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| IN THE MATTER OF | * | BEFORE THE MARYLAND |
| JOHN ELLIOT CHRISTIE, M.D. | * | STATE BOARD |
| RESPONDENT | * | OF PHYSICIANS |
| LICENSE NO.: D50605 | * | CASE NO.: 2017-0372 B |

* * * * *

CONSENT ORDER

On 2018, Disciplinary Panel B of the Maryland State Board of Physicians ("Panel B") charged **John Elliot Christie, M.D.** (the "Respondent"), License No. D50605, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §14-401 *et seq.* (2014 Repl. Vol. & 2017 Supp.)

The pertinent provisions of Health Occ. §14-404(a) under which Panel B voted to charge Respondent provide the following:

- (a) 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 licensee if the licensee:
 - (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
 - ...
 - (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On April 25, 2018, Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring because of the DCCR, Respondent agreed to enter this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel B makes the following findings of fact:

I. License and Medical Background

1. At all times relevant hereto, Respondent was, and is, licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on May 22, 1996 under license number D50605. Respondent last renewed his license in or about September 2016 which will expire on September 30, 2018.

2. In or about 1979, until in or about 1996, Respondent was licensed to practice medicine in Canada.

3. Between 1996 and 2004, Respondent practiced internal medicine in several locations in Maryland.

4. Since 2004, Respondent has maintained an office for the solo practice of internal medicine in Anne Arundel County.

II. Complaint

5. On or about November 28, 2016, the Board received a complaint from the step-father of a patient (the "Complainant"¹) of Respondent's ("Patient 8"). The Complainant stated that his step-daughter, Patient 8, has become addicted to pain medications which were prescribed by her surgeon and subsequently by Respondent. The Complainant stated that in the previous several months, Patient 8 had been receiving many Schedule II and Schedule IV medications from Respondent and has

¹ Family and patient names are confidential and are not used in the Consent Order. Respondent was provided a Confidential Patient Identification List containing the names of each of the individuals referenced in the Consent Order.

also been consuming alcohol.

III. Board Investigation

6. On March 16, 2017, Board staff sent correspondence to Respondent, notifying him of the initiation of a full investigation. The Board issued a subpoena to Respondent for a complete copy of the medical records of ten patients, including the records of Patient 8, who were selected by Board staff from the Maryland Prescription Drug Monitoring Program ("PDMP") printouts; and, requested that Respondent provide a response to the allegations of the Complaint and a summary of care for each patient listed in the subpoena.

7. On April 7, 2017, Respondent submitted to the Board the ten subpoenaed medical records and the summaries of care.

8. On July 14, 2017, the Board referred the case to an independent peer review agency, requesting independent peer review by two physicians who are board-certified in pain medicine.

9. On October 11, 2017, the Board received the peer review reports. The peer reviewers concurred that regarding six of the ten patients reviewed, Respondent failed to meet the appropriate standards for the delivery of quality medical care, and in one out of ten cases, Respondent failed to maintain adequate medical records.

10. On October 17, 2017, the Board sent copies of the peer review reports to Respondent with the names of the reviewers redacted requesting Respondent to provide a Supplemental Response.

11. On November 3, 2017, the Board received Respondent's Supplemental Response, which was subsequently reviewed by the two peer reviewers, prior to the

issuance of Charges. Respondent stated that he has made significant changes to his practice with regard to opioid prescribing for chronic pain since the time period reflected in the records reviewed, including transfer of all patients on high dose opioids to pain management specialists, avoiding prescribing over 90 milligram equivalents of opioids, transferring patients with addictive behavior to addiction and/or psychiatric specialists, more “robust” compliance monitoring with a lower threshold for referral and/or discharge, and increasing his time each day to ensure documentation is in compliance.

IV. Summary of Findings of “Fails to Meet Standards of Quality Medical Care”

12. In six of the ten of the cases reviewed, the peer reviewers concurred that Respondent fails to meet standards for quality medical care; and, in one of the ten cases reviewed Respondent fails to maintain adequate documentation, in that Respondent:

- a. Predominately fails to meet standards of quality care and documentation regarding prescribing of opioids in the years prior to 2016 when thereafter, Respondent’s monitoring and documentation improved;
- b. Lacks a willingness to discharge patients from his practice for non-compliance or pressure patients to seek care at a rehabilitation facility, for example, Patients 9 and 10, until 2017;
- c. Prescribes two strong immediate release (IR) opioids, such as oxycodone and MSIR (morphine sulfate instant release), together, creating a situation for accidental overdose and difficulty in monitoring compliance;
- d. Prescribes adjunct medications such as gabapentin and Lyrica, while prescribing anti-depressants, Adderall and Tramadol, without a rationale for such combinations;
- e. Treats chronic pain patients who have a concomitant psychiatric disease and/or substance abuse disorder without adequate training;

- f. Fails to maintain his documentation in a manner that is clear as to the dates of the events;
- g. Fails to routinely use adequate laboratory testing for urine drug screens (UDS) and fails to send samples for confirmation with quantitative testing at an outside facility;
- h. Fails to routinely use medication agreements for controlled substances;
- i. Fails to document his rationale or justification for changes in opioids, sometimes doubling doses and rapidly escalating and or adding new opioids; and
- j. Fails to appropriately respond to "red flags" such as lost or stolen medications, requests for early refills, and abnormal toxicology screens by having more frequent monitoring.

V. Patient Specific Standard of Care Findings Pertaining to Patients 2, 3, 6, 8, 9, and 10.²

Patient 1³

Patient 2

13. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 2, for reasons including but not limited to that he:

- a. Prescribed oxycodone 15 mg and MSIR 30 mg when Patient 2, a person with a history of mental instability, returned to Respondent's practice after a two-year absence, and after having been de-toxified from opioids by another provider, without understanding the risks and benefits, without inquiring about her opioid history, and her reason for detoxing from all opioids;
- b. Failed to document his rationale for prescribing CDS;

² The Peer Review reports contain a synopsis of the care provided by Respondent to each patient as understood by both reviewers from a review of Respondent's medical records. Respondent has been provided a copy of the peer review reports.

³ There were no charges pertaining to Patient 1.

- c. Prescribed two short acting and two long acting opioids at the same time;
- d. One year following Patient 2's return to his practice, Respondent prescribed very high doses of opioids;
- e. Failed to act in response Patient 2's UDSs which revealed tetrahydrocannabinol (THC), amphetamines, phencyclidine (PCP), and Ecstasy; and specifically failed to appropriately respond to the "red flag" of Patient 2's testing positive for cocaine and THC on June 3, 2014, by ascribing the results to poppy seeds;
- f. Failed to consider Patient 2's potential for diversion of the high quantities of pain medication which he was prescribing for her;
- g. Failed to test Patient 2 for fentanyl use; and
- h. Failed to obtain a medication agreement with Patient 2.

Patient 3

14. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 3 for reasons including but not limited to that he:

- a. Prescribed opiates without documenting justification for initiating, refilling, adding, discontinuing the CDS, as well as documenting side effects and clinical effects;
- b. Failed to appropriately act on deviations from compliance which were revealed on UDSs that showed at times prescribed opioids were not present, illicit substances were present, or the urine had been tampered;
- c. Treated Patient 3, a patient with a complex medical history, significant psychiatric history, difficult social situation, substance abuse, history of overdoses of pain medications, and history of positive PCP with chronic opioids, which is beyond the skill of Respondent, an internist; and
- d. Prescribed high doses of opioids and benzodiazepines despite Patient 3's history of overdose of Xanax in 2009 and 2015 and positive UDS for PCP and THC, placing Patient 3 at risk, rather than referring her to a rehabilitation clinic or a pain management specialist, or refusing to write prescriptions for opioids and benzodiazepines.

Patient 4⁴

Patient 5⁵

Patient 6

15. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 6 for reasons including but not limited to that he:

- a. Continued to prescribe opioids to Patient 6 despite a positive UDS for cocaine in July 2016 and multiple positive tests for THC in 2015;
- b. Refilled prescriptions for opioids at office visits which occurred prior to the medication "running out" thereby allowing Patient 6 to accumulate extra medications;
- c. Failed to follow the standard of "start low and go slow" in that on June 25, 2015, he doubled morphine 30 mg from twice a day to four times a day, increased fentanyl from 25 mcg to 50 mcg, and increased oxycodone from three times a day to four times a day;
- d. Failed to recognize possibility of diversion of medications as a means of paying for cocaine, especially based on UDS in 2015 which were negative for opioids; and failed to discharge Patient 6 for non-compliance, refuse to write for more CDS, or make continuing prescriptions contingent on evaluation of use of cocaine by a substance abuse counselor; and
- e. Failed to refer Patient 6 to a rehabilitation facility based on her history of cocaine addiction.

Patient 7⁶

Patient 8⁷

16. Respondent fails to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 8 for reasons including but not limited to he:

⁴ There were no charges pertaining to Patient 4.

⁵ There were no charges pertaining to Patient 5.

⁶ There were no charges pertaining to Patient 7.

⁷ Patient 8 is the subject of the complaint.

- a. Failed to regularly check CRISP (Chesapeake Regional Information System for our Patients), which revealed that Patient 8 had received oxycodone 10 mg 60 tablets from another prescriber two days prior to receiving oxycodone 15 mg 60 tablets from Respondent;
- b. Frequently escalated Patient 8's doses of opioids, rather than keeping the doses constant or reduced, in spite of concerns expressed by Patient 8's step-father and Patient 8's rising need for opioids;
- c. Failed to address multiple "red flags" (such as UDS positive for buprenorphine and THC, running out of prescriptions early, taking more medication than prescribed) by tapering medications, changing to opioids with less risk of addiction, attempting deterrent formulations of opioids⁸, or referring Patient 8 for an addiction evaluation;
- d. Failed to recognize that Patient 8 could not manage her use of opioids and send her to a rehabilitation facility or to a pain management specialist.

Patient 9

17. Respondent fails to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 9 for reasons including but not limited to that he:

- a. Offered Patient 9 to resume oxycodone 30 mg IR instead of her continuing with a methadone program for addition to opioids, where she had been going for 14 years;
- b. Failed to recognize "red flags" and discounted the results of UDS with explanations of "false positive", "lost medication in toilet", "stolen medications", or "took more than prescribed" and
- c. Continued to prescribe opioids for Patient 9 even though Patient 9 was non-compliant as shown by UDSs which were positive for methadone, which she supposedly was no longer taking.

Patient 10

18. Respondent fails to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 10 and fails to maintain

⁸ Deterrent formulations of opioids are opioid tablets that are harder to crush/dissolve.

adequate documentation regarding Patient 10, for reasons including but not limited to that he:

- a. Prescribed high doses of oxycodone and fentanyl to Patient 10 for seven years despite the existence of "red flags" such as lack of documented pathology, lack of referral to or notes from consultations with spine or orthopedic specialists, cash paying visits, and residence in Pennsylvania, where Respondent was unable to monitor Patient 10 through a prescription drug monitoring program;
- b. Failed to refer Patient 10 for physical therapy;
- c. Failed to use a method of UDS to confirm whether Patient 10 was using the fentanyl patch since Respondent's testing agents did not include testing for fentanyl;
- d. Failed to address abnormal UDS;
- e. Post-dated prescriptions;
- f. Prescribed multiple short-acting prescriptions during one office visit without a rationale, and prescribed two short-acting opioids over several years instead of long-acting opioids;
- g. Failed to document sufficient information that would allow another clinician to read his notes and decipher the treatment plan and the rationale for refilling the controlled substances, and failed to document the effects of the prescriptions on Patient 10;
- h. Failed to document significant changes in the history of present illness (HPI) and assessments and plan over several years; and
- i. Failed to provide any new details in his follow-up notes over several years.

VI. Summary of Findings

19. Respondent's failure to meet standards of quality medical care constitutes evidence of violation of Health Occ. §14-404(a)(22).

20. Respondent's failure to maintain adequate medical records constitutes evidence of violation of Health Occ. §14-404(a)(40).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B of the Board concludes as a matter of law that Respondent violated Health Occ. § 14-404(a)(22) (fails to meet appropriate standards) and (40) (fails to keep adequate records).

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby:

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

ORDERED that the Respondent is permanently prohibited from prescribing opioids, except as specifically provided in this paragraph. In emergency cases, the Respondent may issue no more than one prescription of an opioid medication to a patient, but the prescription may not exceed the lowest effective dose and quantity needed for a duration of five days. The prescription may not be refilled, nor may it be renewed. The Respondent may not prescribe an emergency prescription for an opioid to a patient more than once per year per patient. The Respondent shall notify the Board within 24 hours of any prescription authorized under this paragraph. This paragraph goes into effect in 90 days from the date this Consent Order goes into effect; and it is further

ORDERED that the Panel may issue administrative subpoenas to the Prescription Drug Monitoring Program (PDMP) on a quarterly basis for Respondent's CDS prescriptions. The administrative subpoenas may request a review of Respondent's CDS prescriptions from the beginning of each quarter; and it is further

ORDERED that Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS**⁹, and shall fully and satisfactorily comply with the following probationary terms and conditions:

1. Within six (6) months, Respondent shall successfully complete a Board disciplinary panel-approved course in opioid prescribing. The board 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. Respondent must provide documentation to the Board that Respondent has successfully completed the course;
2. 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 this Consent Order;
3. 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 Respondent shall not apply for the early termination of probation; and it is further

ORDERED that after a minimum of **TWO (2) years**, 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. Respondent may be required to appear before the Board or disciplinary panel to discuss his petition for termination. The Board or disciplinary panel will grant the petition to terminate the probation if Respondent has complied with all the probationary terms and conditions and there are no

⁹ If Respondent's license expires during this two-year period, the two-year period and any conditions will be tolled.

pending complaints related to the charges; and it is further

ORDERED that if Respondent allegedly fails to comply with any term or condition imposed in this Consent Order, Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel or the Board; and if there is no genuine dispute as to a material fact, Respondent shall be given a show cause hearing before a Board or disciplinary panel; and it is further

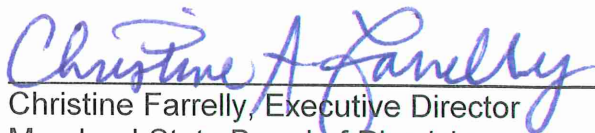
ORDERED that after the appropriate hearing, if the Board or disciplinary panel determines that Respondent has failed to comply with any term or condition of this Consent Order, the Board or disciplinary panel may reprimand Respondent, place Respondent on probation with appropriate probationary terms and conditions or suspend or revoke Respondent's license to practice medicine in Maryland. The Board or disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Respondent; and it is further

ORDERED that 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 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 it is further

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

May 23, 2018
Date


Christine Farrelly, Executive Director
Maryland State Board of Physicians

CONSENT

I, John E. Christie, M.D., License No. D50605, by affixing my signature hereto, acknowledge that:

I am represented by counsel, Anthony J. Breschi, Esquire, and have consulted with counsel before entering 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 after the conclusion of a formal evidentiary hearing in which I would have 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 am waiving those procedural and substantive protections. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction 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 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, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. *Signature on File*

May 18 2018
Date

John E. Christie, M.D., Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 18th day of May, 2018 before me, a Notary Public of the State and County aforesaid, personally appeared John E. Christie, M.D., License number D50605, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Kevin Jackson
Notary Public

18 May 2018
Date

My commission expires 1/18/2022

