IN THE MATTER OF	*	**BEFORE THE**
THEODORE C. HOUK, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D41104	*	**Case Number: 2220-0221A**

* *

CEASE AND DESIST ORDER

Pursuant to the authority granted to Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") under Md. Code Ann., Health Occ. ("Health Occ.") § 14-206(e)(3) (2014 Repl. Vol. & 2020 Supp.), Panel A hereby orders **THEODORE C. HOUK, M.D.** (the "Respondent"), License Number D41104 to immediately **CEASE AND DESIST** from prescribing and dispensing all Controlled Dangerous Substances ("CDS") as defined under Criminal Law § 5-401.

The pertinent provisions of the Maryland Medical Practice Act (the "Act"), Health Occ. §§ 14-101 *et seq.*, under which Panel A issues this Order provide the following:

> **§ 14-206. Judicial Powers.**
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> (e) *Cease and desist orders; injunctions.* – A disciplinary panel may issue a cease and desist order or obtain injunctive relief against an individual for:
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> . . .
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> (3) Taking any action:
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> (i) For which a disciplianry panel determines there is a preponderance of evidence of grounds for discipline under §14-404 of this title; and
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> (ii) That poses a serious risk to the health, safety, and welfare of a patient.

§14-404. Denials, reprimands, probation, suspensions, and revocations.

(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[.]

INVESTIGATIVE FINDINGS[1]

Based on the investigatory information received by, made known to, and available to Panel A, there is reason to believe that the following facts are true:

I. BACKGROUND

1. At all relevant times, the Respondent was licensed to practice medicine in Maryland. He was originally licensed on December 17, 1990. His license is scheduled to expire on September 30, 2022.

2. The Respondent was board-certified in internal medicine; however, his board certification expired on December 31, 2015.

3. The Respondent maintains an office for the solo practice of internal medicine in Towson, Maryland.

[1] The statements regarding the Board's investigative findings are intended to provide the Respondent with reasonable notice of the Board's action. 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.

4. The Respondent is a certified provider with the Maryland Medical Cannabis Commission.

5. On or about December 11, 2019, the Board received a referral from the Maryland Department of Health, Office of Controlled Substances Administration ("OCSA") regarding the Respondent's CDS prescribing practices. Specifically, the OCSA referral stated that it was initiated by a pharmacist who complained that the Respondent was prescribing multiple CDS to a patient using multiple pharmacies and payment methods. OCSA obtained and verified documentation of CDS prescriptions written by the Respondent from September 2017 through September 2019. OCSA validated the pharmacist's concern and requested the Board to review the Respondent's CDS prescribing practices.

6. The Board thereafter initiated an investigation of the Respondent's CDS prescribing practice that included subpoenaing from the Respondent nine (9) patient records, referring the records for independent peer review by two (2) physicians who are board-certified in anesthesiology and pain management (the "Peer Reviewers"), requesting the Respondent to provide summaries of care of the patients, and interviewing the Respondent under oath.

The Respondent's Interview

7. On August 20, 2020, Board staff interviewed the Respondent under oath. In response to Board staff questions, the Respondent stated that he orders urine drug testing ("UDT") for his chronic pain patients once a year. The Respondent screens for opioids the patient has been prescribed, but not for illicit drugs.

8. The Respondent stated that he has been "trying to get everybody to sign a [controlled substance] contact once a year." The Respondent further stated that he has not discharged from his practice patients who have violated their opioid contract.

9. The Respondent stated that "for years" he has accepted medications, including opioids, that are returned by patients because "the D[rug]E[nforcement]A[dministration] asked me to do it that way." The Respondent stated that he maintained the returned medications in a locked safe in his office and that he currently has "about 50 pill containers in the locked box in my house."

10. Shortly after his Board interview, the Respondent submitted to the Board a written statement that stated in pertinent part, "[o]n rare occasions, probably less than 10 or 12 times in my 28 years of practice, patients have returned to me unused medications previously prescribed for them by me."

11. On September 14, 2020, the Board subpoenaed the Respondent's inventory of medications returned to him by patients.

12. On September 25, 2020, the Respondent submitted the inventory which documented that he accepted from patients over 100 medications, including opioids, from 2009 through July 2020. Many of the entries on the Respondent's inventory indicated "no name, no date of birth." The Respondent stated that patient names were removed from the medication labels at the patients' request.

Findings of the Peer Reviewers

13. The nine (9) patient records transmitted to the Board by the Respondent were referred for peer review. The Peer Reviewers separately reviewed the nine (9) patient records and submitted their individual reports to the Board.

14. The Peer Reviewers concurred that the Respondent failed to meet the standard of quality care in all nine (9) patient records they reviewed and failed to maintain adequate medical records in all nine (9) patient records.

15. Specifically, the Peer Reviewers found that the Respondent failed to meet the standard of quality care for reasons including, but not limited to, the following. The Respondent

a) prescribed and maintained chronic opioid regimens in dosages that exceeded 90 morphine milligram equivalents ("MME"[2]) per day. The Respondent frequently prescribed oxycodone, a CDS and commonly abused opioid;

b) prescribed and maintained chronic opioid regimens with dosages in excess of 90 MME per day to high-risk patients, including patients with extensive histories of alcohol and/or substance abuse, mental illness or severe obstructive sleep apnea;

c) prescribed benzodiazepines in conjunction with high dosages of opioids;

d) failed to discuss with patients the risks of taking benzodiazepines in conjunction with opioids;

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[2] MME is a value assigned to each opioid to represent its relative potency by using morphine as the standard comparison. The *Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain* uses MME to establish recommended opioid dosing and currently recommends using caution when prescribing opioid doses greater than 50 MME per day and avoiding or carefully justifying a decision to increase opioid doses to greater than or equal to 90 MME per day.

e) failed to conduct frequent and regular UDTs; several patients had no urine screenings in their records;

f) failed to conduct confirmatory UDTs to verify the presence of prescribed medications;

g) failed to review on a consistent and regular basis the Prescription Drug Monitoring Program ("PDMP") when prescribing high levels of opioids;

h) failed to conduct pill counts or other methods of monitoring patients' medication usage;

i) failed to consistently prescribe Naloxone to patients to whom he prescribed high dosages of opioids or opioids in conjunction with benzodiazepines;

(j) failed to consistently require patients to whom he prescribed opioids to sign a controlled substance contract.

16. The Respondent's medical documentation is frequently cryptic and fails to describe adequately his treatment rationale.

Additional Concerns Regarding the Respondent

17. Based on one of the Peer Reviewer's comments regarding the Respondent's overall opioid prescribing practices, the Board sought the Peer Reviewer's opinion on the safety of the Respondent continuing to prescribe CDS during the disposition of Panel A's charges against him.

18. The Peer Reviewer opined that the Respondent's prescribing practice is "highly risky" because he prescribes high dosages of commonly abused opioids, often in conjunction with benzodiazepines, in the absence of adequate and appropriate monitoring.

The Respondent prescribed excessive opioid regimens to several patients with comorbidities such as alcohol and/or substance abuse that further exacerbated the risk to the patient.

19. The Peer Reviewer further opined that the Respondent's practice of accepting and storing unused opioids from patients was inappropriate. The Peer Reviewer was unable to find any official guidelines over the past decade that corresponded to the Respondent's practice.

20. The Peer Reviewer concluded that there were enough concerns regarding the Respondent's opioid prescribing practices to warrant a cessation of the Respondent's ability to prescribe opioids.

CONCLUSIONS OF LAW

Based on the foregoing Investigative Findings, Panel A concludes as a matter of law that the Respondent failed to meet the standard of quality medical care and failed to keep adequate medical records with regard to his CDS prescribing practices. Because the Respondent's deficient CDS prescribing practices pose a serious risk to the health, safety, and welfare of a patient, a disciplianry panel may issue a cease and desist order. Health Occ. § 14-206(e)(3).

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law, it is by Panel A hereby:

ORDERED that pursuant to the authority under the Maryland Medical Practice Act, Health Occ. § 14-206(e)(3), the Respondent, Theodore C. Houk, shall **IMMEDIATELY**

CEASE AND DESIST from prescribing and dispensing all CDS, thus the Respondent shall not prescribe or dispense CDS to any person; and it is further

ORDERED that if the Respondent violates this Cease and Desist Order, Panel A may impose a fine, pursuant to Md. Code Regs. 10.32.02.11E(4)(a); and it is further

ORDERED that this Cease and Desist Order is **EFFECTIVE IMMEDIATELY** pursuant to Md. Code Regs. 10.32.02.11E(1)(b), and it is further

ORDERED that this is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* and Md. Code Regs. 10.32.02.11E(1)(a).

Signature on File

04/13/2021
Date

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians

NOTICE OF OPPORTUNITY FOR A HEARING

The Respondent may challenge the factual or legal basis of this initial order by filing a written opposition, which may include a request for a hearing, within 30 days of its issuance. The written opposition shall be made to:

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, Maryland 21215

A copy shall also be mailed to:

Victoria H. Pepper
Assistant Attorney General
Maryland Office of the Attorney General
Health Occupations Prosecution and Litigation Division
300 West Preston Street, Suite 201
Baltimore, Maryland 21201

If the Respondent files a written opposition and a request for a hearing, the Board shall consider that opposition and provide a hearing if requested. If the Respondent does not file a timely written opposition, the Respondent will lose the right to challenge this Initial Order to Cease and Desist and this Order will remain in effect.