>
Subject: Increasing Use of Capital Region Outpatient Pharmacy for Discharge Prescriptions - PLEASE READ

Dr. Elmurodov,

Hope all is well. As you know, Capital Region has an outpatient pharmacy that is located on the 1st floor of the medical center that is open Mon-Fri from 9am to 5pm. During these times, the pharmacy provides direct bedside delivery to patients for their discharge prescriptions. This also includes to the Emergency Department for patients who are not being admitted but are being sent home with prescriptions. The pharmacy also is able to assist with any prior authorization needs for prescriptions and handles the patient co-payment with them at bedside. In situations where the patient is unable to pay at the time of discharge, the pharmacy is able to set up billing the patient at home via a mailed invoice to the patient. Prices are extremely competitive and many times are even lower than those available to the patient at chain pharmacies.

Clearly, benefits of the program is that you are ensured that your patients get their medications filled, as literature shows that as many as 40% of patients will either not get their prescription filled or will wait several days post-discharge to do so. Additionally, with Capital Region being eligible for the 340b program, there are significant financial benefits to the organization for every prescription that stays in house as opposed to “leaking” outside of the system.

Currently, the service has been provided for about 1 year, however, the use of the Capital Region Outpatient Pharmacy for discharge prescriptions is lower than at other UMMS facilities and thus we are trying to connect with all providers to encourage use of the service whenever possible M-F (9am to 5pm).

In January, data indicate that you wrote 36 prescriptions to “other pharmacies” and sent 17 prescriptions to Capital Region for a capture rate of ~33%. Congratulations as this is one of the highest resident capture rates that we have. Hopefully you have been satisfied with the service provided. Clearly we don’t know your working schedule, hours, etc. but the ask would be to partner with the pharmacy at times when this may be possible for you and when the Pharmacy is open.

As we try to grow the program, if you could please:

1. Ask patients during the times the pharmacy is open, if they would be interested in having their medications delivered to them at bedside (even to the ED).
2. If patients are interested, please send the prescriptions electronically to the UMMS at Capital Region Pharmacy.

3. After sending the prescriptions, send a Tiger Connect message to “UM CAP Bedside Delivery” indicating the patient name, DOB and estimated time the medication is needed at bedside.

Some quick tip reference sheets are included above about the program to provide additional information.

Thank you for the consideration and we look forward to partnering with you on improving the transitions of care of your discharged patients.

As you are one of the more prevalent users of the service, if you could please try to communicate the service with your colleagues so that we can continue increasing business.

Greg A. Bauer, M.S., Pharm.D, DPLA
University of Maryland Capital Region Health
901 Harry S. Truman Drive North
Largo, Maryland 20774
(M): 215-870-7649
Gregory.Bauer@umm.edu

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Stephen I. Proctor, MD

6188 Oxon Hill Rd. STE 603

Oxon Hill, MD 20745

August 14, 2023

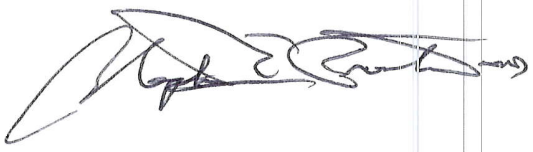
Re: Otabek Elmurodov, MD

To whom it may concern,

I am an employed Obstetrician and Gynecologist providing Obstetric Hospitalist coverage at The University of Maryland Capital Region Hospital, Largo, MD. In my role there, I not only provide coverage to L&D but also have some student and resident education responsibility. I am writing this letter at the request of your resident, Otabek Elmurodov, MD. He expressed that his performance has been called into question. I can say that there was one situation that he and I were involved in that may advocate his position. At morning huddle, I was informed that there were 3 infant circumcisions that needed to be completed for babies that were scheduled for discharge. Dr. Elmurodov approached me and asked if he could do them. I went with him and had him observe me perform one the way I wanted him to do it. The second infant, he was the primary operator under my direct supervision. I was subsequently called to L&D between the second and third babies. Since I was satisfied with his ability to perform the procedure, I permitted him to do the third and report to me once it was complete. He not only successfully completed the task but completed the appropriate documentation as well.

I can say that Dr. Elmurodov has a strong desire to learn and has demonstrated an eagerness to obtain knowledge and skill. Based on my interaction with him, I appreciate his eagerness to learn and be an active participant in his education. If you have any questions regarding this or any other issue relating to Dr. Elmurodov, please call. Thanks.

Sincerely,



Subject: Reconsideration Appeal for Otabek's Termination

Dear Committee,

I am writing to respectfully request a review of the decision regarding Otabek's termination from the residency program. As a colleague in the Internal Medicine department for the past three years, I have had the privilege of observing Otabek's professional growth and commitment firsthand.

Otabek is diligent, empathetic, passionate, and resilient. His ability to demonstrate exceptional care for his patients has been evident throughout our shared shifts during the night float and ER rotations. His notes stand as a testament to his meticulousness, wherein he thoroughly lists each diagnosis and outlines comprehensive plans for patient care.

In light of the rigors of medical residency, continuous improvement is a necessity rather than an option. Otabek has consistently exhibited this dedication towards progress. He has demonstrated a commendable openness to feedback and an ability to integrate suggestions into his practice.

Therefore, I kindly urge you to reconsider the decision to terminate Otabek's residency. It is worth noting that Otabek's responsibilities extend beyond his professional commitments, as he is a father to three children and a husband of a 36 week pregnant wife. The impact of this decision is far-reaching and affects not just a promising doctor, but a family that relies on him.

Thank you for your consideration.

Oyinkansola Awodiya, MD

8/2/23

To Whom It May Concern:

I have had the pleasure to work with Dr. Otabek since November 2021. I am an Ambulatory Informaticists and I provide support to providers to assist with various workflows and documentation within the electronic health record (EHR). We now live in a digital society and understanding the use of the EHR helps healthcare professionals manage illnesses and health risk to promote wellness. Understanding the use of the EHR is key to providing high quality and safe patient care.

Dr. Otabek has taken the initiative to not only understand the basic functionality of the EHR but he has developed advanced skills. He has used various smart tools such as smart phrases and smart lists to manage notes and letters. He has taken the effort to make sure he manages his In Basket in a timely fashion by reaching out to our team for assistance with troublesome workflows such as open encounters, refill requests, staff messages, patient messages, and results. Dr. Otabek is eager to learn new workflows and he quickly grasp tasks easily without having to be taught the same techniques repeatedly. Dr. Otabek has also been able to assist other members of the healthcare team with functionality of the EHR.

Navigating the EHR can be challenging at times, but Dr. Otabek has taken on this task with ease. He has also taken the time to notify our team of issues with the EHR which could negatively impact patient care. His attention to detail and advocacy for high quality patient care has helped to escalate issues noted within the EHR and achieve a speedy resolution.

It has been wonderful to work with Dr. Otabek and he will be a great asset to any team he joins. If you have any further questions or concerns, please feel free to contact me.

Sincerely,

Kendra Johnson MSN, RN

Capital Region Ambulatory Informaticist

University of Maryland Medical Systems

Kendran.johnson@umm.edu

443-534-4862

The members of the Appeal Committee,

Ref: Dr. Otabek Elmurodov

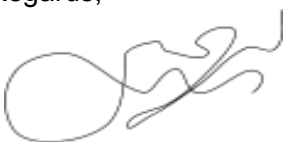
I, Dr. Parvin Zafarani, am writing this letter in support of Dr. Elmurodov. I was the chief resident of the Family Medicine program when Dr. Elmurodov first joined our residency team. He was hard working and a responsible resident. And, although he needed training to survive the residency program, I never encountered an alarming situation where a patient's safety was compromised while I worked with him.

Unfortunately, Dr. Elmurodov's dismissal did not take me by surprise, and I suspect, not due to his work ethics or performance as a physician. University of Maryland Family Health Center Residency program has a record for mistreating its residents. The year I began as an Intern, I was terrified to find out that two of my seniors had been offered to resign or be dismissed from the program. That year was not easy, many threats were made to myself and other interns that our residency contracts may not be extended to second year if any mistakes were made or ITE scores were not high enough. This was always offered first before any feedback or proper evaluation.

When I began my final year as chief, one of our residents quit without notice. (As she notified me later, due to the abuse and trauma that she encountered during her first year.) Dr. Elmurodov was hired to replace this individual. It is with great dismay that I say that the toxicity of this program has ruined several lives. In my professional opinion, Dr. Elmurodov deserves to finish residency; his performance by no means was ever justifiable for a dismissal. Residency programs are here to train the future independent physicians. I urge you to reconsider his dismissal as well as the tactics used to motivate doctors within this program.

Currently I am practicing at an outpatient clinic and I am grateful for the opportunity to complete my residency. I believe Dr. Elmurodov deserves the same opportunity.

Regards,



Parvin Zafarani, MD
Board Certified Family Medicine physician
Family Health Centers of SouthWest Florida
Email: parvin.zafarani@gmail.com

September 23, 2023

Annapolis, Maryland

To Whom It May Concern

I am writing this letter as a request to share my experience with the Family Medicine Residency Program that was initially founded under Dimensions Health care systems, later becoming part of Capital Region University of Maryland.

I am a foreign medical graduate from El Salvador. I became a Physician Assistant in 2010, and have practiced since then in that position, except for the time I spent in residency from July 2020 to July 2021.

I worked for University of Maryland from 2012 to 2020 and my experience with them had been none other than pleasant. The work environment was professional and respectful. Attendings, residents, PAs, nurses, and ER techs were part of a family. We were all learning, and willing to teach. The attitude towards the less experienced was always respectful and never belittling, rude or condescending.

I was accepted to this residency program thanks to my effort, but I also know, that my supervisors at University of Maryland ER group provided a good reference about my experience with them. My work ethics and commitment to patient care was recognized; and I continued with that same behavior and attitude during my time in residency.

I was never made aware of the flaws the program had. I was advised by some ED attendings to keep my options open and to look for other programs, that there were a lot of “personality” issues in this program. I assume no one revealed any details of what was going on within to maintain professionalism. Or maybe, nobody was fully aware.

Being such a small program, it felt as if the residents lived in their own bubble, surrounded by their prison guards and abusers. That was my impression.

I heard stories from the second-year residents about how they were harassed, called at any hour of the day or night about patients when they were not on-call or on other duties involving academics, and even to care for faculty private patients. Some reported being threatened about grades, or if they dared to speak out. There was a particular faculty member against whom multiple letters of complaints had been written to HR, who was very close to the director of the program, Dr. Ross. Her behavior was unprofessional and abusive, and nothing had been done. She was protected by the director, and ignored by others.

I had my own experience with Dr. Mapp during my first month. It was during clinic hours, when I “made a mistake”. I was screamed at “you need to stop thinking as an ER PA”. She said that things were done differently here. She raised her voice, angry and walked around the hallways of the clinic, continuing with her remarks, raising her voice, and belittling my decision.

I wrote to the program complaining about the situation. A few months later, she was no longer in the program. Despite her absence, the behaviors learned and repeated, not just from her, but from the other faculty members, passed on to their trainees, some of which later became faculty, continued.

The program suffered from lack of organization in many aspects. It felt as if the least of their worries was teaching and how residents were learning to practice proper family medicine. Their "teaching style" as so many said, was the excuse. The teaching style consisted on harassing, humiliating, making condescending, sarcastic comments, aimed at making fun of the resident; instead of guiding the resident in a professional and compassionate manner to achieve the learning goals.

The academic lectures were responsibility of the chief residents. There was an occasion when we had three podiatrist lectures talking about diabetic foot because there were no other options. The faculty needed training. Their lecturing skills were mediocre.

It was a façade, I said.

The new residents were thrown into the clinic with no instruction, except for an orientation that lasted 2 to 3 hours in the first week. Then, we were on our own, not knowing, or having a clear idea how to conduct the evaluations. I had to go home at night and do my own research about what kind of evaluation I needed to perform on adult patients with Medicare, for instance.

There were no lectures on pediatric pathology, i.e. fever in the newborn.

When a new faculty joined the program, and the façade was at risk of being revealed; on one occasion, during huddle, we were told that a pelvic exam should and could be done during the same visit when performing women's well checkups; however, we had been instructed to bring back the patient on a second visit for the purpose of performing the pelvic exam. Evidently, there was no consensus. Each faculty had different requirements, no unity of knowledge or teaching. For me, it was a total mess, not worth my time, my suffering, my frustration, and at the end, the money I was losing by taking the pay cut with the hopes to achieve the goal to become a doctor.

I had to start taking antidepressants, had insomnia and flash backs of traumatic experiences on previous days. The level of stress that the environment brought to my life was significant. I felt mistreated, belittled and that my work was taken for granted, particularly, when rotating in the inpatient service. My frustration reached a tipping point.

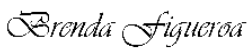
Residents were told we could no longer park in the garage of the new hospital. I received a parking ticket because the only option was to park on the street, outside the hospital. I expressed my frustration on a wellness group chat. My comment was not unprofessional, I think. I said that residents run the hospital, and not having a safe place to park was outrageous. I was asked to remove those comments from the chat. I refused. My freedom of speech was also being threatened by the leadership of the program.

It was time for me to go.

This was my experience, my view, what I lived, witnessed firsthand and heard from other residents.

Sincerely,

Brenda Figueroa, MD, PA-C, MMS



Lakeside Medical Group
14300 Gallant Fox Lane Ste#205
Bowie, MD 20715

Phone Number: 301-809-6494
Fax No. 3018096497

July 30, 2023

RE: Dr. Otabek Elmurodov

Dear Members of the Appeals Panel,

I am writing this letter in support of Dr. Otabek Elmurodov, with whom I have had the pleasure of working multiple times during his family medicine rotation at the University of Maryland Capital Region Medical Center. I spent almost an entire month of June with him. Dr. Otabek is hard-working, resilient, and compassionate, he knows there is always room to grow in his medical profession and takes constructive criticism in a positive manner.

During the month of June, he performed his duties diligently and in an efficient manner. He took his responsibilities seriously, he was a good team leader, and he supervised his junior resident and students very well. He actively participated in clinical rounds and took significant clinical decisions independently. His admissions and discharges were safe and according to the standard of care of medicine. I did not encounter any issues with him and was very happy with his progress during the month.

While I understand there may be circumstances leading to his termination, I urge the appeals panel to consider Dr. Otabek’s record in its entirety, including his significant clinical improvement and dedication to patient care. I genuinely believe he has the potential to become a proficient and competent family medicine physician.

I kindly request the appeals panel to carefully consider the impact of their decisions on Dr. Otabeks future career and the well-being of the community he will be serving. I believe it is in the interest of the medical community at large that he be allowed to complete his training and be a practicing physician.

I trust the appeals panel's fairness and wisdom will lead to a just resolution.

Thank you.
Sincerely,
Dr. Raj Chawla

Daniel E. Brewer, DNP, CRNP, NNP-BC
1720 New Jersey Ave NW #201
Washington, DC 20010
dbrewerrn@gmail.com
910-580-1528
August 10, 2023

Residency Appeal Panel
UM Capital Region Medical Center
Family Medicine Residency Program

To: Appeal Panel

My name is Daniel Brewer and I am writing this letter in support of Dr. Elmurodov who I met briefly while he was covering newborn service for Family Practice. I was the covering Neonatology provider for the NICU from 2000 6/26 to 0800 6/27. I would like to provide some details during early 6/27 where a newborn required transfer for respiratory support to the NICU.

I received a call from RN Welsch stating that she was unable to reach the covering newborn physician and she was hoping that I could look at a newborn who had some tachypnea. I arrived to the newborn's room on the mother-baby unit at 0300 where I examined the newborn. The newborn was initially well-appearing with desire to PO feed in an open crib. The infant was in a long sleeve outfit double swaddled with a hat. I personally assessed VS and received a temperature of 37.3 C and respiratory rate of 72. There were no retractions, no cyanosis, and a pulse oximeter was 95%. Mother's room was extremely warm. Since the newborn was otherwise well-appearing, the RN and I decreased swaddling and removed the hat to decrease temperature which I initially believed to be a potential cause for the mild tachypnea without retractions. Additionally, I noted the newborn to be jaundice <24 hours of life and a transcutaneous bilirubin done at that time was 10.4 mg/dL.

Given these findings, I told the RN to draw a CBCd and Bilirubin level which were orders I placed. I also verbally told her to monitor the respiratory rate hourly and notify me if the respiratory rate worsened, there was increased work of breathing, or if there were any further concerns. At that time, in my medical opinion I did not feel the newborn required separation for escalation of care from mother given the importance of maternal-newborn bonding and confidence in nursing staff in mother-baby unit to further monitor. The mother was updated via translator video. I did not hear anything further from nursing the next few hours.

At 0533 I received a call from Dr. Elmurodov requesting transfer to the NICU. He verbalized an apology for not being able to assess the newborn earlier in the night, however his exam at that time had changed from my exam at 0300. He noted the newborn had worsening respiratory distress. I instructed him to go ahead and transfer the newborn to NICU. I told him that I would write the order and let the NICU staff know, and if he could, update the mother and notify mother-baby staff that would be helpful. My understanding is there was a slight period of delay from order entry to NICU admission given updating mother, letting nursing staff know, nursing removal of security tags, gathering charts, and physical transfer of a patient to a new unit which were things required before transfer.

Upon admission to the NICU I observed a newborn in respiratory distress where I ordered respiratory support, further lab work, and antibiotics for possible infection. During the admission process, Dr. Elmurodov asked appropriate learning questions regarding the admission process being done to the newborn, rationales of therapy, and diagnosis. He stayed for almost an hour making sure the newborn was stabilized in the NICU and as an extra set of hands. We reviewed orders and x-rays.

While it is unfortunate that Dr. Elmurodov was unable to be reached earlier in the morning, I was able to be reached shortly thereafter by nursing staff taking the appropriate steps of reaching back-up for an initial examination. The newborn did not require transfer at the time Dr. Elmurodov was unable to answer his phone. When Dr. Elmurodov was available to reassess the newborn, he appropriately noticed worsening symptoms requiring escalation of care and called me immediately. I did not hear anything further from nursing staff from my examination until Dr. Elmurodov called me. During that call he communicated clearly to me what was needed. Additionally, he stayed in the NICU to help where needed, to learn, and ensure stabilization.

I do not believe Dr. Elmurodov's inability to answer the phone caused any harm to the newborn. I believe the infant had slightly elevated vital signs that required further monitoring but not urgent transfer until further symptoms were noted after 0500 by Dr. Elmurodov. Any delay in transfer can be attributed to the equipment, process, and security/safeguards the mother-baby unit has in transferring a patient anywhere. In my experience both using and having to contact other providers via cell phone, can be a source of difficulty. I have personally had a required phone update that does not allow me to answer a phone call during the update. In the future I would recommend that the residency program have a back-up phone number for the night such as the land-line phone in the resident call room. Nursing staff can also attempt to page overhead.

I urge the appeal panel to reconsider his termination from the Family-Medicine Residency program over a simple mistake. The newborn was evaluated by a qualified provider and treatment options were provided to the newborn in a step-wise fashion as the night progressed. Dr. Elmurodov showed a passion for learning and exceptional compassion by staying and helping with the NICU admission and ensuring stabilization. I ask you not to interrupt that passion he has for medical learning and please show compassion to him during your hearing. Please feel free to reach out to me with any further questions.

Sincerely,

Daniel E. Brewer, DNP, CRNP, NNP-BC

Daniel E. Brewer, DNP, CRNP, NNP-BC
1720 New Jersey Ave NW #201
Washington, DC 20010
dbrewerrn@gmail.com
910-580-1528
November 5, 2023

Residency Appeal Panel
UM Capital Region Medical Center
Family Medicine Residency Program

To: Appeal Panel

I am writing this additional letter of support for Dr. Elmurodov since I have been made aware of a letter written by faculty on June 27th 2023 citing reasons for Dr. Elmurodov's dismissal. While I have the upmost respect for faculty members of this organization, I am concerned that some of the statements made in that letter support false assertions on events that occurred on the night of June 26th. Again, I would like to reiterate to the panel that I was the Neonatology provider for the NICU from 2000 on June 26th to 0800 June 27th. I was physically present in the building.

The letter stated Dr. Elmurodov did not hear overhead pages. I do not recall overhead pages that night specifically asking for Dr. Elmurodov. I encourage the panel to assess nursing charting or security overhead paging record to be certain. I am 100% certain that there were no pages overhead asking for medical personnel to the mother-baby unit or newborn nursery for any baby that night. The NICU team responds to any overhead page regarding nursery or mother-baby unit in case there is a major concern with a newborn or NRP is warranted. There were none that night asking for medical response to nursery or mother-baby.

The letter states that a newborn patient became unstable. I encourage the panel to reread my statement letter written August 10th, 2023 which gave a timeline of events that occurred surrounding the newborn. I was able to assess the infant at 0300 in which I did not feel like escalation of care, but further monitoring was warranted at that time. It is my professional medical opinion that the newborn's clinical course and disease process would not been any different regardless of Dr. Elmurodov's reachability given nursing ongoing monitoring and evaluation by me.

The letter additionally states that the covering attending physician called me after he was reached. That simply is NOT TRUE. I never received any communication from any Family Practice attending until Dr. Kaysin reached out to me personally two days later on June 29th while I was off duty asking me for a brief summary of the events of that night. Nurse Welsch

reached out to me for the 0300 exam and the only remaining communication I received the rest of the night was directly from Nurse Welsch or Dr. Elmurodov.

Again, If the panel has any concern on what occurred with the newborn that night, I encourage them to read my August 10th statement. Dr. Elmurodov's unreachability that night did not affect this newborn's clinical course or disease process. The newborn was being monitored by nursing staff and I had been made aware of the newborn's clinical status by nursing staff. When the infant did eventually become unstable, Dr. Elmurodov did transfer the baby to me for a higher level of care.

Thank you again for your consideration.

Sincerely,

Daniel E. Brewer, DNP, CRNP, NNP-BC

Amicus Statement in the Appeal of Dr. Otabek Elmurodov

Graduate Medical Education Compliance Project
M. Todd Rice, MD, MBA
14 September 2023

Dear Appeals Committee,

For background, I am a practicing, board-certified anesthesiologist since 2006, with an array of academic, private and hybrid experience in multiple geographic regions, to include San Antonio, Dallas, St. Louis, Pittsburgh, and now finally, in the lifestyle destination of Hot Springs National Park, AR. While assistant professor at Washington University School of Medicine in St. Louis in 2017, I witnessed failures of program and institutional due process for a number of residents in a local non-affiliate health system. They had been selected in seemingly subjective manner for probation, remediation and/or termination.

These disciplinary actions did not appear to be well-supported, appropriately documented or in accordance with extant policies. Worse still were the retaliatory treatments that would follow as the residents attempted to advocate for themselves through their rightful appeals processes. The maltreatment included department-wide character defamation, purposeful attempts to garner negative evaluations of the residents from other attendings, hyper-criticism of minor issues elevated to significant importance against them which were not deemed noteworthy when similarly encountered with their cohort residents (holding them to a different standard), and an apparent attempt to build a negative case and file against them to retroactively justify disciplinary actions. Often, despite previous evaluations to the contrary, these residents would suddenly be labeled with charged descriptors, like "unteachable" or "unsafe." What became clear to me is that personal agenda, bias and subjectivity by some powerful attendings could completely derail the career of a resident, even in the absence of significant academic or professional deficit.

As I began to communicate with attendings and program leadership to advocate for following ACGME requirements regarding resident evaluation and due process, I was met with disinterest or resistance. Somewhat shocked to find this dysfunction in our systems, I escalated my concerns to the Designated Institutional Officer (DIO) who was very willing to help, but whom I noted to be entirely ineffectual in the presence of well-established program directors and attendings who held significant institutional power and strong personality traits.

Next, I communicated with the department chair, whom I knew from a few social interactions. He listened, but had no advice other than to trust the system (which I was witnessing to be dysfunctional and unresponsive). From there, I emailed a detailed explanation of events, concerns and documented violations to to the dean of the medical school. Ultimately, he would deflect evidences and responsibility by saying that "we have had our site visit" (by the ACGME) and they didn't find anything wrong.

Out of frustration, in 2017, I set up the Graduate Medical Education Compliance Project (GMECP) webpage, www.gmecomplianceproject.org, to post up resources that I was finding and creating for

residents in distress and to attempt to shame bad actors. The GMECP was not the original name of the project, by the way. After I was sued by the target institution for trademark infringement, I was forced to change it.

Although the website obviously got the attention of people high enough in the institution to sue me, it did not readily alter behaviors or the course for the residents. Interestingly, however, the medical school did eventually outsource a SWOT analysis in which each resident and attending of this particular department was interviewed, and the findings were leaked broadly. The results showed numerous violations of policies, various forms of discrimination and retaliation. Disciplinary actions were subsequently dropped for any of the remaining residents, the program director was replaced, and the new leadership was sent for ACGME training. This was too little, too late for a number of the residents who lost their positions – some of whom never found another residency in their specialty training track.

Subsequently, over the past 6 years I have spoken with and attempted to advise well over 100 residents who have found me through the website. I charge them nothing and gain nothing personally, other than the hope that together we may be improving our own medical education systems and forcing some sunlight into dark places.

For the members of the appeals committee, I would like to share some of the typical failures and violations of ACGME and institutional policies that underpin many resident's plights. As you consider Dr. Elmurodov's case, please compare the processes applied to him with the overly common errors and violations that have been encountered in similar cases.

ACGME Common Program Requirements (commonly encountered violations excerpted):

II.A. Program Director

II.A.4.a).(7) provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;

II.A.4.a).(8) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident;

II.A.4.a).(9) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination;

V.A. Resident Evaluation

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.

V.A.1.b) Evaluation must be documented at the completion of the assignment.

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d).(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;

V.A.1.d).(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,

V.A.1.d).(3) develop plans for residents failing to progress, following institutional policies and procedures.

V.A.3. The Clinical Competency Committee

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b).(1) review all resident evaluations at least semi-annually;

V.A.3.b).(2) determine each resident's progress on achievement of the specialty-specific Milestones; and,

V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

VI.B Professionalism

VI.B.5. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

Questions regarding the function and compliance of the Clinical Competency Committee, based on the ACGME's CCC Guidebook, 2nd edition (which can no longer be found online).

Pg 9 Have the CCC members received training in evaluation, data quality and interpretation, Milestones development, and their member roles which "… will typically include the need for substantial faculty development."

Pg 13 Does the selected Chair of the CCC "best solicit broad input… and ensure all voices are heard?" Does s/he encourage a "positive working environment and open communication from all members" or does s/he have tendencies to dominate with personal opinion, promote a particular rater bias, entrench groupthink, or even disallow dissenting opinion? Are other CCC members intimidated into agreement or silence, due to the Chair's power positions or personality?

Is the Chair "the Milestones expert"?

Does the Chair "use best practices in effective group processes (per pg 21),…" e.g. using structured formats and seeking junior member inputs first?

Is there a "plan for professional development of CCC members"?

Pg 14 Does the program director "detract" from the participation of other CCC members, or prematurely insert his or her perspective, or predetermine residents' Milestone performance then bring them to the CCC for "ratification?" Are the roles and power of the CCC appropriately balanced?

Pg 15 Do the Milestones ranking of residents tend to be arbitrary, or scored with too little or a particularly over-weighted faculty input? "Faculty members should reach a common understanding on the meaning of the narratives of each milestone in the context of the specialty."

pg 27 Are the resident assessments produced by the CCC supported by written evaluations? If not, "… it should consider revising its assessment tools or processes and/or faculty development to solicit better written/recorded information." Are the findings transparent to the residents via timely and personal feedback?

Pg 29	Has the CCC been annually re-evaluated on the basis of its purpose, model, procedures, and potential for groupthink or drift from its purpose?
Pg 30	High quality feedback. Is the CCC feedback overly general, lacking specificity, to the point of adding little value in directing a resident's development? Is it balanced for construction, as well as correction? Are residents assisted to create and execute Individualized Learning Plans (ILPs), which are "critical to professional development"?
Pg 35, 39	Are keys components of due process provided to residents, to include "a careful and deliberate decision-making process" while reviewing all available inputs, a specific list of any noted deficiencies, and the opportunity to improve/cure those deficiencies?

I appreciate the opportunity to share insights from my experience with residents facing disciplinary actions. As established physicians, we all hope that our systems are high functioning and in compliance with meaningful policies and procedures. Inherently, however, many of us understand that is not the reality. As a result, all too frequently, residents are deprived of feedback, unbiased and meaningful evaluations, opportunity to cure deficiencies, and/or the due process that they are owed and promised through ACGME and institutional policies. In addition, these processes can be subverted by a single or small number of attendings with out-sized power and personality, pulling others along with subtle intimidation and/or groupthink. As Dr. Elmurodov's career and future are being considered, please take the time to insure that he is offered unbiased consideration regarding the continuation of his residency training.

M. Todd Rice, MD, MBA
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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT LAW DIVISION

OTABEK ELMURODOV,	)	
	)	
Plaintiff,	)	
	)	No. 2025 L 001754
v.	)	(Subpoena Ancillary to Case No.
	)	C-16-CV-23-005681, Circuit Court for
	)	Prince George's County, Maryland)
STACY ROSS, et al.	)	
Defendants.	)	
	)	

NOTICE OF MOTION TO QUASH SUBPOENA

TO: **Attorneys of Record**
Jennifer L. Curry, Esq.
Chaitra Gowda, Esq.
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PLEASE TAKE NOTICE that on _____, 2025, at 9:00 a.m. or as soon thereafter as counsel may be heard, I shall appear in person in Courtroom 2206 before the Honorable Judge Barbara Flores or any judge sitting in her stead in the Richard J. Daley Center in Chicago, Illinois, and then and there present the Motion to Quash Subpoena, a copy of which is herewith attached and served upon you.

/s/ Mark J. McLoughlin
One of the Attorneys for Subpoena Respondent, Accreditation Council for Graduate Medical Education

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on **March 11th, 2025**, a copy of the foregoing **Motion of Subpoena Respondent to Quash Subpoena** was filed electronically, notice of which will be sent by operation of the court's electronic filing system and by email.

/s/ Mark J. McLoughlin

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

OTABEK ELMURODOV, Plaintiff, v. STACY ROSS, et al. Defendants.	)	No. 2025 L 1754 (Subpoena Ancillary to Case No. C-16-CV-23-005681, Circuit Court for Prince George's County, Maryland

MOTION OF SUBPOENA RESPONDENT ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION TO QUASH SUBPOENA

Subpoena respondent, ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION ("ACGME"), by its attorneys, in response to a subpoena for documents received from defendant/petitioner University of Maryland Health in a Maryland lawsuit, and pursuant to Supreme Court Rule 204 and 735 ILCS 5/2-1101, moves to quash the subpoena, and as support, states:

1. Almost all the documents responsive to the subpoena are in the possession of plaintiff in the underlying lawsuit and should be first sought from plaintiff by defendant/petitioner and pursued through production from plaintiff by court order in that lawsuit before burdening third party ACGME; privileged; and in electronic form such that production that would cause undue burden to third-party subpoena respondent ACGME. In addition, the subpoena has a return site not authorized by statute.

The Subpoena

2. On or about February 14, 2025, the ACGME received a Subpoena, returnable on March 12, 2025 (9:00 am) at the law firm of Baker, Donelson, Bearman, Caldwell & Berkowitz, 100 Light Street, 19th Floor, Baltimore, MD 21202. The subpoena was issued by defendant/petitioner University of Maryland Health, ancillary to an action pending in the Circuit

Court for Prince George's County, Maryland, *Otabek Elmurodov v. Stacy Ross, et al*, Case No. C-16-CV-23-005681. The ACGME is not a party in the underlying lawsuit.

Underlying Lawsuit

3. According to the complaint in the underlying lawsuit (273 pages), *pro se* plaintiff Otabek Elmurodov worked as a resident physician in a family medicine residency program at the University Maryland Capital Regional Health Medical Center and Family Medicine Cleverly and New Carrollton Outpatient Offices from November 1, 2021 to July 24, 2023. Plaintiff alleges that the residency program was accredited by the ACGME. Plaintiff also alleges that he was unlawfully terminated from the residency program. The Maryland complaint in the underlying action is not attached to the subpoena.

Plaintiff's Complaint Submitted to the ACGME

4. The ACGME has a complaint process through which it addresses allegations of non-compliance with ACGME accreditation requirements by Sponsoring Institutions and residency programs. In February 2024, plaintiff submitted to the ACGME a complaint about his residency program, and thereafter the ACGME determined that it would not be processed as a formal complaint per ACGME policy, and it so informed plaintiff. See §27.10 Complaints, *ACGME Policies and Procedures*, available on the ACGME website.

The Subpoenaed Documents

5. The documents sought by the subpoena are:

> 1. Any and all documents Related To any and all complaints by Dr. Elmurodov to You from January 1, 2021 to the present. This request includes, but is not limited to, the following documents:
>
> a. Any and all complaints from Dr. Elmurodov to You Related To University of Maryland Capital Region Health, the University of Maryland Medical School, and/or the Residency Program thereto;
>
> b. Any and all responses to any complaints from Dr. Elmurodov to You Related To University of Maryland Capital Region Health, the University of Maryland Medical School, and/or the Residency Program thereto;

c. Any and all documents that Refer or Relate To Dr. Elmurodov from January 2021 to the present.

6. Documents responsive to the subpoena include (I) the complaint submitted to the ACGME by plaintiff; (II) correspondence submitted to plaintiff by the ACGME informing him of the disposition of the complaint; (III) limited exchange of emails between plaintiff and the ACGME relating to the complaint; (IV) limited emails among ACGME personnel relating to the complaint; and (V) limited information about plaintiff submitted to the ACGME by the program in the normal course of accreditation of the program.

7. Plaintiff should possess (I-III) and defendant/petitioner should possess (V). It is likely that the substantive document responsive to the subpoena is the complaint submitted to the ACGME by plaintiff. However, the substance of this is likely duplicated in plaintiff's 273 page complaint in the underlying action. If plaintiff were to consent in writing, the ACGME would submit I and II to plaintiff and defendant/petitioner.

Subpoena Respondent ACGME

8. The ACGME is a not for profit corporation organized under the laws of the State of Illinois, and it is headquartered at 401 North Michigan Avenue, Chicago, Illinois. The ACGME accredits over 13,000 residency (specialty) and fellowship (subspecialty) programs in the United States, its territories and possessions.

9. As part of its accreditation function, the ACGME maintains records on its accredited programs and institutions, consisting mostly of information submitted to ACGME by the accredited programs and institutions. Some basic information about each accredited program and institution is provided to the public on the ACGME public website, www.acgme.org. However, as is common among educational accrediting agencies, most of the information is maintained as confidential by ACGME. There is a reason for this.

10. As a non-government entity, ACGME has no power to compel residency programs and institutions seeking accreditation and re-accreditation to submit complete and accurate

information, but must rely on those that apply for accreditation and re-accreditation to provide information willingly. Assurance of confidentiality allows programs and institutions to provide sensitive, and sometimes proprietary, information without fear that it will be disclosed outside the accreditation process. The same is true of information received from, and submitted to, complainants.

11. Intrinsic to ACGME accreditation (and to educational accreditation, generally) is the promotion of candor within its process, which includes constructive criticism that leads to improvement in the educational quality of a residency program. Maintaining confidentiality within the accreditation process promotes candor. Personnel within residency programs are more forthright and candid because they trust that the information they disclose during the accreditation process (which includes complaints and their investigation) will be used solely within that process and will not be otherwise disclosed.

12. Disclosure of accreditation records outside the accreditation process would have a "chilling effect" on ACGME's ability to receive full and frank information and would ultimately reduce confidence in the quality assurance aspect of accreditation. Lack of access to full information (because it is not protected and confidential) would hinder the ability of ACGME to do its job, which is to foster the provision of physician training consistent with national standards.

The Motion to Quash

13. The motion to quash is made pursuant to Illinois Supreme Court Rule 201(c)(1). In satisfaction of Illinois Supreme Court Rule 201(k), reasonable efforts have been made to resolve differences, and the parties to this subpoena matter have been unable to achieve accord.

Illinois Discovery Law Applies

14. The parameters and rules of discovery in an ancillary action under Rule 204(b) are the same parameters and rules as if the underlying action was pending in the Circuit Court of Cook County.

> While Rule 204(b) deals specifically with deposition testimony in aid of an action pending in another State, territory or country, it is the intent of the rule to empower the circuit court to grant the same discovery in Illinois in aid of an action pending in another State as it could order in an action pending in Illinois.

15. *Eskandani v. Phillips*, 61 Ill.2d 1273, 194, 334 N.E.2d 146 (1975). See also, *Daewoo International v. Luis Eduardo Monteiro*, 2014 Ill. App. (1st) 140573 (2014) ("Even when discovery is conducted on behalf of an out-of-state action, if it is conducted in Illinois, it "must be conducted pursuant to our rules." *Eskandani*, 61 Ill. 2d at 194.").

Petitioner/Defendant Has Failed to Exhaust Remedies in the Underlying Lawsuit to Obtain the Same Documents from Plaintiff before Burdening Third-Party ACGME

16. Although the subpoena does not state whether defendant/petitioner has first sought the same documents (I-III) from the plaintiff and pursued production through court order in the underlying lawsuit, during discussions between defendant/petitioner's counsel and ACGME counsel, defendant/petitioner's counsel stated that defendant/petitioner has requested (I-III) from plaintiff; has not received (I-III) from plaintiff; and has not yet moved the Court in the underlying action for plaintiff's production of (I-III). This is insufficient to burden third-party ACGME with production of the same documents. Under these circumstances, this Court should quash the subpoena.

17. The fact that petitioner/defendant has failed to exhaust remedies in the underlying action to obtain documents within the scope of the subpoena first from plaintiff before burdening the ACGME with responding to this subpoena constitutes "good cause shown" under 735 ILCS § 2-1101 and "unreasonable annoyance, expense, embarrassment, disadvantage, or oppression" under Illinois Supreme Court Rule 201(c)(1).

18. Illinois caselaw on this principle is scant. However, there is Illinois caselaw on related principles.

19. One related principle is that of "proportionality" embodied in Illinois Supreme Court Rule 201(c). Proportionality imposes a limitation on what is discoverable: even if it is relevant, information need not be produced if the benefits of producing it do not outweigh the burdens.

20. The fact that ACGME is not a party to the underlying lawsuit is an important factor in the "proportionality" balancing test resulting in a finding that the subpoena is unduly burdensome to the ACGME.

> Another potentially relevant factor is whether the discovery is sought from a nonparty without any direct stake in the outcome of the litigation. See *Tucker v. American International Group, Inc*., 281 F.R.D. 85, 92 (D. Conn. 2012) (nonparty status is "a significant factor in determining whether discovery is unduly burdensome" (internal quotation marks omitted)); see also *Katz v. Batavia Marine & Sporting Supplies, Inc.,* 984 F.2d 422, 424 (Fed. Cir. 1993) (nonparty status weighs against requiring disclosure of confidential information).

Carlson v. Jerousek, 2016 IL App (2d) 151248, 68 N.E.3d 520 (2016).

21. This Court, like the appellate court in *Carlson*, could look to federal law for guidance.

> Because Langford has not shown that he exhausted his efforts to seek production of these materials from the defendant, the subpoena executed upon Gallup is quashed. (footnote omitted) See, e.g., *Echostar Commc'n Corp. v. New Corp. Ltd*., 180 F.R.D. 391, 395 (D. Colo. 1998) (finding that the plaintiff failed to demonstrate any need for the information sought by subpoena from nonparties, that such materials were readily available from the defendant, and that plaintiff could not begin to argue a "substantial need" for such documents until it exhausted its efforts to seek production of those materials from the defendant).

Langford v. Alegent Health, 2010 WL 2732876 (D. Neb. July 8, 2010).

> If the material sought by subpoena is readily available…from a party to the action, obtaining it through subpoena on a nonparty will often create undue burden.

Moore's Federal Practice § 45.32 (Third Ed.).

22. The privacy concerns of the subpoena respondent are one of the burdens that a court can and should consider in conducting this balancing test. Not only does the ACGME maintain all of the requested documents as confidential, a host of federal government, state government and private entities rely on ACGME accreditation decisions (see below), inherent within the integrity of which is the maintenance of confidentiality by the ACGME. Invading this confidentiality would be a "burden" that weighs substantially in favor of the maintenance of confidentiality.

23. As stated above, Illinois caselaw is scant on the principle of seeking documents from a defendant before burdening a third-party subpoena respondent. However, even before the

adoption of the proportionality rule, this principle was accepted by the Circuit Court of Cook County in a different action.

> Virtually all of the documentation being requested in this subpoena sent to the Accreditation Council for Graduate Medical Education is information, documents, evidence, data, etc., which would be in the possession of any and all of the Defendants in the underlying medical malpractice action, including but not limited to the University of Hawaii, Queens Medical Center, all of the individual Defendants and the Hawaii Residency Programs, Inc. There is no indication that any of this discovery was previously asked for in the Hawaiian medical malpractice litigation, and until such time as this Court is shown that there is no ability to get this information directly within the confines of the Hawaiian litigation, this Court will not burden a non-party to a lawsuit with the onerous task of compiling any and all of the requested information. If it is shown that such information was requested and no such information is in the position of any of the Defendants in the Hawaiian litigation, then and only then would a subpoena to the ACGME to obtain discovery in the State of Illinois be appropriate. Therefore, there is no necessity for this Court to address the issues of whether or not these documents would be privileged under any statutory and/or common law privilege existing in the State of Illinois.

Moniz v. The Queen's Medical Center, et. al., No. 07-L-13396, Circuit Court of County, order of January 17, 2008.

The Documents Sought by the Subpoena are Privileged under Illinois Statute

24. The documents responsive to the subpoena are privileged and not discoverable under the Illinois peer review/quality assurance statute and case law construing same.

25. As an educational accrediting agency, ACGME maintains a list of accredited sponsoring institutions and residency programs on its public website. The public relies on ACGME accreditation decisions and the ability of ACGME to make those decisions. For example,

- By law, virtually all state medical licensing agencies (a) maintain as a condition of physician licensure the completion of one or more years in a residency program that is accredited by ACGME, and (b) grant training licenses to resident physicians who are participating in residency programs that are accredited by the ACGME, and who have not yet attained full medical licensure. See, 225 ILCS 60/11(A) (requirements for completion of clinical training to qualify for medical licensure); Illinois Administrative

Code, Section 1285.40(d) (clinical training programs accredited by ACGME are approved for licensure requirements).

●By law, the Centers for Medicare & Medicaid Services makes Medicare graduate medical education payments to institutions sponsoring residency programs that are accredited by ACGME.

●The Educational Commission for Foreign Medical Graduates is authorized by the United States Department of State to sponsor foreign national physicians as Exchange Visitors in ACGME accredited residency programs.

●By law, many state medical licensing agencies accept participation in a residency program that is accredited by ACGME as satisfaction of continuing medical education requirements for re-licensure. Illinois Administrative Code, Section 1285.110(b)(2) (participation in clinical training programs accredited by ACGME satisfies continuing medical education re-licensure requirements).

●By law, many states and other government entities require completion of one or more years of training in a residency program that is accredited by ACGME for eligibility to serve in government or state regulated positions, i.e. county medical examiner, etc.

●Many professional medical certification organizations require completion of a residency program accredited by ACGME as one qualification for certification.

●Many hospitals use the completion of all or part of a residency program accredited by ACGME as one prerequisite to the grant of hospital privileges.

●Illinois statute requires licensed hospitals to comply with ACGME duty hour requirements for resident physicians. 210 ILCS 85/6.14.

26. All of this evidences an overwhelming public interest in providing residency program sponsors, complainants and ACGME with the necessary confidential context in which to evaluate the quality of clinical training programs for our nation's physicians. The ACGME's confining its use and disclosure of the subpoena-requested documents within its accreditation

process is intrinsic to that process and necessary to the maintenance of the accreditation function of the ACGME.

27. The Illinois peer review/quality assurance statute states, in part,

> All information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a health care practitioner's professional competence, or other data of ……allied medical societies, ……used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care ……, shall be privileged, strictly confidential and shall be used only for medical research, increasing organ and tissue donation, the evaluation and improvement of quality care, or granting, limiting or revoking staff privileges or agreements for services, ……

735 ILCS 5/8-2101.

28. In 1985, the Illinois Supreme Court reversed a trial court's denial of a motion to quash a subpoena on the accreditor of hospitals, the Joint Commission on Accreditation of Hospitals (Joint Commission), holding that the accreditor is an "allied medical society" within this statute. *Niven v. Siqueira*, 109 Ill.2d 357, 487 N.E.2d 937 (1985). The subpoena requested documents relating to a hospital's accreditation.

29. Like the Joint Commission, ACGME is an "allied medical society" within the statute, and, as in *Niven*, the documents requested are within the statute.

30. At the time of *Niven*, the Joint Commission was governed by "a committee of delegates selected by the American Medical Association, the American Dental Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians." Its basic purposes were "to establish standards for the operation of health care facilities, to conduct survey and accreditation programs that encourage and assist health care facilities in the task of promoting efficient, high quality patient care, and to recognize compliance with their standards by issuance of certificates of accreditation." *Niven* at p. 363.

31. The ACGME is an Illinois not for profit corporation, the members of which are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Council of Medical Specialty

Societies, the American Osteopathic Association, and the American Association of Colleges of Osteopathic Medicine. Its mission is "to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education."

32. As both the ACGME and the documents within the scope of the subpoena are within the Illinois peer review/quality assurance statute, the subpoena must be quashed, as required by that statute.

33. Other courts have held materials of hospitals generated in compliance with national hospital accreditation standards to be non-discoverable under state and federal peer review statutes. See, for example, *Humana Hospital Corp. v. Spears-Petersen*, 867 S.W.2d 858 (Tex. App.--San Antonio 1993, no pet.); *Utterback v. United States*, 121 F.R.D 297 (W.D. Ky. 1987).

The Documents Sought by the Subpoena are Privileged under Illinois Common Law

34. In addition to the above cited statutory privilege, the Illinois Supreme Court recognizes information as privileged where four conditions are met, all of which are satisfied by the documents in the possession of the ACGME and responsive to the subpoena.

> Furthermore, if one claims to be exempt from disclosing information by reason of a privilege, then that party has the burden of establishing the privilege. (*See Krupp v. Chicago Transit Authority* (1956), 8 Ill.2d 37, 42.) Nevertheless, this court will recognize a privilege to protect communications in certain rare instances where the following four conditions are present:
>
> > "`1. The communications must originate in a confidence that they will not be disclosed.
> > 2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
> > 3. The relation must be one which in the opinion of the community ought to be sedulously fostered.
> > 4. The injury that would inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of litigation.'" (Emphasis in original.) *In re October 1985 Grand Jury No. 746* (1988), 124 Ill.2d 466, 475, quoting 8 J. Wigmore, Evidence § 2285, at 527 (McNaughton rev. ed. 1961).

Illinois Educational Labor Relations Board v. Homer Community Consolidated School District No. 208, 132 Ill. 2d 29, 547 N.E.2d 182 (1989) (labor negotiation strategy recognized as privileged and not subject to subpoena).

35. The circumstances of this subpoena satisfy all of these requirements.

Documents Possessed by Defendant/Petitioner

36. Defendant/petitioner should not be allowed to obtain from the ACGME documents/information that it submitted to the ACGME (V). As to the internal ACGME documents (IV), they are electronic and the ACGME should not be burdened with retrieving and producing; they are also beyond permissible subject matter scope of discovery.

Electronically Stored Information

37. The ACGMTE objects to the subpoena because many of the requested records are not reasonably accessible without undue burden or cost in violation of Rule 214 of the Illinois Supreme Court Rules, particularly insofar as requested records include electronically stored information, on backup media or otherwise, and not reasonably accessible because of burden or expense. See Rules 201 (General Discovery Provision) and 214 (Discovery of Documents, Objects, and Tangible Things-Inspection of Real Estate). They are also beyond permissible subject matter scope of discovery.

The Subpoena Does not Comply with Illinois Statute

38. The subpoena is procedurally based on Supreme Court Rule 204(b) and 735 ILCS 35 (Uniform Interstate Depositions and Discovery Act). These state,

> (b) Action Pending in Another State, Territory, or Country. Any officer or person authorized by the laws of another State, territory, or country to take any deposition in this State, with or without a commission, in any action pending in a court of that State, territory, or country may petition the circuit court in the county in which the deponent resides or is employed or transacts business in person or is found for a subpoena to compel the appearance of the deponent or for an order to compel the giving of testimony by the deponent. The court may hear and act upon the petition with or without notice as the court directs.

Supreme Court Rule 204(b).

> Sec. 3. Issuance of subpoena.

(a) To request issuance of a subpoena under this Section, a party must submit a foreign subpoena to a clerk of court in the county in which discovery is sought to be conducted in this State. A request for the issuance of a subpoena under this Act does not constitute an appearance in the courts of this State.

(b) When a party submits a foreign subpoena to a clerk of court in this State, the clerk, in accordance with that court's procedure, shall promptly issue a subpoena for service upon the person to which the foreign subpoena is directed.

(c) A subpoena under subsection (b) must:
(A) incorporate the terms used in the foreign subpoena; and
(B) contain or be accompanied by the names, addresses, and telephone numbers of all counsel of record in the proceeding to which the subpoena relates and of any party not represented by counsel.

Sec. 4. Service of subpoena. A subpoena issued by a clerk of court under Section 3 must be served in compliance with Illinois Supreme Court Rules 204 and 237 and Section 2-1101 of the Code of Civil Procedure.

Sec. 5. Deposition, production, and inspection. With respect to depositions, production of documents or other tangible items, or inspections of premises, Illinois Supreme Court Rules 204 and 237 and Section 2-1101 of the Code of Civil Procedure apply to subpoenas issued under Section 3.

735 ILCS 35.

39. 735 ILCS 35/9.5, which is part of the Uniform Interstate Depositions and Discovery Act, states “A subpoena issued under this Act may not require compliance outside a deponent's county of residence in the State of Illinois.” The subpoena in this matter does not comply with this statute, as it is returnable at the law firm of Baker, Donelson, Bearman, Caldwell & Berkowitz, 100 Light Street, 19th Floor, Baltimore, MD 21202.

Reasonable Attempts to Resolve Differences

40. Supreme Court Rule 201(k) states,

(k) Reasonable Attempt to Resolve Differences Required. The parties shall facilitate discovery under these rules and shall make reasonable attempts to resolve differences over discovery. Every motion with respect to discovery shall incorporate a statement that counsel responsible for trial of the case after personal consultation and reasonable attempts to resolve differences have been unable to reach an accord or that opposing counsel made himself or herself unavailable for personal consultation or was unreasonable in attempts to resolve differences.

41. Counsel for the subpoena proponent and the subpoena respondent have made reasonable attempts to resolve differences regarding the subpoena and have been unable to reach an accord.

WHEREFORE, for the foregoing reasons, Subpoena Respondent, Accreditation Council for Graduate Medical Education, respectfully moves this Court to quash the subpoena.

Respectfully submitted,

/s/ Mark J McLoughlin

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