IN THE MATTER OF	*	BEFORE THE MARYLAND
FRED C. GEBHARDT, M.D.	*	STATE BOARD OF
Respondent	*	PHYSICIANS
License Number: D19529	*	Case Number: 2007-0353

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CONSENT ORDER

On December 29, 2011, the Maryland State Board of Physicians (the "Board"), charged Fred C. Gebhardt, M.D. (the "Respondent") (D.O.B. 01/02/1950), License Number D19529 under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 14-404(a) (2005 & 2009 Repl. Vol.).

The pertinent provisions of the Act provide the following:

(a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(3) Is guilty of:

...

(ii) Unprofessional conduct in the practice of medicine[.]

THE AMA CODE OF MEDICAL ETHICS

The American Medical Association ("AMA") Code of Medical Ethics provides in pertinent part:

Opinion 8.19 – Self-treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby

interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination...When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training.

...Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preferences for another physician or decline a recommendation for fear of offending the physician...

...Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

On March 7, 2012, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution Conference, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

I. FINDINGS OF FACT

The Board finds the following:

BACKGROUND

1. At all times relevant hereto, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 9, 1976, and his license is presently active.

2. The Respondent, a pathologist, was Chair of Pathology at Hospital A[1] from approximately 1986 until 2006, when he resigned. For approximately one year prior to his resignation, he had been on a leave of absence

[1] In order to maintain confidentiality, facility or patient names have not been used in this document.

because of his wife's illness. On or about August 2008, he became employed by Hospital B as a pathologist.

3. On or about November 29, 2006, the Board received a complaint from a pharmacist at Pharmacy A, alleging "suspicious" prescribing practices by the Respondent. According to the complainant, after telephoning in prescriptions for patients, the Respondent would subsequently be present to pick up the prescriptions from the pharmacy.

4. The Board opened an investigation and by hand-delivered letter dated February 5, 2009, the Board notified the Respondent of its full investigation. The Board's staff also hand-delivered a subpoena requesting seven patient records. The Board had obtained the patient names from conducting area pharmacy surveys.

5. On February 6, 2009, the Respondent verbally provided information to the Board's staff regarding his prescriptions of controlled and non-controlled substances to the seven patients. He stated that he did not keep medical records for any of the patient records subpoenaed by the Board; they were either family or family friends and he "helped them when they needed the help of a doctor."

6. By letter dated March 4, 2009, the Respondent, through his attorney, submitted a written response noting that he did not have any medical records for the individuals named in the subpoena specified in ¶ 5.

7. On or about March 9, 2009, the Respondent, through his attorney, submitted a written response to the Board with regard to patients identified as A, B, C , D and E for purposes of this document.

8. On or about March 24, 2009, the Board's staff conducted an interview under oath of the Respondent regarding the allegations.

9. The Board sent relevant documents from its investigative file to a physician reviewer with a specialty in bioethics.[2] He submitted a written report to the Board based on his review of the documents opining that Dr. Gebhardt's prescribing practices constituted unprofessional conduct in the practice of medicine.

INTERVIEW OF RESPONDENT

10. During the course of the Board's staff interview of the Respondent on March 24, 2009, he admitted that he had prescribed medications to family members and friends without keeping medical records. He conceded during the interview that "...you're supposed to keep a medical record."

SELF-PRESCRIBING

11. The Respondent prescribed the following medications to himself, and had the prescriptions filled on the following dates:

    a. August 23, 2006-30 tablets of hydrochlorothiazide ("HCTZ") (diuretic used in the treatment of high blood pressure);

    b. October 7, 2006-120 tablets of carisoprodol (a muscle relaxant);

    c. March 14, 2007-60 tablets of fexofenadine (allergy medication);

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[2] The physician reviewer is board-certified in Internal Medicine, Pulmonary Medicine and Critical Care Medicine, received an M.A. in bioethics and has been the Chair of the Ethical Advisory Committee at a large teaching hospital since 1990.

d. March 14, 2007-30 tablets of trazodone (used to treat depression and anxiety disorders);

e. April 10, 2007-180 tablets of Welchol (cholesterol lowering medication)

f. June 16, 2008-30 tablets of Diovan 320 mg. (with 2 additional refills) (used in the treatment of blood pressure)

g. June 18, 2008-90 tablets of ibuprofen 800 mg. (with 2 additional refills)

h. July 19, 2008- 60 tablets of Cymbalta 60 mg. (used in the treatment of depression and anxiety disorders)

i. September 10, 2008-10 tablets of Viagra 100 mg. (with 1 refill)

j. November 17, 2008 280 tablets of Ammonium Lactate (used in the treatment of skin conditions)

k. February 5, 2009-90 tablets of ibuprofen 800 mg. (with 1 refill)

l. February 5, 2009- 10 tablets of Viagra 100 mg.

m. March 13, 2009- 30 tablets of Diovan 320 mg.

n. March 13, 2009-60 tablets of Niaspan 1,000 mg. (used in the treatment of high cholesterol)

o. March 13, 2009-30 tablets of HCTZ

p. April 27, 2009-30 tablets of HCTZ (with 3 refills)

q. April 28, 2009-10 tablets of Viagra 100 mg.

r. May 29, 2009-10 tablets of Viagra 100 mg.

s. September 14, 2009-180 mg of Welchol 625 mg.

12. On or about February 6, 2009, the Respondent admitted that he had written prescriptions for himself for "Motrin."

13. During the Respondent's interview with the Board's staff on March 24, 2009, when asked, he admitted that he had self-prescribed cholesterol medication, allergy medication, trazodone and HCTZ.

PATIENT RELATED FINDINGS

PATIENT A

14. Patient A, a female, had been a member of the Respondent's immediate family, until her death in March 2007. The Respondent prescribed hydrocodone with and without APAP[3] on multiple occasions to Patient A between September 2000 and February 2007.[4]

15. The Respondent also prescribed several other medications to Patient A between 2000 and 2007, including: diazepam,[5] Ambien,[6] zithromax,[7] carisoprodol, Kwelcof,[8] ciprofloxacin,[9] oxycodone,[10] triazolam[11] and ibuprofen.

16. On or about February 5, 2009, the Board issued a Subpoena *Duces Tecum* for Patient A's medical records.

17. As stated above, the Respondent had not maintained a medical record for Patient A.

18. The Respondent's March 9, 2009 letter stated that Patient A had a treating physician; however, when they were out of town and could not reach the

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[3] Schedule II or III Controlled Dangerous Substances ("CDS").
[4] The Respondent issued more than 60 prescriptions for hydrocodone to Patient A.
[5] Schedule IV benzodiazepine.
[6] Schedule IV benzodiazepine.
[7] An antibiotic.
[8] Schedule III CDS cough syrup.
[9] An antibiotic.
[10] A Schedule II CDS.
[11] A Schedule IV sleep aid.

physician, the Respondent would write a prescription for either pain or sleep medication for his wife.

19. The Respondent testified during his March 24, 2009 interview with the Board's staff that Patient A had cancer that was diagnosed in April 2004. When she ran out of her pain medication, or if they were out of town, the Respondent would write pain prescriptions for her as well as muscle relaxants and non-controlled substances. He stated that initially he would document the medications on a calendar at home, but then he met with Patient A's internist and told him what Patient A had been taking.

20. The Respondent admitted during his interview that over the course of three years (from his wife's diagnosis until her death) he had prescribed hydrocodone for Patient A on approximately 66 occasions and that he prescribed Soma[12] for her whenever she needed it.

PATIENT B

21. Patient B is a close friend of the Respondent.

22. The Respondent prescribed CDS and non-controlled medications to Patient B on multiple occasions between January 2006 and September 2009, including Endocet,[13] diazepam,[14] Ambien, ibuprofen, Viagra, trazodone, hydrocodone, oxycodone, naproxen[15] and alprazolam.[16]

23. On or about February 5, 2009, the Board issued a Subpoena *Duces Tecum* for Patient B's medical records.

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[12] Carisoprodol.
[13] Oxycodone and acetaminophen, a Schedule II CDS.
[14] A Schedule IV benzodiazepine.
[15] Non-controlled substance used in the management of mild to moderate pain.
[16] A Schedule IV CDS.

24. As stated above, the Respondent had not maintained a medical record for Patient B. He testified that initially when he began prescribing for Patient B he had kept a calendar of the medications prescribed. He stated that he had stopped that practice however, and was not able to locate a copy of the "calendar."

25. The Respondent stated to the Board's staff on February 6, 2009 that he had been giving Patient B narcotics for his back, "sometimes when he runs out of pain medication." He stated that he periodically meets with Patient B's radiologist[17] for lunch to talk about how Patient B was doing and he (the radiologist) had him prescribe for Patient B.

26. The Respondent's March 9, 2009 letter confirmed that Patient B had a physician; however, he recalled an occasion in which Patient B was unable to reach his physician and he prescribed Percocet so his friend could go to Florida.

27. On June 18, 2009, the Board's staff interviewed Patient B's radiologist ("Dr. T") under oath. Patient B had been under the care of Dr. T, who specializes in spinal diagnostics and pain management, from approximately 1989 through at least June 2009. Initially, Dr. T was under the impression that the Respondent had been Patient B's primary care physician; he had been unaware for several years that the Respondent's specialty was pathology. Sometime in 2005, Dr. T learned that the Respondent was a pathologist.

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[17] The radiologist at issue is Dr. T described in ¶ 27.

28. According to Dr. T, the Respondent never consulted him or contacted him about Patient B.

29. Dr. T testified that he had a "very serious concern" about the Respondent's prescribing of CDS for Patient B. Dr. T testified further about Patient B:

> ...I'm going to guess on three occasions in the last five to six years—I had facilitated detoxification of [Patient B]. It was evident to me that this patient was over-medicated; it concerned me; it concerned the patient. [Patient B] expressed concern that he felt uncomfortable with his level of medication. It was unacceptable...

30. In addition, Dr. T testified:

> ...the medications I individually was giving [Patient B] was probably as much as I've ever, ever given a patient. And, then, ultimately to find out he had another source for medication was, you know, so – so unbelievable to me that–those are the instances in which I again suggested he seek detoxification.

31. During his interview under oath with the Board's staff on March 24, 2009, the Respondent confirmed that he had written 58 prescriptions for hydrocodone for Patient B;[18] for a period of time he prescribed the CDS approximately every 11-12 days. He testified that Patient B had a pain management physician, but that if he (Patient B) could not reach him (the pain management physician), the Respondent would write CDS prescriptions for Patient B. The Respondent did not directly contact Patient B's physician regarding the prescriptions. He testified that it was "up to [Patient B]" to update his physician.

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[18] The Respondent testified that Patient B would switch between hydrocodone and Percocet, as the Percocet caused constipation.

32. On or about September 1, 2006, Dr. M, Patient B's orthopedic surgeon, documented that Patient B's narcotic pain medication intake is "chronic" and he recommended weaning Patient B off of the CDS because of their "physical dependency" and in order to improve other qualities of Patient B's life.

33. A July 26, 2007 note in Patient B's orthopedic surgery chart noted:[19]

> Spoke to Dr. [T][20] regarding this patient's pain medication and management of same. Discussed with Dr. [T] the medications the patient currently states he is using, including Oxycontin 80 mg., Percocet 10 mg., and Valium 5 mg. Dr. [T] expressed concern since these are not what he most recently prescribed for the patient. Dr. [T] had most recently prescribed Fentanyl patch, 100 mcg, with Percocet for breakthrough, with a Valium ordered. Talked with Dr. [T] at length about the difficulty of managing this patient's medications, especially if the patient gets them from two sources. Dr. [T] agrees and is willing to manage this patient's medication regime entirely. At this time, the patient will be taken off of the Oxycontin, started on a 100 mcg Fentanyl patch, maintain Percocet 5 mg..., and Valium 10 mg. q 6 hrs PRN. Prescriptions for the same given to the patient prior to discharge. The patient and his wife both made aware of the above plan and that Dr. [T] should be the only physician that the patient received medication from. The patient's wife will also gather all current medications at home and dispose of them prior to the patient's discharge so that there is no confusion about medication usage. The patient, and wife, verbally express understanding of the above instructions.

34. The Respondent also testified during his interview with the Board's staff that if Patient B ran out of other medications, he would show him the prescription from his physician and the Respondent would refill the prescription for him.

[19] The note was documented by a nurse in Dr. M's office.
[20] Dr. T is a radiologist specializing in spinal disorders.

PATIENT C

35. The Respondent prescribed Sulfamethazole/TMP DS[21] to Patient C on two occasions: June 15, 2006 and June 30, 2006.

36. On or about February 5, 2009, the Board issued a Subpoena *Duces Tecum* for Patient C's medical records.

37. As stated above, the Respondent had not maintained a medical record for Patient C.

38. The Respondent stated to the Board's staff on February 6, 2009 that he had written prescriptions to Patient C for Fiorinal and that she was in "remission" for bilateral breast cancer.

39. The Respondent's March 9, 2009 letter stated that Patient C was a close friend, that she suffers from migraine headaches and he recalled a "couple of occasions" when Patient C was unable to reach her physician and he provided her with a prescription for Fiorinal. He recalled that Patient C told him that she had some blood work done and the Fiorinal had been causing elevated liver enzymes, so her physician had taken her off of it, but then subsequently restarted it.

40. During the Respondent's March 24, 2009 interview with the Board's staff, he testified that he prescribed the Sulfamethazole for Patient C before she was to travel, and also prescribed hydrocodone and diazepam for her migraines. He did not know who Patient C's physician was.

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[21] An antibiotic commonly used for urinary tract infections.

41. According to Patient C, the Respondent prescribed Valium for her on one occasion; however, the pharmacy would not fill it since the Respondent was present with her husband to pick up the medication.

PATIENT D

42. The Respondent prescribed Ambien on three occasions to Patient D in 2006: January 3, January 24 and February 24.

43. On or about February 5, 2009, the Board issued a Subpoena *Duces Tecum* for Patient D's medical records.

44. As stated above, the Respondent had not maintained a medical record for Patient D.

45. During the Respondent's February 6, 2009 meeting with the Board's staff, he stated that he did not know who Patient D was.

46. The Respondent's March 6, 2009 letter to the Board stated that Patient D had metastatic carcinoma in her head and that the Respondent recalled prescribing hydrocodone to her when she was having a severe headache and coughing fits.

47. During the Respondent's March 24, 2009 interview with the Board's staff, he recalled that Patient D had been a neighbor. He did not however, know who her treating physician was.

PATIENT E

48. Patient E, a female, is a member of the Respondent's immediate family, to whom the Respondent prescribed medications, including CDS.

49. On several dates, the Respondent prescribed hydrocodone to Patient E without a documented progress note. Patient E had the prescriptions filled on the following dates: January 21, 2009, February 15, 2009, March 13, 2009 and August 7, 2009.

50. On April 19, 2009, the Respondent documented a progress note that included a medical history and present complaint of back pain. He prescribed diazepam and hydrocodone.

51. On May 18, 2009, the Respondent again prescribed hydrocodone and diazepam for Patient E's continued back pain. He documented a progress note.

52. On June 21, 2009, the Respondent prescribed hydrocodone for an exacerbation of her back pain. He documented a progress note.

53. On March 6, 2010, the Respondent prescribed hydrocodone and diazepam for Patient E's back pain after "falling down steps carrying laundry baskets."

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions and inactions as outlined above constitute violations of Md. Health Occ. Code Ann. § 14-404(a) (3) (ii).

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 11th day of April, 2012, by a majority of a quorum of the Board considering this case:

ORDERED that the Respondent be and is hereby **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS** and until the following terms and conditions are fully and satisfactorily complied with:

1. Within six (6) months of the date of this Consent Order, the Respondent shall successfully complete, at his own expense, a Board-approved comprehensive course or 1:1 tutorial in medical ethics focusing on self-prescribing and prescribing for family members and close friends. This course or tutorial is not to be counted towards the Respondent's Continuing Medical Education ("CME") requirement for licensure. It shall be the Respondent's burden to provide the Board with proof that he successfully completed the course or tutorial;

2. The Respondent shall not prescribe any controlled dangerous substances ("CDS") during his probationary period. Any prescriptions for CDS issued by the Respondent during his probationary period shall be considered a violation of his probation and of this Consent Order;

3. The Respondent shall not self-prescribe or prescribe any medications to family members or close friends. Any prescriptions issued by the Respondent to himself, to family members or close friends shall be considered a violation of his probation and of this Consent Order;

4. The Respondent shall provide a copy of this Consent Order to his physician employer or supervisor at each place of medical employment; and it is further

ORDERED that there shall be no early termination of these probationary terms and conditions; and it is further

ORDERED that after **TWO YEARS** from the date of this Consent Order, the Respondent may submit a written petition to the Board requesting a termination of his probation. After consideration of the petition, the probation

may be terminated through an Order of the Board, or a designated Board Committee. The Board, or designated Board Committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

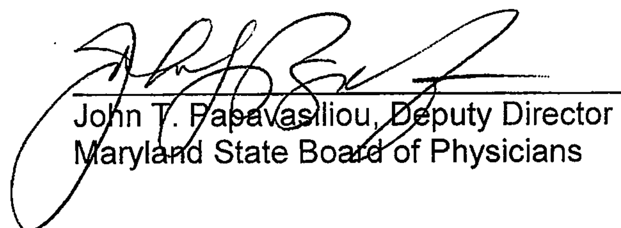
ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of probation or this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including probation, reprimand, suspension, revocation and/or a monetary fine; and it is further

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2009 Repl. vol.).

4/11/2012
Date



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

CONSENT ORDER

I, Fred C. Gebhardt M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

3/14/12
Date

Fred C. Gebhardt, M.D.

Reviewed and Approved by:

Jeffrey L. Forman, Esquire

STATE OF : Maryland

CITY/COUNTY OF Harford

I HEREBY CERTIFY that on this 14 day of March, 2012, before me, a Notary Public of the foregoing State and City/County personally appeared Fred C. Gebhardt, M.D., License Number D19529, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

[signature]
Notary Public

Commission expires: 11/10/2014