IN THE MATTER OF	*	**BEFORE THE**
JACK D. BLAINE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D04502	*	**Case Number: 7718-0021A**

* * * * * * * * * * * *

CONSENT ORDER

On May 3, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **JACK D. BLAINE, M.D.** (the "Respondent"), License Number D04502, with violating the probationary conditions imposed under the Consent Order, dated August 17, 2017 (the "2017 Consent Order") and with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2018 Supp.).

VIOLATION OF CONSENT ORDER

Panel A charged the Respondent with violating the following terms and conditions of the 2017 Consent Order:

Condition No. Three (3)

> During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation[.]
>
> The Consent Order also states:
>
> **ORDERED** that the Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II § 14-101 – § 14-702, and all laws and regulations governing the practice of medicine in Maryland[.]

VIOLATIONS OF HEALTH OCC. § 14-404

Panel A charged the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and/or]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On August 14, 2019, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

Panel A finds:

I. Background/Disciplinary History

1. The Respondent was originally licensed to practice medicine in Maryland on November 24, 1969, under License Number D04502. The Respondent's medical license is active and current through September 30, 2020.

2. The Respondent is board-certified in psychiatry and neurology. The Respondent maintains a medical office at 6270 Montrose Road, Rockville, Maryland 20852.

3. The Board initiated an investigation of the Respondent in 2017 after receiving a complaint from a pharmacist who reported that patients had been coming into the pharmacy to fill prescriptions written by the Respondent, whose office was located three hours away. The pharmacist reported that he had not seen these patients previously, and that some of them were from other states (*e.g.,* West Virginia) and were filling prescriptions for controlled dangerous substances ("CDS") including Xanax (generic name alprazolam, a benzodiazepine and Schedule IV CDS) and Subutex[1] (an opioid medication and Schedule III CDS). The pharmacist reported that when one patient attempted an early refill, he called another pharmacy, which informed him that it no longer fills the Respondent's prescriptions.

4. The Board ordered a peer review which determined that in all ten cases reviewed, the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records.

5. After reviewing these findings, Panel A issued disciplinary charges against the Respondent under Case Number 2014-0876A.

6. The Respondent resolved Panel A's charges by entering into the Consent Order, dated August 17, 2017, in which Panel A found as a matter of law that the

[1] Subutex is a brand name for a medication that contains buprenorphine, an opioid medication and Schedule III CDS that is used to treat opioid dependency.

Respondent: failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

7. Pursuant to the Consent Order, Panel A reprimanded the Respondent and placed him on probation for a minimum period of one year, subject to a series of probationary conditions, including the following:

> Condition No. Three (3)
>
> During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation[.]

8. The Consent Order also required the following:

> **ORDERED** that the Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II § 14-101 – § 14-702, and all laws and regulations governing the practice of medicine in Maryland[.]

9. As of the date of these charges, the Respondent remains on probation with the Board.

II. Current Investigation

10. Pursuant to Condition No. Three (3) of the Consent Order, the Board obtained ten patient records and supporting materials from the Respondent and ordered a practice review. The practice review was performed by two physicians who are board-

certified in psychiatry and neurology. The reviewers reviewed the Respondent's treatment provided to patients after November 19, 2017.

11. The peer reviewers jointly concluded that in a majority of the cases ("Patients A through G," *infra*),[2] the Respondent failed to meet appropriate standards for the delivery of quality medical care and in one case, failed to keep adequate medical records.

12. Examples of these deficiencies are set forth in the following patient summaries.

Patient A

13. The Respondent treated Patient A, a man then in his 40s, from in or around 2014 to in or around February 2018. Patient A's medical history included substance abuse disorder, generalized anxiety disorder ("GAD") and nicotine use disorder.

14. The Respondent recorded an office note that is difficult to decipher, dated December 20 or 21, 2017. It appears that the Respondent sent Patient A's prescriptions to another individual, consisting of buprenorphine 8 mg three times per day ("TID"); zolpidem (a sedative hypnotic and Schedule IV CDS) 10 mg at bedtime ("qHS"); and alprazolam 2 mg four times per day ("QID").

15. Patient A failed to appear for a visit on January 15, 2018, reportedly due to an automobile accident. It is unclear whether the Respondent prescribed medications for

[2] For confidentiality purposes, the names of patients will not be identified in this document. The Respondent may obtain the identity of any patient referenced herein by contacting the assigned administrative prosecutor.

Patient A. The Respondent did not address the circumstances surrounding this automobile accident or whether it was related to the treatment regimen.

16. The Respondent last saw Patient A on December 18, 2017.

17. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient A, for reasons including:

(a) The Respondent failed to attempt more conservative measures when treating Patient A's anxiety;

(b) The Respondent continued to maintain Patient A on an excessively high dosage of alprazolam on a chronic basis;

(c) The Respondent inappropriately maintained Patient A on an excessively high dosage of alprazolam in conjunction with his prescribing of buprenorphine;

(d) The Respondent failed to attempt to taper Patient A's dosage of alprazolam;

(e) The Respondent's entries for visits occurring in December 2017 and January 2018 are difficult to decipher; and

(f) The Respondent failed to record adequate documentation about Patient A's automobile accident.

Patient B

18. The Respondent treated Patient B, a woman then in her 50s, from in or around 2013 to in or around January 2018.[3] Prior to receiving treatment from the Respondent, Patient B was receiving chronic opioid and benzodiazepine treatment for chronic pain due to rheumatoid arthritis and degenerative disc disease. Patient B's medical history also included a variety of psychiatric disorders, diabetes mellitus, hypertension, asthma and cerebrovascular accidents. The Respondent also diagnosed and treated Patient B for opioid use disorder, GAD and psychiatric conditions. The Respondent treated Patient B with a variety of medications, including: buprenorphine 8 mg QID; alprazolam 4 mg TID; mirtazepine (a prescription-only antidepressant medication) 45 mg qHS; and gabapentin (a prescription-only neuropathic medication).

19. The Respondent last saw Patient B on January 24, 2018.

20. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient B, for reasons including:

(a) The Respondent continued to maintain Patient B on an excessively high dosage of alprazolam on a chronic basis;

[3] The Respondent reported that Patient B was incarcerated from 2013 to 2016, after which she resumed seeing him for treatment.

(b) The Respondent inappropriately maintained Patient B on an excessively high dosage of alprazolam in conjunction with his prescribing of buprenorphine;

(c) The Respondent failed to undertake or document that he considered tapering Patient B's alprazolam dosage in view of her stable symptoms;

(d) The Respondent failed to order compliance measures, such as urine toxicology screening, at sufficient intervals; and

(e) The Respondent failed to adequately document his rationale for the prescribing of Patient B's psychiatric medications for the period of November 2017 to January 2018.

Patient C

21. The Respondent treated Patient C, a woman then in her 30s, from in or around 2010 until in or around March 2018. He transferred her care to another provider on March 15, 2018, when she was referred to an addiction specialist and another psychiatrist in Virginia. Patient C had a medical history that included polysubstance abuse and a variety of serious psychiatric conditions, including major depression, chronic insomnia, attention deficit hyperactivity disorder ("ADHD"), anorexia nervosa, suicidality and borderline personality disorder. The Respondent managed Patient C's conditions using multiple psychiatric medications including an ADHD medication, despite Patient C's chronic anorexia, and sedative hypnotics, despite her prior history of benzodiazepine abuse.

22. In 2018, the Respondent maintained Patient C on a medication regimen that included but was not limited to: buprenorphine 8 mg four tablets every morning ("qAM"); Vyvanse (an ADHD medication and Schedule II CDS) 70 mg qAM; amphetamine salts (a Schedule II CDS) 30 mg QID; alprazolam 2 mg QID; and Belsomra (an insomnia medication and Schedule IV CDS) 20 mg qHS. The Respondent last saw Patient C on March 14, 2018 and she was referred to an addiction specialist and another psychiatrist.

23. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient C, for reasons including:

(a) The Respondent continued to maintain Patient C on high dosages of buprenorphine and benzodiazepines above therapeutic levels, despite Patient C's history of anorexia and benzodiazepine abuse;

(b) The Respondent inappropriately prescribed high dosages of benzodiazepines and stimulants after Patient C had been hospitalized and detoxified from these medications;

(c) The Respondent inappropriately prescribed up to three benzodiazepines concurrently;

(d) The Respondent inappropriately prescribed amphetamines despite Patient C's severe abuse issues; and

(e) The Respondent failed to document or attempt to taper Patient C off of high dosages of stimulants.

Patient D

24. The Respondent began treating Patient D, a woman then in her 40s, from in or around 2010. Patient D's history included opioid dependence, depression and anxiety. The Respondent initiated a Suboxone regimen after Patient D became dependent on opioids after being treated for vertebral disc disease. Patient D was maintained on Suboxone but periodically discontinued Suboxone treatment and returned to using prescribed opioids. The Respondent treated Patient D until March 26, 2018.

25. In 2018, the Respondent was prescribing: Suboxone 24 mg per day; two benzodiazepines (diazepam 10 mg QID and alprazolam 2 mg as needed); Belsomra 20 mg qHS; and Cymbalta (duloxetine, a prescription-only medication used to treat depression and anxiety) 120 mg daily. In 2018, Patient D was involved in a motor vehicle accident. The Respondent did not document or evaluate how the patient's medication regimen may have contributed to the incident.

26. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient D, for reasons including:

(a) The Respondent prescribed multiple benzodiazepines despite Patient D's history of substance abuse disorder and Suboxone maintenance therapy;

(b) The Respondent failed to explore other medication options when addressing Patient D's psychiatric symptoms;

(c) The Respondent failed coordinate his treatment with Patient D's pain management specialist; and

(d) The Respondent failed to document or evaluate how his medication regimen may have contributed to Patient D's motor vehicle accident.

Patient E

27. The Respondent began treating Patient E, a woman then in her early 40s, in or around 2005. The Respondent treated Patient E for various conditions including opioid dependence, generalized depressive disorder, GAD, panic disorder, migraine and chronic back pain. Patient E's history included alcohol, marijuana, cocaine and opiate abuse. The Respondent ceased treatment of Patient E in 2018.

28. In his last visit on January 24, 2018, the Respondent's treatment plan included prescribing medications beyond their therapeutic doses, including two types of benzodiazepines (diazepam 5 mg TID and two tablets qHS; and alprazolam 2 mg BID) and a very high dosage of Lunesta (a non-benzodiazepine sedative-hypnotic and Schedule IV CDS) 6 mg qHS. The Respondent also noted prescribing methylphenidate (a stimulant ADHD medication and Schedule II CDS) 20 mg TID.

29. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient E, for reasons including:

(a) The Respondent prescribed multiple benzodiazepines in high dosages despite Patient E's history of substance abuse disorder and Suboxone maintenance therapy;

(b) The Respondent prescribed multiple benzodiazepines in combination with a sedative hypnotic; and

(c) The Respondent prescribed a stimulant while concurrently prescribing benzodiazepines and a sedative hypnotic.

Patient F

30. The Respondent began treating Patient F, a man then in his mid-20s, in or around 2012. The Respondent treated Patient F for opioid dependence, anxiety, insomnia and ADHD. Patient F also had a previous history of marijuana and cocaine use. The Respondent last saw Patient F on January 30, 2018.

31. The Respondent maintained Patient F on a Suboxone regimen and also prescribed a variety of other medications. In a visit dated January 3, 2018, the Respondent maintained Patient F on a medication regimen that included: Suboxone; alprazolam up to 6 mg per day; and methylphenidate. On January 30, 2018, the Respondent switched Patient F from methylphenidate to Vyvanse after noting that Patient F took his girlfriend's medication and "felt better."

32. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient F, for reasons including:

(a) The Respondent inappropriately prescribed opioids and benzodiazepines in combination, while also prescribing a stimulant;

(b) The Respondent prescribed an excessive dosage of a benzodiazepine, alprazolam;

(c) The Respondent failed to document or explore non-addictive medications and non-pharmacological treatments for anxiety prior to starting a benzodiazepine;

(d) The Respondent failed to document or consider a longer-acting benzodiazepine;

(e) The Respondent failed to attempt to taper the dosage of alprazolam; and

(f) The Respondent failed to document or explore non-addictive alternatives and non-pharmacological alternatives to amphetamines when treating ADHD symptoms.

Patient G

33. The Respondent began treating Patient G, a man then in his 20s, in or around 2006 and last saw him December 4, 2017. Patient G's medical history included substance abuse/opioid dependence, major depression, GAD and ADHD. The Respondent treated Patient G until December 2017 for these conditions. In late 2017, the Respondent prescribed a medication regimen that included: amphetamine salts 30 mg BID; alprazolam 1 mg BID; Zubsolv (an opioid medication containing buprenorphine

and naloxone and Schedule III CDS) 5.7 mg/1.4 mg one tablet qAM; Vyvanse 70 mg qAM; and Cymbalta 60 mg two tablets qAM.

34. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and/or violated Condition No. Three (3) of the 2017 Consent Order, with respect to Patient G, for reasons including:

(a) The Respondent prescribed an excessive dosage of benzodiazepines;

(b) The Respondent inappropriately prescribed benzodiazepines concurrently with an opioid medication;

(c) The Respondent failed to attempt to taper the dosage of alprazolam;

(d) The Respondent prescribed an inappropriately high dosage of amphetamines;

(e) The Respondent prescribed an inappropriately high dosage of amphetamines in conjunction with Vyvanse; and

(f) The Respondent failed to document or clarify his diagnosis and treatment plan for ADHD.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), and violated Condition No. Three (3) of the Consent Order dated August 17, 2017.

ORDER

It is thus by Disciplinary Panel A of the Board, hereby:

ORDERED that the probation imposed by the Consent Order dated August 17, 2017 is **TERMINATED**; and it is further

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is permanently prohibited from prescribing and dispensing all Controlled Dangerous Substances (CDS); and it is further

ORDERED that the Respondent is permanently prohibited from delegating to a Physician Assistant the prescribing or dispensing of all CDS; and it is further

ORDERED that the Respondent is permanently prohibited from certifying patients for the medical use of cannabis; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds an active Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not prescribed, dispensed, or delegated the prescribing or dispensing of all CDS in the past year and an affidavit verifying that the Respondent has not certified patients for the medical use of cannabis in the past year; and it is further

ORDERED that if the Respondent fails to provide the required annual verification of compliance with this condition: (1) there is a presumption that the Respondent has violated the permanent condition; and (2) the alleged violation will be adjudicated pursuant to the procedures of a Show Cause Hearing; and it is further

ORDERED that the disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's Controlled Dangerous Substances ("CDS") prescriptions for the duration that the Respondent possesses an active license; and it is further

ORDERED this Consent Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

09/26/2019
Date

Signature on File
Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Jack D. Blaine, M.D. acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 et seq. concerning the pending charges. I waive this right and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

October 19, 2019
Date

Signature on File
Jack D. Blaine, M.D.
Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF MONTGOMERY

I HEREBY CERTIFY that on this 19 day of SEPTEMBER 2019, before me, a Notary Public of the foregoing State and City/County, personally appeared Jack D. Blaine, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

EDWARD A. ARABIAN
Notary Public – State of Maryland
Montgomery County
My Commission Expires Oct 10, 2021

Notary Public

My Commission expires: 10-10-2021