IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JANET L. WASSON, M.D.	*	**STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License Number: D44979	*	**Case Number: 7715-0064A**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Janet L. Wasson, M.D., (the "Respondent"), License Number D44979, to practice medicine in the State of Maryland. Disciplinary Panel A takes such action pursuant to its authority under Md. Code Ann., State Govt § 10-226(c)(2)(2014 Repl. Vol. & 2015 Supp.) concluding that the public health, safety or welfare imperatively requires emergency action.

PROCEDURAL HISTORY

On October 10, 2013, the Board received an Adverse Action Report from Hospital A, a hospital in Anne Arundel County, Maryland where the Respondent then had medical privileges. The report notified the Board that the Respondent had voluntarily resigned her medical staff membership and clinical privileges while undergoing a Focused Professional Practice Evaluation ("FPPE") of her surgical practice. Hospital A had initiated the FPPE based on concerns that the Respondent's surgical complication rate was significantly higher than the rest of Hospital A's general surgeons and that the difference was not explained by the higher number of severely ill patients she saw. Hospital A terminated the FPPE without action when the Respondent resigned; however, the results of the independent review of her practice concluded that

her "practice patterns resulted in a clinically significant poorer outcome than would have been expected."

Upon receipt of Hospital A's report, the Board initiated an investigation, which included a peer review of several of the Respondent's surgical cases. Based upon the peer reviewers' findings, Panel A charged the Respondent with professional incompetence, in violation of Health Occ. § 14-404(a)(4) and failure to meet appropriate standards for the delivery of quality medical and surgical care, in violation of Health Occ. § 14-404(a)(22).

On March 10, 2015, the Respondent entered into a Consent Order with Panel A to resolve the charges. Under the terms of the Consent Order, the Respondent was reprimanded and placed on probation for a minimum of two years. The Respondent was ordered to successfully complete a Board-approved remedial course in medical record-keeping. The Respondent was also ordered to successfully complete a Board-approved course in pain management because she had shifted the focus of her practice from surgery to pain management. The Respondent was further required to undergo a peer review.

CURRENT INVESTIGATIVE FINDINGS

Based on information received by, and made known to Panel A and the investigatory information obtained by, received by and made known to and available to Panel A, including the instances described below, Panel A 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 in connection with this matter.

1. At all times relevant hereto, the Respondent, who is not currently board-certified in a medical specialty,[2] was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on August 16, 1993. Her license is scheduled to expire on September 30, 2017.

2. The Respondent owns and operates an office for the practice of pain management in Upper Marlboro, Maryland.

3. Pursuant to the Respondent's 2015 Consent Order, the charts of six of the Respondent's pain management patients were transmitted to an expert in pain management ("Expert") for review of her care. The review focused on the period subsequent to November 15, 2015, the date she completed both of her remedial courses.

General Practice Deficiencies

4. The Expert found that for all six patients, the Respondent:

   a. Initiated opioid therapy at high dosages without a trial at lower dosages to assess efficacy;

   b. Prescribed excessively high dosages of opioids in the absence of adequate pathology to substantiate treatment;

   c. Prescribed excessive and medically unjustified opioids having significant diversion potential, including OxyContin and oxycodone, yet consistently failed to monitor adequately the patients' compliance with the prescribed regimen. The Respondent typically ordered urine drug testing at a patient's initial visit but rarely, if at all, at subsequent visits;

[2] The Respondent's board certification in general surgery expired in 2014.

d. Increased dosages of already excessive and medically unjustified opioids in the absence of an assessment of whether the lower dosage had improved function or better pain control as compared to the patient's baseline presentation. Such increases in dosages are a potential danger to patient safety; and

e. The Respondent uses an electronic medical record system to document her care. The Respondent's documentation was extensive and repetitive making it difficult to discern what care the Respondent actually provided at each visit. Despite the repetitive nature of the Respondent's notes, she failed on occasion to document pertinent information such as her treatment rationale for changing opioids, adding medications and changing dosages.

5. In addition to the general practice deficiencies summarized in ¶ 4, the Expert found the following patient-specific deficiencies as indicated:

a. The Respondent ignored "red flags" of abuse or diversion such as patient reports of running out of medication early, theft of prescription or medication; **Patient 2, Patient 3 and Patient 6**

b. The Respondent increased dosages of opioids even after documenting that patient's pain was controlled with a lower dosage and/or without significant change in physical examination, patient function and/or diagnostic testing; **Patient 2, Patient 3, Patient 4 and Patient 6**

c. The Respondent failed to address urine drug screen results that indicated the use of illicit drugs or drugs not prescribed by the

Respondent. These results constitute violations of the "Consent for Chronic Opioid Therapy" agreements each patient signed when initiating treatment with the Respondent; however, the Respondent failed to take appropriate action to address results that were inconsistent with her prescribed regimen. **Patient 3, Patient 5 and Patient 6**

d. The Respondent prescribed sedatives, benzodiazepines, muscle relaxants and/or sleep aids to patients to whom she prescribed high dosages of opioids The combination of these medications with opioid-potentiating effects increases the risk for opioid-related adverse events such as respiratory depression and death. **Patient 1, Patient 2, Patient 5 and Patient 6**

e. **Patient 2** and **Patient 3** are a married couple who reside at the same address. During their one-year course of treatment, the Respondent massively increased each patient's daily dosage of oxycodone to 200 mg in the absence of medical justification. The Respondent failed to address red flags including: Patient 2's report that one of her prescriptions and identification had been stolen; and Patient 3's reports that he had exhausted his monthly allotment of medication and that he had taken some of Patient 2's OxyContin before the Respondent began prescribing it to him. The Respondent increased each of the patient's dosages without ordering additional urine drug testing to ensure that they were complying with her prescribed regimen.

SUMMARY

The Respondent prescribes consistently excessive and medically unjustified opioids to her pain management patients. She fails to conduct appropriate compliance monitoring for abuse or diversion. The Respondent's opioid prescribing practices constitute a substantial likelihood of risk of serious harm to the public health, safety or welfare.

CONCLUSION OF LAW

Based on the foregoing facts, Disciplinary Panel A concludes that the public health, safety or welfare imperatively requires emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226 (c)(2)(i) (2014 Repl. Vol. & 2015 Supp.), Md. Code Regs. 10.32.02.08B(7)(a).

ORDER

Based on the foregoing, it is, by a majority of the quorum of Disciplinary Panel A, hereby

ORDERED that pursuant to the authority vested by Md. Code Ann., State Gov't § 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 Md. Code Regs. 10.32.02.08B(7)C and E, has been scheduled for **May 10, 2017, at 1:00 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 Disciplinary Panel A, 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 D44979; and

(2) the Respondent's current renewal certificate; and be it further

ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Code Ann., Health Occ. § 14-407 (2014 Repl. Vol. & 2015 Supp.); and be it further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

04/25/2017
Date

Christine A. Farrelly
Christine A. Farrelly
Executive Director
Maryland State Board of Physicians