IN THE MATTER OF	*	BEFORE THE
MARTIN W. GALLAGHER JR., M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License Number: D31880	*	Case Numbers: 2010-0659 & 2010-0745

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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 Martin W. Gallagher, M.D. (the Respondent") (D.O.B. 08/16/1937), License Number D31880, 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)(2)(i) (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 and the Office of the Attorney General, including the instances described below, the Board has reason to believe that the following facts are true:[1]

[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 with this matter.

PROCEDURAL BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on January 30, 1985.

2. At the time of the incidents described herein, the Respondent, an internist, was in private practice in Hagerstown, Maryland. His practice was limited to "people addicted to opiates and alcohol."

3. On or about March 11, 2010, the Board opened an investigation of the Respondent based on a complaint received from a pharmacist at Pharmacy A,[2] alleging an increase in the Respondent's Controlled Dangerous Substance ("CDS") prescriptions and questioning the legitimacy. (MBP Case # 2010-0659)

4. On or about April 6, 2010, the Board received a second complaint from an anonymous source alleging in part that the Respondent was prescribing a large amount of narcotics, including issuing prescriptions to addicts. (MBP Case # 2010-0745)

5. On or about May 7, 2010, the Board notified the Respondent of its investigation in Case # 2010-0659, requested a written response to the allegations, subpoenaed six medical records and requested summaries of care on the six patients.

6. On or about June 15, 2010, the Respondent, through his attorney, submitted a response to the complaint and the medical records and provided summaries of care.

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[2] For purposes of confidentiality, the names of facilities and patients will not be used in this document, but will be provided to the Respondent on request.

7. On or about August 11, 2010, the Board notified the Respondent of its investigation in Case # 2010-0745, requested a written response to the allegations, subpoenaed six additional medical records and requested summaries of care on the six additional patients. On or about September 10, 2010, the Board received the records.

8. In furtherance of its investigation, on or about December 29, 2011, the Board transmitted the 12 patient records and other relevant documents to Permedion, a formal peer review organization, requesting that an expedited peer review be conducted. Permedion assigned the peer review to two physicians board-certified in internal medicine (hereinafter, the "peer reviewers"). The peer reviewers concurred that the Respondent failed to meet the standard of quality medical care in 10 of the 12 records reviewed, and that his documentation was inadequate in all 12 of the records reviewed.

9. On or about January 31, 2012, copies of the peer review reports were sent to the Respondent, through his attorney, providing him an opportunity for a supplemental response to the peer reviewers' opinions. To date, the Respondent has not filed a supplemental response.

10. As a result of the peer review as set forth in pertinent part below, the Board voted to summarily suspend his license to practice medicine pursuant to Md. State Gov't Code Ann. § 10-226(c)(2)(i) (2009 Repl. Vol.), concluding that the public health, safety or welfare imperatively requires emergency action.

PEER REVIEW

FOCUS OF THE PEER REVIEW

The peer reviewers evaluated patient records and related documents for 12 separate patients. The focus of the peer review included but was not limited to the following factors:

1. appropriately prescribing medications (type and dosage) to patients;
2. appropriately prescribing CDS to patients with drug seeking behavior and/or who are known addicts;
3. appropriately documenting treatment, prescriptions and any referrals to other health care practitioners;
4. continuous proper monitoring and follow-up, including but not limited to appropriate lab work and appropriate consultations;
5. adequately assessing the continued need for narcotics or evaluation of possible abuse and/or compliance;
6. appropriately prescribing Suboxone to patients for the purpose of treating the patients for withdrawal from narcotics; and
7. whether the Respondent's documentation was adequate, thorough and timely.

SUBOXONE PRESCRIBING

Suboxone is a partial opioid agonist used to treat opioid addiction. The standard of quality medical care for a Suboxone provider should include but is not limited to the following:

a. A relationship with a mental health facility because psychosocial therapy is a critical component of successful addiction treatment;
b. Laboratory monitoring of blood and urine prior to initiation of therapy and for ongoing monitoring to include liver function tests every six months or more frequently if the patient is Hepatitis C positive;
c. Close monitoring of patients to ensure appropriate dosing; and
d. Screening of patients for abuse to include modalities such as random urine toxicology screening and pill counts.

STANDARD OF QUALITY MEDICAL CARE AND RECORD-KEEPING

The peer reviewers concurred as to the following patient specific allegations:

PATIENT 1

11. The Respondent treated Patient 1, a male, DOB 1967, for chronic pain management between November 2009 and April 2010. He had a history of chronic back pain after a fall and spinal fusion surgery, alcoholism, bipolar disorder, attention deficit hyperactivity disorder ("ADHD"), generalized anxiety disorder and Hepatitis C.

12. The Respondent treated Patient 1 with several CDS including oxycodone, OxyContin, methadone[3] and Xanax.[4]

13. By Patient 1's second visit, the Respondent was prescribing large dosages of OxyContin and oxycodone without having obtained previous medical records regarding Patient 1's history or narcotic analgesic requirement.

14. The Respondent disregarded (by continuing to prescribe CDS) several indications that Patient 1 was diverting or abusing the prescribed CDS including: 1) Patient 1 reported losing his medication on two occasions (12/1/09 and 4/14/10) and the Respondent issued new prescriptions; and 2) on or about December 12, 2009, a pharmacist sent the Respondent a note indicating Patient 1 had misrepresented that he had no insurance when he was covered, and paid cash for his prescription; and that Patient 1 had gone to multiple pharmacies and doctors for CDS prescriptions.

15. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 1 for reasons including but not limited to the following:

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[3] Oxycodone, OxyContin and morphine are Schedule II CDS.
[4] Xanax is a Schedule IV benzodiazepine.

a. The Respondent failed to refer Patient 1 to a formal pain management specialist despite his history of Hepatitis C, psychiatric history and history of addiction (alcoholism);
b. The Respondent failed to document any concerns about drug abuse or addiction;
c. The Respondent failed to discuss or document that he had discussed with Patient 1 analgesic modalities other than CDS;
d. The Respondent failed to adequately monitor Patient 1's use of the prescribed medication through urine drug screening;
e. Patient 1 did not enter into a pain management contract with the Respondent;
f. The Respondent failed to adequately address Patient 1's psychiatric history in his record;
g. The Respondent failed to perform a comprehensive physical examination or to consistently perform a focused physical examination for Patient 1 when prescribing CDS;
h. The Respondent failed to consistently document the names and quantities of CDS prescribed; and
i. The Respondent consistently failed to document the source of Patient 1's pain, scale and mitigation.

PATIENT 2

16. The Respondent treated Patient 2, a male, DOB 1952, for chronic pain between October 2009 and May 2010. Patient 2 had a history of a traumatic leg amputation in a motor vehicle accident, a methicillin-resistant staph aureus (MRSA) infection and required surgery in July 2009 to revise his stump. Additionally, he had a history of Hepatitis C.

17. The Respondent prescribed pain medications including oxycodone and OxyContin to Patient 2 primarily for postoperative pain relating to his leg amputation and revision of his stump and phantom limb pain.

18. The Respondent's prescribing of oxycodone quickly accelerated to a very high level. Within two visits, he prescribed 160 mg of OxyContin daily and up to 120 mg of oxycodone for breakthrough pain.

19. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 2 for reasons including but not limited to the following:

    a. The Respondent failed to monitor Patient 2's laboratory studies, despite his history of Hepatitis C;
    b. The Respondent failed to adequately document the amounts of CDS he was prescribing for Patient 2;
    c. The Respondent failed to document any communication with Patient 2's orthopedic surgeon who was concurrently treating him;
    d. The Respondent failed to adequately document Patient 2's history of addiction;
    e. The Respondent's documentation is partially illegible;
    f. Patient 2 did not enter into a pain management agreement with the Respondent;
    g. The Respondent failed to adequately monitor Patient 1's use of the prescribed medication through urine drug screening;
    h. The Respondent failed to discuss and/or document the consideration of other analgesic modalities with Patient 2;
    i. The Respondent failed to document a comprehensive physical examination for Patient 2; and
    j. The Respondent failed to formulate a clear treatment plan.

PATIENT 3

20. The Respondent treated Patient 3, a male, DOB 1960, for "shoulder pain." He treated Patient 3 with large doses of oxycodone and OxyContin for three months between January and April 2010. The Respondent prescribed 40 mg OxyContin three to four times daily and 30-60 mg of oxycodone every four to six hours daily.

21. On or about May 6, 2010, Patient 3 stopped taking his oxycodone and OxyContin, and experienced withdrawal symptoms; the Respondent began prescribing Suboxone.

22. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 3 for reasons including but not limited to the following:

a. The Respondent treated Patient 3 with large doses of narcotics without obtaining an adequate history and physical examination;
b. The Respondent failed to make adequate attempts to diagnose Patient 3 before treating him with large doses of narcotics;
c. The Respondent failed to conduct any urine monitoring to evaluate possible abuse or compliance with prescribed narcotics;
d. The Respondent failed to adequately document Patient 3's medications;
e. Patient 3 did not enter into a pain management agreement with the Respondent;
f. When prescribing Suboxone, the Respondent failed to refer Patient 3 for appropriate therapy, failed to conduct adequate laboratory testing, failed to closely monitor him to ensure appropriate dosing and failed to conduct urine monitoring and other modalities to evaluate possible Suboxone abuse;
g. The Respondent's records were partially illegible; and
h. The Respondent failed to document a comprehensive problem list.

PATIENT 4

23. The Respondent treated Patient 4, a male, DOB 1961, for chronic neck and shoulder pain, between September 2009 and May 2010. Patient 4 had a history of cervical post laminectomy syndrome and chronic left shoulder pain after undergoing surgery, and a history of anxiety/depression and multiple psychosocial stressors.

24. In March 2009, a pain management center discharged Patient 4 after he violated his narcotics contract by obtaining narcotics prescriptions from other physicians.

25. On April 14, 2009, the Respondent noted that he was "going to need to refer [Patient 4] to another pain management group."

25. The Respondent prescribed several different CDS including narcotics and benzodiazepines for Patient 4 such as oxycodone, OxyContin, Klonopin[5] and

[5] A Schedule IV benzodiazepine.

Ambien.[6] The Respondent also prescribed several non-CDS medications for Patient 4 including Cialis, Viagra, Atarax,[7] Levitra[8] and Seroquel.[9]

26. The Respondent's rapidly accelerated his prescription of OxyContin and oxycodone to Patient 4; he prescribed 160 mg of OxyContin daily and up to 180 mg of oxycodone for breakthrough pain.

27. The Respondent disregarded (by continuing to prescribe CDS) several indications that Patient 4 was diverting or abusing the prescribed CDS, including Patient 4's requests for early refills of his CDS from the Respondent on several occasions.

28. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 4 for reasons including but not limited to the following:

    a. The Respondent failed to document a clear treatment plan for Patient 4;
    b. The Respondent's records were partially illegible;
    c. The Respondent failed to conduct proper monitoring for Patient 4 including obtaining the appropriate laboratory studies and consultations;
    d. The Respondent failed to conduct any urine monitoring for Patient 4 to evaluate for compliance with narcotics use;
    e. The Respondent treated Patient 4 with narcotics and benzodiazepines without an attempt to treat his pain with non-narcotic modalities;
    f. The Respondent failed to adequately address Patient 4's issues with addiction;
    g. Patient 4 did not enter into a pain management agreement with the Respondent;
    h. The Respondent failed to discuss any alternative non-narcotic analgesic modalities with Patient 4; and
    i. The Respondent failed to adequately document a medication list for Patient 4.

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[6] A Schedule IV sedative.
[7] Used in the treatment of anxiety disorders.
[8] Cialis, Viagra and Levitra are used in the treatment of erectile dysfunction.
[9] Used in the treatment of bipolar disorders.

PATIENT 5

29. The Respondent treated Patient 5, a male, DOB 1964, for back pain between December 2009 and May 2010, following a former motor vehicle accident. He had a history of bipolar disorder.

30. The Respondent prescribed extremely high quantities of OxyContin and oxycodone to Patient 5 over a six month period, without formulating a clear treatment plan. The Respondent prescribed at some points, 80 mg of OxyContin four times daily with 180 mg of oxycodone for breakthrough pain (for a total of 500 mg daily). The Respondent saw Patient 5 on a monthly basis and refilled his CDS prescriptions.

31. During Patient 5's second visit, on December 22, 2009, he reported his medications had been stolen. The Respondent issued Patient 5 another prescription.

32. On another occasion, on February 18, 2010, a physician provider contacted the Respondent's practice with concern regarding Patient 5's OxyContin usage.

33. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 5 for reasons including but not limited to the following:

    a. The Respondent failed to conduct adequate physical or neurological examinations to evaluate Patient 5's pain source or to elicit an adequate medical history;
    b. Patient 5 did not enter into a pain management contract with the Respondent;
    c. The Respondent failed to conduct any urine monitoring or any other modality to evaluate possible abuse or compliance with narcotics;
    d. The Respondent failed to conduct proper monitoring for Patient 5 including obtaining the appropriate laboratory studies;

e. The Respondent failed to discuss or explore any alternative non-narcotic analgesic modalities with Patient 5;
f. The Respondent failed to formulate a clear treatment plan for Patient 5 regarding the prescribing of his narcotic medications; and
g. The Respondent's medical records were partially illegible.

PATIENT 6

34. The Respondent treated Patient 6, a female, DOB 1978, for pain management from August 2009 through August 2010. Patient 6 had a history of an ankle fracture with persistent pain, kidney stones and psychosocial stressors. She was also followed by urology and nephrology for her kidney stones. Additionally, her record indicated a history of Crohn's disease. Patient 6 had a documented history of opiate abuse and had previously been on Suboxone.

35. The Respondent treated Patient 6 with large amounts of narcotic analgesics on an ongoing basis including oxycodone and OxyContin. The treatment was for presumed renal colic and foot pain following a fracture.

36. Beginning on September 1, 2009, the Respondent also intermittently prescribed Suboxone for Patient 6.

37. On March 16, 2010, Patient 6 reported she lost her prescription written for oxycodone 30 mg.

38. A June 9, 2010 letter in the Respondent's records for Patient 6 from Dr. T, a primary care provider, noted that Patient 6 had been discharged from Dr. T's practice as she had made false statements regarding scheduled appointments.

39. On June 16, 2010, the Respondent documented that Patient 6 had been injecting herself with heroin as the Suboxone did not help. He noted that other physicians had dropped her from their practices because she admitted to taking drugs. The

Respondent documented that he prescribed six oxycodone daily for a week, as he did not want her to take heroin.

40. On June 22, 2010, the Respondent noted that Patient 6 had been discharged from her urologist's practice. He provided her with another prescription for oxycodone.

41. On July 14, 2010, the Respondent documented that he had received notification that Patient 6's primary care physician had prescribed oxycodone for her. When the primary care physician found out Patient 6 had an addiction problem, he discharged her from his practice.

42. On July 20, 2010, the Respondent refilled Patient 6's Suboxone prescription.

43. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 6 for reasons including but not limited to the following:

    a. The Respondent prescribed large amounts of narcotics to a patient with a known addiction without substantiating her complaints through an adequate physical evaluation;
    b. Patient 6 did not enter into a pain management contract with the Respondent;
    c. The Respondent failed to conduct any urine monitoring or any other modality to evaluate possible abuse or compliance with narcotics;
    d. The Respondent failed to coordinate Patient 6's care with her other health care providers;
    e. The Respondent failed to refer Patient 6 for an orthopedic evaluation for her ankle pain;
    f. The Respondent's medical records were partially illegible;
    g. The Respondent failed to document a treatment plan, medication list or face sheet for Patient 6; and
    h. When prescribing Suboxone, the Respondent failed to refer Patient 6 for appropriate therapy, failed to closely monitor her to ensure appropriate dosing and failed to conduct urine monitoring and other modalities to evaluate possible Suboxone abuse.

PATIENT 7

44. The Respondent treated Patient 7, a male, DOB 1982, from December 2009 through July 2010, for complaints of chronic back pain of unclear etiology.

45. The Respondent prescribed large amounts of oxycodone to Patient 7 for pain during an eight month period; he prescribed 30 mg 4-6 times daily.

46. On February 9, 2010, Patient 7 reported that he lost his narcotic medication in a pile of snow, and on April 15, 2010, he reported that his medications had been stolen from a hotel room in North Carolina. The Respondent provided replacement prescriptions on both occasions.

47. On or about June 8, 2010, the Respondent ordered an MRI of Patient 7's back. The results were nonspecific/benign, yet the Respondent used an "abnormal MRI" as a justification to prescribe oxycodone. The Respondent ultimately referred Patient 7 to a neurosurgical practice.

48. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 7 for reasons including but not limited to the following:

    a. Patient 7 did not enter into a pain management contract with the Respondent;
    b. The Respondent failed to conduct any urine monitoring or any other modality to evaluate possible abuse or compliance with narcotics;
    c. The Respondent's medical records were partially illegible;
    d. The Respondent misinterpreted Patient 7's MRI and used it as a justification to continue to prescribe oxycodone;
    e. The Respondent failed to document a treatment plan, medication list or face sheet for Patient 7; and
    f. The Respondent failed to order/document laboratory testing.

PATIENT 8

49. The Respondent treated Patient 8, a male, DOB 1978, from June 2009 through August 2010 with Suboxone for opiate addiction, and with medications (methylphenidate)[10] for Attention Deficit Disorder ("ADD").

50. The Respondent's documentation was inadequate for Patient 8 for reasons including but not limited to the following:

    a. The Respondent failed to document a clear medical history;
    b. The Respondent failed to document a treatment plan, medication list or face sheet for Patient 8; and
    c. The records were partially illegible.

PATIENT 9

51. The Respondent treated Patient 9, a female, DOB 1962, between June 2009 and August 2010, for chronic back pain and neuropathic pain. When Patient 9 initially presented to the Respondent in 2009 for pain management, she was taking two Percocet four times daily for pain. She was on multiple medications including Coumadin (an anticoagulant), Lopid (cholesterol lowering medication), lisinopril (used in the treatment of hypertension), glipizide (used in the treatment of Type 2 diabetes), Humalog (a type of insulin), Singulair (used in the treatment of asthma), Lunesta(a sleep aid), albuterol (used in the treatment of asthma), Advair (used in the treatment of asthma), ranitidine (used in the treatment of ulcers), Xanax, Wellbutrin XL (used in the treatment of depression), and Flexeril (a muscle relaxant).

52. Initially, the Respondent treated Patient 9 with large quantities of Percocet and Valium[11] and later with oxycodone and OxyContin.

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[10] Schedule II CDS.

53. Patient 9's June 2009 MRI of the lumbar spine did not show significant disease and her nerve conduction study showed mild diabetic neuropathy. The Respondent, however, increased Patient 9's oxycodone dose to 30 mg four to six times daily.

54. On the following dates, Patient 9 requested that her oxycodone prescriptions be filled early: April 27, 2010, May 20, 2010 and July 8, 2010. The Respondent provided her with refills.

55. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 9 for reasons including but not limited to the following:

    a. The Respondent failed to conduct and/or document a physical examination for Patient 9;
    b. Patient 9 did not enter into a pain management contract with the Respondent;
    c. The Respondent failed to conduct any urine monitoring or any other modality to evaluate possible abuse or compliance with narcotics;
    d. The Respondent failed to document any discussion with Patient 9 regarding addiction issues;
    e. The Respondent failed to discuss or explore any alternative non-narcotic analgesic modalities with Patient 9;
    f. The Respondent's records were partially illegible;
    g. The Respondent failed to document a clear treatment plan, medication list or face sheet for Patient 9;
    h. The accelerated prescribing of oxycodone was not supported by the objective findings for Patient 9; and
    i. The Respondent failed to include any documentation of Patient 9's care by other physicians.

PATIENT 10

56. The Respondent treated Patient 10, a female, DOB 1969, between September 2009 and May 2010, for chronic back pain. She had a history of degenerative

[11] Schedule IV benzodiazepine.

joint disease, endometriosis, anxiety, insomnia and an admitted addiction to prescription drugs.

57. The Respondent initially treated Patient 10 with Suboxone for her drug addiction, and shortly thereafter began treating Patient 10 with large quantities of oxycodone to treat her pain.

58. On an undated laboratory slip, the Respondent ordered a urine toxicology screen for opiates for Patient 10, but there are no results noted in the chart.

59. On November 26, 2009, the Respondent received notice from a prescription company that Patient 10 had been receiving addictive substances from two or more providers. The printout reflected that she had been receiving oxycodone from Dr. R and Percocet from Drs. Y and T in October and November 2009.

60. On December 15, 2009, Dr. R contacted the Respondent to inform him that he had been prescribing oxycodone and Suboxone to Patient 10. Dr. R discharged Patient 10 from his practice.

61. On December 30, 2009, a pharmacy notified the Respondent about a police report having been filed regarding oxycodone prescriptions. Also on that date, Patient 10 reported her medications had been stolen and requested a new prescription.

62. On December 31, 2009, Patient 10 requested another prescription for oxycodone as the pharmacy would not honor the prescription for the "rest of the pills." The Respondent provided her with an additional prescription.

63. On January 12, 2010, the Respondent documented Patient 10 was "out of pain meds."

64. On January 26, 2010, the Respondent documented that Patient 10 had an "inclination" to "use more [CDS] than written for" and questioned whether she was using the medications for pain or whether she was "selling pills?"

65. On February 3, 2010, the Respondent documented that Patient 10's pain management referral had been scheduled for the end of April. There is no documentation in her chart that she complied.

66. On or about March 23, 2010, a pharmacist wrote the Respondent a note telling him to watch Patient 10 as she requested her oxycodone be filled six days early, she wanted the prescription filled for cash and "she runs around all over for meds." The Respondent continued to prescribe CDS to Patient 10 after this notification.

67. On March 23, 2010, Patient 10 reported her medications were stolen.

68. On April 22, 2010, the Respondent documented that Patient 10 went through 240 tablets of 30 mg oxycodone in two weeks and characterized this as "excessive use." The Respondent documented that she "needs referral" to pain management. There is no evidence that she complied.

69. On May 13, 2010, the Respondent began prescribing Suboxone again.

70. On June 24, 2010, the Respondent documented that he had referred Patient 10 to a pain specialist; however, there is no evidence in the chart that she complied.

71. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 10 for reasons including but not limited to the following:

    a. Despite admitted drug abuse and continued signs of possible diversion and/or abuse, the Respondent continued to prescribe for Patient 10

without any monitoring or any other modality to evaluate possible abuse or compliance with narcotics;

b. The Respondent failed to make any referrals to addiction specialists or psychiatrists for Patient 10;

c. The Respondent failed to document a clear treatment plan or medication list for Patient 10;

d. The Respondent prescribed increasingly larger amounts of CDS but failed to document why Patient 10 had worsening pain;

e. Patient 10 did not enter into a pain management contract with the Respondent;

f. The Respondent's records were partially illegible; and

g. The Respondent failed to conduct and/or document a physical examination for Patient 10.

PATIENT 11

72. The Respondent treated Patient 11, a male, DOB 1967, between December 2009 and June 2010, for lower back pain. During Patient 11's initial visit with the Respondent on December 3, 2009, he admitted to selling prescription drugs in the past, and buying prescription drugs from his mother. He had a history of ADHD.

73. The Respondent ordered an MRI for Patient 11, documented that he received a CD of the results and referred him to a spine center.

74. The Respondent prescribed oxycodone to Patient 11 for several months through June 2010.

75. On June 1, 2010, Patient 11 presented in withdrawal and the Respondent prescribed a smaller amount of oxycodone. He told Patient 11 that any further prescriptions would be for Suboxone. Patient 11 did not return.

76. The Respondent's documentation was inadequate for Patient 11 for reasons including but not limited to the following:

a. The Respondent's records were partially illegible;

b. The Respondent failed to document an adequate physical examination;

c. The Respondent failed to document any laboratory work; and
d. The Respondent failed to document a medication list.

PATIENT 12

77. The Respondent treated Patient 12, a male, DOB 1966, for pain management between March 2009 and August 2010, for his back. Patient 12 had a history of a lumbar fusion. He had a history of alcohol and crack cocaine abuse.

78. The Respondent prescribed OxyContin and methadone to Patient 12 for pain control.

79. On March 18, 2009, during Patient 12's first visit, the Respondent noted that past trials of Suboxone as a treatment for chronic pain had failed, and prescribed opiates to him "with the understanding he would be seen by pain management."

80. The Respondent prescribed large amounts of OxyContin and methadone to Patient 12. Previously, Patient 12 had seen another pain provider and had been prescribed Mobic[12] and Tramadol[13] with "good" pain control. The Respondent escalated to 160-240 mg of OxyContin daily with no documented clinical change that would necessitate an increase in CDS prescription.

81. The Respondent referred Patient 12 to a pain management specialist, but there is no evidence in the record that he complied.

82. On December 15, 2009, the Respondent documented that Patient 12 had been having "problems [with] meds." The Respondent's handwriting is partially illegible, but he documented in part, "rewrote rx."

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[12] Non-steroidal anti-inflammatory drug.
[13] Analgesic non-controlled by DEA. It is considered a controlled substance by only two states, Arkansas and Kentucky.

83. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 12 for reasons including but not limited to the following:

   a. The Respondent failed to perform adequate urine monitoring or any other modality to evaluate possible abuse or compliance with narcotics;
   b. Patient 12 did not enter into a pain management contract with the Respondent;
   c. The Respondent failed to discuss or explore any alternative non-narcotic analgesic modalities with Patient 12;
   d. The Respondent continued to prescribe CDS to Patient 12 despite his history of alcohol and crack cocaine abuse;
   e. The Respondent's records were partially illegible;
   f. The Respondent failed to conduct or document a physical examination for Patient 12; and
   g. The Respondent failed to obtain/document any laboratory work.

CONCLUSION OF LAW

Based on the foregoing 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) (i) (2009 Repl. vol.).

ORDER

Based on the foregoing, it is this 17th day of April, 2012, 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 be and is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation hearing in accordance with Code Md. Regs. tit. 10, § 32.02.05.B (7) (c), D and E on the Summary Suspension has been scheduled for **April 25, 2012**, at **3:00 p.m.**, at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it 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 request within ten (10) days 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 be it further

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

(1) the Respondent's original Maryland License D31880;

(2) the Respondent's current renewal certificate;

(3) the Respondent's Maryland Controlled Dangerous Substance Registration;

(4) all controlled dangerous substances in the Respondent's possession and/or practice;

(5) all Medical Assistance prescription forms:

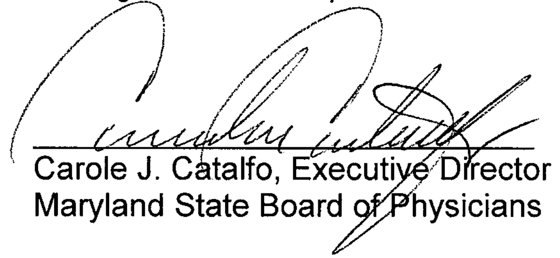
(6) all prescription forms and pads in his possession and/or practice; and

(7) Any and all prescription pads on which his name and DEA number are imprinted; and be it 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 be it 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.*

4-17-12
Date



Carole J. Catalfo, Executive Director
Maryland State Board of Physicians