IN THE MATTER OF	*	**BEFORE THE**
GEORGE WATHEN, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D20629	*	**Case Number: 2218-0297B**

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CONSENT ORDER

On January 8, 2021, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged George Wathen, M.D. (the "Respondent"), License Number D20629, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.). Panel B charged the Respondent with violating the following provisions of the Act:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (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:
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> . . .
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> (3) Is guilty of:
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> . . .
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> (ii) Unprofessional conduct in the practice of medicine [and]
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> . . .
>
> (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.

On March 24, 2021, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this

DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel B finds the following:

I. BACKGROUND

1. At all times relevant, 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 June 28, 1977. The Respondent's license is active through September 30, 2021.

2. The Respondent is board-certified in Internal Medicine.

II. PRIOR DISCIPLINARY HISTORY

1996 Consent Order

3. The Board initiated an investigation of the Respondent after receiving two complaints about the Respondent. In Case Number 94-1186 the Board received a notification of a Health Claims Arbitration case filed against the Respondent and sent the medical records for a peer review. The peer review committee found that the Respondent violated the standard of care by failing to review the results of a patient's mammograms on two separate occasions, failed to follow-up, monitor and track the mammogram results, failed to review and communicate the results of the mammograms with the patient, failed to file the results in the patient's chart, and had inadequate documentation and illegible handwriting.

4. In Case Number 95-0005, the family of a deceased patient who had been under the care of the Respondent filed a complaint with the Board. The matter was referred for a peer review and the peer review committee issued a report finding that the Respondent breached the standard of care by his inaction in responding to the patient's theophylline toxicity, his failure to timely and properly treat the patient's cardiac problems, and by having illegible records.

5. The Respondent entered into a Consent Order with the Board, dated February 13, 1996, in which the Board found as a matter of law that the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care in violation of Health Occ. § 14-404(a)(22) (1994).

6. The Board reprimanded the Respondent, ordered him to pay a $10,000 fine, placed him on probation for three years subject to certain terms and conditions including taking a clinical medical review course, a comprehensive medical records course, and that he be subject to periodic peer review.

1998 Consent Order

7. Pursuant to the February 13, 1996 Consent Order the Board conducted a peer review of the Respondent's patient records for care provided on or after June 1, 1996. The peer review committee issued a report finding that the Respondent failed to meet appropriate standards for the delivery of quality medical care in nine out of eighteen patients.

8. On May 27, 1998, the Respondent entered into a Consent Order with the Board, in which the Board found as a matter of law that the Respondent failed to meet

appropriate standards as determined by appropriate peer review for the delivery of quality medical care in violation of Health Occ. § 14-404(a)(22). The Board reprimanded the Respondent, extended his probation for an additional three years subject to certain terms and conditions including that he be required to have a supervising physician, he was required to attend fifty-two sessions of the Medical Grand Rounds at Johns Hopkins University School of Medicine, and he was subject to peer review.

III. CURRENT ALLEGATIONS

9. At all times relevant, the Respondent owned and operated a family practice (the "Clinic")[1] located in Southern Maryland. The Clinic has a high number of geriatric patients.

10. On or about June 6, 2018, the Board received a complaint from the son-in-law (the "Complainant") of two of the Respondent's patients (Patients 9 & 10), alleging that the Respondent prescribes "huge" amounts of Percocet without seeing the Patients for appointments. The Complainant also alleged that Patients 9 & 10 did not take the medication and that the medication was being filled and used by the Complainant's spouse. The Complainant advised that his spouse had ingested 80 of Patient 9 and 10's Percocet pills in an attempt at suicide.

11. Upon receipt of the Complaint, the Board initiated an investigation of the Respondent. As part of its investigation, the Board subpoenaed the Prescription Drug Monitoring Program ("PDMP") for a list of prescriptions written by the Respondent as well

[1] For confidentiality and privacy reasons, the names of offices, complainants, clients, staff or other individuals involved in this case are not disclosed in this Consent Order.

as the medical records of ten patients to whom the Respondent provided medical care. The Board submitted the medical records and related materials for a practice review to two physicians who are board-certified in pain medicine.

12. The peer reviewers found that the Respondent failed to meet the appropriate standards for the delivery of quality medical care for reasons including but not limited to the following:

a. The Respondent failed to conduct physical examinations or evaluate patients when prescribing high dose narcotics. (Patients 1-10);

b. The Respondent failed to discuss with the patients the efficacy of the medications he prescribed to the patients. These medications included but were not limited to fentanyl patches and oxycodone. (Patients 1-10);

c. The Respondent refilled prescriptions solely based on the request of the patients' phone calls and failed to assess patients for medical necessity of continued high dose narcotic opioid medications and benzodiazepines. (Patients 1-10);

d. The Respondent failed to utilize the lowest effective dosage of immediate release opioids instead of extended release or long acting opioids to achieve pain management, functional ability and to avoid adverse events/maladaptive behaviors. (Patients 1-10);

e. The Respondent failed to consider the use of non-pharmacologic therapy and non-opioid pain medication. (Patients 1, 3, 4, 5, 6, 8, 9, 10);

f. The Respondent prescribed opioids in high doses concomitantly with benzodiazepines or sedatives without adequate justification and/or without adequate counseling about the side effects and/or despite the side effects. (Patients 1-10);

g. The Respondent continued opioid therapy without clinically meaningful improvement in pain and function that outweighed risks to patient safety and failed to evaluate benefits and harms every three months or more frequently. (Patients 1-10);

h. The Respondent conducted inadequate patient surveillance with high dose opioid therapy including urine toxicology screening, pill counting and/or PDMP monitoring. (Patients 1-10);

i. The Respondent failed to reassess the evidence of benefits and risks when increasing dosage to > 50 MME (morphine milligram equivalents), and should have avoided increasing dosage to > 90 MME/day or justified a decision to titrate dosage to > 90 MME/day. (Patients 1-10);

j. The Respondent failed to consider and incorporate into the management plan, strategies to mitigate risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages > 50 MME/day or concurrent benzodiazepine use. (Patients 1, 6, 7, 8);

k. The Respondent failed to have a pain contract with his patients for prescribing opioid medications. (Patients 6, 7, 9); and

l. The Respondent failed to address his patient's emergency room visit for overdosed state and admission for detoxification. (Patients 1).

13. The Board received information pursuant to a subpoena to the PDMP for the period June 1, 2017 through June 27, 2018. Based on this information, the Board issued a series of subpoenas to area pharmacies and received information in response to those subpoenas.

14. The Board's investigation determined that the Respondent wrote prescriptions to a family member ("Family Member 1"). The Board therefore sent a second subpoena to the PDMP for the period January 2015 to June 2019. The Board issued additional subpoenas to pharmacies and received information in response to the subpoenas. The documents demonstrated that the Respondent wrote approximately fifty-five prescriptions for controlled dangerous substances ("CDS") to Family Member 1.

15. Board staff conducted an under-oath interview of the Respondent on February 4, 2019. During this interview, the Respondent confirmed that he wrote CDS prescriptions for Family Member 1.

16. On September 9, 2019, following an inquiry by the Board regarding whether the Respondent had prescribed CDS to any other family members, the Respondent wrote a letter to the Board admitting that he prescribed CDS to another family member ("Family Member 2") on two occasions.

CONCLUSIONS OF LAW

Based on the Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that the Respondent engaged in unprofessional conduct in the practice of

medicine, in violation of Health Occ. § 14-404(a)(3)(ii); and failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22).

ORDER

It is, thus by an affirmative vote of a majority of the quorum of Disciplinary Panel B, hereby:

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

ORDERED that the Respondent is permanently prohibited from prescribing and dispensing Controlled Dangerous Substances ("CDS") to himself or family members; and it is further

ORDERED that on every January 31st thereafter if the Respondent holds a Maryland medical license, the Respondent shall provide the Board with an affidavit verifying that the Respondent has not prescribed or dispensed CDS to himself or family members 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 this 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 Respondent is placed on **PROBATION** for a **minimum of TWO (2) YEARS.**[2] During probation, the Respondent shall comply with the following terms and conditions of probation:

(1) **Within six (6) months,** the Respondent is required to take and successfully complete a course in CDS prescribing. The following terms apply:

   (a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the course before the course is begun;

   (b) the disciplinary panel will accept a course taken in person or over the internet during the state of emergency;

   (c) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the course;

   (d) the course may not be used to fulfill the continuing medical education credits required for license renewal;

   (e) the Respondent is responsible for the cost of the course.

(2) The disciplinary panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter.

(3) The Respondent shall be subject to supervision during the probationary period by a disciplinary panel-approved supervisor who is board-certified in pain medicine as follows:

   (a) within **30 CALENDAR DAYS** of the effective date of this Consent Order, the Respondent shall provide the disciplinary panel with the name, pertinent professional background information of the supervisor whom the Respondent is offering for approval, and written notice to the disciplinary panel from the supervisor confirming his or her acceptance of the supervisory role of the Respondent and that there is no personal or professional relationship with the supervisor;

   (b) the Respondent's proposed supervisor, to the best of the Respondent's knowledge, should not be an individual who is currently under investigation, and has not been disciplined by the Board within the past five years;

[2] If the Respondent's license expires during the period of probation, the probation and any conditions will be tolled.

(c) if the Respondent fails to provide a proposed supervisor's name within 30 calendar days from the effective date of the order, the Respondent's license shall be automatically suspended from the 31st day until the Respondent provides the name and background of a supervisor;

(d) the disciplinary panel, in its discretion, may accept the proposed supervisor or request that the Respondent submit a name and professional background, and written notice of confirmation from a different supervisor;

(e) the supervision begins after the disciplinary panel approves the proposed supervisor;

(f) the disciplinary panel will provide the supervisor with a copy of this Consent Order and any other documents the disciplinary panel deems relevant;

(g) the Respondent shall grant the supervisor access to patient records selected by the supervisor, which shall, to the extent practicable, focus on the type of treatment at issue in the Respondent's charges;

(h) if the supervisor for any reason ceases to provide supervision, the Respondent shall immediately notify the Board and shall not practice medicine beyond the 30th day after the supervisor has ceased to provide supervision and until the Respondent has submitted the name and professional background, and written notice of confirmation, from a proposed replacement supervisor to the disciplinary panel;

(i) it shall be the Respondent's responsibility to ensure that the supervisor:

(1) reviews the records of 10 patients each month, such patient records to be chosen by the supervisor and not the Respondent;

(2) meets in-person or virtually[3] with the Respondent at least once each month and discuss in-person or virtually with the Respondent the care the Respondent has provided for these specific patients;

(3) be available to the Respondent for consultations on any patient;

(4) maintains the confidentiality of all medical records and patient information;

(5) provides the Board with quarterly reports which detail the quality of the Respondent's practice, any deficiencies, concerns, or needed improvements, as well as any measures that have been taken to improve patient care; and

(6) immediately reports to the Board any indication that the Respondent may pose a substantial risk to patients;

(j) the Respondent shall follow any recommendations of the supervisor;

(k) if the disciplinary panel, upon consideration of the supervisory reports and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care or failing

[3] The meeting may take place virtually during the state of emergency.

to keep adequate medical records in his or her practice, the disciplinary panel may find a violation of probation after a hearing.

(4) **Within the probationary period of TWO (2) YEARS**, the Respondent shall pay a civil fine of **FIVE THOUSAND DOLLARS ($5,000)**. The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

ORDERED that the respondent shall not apply for early termination of probation; and it is further

ORDERED that a violation of probation constitutes a violation of this Consent Order; and it is further

ORDERED that, after the Respondent has complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit to the Board a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss his petition for termination. The disciplinary panel may grant the petition to terminate the probation, through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and there are no pending complaints relating to the charges; and it is further

ORDERED that, if the Respondent allegedly fails to comply with any term or condition imposed by this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If the disciplinary panel determines there is a genuine dispute as to a material fact, the hearing shall be before an administrative law judge of the Office

of Administrative Hearings followed by an exceptions process before a disciplinary panel; and if the disciplinary panel determines there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend with appropriate terms and conditions, or revoke the Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director or her designee signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

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

Signature on File

04/29/2021
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, George Wathen, 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.

Signature on File

4/16/21
Date

George Wathen, M.D.
Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF CHARLES

I HEREBY CERTIFY that on this 16th day of APRIL 2021, before me, a Notary Public of the foregoing State and City/County, personally appeared George Wathen, 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.

ANDREA M. SCOTT
Notary Public
Charles County
Maryland
My Commission Expires May 25, 2024

Notary Public

My Commission expires: MAY 25, 2024