IN THE MATTER OF	*	**BEFORE THE**
DANIEL M. HOWELL, M.D.	*	**MARYLAND BOARD**
Respondent	*	**OF PHYSICIANS**
LICENSE NUMBER: D02975	*	**CASE NUMBERS: 2007-0688 2008-0256 2009-0757**

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CONSENT ORDER

On April 21, 2009, the Maryland Board of Physicians (the "Board") charged Daniel M. Howell, M.D. ("Respondent") (D.O.B. 12/29/43) license number D02975 with violating the Maryland Medical Practice Act (the "Act") codified at Md. Health Occ. Code Ann. (H.O.) §§ 14-101 *et seq.* (2005 Repl. Vol.).

The pertinent provisions of the Act under § 14-404(a) provide the following:

> (a) *In general.* --Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license 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 the State;
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[;].

On September 2, 2009, a Case Resolution Conference was held; and, as a result of negotiations between the Respondent, the Office of the Attorney General, and the Board, the parties agreed to enter into this Consent Order as an appropriate resolution of the Charges.

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background Findings

1. At all times relevant hereto, Respondent was licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on August 26, 1969, under license number D02975. Respondent last renewed his license in 2008, which license will expire on September 30, 2010.

2. On February 22, 2008, the Board issued disciplinary charges against Respondent alleging he prescribed increasing amounts of Percocet to a patient with liver disease, and failed to refer the patient to appropriate medical mental health and pain management specialists.

3. On July 23, 2008, Respondent entered into a Consent Order with the Board wherein he was found to have failed to meet standards of quality care in his care and treatment of this patient. Respondent was Reprimanded and placed on probation for a minimum of two years, requiring that Respondent use a Board approved treatment contract with all patients for whom he prescribes CDS as part of a long-term pain management plan, successfully complete a course in medical record keeping, successfully complete a course in prescribing controlled substances, successfully complete a course in pain management, and be subject to subsequent peer review. Dr. Howell thereafter submitted a treatment contract for use with his patients that was approved by the Board. He also successfully completed the required coursework.

4. Respondent's self-designated specialty is Family Practice. Respondent was originally Board-certified in Family Medicine in 1978. He was last recertified in

1999, which expired December 2006, and did not seek recertification. Therefore, Respondent is not currently Board-certified.

5. At all times relevant hereto, Respondent maintained and maintains an office for the practice of family medicine, known as Shah Associate, M.D., LLC, a multi-specialty group practice in Hollywood, Maryland, where he has practiced since April 2006. Prior to April 2006, Respondent practiced family medicine at Family Health Care Physicians, P.A. in Waldorf and La Plata, Maryland, where he employed associate physicians.

6. Respondent has held privileges at Civista Medical Center in LaPlata, Maryland and currently holds courtesy privileges at St. Mary's Hospital ("St. Mary's") in Leonardtown, Maryland.

7. Respondent holds an inactive license to practice medicine in the District of Columbia.

II. Findings Regarding Complaints and Peer Review

8. On or about April 19, 2007, the Board received an anonymous telephone complaint from a pharmacist from Tidewater Pharmacy in Mechanicsville, Maryland, alleging that Respondent was prescribing excessive narcotics to his patients.

9. Based on this complaint, the Board opened case # 2007-0688 for investigation, and on April 20, 2007, sent a subpoena to Tidewater Pharmacy for a computer printout of any and all CDS prescriptions written by Respondent from April 2006 to present. In addition the Board sent similar subpoenas to Wal-Mart, Whitesell, Rite Aid, Target, Stop and Shop (Giant), and CVS pharmacies, requesting "pharmacy runs" for Respondent.

10. On or about April 23, 2007, the Board received by facsimile an anonymous complaint from "three concerned area pharmacists" regarding "what appears to be excessive narcotic prescribing from one of our local physicians," listing medications such as Methadone, Percocet, OxyContin, Dilaudid, Oxycodone, Fentanyl patches, MSIR, Vicodin, Lortab, Xanax, and Ambien, stating that their concern is that Respondent is not a pain management specialist and Respondent's "patients appear to have questionable and/or documented history of overuse of pain medication."

11. On April 24, 2007, the Board received by facsimile a complaint from "a concerned pharmacist," who had previously, on April 19, 2007 notified the Board of an incident with a particular patient of Respondent's who was seeking to fill a prescription for a large quantity of OxyContin.[1] The complainant listed sixteen (16) patients for whom the pharmacy fills prescriptions for regularly that have either had multiple early requests, go to multiple pharmacies, and/or multiple pain medications with benzodiazepines. The complainant attached copies of Respondent's prescriptions.

12. Based on these complaints, the Board opened case number 2007-0688 for investigation.

13. On August 13, 2007, the Board sent subpoenas to K-mart and Target pharmacies for a printout of Respondent's prescriptions for controlled substances.

14. On October 1, 2007, the Board received a complaint from an emergency room (ER) physician at St. Mary's alleging that Respondent was over prescribing narcotics to his patients, causing them to overdose. The complainant provided the

[1] This patient is subsequently identified in the charges below as Patient 9.

name of one of the patients that he had seen on September 14, 2007 in the ER for an overdose.[2] The complainant stated that the patient was discharged, went to Respondent's office and received another very large prescription for Percocet and Xanax and was then found unresponsive and brought to the ER. The complainant stated that this one case is an example of the type of thing he has observed with other of Respondent's patients.

15. Based on this complaint the Board opened case number 2008-0256 for investigation.

16. On November 30, 2007, the Board sent a subpoena to the ER physician for a list of his patients seen in the ER at St. Mary's from January 1, 2007 to present for narcotics abuse who were patients of Respondent.

17. On December 10, 2007, the Board received a list of nine individuals, four of whom who were seen on several occasions.

18. Upon receipt of a list from the ER physician, on December 12, 2007, the Board sent a subpoena to St. Mary's hospital for the medical records of these nine patients.

19. On December 12, 2007, the Board requested Respondent's response to the complaints and sent a subpoena for his medical records of eleven (11) patients.

20. On December 14, 2007, the Board sent an additional subpoena to Respondent for the complete medical records of a twelfth patient, one of the patients named by the complaining pharmacist on April 19, 2007 and identified below as Patient 9.

[2] This patient is subsequently identified in the charges below as Patient 1.

21. On December 12 and 14, 2007, the Board sent subpoenas to area pharmacies for a printout of all prescriptions written for controlled substances and for Soma and Ultram by Respondent from April 1, 2006 to present for the twelve named patients.

22. On December 19, 2007, through counsel, Respondent requested an extension of time to respond to the subpoenas and complaints.

23. On January 31, 2008, the Board received Respondent's response from Respondent's counsel, and the medical records.

24. On March 17, 2008, the Board sent the two complaints, Respondent's responses to the complaints, Respondent's medical records of twelve patients, including records from other health care providers contained in Respondent's records, medical records from St. Mary's Hospital, and drug surveys from area pharmacies, to Permedion, a subsidiary of Health Management systems, Inc., for peer review of Respondent's practice.

25. Two peer reviewers, both board certified in Family Practice, concurred that Respondent failed to meet standards for quality medical care in his care and treatment of ten of the twelve patients, and that documentation was not met in three of the twelve cases reviewed, as stated below. Based on the reports of the peer reviewers, the Board charged Respondent with the following:

Additional Complaints

26. On February 5, 2009, Board staff received a telephone complaint from a surgeon regarding a patient who previously had been seen by Respondent who the surgeon was seeing for a hernia repair. The surgeon stated that he had concerns about

Respondent's prescribing practices and that he was unable to treat the patient while he was taking "all the medications he was on." According to the surgeon, the patient was taking Methadone and Oxycodone which had been prescribed by Respondent.

27. On February 10, 2009, Board staff received a telephone complaint from the ER physician who had previously complained to the Board on October 1, 2008. The ER physician stated that on February 10, 2009, a female patient, Patient 13, presented to St. Mary's Hospital ER with withdrawal symptoms and seeking refills of medications that Respondent has prescribed for her. Patient 13 showed the ER physician two empty vials. The labels on the vials indicated that Respondent prescribed Percocet 10 mg. 260 tablets and Methadone 10 mg. 300 tablets to Patient 13.

28. On April 7, 2009, the Board received a new complaint regarding another patient, Patient 14. A case was opened and assigned case number 2009-0757. At the time of negotiating this Consent Order, the case was being investigated by the Board and had not yet been sent for peer review; however, a review of Respondent's medical records of care of Patient 14 since 2006 and "pharmacy runs" for Patient 14 indicate that the clinical and prescribing issues are similar to those contained in the Board's Charges.

29. The Board did not conduct further investigation of these complaints because the Board had already voted to charge Respondent in the existing two cases.

Patient Specific Finding

Patient 1[3]

30. On February 1, 2007, Patient 1, then a 33 year old female, initially consulted Respondent for depression and insomnia. Patient 1 had a history of asthma, chronic pain from a pinched nerve attributed to an auto accident in 2005, and depression. Previously, Patient 1 was cared for by a pain management specialist in Waldorf, Maryland but transferred care to Respondent allegedly due to loss of insurance.

31. Respondent diagnosed asthma, rotator cuff pathology, chronic back pain, cervical disc disorder, and sinusitis. Respondent prescribed Methadone 10 mg #60. Respondent also prescribed, Advair, Xanax, and Lexapro. Respondent contracted with Patient 1 for responsible use of narcotics.

32. On February 13, 2007, Respondent prescribed Methadone #120.

33. On March 20, 2007, Respondent prescribed Methadone #240.

34. From March 24 to March 26, 2007, Patient 1 was admitted to St. Mary's Hospital with Methadone poisoning and tested positive for cocaine. Testing at St. Mary's showed that Patient 1 had abnormal liver function CPK tests.

35. On April 9, 2007, Respondent prescribed Methadone #240.

36. On April 27, 2007, Respondent refilled a telephone request for Methadone without an office visit.

37. On May 17, 2007, Respondent refilled a telephone request for Methadone without an office visit.

[3] Patient names are confidential and are not used in the Consent Order. Respondent has a Confidential Patient Identification List with the identities of the patients specified.

38. On June 7, 2007, Respondent refilled a telephone request for Methadone without an office visit.

39. On June 26, 2007, Respondent refilled a telephone request for Methadone without an office visit.

40. On July 11, 2007, Respondent saw Patient I in the office, refilled Methadone, and added Percocet #100.

41. On July 11, 2007, Respondent was notified that Patient 1 was going to a different pharmacy, contrary to her narcotics contract with Respondent.

42. On August 2, 2007, Respondent prescribed Methadone and increased Percocet to #180.

43. On August 22, 2007, Respondent refilled a telephone request for Methadone without an office visit.

44. On September 4, 2007, after Respondent received a phone call that Patient 1 was selling Respondent's prescriptions and tested positive for cocaine, Respondent notified Patient 1 by certified mail that he was discharging her from his care.

45. On September 14, 2007, Patient 1 attempted suicide by taking 47 Xanax and was admitted to St. Mary's Hospital.

46. On September 19, 2007, Respondent resumed treatment of Patient 1 and prescribed Methadone and Percocet.

47. On September 26, 2007, Respondent again prescribed Methadone and Percocet.

48. Between February 2007 and September 26, 2007, Respondent also prescribed Advair, Xanax, Lexapro, Promethazine, Celexa, Levaquin, and prednisone. On three occasions, Respondent prescribed Percocet.

49. Respondent failed to meet standards for quality medical care in his care and treatment of Patient 1, including but not limited to the following, in that he:

a. Failed to order any tests such as regular urine drug screens and tests of end organ damage such as liver and kidney function tests;

b. On multiple occasions prescribed Methadone without an office visit and examination;

c. Prescribed chronic pain medicine, such as, Methadone and Percocet, more frequently than on a monthly basis;

d. Increased Patient A's Methadone too rapidly and at higher doses than within standards of quality care;

e. Failed to discontinue Methadone when Patient 1 did not get adequate relief and substitute a different narcotic;

f. Continued to prescribe narcotics for Patient 1 contrary to the terms of the contract in that she filled her prescriptions at multiple pharmacies and sold her prescriptions;

g. Failed to obtain specialty consultation with, or refer to, pain management, addiction, and mental health professionals;

h. Failed to address issues regarding Patient 1's addiction to and diversion of drugs;

i. Failed to refer Patient 1 for physical therapy.

Patient 2[4]

[4] There were no charges in regard to Patient 2.

Patient 3

50. Patient 3, then a 48 year old female, without significant medical history presented with low back pain, was initially treated in October 2001 by another physician in Respondent's office who prescribed Ultracet, a non - narcotic.

51. Respondent saw Patient 3 on November 7, 2006 and prescribed Ultracet and Celebrex.

52. On December 19, 2006, Patient 3 consulted Respondent for low back pain after falling. Respondent prescribed Hydrocodone 10/325 #100.

53. Prior to these visits, Patient 3 had had lumbar spine x-rays which showed mild DJD, but otherwise were normal.

54. On April 9, 2007, Patient 3 presented with low back pain. Respondent prescribed Ultracet and ordered an MRI.

55. Patient 3 failed to show for the MRI.

56. On April 30, 2007, Respondent prescribed Vicodin 5/500 # 30 but did not document a phone call or a reason for the change.

57. On May 14, 2007, Patient 3 called and asked for more pain medication. Respondent prescribed Ultracet.

58. Respondent failed to keep adequate medical records in regard to his care and treatment of Patient 3, including but not limited to the following, in that Respondent:

a. Failed to adequately document past medical history, including abuses and overdoses, tests performed or specialists seen, subjective complaints, compliance with past recommendations, and review of systems;

b. Failed to adequately document a physical examination beyond brief reference to hear , lungs, abdomen and palpation of tender area;

c. Consistently documented a vague diagnosis of "chronic back pain";

d. Failed to document order for lab tests, urine drug screens for street drugs, recommendations for follow-up, referrals to specialists, and referrals for MRIs or x-rays.

e. Prescribed Vicodin, a controlled dangerous substance, without an office visit or a note explaining the indication for the medication;

f. Prescribed Hydrocodone and Vicodin without completing a history of the complaint by assessing location, quality, quantity, chronology, aggravating factors, alleviating factors and associated manifestations to determine the cause of Patient 3's pain such as cancer, infection, or trauma.

Patient 4

59. Patient 4, then a 57 year old male, initially saw Respondent in June 2006 after having been seen by other physicians in Respondent's practice. Patient 2 had a history of CAD, CHF, pacer placement and stenting of the coronary arteries and was on chronic pain medication.

60. On June 2006, Respondent saw Patient 4 for a sinus infection. Respondent prescribed Lorazepam, Lorcet, and an antibiotic. Respondent provided three months of prescription narcotics.

61. On August 14, 2006, Patient 4 complained that the pain was not adequately controlled. Respondent added Oxy IR (OxyContin Immediate Release) to Lorcet, Methadone, Flexeril, Indomethacin and Neurontin.

62. On August 22, 2006 Respondent saw Patient 4 and prescribe 60 tablets of Oxy IR and a three month supply of Lorcet.

63. On November 15, 2006, Patient 4 presented with dental and low back pain. Respondent prescribed Lorcet #120.On August 22, 2006, Patient 4 presented for a refill of the Oxy IR and Respondent prescribed another three month supply of Lorcet # 60.

64. On November 15, 2006, Patient 4 presented with dental and low back pain and Respondent gave him Lorcet #120.

65. From November 2006 to January 2008, Patient 4 presented to Respondent's office requesting refills which Respondent, at times, provided without an examination.

66. On January 8, 2008, Respondent prescribed Oxy IR #100.

67. Respondent failed to meet standards of quality medical care in regard to his care and treatment of Patient 4, including but not limited to the following, in that he:

a. Treated symptoms individually without a long term plan to assess the reason for the lumbar spine pain and the extent of the medications that would be need to adequately treat the pain;

b. Failed to put a system in place to be able to determine when Patient 4 was due for prescriptions;

c. Failed to order any tests, such as liver or kidney function tests, and drug screens; or conduct further assessment of back pain by referral for MRI and X-ray or referral for PT or orthopedics;

d. Failed to obtain specialty consultation in regard to Patient 4's drug abuse history; such as addiction medicine or possibly psychiatry;

e. Failed to enter into a controlled substance agreement with Patient 4 until over a year after first seeing him;

f. Failed to make recommendations for follow up visits as evidenced by approximately 9 visits over approximately 18 months but approximately 48 telephone calls for prescriptions for controlled substances.

Patient 5

68. In June 2006, Patient 5, then a 45 year old male, diagnosed with schizophrenia, had a past medical history of migraine headaches, addiction, chronic low back pain, multiple musculoskeletal traumas, and insomnia. He had been treated by multiple physicians.

69. On June 9, 2006, Respondent initially saw Patent 5 and prescribed refills for Fioricet and Robaxin for one month.

70. Respondent diagnosed dental infection, chronic severe headache, ankle pain, animal exposure, and polyarthritis.

71. On September 7, 2006, Respondent prescribed Fioricet, increased the number of pills to 100, and prescribed Equagesic at an increased dose.

72. On September 25, 2006, Patient 5 complained a dental pain. Respondent prescribed Pen VK and Meprobamate for three months.

73. On November 28, 2006 and January 10, 2007, Patient and failed to show for a visit.

74. On January 18, 2007, Patient 5 presented with headaches. Respondent prescribed Fiorinal and Fioricet.

75. On February 6, 2007, Patient 5 presented with headache and ankle pain. Respondent prescribed Darvocet.

76. On April 3, 2007, Patient 5 presented with headache, Respondent prescribed Fioricet and Ativan.

77. On April 20, 2007, Patient 5 presented with headache, Respondent prescribed Phenobarbital and Robaxin.

78. On October 19, 2007, Patient 5 gave a rambling history. Respondent diagnosed schizophrenia, periodontal disease and animal exposure. Respondent prescribed doxycycline, fioricet and ativan.

79. On November 13, 2007, Respondent noted, as he had before, that Patient 5 needed to see a psychiatrist. Respondent prescribed Tylenol #3 for "polyarthritis."

80. On December 14, 2007, Patient 5 was "rambling." Respondent refused any new prescriptions and documented the need for Patient 5 to bring in prescriptions he was already taking.

81. Respondent saw Patient 5 approximately 11 times from June 2006 through December 2007 during which he prescribed Fioricet, Meprobamate, Fiorinal, Darvocet, Ativan, Phenobarbital and Equagesic. Patient 5 also called Respondent approximately 12 times and on all but one occasion, Respondent prescribed Fioricet, Robaxin, or Ultram.

82. Respondent failed to meet standards of quality care in regard to his care and treatment of Patient 5, including but not limited to the following, in that he:

a. Failed to look for an etiology for Patient 5's migraines;

b. Failed to adequately work up Patient 5's musculoskeletal complaints;

c. Failed to obtain blood work and imaging;

d. Failed to order any tests, such as liver and kidney function tests, obtain any drug screens, or specialty consultation given Patient 5's documented abuse history;

e. Failed to have a documented substance abuse agreement with Patient 5;

f. Failed to make any recommendations for follow-up visits as evidenced by Patient 5's 12 telephone calls for controlled substance prescriptions;

g. Prescribed both Fiorinal and Fioricet together, medications which are essentially the same other than Fioricet contains Tylenol.

Patient 6

83. On June 13, 2006, Patient 6, then a 34 year old male, presented to Respondent for back pain and a skin lesion. Patient 6 had previously been diagnosed with back pain and treated by chiropractic. In 1966 Patient 6 was identified as a "crack cocaine user." Respondent diagnosed chronic low back pain, kidney stone, acute low back strain, penile contusion, allergic rhinitis and pharyngitis.

84. On June 13, 2006, Respondent ordered a lumbar x-ray and prescribed Ultram and Flexeril.

85. In October 2006, Patient 6 made a suicide attempt by overdosing on cocaine.

86. Respondent saw Patient 6 approximately 10 more time through November 19, 2007. He ordered a second lumbar lumbar x-ray a year later and an MRI. Respondent referred Patient 6 to an orthopedic specialist on July 5, 2006 and to an urologist a year later.

87. From June 2006 through November 2007, Respondent prescribed Vicodin, then Percocet, first at 5 mg. then 10 mg and in increasing quantities, in addition to Veramyst and amoxicillin. In addition, Patient 6 called approximately 3 times for pain medication, for which Respondent prescribed Percocet.

88. On June 15, 2007, Patient 6 signed a controlled substances agreement.

89. Respondent failed to meet standards of quality medical care in regard to his care and treatment of Patient 6, including but not limited to the following, in that he:

a. Failed to recognize and treat Patient 6's narcotic addiction;

b. Failed to obtain tests to explore Patient 6's complaint of penis pain with sex and low back pain;

c. Failed to obtain drug screens, even after Patient 6's suicide attempt/ cocaine abuse in October 2006;

d. Failed to obtain mental health consultations and failed to follow-up on outpatient mental health recommendations after Patient 6's suicide attempt/drug abuse hospitalization;

e. Failed to have a controlled substances agreement until 18 months after Patient 6's suicide attempt/cocaine abuse;

f. Continued to prescribe Percocet to Patient 6 in steadily increasing strengths and quantities after Patient 6's suicide attempt/drug hospitalization.

g. Failed to respond to Patient 6's noncompliance with getting MRI by conditioning further prescriptions of CDS on compliance.

Patient 7

90. On June 2, 2006, Respondent first saw Patient 7, then a 43 year old female, with complaint of back pain while working out in the gym and stomach pains.

Patient 7, recently discharged form the hospital following a bowel obstruction, complained of depression, anxiety, and chest and stomach pain. Patient 7 had been followed by another physician in Respondent's office, with a past history of seizure disorder, bipolar disorder, psoriasis, hysterectomy, ovarian cyst, and abdominal adhesions. Respondent diagnosed functional bowel, recurrent bowel obstructions, Crohn's disease, chronic abdominal pain, questionable seizure, urinary infection and menopause. Respondent prescribed Dicyclominie, Percocet, and Xanax.

91. Respondent saw Patient 7 on approximately 5 additional visits during which he prescribed Percocet on all five visits, along with Xanax, Trazadone, estrogen patch, and Levaquin.

92. On June 29, 2006, Patient 7 returned with abdominal pain, vomiting and requested Percocet, which Respondent prescribed.

93. On November 30, 2006, Respondent terminated Patient 7 from his practice.

94. Patient 7 attempted to obtain more prescriptions by phone on approximately five occasions, which Respondent refused.

95. On July 17, 2006, Respondent referred Patient 7 for a colonoscopy

96. On October 12, 2006, Respondent referred Patient 7 to a neurologist.

97. Respondent failed to meet standards of quality medical care in regard to his care and treatment of Patient 7, and failed to meet standards for adequate medical record keeping, including but not limited to the following, in that he:

a. Failed to document an adequate physical examination;

b. Failed to order and lab tests, obtain drug screens and a controlled

substances agreement, despite Patient's 7 long history of substance abuse;

c. Failed to evaluate Patient 7 for narcotic withdrawal;

d. Failed to address Patient 7's addiction;

e. Missed Patient 7's diagnosis of drug seeking behavior and symptoms of addiction;

f. Failed to adequately work up Patient 7;

g. Should have referred Patient 7 to a specialist sooner;

h. Prescribed Percocet without an adequate examination and without a plan;

i. Performed an incomplete workup for pain;

j. Failed to make any mental health referrals;

k. Failed to document date of dictation of office visits and occasionally failed to document the amounts of the controlled substances.

Patient 8

98. On May 30, 2006, Respondent first saw Patient 8, then a 32 year old female, for chronic pain, seizures, and bipolar depression. Patient 8 had a history of six psychiatric hospitalizations in the prior ten years, hospitalization for drug overdose, chronic back pain, and dental caries. Patient 8 had been treated with hydrocodone, Xanax, Risperdal, and Trileptal. Respondent diagnosed migraine, drug addiction, endometriosis, menorrhagia, and coccyx injury. Respondent prescribed Norco, ambient, and Neurontin.

99. Respondent saw Patient 8 approximately 21 times through August 29, 2007. Respondent prescribed Norco, Ambien, Percocet, Ativan, Xanax, and/or Methadone (starting September 2006) at almost every visit.

100. Patient 8 called approximately 27 times for more controlled substance prescriptions and on approximately 22 occasions, Respondent prescribed them.

101. In May 2006, a pharmacy called Respondent about Patient 8's drug use

102. In June 2006, Respondent threatened to discharge Patient 8, but did not.

103. In September 2006, Respondent prescribed Xanax, Percocet, Dilantin and Methadone.

104. In November 2006, Patient 8 was hospitalized at St. Mary's for a drug overdose.

105. On April 14, 2007, Respondent prescribed Methadone 10 mg #150 and on April 30, 2007, Respondent refilled her prescription. Respondent did not require Patient 8 to account for the medication.

106. Respondent failed to meet standards of quality medical care in regard to his care and treatment of Patient 8, including but not limited to the following:

a. Failed to obtain EEG, brain imaging, and laboratory studies to assess Painted 8's abnormalities and evaluate the root causes;

b. Failed to obtain drug screens and failed to obtain a controlled substances agreement given Patient 8's drug abuse and overdose history;

c. Failed to confront Patient 8 and hold her accountable for the medications he prescribed when she sought early refills;

d. Continued to prescribe Methadone, Xanax and other psychotropic medications even after he advised Patient 8 to obtain her medications from her psychiatrist, thereby undermining the requirement that she obtain mental health counseling.

Patient 9

107. On October 9, 2006, Patient 9, then a 30 year old male with a past history

of back pain, presented to Respondent for testicular swelling. Respondent prescribed Lamisil and referred Patient 9 to a urologist.

108. Respondent diagnosed possible testicular mass, arm burn, lumbar stress fracture, chronic back pain and panic attacks.

109. Respondent saw Patient 9 approximately 9 additional visits through March 19, 2007, during which Respondent prescribed Percocet, Oxy IR, OxyContin in gradually increasing strengths and quantities, Alprazolam, Methadone, as well as, Silvadene, Flexeril, and Celexa.

110. Also, on four occasions, Patient 9 received telephone prescriptions for Percocet, Oxy IR, and OxyContin.

111. Respondent referred Patient 9 to an orthopedist and in January 2007, attempted to get Patient 9 into a university pain center.

112. On April 13, 2007, Respondent discharged Patient 9 from his practice when Patient 9 lied about losing a prescription.

113. Respondent failed to meet standards of quality medical care in his care and treatment of Patient 9, including but not limited to the following in that he

a. Failed to fully evaluate Patient 9's back pain;

b. Failed to obtain records from Patient 9's urologist;

c. Failed to order lab tests such as liver and kidney function test, obtain urine drug testing, or obtain a controlled substances agreement;

d. Prescribed controlled substances without checking with Patient 9's surgeon to determine if the surgeon had given Patient 9 pain medicine post-operatively;

e. Failed to confront Patient 9 when Patient 9 failed to follow through with the plan of care;

f. Failed to respond to the "red flag" when Patient 9 complained of chronic back pain yet was going dancing;

g. Failed to regularly space office visits, with the number of pills prescribed to last the time frame and to confront Patient 9 if he did not make the pills last;

h. Failed to diagnose Patient 9's addiction to controlled substances, despite the "red flags."

Patient 10

114. On May 25, 2006, Respondent first saw Patient 10, then a 51 year old male, with a diagnosis of postlaminectomy syndrome. Patient 10 presented with back and neck pain and requested OxyContin, which Respondent prescribed.

115. Respondent saw Patient 10 on 18 additional visits through November 28, 2007. Subsequently, Respondent diagnosed upper respiratory infection and depression. Respondent prescribed OxyContin at almost all but one of these visits along with Lorazepam, Amitriptyline, and Cymbalta. On each visit, Respondent prescribed OxyContin 20 mg. tid # 90.

116. On June 27, 2006, Respondent referred Patient 10 to pain management but Patient 10 was unable to go.

117. In January 2007, Patient 10 had surgery on a Hydrocele and wanted pain medication.

118. On February 13, 2007, Patient 10 was hospitalized for a drug overdose/confusion and Respondent was notified. Patient 10's wife requested that Patient 10 discontinue OxyContin.

119. On February 19, 2007, Respondent prescribed OxyContin 40 mg. bid # 60.

Respondent continued to prescribe OxyContin through November 28, 2007.

120. In April 2007, Respondent offered a neurosurgical and orthopedic consults

121. On October 30 2007, Respondent ordered an MRI.

122. Respondent failed to meet standards of quality medical care in his care and treatment of Patent 10, including but the limited to the following, in that he:

a. Failed to perform a re-evaluation of Patient 10's lumbar disc pain at the initial visit and develop a short and long term plan, other than merely prescribing a narcotic;

b. On February 19, 2007, failed to address Patient 10's having overdosed by referring Patient 10 to a pain management specialist to get Patient 10 of CDS;

c. Failed to order any drug screen and failed to have a controlled substances agreement, even after Patient 10's overdose;

d. Continued to prescribe OxyContin and failed to obtain mental health specialty consultation even after Patient 10's overdose.

Patient 11

123. On November 2, 2006, Respondent saw first saw Patient 11, then a 49 year old female, for follow-up of her back pain after she "lost her prescription." Patient 11 had previously been diagnosed by another physician in Respondent's practice with alcohol abuse and lumbar disk disease for which she had been on Percocet, Lidoderm Patch, Neurontin and Methadone, as well as edema and schizophrenia. Respondent diagnosed upper GI pain with a history of ulcer, upper respiratory infection, acute back injury, stress and osteoarthritis of the knees. Respondent prescribed Percocet.

124. Respondent saw Patient 11 approximately 13 more times through June 19, 2007.

125. On all visits except two, Respondent prescribed controlled substances such

as Percocet, Dilaudid, Valium, MS Contin, OxyContin, Hydrocodone, MSIR, and/or Percocet.

126. Patient 11 called approximately 13 times for controlled substance prescriptions, which Respondent provided.

127. Respondent failed to meet standards of quality medical care in his care and treatment of Patent 11, including but the limited to the following, in that he:

a. Failed to perform an adequate workup of Patient 11's complaints;

b. Failed to order any drug screens or alcohol levels, despite Patient 11's alcohol history and frequent telephone requests for CDS;

c. Failed to treat Patient 11's addiction to CDS;

d. Failed to refer for mental health specialty consultation, despite Patient 11's history of schizophrenia;

e. Failed to have a controlled substances agreement;

f. Failed to confront Patient 11 about the possibility of her diverting CDS.

Patient 12

128. On June 26, 2006, Respondent first saw Patient 12, then 31 year old male who had previously been diagnosed with a fractured tibia and back disk and fracture for which he had been on Percocet, Ultram, Skelaxin, and Flexeril. Respondent diagnosed cervical pain, lumbar disk, cervical disk, positive PPD, and dental pain. Respondent prescribed Percocet, Valium, a muscle relaxant and Vicodin.

129. Respondent initiated a workup for the etiology of the pain with the first visit.

130. Respondent saw Patient 12 approximately 20 times through November 14, 2007. Respondent provided narcotic prescriptions and trigger point injections.

131. Respondent failed to maintain adequate medical records in that he:

a. Failed to provide adequate information to explain the procedures that were done;

b. Transcribed manually written notes but failed to state how soon after seeing the patient these were dictated;

c. Occasionally omitted diagnoses and amounts dispensed of some of the controlled substances;

d. Failed to document an adequate history, subjective complaints, and review of systems; failed to describe tests that were performed and specialists that were seen; failed to document the patient's past medical history including abuse or overdose of controlled substances, and compliance with past recommendations

e. Failed to fully document a physical examination;

f. Described symptoms rather than documenting a diagnosis;

g. Failed to document orders for liver and kidney lab tests;

h. Failed to fully describe specialty referrals.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent's actions constitute failure to meet standards of quality care, in violation of H.O. § 14-404(a)(22) and failure to keep adequate medical records in violation of H.O. § 14-404(a)(40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of October, 2009, by a majority of the quorum of the Board considering this case hereby:

ORDERED that effective the date of this Consent Order, Respondent's license shall be Suspended; however, such Suspension shall be immediately Stayed and Respondent shall be subject to the following conditions of probation for a minimum of three (3) years, effective on the date of this Consent Order:

1. Respondent shall not treat any patients for chronic pain management;

2. Respondent may only prescribe a single Schedule II controlled dangerous substance ("CDS") to a patient for a maximum of 7 days for acute conditions only, without any refills, and without changing to a different CDS;

3. Respondent may only prescribe Schedule IV anxiolytic (antianxiety) medications such as Valium, Xanax, Tranxene, Ativan, and Klonopin, to a patient, if no other psychoactive medications, or Catapres (Clonidine), are prescribed and for a maximum of 14 days, without any refills and without changing to a different anxiolytic medication;

4. Within two (2) months of the date of this Consent Order, Respondent shall begin supervision with a Board-approved supervisor who is Board-certified in Family Medicine. Respondent shall obtain prior approval from the Board of the supervisor before entering into the supervisory arrangement. As part of the approval process, Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board regarding the qualifications of the physician who is submitted for approval. The supervisory arrangement shall continue as described for a minimum of one (1) year, subject to the following:

    a. The supervisor shall have no personal, professional relationship with Respondent;

    b. The supervisor shall notify Board in writing of acceptance of the supervisory role with Respondent;

    c. Respondent shall agree that the Board will provide the supervisor with a copy of the charging document, this Consent Order, and any other documents from the investigation file that the Board deems relevant, including the Consent Order of July 23, 2008, the Peer Review Reports of May 28, 2008 and May 29, 2008, and the complaint of April 7, 2009;

d. Respondent shall meet in person with the supervisor on a monthly basis. The supervisor will randomly select records of Respondent's patients in his office and review and discuss Respondent's differential diagnoses and treatment plans. The supervisor will assess and provide feedback to Respondent in regard to whether his practices are within the appropriate standard of quality care;

e. Respondent shall ensure that the supervisor submits written reports to the Board on a quarterly basis regarding his/her assessment of Respondent's compliance with appropriate standards of care and appropriate documentation;

f. Respondent shall have sole responsibility for ensuring that the supervisor submits the required quarterly reports to the Board in a timely manner; and

g. Respondent may petition the Board for a decrease in the frequency of supervisory meetings after one (1) year of supervision;

5. Within six (6) months after the initiation of the supervision and completion of the courses on medical record keeping, prescribing controlled substances, and pain management, as required by the prior Consent Order of July 23, 2008, Respondent's practice shall be subject to peer review by an appropriate peer review entity, or a chart review by a Board designee, to be determined at the discretion of the Board;

6. An unsatisfactory peer review by an appropriate peer review entity, or unsatisfactory reports from the clinical supervisor, shall be deemed a violation of probation;

7. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that any violation of the terms/and or conditions of the Consent Order, shall be deemed a violation of this Consent Order; and be it further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative

Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a reprimand, probation, suspension, revocation and/or a monetary fine; and be it further

ORDERED that after a minimum of three (3) years and after the conclusion of a satisfactory peer review, and satisfactory reports from his supervisor, Respondent may file a written petition for termination of probation without further conditions or restrictions, but only if Respondent has satisfactorily complied with all conditions of probation, and if there are no pending complaints regarding Respondent before the Board, and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2004 Repl. Vol.)

10/28/09
Date

Robert G. Hennessy, M.D., Chair
Maryland Board of Physicians

CONSENT

I, DANIEL M. HOWELL, M.D. License No. D02975, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, Andrew J. Marter, Esquire, and knowingly and voluntarily elected to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2005 Repl. Vol.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2004 Repl. Vol.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into 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 as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I maybe subject to disciplinary actions, which may include revocation of my license to practice medicine.

6. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

10-1-09
Date

Daniel M. Howell, M.D.
Respondent

10-5-09
Date

Andrew J. Marter, Esquire
Counsel for Respondent

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF :

I HEREBY CERTIFY that on this 1st day of October, 2009 before me, a Notary Public of the State and County aforesaid, personally appeared Daniel M. Howell, M.D., License number D02975, 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.

Notary Public

My commission expires: 10-01-10