IN THE MATTER OF	*	**BEFORE THE**
THOMAS L. FIELDSON, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D01923	*	**Case Number: 2009-0456**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Thomas L. Fieldson, M.D. (the "Respondent") (D.O.B. 05/23/32), License Number D01923, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Gov't Code Ann. § 10-226(c)(2009 Repl. Vol.), concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Board, and the investigatory information obtained by, received by and made known to and available to the Board, including the instances described below, the Board has reason to believe that the following facts are true:[1]

BACKGROUND FINDINGS

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

to practice medicine in Maryland on August 4, 1969, under License Number D01923.

2. The Respondent practices general medicine and maintains a medical office at the following location: Pinefield Medical, 2068 Crain Highway, Waldorf, Maryland 20601.

3. The Respondent has hospital privileges at Southern Maryland Hospital Center, located in Clinton, Maryland.

4. In an Advisory Letter, dated June 27, 2008, the Board notified the Respondent that it had reviewed a complaint that alleged that he improperly prescribed controlled dangerous substances ("CDS") to a patient. The Board stated that two peer reviewers reviewed the complaint and concluded that he failed to meet appropriate standards of care with respect to this patient. The Board informed the Respondent that it closed the case and intended to conduct a re-review of his medical practice.

5. On or about December 23, 2008, the Board initiated a re-review of the Respondent's practice. The Board acquired a series of the Respondent's patient records and referred them to Maximus Federal Services, Inc. ("Maximus"), for a practice review.

6. Maximus conducted a practice review and submitted its findings to the Board in or around March 2010. This review concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care and failed to keep adequate medical records with respect to a series of patients.

7. After reviewing the Respondent's medical practice, the Board issues this Order for Summary Suspension pursuant to Md. State Gov't Code Ann. § 10-226(c)(2), concluding that the public health, safety or welfare imperatively required emergency action.

8. The Board's investigative findings are set forth *infra*.

GENERAL INVESTIGATIVE FINDINGS

9. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patients A through L, *infra*.

10. The Respondent prescribed escalating amounts of potent opioid medications to patients for extended periods of time—in some instances, for several years--in violation of quality medical standards.

11. The Respondent failed to establish a comprehensive treatment plan when prescribing opioid medications for patients who presented with complaints of pain/chronic pain.

12. When assessing these patients, the Respondent failed to determine the etiology, location, quality, intensity and duration of his patients' pain complaints or document these findings in his patients' medical records.

13. The Respondent typically did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term use of opioid therapy.

14. The Respondent prescribed opioid medications without establishing an appropriate medical justification for their use/continued use, or prescribed based on patient request or prior usage patterns alone.

15. The Respondent prescribed opioid medications without questioning his patients about prior drug use/abuse, duration of usage, side effects, illicit drug use and history of psychiatric problems.

16. The Respondent failed to undertake timely monitoring and periodic assessments of his patients' response to opioid therapy or possible abuse of those medications, or keep adequate documentation of such findings in his patients' medical records.

17. The Respondent sometimes prescribed opioid medications for extended periods of time without an accompanying office visit or assessment, or under circumstances where there was clear misuse/overuse of those medications. In one instance, the Respondent prescribed opiates to a patient for about one year, without a documented office visit. In another instance, the Respondent continued to prescribe opiates to a patient after the patient's hospitalization for overdose/narcotics abuse.

18. The Respondent failed to implement medication contracts when prescribing opiate medications, and failed to refer patients who were candidates for pain management in a timely manner.

19. The Respondent's medical records are cursory, difficult to decipher or are illegible, and frequently do not contain essential elements of a medical record, such as an assessment and treatment plan. The Respondent failed to

keep adequate documentation in his patients' medical records with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

20. The Respondent failed to take or document taking appropriate patient histories or update those histories in a timely manner.

21. The Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner.

22. The Respondent did not maintain an updated medication list, or reconcile medications prescribed from visit to visit.

23. In addition, the Respondent failed to appropriately assess and treat his patients' other medical conditions, including obesity, hypertension, diabetes, renal insufficiency/failure and hyperlipidemia. The Respondent inappropriately prescribed weight loss medications over long periods of time, without appropriate informed consent.

24. Examples of these deficiencies are set forth *infra.*

PATIENT-SPECIFIC FINDINGS

Patient A

25. Patient A, then a 46-year old woman, first saw the Respondent on January 30, 2008, with complaints of neck and lower back pain after picking up a heavy object. Patient A's medical history reportedly included four prior back surgeries, although the Respondent did not specify the dates or specific details of those surgeries in his notes. The Respondent performed a brief physical

examination, which is mostly illegible. The Respondent diagnosed Patient A with fibromyalgia and muscle strain/lower back. The Respondent wrote prescriptions for Motrin, a non-steroidal anti-inflammatory drug ("NSAID"), Soma, a muscle relaxant, and an illegible third medication. The Respondent also administered an intramuscular ("IM") injection of a medication that starts with the letter "D," but is otherwise illegible. The Respondent did not document a dosage for this IM injection.

26. Patient A next saw the Respondent on September 9, 2008, with a complaint of back pain. The Respondent performed a minimal physical examination but did not make or document making a diagnosis. The Respondent prescribed hydrocodone, a narcotic analgesic and Schedule III CDS, Librium, a benzodiazepine and Schedule IV CDS, Soma, and an IM injection of a medication that starts with the letter "D," but is otherwise illegible.

27. Patient A then saw the Respondent on October 6, 2008, with complaints of sore throat, cough, body aches and a fever of 101.2° F. The Respondent did not perform or document performing a physical examination and diagnosed Patient A with bronchitis, arthralgia and Lyme disease. The Respondent prescribed an antibiotic, Cipro, hydrocodone, and Hycotuss cough syrup (containing an expectorant and hydrocodone).

28. Patient A returned to see the Respondent on October 14, 2008, in follow-up to a hospitalization. The Respondent's note for this date does not make it clear for what reason Patient A was hospitalized, but a consulting pulmonologist's note for an office visit dated October 16, 2008, states that Patient

A had a right middle lobe infiltrate with an asthma exacerbation. The Respondent diagnosed Patient A with bronchitis, and prescribed hydrocodone and bronchodilators.

29. Patient A returned for two additional visits, on November 3, 2008, and February 27, 2009, for complaints of neck pain, and back pain, respectively. On the November 3, 2008, visit, the Respondent prescribed Tramadol, a synthetic centrally-acting opioid medication; Soma; and ordered an MRI. On the February 27, 2009, visit, the Respondent prescribed oxycodone, a narcotic analgesic and Schedule II CDS. In this note, the Respondent did not address or mention Patient A's previous complaint of neck pain or the previous MRI. The Respondent prescribed oxycodone and another drug that is illegible.

30. In a letter to the Board dated August 21, 2009, the Respondent stated that as a result of Patient A's February 2009 visit, where she complained of neck pain and headaches, he ordered a "brain MRI," and that "[i]t was becoming apparent that I may be treating a neurotic person. She has not been seen since February 2009."

31. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient A, for reasons including but not limited to the following:

a. the Respondent failed to take or document taking an appropriate medical history, including a history of present illness, social, psychiatric and surgical history, or obtain her prior medical records;

b. the Respondent failed to perform or document performing appropriate physical examinations to assess Patient A's musculoskeletal complaints;

c. the Respondent's medical records are cursory and often illegible, and largely do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent did not obtain or document obtaining Patient A's history of CDS usage, document counseling her with respect to these medications, or her response to these medications;

e. the Respondent failed to justify prescribing opioid and other medications that have habituating potential;

f. the Respondent's diagnoses did not always reflect the need for opioid therapy; and

g. the Respondent did not reassess or document reassessing Patient A's musculoskeletal complaints from visit to visit.

Patient B

32. Patient B, then a 45-year old woman, initially saw the Respondent on August 26, 2008, after hurting her back and left ankle after a fall. The Respondent prescribed hydrocodone, Soma and Motrin.

33. Patient B returned on September 5, 2008, and stated that she was "not getting any better." The Respondent again prescribed hydrocodone, Soma and Motrin. The Respondent noted that he referred Patient B for an orthopedic consultation. There is no consultant's note in Patient B's chart, however.

34. Patient B returned on September 18, 2008, for a "med refill." The Respondent diagnosed Patient B with back strain and prescribed hydrocodone, Soma and Motrin.

35. Patient B returned on October 14, 2008, with complaints of sore throat and cough. The Respondent gave Patient B a prescription for phenergan with codeine. The Respondent gave Patient B an additional prescription of phenergan with codeine on November 13, 2008.

36. Patient B returned on November 21, 2008, now complaining of "shooting pain in right shoulder and neck." The Respondent diagnosed Patient B with fibromyositis and prescribed hydrocodone, Soma and Motrin.

37. Patient B returned on December 5, 2008, and stated that her pain in her right shoulder was "no better." The Respondent prescribed hydrocodone and Motrin and referred her for an MRI of her right shoulder. Patient B did not obtain the MRI, however.

38. Patient B returned on January 20, 2009, for a refill of her medications. The Respondent diagnosed Patient B with a torn rotator cuff, prescribed hydrocodone and referred her for an MRI for February 17, 2009.

39. Patient B returned on February 18, 2009, stating that she "twisted left ankle yesterday." The Respondent did not document whether Patient B obtained the MRI that was scheduled for the day before this appointment. The Respondent prescribed additional hydrocodone.

40. Patient B returned on February 26, 2009, claiming that her left ankle was "no better." The Respondent gave Patient B a prescription for hydrocodone.

41. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), with respect to Patient B, for reasons including but not limited to the following:

a. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history, or obtain her prior medical records;

b. the Respondent did not obtain a history of Patient B's prior usage of CDS or counsel or document counseling her on the potential addicting nature of the medications he prescribed;

c. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent failed to attempt a trial of non-narcotic medications to treat Patient B's musculoskeletal complaints;

e. the Respondent did not establish or document establishing a comprehensive treatment plan to address Patient B's various musculoskeletal complaints;

f. the Respondent did not follow up on or document following up on Patient B's failure to obtain diagnostic studies to assess her various musculoskeletal complaints;

g. the Respondent failed to justify the continuing prescribing of opioid medications to treat Patient B's various musculoskeletal complaints;

h. the Respondent failed to reconcile Patient B's use of CDS from visit to visit;

i. the Respondent did not assess or document assessing Patient B's response to the medications he prescribed; and

j. the Respondent did not reassess or document reassessing Patient A's musculoskeletal complaints from visit to visit.

Patient C

42. Patient C, then a 33-year old man, initially saw the Respondent on April 28, 1998, for a transportation physical examination. On April 20, 1999, Patient C was treated in the emergency room ("ER") at Southern Maryland Hospital Center for prostititis, where he was given morphine and Percocet

(oxycodone) (both narcotics and Schedule II CDS), Motrin, phenergan and Cipro. The Respondent saw Patient C on three visits after his ER visit and prescribed hydrocodone and then Percocet.

43. Patient C next saw the Respondent in April 2003, with a complaint of back pain. The Respondent prescribed hydrocodone, Soma, Motrin, and administered an IM injection of a medication that starts with the letter "D," but is otherwise illegible, without a dosage amount.

44. Patient C returned on January 5, 2004, complaining of back pain. At this point, Patient C's office visit frequency escalated. During these visits, the Respondent prescribed opiates for back pain, including hydrocodone and oxycodone. The Respondent also typically prescribed Soma and Motrin.

45. In 2004, the Respondent recommended MRIs of the lumbosacral spine and neck, but reports of these studies do not exist in Patient C's chart. By 2005, Patient C returned for almost monthly visits or medication refills for hydrocodone or oxycodone. In 2006, Patient C saw the Respondent on about five visits, during which he prescribed opioid medications. Patient C was reportedly involved in a motor vehicle accident during 2006 and was hospitalized. Patient C's chart contains a consultation letter, dated August 9, 2006, from a physiatrist, who stated that Patient C had disc disease at L5-S1.

46. Patient C's chart contains laboratory studies that showed a creatinine level of 0.6 mg/dl in 2005 (with a range of normal being 0.5 to 1.3) and 4.8 in May 2007. In notes, dated June 25 and July 24, 2007, the Respondent

listed renal failure as a diagnosis. The Respondent did not address or document addressing this finding in subsequent entries, however.

47. Beginning in August 2007, the Respondent began prescribing Vicodin (hydrocodone) without a documented examination. For about a period of one year--from August 22, 2007 to August 11, 2008--the Respondent consistently wrote prescriptions for 60 tablets of Vicodin ES as needed for pain, often at two-week intervals, without an accompanying office visit. Patient C then saw the Respondent on August 11, 2008, for "med refills." The Respondent then refilled Patient C's Vicodin for an additional four months without an accompanying office visit. The Respondent continued to prescribe various opiates until April 2009.

48. In a visit on March 24, 2009, the Respondent's note states, "no more refills on pain meds, seek pain management." On the next visit, the Respondent prescribed 120 oxycodone and again noted referring Patient C to an unspecified pain management practice.

49. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient C, for reasons including but not limited to the following:

a. the Respondent did not establish or document establishing a comprehensive treatment plan to address Patient C's musculoskeletal complaints;

b. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

c. the Respondent did not take or document taking a comprehensive medical history including a history of present illness, prior opiate usage, social and psychiatric history;

d. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

e. the Respondent did not attempt a trial of non-narcotic medications or other modalities prior to prescribing opioid medications for Patient C;

f. the Respondent inappropriately prescribed opioid medications for Patient C;

g. the Respondent did not obtain appropriate diagnostic testing to evaluate Patient C prior to providing long-term opioid therapy, or failed to follow up on Patient C's non-compliance with his recommendations for such testing;

h. the Respondent prescribed opioid medications for Patient C for about one year without accompanying office visits;

i. the Respondent failed to evaluate Patient C in a timely manner for possible opioid abuse;

j. the Respondent failed to implement or document implementing medication contracts in view of his escalating opiate prescribing;

k. the Respondent failed to appropriately assess or document his assessment of Patient C's renal insufficiency/failure, or perform or document performing follow-up evaluations for this condition; and

l. the Respondent failed to keep adequate documentation in Patient C's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

Patient D

50. Patient D, then a 38-year old woman, began seeing the Respondent in June 1984, and last saw him in 2009. Patient D sought medical care for a

variety of medical conditions, including sore throats, dizziness and other minor complaints.

51. The Respondent also followed Patient D for diabetes and hypertension. The Respondent ordered Patient D's first glycohemoglobin test in 1998. Patient D did not seek regular care from the Respondent despite being on insulin. The Respondent's record for Patient D contains five glycohemoglobin determinations in ten years.

52. Patient D saw the Respondent in 2006 for back pain that radiated to her left leg. The Respondent began treating Patient D with Percocet. Thereafter, the Respondent began a slow escalation of oxycodone prescribing through 2007 and 2008, until the Respondent was prescribing 50 tablets of 10 mg Endocet (oxycodone), a narcotic analgesic and Schedule II CDS per month, usually without an office visit.

53. The Respondent referred Patient D to an orthopedist in 2008 who took a lumbosacral MRI that revealed an incidental finding of a pelvic mass. Patient D subsequently underwent surgery for removal of a clear cell carcinoma of the ovary. Patient D started chemotherapy and surveillance laboratory tests were drawn at the Respondent's office.

54. In a letter to the Board, dated August 21, 2009, the Respondent stated that after oncologic surgery, he "was assigned treatment of her pain."

55. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep

adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient D, for reasons including but not limited to the following:

a. the Respondent did not establish or document establishing a comprehensive treatment plan to address Patient D's pain/medical complaints;

b. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history, or obtain her prior medical records;

c. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

e. the Respondent did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term opioid therapy;

f. the Respondent failed to provide or document providing timely monitoring and assessment of Patient D's response to opioid therapy or possible abuse;

g. the Respondent prescribed opioid medications, sometimes for several months at a time, without an accompanying office visit;

h. the Respondent failed to reconcile Patient D's medications from visit to visit;

i. the Respondent failed to record adequate documentation with respect to his assessment and treatment of Patient D's diabetes and hypertension;

j. the Respondent failed to provide appropriate treatment of Patient D's diabetes;

k. the Respondent failed to refer or document referring Patient D for annual ophthalmic examinations; and

l. the Respondent failed to keep adequate documentation in Patient D's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

Patient E

56. In his letter to the Board, dated August 21, 2009, the Respondent stated that he had treated Patient E for over 40 years. The Respondent stated,

> "[h]e was always a neurotic person who was a medical wreck. He has many system complaints which have been evaluated by Consultant Physicals. As a result of his knowledge he has received many medications ... His tolerance is poor, pain is a major concept. The object here is to provide comfort and functional ability to make him useful and to prevent a disorganized useful person. He is still a difficult person to keep in a control, and I have done this by keeping him in low dose pain control."

57. The Respondent supplied records for Patient E that go back to 1989, and continue until 2009. Patient E's medical history included hypertension, diabetes, hyperlipidemia, carotid artery disease, tobacco abuse, neuropathy and chronic pain.

58. In May 1999, Patient E, who was then 47-years old, saw the Respondent for back pain, for which the Respondent prescribed OxyContin 20 mg. The Respondent wrote an additional prescription for Patient E in August 1999 for OxyContin without an accompanying office note. The Respondent also prescribed Flexeril, a muscle relaxant, and Neurontin, a drug used to treat neuropathic pain.

59. The Respondent provided a few refills of opioids in 2000 and 2001. By 2002, the Respondent began prescribing Patient E 60 tablets of OxyContin 20 mg on a monthly basis, reportedly for a diagnosis of peripheral neuropathy. The

Respondent also attempted to treat the neuropathy with Neurontin. The Respondent slowly increased his prescribing of opiates to Patient E into 2007. Beginning in 2007, the Respondent significantly increased his prescribing of opiates. The Respondent began prescribing 60 tablets of 20 mg OxyContin every two weeks, alternating with 60 tablets of 40 mg OxyContin every two weeks (*e.g.*, on May 9, 2007, the Respondent prescribed 60 tablets of 20 mg OxyContin; three days later, on May 12, 2007, the Respondent prescribed 60 tablets of 40 mg OxyContin). The Respondent continued to prescribe these opioids at frequent levels into 2009, often without an accompanying office visit.

60. Patient E's chart contains several laboratory test results with markedly abnormal values. In December 2001, Patient E was noted to have highly elevated cholesterol (587 mg/dl, with a range of normal being 100-200) and triglyceride levels (3457 mg/dl, with a range of normal being 25-150). In June 2002, the Respondent's cholesterol level was 860, and his triglycerides were 9070. Patient E continued to have hypertriglyceridemia over the course of several years. The Respondent failed to address or document addressing Patient E's hypertriglyceridemia during this period. Patient E also had elevated blood glucose and glycohemoglobin levels. The Respondent failed to appropriately address and/or document addressing Patient E's diabetes. In June 2008, laboratory tests indicated that Patient E's blood glucose and cholesterol levels were still uncontrolled. Patient E's chart contains one ophthalmic examination report, dated December 30, 2008.

61. On April 24, 2009, Patient E was hospitalized at Anne Arundel Medical Center for altered mental status secondary to an overdose of his OxyContin 40 mg. According to a hospital consultation note, Patient E had also been hospitalized about one year prior for psychiatric reasons, in which it was determined that he was "overusing and seeking pain medications and, at the same time, denying that he had a problem with them." The hospital physician reported that in addition to the OxyContin, Patient E probably also took some Fiorinal (containing butalbital, aspirin and caffeine) that he possibly obtained over the Internet. Patient E was discharged on April 27, 2009, and returned to the Respondent's care. The Respondent changed Patient E's OxyContin prescriptions to 20 mg twice daily with 240 tablets of 5 mg oxycodone for breakthrough pain. In August 2009, the Respondent also began prescribing Valium and Cymbalta, a psychotropic medication.

62. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient E, for reasons including but not limited to the following:

a. the Respondent did not establish or document establishing a comprehensive treatment plan to treat Patient E other than providing escalating dosages of opioid medications;

b. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history;

c. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

e. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

f. the Respondent failed to provide or document providing timely monitoring and assessment of Patient E's response to opioid therapy or possible abuse;

g. the Respondent prescribed opioid medications, sometimes for months at a time, without an accompanying office visit or assessment;

h. the Respondent continued to prescribe opiates to Patient E after Patient E's hospitalization for overdose/narcotics abuse;

i. the Respondent failed to implement or document implementing medication contracts in view of his escalating opiate prescribing, or possible referral of Patient E for pain management;

j. the Respondent failed to reconcile Patient E's medications from visit to visit;

k. the Respondent failed to record adequate documentation in Patient E's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications;

l. the Respondent failed to appropriately assess, monitor and treat Patient E's hypertriglyceridemia; and

m. the Respondent failed to appropriately assess and treat Patient E's diabetes.

Patient F

63. Patient F, who was then a 45-year old woman, saw the Respondent in 2000, with complaints of headaches, head congestion and cough. Patient F

continued to see the Respondent for frequent office visits into 2009, according to the Respondent's office notes. In his letter to the Board, dated August 21, 2009, the Respondent stated that Patient F "is a very complicated medical problem ... [i]t seems the treatment of her back pain has fallen on my shoulders."

64. During this period, the Respondent treated Patient F for back pain. The Respondent initially prescribed Esgic (a combination of butalbital, a barbiturate, acetaminophen and caffeine). The Respondent also prescribed two stimulants for weight loss, phentermine and phendimetrazine. In mid-2002, the Respondent began prescribing Lorcet (hydrocodone), a narcotic analgesic and Schedule II CDS. The Respondent continuously prescribed Lorcet for Patient F into 2009. During this seven year period, the Respondent prescribed Lorcet on a monthly basis, often accompanied by 90 tablets of Valium, 100 Esgic, 30 phentermine and 90 phendimetrizine.

65. The Respondent also followed Patient F for diabetes and hyperlipidemia. The Respondent's office record for Patient F contains a Medicare medication list that lists Synthroid, a thyroid medication. The Respondent's notes do not reference whether Patient F was on Synthroid on a regular basis.

66. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient F, for reasons including but not limited to the following:

a. the Respondent did not establish or document establishing a comprehensive treatment plan to treat Patient F other than providing continued prescribing of opioid medications;

b. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history;

c. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

e. the Respondent inappropriately prescribed opiates, stimulants and benzodiazepines in combination;

f. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

g. the Respondent failed to provide or document providing timely monitoring and assessment of Patient F's response to opioid therapy or possible abuse;

h. the Respondent failed to appropriately treat Patient F other than providing opiate therapy;

i. the Respondent failed to implement or document implementing medication contracts in view of his continued opiate prescribing, or possible referral of Patient F for pain management;

j. the Respondent failed to reconcile Patient F's medications from visit to visit;

k. the Respondent failed to keep adequate documentation in Patient F's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications;

l. the Respondent failed to appropriately assess and treat Patient F's elevated blood glucose and cholesterol levels;

m. the Respondent failed to appropriately assess, monitor and treat Patient F's diabetes, including referring her for annual

eye examinations, timely glycohemoglobin monitoring and microalbumin measurements; and

n. the Respondent inappropriately prescribed stimulant medications to Patient F for an extended period of time, without proper informed consent.

Patient G

67. Patient G, then a 33-year old woman, initially saw the Respondent in 1996, according to the Respondent's office chart. The Respondent treated Patient G until 2009.

68. In a letter, dated August 21, 2009, the Respondent stated that Patient G had a "history of emotional and physical problems," and at one point was enrolled in a pain management program. The Respondent stated that Patient G left the program after having "some trouble" with it, after which he resumed treating her.

69. During the treatment period reflected in the Respondent's office record, he treated Patient G for migraines, weight loss, insomnia, osteoarthritis and back pain. Over the treatment period, the Respondent typically listed the reason for Patient G's visits as "headache," "migraine," "check up,", "rx refills," or "medication refills."

70. On Patient G's initial visit on July 7, 1996, the Respondent prescribed Vicodin when Patient G claimed she fell and injured her left shoulder. On December 12, 1996, the Respondent prescribed Lorcet after Patient G reported falling and injuring her ribs.

71. Thereafter, on return visits, Patient G complained of headaches, for which the Respondent prescribed a slow and steady progression of various opioid

medications. In 1997 and 1998, the Respondent prescribed two opioid medications for Patient G. In 1999, the Respondent provided Patient G with five such prescriptions. In 2000, the Respondent wrote Patient G about eight prescriptions for opiates, with the addition of phentermine and phendimetrizine. In 2001, the Respondent began writing prescriptions for opiates, Klonopin, a benzodiazepine, and the same weight loss stimulants. At that point, the Respondent settled on a diagnosis of "chronic pain syndrome."

72. In 2002, Patient G returned for monthly opiate medication refills. In 2003, Patient G returned for office visits, often at two-week intervals, during which time the Respondent changed her prescription from Vicodin to Vicodin ES (Vicodin contains 5.0 mg of hydrocodone; Vicodin ES contains 7.5 mg of hydrocodone). Thereafter, the Respondent recorded a number of different diagnoses, including chronic pain, HNP (herniated nucleus pulposus, or herniated disc), migraine and fibromyositis.

73. In or around March 2004, the Respondent noted that he referred Patient G for a psychiatric consultation, but did not specify his reason.

74. By late 2004, the Respondent was prescribing hydrocodone products at a rate of 100 tablets per month. Throughout 2005 and 2006, the Respondent prescribed Patient G 100 hydrocodone tablets every three to four weeks. In August 2006, the Respondent's note consists of the statement, "serious discussion of pain Rx med," Patient G's weight, and a notation that he gave her a prescription for 100 tablets of Vicodin.

75. The Respondent continued prescribing hydrocodone until October 2006, when he changed Patient G's medication regimen to Methadone, with a notation that is illegible. The Respondent then began prescribing Methadone for Patient G. In December 2006, the Respondent gave Patient G prescriptions for Methadone and Vicodin.

76. For reasons that are not clear in his records, the Respondent discontinued prescribing Methadone for Patient G in 2007 and returned to prescribing Vicodin.

77. During 2003, 2005, 2006 and 2007, the Respondent received notifications from various sources, including Express Scripts, that Patient G was receiving opioid medications from as many as eight different physicians. The Respondent took no apparent action based on this information.

78. In May 2008, the Respondent again changed the opiate he was prescribing for Patient G from Vicodin to Methadone, without a documented explanation of his rationale.

79. In February 2009, the Respondent noted, "abusing Rx" in a one-line note. The Respondent referred Patient G to someone whose name is illegible. Eighteen days later, the Respondent noted that Patient G had been "kicked out of pain management." The Respondent's office record contains a letter, dated January 29, 2009, which describes her dismissal from a pain clinic for violating her narcotic contract. The Respondent then reinstituted prescribing Methadone, which he continued doing until her last recorded visit, July 28, 2009.

80. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient G, for reasons including but not limited to the following:

a. the Respondent did not establish or document establishing a comprehensive treatment plan to treat Patient G other than providing long-term, frequent prescriptions for opioid medications;

b. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history;

c. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

e. the Respondent did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term high dosages of opioid therapy;

f. the Respondent facilitated Patient G's addiction to opiates;

g. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

h. the Respondent failed to provide or document providing timely monitoring and assessment of Patient G's response to opioid therapy or possible abuse;

i. the Respondent continued to prescribe opiates to Patient G after receiving multiple written warnings about Patient G's acquisition of opiate medications from several other physicians at the same time;

j. the Respondent continued to prescribe opiates for Patient G after her termination from a pain management program for non-compliance;

k. the Respondent failed to appropriately treat Patient G other than providing escalating dosages of opiates;

l. the Respondent failed to implement or document implementing medication contracts in view of his escalating opiate prescribing;

m. the Respondent did not document his rationale for changing Patient G's opiate medication regimen;

n. the Respondent failed to reconcile Patient G's medications from visit to visit; and

o. the Respondent failed to keep adequate documentation in Patient G's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

Patient H

81. Patient H, then a 38-year old woman, first saw the Respondent in April 1997 for back pain. The Respondent diagnosed Patient H with HNP and prescribed Lorcet, Naprosyn, an NSAID, and Robaxin, a muscle relaxant. The Respondent also administered an IM injection of a medication that starts with the letter "D," but is otherwise illegible. The Respondent did not document a dosage for this IM injection.

82. Patient H returned to see the Respondent in January 1998, again for back pain. The Respondent diagnosed Patient H with HNP and prescribed the same medications. Patient H returned in October 1998, complaining of back pain and a cough. The Respondent prescribed additional Lorcet.

83. In March 1999, Patient H was injured at work after she slid off a chair and was provided with Motrin and Flexeril by another provider. Ten days later, Patient H returned to see the Respondent, who prescribed Lorcet and Naprosyn. Patient H continued to complain of pain, and the Respondent prescribed Percocet or Vicodin about every three weeks.

84. In June 1999, Patient H underwent a lumbosacral MRI that revealed a ruptured disc at the L5-S1 level. Patient H was referred to a neurosurgeon and underwent a lumbar laminectomy in July 1999.

85. Patient H returned to see the Respondent in 2001 and was treated for unrelated conditions without opiates. In June 2006, the Respondent performed a Department of Transportation physical examination.

86. In February 2007, Patient H saw the Respondent with complaints of back pain radiating into the left leg. The Respondent diagnosed Patient H with HNP and DJD (degenerative joint disease) spine. The Respondent prescribed Lyrica, an anticonvulsant medication sometimes used for peripheral neuropathic pain.

87. Patient H returned to see the Respondent in May 2007 for a sore throat. The Respondent prescribed multiple medications, the notations of which are largely illegible. Patient H returned in June 2007, at which point the Respondent prescribed 100 tablets of hydrocodone 10 mg and 30 tablets of Valium 10 mg. The Respondent prescribed additional hydrocodone in August and November 2007, and February 2008. From August 2008 onward, the Respondent began writing prescriptions for 120 tablets of Lorcet at three to four week intervals,

largely without an office visit. The Respondent provided multiple refills of Lorcet to Patient H on a monthly basis from December 2008 to July 2009, without an office visit.

88. Patient H returned to see the Respondent on August 7, 2009, with a complaint of back pain. The Respondent diagnosed Patient H with a muscle spasm and provided her with a prescription for Lorcet.

89. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient H, for reasons including but not limited to the following:

a. the Respondent did not establish or document establishing a comprehensive treatment plan to treat Patient H other than providing long-term, frequent prescriptions of opioid medications;

b. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history;

c. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

d. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

e. the Respondent did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term opioid therapy;

f. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

g. the Respondent prescribed opiates for Patient H for extended periods of time without an office visit or assessment;

h. the Respondent failed to provide or document providing timely monitoring and assessment of Patient H's response to opioid therapy or possible abuse;

i. the Respondent failed to appropriately treat Patient H other than providing escalating dosages of opiates;

j. the Respondent failed to implement or document implementing medication contracts in view of his long-term opiate prescribing;

k. the Respondent prescribed opioid medications prior to his dosing schedule and without being aware of or documenting this fact in Patient H's chart;

l. the Respondent failed to reconcile Patient H's medications from visit to visit; and

m. the Respondent failed to keep adequate documentation in Patient H's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

Patient I

90. In a letter to the Board, dated august 21, 2009, the Respondent described Patient I as a "basically healthy woman with pain complaints ... [who] ... had been treated for years with a controlled pain medication. She was fully functional and productive. I do not believe that changing at this age of life would help her life and function ability."

91. Patient I, then 52 years old, first saw the Respondent in November 2006, with complaints of chest congestion. Patient I reported that she had been taking Vicodin and Ativan, a benzodiazepine and Schedule IV CDS, without an explanation for such prescriptions. The Respondent diagnosed Patient I with URI

(upper respiratory infection) and thyromegaly (enlarged thyroid gland) and prescribed 100 tablets of Vicodin ES on this visit.

92. Patient I returned one month later, at which point the Respondent diagnosed her with arthritis and DJD, at an unspecified site, and prescribed an unspecified quantity of Vicodin. The Respondent's office note for this visit is otherwise largely illegible. The Respondent ordered a thyroid sonogram and referred Patient I to a local endocrinologist.

93. The Respondent then prescribed 90 tablets of Vicodin ES, without accompanying office visits, in February and March 2007.

94. Patient I returned for about ten office visits in 2007-2008 for such illnesses as respiratory infections, allergic rhinitis, otalgia and dermatitis. On each visit, the Respondent typically prescribed 90 tablets of Vicodin. From 2007 to 2009, the Respondent consistently provided monthly prescriptions for Vicodin.

95. In early 2009, the Respondent diagnosed Patient I with bursitis and gave her a corticosteroid injection and a prescription for Vicodin.

96. From March to June 2009, the Respondent provided Patient I with five Vicodin prescriptions, three Ativan prescriptions, and one prescription for phenergan with codeine, without an accompanying office visit. Patient I returned in July 2009, complaining of back pain for which the Respondent prescribed Vicodin. On August 16, 2009, the Respondent provided Patient I with prescriptions of Vicodin and Ativan without an accompanying office visit.

97. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep

adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient I, for reasons including but not limited to the following:

a. the Respondent inappropriately prescribed opioid medications for Patient I, based on her purported earlier usage of such medications;

b. the Respondent failed to establish or document establishing an objective pathological basis for providing long-term opioid therapy;

c. the Respondent did not establish or document establishing a comprehensive treatment plan to treat Patient I other than providing long-term, frequent prescriptions of opioid medications;

d. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, substantiation of prior opiate usage, social and psychiatric history, or obtain Patient I's prior medical records;

e. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

f. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

g. the Respondent did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term opioid therapy;

h. the Respondent facilitated Patient I's misuse/dependency/habituation to opiates;

i. the Respondent prescribed opioid medications and benzodiazepines without an accompanying office visit;

j. the Respondent prescribed opioid medications and benzodiazepines without establishing or documenting establishing medical justification for their continued use;

k. the Respondent failed to provide or document providing timely monitoring and assessment of Patient I's response to opioid therapy or possible abuse;

l. the Respondent failed to appropriately treat Patient I other than providing escalating amounts of opiates;

m. the Respondent failed to implement or document implementing medication contracts in view of his continued opiate prescribing;

n. the Respondent failed to reconcile Patient I's medications from visit to visit; and

o. the Respondent failed to keep adequate documentation in Patient I's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

Patient J

98. Patient J, then a 38-year old man, first saw the Respondent on four visits in 1997 for obesity. The Respondent treated Patient J with the stimulant combination phentermine and Pondimin (fenfluramine). In the notes for these visits, the Respondent diagnosed Patient J with exogenous obesity but did not document Patient J's actual weight.

99. Patient J next returned to see the Respondent in December 2003, with complaints of back pain. The Respondent noted that Patient J underwent spinal fusion surgery in 1986, diagnosed him with fibromyositis, and prescribed Vicodin and Flexeril.

100. Patient J next returned to see the Respondent in May 2007. The Respondent noted what appears to be, "Back MD gave Rx hydrocodone." The Respondent diagnosed Patient J with hypertension and back strain and prescribed Vicodin, Flexeril, phentermine and phendimetrizine.

101. From this point onward, Patient J saw the Respondent at roughly monthly intervals. During these visits, the Respondent provided escalating numbers of Vicodin prescriptions. By 2008, the Respondent was providing Patient J with about 100 tablets of Vicodin per month, in addition to phentermine.

102. In April 2009, the Respondent noted that he had a discussion with Patient J about medications, but the note is largely illegible. The Respondent's diagnosis for this visit appears to be "case management." In another visit in April 2009, the Respondent noted what appears to be "pain management."

103. During 2009, Patient J's blood pressure was noted to be significantly elevated. In addition, laboratory studies showed various abnormalities (*e.g.*, elevated triglycerides). During 2009, the Respondent continued to prescribe phentermine and opiates, including Lorcet and perhaps Methadone.

104. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient J, for reasons including but not limited to the following:

a. the Respondent inappropriately addressed and treated or documented addressing and treating Patient J's hypertension;

b. the Respondent inappropriately prescribed stimulant medications to Patient J for an extended period of time, without proper informed consent;

c. the Respondent inappropriately prescribed stimulant medications to Patient J, who had significant hypertension;

d. the Respondent failed to address or document addressing laboratory abnormalities;

e. the Respondent did not establish or document establishing a comprehensive treatment plan for Patient J other than providing long-term, frequent prescriptions of opioid medications;

f. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history, or obtain Patient J's prior medical records;

g. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

h. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

i. the Respondent did not attempt a trial of non-narcotic medications or other treatment modalities prior to resorting to long-term opioid therapy;

j. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

k. the Respondent failed to provide or document providing timely monitoring and assessment of Patient J's response to opioid therapy or possible abuse;

l. the Respondent failed to appropriately treat Patient J other than providing long-term opioid therapy;

m. the Respondent did not adequately investigate or document his investigation of what medications Patient J's health care providers were also prescribing, or coordinate his prescribing practices with those other providers;

n. the Respondent failed to implement or document implementing medication contracts in view of his long-term opiate prescribing;

o. the Respondent failed to reconcile Patient J's medications from visit to visit; and

p. the Respondent failed to keep adequate documentation in Patient J's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

Patient K

105. In a letter to the Board, dated August 21, 2009, the Respondent stated that he had treated Patient K for 40 years, describing her as growing up in a family with "drug problems." The Respondent stated that she had "many physical complaints" for which he treated her with "low dose pain control." The Respondent stated that Patient K was a "fully functional productive person with her treatment."

106. The Respondent supplied office records for Patient K that go back to 1992 and extend into 2009. In 1992, the Respondent diagnosed Patient K with anxiety and treated her with Valium. Over the treatment period, the Respondent continued to prescribe Valium and other benzodiazepines—sometimes in combination--for Patient K. The Respondent also prescribed other medications, including opioids, such as Percocet and Vicodin; Ritalin, a stimulant medication commonly prescribed for attention deficit/hyperactivity disorder ("ADHD"); Ambien, a sedative/hypnotic; Vitamin B12; and Cialis, a drug used to treat male erectile dysfunction. The Respondent did not document a reason for prescribing Cialis to Patient K, a female. The Respondent also prescribed various stimulant weight loss medications, including phentermine and Pondimin.

107. In October 2007, Patient K saw the Respondent for influenza and pneumonia vaccines and an "ear check," for which the Respondent prescribed Vicodin ES, although the number of pills provided is not legible. Patient K then

received two additional refills of Vicodin (90 tablets) in November and December 2007, without an accompanying office visit/note.

108. In January 2008, the Respondent performed a Department of Transportation physical examination and diagnosed Patient K with ADHD. The Respondent's office note for this date is largely illegible and does not document his basis for making this diagnosis. The Respondent maintained Patient K on maintenance Ritalin until the final entry in her chart in August 2009.

109. On about a monthly basis from 2007 to 2009, Patient K received prescriptions for various drugs (*e.g.*, Ritalin ES, Valium 5 mg, Vicodin, Klonopin 0.5 mg, and Ambien 10 mg), with infrequent office visits. The Respondent did not document a clear indication of what he was treating with maintenance narcotics, multiple benzodiazepines, or why he prescribed an erectile dysfunction drug to Patient K, a female.

110. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient K, for reasons including but not limited to the following:

a. the Respondent failed to document Patient K's chronic medical conditions;

b. the Respondent inappropriately prescribed stimulant weight loss medications to Patient K for an extended period of time, without proper informed consent;

c. the Respondent failed to establish or document establishing his diagnosis of ADHD;

d. the Respondent diagnosed Patient K with ADHD without clear indication;

e. the Respondent inappropriately prescribed stimulant medications (*i.e.*, Ritalin) without confirming a basis for such prescribing;

f. the Respondent did not establish an appropriate medical indication for prescribing long-term opioid therapy;

g. the Respondent did not establish or document establishing a comprehensive treatment plan for Patient K other than providing long-term opioid therapy;

h. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history, or obtain Patient K's prior medical records;

i. the Respondent noted conflicting drug allergies (*e.g.*, NKA (no known allergies) and sulfa);

j. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

k. the Respondent failed to perform or document performing physical examinations. When the Respondent did perform physical examinations, he failed to perform or document performing them in an appropriate manner;

l. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

m. the Respondent did not undertake or document undertaking alternatives to long-term opioid therapy;

n. the Respondent failed to provide or document providing timely monitoring and assessment of Patient K's response to opioid therapy or possible abuse;

o. the Respondent provided early refills of opioid medications without documentation of the basis for the early refill;

p. the Respondent failed to order objective diagnostic studies to support his prescribing of long-term opioid therapy;

q. the Respondent provided long-term opioid therapy without appropriate follow-up visits/monitoring;

r. the Respondent failed to implement or document implementing medication contracts in view of his long-term opiate prescribing;

s. the Respondent inappropriately prescribed benzodiazepines;

t. the Respondent failed to reconcile Patient K's medications from visit to visit;

u. the Respondent failed to keep adequate documentation in Patient K's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications;

v. the Respondent inappropriately prescribed an erectile dysfunction drug to Patient K, a female; and

w. the Respondent failed to document a rationale for prescribing an erectile dysfunction drug to Patient K, a female.

Patient L

111. In a letter to the Board, dated August 21, 2009, the Respondent stated that he initially treated Patient L when she was a teenager, and that "[s]he was a problem to her parents at that time." The Respondent stated that Patient L came back to his practice in 2008 with neck/back pain. He stated that he examined her and did a diagnostic work up and "found no symptom problem." He further stated that "pain was always a problem" and that in early 2009 he received information that she was "doctor shopping." The Respondent stated that he last treated Patient L in February 2009, during which time "she did not get pain treatment ...."

112. The Respondent's chart for Patient L contains a medical history form, dated June 11, 2008, that Patient L completed, and laboratory studies from

that date. The Respondent's chart does not contain an office note for this date, however.

113. Patient L, then 38-years old, saw the Respondent on October 9, 2008, with complaints of a "bad persistent cough." The Respondent diagnosed Patient L with HNP, cough and a third word that is illegible, and prescribed 100 tablets of Percocet.

114. Patient L returned in November 2008, with a cough. The Respondent diagnosed Patient L with cough, muscle spasm and DJD spine. The Respondent prescribed a variety of medications on this visit, including 100 tablets of Percocet, diazepam (Valium), Xanax, and Adderall, a stimulant drug used to treat ADHD. The Respondent prescribed other medications that are illegible.

115. Patient L returned in December 2008, with complaints of UTI (urinary tract infection) and other complaints that are illegible. The Respondent prescribed Percocet, Adderall, Cipro and another illegible medication.

116. Patient L returned in January 2009, with complaints of a sore throat. The Respondent prescribed Xanax, Adderall, Zithromax, an antibiotic, and oxycodone.

117. Patient L returned in February 2009, with complaints of a UTI. The Respondent prescribed 28 tablets of 500 mg Cipro, to be taken twice a day, and Pyridium, a UTI medication. The Respondent did not document in this note that Patient L was "doctor shopping," which he stated he was aware of in his August 21, 2009, letter to the Board.

118. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22), and failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40), with respect to Patient L, for reasons including but not limited to the following:

a. the Respondent failed to take or document taking an appropriate medical history including a history of present illness, prior opiate usage, social and psychiatric history, or obtain Patient L's prior medical records;

b. the Respondent's medical records are cursory and often illegible, and frequently do not contain essential elements of a medical record, including an assessment and treatment plan;

c. the Respondent did not adequately document his plan for re-evaluating Patient L;

d. the Respondent prescribed opiates to Patient L under inappropriate circumstances;

e. the Respondent prescribed opiates or other CDS without a documented reason (*e.g.*, Xanax and Adderall for chief complaints of sore throat or UTI; oxycodone with no objective findings);

f. the Respondent prescribed opiate medications without determining objective findings for such prescribing, or based solely on Patient L's request for such medications;

g. the Respondent prescribed opioid medications without establishing or documenting establishing medical justification for their continued use;

h. the Respondent failed to provide or document providing timely monitoring and assessment of Patient L's response to opioid therapy or possible abuse;

i. the Respondent failed to establish or document establishing his diagnosis of ADHD;

j. the Respondent inappropriately prescribed stimulant medications (*i.e.*, Adderall) without confirming a basis for such prescribing;

k. the Respondent failed to perform or document performing physical examinations in an appropriate manner;

l. the Respondent failed to reconcile Patient L's medications from visit to visit;

m. the Respondent failed to document Patient L's purported "doctor shopping"; and

n. the Respondent failed to keep adequate documentation in Patient L's medical record with respect to medication prescribing, including potential drug-drug interactions, side effects, and prior responses to the medications.

CONCLUSIONS OF LAW

Based on the foregoing investigative facts, the Board concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(2009 Repl. Vol.).

ORDER

It is this 10th day of June 2010, by a majority of the quorum of the Board:

ORDERED that pursuant to the authority vested by Md. State Gov't Code Ann. §10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland is hereby **SUMMARILY SUSPENDED**; and it is further

ORDERED that a post-deprivation hearing in accordance with Code of Maryland Regulations tit. 10, § 32.02.05.B(7), C and E on the Summary Suspension has been scheduled for **Wednesday, June 23, 2010 at 1:00 p.m**, at the Maryland State Board of Physicians, 4201 Patterson Avenue, Room 108, Baltimore, Maryland 21215-0095; and it is further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before the Board, the Respondent, if dissatisfied with the result of the hearing, may, within ten (10) days, request an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an administrative law judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and it is further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's investigator the following items:

(1) his original Maryland License D01923;

(2) his current renewal certificate;

(3) DEA Certificate of Registration, # AF2554029 (exp. 09/30/11);

(4) Maryland Controlled Dangerous Substance Registration, # M03579 (exp. 09/30/10);

(5) All controlled dangerous substances in his possession and/or practice;

(6) All Medical Assistance prescription forms;

(7) All prescription forms and pads in his possession and/or practice; and

(8) Any and all prescription pads on which his name and DEA number are imprinted.

AND IT IS FURTHER ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Health Occ. Code Ann. § 14-407 (2009 Repl. Vol.); and it is further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol.)

6/10/10
Date

John T. Papavasiliou
Deputy Director
Maryland State Board of Physicians