IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Gary L. Gay, D.O.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: H51399	*	**Case Number: 2016-0370B**

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CONSENT ORDER

On February 2, 2017, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Gary L. Gay, D.O., (the "Respondent"), License Number H51399, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II") § 14-404(a) (2014 Repl. Vol. & 2015 Supp.).

The pertinent provisions of the Act provide:

> (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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> ...
>
> (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 location in this state;
>
> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On May 24, 2017, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Disciplinary Panel B finds:

I. BACKGROUND

1. The Respondent is a psychiatrist. He is board-certified in psychiatry and neurology. The Respondent was initially licensed by the Board in November 1996. The Respondent's medical license expired on September 30, 2016.[1]

2. At all times relevant to these charges, the Respondent was a solo practitioner in Churchville, Maryland. He had no hospital privileges.

3. On or about November 9, 2015, the Board received an anonymous complaint alleging that the Respondent had overprescribed Xanax[2] without medical justification. Additionally, the complainant alleged that a former patient of the Respondent had "passed away" due to drug-related issues.

4. The Board initiated an investigation.

5. On or about February 10, 2016, the Board notified the Respondent of its investigation, requested a written response, and subpoenaed patient appointment logs and the medical records of 10 patients. Additionally, Board staff requested summaries of care of the 10 patients.

6. In furtherance of its investigation, the Board requested that a peer review be conducted of the 10 patient records, the results of which are set forth in pertinent part below.

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[1] Md. Code Ann., Health Occ. § 14-403(a) provides that, "Unless a disciplinary panel agrees to accept the surrender of a license...the individual may not surrender the license...nor may the license...lapse by operation of law while the individual is under investigation or while charges are pending."

[2] A Schedule IV benzodiazepine.

7. On or about July 12, 2016, the Board provided the Respondent with copies of the peer review reports and provided him an opportunity to file a supplemental response.

8. On or about July 25, 2016, the Respondent filed a supplemental response with the Board.

BOARD NOTICE RELATING TO PRIOR INVESTIGATIONS

9. On or about March 13, 2013, the Board issued an Advisory Letter to the Respondent in order to resolve two complaints that initiated Board Case ##2012-0551 and 2012-0892, alleging that he had continued to prescribe Controlled Dangerous Substances ("CDS") to patients with known histories of addiction. Although the peer reviewers found the Respondent had met the standard of quality care with regard to the patients reviewed, they concurred that some of the Respondent's medical recordkeeping was inadequate.

PATIENT-RELATED FINDINGS RELATING TO CASE# 2016-0370B

10. The peer reviewers concurred on the following deficiencies relating to Patients 1, 5, 6, 9 and 10:

PATIENT 1

11. Patient 1, a female in her 40s, began treatment with the Respondent in 2011. She had a history of bipolar disorder, anxiety and panic attacks and opioid addiction. Patient 1 was prescribed methadone[3] by another provider at a methadone clinic for her opioid addiction. In January 2014, Patient 1 was diagnosed with chronic myelocytic leukemia.

[3] A Schedule II CDS.

12. The Respondent prescribed medications for Patient 1 through January 2016 including diazepam;[4] however, her last office visit with the Respondent was on April 3, 2015.

13. The Respondent prescribed several other medications over time to Patient 1 including Seroquel,[5] trazadone,[6] Ambien,[7] Vistaril,[8] Neurontin,[9] Suboxone[10] and alprazolam (Xanax).

14. In January 2016, the Respondent discharged Patient 1 from his care for prescription misuse (Valium).

15. The Respondent's documentation was repetitive for extended periods of time, most prominently in the "Mental Status Examination" portion of Patient 1's progress notes for the dates September 27, 2012 through November 12, 2013; and December 13, 2013 through June 5, 2014.

16. The Respondent failed to document any discussion of overdose potential with the prescribed combination of opioids and benzodiazepines.

PATIENT 5

17. Patient 5, a male in his 60s, was treated by the Respondent for approximately 9-10 years for generalized anxiety disorder ("GAD"), through January 2016. Patient 5's last visit to the Respondent was on April 8, 2015.

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[4] Schedule IV benzodiazepine, with the brand name of Valium.
[5] Used in the treatment of antipsychotic disorders.
[6] Used in the treatment of insomnia.
[7] A Schedule IV CDS used in the treatment of insomnia.
[8] Used as a sedative to decrease anxiety and tension.
[9] Used in the treatment of nerve pain and seizures.
[10] Used in the treatment of opioid addiction.

18. The Respondent has treated Patient 5 with several medications over the years including Xanax (which had been prescribed for Patient 5 by a prior provider), trazadone, Sonata[11] and Celexa.[12]

19. The Respondent maintained Patient 5 on Xanax 8 mg for several years (which exceeds the recommended dosage of 0.25 to 0.5 mg up to three times daily with a maximum of 4 mg daily).[13] He failed to decrease the dosage until 2014.

20. The Respondent documented several instances of potential abuse or diversion, including that Patient 5 ran out of Xanax earlier than scheduled, missed appointments and "theft" of his medications.

21. The Respondent failed to document that he had any discussion with Patient 5 of overdose potential, safe handling and storage of the medications or safety considerations for self-harm.

22. The Respondent's documentation was repetitive, most notably in the "Mental Status Examination" section of Patient 5's progress notes.

23. In 2014, however, the Respondent failed to document any mental status examination for Patient 5.

24. The Respondent failed to document that he had discussed the risks and benefits of Patient 5's current therapy versus any alternative therapy.

25. The Respondent failed to document a comprehensive psychiatric examination.

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[11] A sedative.
[12] The Respondent prescribed a sub-optimal dose of Celexa to Patient 5, a Selective Serotonin Reuptake Inhibitor ("SSRI") used in the treatment of depression.
[13] The Respondent acknowledged in his written response that this was an "obscene dose."

PATIENT 6

26. Patient 6, a male in his 40s, began treatment with the Respondent during December 2010 after hitting a pedestrian with his vehicle, and developing severe anxiety. Patient 6 had a history of opioid addiction, and was being prescribed methadone by a methadone treatment provider. The Respondent treated Patient 6 through January 2016; however, his last visit was documented as April 8, 2015.

27. The Respondent initially prescribed Lexapro[14] and Xanax to Patient 6; however, in January 2011, Patient 6 stopped taking the Lexapro due to headaches. The Respondent made no other efforts to prescribe any other antidepressants for Patient 6.

28. Initially, the Respondent prescribed 2 mg of Xanax to Patient 6; however, in 2011 he increased the dosage to 4 mg daily.

29. On January 18, 2011, Patient 6 acknowledged that he had taken more Xanax than had been prescribed (6 mg). The Respondent failed to document that he had discussed with Patient 6 any overdose potential, despite the concomitant use of Xanax and methadone.

30. On April 12, 2011, Patient 6 was involved in a motor vehicle accident. The Respondent failed to document any discussion with him of the risk of sedation while driving under the influence of his medications.

31. On or about January 3, 2012, Patient 6's methadone treatment program required a reduction in dosage due to the concomitant prescribing of methadone with a benzodiazepine.

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[14]Lexapro is an SSRI used in the treatment of depression and generalized anxiety disorder.It can treat depression and generalized anxiety disorder (GAD).

32. The Respondent did not attempt to limit or eliminate the prescription for Xanax, and continued Patient 6 on the same dose of Xanax despite the concomitant use of methadone.

33. From approximately 2012, Patient 6 began weaning off of his methadone, but as of January 16, 2016, he was still taking 50 mg daily.

34. On or about September 1, 2015, Patient 6 represented to the Respondent that he had "lost" his Xanax, and requested an early prescription. The Respondent requested that Patient 6 file a police report. A few days later, the Respondent document that Patient 6 had found the "lost" medication. The Respondent failed to document that he had discussed with Patient 6 safe handling of medications or prescriptions.

35. The Respondent did not consistently document a mental status examination of Patient 6, especially after April 2015.

36. The Respondent failed to document that he had discussed the risks and benefits of Patient 6's current therapy versus any alternative therapy.

37. The Respondent failed to order or reference any toxicology screenings that were conducted for Patient 6.

38. The Respondent's pattern of prescribing to Patient 6 constitutes evidence in whole or in part of a failure to meet the standard of quality medical care for Patient 5 in violation of Health Occ. II § 14-404(a)(22).

PATIENT 9

39. Patient 9, a male in his 40s, was treated by the Respondent for 10+ years for bipolar disorder and an anxiety disorder.[15] The Respondent prescribed several

[15] The Respondent reported in a written summary to the Board that he had treated Patient 9 at a prior facility. His notes for Patient 9 that he provided to the Board in response to its subpoena begin in March 2008.

medications for Patient 9 including Geodon,[16] trazodone, Klonopin,[17] and Ambien. The Respondent prescribed for Patient 9 through February 2016; however, the last visit recorded by the Respondent for Patient 9 was on November 23, 2015.

40. On or about April 21, 2010, the Respondent started Patient 9 on Geodon, but failed to document he had discussed the risks and benefits, and potential adverse effects with Patient 9.

41. In January 2014, the Respondent documented that Pharmacy A refused to fill a prescription for clonazepam because of an alert raised by another physician ("Physician A") relating to CDS prescriptions.

42. Physician A worked for a county health department, and reportedly discontinued Patient 9's Geodon and clonazepam during Patient 9's alcohol detoxification.

43. On May 23, 2014, the Respondent documented that Patient 9 had a history of alcohol abuse and was in a program with Physician A. Concomitant use of benzodiazepines and alcohol are contraindicated as the combination can cause respiratory depression.

44. The Respondent failed to document that he had addressed with Patient 9 issues involved with the concomitant use of benzodiazepines and alcohol, including overdose potential and potential treatments.

45. The Respondent failed to adequately monitor Patient 9 for his history of alcohol abuse, and continued to prescribe medications including benzodiazepines.

46. The Respondent failed to adequately conduct a mental status evaluation of Patient 9 during several visits that took place from March 2008 through 2015.

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[16] Antipsychotic used in the treatment of schizophrenia and bipolar disorder.
[17] Schedule IV benzodiazepine used in the treatment of panic disorders, anxiety and seizures.

47. On June 25, 2014 the Respondent telephoned a prescription for clonazepam to a pharmacy in San Francisco for Patient 9.

48. When Patient 9 resumed care with the Respondent after his alcohol detoxification, the Respondent restarted him on clonazepam and Geodon despite receiving notice that Patient 9 had been treated for alcohol dependency. The Respondent noted in his summary that Patient 9 was "in a bad way."

PATIENT 10

49. In 2009, the Respondent began treating Patient 10, a male in his 40s, for major depression and anxiety. Patient 10 was opioid-dependent, and was being prescribed methadone by another treatment provider. The Respondent stated that he last saw Patient 10 on September 17, 2015.[18]

50. The Respondent prescribed several different medications for Patient 10 that primarily included Lexapro, Celexa, Pristiq,[19] and Xanax. The Respondent also prescribed two antipsychotics at different times, Latuda and Abilify.

51. From at least 2010 through September 2015, the Respondent prescribed to Patient 10, Xanax 1 mg 5 times daily.

52. On or about April 15, 2010 Patient 10 informed the Respondent he was being prescribed Methadone, and was on "pill counts" for Xanax.[20] Over time, Patient 10's Methadone dosage increased (from 31 to 60 between October 2012 and December 2013), but the Respondent made no attempt to decrease Patient 10's Xanax, even during his periods of stability.

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[18] The Respondent's last progress note for Patient 10 is dated April 1, 2015, and he noted that this was the last visit.

[19] Pristiq is used in the treatment of depression.

[20] The Respondent documented two separate notes for Patient 10 dated April 15, 2010. He only noted Patient 10's methadone prescription in one of the notes.

53. The Respondent failed to discuss overdose potential with Patient 10 despite prescribing benzodiazepines concomitantly with Patient 10 being prescribed methadone.

54. The Respondent failed to conduct any toxicology screening and/or pill counts.

55. On or about October 28, 2015, Patient 10's wife notified the Respondent's office that Patient 10 had died. The cause of death was listed as complications from morbid obesity.

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B concludes as a matter of law that the Respondent failed to meet appropriate standards for the delivery of quality medical care and failed to keep adequate medical records, in violation of Md. Code Ann., Health Occ. II § 14-404 (a) (22) and (40).

III. ORDER

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 should the Respondent apply for reinstatement of his Maryland license, prior to reinstatement, he shall appear before the Board or Disciplinary Panel for the imposition of terms and conditions at that time, including but not limited to probation; 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 it is further

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

06/08/2017
Date

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

CONSENT

I, Gary L. Gay, D.O., License No. H51399 (expired), by affixing my signature hereto, 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 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 and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

6/1/17
Date

Gary L. Gay, D.O.
Respondent

STATE OF ~~MARYLAND~~ Alabama

CITY/COUNTY OF: Dothan/Houston

I HEREBY CERTIFY that on this 1st day of June, 2017, before me, a Notary Public of the State and County aforesaid, personally appeared Gary L. Gay, D.O., 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.

Shawn Michael Hartline
Notary Public

My commission expires: Oct. 5 2020

SHAWN MICHAEL HARTLINE
NOTARY
My Comm. Expires
Oct. 5, 2020
PUBLIC
ALABAMA STATE AT LARGE

I HEREBY ATTEST AND CERTIFY UNDER PENALTY OF PERJURY ON 06/08/2017 THAT THE FORGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE AND IN MY LEGAL CUSTODY.

Christine A. Farnelly
EXECUTIVE DIRECTOR
MARYLAND BOARD OF PHYSICIANS