IN THE MATTER OF	*	**BEFORE THE**
THOMAS DOOLEY, M.D.	*	**MARYLAND STATE**
Respondent.	*	**BOARD OF PHYSICIANS**
License Number D16458	*	**Case Number 2013-0971**

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FINAL DECISION AND ORDER

INTRODUCTION

On September 12, 2014, Thomas Dooley, M.D. ("Dr. Dooley"), a general practitioner, was charged with failure to meet appropriate standards for the delivery of quality medical care under the Maryland Medical Practice Act. *See* MD. CODE ANN., HEALTH OCC. ("Health Occ.") § 14-404(a)(22). Specifically, the charges were based on complaints concerning Dr. Dooley's prescribing of opioids and his overall approach to the practice of pain medicine.

Prior to charging Dr. Dooley in this case, the Maryland State Board of Physicians ("Board") issued subpoenas to Dr. Dooley, requesting the complete medical records for twelve of his patients. The Board also requested that Dr. Dooley provide summaries of care for each patient and a response to the allegations in the complaints. Dr. Dooley responded to the Board's request and certified, on September 20, 2013, that he provided the complete medical records for each of the patients. In January of 2014, the Board sent the medical records, patient summaries, and Dr. Dooley's response to two board-certified pain medicine physicians for peer review. The peer reviewers agreed that Dr. Dooley failed to meet the standards for the delivery of quality medical care for ten out of the twelve patients reviewed. Dr. Dooley was provided the peer review reports and he filed a response with the Board. After consideration of the Board's

investigatory file, the documentation provided by Dr. Dooley, the peer reviews, and Dr. Dooley's response, a disciplinary panel of the Board voted to charge Dr. Dooley in this case.

The case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing and a proposed decision. At the hearing, the State presented testimony from Thelma Wright, M.D. ("Dr. Wright"), one of the Board-certified peer reviewers, who was qualified as an expert in pain medicine.[1] Dr. Dooley did not object to Dr. Wright being qualified as an expert and, in fact, stated that he was "honored Dr. Wright has taken the time to read [his] charts." Dr. Dooley cross-examined each of the State's witnesses and testified at length on his own behalf, but he did not present any other witnesses, expert or otherwise.[2] The State submitted the medical records and patient summaries that Dr. Dooley provided to the Board, and Dr. Dooley's responses to the complaints and the peer reviews, which were admitted into evidence by the Administrative Law Judge ("ALJ").

After a three day hearing at OAH, the ALJ issued a proposed decision on July 2, 2015, concluding that Dr. Dooley failed to meet appropriate standards as determined by peer review for the delivery of quality medical care for ten patients, Patients A-J, in violation of Health Occ. § 14-404(a)(22). In doing so, the ALJ proposed that the charges be upheld and recommended a one-year suspension followed by three years of probation with conditions to be determined by a Board disciplinary panel. The ALJ also proposed that Dr. Dooley permanently terminate his pain management practice and that he be prohibited from prescribing opioid medications.

[1] Dr. Wright is the Medical Director of the Pain Management Center and the Director of the Pain Fellowship Program at the University of Maryland.

[2] Dr. Dooley was represented by counsel during pre-hearing proceedings before the Board, but chose to represent himself at the OAH hearing.

On July 24, 2015, Dr. Dooley filed exceptions to the ALJ's proposed decision and the State filed a response to Dr. Dooley's exceptions. Both parties appeared before Board Disciplinary Panel B ("Panel B") for an oral exceptions hearing.[3]

FINDINGS OF FACT

Panel B adopts the facts stipulated to by the parties and the ALJ's proposed findings of fact numbers 1-111. *See* ALJ proposed decision, attached as **Exhibit A**. These facts are incorporated by reference into the body of this document as if set forth in full, with the modifications set forth below, pursuant to Panel B's authority under Section 10-216(b) of the State Government Article.[4] Dr. Dooley does not specifically challenge any of the ALJ's proposed findings of fact in his exceptions, thus the facts are largely undisputed. The factual findings were proved by a preponderance of the evidence.

Panel B also adopts the ALJ's discussion set forth on pages 23-42 of the proposed decision, with the modifications below.[5]

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[3] Dr. Dooley was represented by counsel at the exceptions stage of the proceedings.

[4] On page 12, Panel B modifies finding of fact 25 to reflect that Patient A was initially seen by the nurse practitioner, not Dr. Dooley, and finding of fact 26 to reflect that the x-rays were ordered on October 29, 2012. On page 16, Panel B does not adopt finding of fact 55 and modifies the language in finding of fact 58 to reflect that the prescribing information from Patient D's previous physician was documented in a letter from two years prior, dated April 12, 2011. On page 17, Panel B modifies finding of fact 59 to reflect that Patient D was referred for emergency surgery on April 23, 2013, corrects the dosage information in finding of fact 62 to 30 mg of Oxycodone and 80 mg of Oxycontin, and modifies the months listed in finding of fact 63 to April, June, and July 2013. On page 18 in finding of fact 68, the Panel clarifies that Patient E was referred for chiropractic treatment and initially prescribed Oxycodone by other practitioners at XpressMedCare, as Patient E was first seen by Dr. Dooley on October 3, 2012. Panel B modifies the date in finding of fact 71 to April 25, 2013 based on what is documented in the medical records and clarifies in finding of fact 72 that Patient E saw Dr. Sani, another doctor at XpressMedCare, on May 17, 2013. Panel B changes the date in findings of fact 91 and 92 to January 28, 2013 to match what is reflected in the medical records.

[5] On page 25, Panel B modifies footnote 5 to reflect that the State has the burden of proving the standard of care. On Page 27, Panel B clarifies that Patient A's initial visit to XpressMedCare was on October 19, 2012, but his first appointment with Dr. Dooley was on October 23, 2012. On page 32, Panel B modifies the months that Patient D received early prescription refills to April, June, and July of 2013. On page 33, Panel B clarifies that Patient E was not seen by Dr. Dooley on May 17, 2013.

The Panel has also reviewed and considered additional exhibits proffered by Dr. Dooley. As explained on pages 5-12, these exhibits do not alter Panel B's findings in this case.

Dr. Dooley conceded at the exceptions hearing that he is not equipped to handle pain management and stated that, as a result, he will not return to practicing pain management. Panel B agrees that Dr. Dooley is not equipped to practice pain medicine.

There was a consistent pattern of substandard care throughout Dr. Dooley's treatment of Patients A-J. Dr. Dooley identified himself to Patients A-J as a pain management specialist, despite the fact that he only had 19 hours of pain management training and was not Board certified in pain medicine. Dr. Dooley ignored or was oblivious to major red flags, such as patients requesting early prescription refills and reporting that prescriptions had been stolen. Dr. Dooley did not conduct random urine toxicology screens or engage in random pill counting for any of the ten patients and did not independently verify the medications the patients were taking when they entered the practice. Dr. Dooley, for the most part, treated his chronic pain patients using only short acting opioids without ever transitioning them to long acting opioids with short acting opioids, as needed, for breakthrough pain. Dr. Dooley failed to utilize other treatment options and, in many instances, failed to utilize non-opioid medications. Dr. Dooley's chart notes were largely repetitive across patient visits, had numerous typographical errors, and, in many cases, lacked sufficient objective supporting documentation to support the patients' subjective complaints of pain.

EXCEPTIONS

Dr. Dooley contends that the Panel should decline to adopt the ALJ's proposed decision because the ALJ impermissibly excluded several of his exhibits, which violated his statutory and

constitutional rights to due process. Dr. Dooley also takes exception to the sanction proposed by the ALJ.

I. Exclusion of Exhibits by the ALJ

On March 13, 2015, in accordance with the ALJ's amended scheduling order, Dr. Dooley submitted 21 exhibits to the administrative prosecutor and ALJ. At issue before the Panel are Dr. Dooley's Exhibit 1 (paragraphs 17-122) and his Exhibits 2 through 11. Dr. Dooley's Exhibit 1 was a copy of the charging document with his response beneath each allegation and Exhibits 2 through 11 contained the medical records and new patient summaries for Patients A-J.[6] In response, the administrative prosecutor filed a Motion *in Limine* to Exclude Newly Proposed Documentary Evidence based, in part, on COMAR 10.32.02.04C. This regulation pertains solely to standard of care cases and requires that, no later than 45 days after the issuance of charges, the respondent notify the administrative prosecutor of certain patient statements, consultations with other providers, and communications with family members that affected the patient's course of treatment and are not recorded in the patient's medical record. If the required notice from the respondent is not provided, any evidence described in the regulation must be excluded. COMAR 10.32.02.04C(2)(d).

Before the ALJ, the administrative prosecutor argued that the exhibits, presented by Dr. Dooley long after 45 days from the issuance of charges in September, 2014, must be excluded because they contained statements within the scope of this regulation. She also argued that the Administrative Procedure Act permits the exclusion of "evidence that is incompetent, irrelevant, immaterial or unduly repetitious." *See* Md. Code Ann., State Gov't § 10-213(d). Dr. Dooley submitted a letter in response acknowledging that he failed to comply with the regulation, but

[6] The medical records were, for the most part, the same as the records already produced by the State and entered into evidence by the ALJ. As discussed below, there were several additional records that were included in Dr. Dooley's exhibits, but not in the State's exhibits.

asked the ALJ to allow the evidence because his poor health, at the time, prevented him from complying. The ALJ acknowledged Dr. Dooley's health condition, but recognized that he was "precluded from taking that factor into consideration in determining whether certain proposed exhibits should be excluded from the evidence in this case." The ALJ determined that the exclusion of any exhibits described in the regulation was mandatory, pursuant to COMAR 10.32.02.04C(2)(d). Accordingly, the ALJ granted the State's motion, in part, and excluded paragraphs 17 to 122 of Exhibit 1 and Exhibits 2 through 11, to the extent they were different from the medical records and exhibits produced by the State.

Dr. Dooley takes exception to the ALJ's decision to exclude paragraphs 17 to 122 [7] of his Exhibit 1 and his Exhibits 2 through 11.[8] Dr. Dooley argues that the ALJ abused his discretion by applying COMAR 10.32.02.04C(2) in an overbroad manner, and further, argues that the ALJ should have admitted the exhibits and redacted any statements within the scope of COMAR 10.32.02.04C(2), rather than excluding the exhibits as a whole.

The ALJ correctly determined that COMAR 10.32.02.04C is mandatory and that any evidence within the scope of the regulation must be excluded if proper notice was not provided within 45 days of the issuance of charges. Based on COMAR 10.32.02.04C, the ALJ excluded the exhibits outright and did not exercise discretion under State Gov't § 10-213(d) to exclude any "incompetent, irrelevant, immaterial or unduly repetitious" evidence in Dr. Dooley's additional exhibits. Both parties acknowledge, however, that Dr. Dooley's Exhibits 2-11 contained the same medical records for Patients A-J that were produced by the State and admitted into evidence by the ALJ. Thus, the ALJ mistakenly concluded that all of Dr. Dooley's exhibits fell

[7] The ALJ's proposed decision states that he excluded paragraphs 17 to 22 of Dr. Dooley's Exhibit 1. Both parties, however, agree that this was a typographical error and that the ALJ, in actuality, excluded paragraphs 17-122.

[8] The exhibits excluded by the ALJ were attached as an appendix to Dr. Dooley's exceptions.

within the scope of this regulation. Dr. Dooley asks the Panel to at least consider the exhibits, even if consideration does not change the outcome. The Panel grants Dr. Dooley's exception and will accept and consider Dr. Dooley's Exhibits 1 - 11 pursuant to COMAR 10.32.02.05B(3)(b)(ii).[9]

II. Consideration of Exhibits

Dr. Dooley argues that "the ALJ erred in excluding ten of [his] most important exhibits from evidence"[10] and that the exclusion of these exhibits "caused unfair and untrue findings." The Panel rejects Dr. Dooley's arguments. Dr. Dooley never took the time to isolate the additional patient records and responses or explanations from the State's exhibits admitted by the ALJ. Panel B has painstakingly compared Dr. Dooley's exhibits to the State's exhibits that were admitted and has isolated the few additional documents that have not already been admitted. The additional evidence consists of Dr. Dooley's paragraph by paragraph response to the charging document, new patient summaries, and medical records for Patients A-J.

Responses to the Charging Document and New Patient Summaries

Dr. Dooley's responses to the charging document repeat information from the medical records that he originally submitted to the Board. At the evidentiary hearing, Dr. Dooley was granted, and availed of, the opportunity to fully address these responses in his testimony. Dr. Dooley's new patient summaries also repeat information from his original patient summaries and information already included in the medical records. In addition, Dr. Dooley testified before the ALJ in great detail regarding his care and treatment for each of the ten patients. He provided

[9] COMAR 10.32.02.05B(3)(b)(ii) provides: "At the oral exceptions hearing, the disciplinary panel may not accept additional evidence unless: . . . (b) The disciplinary panel determines that either: . . . (ii) The evidence has been timely proffered before the administrative law judge and the administrative law judge abused his or her discretion in refusing to admit the evidence."

[10] Dr. Dooley's Exhibits 1-11 were identified in his Exceptions Appendix and, therefore, Panel B assumes that Dr. Dooley refers to the ALJ's exclusion of all eleven exhibits.

justification for his treatment plans and prescribing, described his care of each patient, and gave explanations for why he believed his treatment met the standard of care. The information in Dr. Dooley's responses and new patient summaries, therefore, was considered by the ALJ at the OAH hearing.

Further, neither at the OAH hearing nor at the exceptions hearing did Dr. Dooley articulate how any of this additional evidence affected the standard of care determination. It does not. Dr. Dooley's responses to the charging document and the new patient summaries contain no information that mitigates the serious deficiencies in his care and treatment of these patients. The Panel gives this evidence little weight. Dr. Dooley's testimony that he properly treated all ten patients is unpersuasive when compared to Dr. Wright's convincing expert testimony that the standard of care was not met for all ten patients.

Medical Records for Patients A-J

The patient medical records in Dr. Dooley's exhibits are identical to the medical records that were already admitted into evidence and considered by the ALJ for eight out of the ten patients. Accordingly, there are no new medical records for the panel to consider for Patients A, B, C, E, G, H, I, and J.[11] For the remaining two patients, Patients D and F, the majority of the medical records were already admitted by the ALJ, but there are a few chart notes and imaging reports that Dr. Dooley submitted in his exhibits, which he did not include in the medical records he originally submitted to the Board.[12]

[11] Dr. Dooley submitted urine drug screen forms for Patients G and H, which were not admitted into evidence by the ALJ, but these urine drug screens were ordered after Dr. Dooley submitted his records to the Board and certified that he provided the complete medical records. The charges were based on Dr. Dooley's care of his patients through September 20, 2013. Any records from dates of service after September 20, 2013 are not relevant to the charges and the standard of care determination in this case. The Panel declines to accept these urine drug screen forms.

[12] Although Dr. Dooley certified that he provided complete medical records for each of the ten patients on September 20, 2013, he failed to include these additional records in his response to the Board's investigatory subpoena.

Patient D – Additional Evidence

The additional evidence for Patient D consists of chart notes from April 8, 2013, April 15, 2013, April 19, 2013, and April 23, 2013 ("pre-surgery records") pertaining to Dr. Dooley's care and treatment of Patient D prior to her undergoing spinal cord surgery. The State's records admitted into evidence included a letter, dated April 12, 2011, from Patient D's prior physician reflecting that he maintained her on 80 mg of Oxycontin three times per day, 30 mg of Oxycodone four times per day for break through pain, and Fentanyl patches of 50 mcg every two to three days. When Patient D initially presented to Dr. Dooley, on April 8, 2013, Dr. Dooley ordered a urine test, but he did not wait for the results before prescribing a new regimen of pain medications. Dr. Dooley also discontinued the Oxycontin, increased the Oxycodone to 60 mg four times per day, and prescribed Fentanyl patches of 100 mcg every three days. Dr. Dooley never independently verified the medications and dosages that Patient D was taking and did not have any documentation of the medications that Patient D was prescribed in the two years prior to entering his practice.

The results of the urine screen were inconclusive, but Dr. Dooley continued to prescribe the same medications and dosages, and he never conducted another urine screen between April and September of 2013. Although Dr. Dooley testified that he saw pain management patients for follow-up visits and prescription refills every two weeks, the additional notes reflected that he routinely saw Patient D more frequently than every two weeks and prescribed early refills of her medications. Dr. Dooley summarized these pre-surgery visits in the original patient summary for Patient D that was admitted into evidence, testified in great detail about the pre-surgery visits, and cross-examined Dr. Wright regarding her expert opinion of his care.[13]

[13] Dr. Dooley was notified in the September 12, 2014 charging document that there was no progress note for April 8, 2013. He failed to provide this note and the other missing notes in discovery until March 13, 2015.

The treatment regimen documented by Dr. Dooley in the additional pre-surgery notes is consistent with the substandard treatment and care documented in the post-surgery notes that were considered and evaluated by the ALJ. Dr. Dooley prescribed high doses of opioids to Patient D for an extended period of time without a plan of weaning her off the medications and without attempting other modalities and treatment options. The medical records do not reflect that Dr. Dooley ever considered or prescribed non-opioid medications for Patient D's pain.

Based on his lack of monitoring, the frequency of prescriptions, his unimodal approach, and his failure to implement a plan to wean, the ALJ found, based upon Dr. Wright's expert opinion, that Dr. Dooley failed to meet the appropriate standard of quality care for Patient D, in violation of Health Occ. § 14-404(a)(22).

Dr. Dooley has consistently maintained that Patient D was properly diagnosed, treated, and prescribed the appropriate medications the entire time she was his patient. Panel B disagrees. Dr. Dooley's arguments are inconsistent with the overwhelming weight of the evidence. The additional documents he submitted for Patient D do not change any of the findings of fact. Rather, these additional documents provide further evidence of Dr. Dooley's deviations from the standard of care.

Patient F – Additional Evidence

The additional evidence for Patient F includes several imaging reports, a signed pain management contract, and two additional chart notes.[14] X-rays of Patient F's left knee and lumbar spine were taken on May 17, 2013, but the x-ray reports were not included in the original medical records Dr. Dooley submitted to the Board and were not admitted into evidence or

[14] The additional chart notes were for dates of service (September 24, 2013 and February 5, 2015) that occurred after Dr. Dooley provided his records to the Board and certified that he provided the complete medical records. The charges were based on Dr. Dooley's care of his patients through September 20, 2013. Any chart notes from dates of service after September 20, 2013 are not relevant to the charges and the standard of care determination in this case. The Panel declines to accept them.

reviewed by Dr. Wright. The x-ray results, however, were discussed in the original records and original patient summary and Dr. Dooley indicated the x-rays were essentially normal.

X-rays of the left foot and left ankle were conducted on June 11, 2013. Again, Dr. Dooley provided these imaging reports in his Exhibit 7, but they were not originally submitted to the Board, and therefore, were not admitted into evidence or reviewed by Dr. Wright. The reports, however, were discussed in the original records admitted into evidence and a chart note from June 17, 2013 indicates that Patient F was informed the x-ray results were normal.

Dr. Dooley also submitted an MRI report of the lumbar spine conducted on August 6, 2013, which was not admitted into evidence at the OAH hearing. The results of the MRI were, however, recorded in Dr. Dooley's chart notes and original patient summary, which were reviewed by Dr. Wright and admitted into evidence.

While Dr. Wright stated that she would have liked to have seen the original x-ray and MRI reports and noted in her peer review report that there was no documentation of x-ray or MRI findings to support continued usage of opioids, these documents would not have changed her determination that Dr. Dooley did not meet the standard of quality care for Patient F, as her opinion was based on other deficiencies. According to Dr. Wright:

> Patient with chronic pain that has lasted for more than 3 months should not be maintained on short acting opioids, but rather a long acting with break through opioids must be instituted. Patient must have regular urine drug screens to check for compliance. Use of other adjuncts such as anticonvulsants should be considered in patients with complaints of radicular symptoms.

Dr. Dooley also submitted a pain management contract, dated August 29, 2013,[15] that was not included in the original records he submitted. Neither Dr. Wright nor the ALJ discussed

[15] There is no documentation of a previous pain management contract in the records. In Dr. Dooley's new patient summary for Patient F, he states that he believes a medical assistant destroyed the original pain management contract when the new contract was signed.

the lack of a pain management contract and the consideration of the contract now has no impact on the Panel's standard of care determination.

After considering the additional records, Panel B agrees with the ALJ's and Dr. Wright's determinations that the standard of quality care was not met with respect to Patient F. The contents of the additional documents were largely discussed in other notes, the original patient summaries, or testified to by Dr. Dooley at the OAH hearing. Further, the consideration of the additional documents did not change the fact that Dr. Dooley failed to order any urine drug screens for almost two years, provided Patient F with early prescription refills, and did not transition Patient F to a long acting opioid medication even though his pain was chronic and lasted over three months. The additional documents also do not change the fact that Dr. Dooley never verified with the pharmacy that they dispensed 20 Percocet pills less than prescribed and never asked Patient F for any documentation of the shortage before writing a prescription for an additional 20 pills. The additional documents have no impact on the ALJ's proposed findings concerning the standard of care.

CONCLUSIONS OF LAW

Based on the foregoing factual findings, Panel B concludes that Dr. Dooley failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care concerning his treatment of Patients A-J, in violation of Health Occ. § 14-404(a)(22).

SANCTION

Dr. Dooley excepts to the ALJ's proposed sanction of a one-year suspension and three years of probation. He requests a one-year period of probation with conditions that would restrict him from practicing pain medicine and prescribing opioids to patients except in

emergency situations. Dr. Dooley acknowledges that a disciplinary panel has broad discretion in sanctioning licensees and that the permissible sanction for a standard of care violation ranges from a reprimand to a revocation. COMAR 10.32.02.10B(22). Dr. Dooley argues that the mitigating factors in his case warrant a less severe sanction than a suspension. Panel B disagrees.

The ALJ correctly recognized that Dr. Dooley's care and treatment had the potential for patient harm. The evidence shows that Dr. Dooley failed to address the underlying cause of his patients' pain before he resorted to prescribing opioids. Dr. Dooley's pain management practices made his patients more dependent on opioids, rather than less dependent. The ALJ concluded that because Dr. Dooley "did not acknowledge any wrongdoing, his practice of issuing opioid prescriptions would likely continue if he were permitted to return to his pain medicine practice." The Panel agrees. For all ten patients, a consistent pattern of serious deficiencies permeated Dr. Dooley's treatment regimen.

In his exceptions, Dr. Dooley cites several consent orders where the Board imposed less severe sanctions on licensees for substandard pain medicine practice. Dr. Dooley, however, is not similarly situated to practitioners who entered into consent orders as a result of settlement negotiations.

After considering all of the evidence in this case, including the additional exhibits that Dr. Dooley presented, Panel B denies Dr. Dooley's exception to the ALJ's proposed sanction.

ORDER

Based on the foregoing findings of fact and conclusions of law, it is, on the affirmative vote of a majority of the quorum of Disciplinary Panel B, hereby

ORDERED that the medical license of Thomas Dooley, M.D. (license number D16458) to practice medicine in Maryland is **SUSPENDED** for a minimum period of **ONE (1) YEAR** beginning thirty (30) days from the date of this Order; and it is further

ORDERED that after a minimum period of **ONE (1) YEAR**, Dr. Dooley may petition Panel B or the Board for the termination of his suspension and shall meet with Panel B or the Board to determine probationary terms and conditions; and it is further

ORDERED that upon termination of Dr. Dooley's suspension,[16] Dr. Dooley shall be placed on **PROBATION** for a minimum period of **THREE (3) YEARS** with terms and conditions as determined by Panel B or the Board; and it is further

ORDERED that if Dr. Dooley violates any of the terms or conditions of this Final Decision and Order, Panel B or the Board, after notice and an opportunity for a show cause hearing before the Board or an evidentiary hearing at the Office of Administrative Hearings if there is a genuine issue as to the underlying material facts, may impose additional sanctions authorized under the Medical Practice Act, including a reprimand, additional probation, another period of suspension, revocation, and/or a monetary fine; and it is further

ORDERED that this final order is a **PUBLIC DOCUMENT**.

02/25/2016
Date

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

[16] Dr. Dooley's license expires on September 30, 2016. If Dr. Dooley fails to renew his suspended license during the renewal period, he "may petition the disciplinary panel for termination of suspension only after applying for and meeting the requirements for reinstatement set out in COMAR 10.32.01.10." COMAR 10.32.02.06A(4). Further, the failure to renew his license does not remove the suspension or probation from Dr. Dooley's disciplinary record during the period of nonrenewal and any probationary conditions will be tolled until Dr. Dooley possesses a license. COMAR 10.32.02.05C(3).

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408, Dr. Dooley has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this Final Decision and Order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Dooley files a Petition for Judicial Review, the Board is a party and should be served with the court's process at the following address:

Christine A. Farrelly, Executive Director
Maryland State Board of Physicians
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any Petition for Judicial Review should also be sent to the Board's counsel at the following address:

Stacey M. Darin, Assistant Attorney General
Office of the Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

MARYLAND STATE BOARD OF	*	BEFORE STUART G. BRESLOW,
PHYSICIANS	*	AN ADMINISTRATIVE LAW JUDGE
v.	*	OF THE MARYLAND OFFICE OF
THOMAS DOOLEY, M.D.,	*	ADMINISTRATIVE HEARINGS
RESPONDENT	*	OAH No.: DHMH-SBP-71-14-42199
License No.: D16458	*	Board Case No.: 2013-0971

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
STIPULATIONS OF FACT
PROPOSED FINDINGS OF FACT
DISCUSSION
PROPOSED CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On or about September 12, 2014, a disciplinary panel of the Maryland State Board of Physicians (Board) issued a charge against Thomas Dooley, M.D. (Respondent), License No. D16458, for violating the Medical Practice Act (Act). Md. Code Ann., Health Occ. §§ 14-101 through 14-507, and 14-601 through 14-602 (2014). He was charged with violating §14-404(a)(22) of the Act.

On December 1, 2014, this matter was forwarded to the Office of Administrative Hearings (OAH) for a hearing. On December 3, 2014, the OAH sent a Notice of Scheduling Conference to the parties, notifying them that a telephone scheduling conference would take place at 9:30 a.m. on December 18, 2014. On December 18, 2014, I conducted a telephone scheduling conference in the above-captioned case from the OAH in Hunt Valley, Maryland.

Dawn L. Rubin, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). The Respondent participated at the scheduling conference *pro se*. I issued a Scheduling Order on December 19, 2014, scheduling a Prehearing Conference (PHC) for February 12, 2015 commencing at 9:30 a.m. at the OAH.

As part of the Scheduling Order, I ordered the parties to exchange PHC statements and send a copy to me no later than January 28, 2015. On January 27, 2015, I received the PHC statement and attached exhibits from the State and on January 28, 2015, I received the PHC statement and attached exhibits from the Respondent.

In his PHC statement, the Respondent requested that the Board rescind its delegation of authority to the OAH (Motion to Rescind). On January 29, 2015, the State filed its opposition to the Motion to Rescind. At the PHC, I heard arguments from both parties on this issue. After considering the arguments and the applicable law, I denied the Respondent's Motion to Rescind. A Prehearing Conference Report and Order was issued on February 19, 2015 and an Amended Prehearing Conference Report and Order was issued on March 3, 2015.

As part of the Amended Prehearing Conference Report and Order, the parties were required to exchange a final list of exhibits and copies of each with each other and forward a copy to my attention as well. The State provided its exhibits to me and the Respondent on February 12, 2015. On March 13, 2015, the Respondent provided his exhibits to the State and to me.

On March 17, 2015, the State filed a Motion in Limine to Exclude Newly Proposed Documentary Evidence. On March 18, 2015, the Respondent filed his response. On April 3, 2015, I granted the State's Motion, in part, as to Respondent's Exhibit 1, paragraphs 17-22, and

Exhibits 2 through 11 to the extent that they were not identical to the records offered by the State. I reserved ruling on all of the State's other requests for the hearing on the merits.

I conducted the hearing on the merits on April 13, 14 and 15, 2015 at the OAH, 11101 Gilroy Road, Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (2014); Code of Maryland Regulations (COMAR) 10.32.02.04. Dawn L. Rubin, Assistant Attorney General and Administrative Prosecutor, represented the State. The Respondent represented himself.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules for Hearings before the Board of Physicians, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014); COMAR 10.32.02; COMAR 28.02.01.

ISSUES

1. May the State impose disciplinary action under Health Occupations section 14-404(a)(22) because the Respondent 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?
2. What, if any, sanction(s) should be imposed if a violation is proven?

SUMMARY OF THE EVIDENCE

Exhibits

The State submitted the following exhibits, which were admitted into evidence unless otherwise indicated:

State's Ex. #1- Charges Under the Maryland Medical Practice Act, September 12, 2014

State's Ex. #2- Not admitted

State's Ex. #3-	Initial Application for Licensure, April 1, 1974
State's Ex. #4-	Renewal Application, August 24, 2014
State's Ex. #5-	Email with attachment from Drug Enforcement Agency (DEA) Diversion Unit to Board, June 21, 2013
State's Ex. #6-	Complaint filed by [redacted], August 26, 2013
State's Ex. #7-	Letter from Joshua Schaefer, Compliance Analyst, Board, to Respondent, September 19, 2013
State's Ex. #8-	Letter from Respondent to Joshua Schaefer, October 20, 2013
State's Ex. #9-	Letter from Respondent to Joshua Schafer, received by Board on November 15, 2013
State's Ex. #10-	Transcript of Interview with [redacted] October 4, 2013
State's Ex. #11-	Transcript of Interview with Respondent, November 18, 2013
State's Ex. #12-	Letter from [redacted] o Joshua Schafer, February 18, 2014
State's Ex. #13-	Physician Assistant Delegation Agreement, Mike Romain, July 2, 2013
State's Ex. #14-	Medical Record for Patient A, bate stamped 00001-00063
State's Ex. #15-	Post Mortem Examination of Patient A, May 12, 2013
State's Ex. #16a-	Documents concerning Patient A from [redacted] received October 4, 2014
State's Ex. #16b-	Pharmacy records for Patient A, bate stamped 00001-000013
State's Ex. #17-	Medical records for Patient B, bate stamped 00001-000011
State's Ex. #18-	Medical records for Patient C, bate stamped 00001-000056
State's Ex. #19-	Medical records for Patient D, bate stamped 00001-000046
State's Ex. #20-	Medical records for Patient E, bate stamped 00001-000087

State's Ex. #21-	Medical records for Patient F, bate stamped 00001-000028
State's Ex. #22-	Medical records for Patient G, bate stamped 00001-000087
State's Ex. #23-	Medical records for Patient H, bate stamped 00001-000087
State's Ex. #24-	Not offered
State's Ex. #25-	Medical records for Patient I, bate stamped 00001-000038
State's Ex. #26-	Medical records for Patient J, bate stamped 00001-000088
State's Ex. #27-	Pharmacy Surveys, New Market Pharmacy, August 1, 2012 through July 29, 2013
State's Ex. #28-	Giant Pharmacy prescription records, August 1, 2012 through July 25, 2013
State's Ex. #29-	Peer Review Form, April 15, 2014
State's Ex. #30-	Dr. Ira Kornbluth's peer review report, received by Board on June 23, 2014
State's Ex. #31-	*Curriculum vitae* for Ira Kornbluth, M.D.
State's Ex. #32-	Dr. Thelma Wright, Peer review report, May 30, 2014
State's Ex. #33-	*Curriculum vitae* for Thelma Wright, M.D., J.D.
State's Ex. #34-	Letter from Joshua Schafer to Board, June 3, 2014
State's Ex. #35-	Supplemental Response to Board from Respondent, June 18, 2014
State's Ex. #36-	Report of Investigation, July 11, 2014
State's Ex. #37-	*Prescribing for Chronic Pain*, BPQA Newsletter, Vol 2, #4, December 1994

State's Ex. #38- *Prescribing Controlled Drugs*, BPQA Newsletter, Vol. 4, #1

State's Ex. #39- Board Policy on Use of Controlled Dangerous Substances, December 1997

State's Ex. #40- *The Treatment of Chronic Pain*, BPQA Newsletter, Vol. 8, #1, March 2000

State's Ex. #41- Trescot, M.D. *et al.*, *Opiod Guidelines in the Management of Chronic Non-Cancer Pain*, Pain Physician, 2006;9:1-40

State's Ex. #42- *Relief and Regulatory Oversight*, MBP Newsletter, Spring 2007

State's Ex. #43- Argoff, *et al.*, *A Comparison of Long and Short Acting Opiods for the Treatment of Chronic Noncancer Pain; Tailoring Therapy to Meet Patient Needs,* Mayo Clinic Proceedings; July 2009, 84(7); 602-612, July 2009

State's Ex. #44- Not offered

State's Ex. #45- Letter from Respondent to Joshua Schafer, September 24, 2013

The Respondent submitted the following exhibits, which were admitted into evidence:

Resp. Ex. #1- Paragraphs 1-16 only, partial response to charges

Resp. Ex. #12- CDC Guidelines, *Common Elements in Guidelines for Prescribing Opioids for Chronic Pain*, June 12, 2014 updated

Resp. Ex. #14- Patient Treatment Contract, undated

Resp. Ex. #15- Article, *Benzodiazepines: Risks and Benefits, a Consideration*, November 21, 2013

Resp. Ex. #16- Abstract, *American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Non-cancer Pain*, July 15, 2012

Resp. Ex. #19- Abstract, *Carisoprodol: Update on Abuse Potential and Legal Status*, Southern Medical Journal, November 2012

Resp. Ex. #20- Abstract, *Systematic Review: Treatment Agreements and Urine Drug Testing to Reduce Opioid Misuses in Patients with Chronic Pain*, Ann. Internal Medicine, June 1, 2010

Resp. Ex. #22- Photograph and resume of the Respondent

Testimony

The following witnesses testified on behalf of the State:

1. Thelma Bernice Wright, M.D., J.D., accepted as an expert witness in pain management
2. Joshua Joseph Schafer, Investigator, Office of the Attorney General
3. [redacted] psychiatric nurse

The Respondent testified in his own behalf and presented no other witnesses.

STIPULATION OF FACTS

The parties stipulated to the following facts:

1. At all times relevant, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on April 1, 1974. His present license is scheduled to expire on September 30, 2016.
2. At all times relevant to these charges, the Respondent did not hold any hospital privileges.

3. On or about June 21, 2013, the Board received a complaint by telephone from the federal Drug Enforcement Administration (DEA) regarding the Respondent's Controlled Dangerous Substance (CDS) prescribing. The DEA diversion agents alleged that two of Respondent's former patients had died; both had been receiving CDS prescribed by the Respondent.

4. Shortly thereafter, the Board opened an investigation regarding the allegations.

5. On or about August 28, 2013, the Board received a written complaint from the mother of a former patient of the Respondent regarding the Respondent's care of her son (Patient A) who had died suddenly in his sleep. The Respondent had prescribed CDS to Patient A including Percocet[1] and Ambien.[2] Additionally, the complainant alleged that the Respondent had prescribed to Patient A an antipsychotic medication, Navane.

6. On or about September 19, 2013, the Board's staff notified the Respondent of its investigation and requested a response.

7. On or about September 27, 2013, the Respondent filed a response with the Board stating that he gave "special attention" to the prescription of all opioids and any mood-altering medication. He further stated that he was "fully ready to explain and defend if necessary" all of his prescriptions without exception.

8. On November 18, 2013, the Board's staff conducted an interview under oath of the Respondent regarding the allegations cited in the complaints, as set forth more specifically below.

9. In January 2014, in furtherance of its investigation, the Board transmitted twelve patient records (and other relevant documents, including "summaries of care" provided by the

[1] Schedule II CDS.
[2] Schedule IV CDS.

Respondent) for peer review by two physicians board-certified in pain management (the "reviewers"), the results of which are set forth in pertinent part below.

10. The reviewers submitted their respective reports in March 2014 and May 2014.

11. The Respondent described his present clinical practice at Facility A as primary care, with 85% being chronic pain management patients.

12. The Respondent stated that his pain management patients at Facility A enter into pain management contracts.

PROPOSED FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:

1. The Respondent has been practicing medicine for the past 46 years.

2. The Respondent is a member of the American Academy of Pain Management and has received 19 hours of continuing education in classic pain management. Resp. Ex. #22. The Respondent is not Board certified in pain medicine.

3. At all times relevant hereto, the Respondent has been working at XpressMedCare.

4. XpressMedCare established its pain management section in 2012. Approximately 85% of the Respondent's patients are being treated for pain.

5. Random urine testing of patients who were examined and treated at XpressMedCare was initiated in 2012 and mandatory testing of first visit patients began in August 2013.

6. There is no single guideline available to determine the amount of opioids that are reasonable to prescribe for any given patient. One such document used by doctors and insurance companies to determine the amount of opioids or other treatments that may be considered in addressing a patient who presents with pain is the Official Disability Guidelines (ODG).

Another guideline is the Opioid Guidelines in the Management of Chronic Non-Cancer pain. (State's Ex. #41).

7. The Board issues newsletters to physicians on various topics from time to time. Such newsletters have included guidelines concerning pain management which the Respondent receives and reviews as part of his pain management practice.

8. The Federation of State Medical Boards published a guideline titled "Model Policy for the Use of Controlled Substances." As part of the guideline, the document suggests that when working with pain patients, the clinician should consider the evaluation of the patient, a treatment plan, periodic review, consultation, medical records, and compliance with controlled substances laws and regulations. (State's Ex. #42).

9. Management of chronic pain often requires a multimodal approach that integrates pharmacological and non-pharmacological treatments such as rehabilitative measures and interventional techniques. Close monitoring by a treating physician of opioid use by a patient is essential to determine efficacy and to determine whether the patient is taking the medication as prescribed. Monitoring is necessary in all patients, and particularly in patients who present a risk of diverting[3] medications or who may misuse or abuse opioid treatments.

10. Chronic pain is defined as persistent pain lasting longer than the time required for normal tissue healing, which in non-cancer pain patients is generally defined as three months.

11. Opioid formulations are classified as short or long acting on the basis of their duration of action. Short Acting Opioids (SAO) are distinguished from Long Acting Opioids (LAO) by a more rapid increase and decrease in serum levels.

12. LAOs are formulated to release drug more gradually into the bloodstream or have a long half-life for prolonged activity.

[3] Diverting medication means transferring prescribed medication to others not authorized to receive them.

13. SAOs are considered appropriate for transient pain types, such as acute, breakthrough, or chronic intermittent pain, which do not require long-lasting analgesia.

14. Examples of SAOs include oxycodone (Percocet), hydrocodone (Vicodin), morphine, hydromorphone, and oxymorphone.

15. Examples of LAOs include methadone, levorphanol, oxycontin, or extended release or sustained release formulations of oxycodone, oxymorphone, fentanyl and morphine. The analgesic effect of LAO's generally last between eight and 72 hours.

16. It is appropriate to prescribe SAOs for acute short term pain, but for pain that is long term, it is important to determine the source of the pain and use multi-modal treatment to treat pain.

17. Complete physical examinations that correlate to the patient's complaints are necessary before prescribing opioids.

18. In addition to determining compliance with prescribed medications, urine screens are necessary to determine misuse, abuse, or diversion of the medications prescribed.

19. The medical records of the Respondent's patients that were peer reviewed did not all include controlled substance agreements which contain the responsibilities of patients who are being treated with controlled substances.

20. Medication refill requests or lost prescriptions must be monitored closely to determine whether the requests for refills or replacement prescriptions are legitimate, or if there is a question, investigate the reasons for the early request or replacement prescription to determine if the medications are being diverted or abused.

21. The State requested two peer reviews of several of the Respondent's patients.

22. One of the peer reviewers is Thelma Bernice Wright, M.D., J.D. Dr. Wright is the Medical Director of the Pain Management Center at the University of Maryland and is also the Pain Fellowship Program Director at the University of Maryland. Tr. 31. She is Board certified in anesthesiology and pain medicine. Tr. 33. To become Board eligible, there is a four year training program requirement, including a one year internship and three years of anesthesiology. Her practice is 100% dedicated to seeing chronic care pain management patients.

23. The second peer reviewer is Ira Kornbluth, M.D. M.A. FAAPMR, CIME. Dr. Kornbluth is ABPMR Pain Management Board Certified. He is the founder of SMART Pain Management and has been associated with the firm since 2008. He has been a partner in DECK Pain Management from 2005 through 2008 and the Center for Pain Management from 2004 through 2008. He has hospital privileges at the Carroll County Medical Center and Franklin Square Medical Center and has consulted and attended further education courses on pain management. (State's Ex. #31).

Patient A

24. Patient A first visited XpressMedCare on October 19, 2012. Patient A is male and was born on [redacted]

25. Patient A presented with a lump on his right wrist that he had for one and one-half months and complained of lower back pain from a car accident that ran down his leg. He told the Respondent that he had been suffering from low back pain for eight months.

26. X-rays ordered by the Respondent on October 31, 2012 of Patient's lower back were essentially normal. An MRI was not ordered to determine the source of the back pain.

27. Patient A asked the Respondent to prescribe Percocet for him. The Respondent prescribed Patient A oxycodone for pain and Ambien for a sleep disorder.

28. Patient A was not offered any non-pharmacological pain management for his low back pain by the Respondent.

29. Patient A had been incarcerated for 6 years for attempted murder. He also had a tattoo that indicated gang affiliation. The Respondent was aware of his prison record and potential affiliation with gangs during his treatment of Patient A.

30. Patient A drove a tow truck while he was being treated by the Respondent. He lost his job after being involved in two traffic accidents.

31. The Respondent did not order random drug screens, random pill counts, or psychological screening to determine whether Patient A was diverting or abusing his medications.

32. At the same time Patient A was prescribed opioids by the Respondent, Patient A was also receiving prescriptions for opioids from other practitioners in April and early May 2013. The Respondent was unaware at the time he prescribed medication that Patient A was also receiving the same medications he prescribed from other medical providers. The Respondent did not verify that Patient A was taking medications as prescribed.

33. The Respondent did not prescribe Patient A any anticonvulsants, such as Neurontin, which are used for treatment of pain radiating down the leg.

34. The Respondent also prescribed Patient A Xanax, a benzodiazepine. Xanax is used mostly for anxiety.

35. On May 10, 2013, Patient A appeared at XpressMedCare for a follow-up visit. On that day, the Respondent increased the amount of oxycodone from 10 milligrams to 15 milligrams. There is no documentation in the medical records to support the reason for the increase in dosage.

36. Patient A was also prescribed Navane, an antipsychotic medication. Patient A was not referred to a psychiatrist for treatment or evaluation before being prescribed this medication by the Respondent.

37. [redacted] Patient A died from oxycodone and alprazolam (Xanax) intoxication.

38. The combination of drugs prescribed by the Respondent increased the risk of respiratory depression and death.

39. The amount of drugs found in Patient A and the combination thereof that was found in Patient A's body as a result of the autopsy findings were sufficient to cause death to an individual with a healthy heart. Patient A was found not to have a healthy heart through the autopsy results. The medical records of the Respondent did not indicate that the patient had any cardiovascular issues.

Patient B

40. Patient B's first visit to XpressMedCare occurred on September 6, 2012. She was born on [redacted]

41. Patient B was a long term patient of Dr. Hampton Jackson, until Dr. Jackson died. The Respondent was familiar with Dr. Jackson's practice and was concerned that Dr. Jackson was overprescribing pain medications.

42. The Respondent did not accept Patient B as his patient; he referred her to Dr. Gharbani for treatment of pain. The Respondent tried to assist Patient B with his referral by contacting Dr. Gharbani's office directly, but was unsuccessful in making an appointment for Patient B.

43. Patient B told the Respondent that she was prescribed oxycodone by Dr. Jackson for two years for pain, but since Dr. Jackson was deceased, she no longer was able to obtain refills of her medication.

44. The Respondent provided Patient B with a bridge prescription for oxycodone which was prescribed for compassionate reasons. The Respondent did not verify through pharmacy records or pill bottles that Patient B was prescribed oxycodone by Dr. Jackson for back pain for two years.

45. On October 4, 2012, the Patient visited the Respondent at XpressMedCare for a follow-up visit. Once again, her chief complaint was back pain. She was referred to Dr. Gharbani's office for treatment. The Respondent provided her with another prescription for oxycodone and also noted that it would be the final prescription that she would receive from his office. The Respondent did not perform any urine tests during the visit to verify that she was taking the medications as prescribed.

46. On December 7, 2012, Patient B visited the Respondent reporting that she continued to have pain in her lower back and also had acute bronchitis.

47. Patient B was prescribed an antibiotic for her bronchitis and also received another prescription for oxycodone, despite being told at her last visit that the prescription that was written was the final prescription that the Respondent would write for this medication.

48. The Respondent did not verify that Patient B was taking medication as prescribed and there is no indication that she ever scheduled and followed through with her referral to Dr. Gharbani's practice for treatment.

49. Compassionate prescriptions are given to patients to avoid symptoms of sudden withdrawal from opioids after long term use. Sudden withdrawal from opioids after long term use has been known to cause death. Before prescribing compassionate prescriptions, physicians must confirm that the patient is actually on the medication being prescribed to avoid the potential for overdosing.

50. The Respondent did not perform any imaging studies nor did he have records of imaging studies to review before prescribing medications to her.

Patient C

51. Patient C, [redacted] was first seen by the Respondent on May 9, 2013 complaining of neck and back pain resulting from an accident. Patient C has a long history of opioid dependence and had been complaining of chronic pain for approximately four years. She had previously been treated by orthopedic surgeons for her neck and back pain.

52. One preliminary urine screen was conducted that indicated opioid use at the time of her initial visit.

53. Patient C also had a diagnosis of bipolar disorder.

54. Patient C was treated with short acting opioids by the Respondent and was treated with benzodiazepines (Xanax) for her psychiatric disability as well.

55. Prescriptions for opioids and benzodiazepines were given every two weeks during visits with the Respondent which should have lasted until her next visit, however, the prescriptions allowed for three refills.

56. No urine screenings were conducted after the first screening to determine the level of medication in her blood stream.

Patient D

57. Patient D, [redacted] entered the Respondent's medical practice after having been disabled for many years suffering from lumbar discogenic disease and sciatica.

58. At the time of her first visit, her previous physician had prescribed long acting medications, oxycontin, fentanyl, and short term oxycodone.

59. When Patient D presented at the Respondent's office on April 8, 2013, she was referred for emergency surgery to address spinal cord damage and compression that resulted in loss of bowel and bladder function.

60. A urine drug screen was conducted on April 8, 2013, but the results were determined to be inaccurate because there were no results for oxycodone, even though she was taking high doses of the drug at the time of the test.

61. The surgery was able to restore her bladder and bowel function.

62. When she first saw the Respondent on April 8, 2013, Patient D had been prescribed high doses of oxycodone (80 mg) every eight hours and oxycontin (30 mg) every four to six hours. She was also prescribed Fentanyl patches for her lower back. These medications were prescribed by a previous physician, Ronald Hairston, M.D., but were unable to be verified since Dr. Hairston issued his medical summary prior to closing his medical practice in April 2011 and the urine drug screen results were inconclusive.

63. The Respondent schedules his pain management patients for follow-up on two week intervals. In the case of Patient D, during the months of May and July 2013, the Respondent saw Patient D much more frequently and during these visits gave her prescriptions for two weeks worth of medication, even though the medication would not have run out if it was taken appropriately during that shortened period.

64. Following her surgery, Patient D was given short term acting opioids for pain.

65. The Respondent did not utilize any other modalities of treatment for Patient D, including the use of neuromodulator medications which would include anticonvulsants and antidepressants.

Patient E

66. Patient E, [redacted] entered the XpressMedCare practice on August 1, 2012 after falling at work on June 5, 2012.

67. Imaging studies conducted of her left shoulder on August 11, 2012 did not reveal any significant findings.

68. The Respondent prescribed SAOs (oxycodone) and the patient was referred for chiropractic treatment.

69. The Respondent did not prescribe any anti-inflammatory medications to treat her condition because she claimed to have suffered an adverse reaction to several of them. The Respondent did not offer any other anti-inflammatory medications to treat Patient E's condition that may not have caused the adverse reactions she experienced with other medications.

70. The Respondent did not order urine screens or employ other means to verify whether Patient E was using the prescriptions as ordered.

71. On March 30, 2013, Patient E reported to the Respondent that her oxycodone was stolen and he wrote her a replacement prescription of oxycodone.

72. On May 17, 2013, Patent E reported to the Respondent that her oxycodone was stolen and he wrote a replacement prescription.

73. Patient E was charged criminally with altering a prescription for Percocet, by changing a Respondent written prescription from 30 tablets to 80 tablets. Upon learning of the charges filed against Patient E, the Respondent discharged her from the practice.

Patient F

74. Patient F, [redacted] was known to the Respondent's practice because Patient F's wife and two stepdaughters were patients of the practice. His initial visit to the practice occurred on May 16, 2013.

75. Patient F is morbidly obese.

76. Patient F has damaged knee tendons, knee cartilages on the right leg, and the tendons of his right ankle due to repetitive gravitational trauma.

77. Patient F is not a candidate for surgery due to his obesity.

78. The Respondent prescribed Patient F oxycodone for pain, but did not transition him to a long acting opioid medication. He was also treated with Flexeril.

79. The Respondent did not order urine drug screens to determine compliance with medication.

80. There is no mention in the records that the Respondent considered anticonvulsants as part of Patient F's treatment modalities.

Patient G

81. Patient G, [redacted] visited the Respondent's medical practice on November 22, 2012 complaining of neck, lumbar, back, and shoulder pain for three years as a result of a motor vehicle accident.

82. Patient G was previously seen at the American Spine Center for his ailments.

83. While at the American Spine Center, Patient G was prescribed Methadone, 60 mg daily.

84. Methadone is prescribed when there is evidence of previous opioid abuse. The Respondent immediately ceased the Methadone and continued treatment with oxycodone, fentanyl patches, and Soma, a muscle relaxant.

85. Use of morphine based medicines can adversely affect mental status, causing confusion and delirium. Patient G successfully stopped taking Methadone and the result was an improvement in the quality of his life.

86. There were no urine drug screens conducted to verify compliance with medications.

87. Patient G requested and received early refills of his prescriptions.

88. A request for early refills is a warning that the patient may not be taking the prescribed medications properly. If a patient who has been prescribed opioid medications requests early refills, the prescribing physician must inquire as to the reason for the request and verify compliance through pill counting, urine analysis, or other methods to detect potential diversion of the medication. Without a test, there was no assurance that Patient G was taking the prescribed medication at all.

89. The Respondent did not treat the underlying cause of the pain, recommend imaging, or refer Patient G to another physician, including a psychiatrist, to address the underlying cause of the pain and to determine if other treatments would be beneficial to Patient G and improve his quality of life.

Patient H

90. Patient H, [redacted] became a patient of the Respondent since she needed a primary care physician and her husband was already a patient of the Respondent.

91. When she first appeared at XpressMedCare on Monday January 29, 2013, she was not seen by the Respondent, but rather by Abeba Gebregiorgis. She was diagnosed with hypothyroidism, depressive disorder, attention deficit disorder (ADD), and urinary tract infection.

92. On February 8, 2013, Patient H was seen by the Respondent. In addition to the diagnoses identified on January 29, 2013, Patient H was also diagnosed with displacement of lumbar intervertebral disc without myelopathy as well as sciatica and insomnia. She presented for a refill of prescriptions for oxycodone, Fioricet, Adderall, and Xanax.

93. There was no documentation in the medical records that Patient H was on these medications prior to the visit with the Respondent. She told the Respondent that she also suffered from attention deficit hyperactivity disorder (ADHD) and although she was provided medication to treat this condition by the Respondent, there were no documents provided by a neurologist or psychiatrist to confirm the findings of ADHD.

94. There were no imaging studies ordered by the Respondent to support the diagnosis of back pain.

95. The Respondent did not perform routine urine screening for Patient H despite prescribing Synthroid, Celexa, Adderall, Fioricet, Oxycodone, Xanax, and Sumatriptan.

96. The Respondent noticed a change in personality of Patient H and based on this development, finally ordered a urine test. The results indicated that Patient H was taking unprescribed Methadone and not prescribed oxycodone. As a result of the drug screen, she was discharged as a patient of the Respondent.

Patient I

97. Patient I[redacted], came to the Respondent's practice after Dr. Hampton Jackson died. Patient I's wife was also a patient of the Respondent.

98. On September 10, 2012, Patient I was first seen by the Respondent complaining of upper and lower back pain as a result of an accident that occurred several years prior.

99. Patient I was initially referred to Dr. Reza Ghorbani's pain management center by the Respondent, but there is no indication in the records that the patient ever followed up with the referral.

100. The Respondent continued to treat Patient I through August 12, 2013 with short acting opioids (oxycodone) even though he had been taking these medications for many months. Patient I was not transitioned to long acting opioids by the Respondent.

101. There were no drug screens performed or random pill counting or any other modalities used, such as being referred to a psychiatrist, to monitor Patient I for abuse or diversion.

Patient J

102. Patient J, [redacted], was initially seen at XpressMedCare on August 21, 2012 complaining of lower back pain.

103. She had spinal fusion surgery in 2011 that was unsuccessful.

104. A year after the spinal surgery, Patient J was involved in a motor vehicle accident that caused her more pain in the lower back region.

105. She was referred by the Respondent to an orthopedist. She did not go to the orthopedist but was eventually referred by another physician to Dr. Lauerman, a professor of spinal surgery at Georgetown Medical Center.

106. Dr. Lauerman offered a second spinal procedure to correct the problems associated with the first procedure, but Patient J declined.

107. The Respondent prescribed oxycodone in two different prescription strengths as well as Xanax and Ambien for Patient J.

108. The prescriptions for Patient J were given for more than six months and the opioids prescribed were SAOs and no prescriptions were written for LAOs.

109. No other adjuncts such as anticonvulsants were considered in treating Patient J.

110. There were no drug screens conducted of Patient J to monitor compliance with the prescribed medications.

111. Patient J died of alcohol intoxication in 2013.

DISCUSSION

The Board

The Board is Maryland's "governmental agency responsible for investigating and disciplining physicians for professional misconduct." *Cornfeld v. Board of Physicians,* 174 Md. App. 456, 481 (2007). "The Board's mission [is] to regulate the use of physician's licenses in Maryland in order to protect and preserve the public health." *Id.* at 481 (internal quotations and citations omitted). The purpose for the Board's disciplinary authority is to protect the public, not to punish physicians. *McDonnell v. Comm. on Med. Disc.,* 301 Md. 426, 436 (1984).

Charges under the Maryland Medical Practice Act

The Board filed charges on September 12, 2014, alleging that the Respondent was in violation of section 14-404(a)(22) of the Health Occupations Article due to a failure to meet appropriate standards of care.[4] The State presented the testimony of Thelma Bernice Wright, M.D., J.D., who was accepted as an expert witness in pain medicine. The Respondent did not offer any expert testimony. Prior to the filing of charges against the Respondent, the State requested that two peer reviews be conducted of the Respondent's treatment of several patients in his medical practice with XpressMedCare. Md. Code Ann., Health Occ. § 14-401.1(e) (2014); COMAR 10.32.02.03D(1)(a). The peer reviews were conducted by Dr. Wright (State's Ex. #32) and by Dr. Ira Kornbluth (State's Ex.

[4] Section 14-404(a)(22) provides that the Board may suspend or revoke the license of a physician who:
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[.]

#30). The investigation began as a result of an investigation by the DEA and a report of two patient deaths including a complaint filed by Patient A's mother whose son was one of the two patients who died while under the medical care of the Respondent. (State's Ex. #6). Joshua Schafer, Compliance Analyst for the Board, requested both doctors provide a report following their review of the documents submitted with the request. (State's Ex. #29). On March 24, 2014, Dr. Kornbluth submitted his peer review report. (State's Ex. #30). On May 30, 2014, Dr. Wright submitted her peer review report. (State's Ex. 32).

As previously stated, Dr. Wright, who is Board certified in anesthesiology and pain medicine was admitted as an expert in pain medicine. Dr. Wright, as the Medical Director of the Pain Management Center at the University of Maryland, devotes her practice exclusively to chronic care pain management patients.

Dr. Kornbluth is ABPMR Pain Management Board Certified. He has been a founder and partner in pain management practices since 2004. He has hospital privileges at the Carroll County Medical Center and Franklin Square Medical Center.

By contrast to the breadth of experience of both Drs. Wright and Kornbluth, the Respondent, who has practiced medicine for 46 years, has 19 hours of pain management training, is not Board certified in pain medicine and currently has no hospital privileges in the State of Maryland. His pain management practice essentially began when he started working for XpressMedCare in February 2012. When asked whether he had any objections to Dr. Wright being designated as an expert in pain medicine, the Respondent had none whatsoever. He stated that he was honored that Dr. Wright has taken the time to read his patient charts. Tr. 34.

Both the Respondent and Dr. Wright agree that there is no single source for the standard of care in treating patients with chronic non-cancer pain, but many of the guidelines have consistent themes.[5] Tr. 38 and Tr. 344.

Upon consideration of all the evidence, I conclude that the standard of care for prescribing opioids requires that the prescribing physician conduct a comprehensive evaluation including mandatory physical and optional psychological assessment with appropriate documentation at regular intervals to assess the efficacy of therapy, with specific evaluation of the impact on functional status, degree of pain relief, identification and treatment of undesirable side effects, and monitoring for abuse behaviors. The standard of care further requires that the prescribing physician require that the patient adhere to a written controlled dangerous substance agreement. (State Ex. #41). These guidelines are consistent with the Board's newsletter issued in the Spring of 2007 (State Ex. #42) in which the Board cited the Model Policy for the Use of Controlled Substances for the Treatment of Pain, written by the Federation of State Medical Boards, which includes evaluation of the patient, a treatment plan, periodic review, consultation, medical records, and compliance with controlled dangerous substance laws and regulations. Both Drs. Wright and Kornbluth independently agreed that there was insufficient monitoring of the Respondent's patients through random urine drug screens and the Respondent failed to use a multimodal approach to pain reduction. Patients were seldom referred for other forms of treatment besides opioid use such as physical therapy or psychological evaluation. One patient was referred for chiropractic care, but most were not provided with this care or physical therapy. The Respondent continued to prescribe his patients high dosages of short term opioids for pain relief. Importantly, the Respondent did not sufficiently utilize non-opioid medications to minimize the use of opioids to reduce pain.

[5] Standard of care is a legal term found in the statute. The Board has the burden of proving (1) that there is a standard of care and (2) what the standard required of the Respondent.

The Center for Disease Control (CDS) surveyed eight guidelines to identify common recommendations for prescribing opioids for chronic pain. (Resp. Ex. #12). They include the following:

- Conducting a physical exam, pain history, past medical history, and family/social history
- Conducting urine drug testing, when appropriate
- Considering all treatment options, weighing benefits and risks of opioid therapy, and using opioids when alternative treatments are ineffective
- Starting patients on the lowest effective dose
- Implementing pain treatment agreements
- Monitoring pain and treatment progress with documentation, using greater vigilance at high doses
- Using safe and effective methods for discontinuing opioids (e.g., tapering, making appropriate referrals to medication-assisted treatment, substance use specialists, or other services)
- Using data from Prescription Drug Monitoring Programs to identify past and present opioid prescriptions at initial assessment and during the monitoring phase. (This method was unavailable in the State of Maryland at times relevant to this matter.)

The Respondent does not disagree with the guidelines referred to by the CDC or the ODG or other guidelines identified in the articles and abstracts entered into evidence in this case. In fact, the Respondent maintains that his practice was consistent with generally accepted standards and guidelines including the ones entered into evidence. Although the Respondent asserts that he has complied and, therefore, has met the standard of care, a careful review of the

record, indicates that the Respondent has failed to meet the standards of care in his treatment of these ten patients.

Patient A

Patient A first visited the Respondent on October 19, 2012. He complained of back pain and insomnia. He was first given Motrin but returned to the office claiming that it did not alleviate the pain and made him nauseous. Patient A mentioned that the only thing that worked for him was low dosages of Percocet (oxycodone). While this did raise a red flag to the Respondent, he prescribed the medication anyway. The Respondent knew that Patient A had been incarcerated and may have had a connection with a gang due to a tattoo that was a symbol of a prominent gang. Although x-rays were taken, Dr. Wright indicated in her testimony that the x-rays of Patient A were essentially normal. Furthermore, a MRI was not ordered that would have likely identified the source of the pain so that it could be treated either surgically or through other modalities such as physical therapy.

The Respondent deemed it a success that Patient A was able to return to employment driving a tow truck. The Respondent failed to mention that Patient A lost his job driving a tow truck when he crashed two cars. (Tr. 237). The fact that he was involved in several accidents while on opioids suggests that the drug may have been a contributing factor in these two crashes. Patient A also complained of anxiety during all of his visits to the Respondent. The Respondent prescribed Xanax for the anxiety. During the entire time that Patient A was a patient of the Respondent, the Respondent did not order random drug screens, random pill counts, or psychological screening to determine if he was diverting or abusing the medications. Patient A was prescribed, in addition to Percocet and Xanax, Navane (antipsychotic) and Ambien. Patient

A was not evaluated by a psychiatrist before being prescribed Navane. The Respondent, although having some limited background in psychiatry, is not a psychiatrist.

Although the Respondent was well aware of the red flags involving Patient A, he did essentially nothing to determine whether the Respondent was diverting or abusing the medications described. While it was later determined that other physicians prescribed Percocet shortly prior to Patient A's death, this fact alone does not answer the question why the Respondent failed to take appropriate steps to determine whether Patient A was compliant or not with the medications he prescribed. In fact, the day before Patient A died due to an overdose combination of Xanax and Percocet, the Respondent increased Patient A's dosage of Percocet from 10 to 15 milligrams. Especially in a patient that has a history of long term use of a SAOs and with a known history of incarceration and potential gang affiliation, there is simply no excuse for failing to initiate a random drug screen, a pill count program, or other method to determine compliance with medication. The Respondent failed to do so. The guidelines and articles referred to by the State and the Respondent mention some form of verification to assure medication compliance when prescribing opioids.

The Respondent claims that other practitioners contributed to the unfortunate event that resulted in the death of Patient A because Patient A was apparently doctor shopping without the knowledge of the Respondent. The Respondent is correct in that statement. However, that does not excuse the Respondent for his part in failing to implement appropriate procedures that may have revealed to the Respondent that the amount of medication in Patient A's system was greater than what one would expect to find. In that case, had the Respondent looked rather than accept on face value the words of a convicted felon and a possible gang member, perhaps the Respondent could have intervened in time to avoid Patient A's death.

Patient B

Patient B's first visit to XpressMedCare occurred on September 6, 2012. She was seen by the Respondent. The reason for her visit was because she had been treated for two years for lower back pain by Dr. Hampton Jackson. Dr. Jackson died and Patient B needed a new prescription for oxycodone. The Respondent did not conduct any imaging studies or conduct a physical examination because he was not going to accept Patient B into his practice. He referred Patient B to Dr. Gharbani's office, but was unsuccessful in speaking with him and setting up a referral appointment with his office.

The Respondent, based solely on the representations of Patient B, prescribed oxycodone for Patient B as a bridge prescription or a compassionate prescription to avoid the trauma of withdrawal which could, if severe, potentially result in death. There is no evidence in the record that the Respondent asked to see a bottle of the prescribed medication from Dr. Jackson or otherwise verify the reported prescription before prescribing the same medication to Patient B.

On October 4, 2012, Patient B visited the Respondent for a follow-up visit. Once again, the Patient was referred to Dr. Gharbani's office for treatment of back pain. The Respondent did not perform an examination of Patient B. The Respondent did not deem it necessary to perform an examination since Patient B was not going to be accepted into his pain medicine treatment program. Nevertheless, the Respondent provided Patient B with another prescription for oxycodone but noted that it would be the last prescription he writes for her. No urine tests were performed to determine whether Patient B was taking the medications as prescribed.

Finally, on December 7, 2012, Patient B visited the Respondent because she had bronchitis. She was given an antibiotic for her bronchitis but was also given another prescription for oxycodone. The Respondent did not verify that she ever followed through on the referral

with Dr. Gharbani. Although she never returned for another visit with the Respondent, after December 7, 2012, the Respondent disregarded his own instructions on October 4, 2012 that the prescription he wrote on that date would be the last prescription he would write for her. Although there is justification to provide compassionate prescriptions to avoid the potentially severe affects of withdrawal, the Respondent provided this opioid without any verification that she was prescribed the medication in the first place and that she was taking the properly designated amount. He relied solely on the representations of the patient to determine whether he should write a prescription for oxycodone or not. Again, without any verification of compliance by the patient and without conducting a physical examination that justifies the need for a prescription of opioids, the Respondent did not comply with the myriad of guidelines and articles addressing when to prescribe opioids and how to verify compliance.

Patient C

Patient C was first seen by the Respondent on May 9, 2013 complaining of neck and back pain as a result of a motor vehicle accident. She has a long history of opioid dependence and opioid use was confirmed by one drug screen that was conducted at the time of her initial visit. Patient C also has a history of bipolar disease which the Respondent treated by prescribing Xanax. She was also offered and prescribed other medications to address other medical conditions including Lyrica, Ambien, Soma, and Respiridone. She found that Xanax worked best. In this case, the Respondent testified that she was being treated for more than pain. He claimed that she was being treated for her life situation, her disabling psychiatric condition. Tr. 302. The Respondent did not refer her to a psychiatrist or employ any nonpharmacological treatments while addressing her pain and psychiatric conditions. While he claimed that there was no evidence of abuse because he did not see evidence of slurred speech, confusion, delirium,

or encephalopathy, he did not perform any subsequent objective tests to determine whether she was abusing the medication or diverting it. She had been taking these medications for a long time. Additionally, she was given prescriptions for oxycodone every two weeks, but the prescriptions also allowed for three refills that if filled, would greatly exceed the medication necessary for a two week period. There was ample opportunity for the patient to divert or abuse the prescriptions; however, the Respondent never confirmed that she was taking the medications as prescribed. He relied solely on the representations of Patient C to verify that she was complying with his instructions.

As seen with Patient A, the combination of Xanax and high doses of Percocet can have a deadly consequence. Fortunately, this did not occur in the case of Patient C, however, the failure to monitor the patient through additional urine testing or pill counting or other available means may have placed the patient at risk of an overdose due to the combination of opioids and benzodiazepines.

Finally, although the Respondent has, in the distant past, had one year residency experience in psychiatry, he is not a Board certified psychiatrist and did not refer this patient to a psychiatrist for treatment of her bipolar disorder. Instead, he tried various medications with her to see how she would tolerate them and ultimately treated her with Xanax. A psychiatric consultation, given her psychiatric disability, would have been appropriate in this case, especially given the high dosage of SAOs that she was receiving from the Respondent.

Patient D

Patient D entered the practice suffering from long standing lumbar discogenic disease and sciatica. Her previous physician prescribed a LAO, oxycontin, SAO, oxycodone, and a Fentanyl patch for her lower back. The Respondent was unable to independently verify the medications

she was prescribed because her previous physician had closed his practice and the information was not available. The patient was immediately referred by the Respondent following her first visit on April 8, 2013 for surgery to restore loss of bladder and bowel function. The surgery was successful. Patient D was weaned off oxycontin and was prescribed oxycodone, even though her pain was chronic and long term.

Patient D visited the Respondent more frequently than the customary two week intervals during May and July of 2013 but was given prescriptions during these visits for two weeks worth of medication even though the medication would not run out if taken properly. There is no evidence to indicate whether the medications were taken properly because no urine tests were conducted during this period.

Finally, although the Respondent considers the treatment of Patient D as "one of the successes of XpressMedCare's pain management section" (Tr. 306), the Respondent failed to utilize other modalities of treatment for Patient D, including the use of neuromodulator medications such as anticonvulsants and antidepressants to address the pain. Other modalities may have reduced or even eliminated the need for opioid medications.

Patient E

This Patient entered the pain management section of XpressMedCare on August 1, 2012 after having fallen at work on June 5, 2012. A review of the imaging studies conducted of her left shoulder did not reveal any significant findings. She was prescribed oxycodone and was referred for chiropractic treatment. Although she was offered anti-inflammatory medications, she refused to take the ones prescribed because she claimed an adverse reaction to them. She was not offered other alternatives. As in other cases discussed, the Respondent did not order urine screens or employ other means to determine if medications prescribed were being taken as

instructed. In October 2012, the patient was given prescriptions for Percocet on October 3, October 12, and October 20. These prescriptions were not provided in accordance with the Respondent's stated practice of visits every two weeks. It is unknown why so many prescriptions for oxycodone were given in such a short time span.

On March 30, 2013, Patient E reported that her medications were stolen and requested that the Respondent provide her with a new prescription. The Respondent complied and provided the requested prescription without inquiring whether a police report was filed or the circumstances that led to the theft. Claiming that a bottle of opioids was stolen should have raised a red flag and caused the Respondent to conduct a further inquiry. Two months later, on May 17, 2013, Patient E reported that her prescription was stolen. Again, without conducting further inquiry, the Respondent provided her with a replacement prescription. This should have raised another red flag, but apparently, the Respondent did not find a stolen bottle of opioids and a lost prescription to be something that necessitated further inquiry. Additionally, no urine screens were performed to verify compliance.

The final red flag was raised when Patient E was charged with altering a prescription the Respondent wrote for Percocet by changing the prescription from 30 tablets to 80 tablets. As a result of her arrest, Patient E was discharged from the Respondent's practice. Although hindsight is clear, providing early refills without justification and failing to take steps to assure compliance with prescriptions after an instance of a claimed theft of medication and a lost prescription demonstrates a lack of care in the Respondent's prescription practices. The Respondent is acutely aware that opioids can be abused and diverted; however, he took no steps to address that in this case despite two early warning signs.

Patient F

Patient F knew of the Respondent's pain management practice prior to becoming a patient of his due to the fact that his wife and two stepdaughters were patients of the practice. Patient F is morbidly obese and has damaged knee tendons, knee cartilages, and tendons due to repetitive gravitational trauma. He is not a candidate for gastric bypass surgery.

Patient F was prescribed a SAO, Percocet, even though he has chronic pain that has lasted more than three months. Again, drug screens were not ordered to verify compliance with prescribed medication. Other modalities of treatment were not mentioned in the medical records and there is no other evidence that they were considered, including the use of anticonvulsants.

Patient G

Patient G came to the Respondent's practice from the American Spine Center. He had been suffering for years with neck, lumbar, back, and shoulder pain as a result of a motor vehicle accident. While at the American Spine Center, he was prescribed Methadone, 60 mg. daily. Dr. Wright stated in her report that Methadone prescribed for this patient was given because the patient must have had a history of opioid abuse. (State Ex. #32). The Respondent claims that there was no suggestion that he was on methadone because he was an abuser, but most certainly that he had in the past been on other opioids similar to morphine. (Tr. 317). I do not find the Respondent's testimony credible. The Respondent explained that it was his goal to immediately cease the methadone and replace it with a Fentanyl patch, which he deemed successful. The Respondent explained that morphine based medications cause a stupefying effect that impacts intellectual and mental abilities. I do not find it credible that the physicians at the American Spine Center would place Patient G on methadone, knowing the side effects of this treatment, when other treatments were available that did not have the impact on mental function that

methadone causes. It is more likely than not that Patient G abused opioid medications in the past which prompted the use of methadone.

There were no drug screens performed to determine compliance with the treatment program. Additionally, there were requests for early refills of medication which were honored without noting in the records why they were necessary. There was no verification through pill counting or other methods to determine if the patient was diverting his medication.

Most importantly, the Respondent acknowledges that he did not treat the underlying cause of the pain in this patient. He stated that "No disability was removed, but there was progress towards improving the quality of his life." (Tr. 322). The patient did have an improvement in the quality of his life, especially since he was taken off of methadone, but the Respondent failed to refer the Patient to qualified medical practitioners to treat the underlying source of his pain and to determine if treatments other than opioid therapy could be utilized to either reduce the need for opioids or eliminate them entirely. Addressing pain through drug therapy is only one means of treating a patient. Other treatments or modalities were not considered or if they were, not recommended by the Respondent in the case of Patient G.

Patient H

Patient H came to the Respondent's practice because she needed a primary care physician and her husband was already a patient of the Respondent. She presented herself as being depressed, having attention deficit disorder, and had been without thyroid medicine for several weeks. She was diagnosed with a urinary tract infection as well. There was no documentation from a neurologist or psychiatrist to confirm these findings.

On February 8, 2013, Patient H was seen by the Respondent and diagnosed with displacement of lumbar intervertebral disc without myelopathy as well as sciatica and insomnia. There are no imaging studies to support a diagnosis of back pain.

During her entire course of treatment, urine screens were not ordered. On her second to last visit, she reported that she joined Alcoholics Anonymous. When Patient H started exhibiting aggressive behaviors, the Respondent decided that a drug screen was in order. The results of the drug screen indicated that the Respondent was taking unprescribed Methadone and not prescribed oxycodone. The patient was discharged as a result of these findings. Of significance, however, is that during the course of her treatment, she did not have a urine screen to assure compliance with medication. It was only after the Respondent noticed a personality change, did a red flag appear. Urine screens when patients are treated with opioids for extended periods, such as the case with Patient H, should be routine to verify compliance. The Respondent was "astonished" to find that this stay-at-home mom had changed so dramatically and was taking medications that were not prescribed by the Respondent. (Tr. 326). There may have been no need to be astonished had the Respondent utilized the commonly accepted practice of urine tests earlier in her treatment to verify compliance. Again, as in other patients previously discussed, there is simply a lack of verification of prescription compliance that is inconsistent with generally accepted guidelines and newsletters for the use of opioids for non-cancer pain management patients.

Patient I

Patient I was also a patient of Dr. Hampton Jackson who treated patients for pain. He died, and as a result, Patient I looked to the Respondent to continue his treatment. Initially, he was not accepted into the practice but was referred to Dr. Ghorbani of the Waldorf Pain Clinic.

The Respondent gave Patient I medication on a compassionate basis including oxycodone and Valium. Patient I visited the Respondent a second time and was told the same thing as was told on his first visit, to schedule an appointment with Dr. Ghorbani, and was given additional prescriptions for oxycodone and Valium.

Patient I returned to the Respondent's practice having never seen Dr. Ghorbani. He was accepted into the practice. The patient had a spinal cord stimulator implanted that was causing inflammation and pain. Although Patient I was referred to Johns Hopkins to have the device reimplanted, there is no documentation to indicate that the patient ever followed through on the recommendation.

The Respondent continued to treat Patient I with SOAs even though he had been on these medications for many months. He was not transitioned to LAOs and SAOs which would have been used only for breakthrough pain.

The Respondent did not utilize any other modalities of treatment that would allow Patient I's opiate medication to be decreased and eventually discontinued.

Patient J

Patient J was seen at XpressMedCare on August 21, 2012 for lower back pain. A year earlier, she had spinal fusion surgery that was unsuccessful and more recently was involved in an automobile accident on July 31, 2012 that exacerbated her pain. She was referred to a surgeon to correct the initial back surgery but eventually was seen by Dr. Lauerman at Georgetown Medical Center. After declining further surgery, Patient J underwent physical therapy which she claimed caused her additional pain rather than relief. During the fall of 2012 through early 2013, Patient J was treated by the Respondent and given prescriptions for oxycodone Xanax and Ambien. During this time, the patient was urine screened. No LAO's were prescribed during this period

as well and no other adjuncts such as anticonvulsants were considered in treating this patient. Patient J ultimately died from what may have been alcohol intoxication. There is no evidence to indicate that she died from an overdose of opioid medication.

General Analysis

There is a consistent theme running through the treatment regimen provided by the Respondent to these ten patients. First, the Respondent held himself out as a specialist in pain management. He started the section of the practice in 2012 at XpressMedCare and continued it until he stopped practicing due to his own health related issues. The Respondent had only 19 hours of pain medicine training although he has practiced medicine for 46 years. He was not trained as a pain medicine specialist but was rather a family practitioner for most of his medical career. While he had some familiarity with psychiatry, his one year residency in psychiatry took place in 1968. Presumably, psychiatry has advance significantly in forty-five years. This did not, however, deter the Respondent from prescribing powerful psychiatric medications to some of his patients without referring them to a licensed psychiatrist.

The Respondent did not utilize urine drug screens effectively to verify compliance with medication and to limit the opportunity for abuse or diversion of the medication. One of his patients, Patient A, was receiving the same medications from other providers. It is not known whether he was diverting the medications for profit or whether he was taking the medications in dosages that were in excess of what was prescribed. More importantly, the Respondent did not take any measures to check. Although the Respondent was grateful to acknowledge that he was not the sole source of the medications that eventually killed Patient A, he should take no solace in the fact that by prescribing these medications without any verification that they were being

used properly, despite several red flags, he did contribute to an environment that led to the death of Patient A.

I also find that the Respondent was not credible in his testimony discussing each of the ten patients reviewed by the peer reviewers. There is not one single case in which the Respondent acknowledged that he could have done something different or may have taken a different approach in the treatment of his patients. This suggests a degree of arrogance on the part of the Respondent that is simply not justified. Dr. Wright, who is widely recognized as an expert in the field of pain medicine and who was readily accepted as an expert by the Respondent, had significant differences of opinion as to what the Respondent should have done to meet an acceptable standard of care with respect to each and every one of his ten patients. She has many years of experience in pain management and is Board certified in the practice. It is simply not credible that the Respondent would dispute each and every claim of a failure to meet a standard of care by Dr. Wright without acknowledging, at least one time, that he could have done something differently that may have resulted in a better outcome for his patients.

The Respondent's *modus operandi* in all of these patients was to treat them with SAOs instead of LAOs despite literature and guidelines that indicate that LAOs were the opioids of choice when treating patients with chronic pain. SAOs would be prescribed along with LAOs for breakthrough pain on an as needed basis only in patients suffering from chronic pain.

The Respondent utilized a unimodal treatment for his patients. With few exceptions, he treated pain through SAOs without utilizing other modes of treatment including but not limited to physical therapy, psychiatric care, or non-opioid medications for neuropathic pain.

The Respondent was slow or oblivious to obvious red flags. When patients lost medication or prescriptions, he often provided replacements without making further inquiry. He

would often provide refills that were issued well in advance of when the initial prescriptions expired.

The Respondent did, however, cooperate fully with the Board's investigation. He did not retain counsel for this hearing due to financial constraints, but nevertheless presented his defense in a sincere and forthright manner. He is very respectful of the process.

I firmly believe that the Respondent does not find any fault with his pain medicine practice and in particular, his prescribing methods. In view of the testimony of Dr. Wright and the peer reports, it is a concern that if the Respondent were to return to his pain medicine practice, he would continue to utilize the same methods he previously used that caused the Board to charge him with violations of the Maryland Medical Practice Act.

Sanctions

Pursuant to COMAR 10.32.02.09B, there are both aggravating and mitigating factors that may be considered in imposing a sanction against the Respondent. The State acknowledged that the Respondent was cooperative with the Board's investigation, and also, that he has never before been disciplined by the Board. COMAR 10.32.02.09B(5)(a). He did not, however, voluntarily admit any misconduct. COMAR 10.32.02.09B(5)(c). Since he did not claim any misconduct, he did not self-report to the Board any incident.

There was potential harm to patients as at least one of his patients expired due to a combination of drugs that were prescribed by the Respondent, although other providers provided additional quantities of the same drugs. COMAR 10.32.02.09B(5)(h). His actions were intentional as all of the prescriptions for his patients were issued by him and since he did not acknowledge any wrongdoing, his practice of issuing opioid prescriptions would likely continue if he were permitted to return to his pain medicine practice. COMAR 10.32.02.09B(5(g) and(i).

As an aggravating factor, the Respondent's actions had the potential for patient harm. COMAR 10.32.02.09B(6)(c). Prescribing SAOs for chronic pain care patients is not appropriate. They can be used for breakthrough pain, but not for long term pain. The Respondent's failure to refer patients to employ other modalities of pain treatment shows an indifference to reducing dependency of his patients on opioid medications. He did not adequately address the underlying cause of the pain in his patients before placing them on a regimen of opioids. Treating the underlying cause of the pain could have reduced or eliminated the need for opioid medications. His practice made his patients more dependent on opioids rather than less dependent.

While the Respondent has acknowledged that "because of all this, I will never go back to pain management" (Tr. 522), he does not acknowledge that he did anything wrong. He voluntarily surrendered his DEA Certificate of Registration due to the DEA's investigation. Theoretically, the DEA could reinstate his certificate. The State of Maryland has no control over whether the DEA issues a certificate or not. The State is recommending that the Respondent's license to practice medicine be suspended for one year and after the one year suspension, the Respondent would have to petition a disciplinary panel of the Board in order to be reinstated. If he is reinstated, the Respondent would be placed on three years of probation, the terms of which would be determined by the disciplinary board. Additionally, the State recommends that he be banned from prescribing any controlled dangerous substances. This would include not only opioids but any other non-opioid medication as well that is classified as a controlled dangerous substance.

The Respondent has already acknowledged that he will no longer return to the practice of pain management. I concur with the State's recommendation that due to the failure to meet the standards of care with respect to pain medicine management, the Respondent should be

suspended from the practice of medicine for a period of one year. I also concur that the Respondent, if he wishes to be reinstated after a year, petition a disciplinary panel of the Board for reinstatement and have the panel determine the conditions of probations that would last for a period of three years. However, I do not agree with the State on its recommendation that the Respondent be banned from prescribing all control dangerous substances. I do recommend that the Respondent no longer be permitted to write prescriptions for opioid containing medications. As to other medications that may be controlled dangerous substances but not opioid containing medications, I would direct the disciplinary panel to determine what type or category of controlled dangerous substances would be allowed to be prescribed by the Respondent. The total ban of controlled dangerous substances includes many substances that were not part of the focus of this investigation and were not proven to be administered by the Respondent in violation of any identified standard of care. The investigation focused on opioids primarily along with benzodiazepines. Banning the ability to write prescriptions for all controlled dangerous substances could effectively eliminate the Respondent's ability to ever practice medicine again. The evidence in this case does not support such a sanction. Finally, I propose that the Respondent be prohibited from engaging in a pain medicine practice and that the Board retain the ability to monitor the Respondent's medication prescribing practices if his license to practice medicine is reinstated.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude, as a matter of law, that the Respondent's treatment of Patients A, B, C, D, E, F, G, H, I, and J failed 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 in violation of section 14-404(a)(22) (2014) of the Health Occupations Article. As a result, I conclude that the Board may discipline the Respondent for the cited violations. COMAR 10.32.02.09A and B.

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board against the Respondent on September 12, 2014 be **UPHELD**; and

I **PROPOSE** that the Respondent be suspended from the practice of medicine for a period of one year, and if he wishes to have his license reinstated, he must petition a disciplinary panel for approval who would also determine the terms of probation which would last for three years. Additionally, the Respondent will no longer be allowed to prescribe opiate containing medications to patients and will permanently cease his pain management practice. If the disciplinary panel lifts his suspension, the panel will also decide what controlled substances or class of controlled substances the Respondent may prescribe for his patients. Finally, I recommend that the Board maintain the right to monitor the Respondent's medication prescribing practices.

July 2, 2015
Date Decision Issued

Stuart G. Breslow
Stuart G. Breslow
Administrative Law Judge

SGB/cj
#156746