IN THE MATTER OF	*	**BEFORE THE**
NICHOLAS G. SCOTTO, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D43246	*	**Case Number: 2220-0233A**

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CONSENT ORDER

On August 27, 2021, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged **NICHOLAS G. SCOTTO, M.D.** (the "Respondent"), License Number **D43246**, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2014 Repl. Vol. & 2020 Supp.). Panel A charged the Respondent under the following provisions of the Act:

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

One form of unprofessional conduct in the practice of medicine is providing treatment to family members. The American Medical Association has addressed this in a series of ethics opinions:[1]

Opinion 1.2.1 (2016) – Treating Self or Family

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

[1] The Board and the disciplinary panels may consider the Principles of Ethics of the American Medical Association, but those principles are not binding on the Board or the disciplinary panels. *See* COMAR 10.32.02.16.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoiding providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

On December 1, 2021, 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 this Consent Order, consisting of the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel A finds:

I. BACKGROUND

1. At all times relevant hereto, 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 May 28, 1992, under License Number D43246. The Respondent's license is currently active and scheduled to expire on September 30, 2021.

2. The Respondent is board-certified in addiction medicine and psychiatry.

3. At all times relevant hereto, the Respondent operated a general and addiction psychiatry practice (the "Practice") and is the Medical Director at an addiction counseling facility (the "Facility").

4. The Board received a complaint dated February 10, 2020, from the mother (the "Complainant") of one of the Respondent's patient's ("Patient 1") who raised concerns about the medications the Respondent prescribed to Patient 1.

5. Based on the Complaint, the Board initiated an investigation.

6. By letter dated April 29, 2020, the Board notified the Respondent that it had opened an investigation into his conduct and provided the Respondent with a copy of the Complaint. The Board directed the Respondent to provide a response to the Complaint.

7. On April 29, 2020, the Board also issued the Respondent a Subpoena Duces Tecum that directed the Respondent to transmit to the Board "a complete copy of any and all medical records" for twelve specific patients ("Patients 1-12") that "are in [the Respondent's] possession or [the Respondent's] constructive possession and control, whether generated by [the Respondent] or any other health care entity."

II. FAILURE TO MEET STANDARDS OF QUALITY MEDICAL CARE

8. In furtherance of its investigation, the Board submitted the records of Patients 1-10 and related materials to a peer review entity to determine if the Respondent complied with appropriate standards for the delivery of quality medical care. Two peer reviewers, each board-certified in addiction psychiatry, independently reviewed the materials and submitted their reports to the Board.

9. In their reports the two physician peer reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical care

for four (4) out of ten (10) patients (Patients 1, 4, 6, and 9), in violation of Health Occ. § 14-404(a)(22).

A. Patient-Specific Allegations

Patient 1

10. At the time of review, Patient 1 was a female in her late 20s. The Respondent provided medication management to Patient 1 from May 2016 until at least May 2020.

11. Patient 1 first saw the Respondent on May 4, 2016, at which time the Respondent documented that the patient had been using illicit suboxone for the past three weeks; the patient previously had at least four inpatient treatments for chemical dependence; the patient reported that she had reduced cravings when her ADHD was treated; she was severely allergic to Naloxone; and was not currently prescribed medications. The Respondent diagnosed the patient with ADHD (based upon a self-report symptom survey), severe opioid use disorder, and severe sedative, hypnotic, or anxiolytic use disorder, among other things. The Respondent prescribed buprenorphine[2] and Vyvanse[3] 20mg daily, and documented that he would eventually taper the patient off Subutex.

12. At the next visit on June 7, 2016, the Respondent prescribed Subutex 8mg twice daily and increased her Vyvanse prescription to 50mg daily. The next visit was on June 29, 2016, at which time, the Respondent prescribed Subutex, but documented that

[2] Buprenorphine (Brand name Subutex) is an opioid medication used to treat opioid addiction. It is a Schedule III Controlled Dangerous Substance ("CDS").

[3] Vyvanse is a central nervous system stimulant. It is a Schedule II CDS and is FDA-approved to treat attention deficit hyperactivity disorder (ADHD).

he wrote a letter to the patient's probation officer reporting that the patient is prescribed Suboxone.[4]

13. On August 15, 2016, the Respondent prescribed Vistaril[5] 50mg twice daily as needed and Clonidine[6] 0.1mg as needed for restless leg syndrome, and noted that the patient was now in psychotherapy. Vyvanse and Clonidine were discontinued on September 12, 2016, while Requip[7] 0.1mg and Adderall[8] 30mg were added.

14. On October 19, 2016, the patient reported her purse was stolen along with her Adderall and Subutex. The Respondent prescribed a replacement 40 tablets of Subutex 8mg twice daily. The record did not contain a police report or other attempt to verify whether Patient 1's purse was actually stolen. The Respondent also authorized an early refill of Adderall XR 30mg on October 24, 2016.

15. The Respondent discontinued Vistaril on June 28, 2017, and added Bupropion[9] 150mg XL, Seroquel[10] 50mg, and Requip 1mg, as well as continued Adderall

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[4] Suboxone (generic name buprenorphine and naloxone) contains a combination of buprenorphine and naloxone. It is an opioid medication used to treat opioid addiction and it is a Schedule III CDS.

[5] Vistaril (generic name hydroxyzine) reduces activity in the central nervous system and acts as an antihistamine. It is a prescription-only medication used as a sedative to treat anxiety and tension and to treat allergic skin reactions.

[6] Clonidine (Brand names Catapres and Kapvay) is a prescription-only medication used to treat hypertension and ADHD.

[7] Requip is a dopaminergic agent and it has some of the same effects as dopamine. It is a prescription-only medication used to symptoms of Parkinson's disease (stiffness, tremors, muscle spasms, and poor muscle control) and restless legs syndrome (RLS).

[8] Adderall contains a combination of amphetamine and dextroamphetamine. It is a Schedule II CDS used to treat ADHD and narcolepsy.

[9] Bupropion (Brand name Wellbutrin) is an antidepressant medication used to treat major depressive disorder and seasonal affective disorder. It is a prescription-only medication.

[10] Seroquel (generic name quetiapine) is an antipsychotic medicine. It works by changing the actions of chemicals in the brain. It is a prescription-only medication used to treat schizophrenia, bipolar disorder (manic depression), and major depressive disorder.

XR 30mg daily, Subutex 8mg sublingually twice daily, and Clonidine 0.1mg twice daily, among other medications.

16. The patient contacted the Respondent on January 12, 2018, and requested refills of her Adderall and reported that she had relapsed. The Respondent referred the patient to an addiction intensive outpatient program. Then, on February 1, 2018, the Respondent adjusted the patient's Subutex to 8mg 1.5 doses per day and stopped the Adderall. By April 11, 2018, Patient 1 had tested positive for non-prescribed benzodiazepines and amphetamines and was no longer in the addiction program. At that time, the Respondent prescribed Subutex 8mg one and a half daily, Wellbutrin SR 150mg, and Adderall XR 30mg twice daily, among other medications. The Respondent continued the patient's medication regimen until June 19, 2019, when he added Seroquel 50mg.

17. The patient reported that someone stole her medications on August 30, 2019. The Respondent prescribed a replacement of Subutex 8mg sublingual.

18. On September 17, 2019, the Respondent changed the patient from Adderall to Strattera[11] 40mg once a day when the patient reported she was moving into a recovery house that does not allow amphetamines.

19. The patient admitted to relapsing again and using heroin at the appointment on October 29, 2019. At this time the Respondent documented that he suggested that the patient go to a recovery house, and stated he could consider restarting Adderall when the patient has been clean for 90 days as "an incentive not to use." The Respondent also

[11] Strattera is a prescription-only non-stimulant medication used to treat ADHD.

documented for the first time that he discussed the risk of using opioids, as well as the risks of using opioids in conjunction with alcohol and benzodiazepines. The Respondent continued to prescribe Subutex 8mg twice daily, among other medications.

20. On December 10, 2019, forty-two (42) days after the last appointment, the Respondent prescribed Adderall XR 20mg. A week later on December 17, 2019, the Respondent prescribed Clindamycin[12] HCl 300mg without documenting any corresponding diagnosis.

21. On May 16, 2020, following the complaint against the Respondent to the Board, the Respondent called Patient 1 because he wanted to "see how she was doing after having read the complaint written by her mother." During this conversation the patient reported that she "relapsed last January" and was "selling my Adderall and my mother called the Narcotics Task force on me." The Respondent further documented that when he asked the patient why she kept requesting medication refills if she was not taking them, the patient stated she wanted to "have meds around in case my friends hit me up for them." When the Respondent asked the patient if she had another provider caring for her psychologically, she responded "your [*sic*] still my doctor." The Respondent further documented that his "his intent was to explain I could no longer be her psychiatrist and make sure she had someone to take over her care." They agreed to continue their conversation later; however, after being unable to speak with the patient, the Respondent documented that he was sending a letter terminating her care.

[12] Clindamycin is a prescription-only antibiotic.

22. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care regarding Patient 1 for reasons including:

A. Prescribed Subutex while documenting in a note to the patient's probation officer that the patient was prescribed Suboxone;

B. Failed to advise the patient of the risks associated with using opiates and sedative hypnotics together until the patient suffered a relapse on heroin on October 29, 2019;

C. Failed to adequately recognize and address the patient's potential diversion of Adderall to friends despite losing Adderall and other medications on more than one occasion;

D. Prescribed amphetamines without a comprehensive ADHD assessment or comprehensive ADHD treatment plan; and

E. Failed to recognize or adequately address that stimulant use may be complicating the treatment of the patient's other disorders with potential side effects that can produce mood instability, anxiety/panic, depression, and a protracted withdrawal syndrome.

23. The Board provided the Respondent with the peer reviewers' findings. By letter dated April 14, 2021, the Respondent submitted his response. As part of his response regarding Patient 1, the Respondent stated:

A. "I agree this was a mistake in my documentation" to document in a note to the patient's probation officer that the patient was prescribed Suboxone when the patient was actually prescribed Subutex.

B. "I agree with the reviewer I did not mention the risk of respiratory depression until the patient relapsed on 10/29/19."

C. "I did fail to appreciate the patient's diversion on both dates."

D. "I agree with the reviewer. There is no substance use screening tools on this patient[']s chart. Aside for AVSRS screen, there is no documented screening for ADHD. Further I do not clearly document that patient meets criteria for substance use disorders."

Patient 4

24. At the time of review, Patient 4 was a male in his late 40s. Patient 4 first saw the Respondent on May 22, 2017, for a comprehensive psychiatric evaluation. The Respondent documented that the patient reported he has attended NA meetings but "says he can't relate to other[s] there;" has had no rehab treatment; and has been diagnosed with hypertension, dyslipidemia, and chronic prostatitis with severe pain. The patient reported he was being prescribed Zubsolv[13] 5.7/1.4mg twice daily for pain, lorazepam[14]

[13] Zubsolv is a Schedule III CDS. It contains a combination of buprenorphine and naloxone and is used to treat opioid addiction.

0.5mg twice daily, and Motrin 800mg as needed, among other medications. The Respondent diagnosed Patient 4 with an opiate use disorder, prescribed the patient Zubsolv 5mg twice daily, and planned to stabilize on Zubsolv and eventually taper off.

25. After the initial comprehensive psychiatric evaluation the Respondent provided medication management to Patient 4 from May 2017 until at least June 2020.

26. At the second visit on June 19, 2017, Patient 4 reported he had not been able to see his primary care provider, he was in severe prostate pain, and he ran out of lorazepam. The Respondent prescribed the patient lorazepam 0.5mg and increased the Zubsolv dose to 8.6-2.1mg twice daily. The Respondent also documented that he discussed the risks of taking lorazepam with buprenorphine. Then, on August 29, 2017, the Respondent increased the lorazepam to 0.5mg twice daily.

27. On January 22, 2018, at a visit conducted via telephone Patient 4 reported his primary care provider had increased his lorazepam to 1mg three times daily as needed to help relax the patient's pelvic walls. The Respondent prescribed Patient 4 lorazepam 0.5mg twice daily on March 15, 2018. On April 17, 2018, the Respondent prescribed Patient 4 lorazepam 0.5mg twice daily and Zubsolv to 5.7-1.4mg twice daily.

28. On July 3, 2018, Patient 4 reported he had not been to an NA meeting "in a very long time," he "has a new job in NYC," and "he does not want to reestablish with a new provider." The Respondent documented "[o]n observation his pain levels appear to be excruciating," the Respondent suggested that the patient return to his primary care

[14] Lorazepam (Brand name Ativan) is a benzodiazepine used to treat anxiety disorders. It is a Schedule IV CDS.

provider and urologist, and the Respondent prescribed lorazepam 0.5mg twice daily, an increased dose of Zubsolv 8-2mg twice daily, and Ibuprofen 800mg three times a day as needed for pain. The Respondent increased the lorazepam to 1mg twice daily and added Baclofen[15] 20mg on September 4, 2018. The Respondent decreased the Zubsolv dose to 5.7-1.4mg twice daily on November 27, 2018.

29. On December 4, 2018, due to concerns regarding finances the patient requested to switch from Zubsolv 5.7-1.4mg to Suboxone 8-2mg twice daily, which the Respondent did. The Respondent also prescribed tamsulosin HCl[16] 0.4mg and Baclofen 20mg. The Respondent prescribed Patient 4 lorazepam 1mg twice daily[17] on December 18, 2018. By January 16, 2019, the Respondent prescribed Zubsolv 5.7-1.4mg twice daily and told the patient he could not continue to switch back and forth between Zubsolv and Suboxone. On February 11, 2019, the Respondent prescribed Suboxone 8-2mg twice daily to address Patient 4's financial concerns.

30. On July 26, 2019, the Respondent documented that Baclofen 20mg twice daily as needed was stopped due to the patient not using it and "[t]rying to taper both Ativan and Suboxone." The Respondent prescribed lorazepam 1mg twice daily and Suboxone 6mg sublingually twice daily. When the patient called and requested refills, on August 22, 2019, the Respondent prescribed lorazepam 1mg twice daily and increased the Suboxone to 8-2mg sublingually twice daily.

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[15] Baclofen is a prescription-only muscle relaxer and an antispasmodic agent.

[16] Tamsulosin (Brand name Flomax) is a prescription-only alpha-blocker that relaxes the muscles in the prostate and bladder neck, making it easier to urinate.

[17] Subsequently on February 1, 2019, the Respondent prescribed lorazepam 0.5mg with a quantity of 60 tablets for a 15 day supply. But then by March 1, 2019, the Respondent was back to prescribing lorazepam 1mg with a quantity of 30 tablets for a 15 day supply.

31. On April 11, 2020, the Respondent documented that the patient was using lorazepam "more for anxiety lately." He prescribed lorazepam 1mg three times a day and documented the patient "has previously been prescribed #20 of suboxone tab per 15 days, to compensate for days he requires a higher dosage. Qty/directions adjusted today as he finds most days he needs to take an extra half."

32. On June 9, 2020, the patient reported he was able to reduce his Suboxone to 12mg a day and reduce his lorazepam to twice a day, but was still requesting that his prescription remain at three times a day because he was going to be traveling to New York City. The Respondent prescribed the patient Suboxone 8mg sublingual one and a half daily and lorazepam 1mg three times a day.

33. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care regarding Patient 4 for reasons including:

A. Failed to discuss with the patient the risk of respiratory depression when taking benzodiazepines and opiates together; and

B. Prescribed lorazepam for long-term use to manage symptoms of anxiety.

34. The Board provided the Respondent with the peer reviewers' findings. By letter dated April 14, 2021, the Respondent submitted his response. As part of his response regarding Patient 4, the Respondent stated: "I reviewed the chart and understood the reviewers' concerns and I agree with the reviewers. . . . My rationale for picking up the prescribing of [the benzodiazepine] from his primary care physician was to keep the patient safe from the risk of combining benzodiazepines and opiates. While discussing

this plan with my patient, I am sure I referenced this risk; however, I failed to document this important part of my interaction with the patient."

Patient 6

35. At the time of review, Patient 6 was a male in his mid 20s. Patient 6 was first seen by the Respondent on April 1, 2016, while the patient was in a residential treatment program providing comprehensive detoxification. Prior to entering this program the patient admitted that he was abusing amphetamines. Patient 6 had a history that included enrollment in a methadone treatment program, and opioid and amphetamine use disorders. The Respondent diagnosed the patient with severe bipolar disorder, ADHD, and severe opioid use disorder. The patient had been treated without stimulant medication or the need for specific medication management of an opioid use disorder which appeared to be in remission. The Respondent documented the patient's medication list as Seroquel 100 to 200mg at bedtime, Lamictal[18] 25mg titration, Neurontin[19] 600mg three times a day, Zyprexa[20] 20mg a day, and Lithium[21] 600mg at bedtime.

36. On or about April 13, 2016, staff brought Patient 6 to the Respondent's attention because they believed the patient was sedated, behaving bizarrely, disruptive, and not engaged in 1:1 or groups. The patient also requested a medication adjustment. At

[18] Lamictal is a prescription-only medication used to treat epileptic seizures and to delay mood episodes in adults with bipolar disorder (manic depression).
[19] Neurontin (generic name Gabapentin) is a prescription-only medication used to treat neuropathic pain and seizures.
[20] Zyprexa is a prescription-only antipsychotic medication that affects chemicals in the brain. It is used to treat psychotic conditions such as schizophrenia, bipolar disorder (manic depression), and episodes of depression in those who have bipolar I disorder.
[21] Lithium is a prescription-only mood stabilizer that is a used to treat or control the manic episodes of bipolar disorder (manic depression).

this time, the Respondent documented that he discontinued Lithium 300mg and 600 at bedtime, discontinued loxapine,[22] discontinued Zyprexa, increased Wellbutrin xl 300mg once daily, continued Lamictal titration, and prescribed Seroquel 150mg at bedtime.

37. The Respondent provided medication management to Patient 6 from April 2016 until at least June 2020.

38. By April 20, 2016, the Respondent discussed with the patient that Doxepin could be lethal in an overdose and the Respondent adjusted the patient's medication regimen to include Doxepin[23] 50-100mg daily, Wellbutrin xl 300mg once daily, Neurontin 600mg three times a day, Suboxone 12mg sublingual daily, and Adderall XR 30mg.

39. On May 9, 2016, when Patient 6 admitted that he was taking double the amount of Neurontin prescribed "as it helped his anxiety," the Respondent increased the patient's Neurontin prescription to 800mg three times a day. Then, on June 29, 2016, the Respondent documented that Patient 6 was in the hospital and had slurred speech which "could be secondary to taking gabapentin he stored form [*sic*] previous prescription." The Respondent discontinued Neurontin on July 13, 2016, and prescribed Doxepin 100mg, Zubsolv 5.7-1.4 twice daily and Adderall 20mg twice daily, among other medications. Restoril[24] 30mg and Keppra 500mg were prescribed on July 21, 2016.

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[22] Loxapine is a prescription-only antipsychotic medication that is used to treat schizophrenia.
[23] Doxepin is a prescription-only tricyclic antidepressant. It is used to treat symptoms of depression or anxiety associated with alcoholism, manic depression, insomnia, or other mental illness.
[24] Restoril (generic name temazepam) is a benzodiazepine used to treat insomnia. It is a Schedule IV CDS.

40. Then, on August 8, 2016, the Respondent documented that the patient had just been discharged from spending a week in the hospital due to psychosis after not sleeping for at least three days. Then, at the appointment on August 24, 2016, the Respondent documented that the patient reported "taking an old prescription for gabapentin 600mg a day says he was taking handfuls of it." The Respondent further documented that he was concerned about this behavior and that he would taper the patient off of it. The Respondent documented that the new medication regimen included Zubsolv 5.7-1.4, Prolixin 5mg one in the morning and two at bedtime, Neurontin 400mg three times a day, trazodone[25] 100mg at bedtime as needed, Strattera 80mg, and Restoril 30mg at bedtime.

41. Then, on September 12, 2016, the Respondent documented "patient has a number of medication issues" and documented that the new medication regimen included Strattera 80mg, Restoril 30mg at bedtime, Lamictal 25mg titration, taper from Neurontin, Zyprexa 10mg, increased Zubsolv from 5.7-1.4 to 8.6-2.1 twice daily, discontinued Prolixin and discontinued trazodone. On October 26, 2016, when the patient requested Vyvanse for concentration, the Respondent prescribed Vyvanse 50mg and Strattera 60mg with instructions to taper over a few weeks until discontinued, among other medications.

42. On November 11, 2016, when the patient reported that he was anxious and experiencing panic attacks, the Respondent added Klonipin[26] 0.5mg and instructed the patient about potential interactions and to only take the medication if he was having a

[25] Trazodone is a prescription-only antidepressant that belongs to a group of drugs called serotonin receptor antagonists and reuptake inhibitors (SARIs) and is used to treat major depressive disorder.
[26] Klonopin (generic name clonazepam) is a benzodiazepine. It is a Schedule IV CDS used to treat certain seizure disorders and panic disorder.

panic attack. The Respondent changed the Klonipin to Valium[27] 10mg on December 5, 2016.

43. On December 15, 2016, Patient 6 submitted a urine toxicology screen which was positive for amphetamines after the patient obtained a prescription for Adderall from his primary care provider. The Respondent contacted the provider and asked that he not prescribe Patient 6 any CDS as the Respondent would like to keep the patient's prescriptions under tighter control. At this session, the Respondent also documented that the patient would be started on Provigil[28] 100mg. And then, on December 21, 2016, the patient called the Respondent "multiple times" and the patient admitted that he was experimenting with "medical marijuana." The Respondent documented that the plan is to taper off of the suboxone, and prescribed the patient Suboxone 8mg twice daily and Trazodone 150mg at bedtime. Then on January 7, 2017, the Respondent prescribed the patient Adderall 30mg twice daily and Zyprexa 10mg.

44. On January 31, 2017, the patient was referred to a treatment program in Texas, and then when the patient returned, on March 6, 2017, the Respondent prescribed Provigil 200mg, Valium 10mg twice daily, and Zubsolv 8.6-2.1mg twice daily. And then on May 9, 2017, when the patient said he was experiencing increased anxiety and requested more than ten valium pills at a time, the Respondent documented that he instead prescribed one week of gabapentin.

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[27] Valium (generic name diazepam) is a benzodiazepine. It is a Schedule IV CDS used to treat anxiety disorders, alcohol withdrawal symptoms, muscle spasms and stiffness, and seizures.

[28] Provigil (generic name modafinil) is a Schedule IV CDS that promotes wakefulness. It is used to treat excessive sleepiness caused by sleep apnea, narcolepsy, or shift work sleep disorder.

45. On June 12, 2017, the patient submitted a urine toxicology screen which was positive for non-prescribed amphetamines and admitted that he was illegally purchasing amphetamines and gabapentin. The patient requested a prescription for Adderall and to discontinue gabapentin. The Respondent documented that he prescribed Adderall 30mg 1.5 daily, Valium 5mg twice daily and 10mg at bedtime, and Clonidine 0.2mg at bedtime.

46. The Respondent saw the patient again on June 28, 2017, on an emergent request after the patient's mother reported the patient was having mental status changes. The Respondent documented that the patient was using a "marijuana Vape" and was infrequently using his Valium. The Respondent instructed the patient and his mother to withhold the patient's Adderall and the patient was given samples of Vraylar[29] 1.5mg. Subsequently on July 1, 2017, the Respondent documented that the patient was not improving with Vraylar, presented with tangential thoughts, was belligerent and angry. The Respondent further documented that he "called police initiated EP." Then, on July 10, 2017, the Respondent prescribed the patient Zubsolv 8.6-2.1mg twice daily, Lamictal 50mg twice daily titrating to 100mg twice daily, and Invega[30] 6mg for mood stabilization.

47. On September 7, 2017, the Respondent prescribed the patient Zubsolv 8.6-2.1mg twice daily, Lamictal 100mg, Provigil 200mg, and Valium 10mg twice daily, and discontinued the Invega 6mg. Doxepin 50mg at bedtime was added on September 26,

[29] Vraylar is a prescription-only antipsychotic medication used to treat schizophrenia and manic or mixed episodes in adults with bipolar disorder type I.
[30] Invega is a prescription-only antipsychotic medicine used to treat schizophrenia.

2017, for complaints of poor sleep. And then on December 5, 2017, the Respondent documented that the patient had been off of Provigil for one month but reported feeling scattered and was unable to finish tasks, therefore Provigil 200mg was prescribed again.

48. Patient 6 returned to the Respondent on April 11, 2018, after attending another treatment program. For this visit, the Respondent documented that the patient was stable on his current medications which were Valium 10mg twice daily, Zubsolv 8.6-2.1mg twice daily, eszopiclone[31] 3mg at bedtime, Vraylar 1.5mg titrate to twice daily, and Trileptal 150mg which was discontinued. The Respondent further documented that he discussed trying to make Zubsolv temporary and the patient using Valium sparingly.

49. On August 21, 2018, the patient reported he did not like Provigil and requested Adderall. The Respondent documented that he discontinued Provigil and prescribed Adderall 20mg twice daily.

50. On October 15, 2018, the Respondent documented the medication regimen was now Valium 5mg three times a day, Zubsolv 8.6-2.1mg twice daily, Adderall 20mg twice daily, Adderall XR 20mg once a day, Clonidine 0.1mg at bedtime, and eszopiclone 3mg at bedtime. The Respondent continued to prescribe this medication regimen to the patient until May 27, 2020, at which time, the Respondent documented for the first time that he "again explained the titration" of Lamictal, however, Lamictal had not been previously prescribed. Then, two days later on May 29, 2020, the Respondent documented the patient was taking Lamictal, was in agreement to discontinuation of

[31] Eszopiclone (Brand name Lunesta) is a sedative that is used to treat insomnia. It is a Schedule IV CDS.

amphetamines and tapering off of Valium, and the patient reported he was interested in coming off of suboxone as well.

51. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care regarding Patient 6 for reasons including:

A. Changed medications without discussing the potential adverse drug interactions with the patient;

B. Inconsistent documentation of medication changes;

C. Prescribed medications to the patient without adequate rationale;

D. Prescribed CDS and other prescription medications for ADHD without a comprehensive ADHD assessment or comprehensive ADHD treatment plan; and

E. Failed to consider that symptoms including mood instability could have arisen in the context of developing tolerance, withdrawal, or psychological dependence on controlled medications.

52. The Board provided the Respondent with the peer reviewers' findings. By letter dated April 14, 2021, the Respondent submitted his response. As part of his response regarding Patient 6, the Respondent stated: "I agree there are numerous medication changes with little discussion on my clinical thinking and rational for such changes."

Patient 9

53. At the time of review, Patient 9 was a female in her early 30s. Patient 9 was first seen by the Respondent for a comprehensive psychiatric evaluation in 2013, and then was not seen again by the Respondent until December 7, 2015. At the appointment in 2015, the Respondent noted that the patient had bipolar disorder, generalized anxiety disorder, ADHD inattentive type (diagnosed without a well-documented comprehensive assessment), Cluster B personality disorder, opiate dependence, and had a gastric bypass surgery which effects the absorption of certain medications. The Respondent further documented that the prescribed medications were Zoloft[32] 200mg, Suboxone 2mg once daily tapering, Lamictal 150mg, Vyvanse 60mg once a day, Vyvanse 30mg once a day at 2 p.m., and Zofran 4mg ODT three times a day.

54. The Respondent provided medication management to Patient 9 from December 2015 until at least June 2020.

55. On February 17, 2016, when the patient reported her daytime Vyvanse was too high and her evening dose was too low, the Respondent decreased the morning dose

[32] Zoloft is a prescription-only SSRI antidepressant used to treat major depressive disorder, obsessive-compulsive disorder, panic disorder, social anxiety disorder, post-traumatic stress disorder and PMDD.

of Vyvanse to 50mg and increased the evening dose of Vyvanse to 40mg at 2 p.m. Then, on March 9, 2016, when the patient reported she was experiencing intermittent insomnia, the Respondent changed the patient's prescription to Vyvanse 70mg once a day. By May 16, 2016, the Vyvanse had been decreased to just 40mg a day, but then on May 25, 2016, the Vyvanse was increased to 60mg a day when the patient reported she was having problems focusing. The other medications remained the same with the exception that the patient reported she was down to taking half of a strip of Suboxone every other day and that the goal was to be off of the Suboxone completely "by the 8th."

56. When the patient reported the "increased dose of Vyvanse was not working well" on June 6, 2016, the Respondent discontinued Vyvanse and prescribed Adderall IR 20mg twice daily. At the next visit, which was July 1, 2016, the Respondent documented that Patient 9 was taking extra Vyvanse and that she was back to taking half of the 2mg strips of Suboxone every day instead of every other day. The Respondent documented that the goal was to be off of all medications so that the patient could get pregnant, "plan to taper her completely off Vyvanse over the next two months . . . plan is to start at 70mg and reduce dose by 10mg every two to three weeks until she is completely off. . . . Ordered Adderall 70mg daily for 2 weeks." By August 8, 2016, the Vyvanse was reduced to 40mg a day, the Suboxone was documented as tapering down to 1mg one film per day, and Clonidine HCl 0.1mg "one or two daily can take both a[t] bedtime" was added in addition to the currently prescribed Zoloft 200mg and Lamictal 150mg.

57. The next visit was on October 31, 2016, at which time the patient reported she was pregnant and that she stopped all medications including Zoloft, which the patient

reported made her feel very depressed. Instead of stopping Zoloft, the Respondent changed the Zoloft from 200mg a day to 100mg a day and stopped all other medications. Then, on December 5, 2016, the Respondent told the patient she could increase the Zoloft to 150mg a day since she reported mild depression. When the Respondent checked in on the patient on January 9, 2017, the patient reported no longer experiencing depression or any other symptom complaints.

58. On May 1, 2017, following delivery of her child, the Respondent started prescribing medications to Patient 9 again including Vyvanse 30mg once a day, Lamictal titration starting at 25mg increasing dose to 150mg over four weeks, and increased the Zoloft to 100mg twice a day. With the restart of these medications there was a rapid return of symptoms and complaints of focus problems and distraction. At the next visit on May 12, 2016, the patient reported she increased the dose of Vyvanse herself by taking two pills a day, but it still was not helping her focus. Therefore, the Respondent increased the Vyvanse to 70mg once a day. And then on May 31, 2017, the patient reported this still was not enough and requested to go back on 90mg a day. The Respondent increased Vyvanse to 90mg per day. Approximately two weeks later on June 15, 2017, the patient requested a switch to Adderall; the Respondent prescribed Adderall 20mg twice daily. The Adderall was then increased to 20mg three times a day on June 28, 2017. When the patient returned on July 10, 2017, the Respondent observed the patient was experiencing facial twitches therefore the Respondent switched the patient back to Vyvanse 90 mg per day.

59. On July 27, 2017, the patient reported "she is fed up with meds not working wa[nts] to come off." The Respondent started by tapering the Vyvanse to just one dose a day of 70mg plus Zoloft 100mg twice a day and Lamictal 150mg once a day. On August 10, 2017, the Respondent documented that the patient reported that Mydayis[33] is causing side effects, but there is no prior documentation of this medication ever being prescribed.

60. On September 13, 2017, the patient reported she is no longer seeing a therapist and the Respondent continued tapering the Vyvanse by prescribing only 40mg once per day. Then, on October 2, 2017, the patient reported that she stopped taking her Vyvanse and wanted to go back on Suboxone because she was having cravings for opiates. The Respondent changed from prescribing Vyvanse to prescribing Suboxone 8mg twice daily. At her next visit on October 23, 2017, the patient reported that she had been doubling her dose of Suboxone and was having problems sleeping. The Respondent gave the patient the name and contact information of a therapist and recommended that the patient re-engage in therapy. The Respondent also increased her Suboxone to 8mg three times a day and added a prescription for Ambien[34] 5mg at bedtime with instruction not to exceed three consecutive nights. On November 14, 2017, when the patient reported she had started doubling her doses of Ambien, the Respondent increased the patient's Ambien dose to 10mg at bedtime with instruction not to exceed three consecutive nights. Two days later, the patient called and said she was having cravings for opiates even on

[33] Mydayis is a central nervous system stimulant prescription medicine used for the treatment of ADHD. It is a Schedule II CDS.

[34] Ambien (generic name zolpidem) is a sedative, also called a hypnotic. It is a Schedule IV CDS used to treat insomnia.

the increased dose of suboxone and requested an alternative medication for ADHD. The Respondent prescribed Concerta[35] 54mg once a day.

61. By January 3, 2018, the patient reported she still had not contacted a therapist but had stopped taking her Lamictal because it was making her "emotionless." The medication regimen was changed to Trileptal 150mg twice daily, Zoloft 100mg twice a day, Ambien 10mg once a day at bedtime, Suboxone 8mg three times a day, and Concerta 54mg once a day. Less than a week later, on January 8, 2018, the patient reported she had been binge drinking to address anxiety and was requesting Klonopin. The Respondent asked the patient to stop taking Concerta and prescribed a seven day prescription of Klonopin 0.5mg twice daily. On January 31, 2018, the patient reported she was in 1:1 therapy and was in an IOP. The Respondent continued to prescribe her prior medication regimen of Zoloft 100mg twice a day, Suboxone 8mg three times a day, Lamictal 150mg once a day, and Concerta 54mg once a day.

62. On February 20, 2018, the Respondent documented that the patient failed Klonopin detox and started drinking shortly after. The Respondent prescribed the patient a Valium protocol tapering the dose of Valium. However after just seven days the patient reported she was sweating and shaky and restarted taking Valium 10mg four times a day. The Respondent recommended that the patient stop taking Concentra since it may be contributing to her symptoms. The patient failed to follow this regimen and continued to drink and then on March 24, 2018, the patient requested to try the Valium detox protocol

[35] Concerta (generic name methylphenidate) is a central nervous system stimulant used to treat ADHD. It is a Schedule II CDS.

again instead of going to an inpatient program. The Respondent prescribed Valium tapering the dose. By April 30, 2018, the patient was still trying to taper off of Valium, at which time, Latuda[36] 20mg for mood stabilization was added to the medication regimen.

63. By June 6, 2018, the patient had started an IOP program. While in the IOP program the patient relapsed and was placed back on Valium for detox. Valium, Suboxone 8mg three times a day, Zoloft 100mg twice a day, Concentra 54mg, and Ambien 5mg at bedtime were ongoing in conjunction with therapy throughout 2018. Then, Valium was discontinued and Klonopin 0.5mg four times a day was added to the medication regimen on January 23, 2019. And then, on March 19, 2019, when the patient reported that her husband was not giving her as much Klonopin as prescribed because she was drinking, the Respondent recommended that the patient enter treatment either inpatient or IOP, changed the Concentra to Vyvanse 50mg a day, and continued to prescribe Klonopin 1mg three times a day, Suboxone 8mg sublingual twice daily, and Zoloft 100mg twice a day. The Vyvanse was increased to 60mg to control pain at the next visit on April 17, 2019, when the patient reported she was scheduled for surgery for endometriosis.

64. The patient appeared to remain stable and sober until September 24, 2019, when the patient admitted she was taking more Klonopin than prescribed and started drinking again. At the next appointment on November 19, 2019, the patient reported she was still drinking and the Respondent advised the patient to do inpatient treatment or an

[36] Latuda is a prescription-only antipsychotic medication used to treat schizophrenia and episodes of depression associated with bipolar disorder.

IOP program but the patient refused; therefore, the Respondent told the patient that the Respondent "could not continue to treat her unless she takes [the Respondent's] advise." The Respondent also noted that he was tapering the patient's Klonopin while she decided what she was going to do, and that the patient would get back to the Respondent "within the next 10 days." The patient was next seen two months later on January 13, 2020, at which time, the Respondent notified the patient that "if she drinks again she will be referred for inpatient care and no further medications will be prescribed outside of an inpatient setting." The Respondent also discontinued Klonopin 1mg three times a day and started prescribing Valium 10mg three times a day with the current medication regimen.

65. A peer review determined that the Respondent failed to meet appropriate standards for the delivery of quality medical care regarding Patient 9 for reasons including:

A. Inconsistent documentation of medication changes;

B. Failed to set clear boundaries with the patient by the Respondent recommending that the patient enter inpatient treatment or residential treatment rather than demanding that she enter one of these two treatment modalities under the real threat of termination of treatment due to noncompliance;

C. Prescribed stimulant medications for ADHD without a comprehensive ADHD assessment;

D. Failed to recognize or adequately address that stimulant use may be complicating the treatment of the patient's other disorders including mood

instability, anxiety, depression, misuse of controlled medications, and an alcohol use disorder;

E. Prescribed medications with high addictive potential for long term symptom relief of anxiety, PTSD, depression, alcohol use disorder, and attention concentration deficits;

F. Prescribed Vyvanse after 33 weeks of sobriety without first trying to sustain remission through other avenues; and

G. Rapidly increased Vyvanse dosage without significant reduction in identified symptoms while anxiety and tics increased.

66. The Board provided the Respondent with the peer reviewers' findings. By letter dated April 14, 2021, the Respondent submitted his response. As part of his response regarding Patient 9, the Respondent stated: "I agree that [Patient 9] is one of the most extremely-challenging patients that I have ever cared for in my practice. Like most addicted patients, she was deceitful and manipulative during her active addiction. Retrospectively, I see I should have made clearer boundaries and set limits while referring the patient to higher levels of care."

III. PRESCRIBING TO FAMILY MEMBERS

67. The Board's investigation determined that the Respondent wrote prescriptions for CDS and prescription-only medications to two family members – Patient 11 and Patient 12.

Patient 11

68. The Respondent provided the Board with copies of medical records maintained by the Respondent for Patient 11. These medical records revealed between March 7, 2016 and March 20, 2020, the Respondent prescribed Patient 11 three (3) Schedule IV CDS and thirteen (13) non-CDS prescription-only medications. Two of the non-CDS prescription-only medications that the Respondent prescribed to Patient 11 on March 20, 2020, were Hydroxychloroquine Sulfate[37] 200mg and Azithromycin[38] 250mg.

Patient 12

69. The Board obtained pharmacy records for Patient 12 and the Respondent provided the Board with copies of medical records maintained by the Respondent for Patient 12. These records revealed between February 11, 2010 and April 6, 2020, the Respondent prescribed Patient 12 several non-CDS prescription-only medications and at least seven (7) Schedule IV CDS. The non-CDS prescription-only medications that the Respondent prescribed to Patient 12 included Hydroxychloroquine Sulfate 200mg on March 18, 2020; Azithromycin 250mg on March 20, 2020; and Zinc 100mg and Ivermectin[39] 3mg on April 6, 2020.

A. Board's Medical Consultant

70. In review of the care the Respondent provided Patient 11 and Patient 12, the Board's medical consultant reviewed the records and opined that the Respondent's prescribing CDS for Patient 11 "does not comply with AMA Code of Medical Ethics

[37] Hydroxychloroquine Sulfate is an antimalarial medicine approved to treat certain types of malaria, lupus erythematosus, and rheumatoid arthritis. It is a prescription-only medication.
[38] Azithromycin is an antibiotic that fights bacteria. It is a prescription-only medication.
[39] Ivermectin is a prescription-only anti-parasite medication.

Guidelines. He repeatedly prescribed medications (Prozac and Alprazolam) for a significant psychiatric condition independently of a psychiatric opinion. . . . The prescriptions are issued chronically/non-emergently." Furthermore, the Respondent's prescribing of "Covid related drugs in the absence of the diagnosis of Covid is inappropriate and . . . not in keeping with the standard in the community. It may also have been harmful had [Patient 11 or Patient 12] taken those drugs had they presumptively developed Covid."

B. Interview of the Respondent

71. On September 15, 2020, Board staff interviewed the Respondent under oath, during which time the Respondent stated:

A. "I will not do that anymore . . . prescribe for family . . . under any circumstances in any situation."

B. He admitted he prescribed Azithromycin and hydroxychloroquine in March of 2020 to Patient 11 just in case he or she was ever diagnosed with COVID-19.

C. He admitted he prescribed Zinc and Ivermectin to Patient 12 to have on hand just in case he or she contracted COVID-19.

D. He admitted it was not clinically appropriate to prescribe Zinc and Ivermectin to Patient 12 or Azithromycin and hydroxychloroquine to Patient 11.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Panel A concludes as a matter of law that the Respondent violated Health Occ. § 14-404(a)(3)(ii) by engaging in unprofessional conduct in the practice of medicine, and the Respondent violated Health Occ. § 14-404(a)(22) by failing to meet the appropriate standards for the delivery of quality medical care.

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 placed on **PROBATION** for a minimum of **SIX (6) MONTHS**.[40] 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 two courses: a course in ethics and a course in prescribing controlled dangerous substances. The following terms apply:
   (a) it is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the course is begun;
   (b) the Respondent must provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

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

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

(d) the Respondent is responsible for the cost of the courses.

2. Within **SIX (6) MONTHS**, the Respondent shall pay a **civil fine of $1,000**. 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.

ORDERED that a violation of probation constitutes a violation of the 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 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).

12/16/2021
Date

Signature on File

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

CONSENT

I, Nicholas Scotto, 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

12/10/21
Date

Nicholas Scotto, M.D.

NOTARY

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 10 day of December, 2021, before me, a Notary Public of the State and County aforesaid, personally appeared Nicholas Scotto, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

JOANNE E KLEMM
NOTARY PUBLIC
BALTIMORE COUNTY
MARYLAND
My Commission Expires November 7, 2022

Notary Public

My Commission Expires: Nov 7, 2022