IN THE MATTER OF	*	**BEFORE THE MARYLAND**
WILLIAM S. VAUGHN, III, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D43641	*	**Case Number: 2016-0737A**

* *

ORDER OF DEFAULT

BACKGROUND

On June 23, 2017, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians ("Board") charged William S. Vaughn, III, M.D. with unprofessional conduct in the practice of medicine and with selling, prescribing, giving away, or administering drugs for illegal or illegitimate medical purposes. *See* Md. Code Ann., Health Occ. II ("Health Occ. II") § 14-404(a)(3)(ii) and (27). On September 18, 2017, the Board referred the case to the Office of Administrative Hearings ("OAH") for an evidentiary hearing.

After notice was sent to Dr. Vaughn and the State, at their respective addresses of record, a scheduling conference was held at OAH in Hunt Valley, Maryland on October 18, 2017, at 9:30 a.m. Dr. Vaughn appeared at the scheduling conference without counsel and the administrative prosecutor appeared on behalf of the State. During the scheduling conference, a prehearing conference was scheduled for November 13, 2017, at 9:30 a.m. at OAH. COMAR 28.02.01.17.

On October 19, 2017, OAH mailed a Notice of In-Person Prehearing Conference to each party at their respective addresses of record. The Notice of Prehearing Conference informed the parties of the date, time, and location of the prehearing conference and enclosed instructions directing each party to prepare and submit a prehearing statement in advance of the Prehearing

Conference. Further, the Notice of Prehearing Conference informed the parties that failure to attend the November 13, 2017 prehearing conference could result in a decision against the party for failing to appear. On October 19, 2017, OAH also mailed a Notice of Hearing informing the parties that the evidentiary hearing in this case was scheduled for December 13-14, 2017.

On November 13, 2017, Dr. Vaughn appeared at the prehearing conference without counsel and the administrative prosecutor appeared on behalf of the State. At the time of the conference, Dr. Vaughn had not yet filed a prehearing conference statement as he was instructed to do in the Notice of Prehearing Conference. The Administrative Law Judge ("ALJ") instructed Dr. Vaughn to file his prehearing conference statement by the close of business on November 17, 2017.[1]

On December 4, 2017, the administrative prosecutor filed a request for a postponement of the December 13, 2017 hearing. On December 5, 2017, the ALJ sent, by certified mail, a letter to the parties informing them of a prehearing telephone conference scheduled for December 11, 2017 at 9:30 a.m. The letter was sent to Dr. Vaughn's home address, as well as two other addresses that OAH had on file for Dr. Vaughn.[2] The letter was not returned to OAH by the U.S. Postal Service. The ALJ found that Dr. Vaughn received the letter notifying him of the telephone prehearing conference.

The letter informed the parties that the telephone conference would be convened to discuss the administrative prosecutor's postponement request, hear any argument from Dr. Vaughn in opposition, rule on the request for postponement, and set a new hearing date, if needed. The letter notified the parties that the telephone conference was a prehearing conference,

[1] The record in this case does not reflect whether a prehearing conference statement was filed by Dr. Vaughn. Regardless, the default in this case is not based on any failure to file or any deficiencies with the prehearing conference statement.

[2] Dr. Vaughn confirmed his home address at both the scheduling conference and the in-person prehearing conference.

that both parties were required to participate, and that the failure to answer the phone and participate in the conference could result in the issuance of a proposed default order. The letter listed the telephone numbers that the ALJ would use to contact the parties and notified the parties that they should inform the ALJ's assistant if there was a different phone number that should be called. Dr. Vaughn did not request a postponement of the telephone prehearing conference or provide an alternate telephone number.

On December 11, 2017 at 9:30 a.m., the ALJ contacted the administrative prosecutor and Dr. Vaughn at the telephone numbers indicated in the December 5, 2017 letter. The Administrative Prosecutor was present on the phone call, however, both phone numbers for Dr. Vaughn had an automated message saying that the phone number was out of service. The ALJ tried the phone numbers for Dr. Vaughn several times and waited 15 minutes to see if Dr. Vaughn contacted OAH to provide a different phone number. At 9:45 a.m., the ALJ convened the telephone prehearing conference in Dr. Vaughn's absence.

The Administrative Prosecutor moved for a default judgment against Dr. Vaughn and offered the exhibits that she had planned to offer into evidence if the matter had proceeded to a merits hearing. The ALJ admitted those exhibits into evidence.

Under OAH's rules of procedure, "[i]f, after receiving proper notice, a party fails to attend or participate in a prehearing conference, hearing, or other stage of a proceeding, the judge may proceed in that party's absence or may, in accordance with the hearing authority delegated by the agency, issue a final or proposed default order against the defaulting party." COMAR 28.02.01.23A. Similarly, Health Occ. § 14-405 provides, in pertinent part:

> (d) If after due notice the individual against whom the action is contemplated fails or refuses to appear, nevertheless the hearing officer may hear and refer the matter to the Board or a disciplinary panel for disposition.

> (e) After performing any necessary hearing under this section, the hearing officer shall refer proposed factual findings to the Board or a disciplinary panel for the Board's or disciplinary panel's disposition.

Subsection (d) which provides that the ALJ "may hear" the matter if the individual fails to appear, and subsection (e), which uses the language "any necessary hearing," clearly contemplate situations, such as defaults, where no hearing is required. *See also* COMAR 28.02.01.23A.

The ALJ found that Dr. Vaughn had proper notice of the December 11, 2017 prehearing telephone conference and that he failed to appear and participate. On December 15, 2017, the ALJ issued a Proposed Default Order based upon the OAH proceedings described above. The ALJ proposed that the Panel find Dr. Vaughn in default, adopt as fact the statements set out in the allegations of fact section of the charges, conclude as a matter of law that Dr. Vaughn violated Health Occ. II § 14-404(a)(3)(ii) and (27) in the manner set forth in the charges, and revoke Dr. Vaughn's license to practice medicine.

The ALJ mailed copies of the Proposed Default Order to Dr. Vaughn, the administrative prosecutor, and the Board. The proposed decision notified the parties that they may file written exceptions to the proposed decision but must do so within 15 days of the date of the Proposed Default Order. The Proposed Default Order stated that any exceptions and request for a hearing must be sent to the Board with attention to the Board's Executive Director. Neither party filed exceptions.

This case came before Board Disciplinary Panel B ("Panel B") for final disposition.[3]

[3] On December 28, 2017, Panel A summarily suspended Dr. Vaughn's license to practice medicine, in part, based on information that Dr. Vaughn continued to practice medicine after his license had expired and prescribed controlled dangerous substances ("CDS") after he had surrendered his CDS permit to the Drug Enforcement Agency. The summary suspension proceeding is separate from the hearing on the charges that were referred to OAH and resulted in this default.

FINDINGS OF FACT

Because Panel B concludes that Dr. Vaughn has defaulted, the following findings of fact are adopted from the allegations of fact set forth in the June 23, 2017 Charges Under the Maryland Medical Practice Act and are deemed proven by the preponderance of the evidence.

Dr. Vaughn was initially licensed to practice medicine in Maryland on July 31, 1992. His license expired on September 30, 2017.[4] Dr. Vaughn's primary self-designated concentrations are internal medicine and pediatrics; however, he is not board-certified in any medical specialty. Dr. Vaughn was formerly licensed by the District of Columbia Board of Medicine ("D.C. Board"). He allowed his license to expire in 2010, following disciplinary action in 2005 as set forth below. During all times relevant to the facts in this case, Dr. Vaughn was employed part-time at a weight loss center ("Facility A")[5] and an urgent care center ("Facility B"). On or about March 9, 2016, the mother of two former patients of Dr. Vaughn filed a complaint with the Board alleging that Dr. Vaughn, at a restaurant location ("Restaurant A"), had prescribed controlled dangerous substances ("CDS") and other medications to her daughters ("Patients A and B"), without conducting formal office visits or ordering "blood work."

The Board initiated an investigation of the complaint and on or about November 1, 2016, notified Dr. Vaughn of its investigation, and requested a written response. Additionally, Board staff issued a subpoena to Dr. Vaughn for 10 patient records[6] (including Patients A and B) and

[4] Pursuant to section 14-403 of the Health Occupations Article, the license of an individual regulated by the Board may not "lapse by operation of law while the individual is under investigation or while charges are pending." The Board's investigation of Dr. Vaughn and issuance of charges against him occurred before the expiration of Dr. Vaughn's license. Therefore, by operation of law, Dr. Vaughn's license was not permitted to, and did not, expire during these proceedings.

[5] In order to maintain confidentiality, identifying names are not used in this document, but will be provided to Dr. Vaughn on request.

[6] The patient names were randomly selected by Board staff from pharmacy surveys.

requested summaries of care for all ten patients.[7] On or about December 16, 2016, Dr. Vaughn submitted a written response to the complaint. He stated in his response that he had seen Patients A and B for anxiety and/or attention deficit disorder ("ADD"), and had prescribed Xanax[8] to both of them. On or about December 21, 2016, Dr. Vaughn provided summaries of care to the Board, but did not provide any medical records, stating that the records were "too long to send." Regardless, Dr. Vaughn signed the Certification of Medical records forms for each of the 10 patients and attested that he had provided the Board with the "complete medical records" for all 10 patients. Dr. Vaughn did not provide the Board with the subpoenaed medical records until January 26, 2017, when he was subpoenaed to provide interview testimony before Board staff.

Prior Disciplinary History in the District of Columbia and Maryland

On or about September 20, 2005, the District of Columbia ("D.C.") Board summarily suspended Dr. Vaughn's medical license for prescribing Schedule II CDS to a patient after the termination of their physician-patient relationship and without documenting the CDS prescriptions in a medical record. Subsequently, by Order dated May 16, 2006, the D.C. Board revoked Dr. Vaughn's medical license. On or about May 18, 2006, Dr. Vaughn filed a Motion for Reconsideration of the May 16, 2006, D.C. Board's Order (which the Board subsequently denied on May 17, 2007). In its Final Order denying Dr. Vaughn's Motion dated May 17, 2007, the D.C. Board referenced a mental health provider who had evaluated Dr. Vaughn to assist in his defense of the Board's charges:

> Dr. Vaughn did not believe he was violating medical ethics. He didn't know that. And I think he acted purely out of concern for helping indigent clients -- patients -- whom he had diagnosed, had examined their X-rays, really believed that what

[7] On or about November 1, 2016, the Board mailed a contact letter to Dr. Vaughn's address of record notifying him of the complaint, and it was returned to the Board as undeliverable. Dr. Vaughn subsequently updated his address and on November 22, 2016, the Board resent the letter and subpoena to the new address provided by Dr. Vaughn.

[8] Xanax is the brand name for alprazolam, and is a Schedule IV benzodiazepine used in the treatment of anxiety disorders.

they were suffering from he was treating in a medically appropriate way. But he did not know that a condition for treating any patient is you must have a chart.[9]

By Order dated January 22, 2008, the D.C. Board reinstated Dr. Vaughn's medical license, placing him on one year of probation. The D.C. Board terminated Dr. Vaughn's probation on March 12, 2010, but retroactive to December 31, 2008. Dr. Vaughn allowed his D.C. license to expire in 2010. By Order dated August 27, 2008, the Maryland Board imposed reciprocal action based on the D.C. Board's Order, and placed Dr. Vaughn on one year of probation. By Order dated April 7, 2010, the Maryland Board terminated Dr. Vaughn's probation.

Current Complaint

PATIENT A[10]

Patient A, a female in her 20s who worked as a server at Restaurant A, initially saw Dr. Vaughn for "a routine medication refill" at Facility B beginning on December 21, 2015. A prescription drug monitoring program ("PDMP") printout obtained by Board staff reflected that Dr. Vaughn had prescribed several medications to Patient A on the following dates that pre-dated her initial office visit with Dr. Vaughn:

a. Adderall 30 mg, a Schedule II CDS #60 on four dates in 2015: September 2, September 30, October 30 and November 30;
b. Oxycodone, 10 mg, a Schedule II CDS #60 on two dates in 2015: September 9 and October 14;
c. Oxycodone 15 mg #30 on November 19, 2015; and
d. Alprazolam, on two dates in 2015: September 16 #60 and November 4 #60.

Dr. Vaughn did not document any medical visits for Patient A prior to December 21, 2015. He signed a certification of medical records attesting that he had provided the Board with

[9] May 17, 2007 D. C. Board Order, page 8.
[10] On August 15, 2016, Board staff issued a subpoena for Patient A to provide testimony on August 29, 2017, and she failed to appear.

all of Patient A's medical records in his possession. The only visits he documented post-dated the prescriptions he had issued to Patient A cited above.

On January 26, 2017, Board staff interviewed Dr. Vaughn under oath. Dr. Vaughn stated that he initially met Patient A when she was a server at Restaurant A. Dr. Vaughn stated that he had treated Patient A for back pain with prescriptions for Percocet and Xanax. Dr. Vaughn denied that he had written any prescriptions for Patient A at Restaurant A, but was unable to explain or recall at precisely which location he had written the prescriptions for Patient A cited above. Dr. Vaughn stated that two to three months after he had evaluated Patient A at Restaurant A, she came to Facility B to obtain her prescriptions.[11] Dr. Vaughn stated that he did not examine Patient A at Restaurant A with any medical equipment because she was "busy serving other...clients." Dr. Vaughn was unable to provide documentation for any medical visits corresponding to the seven prescriptions he had issued to Patient A cited above. Dr. Vaughn diagnosed Patient A with Attention Deficit Hyperactivity Disorder ("ADHD"), even though, to his knowledge, she had not been previously diagnosed with the disorder. Dr. Vaughn was not aware if Patient A had a primary care provider.

PATIENT B[12]

Patient B, a female in her 20s who was Patient A's sister, initially saw Dr. Vaughn for medical care at Facility B on July 18, 2016. She was being prescribed methadone from another provider. Dr. Vaughn documented the reason for Patient B's visit as chronic anxiety. During the initial visit, Dr. Vaughn prescribed 60 tablets of Xanax, 2 mg, twice daily. Prior to Dr. Vaughn seeing Patient B at Facility B, he had issued to her four prescriptions for Alprazolam (#60) on the

[11] The only visits recorded in Patient A's medical record obtained from Dr. Vaughn were December 21, 2015, January 8, 2016, and October 28, 2016.

[12] By letter dated July 12, 2016, Board staff requested that Patient B contact the Board to schedule a meeting. Patient B failed to comply.

following dates: August 27, 2015, October 12, 2015, December 13, 2015 and March 7, 2016. Dr. Vaughn did not document any medical visits for Patient B prior to July 18, 2016. He signed a certification of medical records attesting that he had provided the Board with all of Patient B's medical records in his possession. The only visits he had documented post-dated all of the prescriptions he had issued to her cited above.

During Dr. Vaughn's January 26, 2017 interview with Board staff, Dr. Vaughn stated that Patient B had been referred to him by her sister, Patient A, and that he treated Patient B for anxiety and sinus issues. Dr. Vaughn was not aware whether Patient B had been treated for anxiety by a prior provider. Dr. Vaughn admitted that he had spoken with Patient B at Restaurant A on approximately three or four occasions. Dr. Vaughn did not recall at precisely which location he had written the prescriptions, which predated Patient B's initial medical visit at Facility B.

PATIENT C[13]

Patient C, a female server at Restaurant A of an undetermined age,[14] received several prescriptions from Dr. Vaughn prior to being seen by him at Facility B for a single visit on August 10, 2016. Dr. Vaughn initially saw Patient C at Facility B on August 10, 2016, and prescribed Adderall, 30 mg twice daily (#60). Dr. Vaughn failed to document that Patient C had previously been prescribed Adderall or any other medication for ADD. Dr. Vaughn wrote "n/a" on the form entitled "medication list." In response to a subpoena issued to Pharmacy A for pharmacy records, Board staff obtained prescriptions that Dr. Vaughn had issued to Patient C for

[13] Board staff obtained Patient C's identify from [Dr. Vaughn] during his interview on January 26, 2017. During the interview, [Dr. Vaughn] acknowledged he had prescribed Adderall to Patient C while she was working at Restaurant A.

[14] The records provided by [Dr. Vaughn] in response to the Board's subpoena reflected a different surname for Patient C than [Dr. Vaughn] had provided to Board staff during his interview. Moreover, the progress note documented by [Dr. Vaughn] on August 10, 2016, was sparse and did not include a date of birth.

Adderall 30 mg twice daily (#60) on the following dates without a corresponding medical note: September 16, 2015, October 14, 2015, January 20, 2016, March 16, 2016, April 13, 2016, May 13, 2016 and July 6, 2016. Dr. Vaughn did not document any medical visits for Patient C prior to August 10, 2016. He signed a certification of medical records attesting that he had provided the Board with all of Patient C's medical records in his possession. The only visits he had documented post-dated all of the prescriptions he had issued to Patient C cited above.

During Dr. Vaughn's January 26, 2017 interview with Board staff, he acknowledged that he treated Patient C for ADD with Adderall 30 mg, twice daily and that, around June or July, 2016, while at Restaurant A, Dr. Vaughn wrote a prescription for Patient C for Adderall.

CONCLUSIONS OF LAW

Panel B finds Dr. Vaughn in default based upon his failure to appear at the Office of Administrative Hearings for the telephone prehearing conference scheduled for December 11, 2017. *See* State Gov't § 10-210(4). Based upon the foregoing findings of fact, Panel B concludes that Dr. Vaughn is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. II § 14-404(a)(3)(ii), and that he sold, prescribed, gave away, or administered drugs for illegal or illegitimate medical purposes, in violation of Health Occ. II § 14-404(a)(27).

SANCTION

Panel B adopts the sanction recommended by the ALJ, which is to revoke Dr. Vaughn's medical license.

ORDER

Based upon the 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 William S. Vaughn, III, M.D.'s license to practice medicine in Maryland (License No. D43641) is **REVOKED;** and it is further

ORDERED that the Summary Suspension imposed on December 28, 2017 is **TERMINATED** as moot; and it is further

ORDERED that this is a public document.

01/30/2018
Date

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. II § 14-408, Dr. Vaughn has the right to seek judicial review of this Order of Default. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Order of Default. The cover letter accompanying this Order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Vaughn files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

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

Notice of any petition should also be sent to the Board's counsel at the following address:

Stacey Darin
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201