

**James P. Jarboe, M.D.  
Philip J. Bean Medical Center  
24035 Three Notch Road  
Hollywood, Maryland 20636**

August 1, 2011

Paul T. Elder, M.D., Chair  
Maryland State Board of Physicians  
4201 Patterson Avenue, 4<sup>th</sup> Floor  
Baltimore, MD 21215

RE: Surrender of License to Practice Medicine  
James P. Jarboe, M.D.  
License Number: D06419  
MBP Case Number: 2009-0996

Dear Dr. Elder and Members of the Board,

Please be advised that I have decided to **PERMANENTLY SURRENDER** my license to practice medicine in the State of Maryland, License Number D06419, effective July 31, 2011, and that I agree to cease prescribing controlled dangerous substances as of the date of this letter. 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. Health Occ. Code Ann., §§ 14-101 *et seq.* (2009 Repl. Vol.) and other applicable laws. In other words, as of the effective date of this Letter of 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 Surrender is a **PUBLIC DOCUMENT** and on the Board's acceptance, becomes a **FINAL ORDER** of the Board.

My decision to permanently surrender my license to practice medicine in the State of Maryland has been prompted by an investigation of my license by the Maryland State Board of Physicians (the "Board") and the Office of the Attorney General and my poor state of physical health which has lead me to pursue retirement from the practice of medicine. The investigation resulted in the Board's vote to charge me under Board Case Number 2009-0996. **[See charging document, incorporated in its entirety as Attachment 1]**

Paul T. Elder, M.D. and Members of the Board

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Permanent Letter of Surrender

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I have decided to permanently surrender my license to practice medicine in the State of Maryland to avoid further prosecution of the disciplinary charges now pending before the Board, and due to my medical condition and retirement from the practice of medicine. I acknowledge that the Board initiated an investigation of this matter and that on January 31, 2011, voted to issue disciplinary charges under Md. Health Occ. Code Ann. § 14-404(a)(22) and (40). Specifically, the Board voted to charge me with a failure to meet the appropriate standards for the delivery of quality medical care and a failure to keep adequate medical records.

I wish to make it clear that I have voluntarily, knowingly and freely chosen to submit this Letter of Surrender to avoid prosecution of the aforementioned Charges under the Act, in order to resolve this matter, and because of my medical condition and retirement from the practice of medicine. I acknowledge that if the case proceeded to an evidentiary hearing, the Board would submit evidence to support the investigatory findings it made in this case. I acknowledge that for all purposes relevant to medical licensure, those investigative findings will be treated as if proven.

I understand that by executing this Letter of Surrender I am waiving any right to contest any charges that would issue from the Board's investigative findings and its vote to issue 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.

I understand that the Board will advise the Federation of State Medical Boards and the National Practitioners' Data Bank and the Healthcare Integrity and Protection Databank of this Letter of Surrender, and in response to any inquiry, that I have surrendered my license in lieu of further disciplinary action under the Act. I also understand that in the event I would apply for licensure in any form in any other state or jurisdiction, that this Letter of Surrender may be released or published by the Board to the same extent as a final order that would result from disciplinary action, pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol.), and that this Letter of Surrender shall constitute a disciplinary action by the Board.

I affirm that on or before July 31, 2011, I will present to the Board my original Maryland medical license number D06419, and my most recent wallet-sized renewal card. I acknowledge that on or before July 31, 2011, I shall deliver to the Board: (1) any and all Medical Assistance prescription forms in my possession; (2) any prescription forms and pads in my possession; (3) any prescription forms or pads on which my name and Drug Enforcement Administration Registration Number are imprinted. I affirm that on or before the

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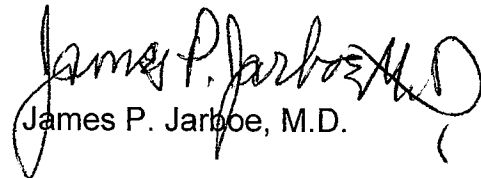
effective date of this Letter of Surrender, I shall deliver to the Board any controlled dangerous substances in my possession, other than those prescribed by a licensed physician for me.

I acknowledge that on or before the effective date of this Letter of Surrender, I shall deliver to Georgette Zoltani, Chief, or any successor, Division of Drug Control, 4201 Patterson Avenue, 1<sup>st</sup> Floor, Baltimore, Maryland 21215, my Maryland Controlled Dangerous Substances Certificate # M04591 (expiration date January 31, 2013); and that on or before the effective date of this Letter of Surrender, I shall deliver to Terry Riley, Group Supervisor, or any successor, Drug Enforcement Administration ("DEA"), 200 Saint Paul Place, Suite 2222, Baltimore, Maryland, 21202, my DEA Certificate of Registration Card # AJ2540602 (expiration date December 31, 2012).

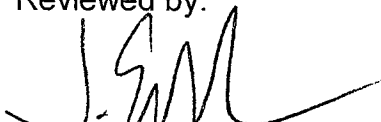
I further recognize and agree that by tendering this Letter of Surrender that my license will remain permanently surrendered effective July 31, 2011. In other words, I agree that I have no right to reapply for a license to practice medicine in the State of Maryland. I further agree that the Board is not obligated to consider any application for licensure that I might file at a future date and that I waive any hearing rights that I might possess regarding any such application.

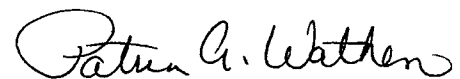
I acknowledge that I may not rescind this Letter of Surrender in part or in its entirety for any reason whatsoever. Finally, I wish to make clear that I have consulted with an attorney before signing this Letter of Surrender. I understand both the nature of the Board's actions and this Letter of Surrender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

Very truly yours,

  
James P. Jarboe, M.D.

Reviewed by:

  
J. Eric Rhoades, Esquire



**Patricia A. Wathen**  
Notary Public  
State of Maryland  
My Commission expires 10-01-14

Paul T. Elder, M.D. and Members of the Board

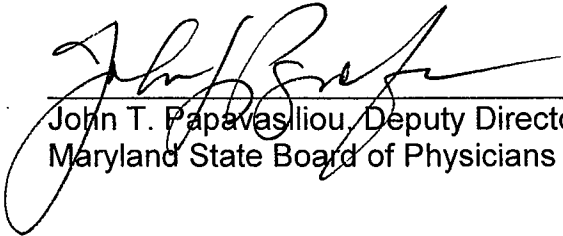
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**ACCEPTANCE**

On behalf of the Maryland Board of Physicians, on this 1<sup>st</sup> day of August, 2011, I, John T. Papavasiliou, Deputy Director., accept James P. Jarboe, M.D.'s **PERMANENT SURRENDER** of his license to practice medicine in the State of Maryland.

  
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John T. Papavasiliou, Deputy Director  
Maryland State Board of Physicians

cc: J. Eric Rhoades, Esquire

Dawn L. Rubin, Assistant Attorney General

John S. Nugent, Principal Counsel, HOPL

Heather McLaughlin, Senior Compliance Analyst

Yemisi Koya, Chief, Investigations

Christine Farrelly, Supervisor, Compliance Administration

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# **ATTACHMENT 1**

IN THE MATTER OF \* BEFORE THE  
JAMES P. JARBOE, M.D. \* MARYLAND STATE BOARD  
Respondent \* OF PHYSICIANS  
License Number: D06419 \* Case Number: 2009-0996

\* \* \* \* \*  
**CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT**

The Maryland State Board of Physicians (the "Board"), hereby charges James P. Jarboe, M.D. (the "Respondent") (D.O.B. 02/25/1934), License Number D06419, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 14-404(a) (2009 Repl. vol.).

The pertinent provisions of the Act provide the following:

- (a) 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 this State;
  - (40) Fails to keep adequate medical records as determined by appropriate peer review.

**ALLEGATIONS OF FACT<sup>1</sup>**

The Board bases its charges on the following facts that the Board has cause to believe are true:

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<sup>1</sup> The allegations set forth in this document are intended to provide the Respondent with notice of the alleged 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 these charges.

## BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on April 14, 1970.
2. The Respondent, board-certified in family medicine, practices medicine at Practice A<sup>2</sup> in Hollywood, Maryland.
3. On or about December 3, 2008, the Board issued the Respondent an "Advisory Letter and Notice of Re-Review" (hereinafter, the "Advisory Letter") in response to three complaints<sup>3</sup> received by the Board alleging the excessive prescribing of controlled dangerous substances ("CDS").
4. By letter dated October 15, 2009, the Board notified the Respondent it had opened an investigation based on the December 3, 2008 Advisory Letter and issued to him a subpoena for twelve randomly selected patient records.
5. By letter dated January 24, 2010, the Respondent noted that he had "retired" from his practice in January 2008, but had continued to supervise a physician assistant in the office for several hours each week for a period of two years.<sup>4</sup> Additionally, he had continued his nursing home practice as well as overseas volunteer work. To the Board's letter, he attached a letter dated November 16, 2009 that was addressed to his "patients on

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<sup>2</sup> In order to preserve the confidentiality of these proceedings, facility names will not be used in this document.

<sup>3</sup> Two complaints were filed by anonymous pharmacists and one complaint was filed by a physician.

<sup>4</sup> The P.A., referred to as "D.N." in the document entered into a Delegation Agreement with the Respondent in 1999, and at all time relevant to these Charges remained in effect. As D.N.'s supervising physician, the Respondent was responsible for the medical care rendered.

opioids for the treatment of long term non-malignant pain” that stated he had “ceased” doing pain management for non-malignant pain.

6. In furtherance of its re-review, the Board transmitted the twelve patient records to Maximus in order to conduct a formal peer review. Maximus assigned the review to two physicians board-certified in family medicine (hereinafter, the “reviewers”), who concurred that the Respondent had failed to meet the standard of quality medical care with regard to nine of the patients, and that his documentation had been inadequate with regard to eight patients reviewed.

#### **STANDARD OF PRACTICE RELATING TO PAIN MANAGEMENT PATIENTS**

7. In general, the standard of quality medical care for patients presenting with pain management issues includes but is not limited to the following:
  1. An appropriate initial history should be elicited including any substance abuse history;
  2. An appropriate physical examination should be conducted relating to the pain;
  3. If complaints of pain are based on past events, patient records should be requested from other providers to substantiate relevant diagnostic and medication history;
  4. Documentation of patient visits for pain management should include an interval history of the problem and reassessment during every visit, even if succinct, and an assessment of the problem, any objective findings and a treatment plan;
  5. The patient should be referred for appropriate evaluation of pain including testing and/or consultations with specialists when indicated;
  6. If there is any suspicion of diversion, toxicology screening should be considered to confirm the patient is taking the prescribed medication and to check for any illicit drugs;
  7. Consideration should be given and documented to appropriate treatment with non-opioid alternatives and adjunctive therapies such as physical therapy and psychotherapy;
  8. If CDS are prescribed in an ongoing fashion, there should be a documented plan for management of pain; and

9. There should be documentation of periodic reevaluation of the need for the medication and if applicable, attempts to wean a patient off the medication.

## PATIENT RELATED ALLEGATIONS

### PATIENT 1<sup>5</sup>

8. Patient 1, a female, D.O.B. 1964, began seeing the Respondent for medical care since at least August 2005.<sup>6</sup> She had a history of joint and abdominal pain, a history of pancreatic cancer at age 25 and diabetes.
9. The Respondent (or another provider in his practice)<sup>7</sup> saw Patient 1 approximately every three months through October 2009. Besides other medications, she was regularly prescribed clonazepam (Schedule IV benzodiazepine used in the treatment of anxiety, with the brand name Klonopin) and Propoxyphene-N-100 (Schedule IV CDS with the brand name Darvocet-N 100).
10. On or about September 27, 2007, the Respondent initially documented that he had prescribed clonazepam for restless leg syndrome, but failed to document any indication of restless leg syndrome in Patient 1's history and physical or that Patient 1 had presented with any complaints of restless legs. He merely documented "I gave her a prescription for clonazepam...to help with, what sounds like, restless leg syndrome." He

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<sup>5</sup> In order to maintain confidentiality, patient names will not be used in the charges, but will be provided to the Respondent on request.

<sup>6</sup> Patient 1's progress notes provided in response to the Board's subpoena begin in August 2005, however, the Respondent documented in his Summary of Care that he had "known" Patient 1 for more than ten years.

<sup>7</sup> The Respondent was Patient 1's primary care provider. Besides the Respondent, Patient 1 was most often seen by DN.

continued prescribing the clonazepam without a documented reason through October 2009, often by telephone.

11. In the Respondent's summary of care that he submitted to the Board on request, he failed to document restless leg syndrome as one of Patient 1's diagnoses.
12. The Respondent began prescribing Darvocet-N to Patient 1 in August, 2005,<sup>8</sup> and consistently refilled her prescriptions through October 2009, often by telephone.
13. Although the Respondent regularly prescribed Darvocet-N and clonazepam to Patient 1, he failed to document a pain management plan including but not limited to the efficacy of the medications, any periodic re-evaluation and any monitoring for drug misuse.
14. The Respondent failed to document that urine toxicology screening had been conducted in order to confirm that Patient 1 had been taking the prescribed medication and/or to check for any illicit drugs.
15. For reasons outlined in pertinent part above, the Respondent's documentation relating to his care of Patient 1 was inadequate in violation of Health Occ. § 14-404(a)(40).

## **PATIENT 2**

16. Patient 2, a female, D.O.B. 1954, saw the Respondent for medical care since at least August 2005. She had an extensive medical history including hypothyroidism, diabetes, spondylosis and osteoarthritis of her

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<sup>8</sup> Patient 1 may have been receiving Darvocet-N prior to this date; however, the progress notes received by the Board begin on this date.

cervical and lumbar spine, GERD, hyperlipidemia, a hiatal hernia, a decreased lung capacity and anxiety.

17. Beginning in August 2005, the Respondent prescribed alprazolam<sup>9</sup> and lorazepam<sup>10</sup> to Patient 2 on a regular basis, through at least June 2009. The Respondent also regularly prescribed Soma.<sup>11</sup>
18. The Respondent documented in his Summary of Care provided to the Board that it was his "intention" to see Patient 2 every three months, however, she had appointments with "several other physicians." Often the Respondent would refill Patient 2's medications, including her CDS, by telephone.
19. On January 8, 2007, Patient 2 saw the Respondent with complaints of pain including neck and low back. She had been in two motor vehicle accidents during the preceding two months. The Respondent began prescribing 100 tablets of Darvocet-N100, one every four to six hours as needed.
20. On May 31, 2007, a neurosurgeon (Dr. K) evaluated Patient 2. He noted that she would be a good candidate for surgery "when all reasonable attempts at outpatient conservative care have been tried and failed." Dr. K prescribed a NSAID<sup>12</sup> and Tylenol #3.<sup>13</sup>

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<sup>9</sup> A Schedule IV benzodiazepine (brand name Xanax) used in the treatment of anxiety disorders.

<sup>10</sup> A Schedule IV benzodiazepine (brand name Ativan) used in the treatment of anxiety disorders.

<sup>11</sup> Soma (generic name carisoprodol) is a muscle relaxant with the potential for abuse; it is not federally controlled.

<sup>12</sup> Stands for nonsteroidal anti-inflammatory drug.

<sup>13</sup> Combination of acetaminophen and codeine.

21. Besides prescribing alprazolam, lorazepam and Soma to Patient 2 on a continuing basis, the Respondent prescribed the following pain medication, often without evaluating her in the office:

Date of Prescription	Medication	Number of Tablets	Number of Refills
November 8, 2007	hydrocodone 7.5/500 <sup>14</sup> and Tylenol #3 <sup>15</sup>	Not specified in record.	Not specified in record.
November 17, 2008	Darvocet-N100	100	3
February 8, 2008	hydrocodone 7.5/500 & Tylenol #3	120 of each	0
April 15, 2008	hydrocodone with APAP 7.5/500	120	3
May 8, 2008	hydrocodone & Tylenol #3	120 (hydrocodone) & 100 (Tylenol #3)	2 (Tylenol #3) ?refills of hydrocodone (not legible)
August 15, 2008	Tylenol #3	120	3
September 29, 2008	hydrocodone	120	3
December 3, 2008	hydrocodone & Tylenol #3	120 of each	3 refills for each
January 22, 2009	hydrocodone with APAP	120	3
February 27, 2009	Tylenol #3	120	3
March 3, 2009	Tylenol #3	120	3
June 4, 2009	hydrocodone with APAP	120	3
August 18, 2009	hydrocodone with APAP	120	3
October 5, 2009	hydrocodone 7.5/500	180	3

22. On December 28, 2007, Patient 2 telephoned the Respondent with symptoms of an upper respiratory infection including a cough. At Patient 2's request, the Respondent telephoned in a prescription for Phenergan

<sup>14</sup> Also known as hydrocodone with APAP.

<sup>15</sup> This was the first time Tylenol #3 was documented as having been prescribed by the Respondent, although the Respondent documented that he was rewriting all of Patient 2's prescriptions.

with Codeine,<sup>16</sup> even though he was simultaneously prescribing two benzodiazepines in conjunction with two opioids (hydrocodone and Tylenol #3)<sup>17</sup>.

23. On September 29, 2008, Patient 2 telephoned requesting a prescription for Tylenol #3. The Respondent denied her request as being too soon. He did, however, prescribe 120 tablets of hydrocodone with three refills.
24. There is a handwritten note in Patient 2's record dated February 11, 2009 stating that Patient 2 would like to see the Respondent for pain management and "won't take no for an answer."
25. The Respondent failed to document an adequate pain management plan for Patient 2.
26. The Respondent failed to adequately attempt or to document non-CDS treatment modalities for Patient 2.
27. The Respondent prescribed opioid pain medication, benzodiazepines and Soma and increased the dosages, without adequately documenting the efficacy of any of these medications.
28. The Respondent failed to document any attempts to taper Patient 2 from the opiates or benzodiazepines.
29. The Respondent failed to document any consideration of CDS abuse or diversion. He failed to conduct any urine toxicology screens or document any discussion with Patient 2 regarding her early requests for CDS refills.

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<sup>16</sup> An opioid.

<sup>17</sup> Both hydrocodone and Tylenol #3 are short-acting opioids.

30. Patient 2's anxiety was not well controlled with the prescribed benzodiazepines. She was first prescribed an antidepressant in April 2009, after several years of treatment with benzodiazepines.
31. The standard of quality medical care in the long-term treatment of anxiety should include other mental health therapies including but not limited to psychotherapy, SSRI's,<sup>18</sup> or other non-habit forming medications.
32. For reasons outlined in pertinent part above with regard to Patient 2, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

### **PATIENT 3**

33. Patient 3, a male, D.O.B. 1955, had multiple medical problems including diabetes, hypertension, hyperlipidemia and renal insufficiency. His surgical history included a below the knee amputation ("BKA"). Patient 3 also had shoulder pain, peripheral neuropathy and degenerative disc disease. He had had multiple snake bites. Patient 3 had a history of hepatitis. His psychiatric history included alcoholism, anxiety, depression and a suicide attempt.
34. The records reviewed from the Respondent's practice reflected medical care rendered from 1998 through September 29, 2009. Patient 3 was seen by both the Respondent and DN for his medical care. He primarily saw DN for his care, and the Respondent prescribed his CDS for chronic

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<sup>18</sup> SSRI stands for Selective Serotonin Reuptake Inhibitors; a class of medications used in the treatment of depression and anxiety.

pain management (for various complaints of pain including shoulder, leg and arm).

35. When the Respondent began seeing Patient 3 in 1998, he had already been taking Darvocet and Tylenol #3 following his BKA. He was also being prescribed Prozac and trazodone.<sup>19</sup> The Respondent continued prescribing these medications.
36. In 1999, Patient 3's medications included Remeron,<sup>20</sup> Zyprexa<sup>21</sup> and clonazepam.
37. In July 1999, there is a note from an insurance company questioning the Patient's long-term use of hydrocodone.
38. From at least 1998 through 2003, Patient 3 had been abusing alcohol<sup>22</sup> while taking CDS including short acting opioids, benzodiazepines and muscle relaxers.
39. Patient 3's medical records are missing from April 2003 through 2007 with a note from the Respondent stating that the records enclosed [for 1998 through 2002] are "antique" and suitable for showing how his (the Respondent's) prescribing practices have changed over 40-50 years.
40. In July 2007, Patient 3 was taking multiple medications including but not limited to Tramadol,<sup>23</sup> Prozac, cyclobenzaprine (a muscle relaxant),

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<sup>19</sup> Both medications are used in the treatment of depression.

<sup>20</sup> A sedating antidepressant.

<sup>21</sup> A psychotropic medication used in the treatment of schizophrenia and bipolar disorder.

<sup>22</sup> A history and physical from a November 2000 hospital admission for peptic ulcer disease reflects that Patient 3 often drank a 12 pack of beer over the weekend and at times during the week, and had been doing so for 20 years.

<sup>23</sup> Brand name is Ultram; medication used in the treatment of moderate to severe pain. Although Tramadol is not a CDS, it does have the potential for abuse.

gabapentin (an antiseizure medication), Remeron, temazepam (a benzodiazepine used in the treatment of insomnia), promethazine<sup>24</sup> and oxazepam (a benzodiazepine used in the treatment of anxiety) in conjunction with hydrocodone with APAP.

41. On or about September 20, 2007, Patient 3 presented to the hospital with three episodes of seizures. He denied any alcohol consumption over the prior three years, however, his alcohol level was elevated when he presented to the Emergency Room.
42. In December 2007, the Respondent began seeing Dr. L at Hospital C for wound care of a leg ulcer. In January 2008, during a visit to Dr. L, the nurse working with Dr. L documented:

P[atient] responsive to questions but pupils dilated and speech is slurred. When getting up from the exam table he was weaving and had difficulty maintaining his balance.

43. On November 11, 2008, the nurse working with Dr. L documented that Patient 3 was to start on oxycodone, a Schedule II CDS, for pain.
44. On December 1, 2008, Patient 3 was admitted to the hospital with a suspected gastrointestinal bleed based on "chronic anti-inflammatory use."
45. On or about April 22, 2009, Patient 3 was hospitalized at Hospital A for a seizure that might have been due to hypoglycemia,<sup>25</sup> the excessive use of Tramadol or both. During the hospitalization, a psychiatric consultation was requested. The psychiatrist noted that Patient 3 had not seen a psychiatrist for 10 years, and was being prescribed Prozac and Remeron

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<sup>24</sup> Used in the treatment of nausea and vomiting.

<sup>25</sup> A common side effect of diabetes or treatment for diabetes.

by his primary care practitioner. Additionally, he noted that Patient 3 had a substance abuse history including marijuana and an admitted dependence on prescription narcotics. The psychiatric consultation recommended not using any addictive medicine if possible. Patient 3's urine toxicology screen had tested positive for THC and negative for benzodiazepines (despite the Respondent's consistent prescriptions for temazepam and oxazepam). Patient 3's discharge instructions indicated that hydrocodone with acetaminophen be discontinued.<sup>26</sup>

46. On May 12, 2009, the Respondent refilled Patient 3's prescription for hydrocodone and provided him with two refills.
47. On May 12, 2009, Patient 3 followed up with Dr. L for debridement of his leg ulcer. Dr. L prescribed 120 tablets of oxycodone 5 mg. to be taken every six hours as needed.
48. On June 29, 2009, DN noted that Dr. L had discontinued Patient 3's hydrocodone with APAP. The Respondent prescribed Patient 3 oxycodone 5 mg. every 6 hours (120 tablets), and refilled the prescription on July 27, 2009. In August and September 2009, however, the Respondent once again began prescribing hydrocodone with APAP for Patient 3 by telephone.
49. In October 13, 2009, according to a pharmacy survey, the Respondent prescribed 120 tablets of hydrocodone with APAP 5/500.

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<sup>26</sup> The psychiatric consult was included in Patient 3's hospital records, and may not have been provided to the Respondent.

50. The Respondent failed to document an adequate initial history or physical related to Patient 3's pain, failed to document a pain management plan including any functional goals, failed to elicit an adequate substance abuse history, failed to adequately document the pain he was treating, failed to document any adverse results from the treatment, failed to document that he had attempted to institute non-opioid pain treatment, failed to monitor Patient 3 for possible diversion including but not limited to urine toxicology screening and he failed to reduce or eliminate the prescribing of addictive medications after Patient 3's April 2009 hospitalization.
51. The Respondent failed to recognize and address Patient 3's psychiatric disorders including recommending that Patient 3 receive a psychiatric consultation.
52. For reasons outlined in pertinent part above with regard to Patient 3, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

#### **PATIENT 4**

53. Patient 4, a female, D.O.B. 1932, had a history of a prior CVA<sup>27</sup> that occurred during a left carotid endarterectomy and resulted in left hemiplegia, expressive aphasia and dysphagia. Other history included hypertension, hyperlipidemia, osteoarthritis, chronic musculoskeletal pain,

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<sup>27</sup> Cerebrovascular accident or stroke.

coronary artery disease, a pacemaker, renal insufficiency, and left renal stent placement and right femoral artery angioplasty.

54. The records reviewed for Patient 4 were from August 1999 through September 2009. Patient 4's final office visit was in July 2009. In September 2009 following a hospitalization for atrial fibrillation, aspiration pneumonia and a right lung mass she was discharged to hospice care, and died a month later.
55. From approximately 1999 through 2007, the Respondent prescribed Darvocet to Patient 4 for either an undocumented reason or her "arthritic pain."
56. Although not documented on Patient 4's medication list, the Respondent began prescribing hydrocodone to Patient 4 around June 28, 2007. On June 28, 2007, Patient 4 complained about not "feeling like herself" and waking up every two hours during the night to urinate. The Respondent began prescribing hydrocodone 7.5/500 mg. (one tablet at bedtime) in addition to one tablet of Darvocet to be taken during the day.
57. From approximately 2007 through October 2009, the Respondent continued prescribing hydrocodone.
58. On January 21, 2009, the Respondent increased Patient 4's Ambien<sup>28</sup> from 5 to 10 mg. and increased her hydrocodone to 10/650 mg every four hours as "she feels her pain medication is inadequate." The Respondent provided Patient 4 with three refills of each medication.

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<sup>28</sup> A Schedule IV CDS used in the treatment of insomnia.

59. On April 22, 2009, the Respondent documented that he was concerned Patient 4 was taking "handfuls of medicines at a time." On that date, he documented that he discussed with Patient 4 and her daughters, the proper way to take the medications and the maximum doses of her medications.
60. On July 10, 2009, the Respondent prescribed for Patient 4 by telephone 120 tablets of hydrocodone 10/650 with three refills. He documented that Patient 4's daughter had called to discuss that Patient 4 had thrown herself on the floor and acted out, and failed to recall the incident.
61. The Respondent failed to document a pain history and physical, failed to document a pain management plan to include the proper monitoring of Patient 4's pain medications with her increasing confusion, and during the last few months of Patient 4's life, failed to monitor the effectiveness of her treatment with CDS including any adverse reactions from the treatment.
62. The Respondent's actions as outlined in pertinent part above, failed to meet the standard of quality medical care for Patient 4 in violation of Health Occ. § 14-404(a)(22).

#### **PATIENT 5**

63. Patient 5, a female, D.O.B. 1963, had a history of drug addiction since her teen years including a 15-30 year history of heroin abuse, migraine headaches, anxiety/depression, insomnia and an episode of a seizure in 1986. She had attempted suicide in 1987 by cutting her wrists. Besides

the Respondent, Patient 5 was also seen by another physician in the Respondent's practice (Dr. H) and by D.N.

64. The Respondent treated Patient 5 on and off since she was born, however, there were lapses of several years in which he did not provide care to her.
65. In 1989, the Respondent started Patient 5 on a methadone taper to help her with detoxification. Two years later, in 1991, she was hospitalized for substance abuse (heroin and cocaine) and again started on a methadone taper. The Respondent had been her admitting physician. In 1993, she again was hospitalized for detoxification with the Respondent as her admitting physician. Her discharge diagnoses included benzodiazepine addiction and withdrawal, methadone withdrawal, addictive personality and seizures.
66. In May 2006, Patient 5 presented to the Respondent's practice after a lapse of several years, with neck pain following a motor vehicle collision. She had been regularly taking clonazepam and methadone (a Schedule II CDS) for back pain.
67. Around September 2006, the Respondent and other providers in the practice began regularly prescribing methadone to Patient 5 (10 mg. three times daily),<sup>29</sup> and clonazepam three times daily for anxiety.
68. On October 3, 2006, the Respondent began prescribing Remeron at bedtime and Wellbutrin XL 150<sup>30</sup> in the morning.

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<sup>29</sup> This dosage is consistent with a pain control dose, not opioid abstinence maintenance dosing.

<sup>30</sup> An antidepressant.

69. There is no documentation in Patient 5's medical record justifying treatment with methadone for her level of back pain in light of her history of heroin addiction. Methadone is used in the treatment of severe pain and must be used with caution in light of its potential risks and side effects. Methadone maintenance can be prescribed to treat opioid dependency only in the context of a certified methadone treatment center.<sup>31</sup> The Respondent and/or providers in the practice continually prescribed methadone to Patient 5 through May 2008.
70. On October 30, 2006, Patient 5 reported that her Klonopin had been stolen from her purse. DN provided her with a new prescription.
71. On February 19, 2007, Patient 5 presented with vomiting, and the Respondent prescribed Donnato!,<sup>32</sup> which increases the effect of clonazepam, and Phenergan which increases the effect of methadone. Both Donnato! and Phenergan have the potential for abuse and diversion.
72. When Patient 5 returned for a follow-up visit in March 2007, the Respondent refilled her prescription for Donnato!, and continued prescribing clonazepam.
73. On May 7, 2007, the Respondent noted that Patient 5 had been seen at Hospital A for pneumonia. He refilled her prescriptions for methadone and Klonopin and prescribed hydrocodone 5/500, one to two, every four to six hours and Levaquin<sup>33</sup> for a diagnosis of pneumonia.

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<sup>31</sup> The Respondent's practice was not a certified methadone treatment center.

<sup>32</sup> Used in the treatment of gastrointestinal complaints.

<sup>33</sup> An antibiotic used to treat infections such as pneumonia.

74. On September 4, 2007, the Respondent documented that Patient 5 presented in a "rather distressed manner." She relayed to the Respondent that her daughter and son had addiction problems. He continued to prescribe methadone and Klonopin to Patient 5. He noted she wanted to get off all of her medicines.
75. On September 27, 2007, the Respondent refilled Patient 5's prescriptions including methadone 10 mg twice or three times daily, and Klonopin, noting "we will gradually get her off the methadone." He did not however, document a tapering schedule.
76. On December 10, 2007, the Respondent prescribed methadone to Patient 5 along with hydrocodone 5/500 for bilateral pleurisy. He noted that she was "not on Klonopin?" yet he provided her with a prescription.
77. On March 26, 2008, Patient 5 stated that she wanted to get off of methadone, but each time she tried, she had withdrawal symptoms. The Respondent noted that she had not used heroin for years, but had used methadone to get off of heroin in the past. Presently, he noted she was on methadone for her back pain. The Respondent planned to decrease her methadone over the course of six months. The Respondent prescribed 25 mg. of methadone daily (down from 50 mg. daily), Klonopin and Clonidine.<sup>34</sup>
78. On June 11, 2008, Patient 5 returned to the Respondent's office and reported that she wanted to get off Klonopin. She had been taking

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<sup>34</sup> Approved for the treatment of high blood pressure, but has been found useful in the treatment of opiate withdrawal.

Klonopin and Remeron, and had been off of methadone for approximately one month.

79. In September 2008, Patient 5 was hospitalized for a diagnosis of presumed ehrlichiosis (an infectious disease caused by a tick bite). The hospital records stated that Patient 5 told her health care providers she had been on Suboxone<sup>35</sup> for a previous methadone addiction and they recommended her dosage be decreased from 8 mg. to 4 mg. The discharge summary also included the name of Patient 5's physician who managed her substance abuse (a "Dr. H."). The Respondent received a copy of the discharge summary.
80. Several months later, on December 11, 2008, Patient 5 telephoned to request that her prescription for Klonopin be moved to another pharmacy. The Respondent documented that her current pharmacy (Pharmacy B) would not fill the prescription as "she has been taking too much." He documented that Patient 5 was "properly repentant" and refilled her prescription for clonazepam.
81. Pharmacy records from Pharmacy A show that the Respondent prescribed Suboxone to Patient 5 on January 19, 2009.<sup>36</sup> He did not however, document this prescription in her medical record. Patient 5 had been regularly prescribed Suboxone by a different provider (Dr. H).

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<sup>35</sup> Used in the treatment of opiate addiction.

<sup>36</sup> In order to prescribe Suboxone for opiate addiction, a physician must be authorized by the Substance Abuse & Mental Health Services Administration of the U.S. Department of Health and Human Services.

82. Pharmacy records from Pharmacy A show that the Respondent prescribed clonazepam on January 7, 2009, and continued to prescribe clonazepam to Patient 5 while she received Suboxone. He also continued prescribing Clonidine and began prescribing Zoloff<sup>37</sup> for her to take in the "p.m."
83. The Respondent refilled Patient 5's prescriptions for clonazepam (and Imitrex and Zoloff)<sup>38</sup> several times without evaluating her. Between January 7, 2009 and September 29, 2009, he provided her with 17 refills of clonazepam.
84. The Respondent inappropriately treated Patient 5 with methadone maintenance for heroin addiction while documenting that he had been prescribing the methadone for back pain.
85. The Respondent failed to acknowledge and/or was unaware of relevant drug interactions including but not limited to his prescriptions for Phenergan and Donnato; and Suboxone in conjunction with benzodiazepines.
86. Despite Patient 5's history, the Respondent failed to conduct any urine toxicology screenings or to closely monitor her refills or conduct any pill counts, and failed to make appropriate referrals for drug treatment counseling. Additionally, there is no documentation that the Respondent required Patient 5 to disclose her other possible providers of CDS.
87. The Respondent's histories, assessments and plans for Patient 5 were consistently inadequate.

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<sup>37</sup> Used in the treatment of depression.

<sup>38</sup> Imitrex, used in the treatment of migraine headaches, has a potentially dangerous interaction with Zoloff, which is another serotonin modifying medication.

88. The Respondent's actions as outlined in pertinent part above, failed to meet the standard of quality medical care for Patient 5 in violation of Health Occ. § 14-404(a)(22).

#### PATIENT 6

89. Patient 6, a female, D.O.B. 1972, had a medical history of fibromyalgia, peripheral neuropathy, cervical disc disease, a double mastectomy with reconstruction, and a motor vehicle accident ("MVA") in June 2009 that caused a fractured thumb and humerus, complicated with an MRSA<sup>39</sup> infection of her knee. Her mental health history included post-traumatic stress disorder, a generalized anxiety disorder and possible bipolar disorder. Additionally, the Respondent documented in his summary of care provided to the Board that Patient 6 had "probable opioid dependency." The hospital records reviewed reflect that Patient 6 was homeless.
90. The Respondent saw Patient 6 beginning in February 2009, through a mobile clinic (not his private office), which was an outreach program for patients without insurance. Prior to receiving care from the Respondent, Patient 6 had received prescriptions for oxycontin 80 mg. twice daily and Percocet 10/325.<sup>40</sup>
91. The Respondent consistently prescribed opiates and a benzodiazepine (Xanax) to Patient 6 through October 2009.

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<sup>39</sup> MRSA stands for Methicillin-resistant staphylococcus aureus.

<sup>40</sup> Both are Schedule II CDS. Percocet is the brand name for oxycodone and acetaminophen.

92. The Respondent documented two progress notes for Patient 6 dated June 1, 2009. On the initial note,<sup>41</sup> there is a notation "July ?" at the top of the page. Patient 6 presented with nausea, vomiting, weight loss and a clogged ear. The Respondent prescribed Tylenol #4<sup>42</sup> with three refills, Soma, Xanax (1 mg.) and Phenergan along with Sudafed and an antibiotic. In the Respondent's second progress note dated June 1, 2009,<sup>43</sup> he discontinued Patient 6's Tylenol #4 and increased her Xanax to 2 mg. three times daily (without explanation) with three refills. He noted she complained of pain of her left thorax, but failed to adequately document any physical findings other than "lungs clear."
93. On June 29, 2009, Patient 6 presented with injuries she had sustained two weeks prior in a motor vehicle accident including a broken thumb and humerus and a knee injury. The Respondent prescribed 60 tablets of oxycodone IR<sup>44</sup> (30 mg.).
94. On August 3, 2009, Patient 6 presented with knee pain (and reportedly had an MRSA wound infection). The Respondent prescribed 100 additional tablets of oxycodone for Patient 6 and another prescription for Xanax with three refills, as she had reportedly relocated to St. Mary's County, from Anne Arundel County.

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<sup>41</sup> Bate stamped page 13933, in Patient 6's medical record provided to the peer reviewers.

<sup>42</sup> Schedule III CDS.

<sup>43</sup> Bate stamped page 13934.

<sup>44</sup> IR stands for immediate release.

95. On August 17, 2009, the Respondent prescribed oxycodone (100 tablets) and Xanax with two refills, but documented that he was canceling further medication refills at Pharmacy B.
96. On August 31, 2009, Patient 6 requested Paxil<sup>45</sup> and Xanax. The Respondent prescribed 60 additional tablets of oxycodone. He noted Patient 6 had left shoulder pain on the elevation of her arm.
97. One month later, on September 28, 2009, following Patient 6's hospitalization for renal failure and rhabdomyolysis,<sup>46</sup> the Respondent continued prescribing opiates (Dilaudid 2 mg., 100 tablets) and Xanax (decreased to 1 mg.).
98. One week later, on October 5, 2009, the Respondent noted that Patient 6 had "excruciating pain" of her legs and flank, and prescribed 100 oxycodone 15 mg tablets as Patient 6 said the Dilaudid was not helping, and additional Xanax (back up to 2 mg.) with one refill. The Respondent documented "last time" next to the oxycodone prescription.
99. On October 11, 2009, Patient 6 was seen in the E.R. at Hospital A with leg pain, and listed her medications as including oxycodone, oxycontin, Xanax and Soma. Her father had counted 90 tablets of Xanax the night before, and Patient 6 only had 50 remaining. Her urine toxicology screen tested positive for benzodiazepines and cannabis, but negative for opioids. She was discharged on Dilaudid prn.

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<sup>45</sup> Used in the treatment of depression and anxiety disorders, including panic disorders.

<sup>46</sup> Breakdown of muscle fibers into the bloodstream.

100. On October 12, 2009, the Respondent saw Patient 6 who continued to complain of leg pain. Despite his disclaimer of October 5, 2009, he provided Patient 6 with another prescription for 15 mg. oxycodone (100 tablets). In the margin of the progress note, he documented:

Pt. was told that we will slowly decrease her oxycodone. There will be no more 15 mg. and 30 mg. oxycodone.

The Respondent also prescribed gabapentin to Patient 6, which is approved as an anticonvulsant and for pain due to neuropathy, but has been used to attenuate the severity of withdrawal symptoms experienced by those physically dependent on opioid analgesics. He failed to mention however, that Patient 6's toxicology screen from her Emergency Department admission had tested negative for opiates.

101. One week later, on October 19, 2009, the Respondent again prescribed oxycodone to Patient 6 (100 tablets of 15 mg.), noting she may need x-rays of the right hip and spine. He continued the gabapentin as well. He failed to document her source of pain. His assessment was "neuropathy."

102. The Respondent failed to elicit an adequate pain history (including a history of or potential for substance abuse) initially or when continuing to prescribe opiates to Patient 6.

103. The Respondent failed to document a pain management plan for Patient 6 when initiating and continuing to prescribe opiates.

104. The Respondent failed to conduct an adequate pain evaluation and/or diagnosis when initiating and continuing to prescribe opiates.

105. The Respondent failed to consider treating Patient 6 with non-addicting medications and other means of pain management.
106. The Respondent initiated and continued to prescribe Xanax to Patient 6 from February through October 2009, without conducting an adequate evaluation of Patient 6's anxiety, and failed to refer her for a psychiatric evaluation.
107. The Respondent failed to order or conduct any urine toxicology screening<sup>47</sup> despite signs of diversion including Patient 6's frequent requests for opiates and benzodiazepines and the documentation of missing Xanax from her hospital record.
108. Despite signs of diversion, the Respondent continued to prescribe oxycodone to Patient 6, the prescriptions were often too frequent and he failed to refer Patient 6 for drug treatment and counseling.
109. The Respondent failed to obtain prior medical records for Patient 6 substantiating her diagnostic and medication history.
110. For reasons outlined in pertinent part above with regard to Patient 6, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

#### **PATIENT 7**

111. Patient 7, a female, D.O.B. 1983, was seen by the Respondent through the mobile clinic from November 2008 through August 2009. Her medical

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<sup>47</sup> The sole urine toxicology screen was conducted during Patient 6's October 11, 2009, hospitalization.

history included supraventricular tachycardia (abnormally rapid heart rate), rhabdomyosarcoma<sup>48</sup> and degenerative disc disease. She had a mental health history that included an anxiety disorder.

112. The Respondent prescribed to her several medications including Soma, Xanax 1 mg. and hydrocodone 7.5 mg. (through June 2009).
113. On November 3, 2008, during her initial visit with the Respondent, Patient 7 presented for medication refills. The Respondent listed her medications as including:

Prednisone, lorazepam, Neurontin, ranitidine (used in the treatment of ulcers), Soma, Tylenol #3 and Albuterol inhaler.
114. On November 17, 2008, the Respondent documented “?allergic to Tylenol #3” and noted that “Ultram doesn’t help.” He prescribed hydrocodone 7.5/500 (100 tablets) with two refills.
115. On December 8, 2008, the Respondent documented that he had prescribed hydrocodone and had provided Patient 7 with two additional refills, but had cancelled the hydrocodone refills from Pharmacy C.
116. On December 15, 2008, the Respondent again refilled Patient 7’s prescriptions for hydrocodone (with three refills), and again documented that he had contacted Pharmacy C to cancel the “prior refills.”
117. On February 2, 200[9],<sup>49</sup> Patient 7 was evaluated by the Respondent. She had several complaints including a headache and bright red rectal bleeding. He found she had a reddened pharynx and some rhonchi in her

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<sup>48</sup> A rare malignancy of the soft tissue found most often in children.

<sup>49</sup> The progress note is dated 2008, however, based on the context and placement in the record, it was likely intended to read 2009.

lungs. He failed to address the rectal bleeding. The Respondent prescribed Xanax with three refills as well as an antibiotic.

118. On February 3, 2009, Patient 7 telephoned the mobile clinic stating she needed a refill of Soma and had been nauseated when taking her hydrocodone. The Respondent authorized a refill for Soma (120 tablets) and advised Patient 7 to eat before taking her pain medication.
119. A few days later, on February 16, 2009, the Respondent documented that Patient 7 had a pinpoint rash on her feet. He prescribed a lotion for her as well as 120 tablets of hydrocodone 7.5/650 with three refills.
120. On March 30, 2009, Patient 7 presented with a leg rash. The Respondent provided her with a refill of 100 tablets of hydrocodone 7.5/325.
121. On April 13, 2009, the Respondent documented that he prescribed 120 tablets of Xanax with three refills.
122. On August 24, 2009, Patient 7 presented with intermittent back pain, insomnia and anxiety. The Respondent failed to record any assessment. He refilled her Xanax, and prescribed ibuprofen and Tramadol.
123. The Respondent consistently prescribed Xanax for Patient 7 without documenting any evaluation for anxiety.
124. The Respondent failed to document an appropriate history of Patient 7's pain including any substance abuse history.
125. The Respondent failed to document and/or conduct an adequate evaluation relating to Patient 7's pain.

126. The Respondent failed to document a pain management plan for Patient 7.
127. The Respondent failed to document any periodic evaluation of the efficacy of the prescribed pain medication.
128. The Respondent failed to conduct any urine toxicology screening to confirm Patient 7 had been taking the prescribed medication and to check for any illicit drugs.
129. For reasons outlined in pertinent part above with regard to Patient 7, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

#### **PATIENT 8**

130. Patient 8, a male, D.O.B. 1981, was seen by the Respondent at the mobile clinic with a self-reported past history including a generalized anxiety disorder ("GAD"), COPD, a possible mood disorder, panic attacks and degenerative disc disease (cervical and lumbar). He initially saw the Respondent on November 3, 2008, and the records reviewed continued through August, 2009.
131. During Patient 8's initial visit on November 3, 2008, he presented with anxiety and panic attacks and the Respondent prescribed Xanax three times daily with three refills.
132. On November 21, 2009, Patient 8 telephoned the office requesting an early refill of Xanax. The provider (not the Respondent) told Patient 8 that

if he was unable to wait until November 24<sup>th</sup>, he should go to the Emergency Room ("ER").

133. On December 1, 2009, Patient 8 returned with complaints of pain in his neck, left arm, left leg and back. The Respondent refilled his Xanax and provided him with three additional refills, along with a prescription for Tylenol #3 with three refills.
134. The Respondent continually prescribed Xanax through at least August 17, 2009<sup>50</sup> for Patient 8's "GAD" with panic attacks.
135. On April 6, 2009, besides the Xanax prescriptions, the Respondent began prescribing Soma 350 mg (120 tablets), with four refills. He continued prescribing Soma through at least August 17, 2009, when he provided Patient 8 with three additional refills.
136. Pharmacy records from Pharmacies A, B and C reflect that Patient 8 had his prescriptions issued by the Respondent for Xanax and Soma filled as follows:

Date Prescription Filled	Pharmacy A	Pharmacy B	Pharmacy C
1/12/09		Xanax 1 mg. (#90)	
1/26/09		Xanax 1 mg. (#120)	
2/16/09		Xanax 1 mg. (#120)	
3/12/09		Xanax 1 mg. (#120)	
3/31/09		Xanax 1 mg. (#120)	
4/6/09	Xanax 1 mg. (#120)		
4/11/09	Soma 350 mg. (#120)		
4/23/09	Xanax 1 mg. (#120)		
4/27/09		Xanax 2 mg. (#60)	
5/5/09	Soma 350 mg. (#120)		
5/13/09	Xanax 1 mg. (#120)		

<sup>50</sup> On this final date, the Respondent provided three refills.

5/20/09		Xanax 2 mg. (#60)	
5/26/09	Xanax 1 mg. (#120)		
5/27/09			Xanax 1 mg. (#120)
6/2/09	Soma 350 mg. (#120)		
6/10/09	Xanax 1 mg. (#120)		
6/13/09		Xanax 2 mg. (#90)	
6/21/09			Xanax 1 mg. (#120)
6/25/09	Soma 350 mg. (#120)		
7/8/09		Xanax 2 mg. (#90)	
7/16/08			Xanax 1 mg. (#120)
7/18/09	Soma 350 mg. (#120)		
8/4/09		Xanax 2 mg. (#90)	
9/04/09			Xanax 1 mg. (#120) <sup>51</sup>
9/28/09			Xanax 1 mg. (#120)
10/17/09			Xanax 1 mg. (#120)

137. The Respondent consistently failed to conduct and/or document an adequate history or evaluation relating to Patient 8's diagnosis of GAD with panic attacks.<sup>52</sup>
138. The Respondent provided Patient 8 with multiple refills and early refills of the Xanax and/or Soma.
139. The Respondent failed to consider treatment with non-CDS medications including SSRI's, Buspar,<sup>53</sup> a referral for cognitive behavioral therapy or other non-habit forming treatments.
140. The Respondent prescribed Soma without an adequately documented medical indication.
141. The Respondent failed to adequately document a plan of care for Patient 8 other than to refill his medications.

<sup>51</sup> Was picked up on 9/5/09.

<sup>52</sup> During Patient 8's initial visit, he recommended a psychiatric evaluation, however, there is no evidence in the record that this was conducted.

<sup>53</sup> Used in the treatment of anxiety disorders.

142. The Respondent failed to conduct any urine toxicology screening to confirm that Patient 8 had been taking the prescribed medication and to check for any illicit drugs.
143. The Respondent failed to obtain any other treatment records for Patient 8 to assist in establishing that he was the sole prescriber of Soma and Xanax.
144. For reasons outlined in pertinent part above with regard to Patient 8, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

#### **PATIENT 9**

145. Patient 9, a male, D.O.B. 1954, had a history of multiple failed back surgeries (following a 1987 MVA), chronic skeletal pain, diabetes, coronary artery disease and cardiomyopathy, hypogonadism, neuropathy, daytime drowsiness and depression. He was on multiple medications including lovastatin,<sup>54</sup> Coreg,<sup>55</sup> amitriptyline,<sup>56</sup> metformin,<sup>57</sup> depo-testosterone,<sup>58</sup> paroxetine,<sup>59</sup> glipzide<sup>60</sup> and Baclofen.<sup>61</sup> The Respondent also prescribed regular CDS prescriptions to Patient 9 including Dilaudid, methylphenidate (a Schedule II stimulant with the brand name Ritalin), Xanax and temazepam.

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<sup>54</sup> Used in the treatment of high cholesterol.

<sup>55</sup> Used in the treatment of heart failure.

<sup>56</sup> Used in the treatment of neuropathy.

<sup>57</sup> Used in the treatment of Type II diabetes.

<sup>58</sup> Used for hormone replacement.

<sup>59</sup> Used in the treatment of depression and anxiety disorders.

<sup>60</sup> Used in the treatment of Type II diabetes.

<sup>61</sup> A muscle relaxant.

146. Patient 9 began seeing the Respondent during the late 1990's. Through approximately October 2001, the Respondent regularly prescribed a Duragesic patch<sup>62</sup> to Patient 9 along with Dilaudid, but at the patient's request on October 8, 2001 due to financial considerations, he requested the Duragesic patch be discontinued and his Dilaudid dosage be increased.
147. The Respondent continually prescribed methylphenidate to Patient 9 for "chronic fatigue syndrome." On February 25, 2009, the Respondent increased the dosage as Patient 9 was having a "lot of drowsiness during the day and wishes to increase his Ritalin..." The Respondent increased the dosage to 10 mg. five times daily (two in the morning, two at noon and one in the late afternoon).
148. For several years, through October 2009, along with his other medications, the Respondent prescribed the following CDS regularly to Patient 9: Dilaudid, methylphenidate and Xanax, often by telephone.
149. The Respondent also frequently prescribed antibiotics over the telephone (without any face to face evaluation) at Patient 9's request, for complaints of upper respiratory infections. For example on January 25, 2006, the Respondent prescribed Doxycycline for Patient 9's complaint of a cold; on November 6, 2006, the Respondent telephoned in a Z-pack when Patient 9 called with complaints of a cough and sore throat; on December 6, 2007 and January 29, 2008, the Respondent prescribed antibiotics for Patient 9's complaints over the telephone of sinus infections; and on November 5,

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<sup>62</sup> Schedule II CDS.

2008, he prescribed an antibiotic for Patient 9's complaints of "yellow green mucus" he had had for ten days.

150. Patient 9's medical record contains multiple notes directed to the Respondent from Patient 9, some of which are dated, and some un-dated. The notes include a list of medications complete with specific dosages including CDS and non-CDS, in which Patient 9 requests specific refills and asks for medication changes.
151. Patient 9's medical record includes infrequent documentation of relevant laboratory results despite his history of diabetes, lipids and prescriptions for depo-testosterone.
152. The Respondent failed to elicit an adequate pain history (including obtaining a substance abuse history) or assessment initially or on an ongoing basis.
153. The Respondent failed to document an adequate pain management plan.
154. The Respondent consistently failed to document any periodic assessments of Patient 9's pain control. He frequently refilled his medications by telephone, at the patient's request.
155. The Respondent failed to consider any other treatment modalities for pain management other than opioids.<sup>63</sup>
156. The Respondent failed to conduct any urine toxicology screens or conduct any other monitoring for possible diversion and/or to ensure Patient 9 had been taking the prescribed medications and no illegal substances.

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<sup>63</sup> He did prescribe Ibuprofen and Baclofen to Patient 9, but these were always in conjunction with opioids.

157. The Respondent failed to document and/or conduct an adequate assessment prior to and during his prescription of methylphenidate to Patient 9. The Respondent failed to have Patient 9 evaluated for sleep apnea.
158. The Respondent frequently prescribed antibiotics over the telephone without a face to face evaluation of Patient 9.
159. For reasons outlined in pertinent part above with regard to Patient 9, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

#### **PATIENT 10**

160. Patient 10, a female, D.O.B. 1980, with a self-reported history of scoliosis, a bipolar mood disorder, degenerative disc disease and left lower extremity neuropathy. She also sustained self-reported neck and back pain following an MVA in June 2009.
161. The Respondent provided care to Patient 10 through the mobile clinic beginning on May 4, 2009.<sup>64</sup> The records reviewed for Patient 10, reflected care rendered by the Respondent through September 2009.
162. Throughout the Respondent's care of Patient 10, besides other medications such as Abilify for her bipolar disorder, he prescribed CDS to her including Tylenol #3 and #4, Vicodin and Xanax (for insomnia and anxiety).

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<sup>64</sup> Patient 10 had been seen previous to this by other providers in the Respondent's private practice.

163. The Respondent failed to conduct an adequate functional or neurological assessment of Patient 10 prior to or while he continued to prescribe CDS to her. Several of the Respondent's progress notes failed to document an assessment or diagnosis for Patient 10. In several of the Respondent's progress notes, the "plan" for Patient 10 is limited to a list of medications.
164. There was inadequate documentation to support the necessity of prescribing continual CDS to Patient 10 for pain control. There was no documentation that the Respondent had tried any non-CDS pain management alternatives including NSAID's.
165. The Respondent continued to prescribe CDS to Patient 10 in increasing dosages without evidence of need and despite records from emergency departments documenting drug-seeking behavior. An example of this occurred on June 7, 2009, during Patient 10's visit to Hospital B's ER following her MVA. Her radiology studies were normal. The staff suspected her of factitious pain when she alternated between no apparent distress and screaming and crying in pain. Additionally, she became very abusive to the ER staff when she was told she would not be discharged with opioids.
166. One day later, on June 8, 2009, the Respondent prescribed 100 tablets of Vicodin to Patient 10 with three refills. The next month, on July 6, 2009, he prescribed 120 additional tablets of Vicodin with a prescription for 100 Soma with three refills.

167. Less than three weeks later, Patient 10 presented with a possible spider bite on her buttocks. The Respondent prescribed an antibiotic (to which she had a reaction) and Tylenol #4 with three refills. One month later, on August 17, 2009, Patient 10 returned with the "painful" lesion on her buttocks and the Respondent provided her with 120 tablets of Vicodin with one refill.
168. On August 31, 2009, Patient 10 returned stating the spider bite was still present; the Respondent documented, "Improved, but..." and prescribed 100 tablets of hydrocodone 10/650 with a refill.
169. On September 28, 2009, Pharmacy B would not honor the refill, so the Respondent telephoned in another 100 tablets with a refill.
170. During a follow-up visit (undated), Patient 10 complained of her left foot tingling and her leg giving out. The Respondent ordered a CT of the cervical spine<sup>65</sup> and refilled her prescription for hydrocodone with APAP 10/650 (100 tablets with one refill). He also prescribed gabapentin.
171. The Respondent failed to conduct any urine toxicology screens or conduct any other monitoring for possible diversion and/or to ensure Patient 9 had been taking the prescribed medications and no illegal substances. The Respondent failed to address the diversion concerns raised by the ER notes from June 2009, although they were made part of Patient 10's office records.
172. The Respondent continued to prescribe Xanax without an appropriate evaluation for insomnia and anxiety.

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<sup>65</sup> September 25, 2009 MRI's of the cervical and lumbar spine showed only mild changes.

173. Despite her self-reported psychiatric history, the Respondent failed to refer Patient 10 for a psychiatric evaluation including an evaluation of substance abuse.<sup>66</sup>
174. The Respondent failed to document a pain management plan.
175. The Respondent consistently failed to elicit an adequate history relating to Patient 10's complaints of pain.
176. The Respondent failed to attempt to obtain Patient 10's medical records from other providers, or acknowledge in his progress notes that he had reviewed Patient 10's ER record from Hospital B.
177. For reasons outlined in pertinent part above with regard to Patient 10, the Respondent failed to meet the standard of quality medical care in violation of Health Occ. § 14-404(a)(22) and/or his documentation was inadequate in violation of Health Occ. § 14-404(a)(40).

#### **NOTICE OF POSSIBLE SANCTIONS**

If, after a hearing, the Board finds that there are grounds for action under Md. Health Occ. Code Ann. § 14-404(a)(22) and/or (40) the Board may impose disciplinary sanctions against the Respondent's license, including reprimand, suspension or revocation and/or impose a fine.

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<sup>66</sup> In his Summary of Care provided to the Board on October 22, 2009, the Respondent noted that he had referred her to a treatment program. Pharmacy B's records reflect however, that the Respondent provided Patient 10 with an additional prescription for hydrocodone with APAP she had filled on October 28, 2009, and a prescription for oxazepam that was filled on November 12, 2009.

**NOTICE OF CASE RESOLUTION CONFERENCE**

A Case Resolution Conference in this matter is scheduled for **Wednesday, May 4, 2011, at 10:00 a.m.** the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The nature and purpose of the case resolution conference is described in the attached letter to the Respondent. If this matter is not resolved on terms accepted by the Board, an evidentiary hearing will be scheduled.

5/31/11  
Date

  
\_\_\_\_\_  
John T. Papavasiliou, Deputy Director  
Maryland State Board of Physicians