IN THE MATTER OF	*	**BEFORE THE**
GARY J. SPROUSE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D32036	*	**Case Numbers: 2218-0276 A** **2218-0283 A**

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CONSENT ORDER

On August 23, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **GARY J. SPROUSE, M.D.** (the "Respondent"), License Number D32036, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 Repl. Vol. and 2018 Supp.).

Panel A charged 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;
>
> . . .
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

In addition, Panel A charged Respondent with having violated Condition 5 of the terms and conditions of the Amended Final Decision and Order of the Board of July 11, 2016 (the "Order"). Under the terms of the Order, Respondent was placed on probation for a minimum period of 18 months. Condition 5 states:

> 5. Dr. Sprouse shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101 – 14-702, and all laws and regulations governing the practice of medicine in Maryland[.]

On October 16, 2019 Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. The Parties did not reach an agreement at the DCCR.

Subsequently, the case was referred to the Office of Administrative Hearings ("OAH"). As a result of recent settlement negotiations, the parties have reached an agreement as detailed below consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel A finds:

I. Background Information

1. Respondent is licensed to practice medicine in the State of Maryland. Respondent was initially licensed to practice medicine in Maryland on March 8, 1985. The Respondent's license is active through September 30, 2021.

2. Respondent is board-certified in internal medicine having been granted lifetime certification in 1985.

3. Respondent maintains two medical offices on the Eastern Shore of Maryland. In his Chester, Maryland office, Respondent practices internal medicine and pain medicine.

In his Salisbury, Maryland office, Respondent practices addiction medicine. Respondent is the sole physician in these offices, although he supervises a physician assistant in his Chester office.

4. Respondent does not hold any hospital privileges. Respondent does have privileges at multiple nursing homes on the Eastern Shore of Maryland.

5. Respondent holds a waiver issued by the Center for Substance Abuse Treatment ("CSAT"), Substance Abuse and Mental Health Services Administration ("SAMHSA") of the U.S. Department of Health and Human Services ("HHS"), to practice opioid dependency treatment with approved buprenorphine[1] medications, for up to 275 patients.

6. As of August 12, 2019, Respondent is prohibited from prescribing opioids.[2]

II. Disciplinary History

7. Respondent has a lengthy disciplinary history with the Board, beginning in 1996. On June 26, 1996, Respondent entered a Consent Order with the Board wherein he was reprimanded and ordered to pay a $5,000 fine for practicing medicine with an unauthorized person or aiding an unauthorized person in the practice of medicine in violation of Health Occ. § 14-404(a)(18). Specifically, Respondent permitted a registered nurse ("RN") who he employed in his medical office to perform as a nurse practitioner, even though she was not certified as a nurse practitioner, including permitting the RN to issue prescriptions which Respondent had pre-signed.

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[1] Buprenorphine, an opioid, is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine.

[2] See Paragraph 13 under Disciplinary history.

8. On July 22, 2013, after an evidentiary hearing before an administrative law judge in June 2012, the Board issued a Final Decision and Order, concluding that Respondent violated Health Occ. § 14-404(a)(2)(deceptively uses a license); (3)(ii)(unprofessional conduct in the practice of medicine); and (11)(false report in the practice of practice of medicine), based on his signing a Certificate of Merit in a medical malpractice action without reviewing the medical records; (22)(fails to meet standards of quality medical care regarding his prescribing opioids to patients with chronic pain, specifically his increasing dosages of opioids, failure to reduce doses, failure to address addictions to medications and failure to refer to specialists); and (40)(inadequate documentation). The Board suspended Respondent's license until he successfully completed Board–approved courses in pain management, medical ethics, and medical record keeping.

9. On September 10, 2013, after Respondent completed the required courses, the Board issued an Order Terminating Suspension and Imposing Probation. Respondent was placed on probation for a minimum of three years under the condition that his practice be subject to a peer and/or chart review and that he comply with the Act.

10. On July 30, 2014, after an evidentiary hearing before an administrative law judge in 2013, the Board issued a Final Decision and Order, concluding that Respondent violated Health Occ. § 14-404(a)(22)(fails to meet standards of quality medical care) based on his improper prescribing of opioids and his treatment of a patient with suicidal depression. The Board noted the seriousness of these findings and that Respondent had already been sanctioned in 2013 for many of the issues in this case. Respondent was still on

probation to address the issues in the previous case. The Board reprimanded Respondent.

11. On July 11, 2016, after an evidentiary hearing before an administrative law judge in 2015, Panel A issued an Amended Final Decision and Order, concluding that Respondent violated the September 10, 2013 Probation Order, which required him to comply with the Act. Respondent failed to meet standards of quality care based on his failure to provide safe and effective treatment for chronic pain in violation of Health Occ. § 14-404(a)(22).

12. Panel A found that Respondent prescribed excessively high doses of opioids, failed to sufficiently describe the pain complaints to justify prescribing opioids, inappropriately simultaneously prescribed benzodiazepines and opioids, and failed to refer the patients to a pain management specialist. Panel A reprimanded Respondent and placed him on probation for 18 months under the condition that his practice be supervised by two supervisors, one who specializes in pain and the other who specializes in psychiatry with experience in treating psychiatric conditions concomitant with pain conditions.

13. On August 12, 2019, the Board issued a Cease and Desist Order, ordering Respondent to "Cease and Desist from prescribing or dispensing opioids in the State of Maryland" and further ordering that "Respondent shall not delegate to any physician assistant the prescribing of any opioids."

14. Respondent has been under the Board's supervision continuously since July 22, 2013. His most current probationary period began on July 11, 2016.

III. Complaints

15. Beginning in October 2017, the Board began to receive numerous complaints about Respondent's prescribing of controlled substances. The Board continued to receive complaints throughout 2018 and 2019, from anonymous sources, named individuals, Maryland physicians, and the Maryland Department of Health ("MDH"), specifically the Office of the Inspector General ("OIG") and the Office of Controlled Substance Administration ("OCSA"), all of which asserted that Respondent improperly prescribed opioids, benzodiazepines, methadone, and buprenorphine. The most recent complaint was received on August 9, 2019. In sum, since late 2017, the Board has received 12 complaints, the majority of which are from health care professionals. The complaints are summarized in the following paragraphs 15 through 25.

16. On October 2, 2017, the Board received a complaint from an anonymous individual stating that Respondent is "prescribing narcotics in too high doses, and too many pills, and prescribing narcotics with sedatives" to a patient ("Patient 11"[3]). The complainant stated that Patient 11 "sells his narcotics and sedatives to anybody who wants them."

17. On December 12, 2017, the Board received a complaint from a physician who is a member of a local drug Overdose Fatality Review ("OFR") team ("Physician A") regarding the death of Patient 12 and the review of Patient 12's CDS prescription records.

[3] For privacy and confidentiality purposes, the names of individuals and patient names are not included in this document. The numbering of the patients in the Consent Order begins with Patient 11 because Patients 1 through 10 are the subjects of the Cease and Desist Order which was issued prior to the Consent Order.

Physician A stated that Patient 12's death was related to morphine and fentanyl intoxication, and other illicit drugs; however, he did not have any of his prescribed buprenorphine/naloxone present in his postmortem toxicology which Respondent had prescribed to treat Patient 12's drug dependence. Physician A reported that Respondent prescribed Zubsolv[4] 11/4, 90 tablets per month for several months in 2017, which represents dosing at a level of more than twice the recommended upper limits; and, in addition, Respondent prescribed alprazolam 1 mg. 90 tablets. Physician A stated that the postmortem toxicology report raised concerns that Patient 12 was diverting his prescriptions that Respondent had prescribed, furthering Patient 12's use of illicit drugs.

18. On March 12, 2018, the Board received a written complaint from the friend of a deceased patient of Respondent's, Patient 1[5], "an active alcoholic with liver failure." The complainant stated that in late 2016, Respondent started prescribing Oxycontin, which Respondent continued to increase, and then started prescribing Ambien, Xanax, and Methadone.

19. On June 28, 2018, the Board received a report from an MDH OIG Pharmacy Claims Investigator (the "Pharmacist A") who had reviewed prescription claims from Medicaid recipients from January 2016 through March 2018. For the 28 patients that Respondent treated with chronic opioids, Pharmacist A reported:

> The doses and quantities were usually excessive. It was common for patients to be prescribed Methadone 10 mg, Hydromorphone 8 mg, and Oxycodone 15 mg and 30 mg at quantities of #100 to #150. These same patients usually received high dose, high quantity

[4] Zubsolv is a combination of buprenorphine/naloxone in the form of sublingual tablets.
[5] Respondent's care of Patient 1 was peer reviewed. See paragraph 29a.

> benzodiazepines, such as Alprazolam 2 mg and Clonazepam 2 mg concurrently.

20. On June 26, 2018, the Board received a complaint from an anonymous health care provider. The complainant stated that he has seen a patient who was on chronic opioids and benzodiazepines ("Patient 2"[6]). The complainant referred the patient to pain management, but the patient continued to present requesting high doses of benzodiazepines. The complainant started to taper the patient, but the patient called and stated, "I found someone who will write me for what I want" and gave the name of the new provider as Respondent. In addition, the complainant referred to a second patient ("Patient 3"[7]) in Respondent's practice who is filling "high doses of opiates and benzodiazepine and paying cash for the prescriptions."

21. On July 18, 2018, the Board received a written complaint from a pharmacist ("Pharmacist B") at a pharmacy in Dorchester County, Maryland, who noted "an unusual prescribing pattern for oxycodone at large quantities and high doses" and that Respondent "frequently writes for multiple controlled substances at once."

22. On April 17, 2019, the Board received a complaint from OCSA, informing the Board that regulatory inspections of pharmacies have revealed prescriptions which OCSA has identified as having "multiple red flags." Pharmacist C reported:

> The PDMP report indicted large amounts of prescriptions are being written to patients under 40 who are traveling long distances for this medication. Many opioid prescriptions are being written for high strength/large quantities and are being filled in combination with

[6] Respondent subsequently identified this individual, based on information in the complaint, as Patient 2. Respondent's care of Patient 2 was peer reviewed. See paragraph 29b.

[7] Respondent subsequently identified this individual, based on information in the complaint, as Patient 3. Respondent's care of Patient 3 was peer reviewed. See paragraph 29c.

> either a benzodiazepine or stimulant. There are multiple patients that live at the same address receiving the same pattern of prescriptions. The data indicates that multiple patients have been receiving opioids for chronic pain rather than acute pain due to the durations of the prescriptions. Dr. Sprouse doesn't seem to attempt to reduce the opioid pain meds he was prescribing not to wean the patients off their medications. Also, he did not appear to be making referrals to pain specialist or psychiatrist when indicated.

Pharmacist C also reported that OCSA has received the following complaints:

> The first complaint was from a pharmacy in Salisbury, MD. The pharmacist had concerns about Dr. Sprouse's prescribing patterns and that Dr. Sprouse gives patients his cell phone number should they have a problem getting their prescriptions filled. When this happened the pharmacy call Dr. Sprouse and he approves the prescriptions.
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> The second complaint was from a pharmacy in Cumberland, MD. The pharmacist stated the prescribing patterns of Dr. Sprouse are egregiously problematic to young patients that are traveling long distances between home, Dr. Sprouse and the pharmacy.

23. On June 25, 2019, the Board received a complaint from an anonymous physician who stated that he/she:

> [T]reat(s) a patient who has been receiving repeating prescriptions for Adderall XR from Dr. Sprouse...My primary concern is that this patient has poorly controlled hypertension. Blood pressure readings are often 160s/100s during his visits. He has a strong family history of stroke and cardiovascular disease. He reports that Dr. Sprouse does not monitor blood pressure during appointments.

24. On July 24, 2019, the Board received a complaint from OCSA. The pharmacist ("Pharmacist D"), reported to the Board that OCSA received an anonymous complaint regarding an individual with whom Respondent has a business relationship. According to the complainant, Respondent is treating the individual and prescribed Suboxone and Xanax to the individual, who has a history of benzodiazepine abuse.

25. On July 18, 2019, the Board received a complaint from a pharmacist ("Pharmacist E") who reported the following:

> On June 19, 2019, he wrote prescriptions for patient ("Patient 21") for Oxycodone 30 and Adderall 20 with notes to fill early due to medial emergency. This was filled 9 days early due to this information. On 7/16/19 we received 2 electronic prescriptions for the same medications. I denied them and Dr. Sprouse called to say he was once again leaving for a medical emergency. I explained it was too soon and he mentioned changing the dose of the medication to allow us to fill it. I still denied it and the patient subsequently went to a pharmacy in Dover DE, roughly 1 hour away from here and had a prescription for Oxycodone 20 mg. filled. I am concerned that patients are traveling 45 minutes or longer to see Dr. Sprouse. I am concerned that he will readily change a dose of a medications for an early fill. I am also concerned that there is a lack of understanding of the position a pharmacist is put in when asked to fill narcotic prescriptions early.

26. On August 9, 2019, the Board received a complaint from a physician ("Physician B") at an emergency department ("ED") of a health care facility on the Eastern Shore of Maryland ("Facility A") who summarized his complaint as:

> Inappropriate prescribing of CDS drugs to a patient with prior history of opioid overdose. By a practitioner with a history of inappropriate prescribing habits.

Physician B included the name of the patient ("Patient 22") and attached supporting documentation which included the medical record of Patient 22's visit to the Facility on August 6, 2019, where Patient 21 presented with the chief complaint of SOB (shortness of breath) and chest pressure. Physician A also attached a Prescription Drug Monitoring Program ("PDMP") Report on Patient 22 and the medical record of Patient 22's treatment at the ED of another facility on the Eastern Shore ("Facility B"), where Patient 22 was seen on March 2, 2019, and treated for a drug overdose after being found

unresponsive at a nursing home. The PDMP report stated that Patient 22 was prescribed oxycodone for pains in the lower extremities. The PDMP report shows that on July 17, 2019, Patient 22 filled a prescription from Respondent for oxycodone 15 mg, 120 tablets, after Patient 22 had recently been treated for an overdose with oxycodone.

IV. Investigation in Case No. 2218-0276 A

27. On February 8, 2019, the Board transmitted the pertinent investigative documents, including Respondent's medical records of ten patients, to an independent peer review entity for review by two physicians, both who are board-certified in Physical Medicine and Rehabilitation with a subspecialty in Pain Medicine.

28. On March 26, and April 4, 2019, respectively, the two peer reviewers submitted their reports to the Board which found that in ten of the ten patient records reviewed, Respondent failed to meet standards of quality medical care.

29. The peer reviewers summarized Respondent's deficiencies regarding each of the ten patients as follows:

a. Patient 1- Respondent prescribed high doses of opioids (500 MME/day) to Patient 1 who had liver cirrhosis from alcohol abuse. Respondent did not adjust Patient 1's doses to take into account the altered metabolism based on liver impairment. Respondent prescribed Methadone chronically for Patient 1 but failed to check a 12 lead EKG for the risk of QTc prolongation, which could lead to a fatal arrhythmia while using Methadone. Respondent did not have a strategy to deal with Patient 1's development of opioid tolerance, such as rotating to another opioid. Respondent provided limited discussion of Patient 1's reported chronic pain syndrome, but no comprehensive patient evaluation, treatment plan, or ongoing assessments. Respondent obtained only limited drug screens;

b. Patient 2 - Respondent concomitantly prescribed Oxycodone and benzodiazepines to Patient 2 but failed to justify why the benefit

outweighed the risk nor did he try safer alternatives. Although he was aware that Patient 2 was cutting his medications in half and was satisfactory, Respondent did not reduce either the opioid or the benzodiazepine. Patient had groin pain from a previous hernia repair, but Respondent failed to do a workup or a referral to a general surgeon for evaluation of post-operative pathology. Respondent only obtained one urine drug screen and no pill counts; and continued high dose opioid medication although Patient 2 did not show any significant improvement;

c. Patient 3 - Patient 3 sought care from Respondent after a pain specialist had decreased Patient 3's opioid regimen. Respondent failed to contact the prior treating pain specialist or obtain medical records to understand why the prior physician made the adjustment. Respondent treated Patient 3 with high dose Methadone but failed to obtain a 12 lead EKG to assess the risk of prolonged QTc and failed to obtain the result of a prior EKG. Respondent stated he intended to reduce Patient 3's pain medications but instead he increased pain medication. Respondent prescribed benzodiazepines chronically even though an anxiety assessment tool noted that Patient 3 had minimal anxiety. Respondent failed to justify why the benefit of concomitant prescribing of opioids and benzodiazepines outweighed the risk nor did he try safer alternatives;

d. Patient 4 - Patient 4 reportedly has been on pain medications for 21 years, off and on, and although Respondent decreased Patient 4's medication, Patient 4 remained on 420 MME/day at the time of the review. Respondent chronically prescribed benzodiazepines and while he noted Patient 4's side effects from SSRI medications used for anxiety, he failed to refer Patient 4 to a psychiatrist for treatment of his panic attacks. Respondent also failed to refer Patient 4 to a spine specialist. Respondent used Methadone to treat Patient 4's chronic pain but failed to obtain a 12 lead EKG to assess the risk of prolonged QTc. Respondent continued to prescribe daily Klonopin even though Patient 4's urine was negative for Klonopin and Patient 4 reported using Klonopin as a "prn" medication; and Respondent failed to address the presence of a marijuana metabolite in Patient 4's urine in multiple drug tests. Respondent did not justify why he prescribed opioids and benzodiazepines concurrently;

e. Patient 5 - Respondent rapidly escalated Patient 5's opioids over the course of seven to eight months, starting a 150 MME and escalating to greater than 800 MME/day instead of the standard of starting low

and titrating slowly. Patient 5 reportedly had been doubling his medication and using his sister's Valium to achieve pain control, but Respondent failed to counsel Patient 5 about the risks and proceeded to increase Patient 5's pain medication dose. Respondent failed to check a 12 lead EKG prior to starting Methadone. Respondent documented only limited monitoring and Respondent failed to respond to a urine drug screen which showed non-prescribed illicit drug use. Respondent did not justify why he prescribed opioids and benzodiazepines concurrently;

f. Patient 6 - Respondent prescribed an exceedingly high opioid regimen to Patient 6 by combining Fentanyl and Oxycodone 30 mg, dispensing 300 tablets a month for a total of 1170 MME/day. Respondent failed to refer Patient 6 to a pain management specialist early in the treatment course because Patient 6's medical conditions and treatment needs, such as a pain pump, were highly complex. When Respondent finally did refer Patient 6 for an evaluation, Respondent failed to ensure and insist that Patient 6 follow through;

g. Patient 7- Respondent treated Patient 7 with high dose opioids, including Methadone, equivalent to 500 MME/day, in combination with a benzodiazepine, but failed to justify why the benefit outweighed the risk nor did he try safer alternatives. Respondent failed to obtain a 12 lead EKG to assess the risk of prolonged QTc;

h. Patient 8 - Respondent treated Patient 8 with high dose opioids, including Methadone, equivalent to 1500 MME/day by July 2018. Respondent failed to obtain a 12 lead EKG to assess the risk of prolonged QTc. Respondent only obtained one urine drug screen on Patient 8 during the review period, which was negative for prescribed oxycodone. Respondent failed to respond to this result;

i. Patient 9 - Respondent prescribed Oxycodone and Klonopin concomitantly to Patient 9, as well as an additional prescription for Xanax because of "multiple stressors" but failed to justify why the benefit outweighed the risk nor did he try safer alternatives, nor did he alter the regimen when Patient 9 used more Klonopin than prescribed. Respondent failed to document that Patient 9 failed a drug test and thereafter, failed to order enough random drug tests. Respondent failed to ensure that Patient 9 followed through with his referral to a Rheumatologist. Patient 9 could have benefited from disease modifying anti-rheumatic drugs which potentially could have reduced Patient 9's opioid load and failed to use non-opioids to treat her Fibromyalgia syndrome which potentially could reduce her opioid

load; and

j. Patient 10 - Respondent failed to request and review Patient 10's past medical records, such as imaging studies or notes from a neurologist who diagnosed Trigeminal Neuralgia, to corroborate Patient 10's reports. Respondent started Patient 10 on an opioid regimen and quickly escalated the dose going from 30 MME/day to 500 MME/day, without any objective evidence of significant pathology, new trauma, or new pathology findings. Respondent failed to appropriately respond to drug test inconsistencies and failed to obtain frequent random drug tests based on prior insistencies, over taking prescription opioids outside of Respondent's instructions, running out of medication early and her reported history of smoking marijuana.

V. Investigation – Case No. 2218-0283

30. On February 8, 2019, the Board transmitted the case to an independent peer view entity for review by two physicians, one who is board-certified in Psychiatry with subspecialty certification in Addiction Psychiatry and the other who is Board certified in Family Medicine and is certified as an Addiction Medicine Specialist by the American Society of Addiction Medicine. The reviewers were provided the pertinent investigative documents, including the medical records of Patients 11 and 12 and eight additional patients.

31. On March 23, and March 25, 2019, respectively, the two peer reviewers submitted their reports to the Board which found that in all ten of the reviewed cases, Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records, with respect to Patients 11 through 20.

32. The peer reviewers summarized Respondent's deficiencies regarding each of the ten patients as follows:

a. Prescribed buprenorphine but on the initial visits, but never obtained vital signs on the initial visit, or subsequently when patients complained of feeling ill and in possible withdrawal, or had a chronic disease, such as Patient 19 who had hyperemesis;

b. In all ten cases, failed to obtain a comprehensive, multidimensional bio-psycho-social history/assessment on all new patients, which is a standard for physicians prescribing buprenorphine to treat opioid use disorder, never obtained a detailed addiction history on any patient, including types of drugs abused methods of abuse, quantity, duration, triggers/cravings, side effects, history of withdrawal, complications, illegal activity, history of recovery efforts, whether abstinence achieved and for how long and never contacted the programs that a few of the patients stated they attended;

c. Failed to fully describe current mental status on each visit and to discuss the psychiatric conditions he was treating;

d. In all ten cases, prescribed very high doses of Suboxone, Subutex or Zubsolv at the outset of treatment, routinely prescribing 24mg buprenorphine without medical justification in the record, instead of appropriately initiating buprenorphine tailored to the patients' last use of opioids and according to recommended guidelines which begin with low doses and titrate slowly; and, failed to determine whether the patient is currently intoxicated or in a state of withdrawal before beginning buprenorphine;

e. Prescribed extremely high doses of buprenorphine, up to 8 mg tid and a sedative, Xanax 2.5 mg bid, to Patient 11. Respondent noted that Patient 11 had a seizure but; Respondent did not document any specifics, and especially failed to consider that the seizure could have been withdrawal from sedatives;

f. Diagnosed co-morbid psychiatric conditions such as anxiety and Attention Deficit Disorder ("ADHD") without a detailed history, including history of prior treatment but instead used a diagnostic tool to diagnose anxiety/panic which has no merit when administered to an addict because it is easily manipulated; and, used a diagnostic tool to diagnose Attention Deficit Disorder ("ADD") which can also be easily manipulated in order to obtain amphetamines;

g. Routinely treated psychiatric conditions in patients with an addiction history with medications without including therapy, using short-

acting drugs, such as benzodiazepines with abuse potential and street value for anxiety/panic, (without regard to the danger of mixing a sedative with buprenorphine) and using instant release amphetamines for ADD/ADHD. In all of these cases, Respondent failed to begin treatment of anxiety or ADD/ADHD with therapy and a non-scheduled, non-abusable prescription medication such as an SSRI/SNRI for anxiety or a norepinephrine reuptake inhibitor for ADD/ADHD;

h. Treated Patient 17 with Thioridazine, an antipsychotic drug belonging to the phenothiazine drug group, previously used in the treatment of schizophrenia and psychosis, along with Xanax, and without a psychiatric evaluation;

i. Failed to collaborate or refer these patients with addiction history and co-morbid psychiatric conditions to counseling services which should be recommended to any patient in treatment for substance use disorder;

j. Failed to order a urine toxicology screen on the initial visit which is vital to determine presence of abusable drugs, to validate history of last drug use and the types of drugs abused;

k. Rarely ordered toxicology screens, and when he did, he failed to recognize that the results demonstrated an unreported relapse, or diversion, or that the specimens had been tampered with (Patients 13 and 20) and failed to respond appropriately. For example, Patients 11 and 13 had urine toxicology screens were negative for all sedatives, even though Respondent had been prescribing high doses of sedatives. Respondent continued to prescribe Xanax to Patient 11 and failed to order subsequent toxicology screens;

l. Failed to recognize that buprenorphine alone is not sufficient treatment for an addiction and failed to demand that his patients enter IOP (Intensive Out-Patient) programs to develop the skills necessary to develop and maintain sobriety;

m. Failed to use an addiction treatment contract but instead used a contract suitable for chronic pain patients and therefore did not have any provisions in the contract demanding the patient do "recovery work" as a condition for receiving medications; and ignored or violated his own rules in the contract which are applicable to addiction patients, such as not refilling lost and/or stolen prescriptions;

n. Mixed Cymbalta and Suboxone and Xanax; mixed Adderall and thioridazine; mixed two benzodiazepines and buprenorphine and Ambien, all of which are dangerous combinations;

o. Prescribed Suboxone/Zubsolv, which contains naloxone and is a high toxicity risk, to Patient 12, who had a diagnosis of hepatitis C, without initially obtaining a liver function test and failed to monitor Patient 12 with monthly liver function tests during treatment;

p. Inappropriately attributed Patient 12's tachycardia to withdrawal even though Patient 12 was on buprenorphine, and failed to investigate other causes of tachycardia, based on Patient 12's history of endocarditis;

q. Failed to assess and titrate Patient 19's dose of buprenorphine to the lowest level that prevented craving or withdrawal symptoms prior to the delivery date, failed to consult with Patient 19's OB/GYN during her pregnancy, failed to lower Patient 19's buprenorphine while she was breastfeeding, and failed to obtain a complete blood count ("CBC") when Patient 19 complained of 4 months' of post-partum bleeding and she no longer had an OB/GYN;

r. Failed to respond to "red flags" such as patients coming from as far away as Carrol County, MD (Patient 16) and Pennsylvania (Patient 20), and Essex, MD (Patient 18); and

s. Failed to determine on the very first visit whether any of the patients had a primary care physician ("PCP") in order to communicate with the PCP, and in the case of Patient 20, prescribed Wellbutrin and Cymbalta even though Patient 20 stated she obtains these from her PCP.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes that the Respondent failed to meet standards of quality medical care in violation of Health Occ. § 14- 404(a)(22) of the Act and failed to keep adequate medical records in violation of Health Occ. § 14-404(a)(40) of the Act, and violated Condition 5 of the Final Decision and Order of July 11, 2016 by failing to comply with the Act, specifically Health Occ. § 14- 404(a)(22) and § 14-404(a)(40).

ORDER

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

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 physician assistants the prescribing or dispensing of all CDS; 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 any of the prohibited CDS 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 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 a Maryland medical license, the Respondent shall provide the Board with 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. The administrative subpoenas will request the Respondent's CDS prescriptions from the beginning of each quarter and it is further

ORDERED that the Respondent agrees to surrender the Respondent's CDS Registration to the Office of Controlled Substances Administration; and it further

ORDERED that within one (1) year, the Respondent shall pay a civil fine of $15,000. 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 effective date of the Consent Order **is 90 days after the date the Consent Order** is signed by the Executive Director of the Board. The Executive Director 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 the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; 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 this Consent Order is a public document. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. § 4-333(b)(6).

03/11/2020
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

CONSENT

I, Gary J. Sprouse, 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 eall 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.

3/16/2020

Date

Signature on File

Gary J. Sprouse, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 10th day of March 2020, before me, a Notary Public of the foregoing State and City/County, personally appeared Gary J. Sprouse, 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.

KATHLEEN MARY TODD
Notary Public-Maryland
Baltimore County
My Commission Expires

Kathleen Mary Todd
Notary Public

My Commission expires: June 1, 2022