IN THE MATTER OF	*	**BEFORE THE MARYLAND**
DINESH SHAH, M.D.,	*	**STATE BOARD OF**
Respondent.	*	**PHYSICIANS**
License No. D 23334	*	**Case Nos. 2007-0339; 2007-0534; 2007-0423; 2009-0649 & 2009-0785**

* *

FINAL DECISION AND ORDER

On August 5, 2010, the Board summarily suspended the medical license of Dinesh Shah, M.D. ("Dr. Shah"), finding that the public health, safety or welfare imperatively required this emergency action under Md. State Gov't Code Ann., § 10-226(c)(2). The Board held a hearing on August 25, 2010, pursuant to Md. State Gov't Code Ann., § 10-226(c)(2)(ii). Following that hearing, the Board affirmed the summary suspension but stayed the effect of the summary suspension under certain conditions. *See* COMAR 10.32.02.05H(4). Dr. Shah violated those conditions, and on October 13, 2010, after another hearing, the Board lifted the stay of the summary suspension.

Meanwhile, Dr. Shah exercised his right to ask for an evidentiary hearing before an Administrative Law Judge ("ALJ") on the issue of the summary suspension. See COMAR 10.32.02.05 I. By the time that the case was at the prehearing stage before the ALJ, however, the stay had been lifted, and the ALJ treated the case as an appeal of an active summary suspension. After an evidentiary hearing held on October 18 and 19, 2010, the ALJ issued a Proposed Decision on November 16, 2010. In that proposed decision, the ALJ made 117 findings of fact, discussed the evidence at great

length and concluded that the health, safety and welfare of the public imperatively requires the Board to issue an order to suspend Dr. Shah's license, under COMAR 10.32.02.05F(2).

Neither party filed exceptions to the Board. In the absence of exceptions, the Board shall issue an order containing findings of fact and conclusions of law. COMAR 10.32.02.03F(4).

FINDINGS OF FACT

The Board adopts and incorporates into this decision the 117 findings of fact proposed by the ALJ. The Proposed Decision of the ALJ is attached to this decision. The Board also adopts and incorporates into this decision the additional facts and the evaluation of the evidence found in the "Discussion" section of the Proposed Decision, except the Board does not adopt the discussion of the "procedural issue" at pages 35-36 of that document.[1] The evidence considered does not include the evidence proffered by the Administrative Prosecutor concerning Dr. Shah's activities between August 26 and October 13, 2010.[2]

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[1] The Board clearly has the authority, after a summary suspension hearing, to issue "any interim order that the circumstances of the case warrant." COMAR 10.32.02.05H(4). In certain cases, a modified summary suspension, or a summary suspension stayed under certain specific circumstances, may be the optimum means to protect the public without overly burdening the practitioner at that early stage of the proceedings, before any evidentiary hearing has been held. In this case, unfortunately, it soon became apparent that this disposition was not working as intended.

[2] It would seem that, as a matter of practicality, and considering the unique nature of the summary suspension proceeding and the possibly increased danger to the public that might have been demonstrated by this additional evidence, this evidence should have been admitted. The Board need not reach this issue, however.

CONCLUSIONS OF LAW

The Board adopts the conclusions of law proposed the ALJ. The health, welfare and safety of the public imperatively require the Board to suspend Dr. Shah's license. COMAR 10.32.02.05F(2). The public health imperatively required this emergency action, under Md. State Gov't Code Ann. § 10-226(c) (2).

ORDER

It is therefore hereby **ORDERED** that Dr. Shah's license to practice medicine **REMAINS SUMMARILY SUSPENDED**; and it is further

ORDERED that this order constitutes a public document pursuant to Md. State Gov't Code Ann. § 10-617.

4/21/11
Date

John T. Papayasiliou
Deputy Director
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Dr. Shah has the right to seek judicial review of this decision. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order is mailed.

Any petition for judicial review shall be made as provided for in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Shah files an appeal, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians

c/o Christine Farrelly, Chief of Compliance Administration

4201 Patterson Avenue,

Baltimore, Maryland 21215.

The Administrative Prosecutor is not involved in the circuit court process and need not be served or copied on pleadings filed in the circuit court.

MARYLAND STATE BOARD OF	* BEFORE JAMES W. POWER,
PHYSICIANS	* AN ADMINISTRATIVE LAW JUDGE
v.	* OF THE MARYLAND OFFICE
DINESH SHAH, M.D.,	* OF ADMINISTRATIVE HEARINGS
RESPONDENT	* OAH No: DHMH-SBP-72-10-33538
LICENSE No: D23334	*

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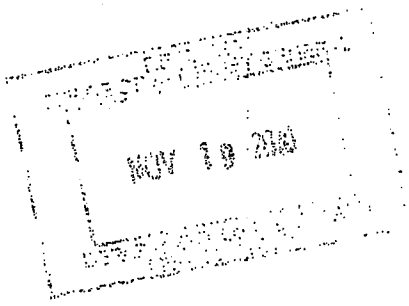
PROPOSED DECISION



STATEMENT OF THE CASE

On August 5, 2010, the Maryland State Board of Physicians (Board) summarily suspended Dinesh Shah, M.D.'s (Respondent) license, alleging that the public health, safety or welfare imperatively required emergency action because the Respondent failed to adhere to the standard of care in pain management. Md. Code Ann., State Gov't § 10-226(c) (2009). The Board forwarded the charges to the Office of the Attorney General for prosecution.

I held a hearing on October 18 and 19, 2010, at the Office of Administrative Hearings (OAH) in Hunt Valley. Md. Code Ann., State Gov't § 10-205 (2009). Tracee O. Fruman, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). Ali Kalarestaghi, Esquire and Jaime Cheret, Esquire represented the Respondent.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure for the Board, and the Rules of Procedure of the OAH. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2009 & Supp. 2010); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUE

Does the Respondent pose a risk of serious harm to the public health, safety, or welfare because he failed to meet the standard of care for pain management?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits for the State:

1. August 28, 2008 Consent Order
2. Complaint #1 (case number 2007-0339, November 3, 2006
3. Complaint #2 (case number 2007-0534), December 28, 2006
4. Respondent's response to Complaint #1, February 15, 2007
5. Complaint #3 (case number 2007-0423), February 21, 2007
6. Interview of Complainant #3, January 26, 2009
7. Interview of the Respondent, January 29, 2009
8. Complaint #4 (case number 2009-0649), March 4, 2009
9. Complaint #5 (case number 2009-0785), March 18, 2009
10. Order for Summary Suspension, August 5, 2010
11. Correspondence from the Respondent to the Administrative Prosecutor, August 23, 2010
12. Board's Order, August 26, 2010
13. Correspondence from Board Staff to the Respondent, September 17, 2010
14. Correspondence from the Respondent to Board Staff, September 17, 2010
15. Correspondence from the Respondent to Board Staff, September 20, 2010
16. Board's Order Vacating the Stay of the Order for Summary Suspension of Medical License, September 23, 2010
17. Correspondence from the Respondent to Board Staff, September 24, 2010
18. Patient A – Respondent's medical records
19. Patient B – Respondent's medical records
20. Patient C – Respondent's medical records[1]
21. Patient E – Respondent's medical records
22. Patient F – Respondent's medical records
23. Patient G – Respondent's medical records

[1] The Board withdrew the case of Patient D and did not rely on it at the hearing.

24. Patient H – Respondent's medical records
25. Patient I – Respondent's medical records
26. Patient J – Respondent's medical records
27. Patient K – Respondent's medical records
28. Respondent's Certification of Medical Records, January 29, 2009
29. Respondent's Summary of Patient Charts, March 27, 2009
30. Death Certificate for Patient E
31. Curriculum Vitae – Anurita Mendhiratta, M.D., F.A.C.P.
32. Peer Review Report – Anurita Mendhiratta, M.D., F.A.C.P.
33. *Prescribing Controlled Drugs*, Maryland Board of Physician Quality Assurance Newsletter, Volume 4, Number 1, March 1996
34. Continuing Medical Education Certificates
    a. May 10-11, 2003 – Certificate of Completion, Pain Management Programs for Primary Care
    b. September 12, 2004 – American Academy of Pain Management Credentialing Exam
    c. April 30, 2005 – Buprenorphine & Office-Based Treatment of Opioid Dependence
    d. September 6-7, 2007 – PAINWeek 2007
    e. Member, Chronic Pain Network

The Respondent did not submit any documents into the record.

Testimony

The State presented the testimony of Dr. Anurita Mendhiratta, M.D., F.A.C.P., expert in Internal Medicine.

The Respondent testified on his own behalf and presented the testimony of Thomas Johnson.

FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

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 on February 9, 1979, under license number D23334. The Respondent is board-certified in Internal Medicine; however, he is also a self designated pain management specialist. The Respondent maintains a private medical practice at 2327 Pulaski Highway, # 101A, North East, Maryland 21901.

2. The Respondent does not hold any hospital privileges.

3. In 2008, the Board initiated an investigation of the Respondent's practice after it received a complaint from a former patient. The complaint alleged that the Respondent, who was providing anti-coagulation therapy for the complainant, was unaware that he had ordered an excessive dosage of anti-coagulation medication. The complaint further alleged that the Respondent failed to take appropriate corrective action after he was notified that he had ordered an excessive dosage of the medication.

4. As a result, the Board charged the Respondent with violating the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 & Supp. 2010). Specifically, the Board charged the Respondent with violating H.O. § 14-404(a)(22).

6. In lieu of an evidentiary hearing, the Respondent agreed to enter into a Consent Order, dated August 28, 2008, which consisted of Findings of Fact consistent with the allegations in the charges, conclusions of law that the Respondent failed to meet quality medical standards and failed to keep adequate medical records, and Order. Pursuant to the Consent Order, the Respondent was reprimanded and placed on probation for a minimum of three years.

9. On or about November 3, 2006, the Board received a complaint from a pharmacist who worked at a pharmacy in Elkton, Maryland, alleging that the Respondent had allowed his secretary, an unlicensed individual, to write and/or sign prescriptions.

10. On or about December 28, 2006, the Board received a second complaint from a relative of one of the Respondent's patients. The Complaint alleged that the Respondent was prescribing controlled dangerous substances (CDS) to an addicted patient without medical necessity.

11. On or about February 21, 2007, the Board received a complaint from a deceased patient's relative. The patient had died of a Methadone overdose. The complaint alleged that the Respondent was aware that the deceased patient was a substance abuser, yet he still prescribed Methadone to the patient.

12. On or about March 4, 2009, the Board received a complaint from a relative of a deceased patient. The complaint alleged that the Respondent may be performing inappropriate examinations in exchange for CDS prescriptions.

13. On or about April 24, 2009, the Board received a complaint from a pharmacist stating that many of the Respondent's patients were prescribed "large amount of Methadone, Oxycodone 15 mg, Oxycodone 30 mg tablets" and that most of the Respondent's patients "are young, of swarthy appearance and appear able bodied and in no apparent pain" when they fill their prescriptions.

14. The Respondent engaged in a pattern of excessive and unjustifiable prescribing of Schedule II opioid analgesics, primarily Oxycodone and Methadone, without medical indication. In doing so, the Respondent placed his patients at risk for potentially serious or life-threatening consequences such as habituation, addiction and/or death.

15. The approach to chronic pain is a comprehensive one. During the initial evaluation, the standard of quality care requires the physician to inquire about the nature, severity, timing, location, quality and aggravating factors of the pain. This requires a full medical history and physical, as well as laboratory testing and diagnostic imaging as necessary. Patients with chronic pain may be candidates for opioid therapy after other appropriate therapies and modalities have been attempted and have failed. For all of the patients reviewed, the Respondent prescribed narcotic

analgesics over long periods of time without implanting a clear pain management plan or implementing a comprehensive strategy to address the patients' medical needs or drug use.

16. The Respondent prescribed potent narcotics without performing thorough examinations, assessing the etiology of their pain, exhausting alternate therapies and modalities, or establishing a clear need for such medication.

17. The Respondent prescribed narcotic analgesics over long periods of time without first exhausting other treatment modalities or therapies. On the rare occasions when the Respondent referred a patient for physical therapy or to pain management specialist, he usually failed to follow-up with the patient or the health care provider to determine whether the patient actually kept appointments for consultations or received the therapy to which he had referred him/her.

18. The Respondent consistently increased patients' dosages without justification other than the patients' subjective complaints of pain.

19. The Respondent required most of his patients whose care was reviewed to sign a pain management contract and to review his pain management policies at some point in their treatment. One of the terms of the agreement provides: "Narcotics will be prescribed to new patients only if old records are available to verify previous treatments, barring some exceptions." In nearly every case reviewed, the Respondent freely prescribed narcotics to patients without any previous records.

20. The Respondent's pain management policy further notified patients to "expect Urine and Blood Drug Screen (sic) from time to time" and "a pill count during every visit" to monitor medication compliance. However, the Respondent did not consistently monitor medication compliance; in fact, some patients were never monitored for medication compliance.

21. Notwithstanding his pain management policy, the Respondent consistently disregarded evidence of drug abuse and diversion and continued to prescribe narcotics to those patients who had violated the policy.

22. The Respondent notified his patients of his Urine Testing Procedures, which mandate at least two urine toxicology screens per year, and additional follow-up testing in the case of abnormal results. The Respondent rarely complied with this policy and never followed up abnormal results with subsequent testing or discussion of the results with the patient.

23. There were many instances where the Respondent should have recognized that his patients were either abusing or diverting the narcotic analgesics he was prescribing. These occurrences, commonly called "red flags," include: claims of theft or frequent loss of prescriptions; early requests for refills or prescriptions, and patients who report diffuse pain that is difficult to verify objectively. In such situations, it is incumbent upon the prescribing physician to recognize these "red flags," address the patients' improper use of these medications, and take action to prevent the misconduct from recurring. The Respondent encountered many "red flags" when treating his patients, yet he failed to curtail or modify prescribing such medications and failed to address these patients' drug abuse issues.

24. In most instances, the Respondent, who served as both pain management and primary care physician for the patients reviewed, focused only on treatment of "chronic pain" complaints and failed to provide adequate primary care to his patients. In doing so, the Respondent placed his patients at risk for potentially serious or life-threatening consequences.

25. Patient A was a 30 year old male when he began seeing the Respondent in December 2006 for low back pain. Patient A reported that he had been in a motor vehicle accident eight months prior to his first visit and had been taking pain medication since that time. Patient A

reported that no X-rays had been conducted after the accident. The Respondent did not order any radiologic studies at the time of Patient A's initial assessment.

26. There are no previous records regarding Patient A's motor vehicle accident in his chart. At Patient A's initial appointment, he signed a copy of the Respondent's Urine Testing Procedures, which mandates at least twice yearly urine toxicology screens as "standard and legally required." According to the Respondent's Urine Testing Procedures, additional testing is done if the results are abnormal.

27. After Patient A's first appointment, the Respondent prescribed Methadone 40 mg, Oxycodone 15 mg and Ativan 1 mg to treat Patient A's pain. There is no indication from the patient's record that the Respondent conducted a comprehensive physical examination. Thereafter, the Respondent followed Patient A on a monthly basis.

28. At each appointment, Patient A filled out a form detailing his pain, which the Respondent used as a history. The Respondent did not take a separate history. The Respondent utilized a pre-printed, cursory examination form on which the Respondent circled his impressions of Patient A. At each visit, the Respondent circled that Patient A's lumbar spine was abnormal, but no further examination or description of the abnormality was noted.

29. The Respondent diagnosed Patient A with chronic low back pain, not otherwise specified, and sacroiliac joint pain. On two occasions, the Respondent included x-rays and nerve conduction velocity studies in Patient A's treatment plan, but there was no mention of any test results in Patient A's chart. In addition, the Respondent failed to document whether he discussed with Patient A the reason X-rays were not done.

30. Patient A regularly indicated that his pain level was a seven out of 10, and the Respondent maintained him on Oxycodone and Methadone. However, the Respondent failed to order an MRI to assess the etiology of the pain.

31. The Respondent failed to refer Patient A to physical therapy or to an orthopaedist.

32. The Respondent failed to offer any medications other than narcotics. He continued to increase Patient A's dosages of Oxycodone and Methadone without medical indication and never attempted to titrate down the drug dosage.

33. Two of the prescriptions included in Patient A's chart are written in different handwriting than the Respondent's handwriting.

34. Patient A's chart contains a photocopy of a prescription for Methadone 40 mg dated April 24, 2007, with a note that states "somebody picked up the rx by paying $60 saying he was [Patient A]." No attempt was documented regarding efforts to ensure that the individual who picked up the prescription was indeed Patient A.

35. Despite his own Urine Testing Procedure stating that urine toxicology screenings were conducted at least twice annually, the Respondent made only one attempt to monitor Patient A for medication compliance. A urine toxicology screen on November 6, 2007 was positive for Methadone but negative for Oxycodone metabolities, indicating possible diversion. The Respondent made a note to repeat the test, but no further mention of Patient A's non-compliance or possible drug diversion is addressed in the record. The Respondent continued his monthly prescribing of opioids for Patient A.

36. Patient B was a 52 year old female when she began seeing the Respondent for chronic pain in her right ankle, left foot and right hand in August 2006. The Respondent did not conduct a complete history. However, there is documentation of a non-displaced fracture in the

fifth metatarsal in September 2006, as well as a history of right hand surgery and open reduction internal fixation of a fracture of the right ankle. According to Patient B's chart, she had two follow-up visits with an orthopaedist for the metatarsal fracture.

37. At Patient B's initial appointment, she signed the Respondent's Urine Testing Procedures. In addition, the Respondent indicated that he would be counting Patient B's pills and conducting a urine toxicology screen for medication compliance four times per year.

38. Despite an incomplete evaluation, the Respondent immediately prescribed Lorcet 10/650 mg QID and MS Contin 30 mg BID to Patient B. In August 2006, the Respondent filled out a Medication Report pertaining to Patient B for the Cecil County Department of Social Services. The Respondent indicated that he did not perform any diagnostic testing on Patient B and that previous records of Patient B's care are "unavailable so far." The Respondent did not answer the question "is substance abuse present," but checked "no" to the question, "would the patient's current condition exist in the absence of current substance abuse?"

39. The Respondent continued to maintain Patient B on heavy narcotics at increasing dosages to treat her chronic pain. By early 2007, the Respondent was prescribing MS Contin 100 mg TID and Oxycodone 15 mg QID.

40. In January 2008, the Respondent added Xanax to Patient B's medication regimen. He initially prescribed 0.25 mg TID and by August 2008, the Respondent was prescribing 0.25 mg (every four hours) with two refills.

41. Despite taking such heavy narcotics, Patient B continued to indicate that her pain level was seven to nine out of 10 at her monthly appointments. The Respondent failed to appropriately treat Patient B's high blood pressure, which was noted to be elevated at almost every

appointment. The Respondent prescribed blood pressure medication in April 2008, but did not follow-up.

42. Laboratory tests were done once in April 2008 and the Respondent prescribed Lovatin to treat Patient B's high cholesterol. The Respondent did not follow up on Patient B's high cholesterol. The Respondent failed to attempt other treatment modalities by referring Patient B to an orthopaedist or to physical therapy.

43. Despite monthly appointments and an initial plan to check for medication compliance four times per year, the Respondent never ordered a urine toxicology screen for Patient B or conducted pill counts. The Respondent failed to abide by his own protocol to monitor Patient B for drug abuse. The Respondent failed to address and document Patient B's possible substance abuse.

44. The Respondent's care of Patient B was limited to analgesic relief, although a reasonable approach would have been rigorous physical therapy with a goal of weaning the patient off of narcotics and returning to her work.

45. Patient C was a 38 year old male when he began seeing the Respondent in October 2003 for chronic back pain. Patient C also had a history of substance abuse (alcohol and intravenous drugs), alcohol-induced seizures, Hepatitis C, and coronary artery disease.

46. On February 17, 2004, Patient C signed a pain contract with the Respondent, which set the parameters for treating Patient C's pain with narcotics. In doing so, Patient C agreed not to use any illegal controlled substance, including marijuana, cocaine, etc. The contract also states that Patient C's medication regimen "will be continued for a period of four months" and that "if there is no evidence that [Patient C] is improving or that progress is being made . . . the regimen will be tapered to [Patient C's] pre-trial medications."

47. In January 2004, the Respondent received an anonymous telephone call from "a concerned friend" of Patient C. The individual stated that Patient C was abusing medication and was extremely intoxicated taking these drugs. The friend was concerned that Patient C might die.

48. At Patient C's next appointment, eight days after the anonymous telephone call, the Respondent failed to mention the concerns of Patient C's friend regarding Patient C's alleged abuse of medication, but instead, issued a prescription to Patient C for Percocet.

49. In February 2004, Patient C called the Respondent's office numerous times seeking prescriptions for his pain medications. A note in Patient C's chart indicated that Patient C was a "no show" at his appointment with another pain management physical and therefore the Respondent would not dispense any medications. However, several days after Patient C's telephone calls, the Respondent prescribed Lorcet 10/650 mg QID for Patient C.

50. In March 2004, Patient C was seen by an orthopaedist for his back pain. However, Patient C was discharged from the orthopaedist's practice because of Patient C's lack of motivation to improve and his "obvious drinking problem." A note written in the Respondent's handwriting on the orthopaedist's discharge letter states "pt to be continued on pain meds only if continues with psychiatrist and substance abuse counselor and AA." Without any evidence that Patient C complied with those conditions, the Respondent continued to prescribe narcotics for Patient C.

51 A 2006 prescription profile for Patient C indicated that he was taking Hydrocodone with acetaminophen. The Respondent noted on the document that he was not prescribing this mediation for Patient C, yet there is no indication that the Respondent followed up on this inconsistency. The Respondent failed to address whether Patient C was abusing drugs by obtaining narcotic medications from multiple sources.

52. A February 2007 note in Patient C's chart indicated that the Respondent was to conduct pill counts six times each year and urine toxicology screens four times each year for Patient C. There is no evidence that the Respondent checked for medication compliance regularly. The Respondent failed to abide by his own protocol for monitoring Patient C for possible drug abuse.

53. On September 18, 2007, Patient C submitted to a urine toxicology screen and the results were inconsistent with his current drug regimen. The results were negative for Oxymorphone and Morphine, and positive for cocaine.

54. The Respondent failed to address Patient C's use of illegal drugs, but continued to supply Patient C with prescriptions for narcotics.

55. On December 17, 2007, Patient C submitted to a urine toxicology screen and tested positive for benzodiazepines, barbiturates, Oxycodone, Marijuana and trace Cocaine. At the time, the Respondent was prescribing MS Contin and Percocet for Patient C. Despite the obvious red flag that Patient C was obtaining CDS from multiple sources, the Respondent failed to inquire and address Patient C's drug seeking behavior with him.

56. Occasionally, the Respondent noted that he referred Patient C for alcohol and addiction counseling, but there is no evidence of follow-up in Patient C's record, and the Respondent continued to prescribe narcotics to Patient C at regular intervals.

57. The Respondent's last progress note, dated January 29, 2009, for Patient C stated "no narcotics"' however, the Respondent prescribed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycodone 15 mg to Patient C.

58. The Respondent continued to supply Patient C with prescriptions for potent narcotics, despite a well documented history of abuse and ample evidence of current abuse in violation of Patient C's pain management contract.

59. Patient E was a 47 year old male who saw the Respondent for chronic back pain from early 2004 until Patient E's death in January 2007. Patient E was seen by another pain management practice in January, February, March and April 2003 and different medications were prescribed to treat Patient E's chronic pain. Patient E had an MRI and planned to have epidural injections; however, there are no further notes after April 2003 in Patient E's chart regarding his treatment with the pain management practice.

60. According to Patient E's record from the pain management practice, Patient E was referred for a psychological evaluation as part of his treatment plan. However, the record did not contain any notes relative to that appointment. The pain management practice referred Patient E to a physical therapist. Patient E began going to physical therapy, but stopped showing up for his appointments and his therapy was therefore discontinued.

61 All subsequent care for Patient E was with the Respondent. In February 2004, Patient E signed a pain management contact, informed consent for narcotics, and the Respondent's Policy for Pain Treatment.

62. The Respondent saw Patient E at regular monthly intervals and prescribed various narcotics (Methadone), anti-anxiety medications (Xanax), and anti-depressants. The Respondent tested Patient E for medication compliance one time, in August 2005.

63. Patient E's record shows that he had an MRI of his knee in 2005 that revealed a partial tear of the meniscus, but there is no evidence that the Respondent referred Patient E to an orthopaedist to address the meniscus tear.

64. An MRI of Patient E's spine revealed severe degeneration at L5-S1 with mild degeneration at L4-5 and the cervical spine.

65. Patient E's record reflects that he suffered carcinogenic shock in November 2006 after heavy bleeding from his nose and required a blood transfusion. The hospital summary indicates that Patient E stated that he wasn't taking any regular medication. At the time, the Respondent had been prescribing Methadone and Xanax for Patient E.

66. In January 2007, Patient E was found unresponsive in his home. Patient E was resuscitated but ultimately expired. The hospital summary states, *inter alia*, alcohol intoxication, cocaine overdose, and possible septic shock with multiple organ failure.

67. Patient E's death certificate identified narcotic (methadone and morphine) and ethanol intoxication as the causes of death. Throughout his treatment of Patient E, the Respondent never addressed or documented a plan to address Patient E's drug abuse.

68. The Respondent ordered laboratory tests for Patient E only twice in three years of caring for Patient E, despite seeing Patient E monthly to refill his prescriptions. The only care that the Respondent provided was to prescribe narcotics to Patient E. Despite Patient E's longstanding problem with chronic pain and drug addiction, the Respondent failed to adequately monitor Patient E's drug use and failed to provide any supportive treatments or approach to meet Patient E's functional goals.

69. Patient F was a 42 year old female when she began seeing the Respondent for back and neck pain and headaches. The Respondent followed Patient F from August 2005 until September 2008. Patient F had a history of hypertension, diet-controlled diabetes mellitus, and migraine headaches.

70. The Respondent documented that Patient F reported that she had been suffering from pain for a long period of time and that she was no longer responsive to over-the-counter non-steroidal anti-inflammatory drugs (NSAIDs).

71. At Patient F's initial visit, she noted on the patient filled form that she suffered from multiple join pains and rheumatoid arthritis. Patient F underwent laboratory testing for Lyme Disease and other connective tissue disorders, all of which were negative.

72. Patient F also had a history of high blood pressure, which the Respondent documented. The Respondent prescribed medication to treat Patient F's high blood pressure on two occasions.

73. The Respondent failed to document routine medical care in Patient F's chart.

74. The Respondent referred Patient F for a MRI of the lumbar spine, but Patient F's record did not contain any MRI results of the lumbar spine. The Respondent failed to document whether Patient F ever complied with his referral for MRI.

75. The Respondent prescribed Xanax and various narcotics (Avinza, Percocet, Fentanyl) for Patient F for a number of years. In addition, the Respondent prescribed Lyrica and Depakote to treat Patient F's headaches. Without documenting his rationale the Respondent resorted to increasing dosages of narcotic analgesics, tranquilizers and sleep producing agents.

76. The Respondent continued to provide higher dosages of the medications at Patient F's request and ultimately prescribed Fentanyl. Patient F tested positive for marijuana three times while under the Respondent's care. In a July 2007 drug screen, Patient F tested positive for Methadone, which the Respondent did not prescribe to her, and "possibly positive" for cocaine. In November 2007, Patient F tested "possibly positive" for amphetamines. There is no record in Patient F's chart to indicate whether the Respondent addressed these inconsistent laboratory results with Patient F.

77. The only documentation of Patient F's visits with the Respondent included statements that she was in pain and copies of prescriptions issued by the Respondent. Patient F entered a substance abuse treatment program in 2007.

78. The Respondent did not appropriately follow up on Patient F's blood pressure or abnormal drug screens, nor did he order laboratory tests regularly.

79. Patient G was a 40 year old male when he began seeing the Respondent in June 2005 for shoulder, knee and hand pain. Over the years, the Respondent diagnosed Patient G with various conditions, such as tendonitis, rotator cuff problems, polyarthritis, chronic pain syndrome, and lumbar stenosis. In 2008, the Respondent diagnosed Patient G with seronegative rheumatoid arthritis based on his family history.

80. Patient G was seen by an orthopaedist in September 2005 for shoulder pain. The physician gave Patient G a local injection into the acromioclavicular joint and recommended physical therapy and anti-inflammatory medication.

81. Patient G saw an orthopaedist again in September 2005 for knee pain associated with a previous injury. The physician prescribed a NSAID, and recommended heat and Tylenol for the pain.

82. Following Patient G's September 2005 appointment with the orthopaedist, he followed up with regular visits to the Respondent, who immediately prescribed various narcotics for Patient G's pain.

83. Between May 2005 and March 2008, Patient G had 10 X-rays and MRI's of his left shoulder, hands, knees, elbow, left foot and lumbar spine. The results indicated that Patient G had arthritis or osteoarthritis in his shoulder, hands, and spine at L4-5.

84. The Respondent initially prescribed Lortab and Ansaid (NSAID) to treat Patient G's pain, and later added Avinza. The Respondent began increasing the dosages of these medications significantly without documenting his rationale.

85. By December 2008, the Respondent was prescribing Dilaudid and Oxycontin, in addition to a muscle relaxant, to treat Patient G's pain. In 2008, the Respondent prescribed Prednisone and Methotrexate to treat Patient G's polyarthritis. The Respondent failed to perform a comprehensive evaluation, including laboratory testing, of Patient G to determine whether he met the criteria for a diagnosis of rheumatoid arthritis.

86. While prescribing Methotrexate to Patient G, the Respondent failed to order any blood tests for Patient G to monitor his liver function in three years.

87. The Respondent failed to refer Patient G to a rheumatologist for evaluation and treatment before prescribing Oxycontin and Dilaudid.

88. Patient H was a 42 year old female when she began seeing the Respondent in February 2007 for burning pain down both legs, buttocks and the middle of the back. Patient H reported an approximately eight year history of chronic low back pain and bipolar disorder.

89. At the time of her initial appointment with the Respondent, Patient H reported that she had not been taking any medications for her pain. After taking a history and conducting a physical examination, the Respondent diagnosed Patient H with chronic low back pain.

90. The Respondent recommended stress management for Patient H and placed her on Klonopin 1 mg QID PRN (as needed), Oxycontin 40 mg TID, Lortab 10/650 BID, and Ansaid 1 mg BID PRN for her pain. Also at her first appointment, Patient H signed an acknowledgement of the Respondent's Pain Management Policy.

91. The Respondent saw Patient H on a monthly basis for refills of her potent narcotics prescriptions. Patient H was instructed to come to her April 24, 2007 appointment with her pills in their original containers for a pill count. There is no notation in Patient H's chart as to whether or not Patient H complied with this requirement.

92. In May 2007, September 2007 and November 2007, the Respondent ordered drug tests for Patient H to monitor her medication compliance. The test results were inconsistent on all three occasions. Patient H tested negative for drugs that the Respondent prescribed for her, and tested positive for drugs not prescribed for her. Further, Patient H's November 2007 toxicology screen was positive for cocaine. Despite proof of drug diversion by Patient H, the Respondent failed to comply with his own drug policy and his obligation by discharging Patient H from his practice immediately.

93. On August 17, 2007, Patient H wrote on her Patient Comfort Assessment that she was moving out of state and that the Respondent stated that she could pick up her prescriptions. However, Patient H did not move out of state and presented to the Respondent for appointments in September, October and November 2007.

94. The Respondent prescribed opiods without any attempt to determine the cause of Patient H's chronic pain. Further, the Respondent did not discharge Patient H from his practice until four months after drug screens indicated that she was diverting her medication and/or taking illicit drugs in violation of her medication contract.

95. Patient I was a 26 year old female, who lived in Philadelphia, Pennsylvania, when she began seeing the Respondent in August 2005 for complaints of left hand pain, which she reported was the result of punching someone. Patient I broke her fifth metacarpal and the injury was

orthopaedically managed. Patient I was taking only Ibuprofen for her hand pain. Patient I reported a history of asthma, carried an Albuterol inhaler, and stated that she often felt irritable.

96. At Patient I's initial appointment, the Respondent obtained a medical history and performed a focused physical examination. The Respondent ordered nerve conduction velocity studies and prescribed Avinza 30 mg QAM, Lorcet 10/650 mg QID, Motrin 600 mg QID, and Xanax 0.5 mg QID PRN, as well as other medications. The Respondent did not have Patient I sign a pain management contract.

97. The Respondent did not order X-rays, nor did he request Patient I's prior treatment records. The Respondent diagnosed Patient I with Chronic Pain Syndrome secondary to Carpal Tunnel Syndrome.

98. The Respondent continued to prescribe CDS and other prescription medications to Patient I, sometimes increasing or decreasing the dosages. The Respondent also prescribed Oxycodone 15 mg QID, but discontinued it because Patient I reported she did not like it.

99. The Respondent attributed Patient I's irritability to bipolar disorder, but failed to document how he arrived at that diagnosis.

100. On September 23, 2005, the results of Patient I's urine toxicology screen were inconsistent with Patient I's drug regimen. The Respondent noted "amphetamine abuse, absence of Hydrocodone, presence of Oxycodone." The Respondent had not prescribed amphetamines for Patient I. A note from Patient I's October 17, 2005 appointment stated that Patient I reported having taken diet pills at the time of her positive toxicology screen.

101. Patient I tested negative for Morphine, which was prescribed by the Respondent. The Respondent failed to discuss or document discussing Patient I's inconsistent drug test results at her

next appointment or anytime thereafter. In May 2006, Patient I ran out of Xanax and was seen in a hospital emergency room with a seizure.

102. At her May 24, 2006 appointment with the Respondent, Patient I reported cocaine use. The Respondent noted "psych referral if any further lapses" and "must go to substance abuse counselor and NA meeting (pt agrees)." The Respondent made no further mention of substance abuse in Patient I's chart and did not follow up at future monthly visits.

103. In November 2006, Patient I stated that her Morphine was stolen and the Respondent provided a duplicate prescription for 28 pills. The Respondent noted "one chance used up" in his progress notes for Patient I. There are several notes in Patient I's chart stating that she ran out of her medications prior to her next scheduled appointment. The Respondent failed to prescribe less addictive medications to Patient I for a minor hand injury that had been previously managed conservatively by an orthopaedist.

104. In addition, the Respondent failed to refer Patient I for psychiatric care, particularly with dual diagnoses of substance abuse and bipolar disorder. Further, the Respondent failed to carefully evaluate Patient I before prescribing Morphine and other narcotics.

105. The Respondent failed to conduct a full evaluation of Patient I, failed to order any radiologic testing, failed to make appropriate referrals and failed to consider Patient I's substance abuse before prescribing potent narcotics. In addition, the Respondent failed to address evidence that Patient I had been diverting her medication, and continued to re-fill her prescriptions.

106. Patient J was a 47 year old male when he began seeing the Respondent for complaints of chronic back pain resulting from a 1988 injury. Patient J had a lumbar laminectomy in September 2003, which had been unsuccessful. He had been going to physical therapy, but discontinued it because he stated that it aggravated his pain. An electrical stimulation unit was also not helpful

according to Patient J. The Respondent diagnosed Patient J with Failed Back Surgery Syndrome with Radiculopathy.

107. The Respondent established a goal of maintaining Patient J in a state that would allow him to continue working. In 2004, Patient J was involved in a motor vehicle accident and thereafter saw the Respondent regularly for pain control. Patient J signed the Respondent's Informed Consent for Narcotics (Opioids) [*sic*], Urine Testing Procedure and the Respondent's Policy for Pain Treatment. Patient J was also under a pain management contract dated February 16, 2006.

108. The Respondent initially prescribed MS Contin 15 mg BID in late 2003, but by 2009 he was prescribing MS Contin 100 mg TID along with Percocet, Dilaudid and Klonopin to Patient J.

109. In July 2007, Patient J tested positive for cocaine and wrote an apology note to the Respondent, admitting that he had used cocaine at a party. The Respondent offered Patient J a period of rehabilitation and Patient J complied.

110. While being treated for chronic pain, Patient J began to suffer from erectile dysfunction and low testosterone, which was attributed to chronic opioid therapy. Patient J received twice monthly injections of testosterone to treat his low testosterone. Further, Patient J had a parotid mass, although it is unclear if it was removed. Despite having appropriately evaluated and referred Patient J for his back pain, the Respondent dispensed narcotics without regard to Patient J's substance abuse. Further, Patient J's substance abuse issues were not adequately addressed by the Respondent.

111. In addition, the Respondent neglected to attend to routine preventative measures. He failed to monitor Patient J's prostate health and PSA, despite Patient J's use of testosterone.

112. The Respondent was serving as Patient J's primary care physician, yet no other preventative measures were taken with regard to Patient J's general health.

113. Patient K was a 25 year old male when he began seeing the Respondent in September 2006 for intrascapular back pain following a motor vehicle accident 10 days prior to his visit. Patient K reported being treated at a New York hospital and being sent home with a prescription for Percocet after a negative X-ray. Patient K claimed an intolerance of Tylenol but tolerated Percocet without issue.

114. The Respondent obtained a medical history and conducted a focused physical examination of Patient K's upper back before diagnosing him with an acute strain to the rhomboids and trapezius muscles.

115. The Respondent prescribed Skelaxin (a muscle relaxant), Percocet, and Ansaid. Patient K was then followed on a monthly basis until December 2007. Throughout his care under the Respondent, Patient K continued to receive prescriptions for potent narcotic analgesics as the sole form of treatment without the proper examination and evaluation.

116. Patient K's record indicated that he did not show up for a pill count and that he had been seeing another physician in New York. The Respondent failed to order X-rays or other radiologic imaging studies and failed to refer Patient K for physical therapy. The Respondent failed to establish a clear treatment plan for Patient K, such as establishing functional goals for him. Further, the Respondent failed to adequately monitor Patient K for compliance, particularly as the record reflects that Patient K became physically dependent, and perhaps addicted, while under the Respondent's care.

117. The Respondent failed to address evidence that Patient K might be receiving narcotics from another physician, in violation of his pain management contract.

DISCUSSION

The Board summarily suspended the Respondent's license because it found that the public health, safety or welfare imperatively require emergency action. Md. Code Ann., State Gov't § 10-226 (c)(2). "The administrative prosecutor bears the burden to show by a preponderance of the evidence that the health, welfare, and safety of the public imperatively requires the Board to issue an order to suspend the respondent's license." COMAR 10.32.02.05F(2). "Imperatively required" is defined as an action which "must be undertaken . . . as a result of factual contentions which raise a substantial likelihood of risk of serious harm to the public health, safety, or welfare." COMAR 10.32.02.02B(14). For the reasons discussed below, I find that such circumstances exist in this case.

The Board relied on the testimony of Dr. Anurita Mendhiratta, M.D., F.A.C.P., who testified as an expert in the area of internal medicine. The Respondent started his practice in the area of internal medicine but shifted to an emphasis on pain management in 2001. Approximately eighty five percent of his practice is in the area of pain management and fifteen percent in the area of internal medicine.

Dr. Mendhiratta explained the differing types of pain, such as chronic and acute, and also explained the standard of care for treating these types of pain. Perhaps the most significant part of her testimony was the emphasis on conservative versus aggressive treatment.

Before prescribing narcotics, a physician should try less aggressive forms of treatment, such as over the counter treatments or physical therapy. There must be some genuine attempt to utilize these treatments before moving on to more potent drugs.

As explained by Dr. Mendhirrata, the obvious danger in overprescribing highly potent drugs is the possibility that the patient could be harmed as well as the potential for drugs being diverted

for illegal purposes. She explained how the physician must be alert to "drug seeking behavior", which is indicative of persons who are addicted to narcotics.

Pain is obviously subjective. However, a physician can still monitor the drugs by using urine and blood tests as well as pill counting, which confirms that the patient has been taking the medicine. An "inconsistent blood test" means that a drug which is supposed to be present is missing, or some other drug which is not supposed to be present is in fact present in the blood.

While the Respondent takes exception to the image of him as being nothing but a pill dispenser, the facts clearly show that this is precisely the case. In reviewing the records, there is no evidence that the Respondent actually tried more conservative treatment. There are a few suggestions that patients try physical therapy, but no follow-up. Conservative treatment does not mean suggesting, but means actually trying other forms of treatment. This means there must be some record of physical therapy or less potent forms of treatment in the patient files. There simply is none.

In terms of monitoring patients' blood and urine, as well as obtaining a history, there is likewise no evidence that the Respondent did this. Part of the drug seeking behavior by patients is moving from one physician to another until the patient finds a doctor who will write the prescription with few questions being asked. The Respondent, by his testimony, received a large number of patients from another physician who closed his practice and yet did little to confirm what medications they were on or their history. There are instances of inconsistent blood tests and no response by the Respondent. One patient, for some reason, came from the Philadelphia area to North East to see the Respondent.

The Respondent's explanation was that his records are not complete and do not fairly depict his practice at the time. He cites a 2008 consent order in which he was required to take a course in

medical record keeping, because of poor patient records. He then attempted to discredit Dr. Mendhirrata's testimony on the ground that she was reviewing incomplete records. He testified that his records today are much more complete and accurate.

The Respondent then proceeded to go through each patent's records and provide numerous details about what he did at the time that are not mentioned in the records. He testified about conversations and information gained many years ago with no reference to any written record.

I find the Respondent's testimony to be self serving. None of the details about his practice at the time were disclosed prior to this hearing. I do not believe he engaged in any such practice as described by him. There is simply no reason to believe that his records were so inadequate that one could not rely on them. The reason that blood and urine tests as well as patient histories are missing, is that they simply were not done. The Respondent stated that today he takes elaborate patient notes and even suggested that a patient history could be as long as seven pages. Yet he provided no example of any recent patient history which would suggest that his practice today is any different than it was in 2008.

The Board's action in this case is based upon twelve patient records. This is not to suggest that every patient seen by the Respondent received substandard care. Given the number of patients reviewed and the breadth of substandard care however, the suspension in this case must be upheld.

After Patient A's first appointment, the Respondent prescribed Methadone 40 mg, Oxycodone 15 mg and Ativan 1 mg to treat Patient A's pain. There is no indication from the patient's record that the Respondent conducted a comprehensive physical examination. The Respondent did not take a separate history, he used a pre-printed, cursory examination form on which he circled his impressions of Patient A. At each visit, the Respondent circled that Patient A's lumbar spine was abnormal, but no further examination or description of the abnormality was noted.

The Respondent included X-rays and nerve conduction velocity studies in Patient A's treatment plan, but there was no mention of any test results in Patient A's chart.

Patient B was a 52 year old female when she began seeing the Respondent for chronic pain in her right ankle, left foot and right hand in August 2006. The Respondent did not conduct a complete history. However, there is documentation of a non-displaced fracture in the fifth metatarsal in September 2006, as well as a history of right hand surgery and open reduction internal fixation of a fracture of the right ankle.

At Patient B's initial appointment, she signed the Respondent's Urine Testing Procedures. Despite an incomplete evaluation, the Respondent immediately prescribed Lorcet 10/650 mg QID and MS Contin 30 mg BID to Patient B. In August 2006, the Respondent filled out a Medication Report pertaining to Patient B for the Cecil County Department of Social Services. The Respondent indicated that he did not perform any diagnostic testing on Patient B and that previous records of Patient B's care are "unavailable so far." The Respondent did not answer the question "is substance abuse present," but checked "no" to the question, "would the patient's current condition exist in the absence of current substance abuse?" The Respondent continued to maintain Patient B on heavy narcotics at increasing dosages to treat her chronic pain. By early 2007, the Respondent was prescribing MS Contin 100 mg TID and Oxycodone 15 mg QID. In January 2008, the Respondent added Xanax to Patient B's medication regimen. He initially prescribed 0.25 mg TID and by August 2008, the Respondent was prescribing 0.25 mg q4 th (every four hours) with two refills. Despite taking such heavy narcotics and other medications, Patient B continued to indicate that her pain level was seven to nine out of 10 at her monthly appointments.

Patient C was a 38 year old male when he began seeing the Respondent in October 2003 for chronic back pain. Patient C also had a history of substance abuse (alcohol and intravenous drugs),

alcohol-induced seizures, Hepatitis C, and coronary artery disease. Patient C agreed not to use any illegal controlled substance, including marijuana, cocaine, etc. In January 2004, the Respondent received an anonymous telephone call from "a concerned friend" of Patient C. The individual stated that Patient C was abusing medication and was extremely intoxicated taking these drugs. The friend was concerned that Patient C might die. At Patient C's next appointment, eight days after the anonymous telephone call, the Respondent failed to mention the concerns of Patient C's friend regarding Patient C's alleged abuse of medication, but instead, issued a prescription to Patient C for Percocet. In February 2004, Patient C called the Respondent's office numerous times seeking prescriptions for his pain medications. A note in Patient C's chart indicated that Patient C was a "no show" at his appointment with another pain management physical and therefore the Respondent would not dispense any medications. However, several days after Patient C's telephone calls, the Respondent prescribed Lorcet 10/650 mg QID for Patient C.

The Respondent failed to address Patient C's use of illegal drugs, but continued to supply Patient C with prescriptions for narcotics. On December 17, 2007, Patient C submitted to a urine toxicology screen and tested positive for benzodiazepines, barbiturates, Oxycodone, Marijuana and trace Cocaine. At the time, the Respondent was prescribing MS Contin and Percocet for Patient C. Despite the obvious red flag that Patient C was obtaining CDS from multiple sources, the Respondent failed to inquire and address Patient C's drug seeking behavior with him.

Patient E was a 47 year old male who saw the Respondent for chronic back pain from early 2004 until Patient E's death in January 2007. Patient E was seen by another pain management practice in January, February, March and April 2003 and different medications were prescribed to treat Patient E's chronic pain. Patient E had an MRI and planned to have epidural injections, however, there are no further notes after April 2003 in Patient E's chart regarding his treatment with

the pain management practice. According to Patient E's record from the pain management practice, Patient E was referred for a psychological evaluation as part of his treatment plan. However, the record did not contain any notes relative to that appointment.

The pain management practice referred Patient E to a physical therapist. Patient E began going to physical therapy, but stopped showing up for his appointments and his therapy was therefore discontinued. The Respondent saw Patient E at regular monthly intervals and prescribed various narcotics such as Methadone and Xanax.

The Respondent tested Patient E for medication compliance one time, in August 2005. Patient E's record reflects that he suffered carcinogenic shock in November 2006 after heavy bleeding from his nose and required a blood transfusion. The hospital summary indicates that Patient E stated that he wasn't taking any regular medication. At the time, the Respondent had been prescribing Methadone and Xanax for Patient E.

In January 2007, Patient E was found unresponsive in his home and ultimately expired. The hospital summary states, *inter alia*, alcohol intoxication, cocaine overdose, and possible septic shock with multiple organ failure. Patient E's death certificate identified narcotic (methadone and morphine) and ethanol intoxication as the causes of death.

The Respondent ordered laboratory tests for Patient E only twice in three years of caring for Patient E, despite seeing Patient E monthly to refill his prescriptions. The only care that the Respondent provided was to prescribe narcotics to Patient E.

Patient F was a 42 year old female when she began seeing the Respondent for back and neck pain and headaches. The Respondent followed Patient F from August 2005 until September 2008. Patient F had a history of hypertension, diet-controlled diabetes mellitus, and migraine headaches.

The Respondent documented that Patient F reported that she had been suffering from pain for a long period of time and that she was no longer responsive to over-the-counter NSAID.

Patient F also had a history of high blood pressure, which the Respondent documented. The Respondent prescribed medication to treat Patient F's high blood pressure on two occasions. The Respondent prescribed Xanax and various narcotics (Avinza, Percocet, Fentanyl) for Patient F for a number of years. In addition, the Respondent prescribed Lyrica and Depakote to treat Patient F's headaches. Without documenting his rationale the Respondent resorted to increasing dosages of narcotic analgesics, tranquilizers and sleep producing agents. The Respondent continued to provide higher dosages of the medications at Patient F's request and ultimately prescribed Fentanyl.

Patient F tested positive for marijuana three times while under the Respondent's care. In a July 2007 drug screen, Patient F tested positive for Methadone, which the Respondent did not prescribe to her, and "possibly positive" for cocaine. In November 2007, Patient F tested "possibly positive" for amphetamines. There is no record in Patient F's chart to indicate whether the Respondent addressed these inconsistent laboratory results with Patient F.

Patient G was a 40 year old male when he began seeing the Respondent in June 2005 for shoulder, knee and hand pain. Over the years, the Respondent diagnosed Patient G with various conditions, such as tendonitis, rotator cuff problems, polyarthritis, chronic pain syndrome, and lumbar stenosis. In 2008, the Respondent diagnosed Patient G with seronegative rheumatoid arthritis based on his family history.

Patient G saw an orthopaedist again in September 2005 for knee pain associated with previous injury. The physician prescribed a NSAID, and recommended heat and Tylenol for the pain. Following Patient G's September 2005 appointment with the orthopaedist, he followed up

with regular visits to the Respondent, who immediately prescribed various narcotics for Patient G's pain.

Between May 2005 and March 2008, Patient G had 10 X-rays and MRI's of his left shoulder, hands, knees, elbow, left foot and lumbar spine. The results indicated that Patient G had arthritis or osteoarthritis in his shoulder, hands, and spine at L4-5. The Respondent initially prescribed Lortab and Ansaid (NSAID) to treat Patient G's pain, and later added Avinza. The Respondent began increasing the dosages of these medications significantly without documenting his rationale. By December 2008, the Respondent was prescribing Dilaudid and Oxycontin, in addition to a muscle relaxant to treat Patient G's pain. In 2008, the Respondent prescribed Prednisone and Methotrexate to treat Patient G's polyarthritis. The Respondent failed to perform a comprehensive evaluation, including laboratory testing, of Patient G to determine whether he met the criterion for a diagnosis of rheumatoid arthritis.

Patient H was a 42 year old female when she began seeing the Respondent in February 2007 for burning pain down both legs, buttocks and the middle of the back. Patient H reported an approximately eight year history with chronic low back pain and bipolar disorder. At the time of her initial appointment with the Respondent, Patient H reported that she had not been taking any medications for her pain. After taking a history and conducting a physical examination, the Respondent diagnosed Patient H with chronic low back pain.

The Respondent recommended stress management for Patient H and placed her on Klonopin 1 mg QID PRN (as needed), Oxycontin 40 mg TID, Lortab 10/650 BID, and Ansaid 1 mg BID PRN for her pain. Also at her first appointment, Patient H signed an acknowledgement of the Respondent's Pain Management Policy).

Patient H was instructed to come to her April 24, 2007 appointment with her pills in their original containers for a pill count. There is no notation in Patient H's chart as to whether Patient H complied with this requirement. In May 2007, September 2007 and November 2007, the Respondent ordered drug tests for Patient H to monitor her medication compliance. The test results were inconsistent on all three occasions. Patient H tested negative for drugs that the Respondent prescribed for her, and tested positive for drugs not prescribed for her. Further, Patient H's November 2007 toxicology screen was positive for cocaine.

The Respondent prescribed opiods without any attempt to determine the cause of Patient H's chronic pain. Further, the Respondent did not discharge Patient H from his practice until four months after drug screens indicated that she was diverting her medication and/or taking illicit drugs in violation of her medication contract.

Patient I was a 26 year old female, who lived in Philadelphia, Pennsylvania, when she began seeing the Respondent in August 2005 for complaints of left hand pain, which she reported was the result of punching someone. Patient I broke her fifth metacarpal and the injury was orthopaedically managed. Patient I was taking only Ibuprofen for her hand pain. Patient I reported a history of asthma, carried an Albuterol inhaler, and stated that she often felt irritable.

At Patient I's initial appointment, the Respondent obtained a medical history and performed a focused physical examination. The Respondent ordered nerve conduction velocity studies and prescribed Avinza 30 mg QAM, Lorcet 10/650 mg QID, Motrin 600 mg QID, and Xanax 0.5 mg QID PRN, as well as other medications. The Respondent did not have Patient I sign a pain management contract.

The Respondent continued to prescribe CDS and other prescription medications to Patient I, sometimes increasing or decreasing the dosages. The Respondent also prescribed Oxycodone 15

mg QID, but discontinued it because Patient I reported she did not like it. The Respondent attributed Patient I's irritability to bipolar disorder, but failed to document how he arrived at such diagnosis. On September 23, 2005, the results of Patient I's urine toxicology screen were inconsistent with Patient I's drug regimen. The Respondent noted "amphetamine abuse, absence of Hydrocodone, presence of Oxycodone." The Respondent had not prescribed amphetamines for Patient I. In May 2006, Patient I ran out of Xanax and was seen in a hospital emergency room with a seizure. At her May 24, 2006 appointment with the Respondent, Patient I reported cocaine use. The Respondent noted "psych referral if any further lapses" and "must go to substance abuse counselor and NA meeting (pt agrees)." The Respondent made no further mention of substance abuse in Patient I's chart and did not follow up at future monthly visits.

Patient J was a 47 year old male when he began seeing the Respondent for complaints of chronic back pain resulting from a 1988 injury. Patient J had a lumbar laminectomy in September 2003, which had been unsuccessful. He had been going to physical therapy, but discontinued it because he stated that it aggravated his pain. A TENS unit was also not helpful, according to Patient J. The Respondent diagnosed Patient J with Failed Back Surgery Syndrome with Radiculopathy.

The Respondent established a goal of maintaining Patient J in a state that would allow him to continue working. In 2004, Patient J was involved in a motor vehicle accident and thereafter saw the Respondent regularly for pain control. Patient J signed the Respondent's Informed Consent for Narcotics. Patient J was also under a pain management contract, dated February 16, 2006. The Respondent initially prescribed MS Contin 15 mg BID in late 2003, but by 2009 he was prescribing MS Contin 100 mg TID along with Percocet, Dilaudid and Klonopin to Patient J. In July 2007, Patient J tested positive for cocaine and wrote an apology note to the Respondent, admitting that he

had used cocaine at a party. The Respondent offered Patient J a period of rehabilitation and Patient J complied.

Patient K was a 25 year old male when he began seeing the Respondent in September 2006 for intrascapular back pain following a motor vehicle accident 10 days prior to his visit. Patient K reported being treated at a New York hospital and being sent home with a prescription for Percocet after a negative X-ray. Patient K claimed an intolerance of Tylenol but tolerated Percocet without issue.

The Respondent obtained a medical history and conducted a focused physical examination of Patient K's upper back before diagnosing him with an acute strain to the rhomboids and trapezius muscles. The Respondent prescribed Skelaxin (a muscle relaxant), Percocet, and Ansaid. Patient K was then followed on a monthly basis until December 2007. Throughout his care under the Respondent, Patient K continued to receive prescriptions for potent narcotic analgesics as the sole form of treatment without the proper examination and evaluation.

Patient K's record indicated that he did not show up for a pill count and that he had been seeing another physician in New York. The Respondent failed to address evidence that Patient K might be receiving narcotics from another physician, in violation of his pain management contract.

The evidence presented in these case histories shows a consistent disregard for the standard of care, not just for pain management, but for internal medicine as well. Pain management contracts were simply ignored when violated by the patient. The Respondent went so far as to make psychiatric conclusions and diagnosed one person with rheumatoid arthritis based on nothing more than a family history. In light of inconsistent blood tests, showing that the patient either had not taken the medicine or taken some other medicine, the Respondent did nothing. He repeatedly failed to take proper measures, not just for pain management but for high blood pressure, spinal

conditions, diabetes and other medical conditions falling within the area of internal medicine. For these reasons, I conclude that the Respondent presents a danger to the public, not only in the area of pain management but in the area internal medicine as well.

Although my decision is not based on any procedural issue in this case, there is a procedural issue meriting discussion because the State attempted to raise it at the hearing.

This case was transmitted to OAH under the emergency suspension provisions of the APA and the Board's emergency suspension regulations. By nature, these provisions are designed to ensure that an individual holding a license is suspended pending some further review by the agency. They are not the same as the general disciplinary regulations of an agency, which provides the agency broader authority in determining the length, condition and nature of any suspension.

The difference between the two types of discipline is seen by the fact that an emergency suspension can be imposed prior to any due process hearing, while the general regulatory authority of an agency can only be imposed after such a hearing. A license holder from any state agency is ether an imminent threat to the public or he is not. Contrary to the Board's assertion at the hearing, there is no such thing as being a danger only at certain times or under certain circumstances. The notion of some limited right to hold a license while being a danger to the public is inconsistent with the summary suspension law.

On August 5, 2010, the Board elected to summarily suspend the Respondent's license. After a postdeprivation hearing, there are only four options available to the Board; affirm the suspension, reverse the suspension, issue a consent order or issue an interim order. COMAR 10.32.02.05. The Board in this case elected none of these options, but made a decision which more closely resembles a "settlement offer" than an order from a regulatory board. The Board "stayed" the suspension on the condition that the Respondent adhere to three limitations of his practice. A stay is not an order.

These limitations would have effectively limited the Respondent to the practice of internal medicine. The Board erroneously advised the Respondent that if he disagreed with these conditions, he could file an appeal.[2]

This was the status of the case when it was transmitted to OAH. At the prehearing conference in October 2010, the first issue addressed was how OAH could have a summary suspension hearing for a suspension that did not exist. I made it clear to the parties that if the Respondent was not actually suspended, there would be no hearing and the case would be dismissed.

At that point, Counsel for the State stated that the Board had met the previous week, September 29, 2010, and voted to lift the stay and impose the emergency suspension. For purposes of this hearing, that was the only fact that needed to be resolved. The reasons why the Board lifted the stay are completely irrelevant to my decision. At the time, I assumed that the Board lifted the stay because that was the consequence of the Respondent's refusal to accept the conditions.

Therefore, a gap existed between August 25, 2010 and September 29, 2010 during which time the legal status of this case is simply unclear. By the terms of the Board's own decision, the Respondent was not suspended because the suspension had been stayed. There is no evidence of a consent order or agreement by the Respondent to abide by any conditions. Given the subsequent lifting of the stay in September however, it was not incumbent on me to sort out the various legal problems created by the Board's August 25, 2010 decision.[3]

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[2] In fact there is no such appeal right. Under the Board's summary suspension rules, a physician can only appeal from the "issuance" of a suspension. COMAR 10.32.02.05J. In this case, the Board "stayed " the suspension, which is defined as the withholding of Board action. COMAR 10.32.02.02b(32).

[3] If the Respondent had agreed to the Board's terms, then there was a consent order and the present hearing was not necessary y because there was no suspension to appeal.

Had the Board simply let the procedural issues in the case rest, it would not be necessary for me to comment on them at this time. Unfortunately, the State attempted to inject into the hearing the events between August 25, 2010 and September 29, 2010 as essentially a new basis for the summary suspension.

During the questioning of the Respondent, Board Counsel asked to submit a letter from Board dated September 29, 2010, indicating that the stay had been lifted. The pretext for submitting this document was that the record was needed to show that the Respondent was in fact suspended. However, the Respondent knew he was suspended and that issue had been resolved at the prehearing conference. In the absence of any objection, I admitted this letter into the administrative section of the file, for the limited purpose of establishing that the Respondent was suspended on an emergency basis at the time of this hearing.

Unfortunately, the real reason for submission of this document had nothing to do with documenting any suspension. Counsel then attempted to delve into the whole area of what the Respondent did between August and September, suggesting that the Respondent had now violated some Board order and thereby attempting to create whole new hearing unrelated to any emergency suspension.

The only basis for summary suspension in this case is the substandard care provided by the Respondent, not violation of a Board order. Attempting to inject into the hearing an alleged violation of some agreement or order, which may not even have existed, is a separate issue unrelated to these proceedings and was done for no reason other than to prejudice the Respondent.

Had the Board followed its own rules and summarily suspended the Respondent on August 25, 2010, there would have been no stay, no conditions, no uncertainty or confusion and indeed no

reason to explain why a physician, who was an imminent danger to the public, was nevertheless given some limited right to practice medicine between August and September.

Although the Respondent cannot prevail on the merits of this case, he is still afforded a certain amount of due process, which includes the right to a hearing based upon the written charges and facts supporting those charges. He was denied numerous requests for postponements, documents, witnesses and subpoenas, precisely on the ground that parties should not be able to create new issues at the last minute of a hearing. However, this principle applies to the Board as well as to the Respondent. Given the confusing posture of this case between August 25, 2010 and September 29, 2010, any factual or legal discussion of the events during this time becomes even more irrelevant.

For these reasons, the Respondent's objection to this line of questioning was sustained and the State was not allowed to present any testimony about this period of time.

CONCLUSIONS OF LAW

I conclude that the health, welfare, and safety of the public imperatively requires the Board to issue an order to suspend the respondent's license." COMAR 10.32.02.05F(2).

PROPOSED DISPOSITION

I **PROPOSE** that the summary suspension of the Respondent's license to practice medicine be **UPHELD**.

November 16, 2010
Date decision mailed

James W. Power
Administrative Law Judge

JWP/
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NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions, in writing, to this Proposed Decision with the Board of Physicians within fifteen days of issuance of the decision. Md. Code Ann., State Gov't § 10-216 (2009) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

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