IN THE MATTER OF	*	**BEFORE THE MARYLAND**
SAMUEL W. ALLEYNE, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D25766	*	**Case Number: 2015-0584B**

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CONSENT ORDER

On January 19, 2017, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board"), charged **SAMUEL W. ALLEYNE, M.D.** (the "Respondent"), under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("H.O.") §§ 14-101 *et seq.* The pertinent provisions of the Act provide the following:

> § 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 of the Board, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> ...
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> (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;
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> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

On March 22, 2017, a conference with regard to this matter was held before Panel B of the Board's Disciplinary Committee for Case Resolution ("DCCR"). As a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

I. BACKGROUND

1. At all relevant times, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on October 23, 1980. His license is presently active and is scheduled to expire on September 30, 2018.

2. The Respondent is a solo practitioner with an office in Cheverly, Maryland and is board certified in family medicine. The Respondent has privileges at Hospital A and Hospital B.[1]

3. On or about February 19, 2015, the Board received a complaint from a pharmacist (the "complainant") at Pharmacy A in Virginia Beach, Virginia. The complainant alleged that Pharmacy A had filled prescriptions for Xanax for a patient ("Patient A") that were also being filled at another pharmacy, Pharmacy B, also in Virginia Beach, Virginia. The complaint alleged that both prescriptions were from the Respondent and that Pharmacy A had filled 3120 tablets of Xanax for Patient A since March 31, 2010. The complainant further stated that he contacted the Respondent to report Patient A's multiple prescriptions for Xanax, but the Respondent "did not seem concerned."

4. Thereafter, the Board initiated an investigation.

5. On or about March 6, 2015, the Board issued subpoenas to five pharmacies for controlled dangerous substance ("CDS") prescriptions prescribed by the Respondent from March 2014 to March 2015.

6. Eleven patients, including Patient A, were selected from the pharmacy records.

[1] In order to maintain confidentiality, names will not be used in this Consent Order.

7. On or about April 23, 2015, the Board notified the Respondent of its preliminary investigation and issued a subpoena for six patient medical records, as well as a request for summaries of care.

8. On or about May 20, 2015, the Board received from the Respondent six medical records and summaries of care.

9. On July 31, 2015, the Board provided the Respondent with a copy of the complaint, as well as a subpoena for four additional patient medical records and a request for summaries of care and a written response to the complaint.

10. On or about August 26, 2015, the Board received the Respondent's written response, as well as the additional four medical records, summaries of care and certifications of medical records. The Respondent also provided supplemental medical records (dated May 15 - August 21, 2015) for the six medical records that the Board initially subpoenaed.

11. On or about October 6, 2015, a member of the Board's staff interviewed the Respondent under oath.

12. On or about October 26, 2016, the Board issued a subpoena for an eleventh medical record and requested a summary of care and certification of medical record.[2]

13. On or about December 1, 2015, in furtherance of its investigation, the Board transmitted the 11 patient records (and other relevant documents) received from the Respondent for peer review by two physicians board certified in pain management ("the reviewers"). The results of the peer review are set forth below.

[2] The eleventh medical record pertained to a second, similar complaint that the Board received on or about August 24, 2015.

14. The reviewers submitted their respective reports on or about February 2, 2016. The reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care for all 11 patients and failed to keep adequate medical records for all 11 patients.

15. On or about February 2, 2016, the Board sent a copy of both reviewers' reports to the Respondent, providing him an opportunity to submit a supplemental response.

16. On or about February 24, 2016, the Board received the Respondent's supplemental response as to 10 patients. The Respondent submitted his supplemental response as to the eleventh patient on or about March 1, 2016.

II. PATIENT-SPECIFIC ALLEGATIONS

Examples of the above investigative findings are set forth in the following patient specific findings. These summaries are not intended as, and do not represent, a complete description of the evidence with respect to the Respondent's conduct in this matter.

PATIENT A

17. Patient A was a female in her 50s when began seeing the Respondent in March 2008 for low back and neck pain.[3] Patient A lived in Virginia Beach, Virginia and traveled to Maryland to see the Respondent. At her initial visit with the Respondent, Patient A reported that her current meds were Percocet[4], Xanax[5], and Restoril.[6]

18. The Respondent's documentation consists primarily of chief complaint, vital signs and photocopies of the medications he prescribed for Patient A.

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[3] The earliest date in the Respondent's medical record for Patient A is March 25, 2008. However, there is no documentation of care provided again until March 31, 2010.
[4] Schedule II CDS.
[5] Schedule IV CDS.
[6] A benzodiazepine.

19. The Respondent failed to document an initial evaluation of Patient A's pain, details of history, physical examination, review of diagnostic testing or plan of care in terms of opioid prescribing.

20. The Respondent failed to conduct or failed to document conducting a risk/benefit assessment regarding the use of opioids to treat Patient A's pain.

21. The Respondent failed to conduct or failed to document conducting an ongoing assessment of the efficacy and side effects of medications prescribed to Patient A.

22. The Respondent engaged in inappropriate dosing of long-acting opioids versus short-acting opioids to treat Patient A's pain.

23. The Respondent inappropriately prescribed more than one short-acting opioid without documenting a rationale for doing so.

24. The Respondent continued to prescribed high-dose opioids, despite inconsistent urine toxicology results.

25. The Respondent failed to conduct or failed to document conducting regular urine drug screens and/or pill counts to assess medication compliance.

26. The Respondent failed to utilize or failed to document utilizing an opioid contract or treatment agreement.

27. The Respondent quickly escalated dosages of opioid pain medication to high doses for a prolonged period of time.

28. Between 2010 and 2012, the Respondent significantly escalated the dosage of Oxycontin[7] from 40mg #120 to 80mg #180, along with ongoing prescriptions for

[7] Schedule II CDS.

oxycodone[8] 30mg #180 and Endocet[9] 10/325 #180. The Respondent failed to document a clear explanation for the dosage escalation.

29. In November 2012, the Respondent prescribed Xanax and Valium[10] along with opioids. The Respondent failed to document a rationale for the addition of these medications.

30. The Respondent saw Patient A monthly from October 2013 through December 2014. The Respondent's documentation included only a partially-completed evaluation form, a list of current medications and copies of prescriptions written at each respective appointment. At these appointments, the Respondent failed to document a history of present illness, assessment or plan. Furthermore, the Respondent failed to conduct or failed to document conducting a physical examination.

31. On December 26, 2013 the Respondent saw Patient A and documented that Patient A was hospitalized from December 5, 2013 until December 11, 2013. The Respondent failed to review or failed to document reviewing records from Patient A's hospitalization.

32. Patient A's medical record includes a report from LabCorp dated January 20, 2015, for a urine toxicology screen. The report states "quantity not sufficient for analysis." The Respondent failed to document the order for and the results of the urine toxicology screen. In addition, the Respondent failed to address or failed to document addressing the urine toxicology screen with Patient A at her next appointment in March 2015.

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[8] Schedule II CDS.
[9] Schedule II CDS.
[10] Schedule IV CDS.

33. The Respondent regularly failed to conduct or failed to document conducting a detailed pain assessment, including deficits reported, pain rating, aggravating or relieving factors or effect of pain on Patient A's daily activities. The Respondent further failed to document Patient A's response to her pain medications and any side effects.

34. On July 15, 2015, Patient A tested positive for morphine[11] and oxycodone. The Respondent was not prescribing morphine to Patient A. The Respondent failed to conduct or failed to document conducting a discussion with Patient A regarding this abnormal urine toxicology screen.

35. In a letter dated July 23, 2015, the Respondent notified Patient A that he "will no longer be able to see you in the future for your pain management needs." The Respondent referenced a discussion of the same at Patient A's appointment on July 21, 2015.

36. The Respondent failed to document in Patient A's medical record his discussion with Patient A regarding her future pain management care.

37. The Respondent's handwritten notes are poor and often illegible.

38. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient A.

39. The Respondent failed to document adequately in Patient A's medical records.

PATIENT B

40. Patient B was a male in his 50s when he began seeing the Respondent in January 2014. Patient B's chief complaint was chronic pain in hip, back and knee. Patient B also had a history of multiple joint pain, hypertension and asthma.

[11] Schedule II CDS.

41. On January 14, 2014, at Patient B's initial visit, Patient B reported that he was currently taking Oxycodone HCL 30mg 2 tabs every 8 hours. The Respondent continued Patient B on the same medication (#200 tabs) without first confirming Patient B's medication intake, any evaluation of Patient B's response to the medication, or a detailed pain history.

42. The Respondent failed to conduct or failed to document conducting a risk assessment for abuse or addiction to opioids before prescribing high-dose Oxycodone.

43. The Respondent failed to discuss or failed to document discussing the risks and benefits of ongoing high dose opioid use.

44. The Respondent failed to discuss or failed to document discussing a plan or time frame to address Patient B's hip pain.

45. The Respondent failed to discuss or failed to document discussing alternative treatments for Patient B's hip pain, such as physical therapy, referral to pain management or adjunctive medications.

46. The Respondent failed to review or failed to document reviewing records of other providers, previous treatments and Patient B's response to previous treatments.

47. The Respondent saw Patient B for monthly appointments through March 2015. The Respondent's documentation of Patient B's monthly visits included chief complaint, a list of current medications, vital signs and copies of prescriptions.

48. The Respondent continued prescribing Oxycodone 30mg #200 monthly. In June 2014, the Respondent also prescribed Tramadol[12] 50 mg #60. He continued to prescribe Oxycodone and Tramadol on July 8, 2014 (two refills of Tramadol), August 1, 2014, August 26, 2014 and September 25, 2014 (two refills of Tramadol).

[12] Schedule IV CDS.

49. Patient B's medical record contains a note from an orthopedic surgeon indicating that Patient B decided to proceed with a total hip replacement, which occurred in October 2014. A discharge summary dated October 7, 2014 in Patient B's medical record indicates that his discharge medication was Percocet 5/325mg 1-2 tabs every 4-6 hours.

50. The Respondent saw Patient B on October 20, 2014 and documented the chief complaint as "left hip replaced." The Respondent prescribed Oxycodone 30 mg #200 without documenting a rationale for doing so.

51. The Respondent failed to conduct or failed to document conducting regular urine toxicology screens.

52. The only urine drug screen documented in Patient B's medical record was on October 20, 2014 and was positive for oxycodone and oxymorphone[13], which was not prescribed by the Respondent.

53. The Respondent failed to address or failed to document addressing the inconsistent results of Patient B's urine drug screen.

54. The Respondent ordered an x-ray of Patient B's wrist on November 21, 2014 and again prescribed oxycodone 30 mg #200.

55. The Respondent saw Patient B on December 22, 2014 and failed to follow up or failed to document following up on the results of Patient B's wrist x-ray.[14] The Respondent also failed to discuss or failed to document discussing Patient B's post-operative progress or response to pain medication.

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[13] Schedule II CDS.

[14] A note on March 31, 2015 states that Patient B continues to have wrist pain but has not had an x-ray of his wrist.

56. The Respondent continued prescribing oxycodone on December 22, 2014, January 16, 2015 (with Tramadol 50mg #90), February 10, 2015 and March 31, 2015.

57. On April 30, 2015, LabCorp reported that Patient B's urine drug screen was negative for all opioids and benzodiazepines, despite Patient B's current prescriptions.

58. On May 6, 2015, the Respondent notified Patient B that he was discharged from the practice due to the inconsistent urine drug screen.

59. On July 3, 2015, Patient B returned to see the Respondent and stated that he did not receive the discharge letter. The Respondent provided him with a copy of the letter. The Respondent documented a prescription for oxycodone 30mg #120 and referrals to pain management and radiology for an x-ray of his right knee. The Respondent failed to conduct or failed to document conducting a history of present illness, physical examination, assessment or plan.

60. The Respondent failed to assess or failed to document assessing how the opioids were helping Patient B function.

61. The Respondent failed to utilize or failed to document utilizing an opioid contract or treatment agreement.

62. The Respondent prescribed high doses of opioids without documentation of pain details, Patient B's response to the pain medication or evaluation of side effects.

63. Despite evidence of diversion or noncompliance, the Respondent continued to prescribe opioids to Patient B.

64. Overall, the Respondent's handwritten notes are minimal, inadequate and illegible.

65. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient B.

66. The Respondent failed to document adequately in Patient B's medical records.

PATIENT C

67. Patient C was a female in her 50s when she began seeing the Respondent in June 2013. Patient C's chief complaints were rheumatoid arthritis, right knee pain and deformity. Patient C also had a history of gastrointestinal bleeding.

68. On June 6, 2013, the Respondent saw Patient C as a new patient and documented that she had severe inflammation of joints secondary to rheumatoid arthritis. The Respondent failed to document any clear details on Patient C's pain history or examination. Patient C was not taking any opioid medication at intake. The Respondent prescribed oxycodone 5/325 #30.

69. Prior to prescribing oxycodone, the Respondent failed to discuss or failed to document discussing an assessment of the risks and benefits of opioid medications.

70. The Respondent failed to utilize or failed to document utilizing an opioid contract or treatment agreement.

71. The Respondent failed to document a treatment plan for Patient C's use of opioids to treat chronic pain.

72. The Respondent saw Patient C on June 20, 2013 and documented the chief complaint, vital signs and medications. The Respondent documented "anemia, rheumatoid arthritis, chest pain" as his assessment. The Respondent refilled all medications without documenting Patient C's response to the medications or any evaluation of side effects.

73. The Respondent prescribed Percocet 5/325 on November 4, 2013 (#180), December 27, 2013 (#90 with two refills), January 24, 2014 (#90), June 4, 2014 (#180). Documentation in Patient C's medical record indicates that Patient C also received prescriptions for Percocet 5/325 on January 23, 2014 (#30) and Tylenol with Codeine[15] #3 30mg on June 5, 2014 (#60) from her rheumatologist.

74. The Respondent continued to prescribe Percocet to Patient C on a monthly basis up to and including January 8, 2015, without proper documentation of a physical examination, assessment or plan of care.

75. The Respondent's documentation is illegible, sparse and insufficient to justify the use of high doses of short-acting opioids for such a long period of time.

76. In June 2014, the Respondent began prescribing a benzodiazepine to Patient C. Initially the Respondent prescribed Valium 5mg #60 and then changed the prescription in to Xanax .5mg #60 in August 2014. The Respondent later raised the dosage of Xanax to 1mg one tab BID #60.[16] The Respondent failed to document a rationale for adding and increasing this medication, other than listing "anxiety" as a chief complaint.

77. On January 26, 2015, Patient C underwent a right total knee replacement. She was discharged from the hospital on January 29, 2015 with a prescription for Percocet 5/325 #40.

78. On January 31, 2015, Patient C returned to the hospital through the emergency department with complaints of knee pain due to not filling per prescription for Percocet. Patient C was admitted to pain control. According to the discharge summary, Patient C

[15] Schedule III CDS

[16] It is unclear from the Respondent's documentation in Patient C's medical record when he increased the dose of Xanax.

opted to go to the emergency department rather than pick up her prescription for pain medication, which was ready at the pharmacy.

79. The Respondent saw Patient C for a follow-up appointment on February 18, 2015. The Respondent continued prescribing Percocet 5/325 #180 monthly until her last visit in June 2015.

80. On June 15 , 2015, Patient C submitted to a urine toxicology screen which was positive for cocaine. As a result, on July 17, 2015, the Respondent notified Patient C that due to her positive urine drug screen, he "will no longer be able to address your pain needs" and will refer her to pain management for further treatment.

81. The Respondent failed to require pill counts or regular urine toxicology screens.

82. The Respondent failed to assess or failed to document assessing how the opioids were helping Patient C function.

83. Overall, the Respondent's handwritten notes are minimal, inadequate and difficult to read.

84. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient C.

85. The Respondent failed to document adequately in Patient C's medical records.

PATIENT D

86. Patient D was a female in her 30s when she began seeing the Respondent in October 1994 for primary care. The Respondent's medical record for Patient D is sparse from 1994 through 2011.

87. The majority of the Respondent's medical record for Patient D consists of laboratory results and notes from other providers.

88. The Respondent's notes from appointments with Patient D are disorganized, not in chronological order, and consist primarily of chief complaints, vital signs and a list of medications. At each appointment, the Respondent failed to document history of present illness, physical examination, assessment or plan.

89. The Respondent's medical record for Patient D includes a "To Whom it May Concern" letter, dated September 2009, stating that Patient D is being treated for migraines and lower back pain "for several years" with Tylenol #3[17]. However, the first documented prescription for Tylenol #3 is in July 2010.

90. The Respondent continued to prescribe Tylenol #3 two tabs BID PRN #240 at every appointment for Patient D, often with three refills.

91. The Respondent also prescribed oxycodone HCL 15 mg one tab TID #90 in September 2013, January 2014 and March 2014 (with three refills). The Respondent also prescribed Tylenol #3 with three refills on the same date in March 2014.

92. The Respondent failed to conduct or failed to document conducting a proper work-up of Patient D's pain .

93. The Respondent failed to document a basis for initiating opioid treatment.

94. The Respondent failed to document a rationale for continued opioid treatment.

95. The Respondents failed to conduct or failed to document conducting an assessment of risk versus benefit of using opioids to treat Patient D's pain.

96. The Respondent failed to obtain or failed to document obtaining informed consent from Patient D prior to initiating opioid treatment.

97. The Respondent failed to utilize an opioid contract or treatment agreement, urine toxicology screens and pill counts to ensure compliance with opioid treatment.

[17] Schedule III CDS.

98. During the many years over which the Respondent prescribed opioids for Patient D, the Respondent failed to assess Patient D's pain, the benefit derived from opioid use, or any adverse reactions from the medication.

99. The Respondent also failed to assess or failed to document assessing the effect of opioids on Patient D's function and activities or the presence of aberrant behavior.

100. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient D.

101. The Respondent failed to document adequately in Patient D's medical records.

PATIENT E

102. Patient E was a male in his 40s when he began seeing the Respondent in June 1997.[18] At Patient E's initial visit, the Respondent documented "migraine" as the reason for the visit. Patient E reported allergies to opium, morphine, codeine and Percocet. Patient E also reported that he was taking Demerol[19] 50mg q6h #40.

103. Patient E reported severe pain at his initial appointment, despite taking Demerol. The Respondent failed to evaluate or failed to document evaluating Patient E regarding the efficacy of Demerol before prescribing the medication.

104. A July 1997 consultation note from a neurologist recommended that Patient E's headaches be treated prophylactically and without Demerol. A September 1997 telephone note from Patient E to the Respondent stated "Refill of same medications he was taking. Went to neurologist and said it was ok to stay on same medication."

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[18] There are very few patient records from 1997 until 1999, some records in 2001 and 2002 and no records from late 2002 until 2010.
[19] Schedule II CDS.

105. An October 1998 consultation note from a gastroenterologist addressed Patient E's Demerol use and stated "I told him that Demerol can be habit forming, so he should not take too much."

106. A hospital note dated March 28, 2002 documented a Utilization Review Committee's review of Patient E's hospitalization, which found that Patient E did not meet the criteria for continued hospitalization for his intractable, chronic abdominal pain. The note further mentioned Patient E's Demerol-seeking behavior and recommended referral to a chronic pain clinic and psychiatric evaluation.

107. The Respondent failed to discuss or failed to document discussing the recommendations of the consulting physicians and Utilization Review Committee with Patient E. The Respondent continued to prescribe Demerol to Patient E.

108. The Respondent prescribed Demerol 50 mg consistently from 2011 until the last documented visit in July 2015. The dosage remained consistent but the frequency changed periodically from once daily to three times daily.

109. It is not clear why the Respondent continued to prescribe Demerol for Patient E. Some documentation indicates that the Demerol was prescribed to treat migraine headaches, while other documentation indicates that it was prescribed for intractable abdominal pain or foot pain.

110. The majority of the Respondent's medical record for Patient E consists of laboratory results, test reports, discharge summaries and prescription refills.

111. The Respondent's medical record for Patient E indicates that Patient E relocated to North Carolina. It is unclear from the medical record when Patient E relocated, but a note in May 2011 has a North Carolina address for Patient E.

112. The Respondent ordered urine toxicology screens in June and July 2015. The June screen was negative for all opioids and benzodiazepines. The July screen was negative for Demerol and positive for benzodiazepines. Despite two urine drug screens that were inconsistent with Patient E's current prescriptions, the Respondent continued to prescribe Demerol without addressing the issue of diversion with Patient E.

113. At follow-up appointments, the Respondent failed to assess or failed to document assessing Patient E's response to the medication or the presence of side effects.

114. The Respondent failed to conduct or failed to document conducting a risk assessment for the use of opioids to treat pain.

115. The Respondent failed to utilize an opioid contract pr treatment agreement, regular urine toxicology screens and pill counts to ensure compliance with opioid treatment.

116. The Respondent failed to document a clear rationale for long-term prescribing of opiate and benzodiazepine medications.

117. The Respondent's medical record for Patient E contained limited information and visit notes consist mostly of the chief complaint, allergies, medications and vital signs.

118. The Respondent's medical record for Patient E is incomplete, illegible and disorganized.

119. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient E.

120. The Respondent failed to document adequately in Patient E's medical records.

PATIENT F

121. Patient F was a male in his 40s when he began seeing the Respondent in May 1997.[20] At his initial visit, Patient F had complaints of hypertension, headache, joint pain and nasal congestion. Patient F also had a history of various co-morbidities, including prostate cancer and abdominal pain.

122. In December 2012, the Respondent prescribed Vicodin[21] 5/500 mg QID #120 and Xanax 0.25 mg TID #90 without documentation of a medical reason for those medications.

123. In September 2014, the Respondent documented an office visit during which Patient F complained of severe abdominal pain and knee pain. The Respondent failed to document a physical examination, assessment or plan at that visit. However, the Respondent prescribed Percocet 5/325 mg TID #90.

124. In March 2015, the Respondent prescribed oxycodone HCL 15 mg TID #90 and Xanax 0.25 mg TID #90 without documentation of a medical reason for the prescription. The Respondent refilled the prescription for oxycodone in April 2015.

125. The Respondent failed to document his rationale for changing Patient F's opioid medication.

126. The Respondent's medical record for Patient E consists mainly of consultation reports from other providers and laboratory reports.

127. The Respondent failed to conduct or failed to document conducting physical assessments at Patient F's office visits.

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[20] The Respondent's medical record for Patient F contains one document from 1997. The remainder of the record is from 2012 to 2015.

[21] Unscheduled pain medication consisting of hydrocodone and acetaminophen.

128. The Respondent failed to obtain or failed to document obtaining details of Patient F's medical history, summary of test results and rationale of care.

129. The Respondent failed to determine or failed to document determining the etiology of Patient F's pain for which opioids were prescribed.

130. The Respondent failed to address or failed to document addressing the effect of analgesics on reducing Patient F's pain and whether Patient F experience side effects or adverse reactions to pain medications.

131. The Respondent failed to assess or failed to document assessment the effect of Patient F's pain on his daily activities.

132. The Respondent's medical record for Patient F is illegible, incomplete and disorganized.

133. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient F.

134. The Respondent failed to document adequately in Patient F's medical records.

PATIENT G

135. Patient G was a male in his 30s when he began seeing the Respondent in October 2003. His chief complaint was shoulder and back pain.

136. In October 2003, the Respondent prescribed Tylenol #3 one or two tablets QID #100 with one refill without documentation of the rationale for the medication. The Respondent refilled the medication in November 2007 without any supporting documentation.

137. In August 2006, the Respondent prescribed Vicodin 7.5/750 mg one or two tablets q10h #120 without any supporting documentation or rationale.

138. From January 2010 through November 2010, the Respondent regularly prescribed Percocet and Flexeril[22] on a monthly basis. In his corresponding visit notes for Patient G, the Respondent documented only that Patient G complained of back and shoulder pain. The Respondent failed to document any physical examination at Patient G's visits.

139. The Respondent continued to prescribe narcotics to Patient G on a regular basis.

140. In January 2013, the Respondent changed Patient G's prescription to Percocet and Oxycontin. The Respondent failed to document a medical rationale for changing Patient G's pain medications.

141. The Respondent failed to clearly evaluate or failed to document evaluating Patient G's shoulder or low back pain.

142. The Respondent failed to document an assessment or treatment plan for Patient G's pain.

143. The Respondent failed to assess or failed to document assessing Patient G's response to the various pain medications, the presence of side effects, any aberrant behavior or the effect on Patient G's function and activities.

144. The Respondent failed to conduct or failed to document conducting a risk assessment for the use of opioids.

145. The Respondent failed to monitor or failed to document monitoring Patient G's use of opioids with an opioid contract or treatment agreement and regular urine screens.

[22] Unscheduled muscle relaxant.

146. The Respondent prescribed high doses and large quantities of two narcotic pain medications for an extended period of time without sufficient documentation of his rationale.

147. The Respondent's medical record for Patient G is illegible and disorganized.

148. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient G.

149. The Respondent failed to document adequately in Patient G's medical records.

PATIENT H

150. Patient H was a male in his 50s when he began seeing the Respondent in March 2009 for low back pain and leg pain. Patient H also had complaints of neck pain and neuropathy.

151. In April 2009, the Respondent began prescribing Percocet 5/325 mg one to two tablets QID #136 for Patient H's pain. The Respondent also referred Patient H for an MRI of the lumbar spine, which revealed spinal degenerative joint disease.

152. The Respondent also referred Patient H to a neurologist who recommended that Patient H stop taking Percocet every four hours. The neurologist also noted that Patient H has a previous history of substance abuse. The neurologist recommended physical therapy and further testing, as well as an epidural steroid injection if necessary.

153. In September 2009 and October 2009, Patient H received steroid injections to treat his back pain.

154. However, the Respondent continued to prescribe Vicodin and Percocet, at high doses and large quantities.

155. In January 2013, Patient H underwent a C4-7anterior cervical discectomy and fusion.

156. In May 2013, Patient H's medical record contains a consultation note from a pain specialist who recommended that the Respondent lower Patient H's Percocet dose, or in the alternative, prescribe a long-acting opioid.

157. In 2013 and 2014, the Respondent continued to prescribe Percocet, Valium, and Gabapentin[23] with minimal documentation of the necessity for continuing these medications.

158. The Respondent's medical record for Patient H consists primarily of consultation notes from other providers, discharge summaries from emergency department visits, imaging results and copies of prescriptions.

159. The Respondent continued prescribing Percocet, Vicodin and Soma[24] despite minimal documentation in support of his rationale.

160. Despite Patient H's history of substance abuse, the Respondent failed to conduct or failed to document conducting a risk assessment for the use of opioids to treat chronic pain.

161. The Respondent failed to monitor or failed to document monitoring Patient H for aberrant behavior by using an opioid contract, or treatment agreement, regular urine screens or pill counts.

162. Despite the recommendation of a pain specialist to consider a long-acting opioid, the Respondent failed to discuss or failed to document discussing this treatment option with Patient H.

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[23] Unscheduled anticonvulsant used to treat nerve pain.
[24] Schedule IV CDS.

163. The Respondent's office notes are very limited, illegible and consist mainly of the chief complaint, vital signs, medications and allergies.

164. The Respondent failed to conduct or failed to document conducting regular physical assessments of Patient H.

165. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient H.

166. The Respondent failed to document adequately in Patient H's medical records.

PATIENT I

167. Patient I was a female in her 50s when she began seeing the Respondent in September 2001for both primary care and pain management. Patient I had complaints of shoulder and back pain.

168. During the years of treatment, the Respondent prescribed multiple pain medications for Patient I without clear documentation of any pain complaint in any visit note.

169. For instance, in November 2007 the Respondent prescribed Tylenol #3 #240 with four refills and hydrocodone/APAP[25] 5/500 #240 with three refills. There is no corresponding office note.

170. In September 2008, the Respondent prescribed Soma 350mg one tablet QID #120 and Vicodin 5/500 QID #180 for Patient I. There is no corresponding office note.

171. In November 2008, Patient I called the Respondent's office and requested that he call in a prescription for Diazepam[26]. A corresponding note from the Respondent

[25] Unscheduled pain medication.
[26] Schedule IV CDS.

indicates that he called in a prescription for Diazepam. The Respondent failed to document the reason for the prescription.

172. The Respondent documented an office visit in December 2013 at which Patient I complained of severe back pain and difficulty walking. The Respondent failed to conduct or failed to document conducting a history of present illness, physical examination, assessment or treatment plan. The Respondent prescribed Vicodin 5/500 #180 with two refills, Xanax 0.5 mg #90 with three refills and Lyrica[27] 75 mg #30 with refills.

173. In January 2014, the Respondent provided Patient I with a referral to a pain management physician, but Patient I decided to wait and see her pain management specialist in Florida. The Respondent failed to document any information regarding Patient I's care by a pain management physician.

174. The Respondent's medical record consists mainly of laboratory results, phone messages from Patient I and copies of prescriptions. The Respondent's office notes are very limited, illegible and consist primarily of chief complaint, vital signs, medications and allergies.

175. The Respondent failed to monitor or failed to document monitoring Patient I for aberrant behavior by using an opioid contract or treatment agreement, regular urine screens or pill counts.

176. The Respondent failed to document an assessment or treatment plan for Patient I's pain.

[27] Schedule V CDS.

177. The Respondent failed to assess or failed to document assessing Patient I's response to the various pain medications, the presence of side effects, any aberrant behavior or the effect on Patient I's function and activities.

178. The Respondent failed to monitor Patient I's use of opioid medications with pill counts or drug screens.

179. The Respondent failed to conduct or failed to document conducting a risk assessment for the use of opioids.

180. The Respondent prescribed pain medications in large quantities without seeing Patient I.

181. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient I.

182. The Respondent failed to document adequately in Patient I's medical records.

PATIENT J

183. Patient J was a female in her 30s when she began seeing the Respondent in 2004 for treatment of back pain. Patient J continued to see the Respondent for treatment until 2015.

184. During the years of treatment, the Respondent consistently prescribed opiates in high doses and large quantities without documenting a medical rationale.

185. For instance, from 2010 to 2013, the Respondent prescribed Percocet 5/325 #240 on a monthly basis. Corresponding notes documenting office visits are brief with chief complaints of knee, back or neck pain with no further details on the pain, physical examination or treatment plan.

186. The Respondent also regularly prescribed Oxycontin, in addition to Percocet without adequate documentation.

187. In July 2014, the Respondent prescribed morphine sulphate 15 mg #60 and Vicodin 7.5/325 #120 without any documented medical rationale.

188. The Respondent failed to adequately document Patient J's complaint, medical history, physical examination, assessment and plan.

189. The Respondent failed to complete or failed to document completing a risk assessment for the use of opioids.

190. The Respondent failed to utilize an opioid agreement with Patient J.

191. The Respondent continued to prescribe opioids despite inconsistent toxicology screenings.

192. The Respondent failed to address or failed to document addressing Patient J's inconsistent toxicology screens.

193. In some instances, the Respondent documented that Patient J refused urine toxicology screens. However, the Respondent continued to prescribe opioids to Patient J.

194. The Respondent failed to conduct regular toxicology screens to ensure medication compliance.

195. Many of the Respondent's progress notes for Patient J are illegible and do not clearly indicate a patient assessment and plan of care.

196. The Respondent failed to assess or document assessing the effect of the medication on Patient J's pain, the effect of the medication on Patient J's function and daily activities or the existence of any aberrant behavior.

197. The Respondent's progress notes are limited, consisting only of chief compliant, medications, allergies and vital signs.

198. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient J.

199. The Respondent failed to document adequately in Patient J's medical records.

PATIENT K

200. Patient K was a female in her 30s when she began seeing the Respondent in 2004. Patient K had multiple co-morbidities including multiple sclerosis, hypertension, diabetes, congestive heart failure, depression and obesity.

201. From 2006 until 2011, the Respondent prescribed multiple prescriptions for Percocet 10. 650 mg #90, then #120. The Respondent then increased the dosage and quantity to 5/325 #240 and then prescribed oxycodone 15mg #120. The Respondent failed to document any details on Patient K's pain, any physical examination, assessment or treatment plan.

202. From 2010 until 2013, on a monthly basis, the Respondent prescribed Percocet 5/325mg #240 for complaints of back, knee and neck pain.

203. The Respondent's handwritten visit notes are illegible, making it difficult to ascertain the rationale for prescribing opioids to Patient K.

204. In 2014, the Respondent began prescribing morphine sulfate. The Respondent failed to document the rationale behind prescribing this medication.

205. A urine toxicology screen in November 2014 was positive for morphine but negative for oxycodone. The Respondent failed to address or failed to document addressing Patient K's inconsistent laboratory reports.

206. In 2015, the Respondent continued to prescribe morphine sulphate 30 mg #60, oxycodone 30 mg #180. He also inexplicably prescribed Adderall[28] 20 mg #60.

207. In July 2015, the Respondent referred Patient K to a pain specialist who planned to aggressively wean Patient K off of her narcotics and utilize a multi-disciplinary approach to pain management. According to the consultation note, Patient K did not return to the clinic.

208. A second pain management consultation recommended that Patient K be weaned from opioid therapy.

209. In August 2015, the Respondent discharged Patient K from his practice and provided a prescription for oxycodone 15 mg #20.

210. The Respondent maintained Patient K on high doses and large quantities of short-acting opiates without appropriately documenting a medical justification.

211. The Respondent failed to adequately document the details of Patient K's pain, history, diagnostic testing, assessment or treatment plan.

212. The Respondent failed to utilize an opioid contract or treatment agreement with Patient K.

213. The Respondent failed document a rationale for the gradual escalation to high doses of opioids over time.

214. The Respondent failed to assess or failed to document assessing Patient K for side effects and efficacy of the medications he prescribed.

215. The Respondent failed to address or failed to document addressing Patient K's inconsistent toxicology screens.

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[28] Schedule II CDS.

216. The Respondent's notes in Patient K's medical record consist mainly of chief complaint, medications, vital signs and allergies. The Respondent failed to conduct or failed to document conducting adequate physical examinations of Patient K.

217. The Respondent failed to meet the standard of quality medical and surgical care with respect to his care of Patient K.

218. The Respondent failed to document adequately in Patient K's medical records.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated. H.O. §§ 14-404(a)(22) and (40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby:

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

ORDERED that the Respondent is permanently prohibited from practicing pain medicine. As part of this prohibition, the Respondent shall not prescribe any Controlled Dangerous Substances ("CDS"), as defined under Md. Code Ann., Crim. Law § 5-101 and Crim. Law §§ 5-401—5-406; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of one (1) year.[29] During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1. Within six months, the Respondent shall successfully complete a Board disciplinary panel-approved course in medical record-keeping. The Board

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

disciplinary panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the Board that the Respondent has successfully completed the course;

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

3. During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation;

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

ORDERED that, after one year, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel B. The Respondent may be required to appear before the Board or Panel A to discuss his petition for termination. The Board or Panel B will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if the Board or Panel B determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or Panel B if there is no genuine dispute as to a material fact, that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Panel B 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 Board or Panel B 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 the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4–101 *et seq.*

06/16/2017
Date

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

CONSENT

I, Samuel W. Allenye, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into 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 own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of a disciplinary panel of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of a disciplinary panel of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

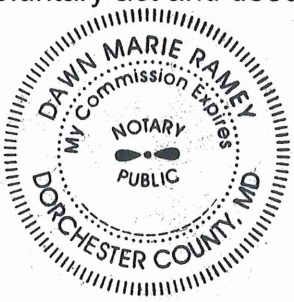
6/7/17.
Date

Samuel W. Alleyne, M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Dorchester :

I HEREBY CERTIFY that on this 7th day of June, 2017 before me, a Notary Public of the foregoing State personally appeared Samuel W. Alleyne, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.



AS WITNESSETH my hand and notarial seal.

Dawn Marie Ramey
Notary Public

My Commission Expires: 8/6/19