IN THE MATTER OF	*	**BEFORE THE**
WILLIAM RUSSELL, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D50636	*	**Case Number: 2218-0254A**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On January 28, 2019, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") charged **WILLIAM RUSSELL, M.D.** (the "Respondent"), License Number D50636, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. and 2018 Supp.).

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

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

On April 10, 2019, a hearing was held before Panel A, sitting as a Disciplinary Committee for Case Resolution. As a result of negotiations occurring before Panel A, the Respondent agreed to enter into the following Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

FINDINGS OF FACT

Panel A makes the following Findings of Fact:

I. Background/Prior Board Action

1. The Respondent was originally licensed to practice medicine in Maryland on May 31, 1996, under License Number D50636. The Respondent's medical license is active and current through September 30, 2019.

2. The Respondent is currently not board-certified in any medical specialty.[1] At all times relevant to these charges, the Respondent maintained a medical office at 909A Seton Drive, Cumberland, Maryland 21502.

3. By letter dated August 28, 2013, the Board issued an Advisory Letter to the Respondent after it initiated an investigation of him based on an allegation that he continued to prescribe controlled dangerous substances ("CDS") to a patient who was already addicted to CDS.

[1] The Respondent was formerly board-certified in physical medicine and rehabilitation but allowed his board-certification to lapse in or around 2017. The Respondent was formerly certified in pain medicine but allowed that subspecialty certification to lapse in or around 2014.

II. The Complaint

4. On or about April 9, 2018, the Board received an anonymous complaint from an individual (the "Complainant") who alleged that the Respondent, who was prescribing Suboxone[2] to a patient, prescribed oxycodone[3] to this patient on March 9, 2018, for purported "severe dental pain." The Complainant stated that the patient was a long-term "drug addict," went "from one clinic to another," and did not have dental pain.

III. Subsequent Board Investigation

5. By letter dated May 29, 2018, the Board notified the Respondent that it had initiated an investigation of him based on an allegation that he continued to prescribe CDS to a known drug addict. The Board requested that the Respondent provide a written response to the above complaint.

6. By letter dated June 21, 2018, the Respondent provided a written response to the Board.

7. Pursuant to its investigation, the Board subpoenaed the medical records of ten patients ("Patients 1 through 10")[4] to whom the Respondent provided medical care, and in or around August 2018, submitted those records and related materials for a practice review to two physicians who are board-certified in physical medicine and rehabilitation, with subspecialty certifications in pain medicine. The reviewers submitted their reports to the Board in or around September and October 2018, respectively.

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[2] Suboxone is a brand name for a drug that contains buprenorphine. Buprenorphine is an opioid that is used to treat opioid addiction. Buprenorphine is a Schedule III CDS.

[3] Oxycodone is an opioid medication and Schedule II CDS.

[4] For confidentiality reasons, the names of patients or other individuals will not be identified in this document.

8. The reviewers independently concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical care in eight of the ten cases reviewed (Patients 2 through 9); and failed to keep adequate medical records in nine of the ten cases reviewed (Patients 2 through 10).

9. The Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to the patients identified herein. Examples of these deficiencies are set forth in the following patient summaries.

Patient 2

10. The Respondent began treating Patient 2, a male patient then about 50 years old, in February 2011, after Patient 2's previous pain management physician was reportedly arrested.[5] The Respondent initially continued Patient 2 on Lorcet[6] 7.5 mg TID[7] for pain management. The Respondent continued to treat Patient 2 until 2018 for lower back, knee and shoulder pain.

11. During the treatment interval, the Respondent prescribed various opioid medications for Patient 2 and titrated those dosages upward. At the end of the treatment interval, the Respondent maintained Patient 2 on monthly prescriptions of OxyContin[8] 40

[5] In a Final Decision and Order, dated November 22, 2011, the Board revoked the other physician's Maryland medical license.
[6] Lorcet is a name brand formulation of hydrocodone, which is now classified as a Schedule II CDS.
[7] Three times per day.
[8] OxyContin is an extended release formulation of oxycodone and a Schedule II CDS.

mg BID[9] and Roxicodone[10] 30 mg TID. In 2015, the Respondent prescribed alprazolam[11] for sleep/anxiety. The Respondent also prescribed Ambien[12] and phentermine.[13] The Respondent offered Patient 2 Narcan[14] but the patient declined. The Respondent also treated Patient 2 with non-opioid medications including steroid injections and non-steroidal anti-inflammatory drugs ("NSAIDs").

12. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 2, for reasons including:

(a) the Respondent failed to discuss, or document discussing, the risk of chronic opioid therapy, and failed to have Patient 2 execute an opioid treatment contract;

(b) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments, or provide a clear rationale for continuation of chronic opioid therapy;

(c) the Respondent failed to record adequate documentation in progress notes. The Respondent's progress notes contain scant notes of the patient's issues and the Respondent's response, without adequate recorded rationale. The Respondent's progress notes inadequately describe his ongoing evaluation

[9] Twice per day.
[10] Roxicodone contains oxycodone, an opioid and Schedule II CDS.
[11] Alprazolam (trade name, Xanax) is a benzodiazepine and Schedule IV CDS.
[12] Ambien is a sedative-hypnotic and Schedule IV CDS.
[13] Phentermine is an anorectic medication and Schedule IV CDS.
[14] Narcan (naloxone) is a drug that is administered to reverse the effects of an opioid overdose.

and treatment and note limited documented reassessment, monitoring and modification of treatment as necessary;

(d) the Respondent failed to implement pertinent aspects of Centers for Disease Control ('CDC") guidelines on opioid prescribing;

(e) the Respondent failed to address increases in opioid prescribing. In or around 2014, the Respondent prescribed a short-term increase in Patient 2's opioid regimen after Patient 2 reportedly sustained burns in a fire; in subsequent visits, the Respondent increased Patient 2's opioid regimen without a clear documented rationale;

(f) the Respondent inappropriately prescribed a benzodiazepine while concurrently prescribing high-dose opioids, without discussing, or documenting discussing, the risk of concomitant use of benzodiazepines and opioids; and

(g) the Respondent failed to adequately document Patient 2's reasoning for declining Narcan or his stated rationale to Patient 2 of the importance of the medication.

Patient 3

13. The Respondent began providing treatment to Patient 3, a male patient then in his mid-50s, in 2009, for complaints of neck pain related to cervical spine pathology. The Respondent also treated Patient 3 for lower back pain related to lumbar spine pathology. Patient 3 subsequently underwent cervical spine surgery and continued pain management under the Respondent's direction. The Respondent provided pain

management treatment using high-dose prescription opioids in the form of methadone 10 mg,[15] as high as six tablets per day, and Roxicodone 15 mg, as high as six tablets per day. These doses fluctuated over the course of the Respondent's treatment of Patient 3, which extended into May 2018, where the Respondent prescribed methadone 10 mg TID and Roxicodone 15 mg, five tablets per day.

14. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 3, for reasons including:

(a) the Respondent inappropriately prescribed high-dose opioid medications with poor documentation during reassessments for the need to continue opioids, as well as no information/explanation regarding decisions to increase or decrease the patient's opioid regimen;

(b) the Respondent made insufficient attempts to taper Patient 3's opioid regimen after noting his intent to do so (*e.g.*, February 23, 2017) but kept the patient on the same regimen for the next four months. In another instance in 2017 (*e.g.*, July 17, 2017), the Respondent decreased Patient 3's dosage of Roxicodone from 120 to 110 tablets but then increased it on the next visit without an adequate explanation in the record;

[15] Methadone is an opioid used for opioid maintenance therapy and to treat pain. Methadone is a Schedule II CDS.

(c) the Respondent, who was prescribing methadone to Patient 3, failed to order an electrocardiogram ("EKG") or verify that Patient 3 had undergone a recent EKG, or alternatively, notified or documented notifying a cardiologist or other practitioner of the need for an EKG;

(d) the Respondent failed to use adjuvant treatments such as physical therapy, acupuncture, chiropractic therapy or back braces;

(e) the Respondent failed to discuss, or document discussing, Patient 3's positive cannabis test or address Patient 3's use of this substance during the time the substance was not approved for therapeutic usage;

(f) the Respondent failed to query the Prescription Drug Monitoring Program ("PDMP") on a sufficient basis;

(g) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments;

(h) the Respondent failed to reassess, or adequately document his follow-up reassessments, after instituting opioid therapy;

(i) the Respondent failed to adequately document his rationale for changing Patient 3's medication regimen; and

(j) the Respondent failed to record adequate documentation in progress notes. The Respondent's progress notes are recorded in a checklist-type format that contain scant notes of the patient's issues and the Respondent's response, without adequate recorded rationale. The Respondent's progress notes inadequately describe his ongoing evaluation and treatment and note

limited documented reassessment, monitoring and modification of treatment as necessary.

Patient 4

15. The Respondent began treating Patient 4, a male patient then about 20 years old, in 2006, for a substance abuse disorder, with Suboxone. Patient 4 reportedly successfully stopped abusing drugs, except for marijuana, and was weaned off Suboxone in January 2011.

16. Patient 4 returned for treatment in June 2011 with complaints of hip pain after being in a car accident. The Respondent noted a brief examination revealing, "a little discomfort with range of motion . . . not a lot." The Respondent ordered radiographs that were negative, but Patient 4 continued to complain of persistent pain. The Respondent also ordered radiographs of the thoracic spine and hip, CT scans of the chest and the abdomen/pelvis, all of which were negative. Notwithstanding these negative findings, the Respondent instituted a pain management regimen using hydrocodone 10 mg, with Patient 4's spouse supervising Patient 4's use of the drug as a way of limiting the risk of relapse. The Respondent did not have Patient 4 execute an opioid medication contract.

17. Thereafter, the Respondent escalated Patient 4's opioid regimen, without any organic etiology. The Respondent switched Patient 4 from hydrocodone to Roxicodone, and gradually titrated Patient 4's Roxicodone from 5 mg to 10 mg for subjective complaints of increased back pain associated with work. At one point, Patient

4 claimed that he needed to take Roxicodone more than QID,[16] at which point the Respondent decided to increase the strength from 10 to 15 mg QID (*e.g.*, visit of September 6, 2013). The Respondent eventually increased Patient 4's Roxicodone to six times per day (*e.g.*, visit of October 20, 2016). In a subsequent note, the Respondent noted that Patient 4's opioid use was high, stating, "MME is now 2-3X CDC guideline 'threshold.'" (*e.g.*, visit of November 28, 2016).

18. The Respondent then added Valium 5 mg,[17] TID, to be used as a muscle relaxant, to Patient 4's prescribing regimen (*e.g.*, visit of February 13, 2017). The Respondent did not note that he counseled Patient 4 on the combination of benzodiazepines with high-dose opioids.

19. The Respondent continued providing pain management treatment to Patient 4 into 2018.

20. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 4, for reasons including:

(a) the Respondent failed to require or document requiring Patient 4 to enter into an opioid treatment contract;

(b) the Respondent inappropriately re-initiated opioid therapy for Patient 4, who had been treated and detoxified from opioid dependency;

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[16] Four times per day.

[17] Valium (diazepam) is a benzodiazepine and Schedule IV CDS.

(c) the Respondent escalated Patient 4's opioid regimen without organic etiology;

(d) the Respondent inappropriately began prescribing a benzodiazepine with high-dose opioid therapy, without counseling the patient on the risks associated with this prescribing regimen;

(e) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments;

(f) the Respondent failed to adequately document his rationale for increasing Patient 4's opioid regime in the absence of an objective medical findings to support such an increase; and

(g) the Respondent failed to record adequate documentation in progress notes. The Respondent's progress notes are recorded in a checklist-type format that contain scant notes of the patient's issues and the Respondent's response, without adequate recorded rationale. The Respondent's progress notes inadequately describe his ongoing evaluation and treatment and note limited documented reassessment, monitoring and modification of treatment as necessary.

Patient 5

21. The Respondent began treating Patient 5, a male patient then in his mid-30s, on August 26, 2013, for chronic back pain and spasms following thoracic spine fusion surgery from T2-T5. The Respondent noted that Patient 5 previously saw a physician for pain management but stopped seeing the physician "for one reason or

another. There might have been some trouble down there in Winchester or Martinsburg." The Respondent further noted that Patient 5 "has lately been taken to buying buprenorphine on the streets." The Respondent instructed Patient 5 to stop using buprenorphine and started him on Roxicodone 15 mg QID. At a visit about two weeks later (September 5, 2013), the Respondent changed Patient 5's opioid regimen to OxyContin 60 mg BID and continued Roxicodone 15 mg QID. Patient 5's urine drug test, taken on his second visit, was still positive for buprenorphine, despite the Respondent's instruction to Patient 5 to discontinue buprenorphine. On September 12, 2013, the Respondent placed Patient 5 on a combination of Valium and baclofen.[18]

22. The Respondent referred Patient 5 for a neurosurgical consultation for an evaluation of alternative treatment of his spasticity, but Patient 5 declined a trial of a baclofen intra-thecal pump.

23. By June of 2014, the Respondent had titrated Patient 5's opioid regimen to OxyContin 80 mg TID and Roxicodone 30 mg TID and increased the baclofen to 20 mg TID. Later, the Respondent weaned Patient 5 off of OxyContin and replaced it with methadone 10 mg TID. The Respondent titrated Patient 5's methadone to as high as 10 mg TID, 360 pills per month (for a total of 12 tablets per day), along with Roxicodone 30 mg QID, Valium 10 mg BID, and Baclofen 20 mg TID.

24. In 2018, the Respondent reduced Patient 5's methadone to 10 mg, five tablets per day, with no changes to his Roxicodone, Valium or baclofen.

[18] Baclofen is a prescription-only medication used to treat spasticity.

25. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 5, for reasons including:

(a) the Respondent inappropriately prescribed benzodiazepines and high-dose opioid medications;

(b) the Respondent ignored "red flag" behaviors, including Patient 5's request to change his Valium to Xanax, and two urine toxicology screenings that were negative for oxycodone;

(c) the Respondent failed to prescribe Narcan in view of Patient 5's high-dose opioid regimen;

(d) the Respondent failed to order an EKG for Patient 5, to whom he was prescribing methadone;

(e) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments; and

(f) the Respondent's clinical records inadequately describe his ongoing evaluation and treatment of Patient 5, with limited documentation of reassessment, monitoring and modification of treatment.

Patient 6

26. The Respondent began treating Patient 6, a female patient in her early 30s, in January 2013, for chronic pain related to medullary sponge kidney disease, which is characterized by the formation of multiple kidney stones. Patient 6 reported that she was

using opioid medications from others. The Respondent placed Patient 6 on Roxicodone 15 mg, every three-to-four hours. Approximately two weeks later, the Respondent doubled Patient 6's Roxicodone to 30 mg. The Respondent continued to treat Patient 6 until 2018.

27. During the treatment interval, the Respondent prescribed various extended release opioids including Exalgo, fentanyl patches, OxyContin, morphine and methadone. The Respondent's final opioid regimen for Patient 6 consisted of methadone 10 mg, two tablets TID and Roxicodone 30 mg QID. The Respondent also prescribed Valium for anxiety, which he switched to Xanax. He also prescribed phentermine in conjunction with opioids and benzodiazepines. During the course of treatment, the Respondent decreased Patient 6's opioid regimen from 420 MMEs[19] to 270 MMEs.

28. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 6, for reasons including:

(a) the Respondent inappropriately prescribed benzodiazepines in conjunction with high-dose opioid medications, and failed to discuss or document discussing the risks associated with this prescribing regimen;

(b) the Respondent failed to sufficiently decrease Patient 6's opioid regimen;

(c) the Respondent failed to definitively refer Patient 6, who had significant anxiety, for mental health counseling;

[19] Morphine milligram equivalents.

(d) the Respondent failed to order routine EKGs for Patient 6, to whom he prescribed methadone;

(e) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments; and

(f) the Respondent's clinical records contain inadequate documentation of monitoring, treatment modification and reassessment. In addition, the records inadequately describe treatment and ongoing evaluation.

Patient 7

29. The Respondent began treating Patient 7, a female patient then in her late 30s, on July 6, 2011, for opioid addiction. Patient 7 had been enrolled in a methadone clinic and did not tolerate being tapered. Patient 7 obtained buprenorphine illicitly and decided to switch from methadone to buprenorphine. Patient 7's opioid of choice was Percocet (oxycodone). The Respondent ordered a toxicology screen that was positive for methadone and buprenorphine and negative for all other substances. Patient 7 executed an opioid treatment contract and was placed on Suboxone once her evaluation was completed.

30. Patient 7 had complaints of back pain, and a radiograph of the lumbar spine revealed moderate disc space narrowing and spondylosis at the L2-L3 segment. The Respondent maintained Patient 7 on Suboxone for opioid maintenance and pain control for about three years.

31. In September 2014, the Respondent switched Patient 7 to Roxicodone 5 mg, and quickly escalated her Roxicodone dosage to 15 mg QID, then to 30 mg QID, for what appeared to be Patient 7's complaints of buprenorphine withdrawal.

32. The Respondent further escalated Patient 7's opioid regimen to OxyContin 40 mg BID along with Roxicodone 30 mg QID in less than two months. In December 2014, the Respondent discontinued Patient 7's OxyContin and replaced it with methadone 10 mg TID, per her request, along with Roxicodone 30 mg TID.

33. The Respondent then discontinued prescribing methadone and started Patient 7 on morphine extended release 60 mg BID, along with Roxicodone 30 mg.

34. During the treatment interval, which continued into 2018, the Respondent also prescribed various other extended release opioid medications, including Opana ER, fentanyl, OxyContin and Exalgo. The Respondent also offered Patient 7 Narcan, which she reportedly refused.

35. The Respondent eventually placed Patient 7 on an opioid regimen that included Dilaudid (hydromorphone) 8 mg TID, Roxicodone 30 mg TID, and phentermine.

36. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 7, for reasons including:

(a) the Respondent inappropriately re-initiated prescribing an opioid, Percocet, to Patient 7, her drug of choice for abuse, after maintaining her on opioid maintenance therapy;

(b) the Respondent inappropriately rapidly escalated Patient 7's opioid regimen, without an appropriate work-up or rationale;

(c) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments;

(d) the Respondent failed to attempt a trial of non-opioid adjuvant medications, physical therapy, or other modalities, such as injection therapy;

(e) the Respondent did not attempt an adequate trial of decreasing Patient 7's opioid regimen;

(f) the Respondent failed to prescribe and train Patient 7 on the need for Narcan, given her use of high-dose opioids;

(g) the Respondent inappropriately prescribed Ativan, a benzodiazepine, in conjunction with high-dose opioids, without appropriately counseling Patient 7 on the dangers of concomitant use of these medications;

(h) the Respondent inappropriately prescribed Dilaudid and Roxicodone, two short-acting agents, at the same time; and

(i) the Respondent's clinical record is insufficient, with limited documentation of treatment, reassessment, monitoring, modifications to treatment, and ongoing evaluation.

Patient 8

37. The Respondent began treating Patient 8, a male patient then in his mid-20s, on January 8, 2007, for substance abuse disorder, mainly related to heroin, but also including cocaine and marijuana. The Respondent treated Patient 8 with Suboxone. In October 2007, the Respondent, in response to Patient 8's complaints of anxiety, also began prescribing a benzodiazepine.

38. The Respondent continued Patient 8 on Suboxone with some success, until Patient 8 sustained a work injury in or around March 2010, at which point the Respondent suggested placing him on a short-term trial of opioids for pain management of his work injury.

39. In July 2010, Patient 8 sustained significant injuries in a motor vehicle accident and was placed on opioid medications by his treating physician.

40. In August 2011, Patient 8 returned for treatment after an absence. Patient 8 reported that he had been purchasing Dilaudid (hydromorphone) and occasionally, buprenorphine, illicitly. The Respondent placed Patient 8 on a medication regimen that included Dilaudid 4 mg and Xanax.

41. The Respondent continued Patient 8 on an opioid regimen into 2018. The Respondent's final medication regimen for Patient 8 (*e.g.*, June 8, 2018) consisted of methadone 10 mg TID, hydromorphone 8 mg QID, and Xanax 0.5 mg QID.

42. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep

adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 8, for reasons including:

(a) the Respondent failed to discuss, or adequately document discussing, the risk of restarting Patient 8 on an opioid regimen in view of Patient 8's prior substance abuse history;

(b) the Respondent failed to discuss, or adequately document discussing, risk with Patient 8 after prescribing a benzodiazepine while concomitantly prescribing high-dose opioid medications;

(c) the Respondent failed to discuss, or adequately document discussing, risk when Patient 8 disclosed drinking alcohol while he was on a high-dose opioid medication regimen;

(d) the Respondent failed to employ non-opioid adjuvants, such as NSAIDs, physical therapy or muscle relaxants;

(e) the Respondent discussed "anti-opioid DEA quotas, laws, policies, attitudes" (e.g., June 8, 2018) but did not attempt to taper Patient 8's opioid medication regimen;

(f) the Respondent failed to prescribe Narcan despite prescribing a high-dose opioid regimen;

(g) the Respondent failed to order periodic EKGs for Patient 8, to whom he was prescribing methadone;

(h) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up assessments; and

(i) the Respondent's clinical record is insufficient, with limited documentation of treatment, reassessment, monitoring, modifications to treatment, and ongoing evaluation.

Patient 9

43. The Respondent began treating Patient 9, a male patient then in his early 40s, in August 2016, for chronic pain related to post-laminectomy/failed back surgery syndrome, and for recurrent renal stones, which caused colicky pain. Patient 9 had been seen at another practice, which instructed him to find another physician/clinic for pain management after the practice adopted policy changes.

44. Upon intake, Patient 9's urine drug screen was positive for methadone and oxycodone (consistent with Patient 9's prior opioid regimen of methadone and Roxicodone). Patient 9's lumbar spine and renal imaging scans documented the etiology of Patient 9's pain sources. The Respondent continued to provide pain management treatment for Patient 9 into 2018, maintaining him on a regimen of methadone 10 mg, two tablets TID, Roxicodone 5 mg, one-to two tablets, six times per day, and phentermine.

45. The Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 9, for reasons including:

(a) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up evaluations;

(b) the Respondent failed to order non-opioid adjuvant treatments; and

(c) the Respondent failed to order periodic EKGs for Patient 9, to whom he was prescribing methadone.

Patient 10

46. The Respondent began providing treatment to Patient 10, a male patient then in his early 30s, on July 1, 2009, for lower back and extremity pain related to sub-optimal lumbar surgery at the L5-S1 level. The Respondent treated Patient 10 over a nine-year period with various opioids including methadone, Percocet, fentanyl, morphine and Roxicodone. The Respondent eventually maintained Patient 10 on methadone 10 mg, using up to nine tablets per day, and Roxicodone 15 mg, using up to four tablets per day. The Respondent tapered Patient 10's medications to methadone 10 mg TID and Roxicodone 15 mg TID, and weaned him off of Xanax.

47. The Respondent failed to failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40), with respect to Patient 10, for reasons including:

(a) the Respondent failed to perform, or adequately document performing, physical examinations on follow-up visits; and

(b) the Respondent's clinical record inadequately describes the comprehensive ongoing evaluation and treatment. The Respondent failed to adequately document reassessment, monitoring and modifying treatment where necessary.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel A of the Board finds that the Respondent violated the following provisions of the Act under Health Occ. §§ 14-404(a): (22) fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and (40) fails to keep adequate medical records as determined by appropriate peer review.

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**[20] for a minimum period of **TWO (2) YEARS.** Within that two-year probationary period, the Respondent shall comply with the following terms and conditions:

(1) Within **ONE (1) YEAR** of the effective date of this Consent Order, the Respondent is required to take and successfully complete **TWO** panel-approved courses: (i) one course in the appropriate prescribing of Controlled Dangerous Substances ("CDS"); and (ii) a separate course in medical recordkeeping. 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 courses begin;

(b) The disciplinary panel will not accept courses taken over the internet;

[20] If the Respondent's license expires while the Respondent is on probation, the probationary period and any probationary conditions will be tolled.

(c) The Respondent shall provide documentation to the disciplinary panel that the Respondent has successfully completed the courses;

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

(e) The Respondent is responsible for the cost of the courses.

(2) During the first year of probation, the Respondent is prohibited from prescribing and dispensing:

(a) All CDS;

(b) In emergency cases, the Respondent may issue no more than one prescription for a CDS for each patient during the first year of probation, but the prescription may not exceed the lowest effective dose and quantity needed for a duration of five days. The prescription may not be refilled, nor may it be renewed. The Respondent shall notify the Board within 24 hours of any prescription written as authorized by this paragraph.

(3) During the first year of probation, the Respondent is prohibited from delegating to a Physician Assistant the prescribing or dispensing of the above prohibited CDS.

(4) During the first year of probation, the Respondent is prohibited from certifying patients for the medical use of cannabis.

(5) 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 subpoena will request the Respondent's CDS prescriptions from the beginning of each quarter.

(6) The Respondent is subject to a chart and/or peer review conducted by the disciplinary panel or its agents as follows:

(a) The Respondent shall cooperate with the peer review process;

(b) The disciplinary panel in its discretion may change the focus of the peer review if the Respondent changes the nature of his practice;

(c) If the disciplinary panel, upon consideration of the chart and/or peer review and the Respondent's response, if any, determines that the Respondent is meeting the standard of quality care and is keeping adequate medical records in his practice, the disciplinary panel shall consider the peer review condition of the Consent Order met;

(d) If the disciplinary panel, upon consideration of the peer review and the Respondent's response, if any, has a reasonable basis to believe that the Respondent is not meeting the standard of quality care or not keeping adequate medical records in his practice or cannot safely and competently practice, the disciplinary panel may charge the Respondent with a violation of probation and/or under the Medical Practice Act.

(7) Within **five (5) business days** of the effective date of this Consent Order, the Respondent shall inform the Board in writing of his current employer or employers, the employer's or employers' address or addresses, and of all locations, including hospitals, at which the Respondent provides health care services. The Respondent shall keep the Board informed of any subsequent employment changes within **five (5) business days** of the change.

(8) The Respondent shall not apply for early termination of probation.

(9) A violation of probation constitutes a violation of the Consent Order.

(10) The Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II §14-101 - §14-702, and all federal and state laws and regulations governing the practice of medicine in Maryland; and it is further

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

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If 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. If 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 of probation or this Consent Order, the disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend 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 upon the Respondent; and it is further

ORDERED that after the Respondent has complied with all the terms and conditions of probation, and the minimum period of **TWO (2) YEARS** of probation imposed by the Consent Order has passed, the Respondent may submit a written petition to the panel requesting termination of probation. The Respondent may be required to appear before the panel to discuss his petition for termination. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The

disciplinary panel may grant the petition to terminate the probation through an order of the disciplinary panel, if the Respondent has complied with all probationary terms and conditions and if there are no pending complaints related to the charges; 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 signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order, and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2), and Gen. Prov. § 4–333(b)(6) (2014 & Supp. 2018).

05/09/2019
Date

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

CONSENT

I, William Russell, 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 these rights 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 their 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 understands the language and meaning of its terms.

4/23/19
Date

Signature on File

William Russell, M.D.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Frederick

I HEREBY CERTIFY that on this 23rd day of April 2019, before me, a Notary Public of the foregoing State and City/County, personally appeared William Russell, 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.

Notary Public

My Commission expires: 8/26/2021

CASSANDRA M. RASO NOTARY PUBLIC FREDERICK COUNTY, MD