Janet L. Wasson, M.D.

September 18, 2017

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue, 4th Floor
Baltimore, Maryland 21215-2299

RE: Permanent Surrender of Medical License
License Number: D44979
Case Number: 7715-0064 A

Dear Ms. Farrelly and Members of Disciplinary Panel A:

I have decided to **PERMANENTLY SURRENDER** my license to practice medicine in the State of Maryland, License Number D44979, effective immediately. I understand that upon surrender of my license, I may not give medical advice or treatment to any individual, with or without compensation, and cannot prescribe medications or otherwise engage in the practice of medicine in the State of Maryland as it is defined in the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II"), §§ 14-101 *et seq.*, (2014 Repl. Vol. & 2015 Supp.) and other applicable laws. In other words, as of the effective date of this Letter of Permanent Surrender, I understand that the surrender of my license means that I am in the same position as an unlicensed individual in the State of Maryland.

I understand that this Letter of Permanent Surrender is a **PUBLIC** document and on upon acceptance by Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") becomes a **FINAL ORDER** of the Board.

I acknowledge that on March 10, 2015, I entered into a Consent Order to resolve charges of professional incompetence, constituting a violation of Health Occ. II § 14-410(a)(4), and failure to meet appropriate standards for the delivery of quality medical and surgical care, constituting a violation of Health Occ. II § 14-404(a)(22). Under the terms of the Consent Order, I was reprimanded and placed on probation for two years. I was required to successfully complete a Board-approved remedial course in medical documentation. I was also required to successfully complete a Board-approved remedial course in pain management because I had shifted the focus of my practice from surgery to pain management. In addition, I was required to undergo a peer review.

I understand that upon acceptance of this Letter of Permanent Surrender by Panel A, the terms and conditions of the March 10, 2015 Consent Order are terminated as moot and have no further force or effect.

I further acknowledge that on April 25, 2017, Panel A summarily suspended my medical license after concluding, based on the results of the peer review, that I prescribed excessive quantities of Controlled Dangerous Substances ("CDS") without medical justification and that the public health, safety or welfare imperatively required emergency action. On May 11, 2017, Panel A held a post-deprivation hearing at which I had the opportunity to argue why the summary suspension should not continue. After consideration of the presentation of the parties, Panel A reaffirmed and continued the summary suspension. I did not appeal the summary suspension of my medical license. I understand that upon acceptance of this Letter of Permanent Surrender by Panel A, the summary suspension imposed by Panel A on April 25, 2017 and affirmed on May 11, 2017, will be terminated as moot.

I further acknowledge that on June 12, 2017, Panel A issued disciplinary charges against me. Specifically, the charges alleged that I had engaged in unprofessional conduct in the practice of medicine, constituting a violation of Health Occ. II § 14-404(a)(3)(ii), am professionally, physically or mentally incompetent, constituting a violation of Health Occ. II § 14-404(a)(4) and failed to meet appropriate standards as determined for the delivery of quality medical and surgical care, constituting a violation of Health Occ. II § 14-404(a)(22). In addition to the concerns regarding my excessive prescribing of CDS, Panel A had reason to believe that I had continued to prescribe CDS to numerous patients after the summary suspension of my medical license, in violation of Health Occ. II § 14-601. I have decided to surrender my license to practice medicine in the State of Maryland to avoid further prosecution of these disciplinary charges now pending before Panel A. The Charges are attached hereto and incorporated herein as **Attachment A**.

I wish to make it clear that I have voluntarily, knowingly, and freely chosen to submit this Letter of Surrender to avoid further prosecution of Panel A's Charges. If this case were to proceed to a hearing, I agree that the State would be able to prove the Charges, and for purposes related to medical licensure, these Charges will be treated as if proven. I understand that by executing this Letter of Permanent Surrender, I am waiving any right to contest the Charges in a formal evidentiary hearing at which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf and all other substantive and procedural protections provided by law, including the right to appeal to circuit court.

I understand that Panel A will advise the Federation of State Medical Boards, the National Practitioner Data Bank, and the Healthcare Integrity and Protection Databank

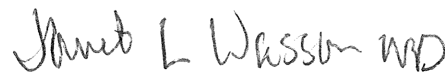
of this Letter of Surrender, and in any response to any inquiry, that I have surrendered my license as if it were revoked. I also understand that in the event I apply for a license in any form in any other state or jurisdiction, this Letter of Permanent Surrender and the underlying investigative documents may be released or published by Panel A to the same extent as a final order that would result from disciplinary action, pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014), and that this Letter of Permanent Surrender is considered a disciplinary action by the Board.

I affirm that on or before the date of Panel A's acceptance of this Letter of Permanent Surrender, I will provide to Board staff my original Maryland medical license, number D44979 drug dispensing permit and my most recent renewal license issued by the Board. I also affirm that I will provide access to and copies of patient medical records in compliance with Title 4, subtitle 3 of the Health General article.

I further recognize and agree that my tendering this Letter of Permanent Surrender, my license will remain permanently surrendered. In other words, I agree I have no right to reapply for a license to practice medicine in the State of Maryland. I further agree that the Board or a disciplinary panel is not obligated to consider any application for licensure that I might file at a future date.

I acknowledge that I may not rescind this Letter of Permanent Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have consulted with an attorney before signing this Letter of Permanent Surrender. I understand both the nature of Panel A's actions and this Letter of Permanent Surrender fully. I acknowledge that I understand and comprehend the language, meaning, and terms and effect of this Letter of Permanent Surrender. I make this decision knowingly and voluntarily.

Sincerely,



Janet L. Wasson, M.D.

NOTARY

STATE OF Maryland

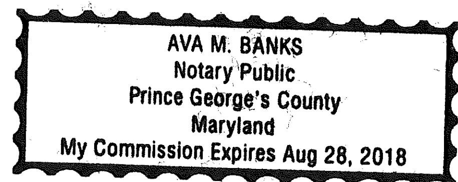
CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 28th day of August 2017, before me, a Notary Public of the State and City/County aforesaid, personally appeared Janet L. Wasson., M.D. and declared and affirmed under the penalties of perjury that signing the foregoing Letter of Permanent Surrender was her voluntary act and deed.

AS WITNESS my hand and official seal.

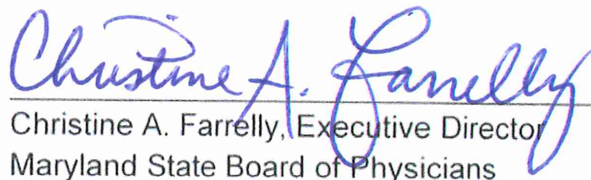
Ava M. Banks
Notary Public

My Commission expires: Aug 28th 2018



ACCEPTANCE

On this 18th day of September, 2017, I, Christine A. Farrelly, Executive Director, on behalf of Disciplinary Panel A of the Maryland State Board of Physicians, accept Janet L. Wasson, M.D.'s **PUBLIC PERMENANT SURRENDER** of her license to practice medicine in the State of Maryland.



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

IN THE MATTER OF * BEFORE THE MARYLAND

JANET L. WASSON, M.D. * STATE BOARD

Respondent * OF PHYSICIANS

License Number: D44979 * Case Number: 7715-0064A

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby charges Janet L. Wasson, M.D., (the "Respondent"), License Number D44979, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-101 *et seq.* (2014 Repl. Vol. & 2016 Supp.).

The pertinent provisions of the Act under Health Occ. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> ...
>
> (3) Is guilty of:
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> ...
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> (4) Is professionally, physically, mentally incompetent;
>
> ...
>
> (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[.]

The pertinent provision under HEALTH OCC. § 14-601 provides as

Attachment A

follows:

§ 14-601. Practicing without license.

Except as otherwise provided in this title,[1] a person may not practice, attempt to practice, or offer to practice medicine in this State unless licensed by the Board.

Section 14-101 of the Act defines "practice medicine" as follows:

...

(o) *Practice medicine.*

(1) "Practice medicine" means to engage, with or without compensation, in medical:

(i) Diagnosis;

(ii) Healing;

(iii) Treatment; or

(iv) Surgery.

(2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:

(i) Diagnosing, healing, treatment, preventing, prescribing for, or removing any physical, mental, or emotional ailment of an individual:

...

(2) By appliance, test, drug, operation, or treatment[.]

INVESTIGATIVE FINDINGS[2]

Panel A of the Board bases its charges on the following facts that it has reason to believe are true:

1. At all times relevant hereto, the Respondent, who is not currently board-certified

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[1] The statutory exceptions to Section 14-601 are not applicable.

[2] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the charges. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

in a medical specialty,[3] was and is licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on August 16, 1993. Her license is scheduled to expire on September 30, 2017.

2. The Respondent owns and operates an office for the practice of pain management in Upper Marlboro, Maryland.

PROCEDURAL HISTORY

3. On October 10, 2013, the Board received an Adverse Action Report from Hospital A, a hospital in Anne Arundel County, Maryland where the Respondent then had medical privileges. The report notified the Board that the Respondent had voluntarily resigned her medical staff membership and clinical privileges while undergoing a Focused Professional Practice Evaluation ("FPPE") of her surgical practice. Hospital A had initiated the FPPE based on concerns that the Respondent's surgical complication rate was significantly higher than the rest of Hospital A's general surgeons and that the difference was not explained by the higher number of severely ill patients she saw. Hospital A terminated the FPPE without action when the Respondent resigned; however, the results of the independent review of her practice concluded that her "practice patterns resulted in a clinically significant poorer outcome than would have been expected."

4. Upon receipt of Hospital A's report, the Board initiated an investigation, which included a peer review of several of the Respondent's surgical cases. Based upon the peer reviewers' findings, Panel A charged the Respondent with

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[3] The Respondent's board certification in general surgery expired in 2014.

professional incompetence, in violation of Health Occ. § 14-404(a)(4) and failure to meet appropriate standards for the delivery of quality medical and surgical care, in violation of Health Occ. § 14-404(a)(22).

5. On March 10, 2015, the Respondent entered into a Consent Order with Panel A to resolve the charges. Under the terms of the Consent Order, the Respondent was reprimanded and placed on probation for a minimum of two years. The Respondent was ordered to successfully complete a Board-approved remedial course in medical record-keeping. The Respondent was also ordered to successfully complete a Board-approved course in pain management because she had shifted the focus of her practice from surgery to pain management. The Respondent was further required to undergo a review of her pain management practice.

6. Pursuant to the Respondent's 2015 Consent Order, the charts of six of the Respondent's pain management patients were transmitted to an expert in pain management ("Expert") for review of her care. The review focused on the period subsequent to November 15, 2015, the date she completed both of her remedial courses.

7. The Expert's review raised such significant concerns regarding the Respondent's pain management practice that, effective April 25, 2017, Panel A summarily suspended the Respondent license, having concluded that the public health, safety or welfare imperatively required emergency action.

8. On May 10, 2017, Panel A held a post-deprivation hearing to give the Respondent an opportunity to argue why the summary suspension should not

continue. At the conclusion of the hearing, Panel A continued the Respondent's summary suspension.

9. Panel A also referred the Respondent's practice for a peer review. The results of the peer review are summarized in Section I, below.

10. On or about May 8, 2017 and May 10, 2017, the Board received two separate complaints from pharmacists alleging that the Respondent was writing prescriptions after her license had been summarily suspended.

11. The Board initiated an investigation of the complaints, the results of which are summarized in Section II, below.

I. VIOLATIONS OF THE STANDARD OF QUALITY CARE

General Practice Deficiencies

12. By example and not in limitation, the peer reviewers found that for all six patients whose care was reviewed, the Respondent:

    a. Failed to conduct a risk assessment for abuse of addiction prior to prescribing opioids;

    b. Initiated opioid therapy at high dosages without a trial at lower dosages to assess efficacy;

    c. Prescribed excessively high dosages of opioids in the absence of adequate pathology to substantiate treatment;

    d. Prescribed excessive and medically unjustified opioids having significant diversion potential, including OxyContin and oxycodone, yet consistently failed to monitor adequately the patients' compliance with

the prescribed regimen. The Respondent typically ordered urine drug testing at a patient's initial visit but rarely, if at all, at subsequent visits;

e. Increased dosages of already excessive and medically unjustified opioids in the absence of an assessment of whether the lower dosage had improved function or better pain control as compared to the patient's baseline presentation. Such increases in dosages are a potential danger to patient safety; and

f. The Respondent uses an electronic medical record system to document her care. The Respondent's documentation was extensive and repetitive making it difficult to discern what care the Respondent actually provided at each visit. Despite the repetitive nature of the Respondent's notes, she failed on occasion to document pertinent information such as her treatment rationale for changing opioids, adding medications and changing dosages.

13. In addition to the general practice deficiencies summarized in ¶ 12, the Expert found the following patient-specific deficiencies as indicated:

a. The Respondent ignored "red flags" of abuse or diversion such as patient reports of running out of medication early, theft of prescription or medication; **Patient 2, Patient 3 and Patient 6**

b. The Respondent increased dosages of opioids even after documenting that patient's pain was controlled with a lower dosage and/or without significant change in physical examination, patient function and/or diagnostic testing; **Patient 2, Patient 3, Patient 4 and Patient 6**

c. The Respondent failed to address urine drug screen results that indicated the use of illicit drugs or drugs not prescribed by the Respondent. These results constitute violations of the "Consent for Chronic Opioid Therapy" agreements each patient signed when initiating treatment with the Respondent; however, the Respondent failed to take appropriate action to address results that were inconsistent with her prescribed regimen. **Patient 3, Patient 5 and Patient 6**

d. The Respondent prescribed sedatives, benzodiazepines, muscle relaxants and/or sleep aids to patients to whom she prescribed high dosages of opioids The combination of these medications with opioid-potentiating effects increases the risk for opioid-related adverse events such as respiratory depression and death. **Patient 1, Patient 2, Patient 5 and Patient 6**

e. **Patient 2** and **Patient 3** are a married couple who reside at the same address. During their one-year course of treatment, the Respondent massively increased each patient's daily dosage of oxycodone to 200 mg in the absence of medical justification. The Respondent failed to address red flags including: Patient 2's report that one of her prescriptions and identification had been stolen; and Patient 3's reports that he had exhausted his monthly allotment of medication and that he had taken some of Patient 2's OxyContin before the Respondent began prescribing it to him. The Respondent increased each of the

patient's dosages without ordering additional urine drug testing to ensure that they were complying with her prescribed regimen.

14. In summary, the Respondent prescribed excessive quantities of potent and highly addictive opioids without medical justification and failed to conduct appropriate compliance monitoring of the patients to whom she prescribed the opioids.

II. UNAUTHORIZED PRACTICE OF MEDICINE

15. On the morning of April 25, 2017, Board staff transmitted to the Respondent by email the Order for Summary Suspension of License to Practice Medicine ("Order").

16. Later that morning, Board staff telephoned the Respondent. The Respondent confirmed that she had read the Order. Board staff informed the Respondent that she could not see or treat patients until the summary suspension was lifted.

17. On May 8, 2017, the Board received a complaint from a pharmacist ("Pharmacist A") that on that date, Pharmacy A had received five prescriptions written by the Respondent for one patient. The prescriptions were written for oxymorphone ER 30 mg, oxycodone 30 mg, baclofen 10 mg, gabapentin 800 mg and Fioricet with codeine.

18. On May 9, 2017, Board staff spoke to Pharmacist A. Pharmacist A informed Board staff that Pharmacy A had received another prescription from the Respondent's office on that date. Pharmacist A further advised that Pharmacy A staff contacted the Respondent to advise her that the pharmacy was not able to

fill the prescriptions. The Respondent replied that she was "not aware that she was summarily suspended."

19. On May 9, 2017, the Board issued to Pharmacy A a subpoena for "copies of any and all prescriptions written by Janet L. Wasson, M.D., DEA Number [ ], from April 25, 2017 to the present."

20. In response to the Board's subpoena, Pharmacy A produced a "Doctor Drug Monitoring Report" that revealed that the Respondent had written and authorized a total of 11 prescriptions for two patients on May 8 and May 9, 2017. The majority of the prescriptions were for opioids.

21. On May 10, 2017, the Board received a complaint from a pharmacist ("Pharmacist B") employed at Pharmacy B, a large chain pharmacy. Pharmacist B alleged that on or about May 6, 2017, the Respondent had electronically transmitted to Pharmacy B a total of five prescriptions for two patients. The prescriptions included oxycodone and morphine ER.

22. Board staff confirmed with Pharmacist B that the prescriptions were new and not refills.

23. On May 11, 2017, the Board issued to Pharmacy B's parent company ("Company A") a subpoena for "copies of any and all prescriptions written by Janet L. Wasson, M.D. DEA Number [ ], from April 25, 2017 to the present."

24. On May 15, 2017, Company A transmitted to the Board a Physician Activity Report of the Respondent's prescriptions during the requested period. The Respondent had written over 70 prescriptions, all of which were for scheduled Controlled Dangerous Substances. The vast majority of the prescriptions were

for hydromorphone, methadone, morphine sulfate and oxycodone. The Respondent prescribed these drugs while her license was summarily suspended.

25. On May 11, 2017, the Board issued a subpoena to the Prescription Drug Monitoring Program ("PDMP") for all controlled substances written by the Respondent from April 25, 2017 to the present.

26. The PDMP report revealed that the Respondent wrote over 250 prescriptions for controlled substances while her license was summarily suspended.[4]

27. On May 11, 2017, the Board issued a subpoena to the Respondent for all "appointment logs/patient logs/sign-in sheets for patients seen by Janet L. Wasson, M.D. at [the Respondent's practice address] for the time period of April 25, 2017 to present."

28. In response to the Board's subpoena, the Respondent transmitted daily appointment logs that revealed that she had seen over 100 patients from April 25, 2017 through May 9, 2017, during which time her license was summarily suspended.

29. The Respondent's conduct, in whole or in part, constitutes violations of the following disciplinary grounds under the Act: is guilty of unprofessional conduct (Health Occ. § 14-404(a)(3)(ii)); is professionally, physically or mentally incompetent (Health Occ. § 140-404(a)(4)); 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

[4] The PDMP report includes only those prescriptions that were filled by pharmacies. The report does not include prescriptions written by the Respondent that pharmacies chose not to fill.

other location in this State (Health Occ. § 14-404(a)(22) and practiced medicine without a license (Health Occ. § 14-601).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, a disciplinary panel of the Board finds that there are grounds for action under Health Occ. § 14-404(a)(3)(ii), (4), (22) and/or Health Occ. § 14-601, it may impose disciplinary sanctions against the Respondent's license in accordance with the Board's regulations under Md. Code Regs. 10.32.02.11, including revocation, suspension, reprimand and/or probation, and/or may impose a monetary fine.

NOTICE OF DISCIPLINARY CONFERENCE FOR CASE RESOLUTION AND HEARING

A Disciplinary Conference for Case Resolution ("DCCR") in this matter has been scheduled for **Wednesday, August 9, 2017, at 9:00 a.m.** at the offices of the Board, 4201 Patterson Avenue, Baltimore, Maryland, 21215. The nature and purpose of the DCCR are described in the attached letter to the Respondent. If this case is not resolved at the DCCR, a prehearing conference and hearing will be scheduled before an Administrative Law Judge at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031.

BRIAN E. FROSH
ATTORNEY GENERAL OF MARYLAND

Date

Victoria H. Pepper
Assistant Attorney General
Office of the Attorney General
Health Occupations Prosecution and Litigation Division

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