IN THE MATTER OF	*	BEFORE THE
N. DAVID TZOU, M.D.	*	MARYLAND STATE
Respondent	*	BOARD OF PHYSICIANS
License Number: D50880	*	Case Numbers: 2010-0039 2012-0603 & 2012-0908

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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 N. David Tzou, M.D., (the "Respondent") (D.O.B. 02/13/1962), license number D50880, to practice medicine in the State of Maryland. The Board takes such action pursuant to its authority under Md. State Govt 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]

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

[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.

originally licensed to practice medicine on Maryland on July 11, 1996, and his license is presently active.

2. The Respondent is not board-certified. He identifies himself as an internal medicine and pain management practitioner.

Procedural History – Board Case Numbers 2006-0871 & 2008-0577

3. On December 11, 2008, the Board charged the Respondent with unprofessional conduct in the practice of medicine and failure to cooperate with a lawful investigation conducted by the Board, in violation of Health Occ. ("H.O.") § 14-404(a)(3)(ii) and (33), respectively.

4. The Board had received two complaints regarding the Respondent's practice. In the first complaint it was alleged that the Respondent had hired untrained personnel to conduct laser hair removal (Board Case Number 2006-0871). The second complaint was filed by the mother of a patient of the Respondent who alleged that the Respondent failed to respond to emergency telephone calls and subsequent correspondence (Board Case Number 2008-0577).

5. In furtherance of its investigation of the first complaint, the Board issued to the Respondent subpoenas in which the Respondent was ordered to produce various records as well as a response to the complaints. Eleven months after the Respondent received the initial subpoena for records, he produced only some of the records and failed to fully comply with the subpoena.

6. In furtherance of its investigation of the second complaint the Board issued to the Respondent a subpoena for the patient's medical records and directed the Respondent to respond to the complaint. The Respondent failed to respond to the subpoena for eight months, whereupon the Board issued the charges.

7. Effective March 27, 2009, the Respondent entered into a Consent Order to resolve the complaints. Under the terms and conditions of the Consent Order, the Respondent was reprimanded and was required to: 1) pay a monetary fine of $10,000.00 to the Board within eighteen months; 2) successfully complete a Board-approved individual course in medical ethics; and 3) adequately respond to all outstanding subpoenas within twenty days.

PROCEDURAL BACKGROUND – Current Investigation

Complaints

Complaint # 1 – Case Number 2112-0039

8. On or about July 13, 2011, the Board received a complaint from a pharmacist in West Virginia. The pharmacist was concerned regarding the excessive number of prescriptions written by the Respondent for high doses of Controlled Dangerous Substances ("CDS"). The pharmacist stated that he refuses to fill the Respondent's prescriptions.

Complaint # 2 – Case Number 2012-0603

9. On February 24, 2012, the Board received a complaint from a pharmacist in Pennsylvania who also expressed concerns about the Respondent's

CDS prescribing practices. The pharmacist described an incident where two men arrived at the pharmacy within five minutes of each other with identical CDS prescriptions (Oxycodone 30 mg[2] – 112 tablets) written by the Respondent. The pharmacist had difficulty confirming the legitimacy of the prescriptions with the Respondent's office and declined to fill them.

Complaint # 3 – Case Number 2012-0908

10. On June 8, 2012, the Board received a complaint from the father of a young patient of the Respondent who died of a drug overdose in May 2012. The complainant alleged that the Respondent is a "pill doctor" who is responsible for, or contributed to, his son's death.

11. In furtherance of its investigation of the complaints, the Board interviewed the Respondent, conducted an on-site visit of the Respondent's office and sought the opinion of a physician with a subspecialty in Pain Medicine (the "Expert") to review pertinent documents and provide an expert opinion regarding the Respondent's professional conduct and competence as well as the propriety of this prescribing practices.

Board Staff's First Attempted On-Site Visit

12. On May 18, 2012, Board staff made an unannounced visit at the Respondent's then current address of record in Laurel, Maryland. The office was a group medical practice ("Practice A").

13. Board staff spoke to an individual ("Person A"), who is not a physician and who identified himself as "sort of a working partner" of the practice.

[2] Oxycodone is a Schedule II CDS.

14. Person A told Board staff that the Respondent had left the practice without notice in late March or early April 2012.

15. Person A further stated that Practice A had opened in 2010 and had initially focused on "men's health issues" and provided treatment for erectile dysfunction. When this undertaking proved to be unprofitable, Practice A began offering treatment to patients with chronic pain.

16. Person A stated that Practice A does not accept insurance; only cash is accepted for services.

17. Person A denied that he had been a patient of the Respondent and was unable to explain why a drug survey obtained by the Board indicated that he had been prescribed CDS by the Respondent.

18. Person A provided Board staff with the Respondent's new office address.

Board Attempts to Obtain Patient Records from the Respondent

19. The Respondent consistently failed to comply satisfactorily with various Board subpoenas for patient records and directives that he provide written summaries of his care of the patients.

20. The Board issued an initial subpoena for patient records on September 21, 2011. Because of the Respondent's failure to comply, the Board issued additional subpoenas for several months thereafter. In one response, the Respondent failed to appropriately certify one set of patient records; his office staff certified the records.

21. It was not until July 27, 2012, that the Respondent satisfactorily complied with Board subpoenas for patient records and directives that he provide summaries of his care.

22. In each summary the Respondent noted that the patient had originally seen him at Practice A and that Practice A failed to provide to him a copy of the patient's record despite multiple requests.[3]

Interview with Board Staff

23. On July 27, 2012, the Respondent, accompanied by counsel, was interviewed by Board staff.

24. With regard to the Respondent's recent employment history, he stated that in 2009, he had been employed by Practice A.

25. In 2010 or 2011, the group practice transitioned to pain management.

26. The Respondent stated that his specialized training in pain management consisted of a one-week course that he took in November 2010. The Respondent was unable to recall the name of the course or the entity that provided it and he was unable to produce any documentation that he had completed the course.

27. The Respondent told Board staff that his brother, who practices in a State other than Maryland, is board-certified in "chronic pain" and that he (the Respondent) visited his brother's office "quite a bit" to review his brother's charts and observe patient treatment.

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[3] Practice A notified the Board that it was unable to provide subpoenaed patient records because the Respondent took them with him when he left the practice.

28. In or about March 2012, the Respondent left the group practice and opened his own solo practice in Gaithersburg, Maryland, specializing in pain management.[4]

29. The Respondent stated that approximately 200 of his former patients followed him to his new office.

30. The Respondent stated that he does not accept health insurance and operates a "cash practice" only. He has no billing system, does not maintain appointment logs and has no employee records.

31. The Respondent was unable to explain why individuals he claimed not to have treated appeared on drug surveys obtained by the Board with prescriptions written by him under his Drug Enforcement Administration ("DEA") number.

Board Staff On-Site Visit of the Respondent's Current Office

32. On August 9, 2012, Board staff conducted an on-site visit of the Respondent's current office in Gaithersburg, Maryland.

33. Board staff arrived shortly before the office opened and observed a truck in the parking lot occupied by three young men. Two of the men entered the office when the office opened for the day.

34. Board staff observed that several more vehicles pulled into the parking lot; some of the occupants left their car engines running as they entered the Respondent's office.

35. The vehicles had Maryland and Pennsylvania license plates.

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[4] The Respondent failed to notify the Board of his change of address in a timely manner as required by H.O. § 14-316(f).

36. Board staff identified themselves to the receptionist and waited for the Respondent to arrive. They observed that there was no check-in procedure or sign-in sheet for patients.

37. When the Respondent arrived, he accompanied Board staff to his office. He identified a piece of equipment as a cold laser[5] and offered to demonstrate it on Board staff, who declined.

38. Board staff stated that their intent was to observe his office and returned to the waiting room. Board staff remained in the Respondent's waiting room for approximately two hours and observed the following:

    a. Patients sat on the floor because the seven chairs in the waiting room were not enough to seat all of the waiting patients;

    b. When called from the waiting room, the patient was accompanied by an office assistant to an examination room for several minutes and returned to the waiting room;

    c. The patient was later called to the Respondent's office. After approximately four or five minutes, the patient emerged from the Respondent's office, some with prescriptions visibly in hand, picked up an appointment card and left the office;

    d. All of the appointment cards were printed with the Respondent's office address on the front and the date, "September 6, Thursday, 10 a.m." handwritten on the back. A young man in the waiting room explained that every day appointment cards are dated in this

[5] Cold laser, or low level laser therapy, is a treatment that utilizes specific wavelengths of light to interact with tissue for the purpose of eliminating pain and reducing spasms.

manner for the next appointment; all patients are given the same date and time to arrive for their next appointment;

e. Although the receptionist told Board staff that patients were required to pay cash after their appointments, Board staff did not observe any cash transactions. When Board staff asked to see a receipt, the receptionist showed them a small blank tablet of paper;

f. No patient used the bathroom or was accompanied by the Respondent's staff to the bathroom for drug testing;

g. An office assistant told Board staff that the Respondent saw an average of twelve patients a day; Board staff observed that the Respondent saw more than twelve patients during the first half hour of office hours.

29. Board staff met with the Respondent prior to their departure. When they asked the Respondent how many prescriptions he had written that morning, the Respondent stated that he did not know. Board staff requested that the Respondent provide by e-mail a print-out of his morning prescriptions. The Respondent agreed, but failed to transmit the print-out to the Board.

Summary of Expert Opinion

30. In furtherance of its investigation, the Board sought the opinion of a physician with a subspecialty in Pain Medicine (the "Expert"), to review pertinent documents and provide an expert opinion regarding the

Respondent's professional competence and conduct as well as the propriety of his prescribing practices.

31. After review, the Expert concluded that the Respondent participated in ongoing unprofessional conduct in the practice of medicine because he provided excessive quantities of CDS for cash while failing to document the clinical need for the drugs he prescribed.

32. The Expert also opined that the Respondent was not professionally competent to practice medicine because he failed to develop appropriate assessments or plans of care in treating patients. He unequivocally concluded that the Respondent's "medical decision making process was grossly incompetent."

33. Finally, the Expert concluded that the Respondent prescribed drugs for illegitimate medical purposes. The Expert found that the Respondent, rather than providing medical services, sold potent narcotic prescriptions for cash.

34. In support of his opinions, the Expert noted numerous deficiencies in the Respondent's prescribing practices, including, but not limited to, the following:

   a. The Respondent wrote prescriptions for potent narcotics and failed to conduct or document a sufficient physical examination, medical history or substance abuse history and he failed to verify prior medical records;

b. The Respondent failed to integrate historical information, physical examination findings or laboratory findings to develop an appropriate assessment or plan of care that considered the risks and benefits of his treatment. The Respondent failed to adequately search for clues as to the patient's complaints, motivations or compliance;

c. The Respondent failed to recognize or act on common drug-related aberrant behaviors and failed to ask why patients traveled from out-of-state or followed him from office to office in different parts of Maryland and were willing to maintain a cash only relationship with him;

d. The Respondent prescribed potent narcotics for what he claimed were complex patients. The amount of time he spent with patients, four to five minutes, is insufficient for adequate assessment, review and treatment; and

e. The Respondent's clear disregard for the appropriate practice of pain medicine contributed to at least one known patient death by overdosing on the narcotics the Respondent prescribed. On May 5, 2012, the patient, a 29-year old male, was found dead in a Frederick, Maryland motel. The police investigatory report states that police found in the patient's motel room several bottles of narcotics and other medications prescribed by various physicians, including the Respondent. The bottles of medications prescribed

by the Respondent had been filled by the patient on May 3, 2012.[6] The medications included: oxycodone 30 mg (112 tablets); oxycodone HCL 15 mg (56 tablets) and carisoporodol[7] (28 tablets).[8] The bottles that had contained the Oxycodone and Oxycodone HCL were empty. Twenty-one of the carisoprodol tablets remained. The May 6, 2012 autopsy report stated that the cause of death was oxycodone intoxication.

35. The Respondent's actions, as set forth above, constitute a substantial likelihood of risk of serious harm to the public health, welfare and safety which imperatively requires the immediate suspension of his license to practice medicine under Md. State Gov't Code Ann. § 10-226(c)(2)(i) and Code Md. Regs. tit. 10, § 32.02.05B(7).

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 24th day of September, 2012, by a majority of the quorum of the Board:

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[6] Bottles of drugs prescribed by a physician at Practice A were also found in the patient's room. Those drugs had been obtained by the patient from a pharmacy on May 4, 2012. The drugs included: oxycodone 30 mg IR (112 tablets prescribed; 42 tablets remaining); oxycodone 15 mg (56 tablets prescribed; 60 tablets in bottle) and carisoprodol (28 tablets prescribed; 28 tablets remaining).

[7] Carisoprodol, the generic form of Soma, is a muscle relaxant. It is not a CDS, but may result in abuse or dependence upon its sedative-hypnotic effects and withdrawal if discontinued after long-term use.

[8] The Respondent's record of the patient indicates that he prescribed these drugs on May 3, 2012.

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) and E on the Summary Suspension has been scheduled for **Wednesday, October 10, 2012, at 2:00 p.m.,** at the Maryland 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;

(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;

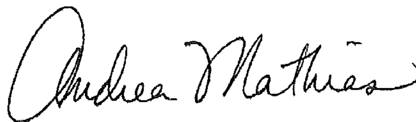
(6) all prescription forms and pads in her possession and/or practice; and

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

ORDERED that during the period of Summary Suspension, in accordance with Title 4, subtitle 3 of the Health-General article, the Respondent shall have a continuing duty, on proper request, to provide details of a patient's medical record to the patient, another physician or hospital; 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 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.*



Andrea L. Mathias, M.D.
Chair
Maryland State Board of Physicians