IN THE MATTER OF	*	**BEFORE THE**
DINESH SHAH, M. D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D23334	*	**Case Numbers: 2009-0649, 2009-0785, 2010-0862, 2010-0422,**
	*	**2010-0918, 2011-0035**

* * * * * * * * * * * *

CONSENT ORDER

On September 20, 2010, the Maryland State Board of Physicians (the "Board") charged **Dinesh Shah, M.D. (the "Respondent") (D.O.B. 06/28/1948)** License Number D23334, under the Maryland Medical Practice Act ("the Act"), Md. Health Occ. Code Ann. ("H.O") §§ 14-101 *et. seq.* (2009 Repl. Vol.). On January 5, 2011, the Board issued amended charges that superseded the charges issued on September 20, 2010.

Specifically, the Board charged the Respondent with violating the following provisions of H.O. § 14-404, which provide:

> (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:
>
> (i) Immoral conduct in the practice of medicine; or
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> (ii) Unprofessional conduct in the practice or medicine;
>
> (4) Is professionally, physically or mentally incompetent;
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; [and]

(27) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes[.]

FINDINGS OF FACT

I. BACKGROUND

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland.[1] 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.

2. At all times relevant to the statements herein the Respondent maintained a private medical practice at 2327 Pulaski Highway, #101A, North East, Maryland 21901.

3. The Respondent does not hold any hospital privileges.

4. 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 complainant further alleged that the Respondent failed to take appropriate corrective action after he was notified that he ordered an excessive dosage of the medication.

[1] The Respondent was also licensed to practice medicine in Pennsylvania, New York, and West Virginia. The Respondent's Pennsylvania license expired on December 31, 2004. He was on probation at the time that his license expired. The Respondent surrendered his New York license in July 20, 2009 as a result of the disciplinary action taken against his Maryland license. In May 2009, the Respondent's West Virginia license was placed on probation for three years as a result of the action taken against his Maryland license. In September 2009, the Respondent's West Virginia license was revoked due to non-compliance with the terms and conditions of the West Virginia consent order.

5. A peer review of the Respondent's medical care of the complainant concluded that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care and failed to keep adequate medical records.

6. 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.* (2005 Repl. Vol.). Specifically, the Board charged the Respondent with violating H.O. § 14-404(a)(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and § 14-404(a)(40) Fails to keep adequate medical records as determined by appropriate peer review.

7. 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. The Respondent's probation was subject to myriad terms and conditions.

8. The Consent Order stated that failure to practice "according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine . . . shall constitute a violation of this Consent Order." The Consent Order further stated that if the Respondent violates

any of the terms or conditions of the Consent Order, the Board may impose other disciplinary sanctions.

9. The Board has received five (5) complaints regarding the Respondent's practice of medicine since November 2006. As a result, the Board opened investigations on each complaint.

10. On or about November 3, 2006, the Board received a complaint ("complaint #1") 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.

11. On or about December 28, 2006, the Board received a second complaint ("complaint #2") from a relative of one of the Respondent's patients. Complaint #2 alleged that the Respondent was prescribing controlled dangerous substances ("CDS") to an addicted patient without medical necessity.

12. On or about February 21, 2007, the Board received a third complaint ("complaint #3") from a deceased patient's relative. The patient had died of a Methadone[2] overdose. Complaint #3 alleged that the Respondent was aware that the deceased patient was a substance abuser, yet he still prescribed Methadone to the patient.

13. On or about March 4, 2009, the Board received a fourth complaint ("complaint #4") from a deceased patient's relative. Complaint #4 alleged that the Respondent may be performing inappropriate examinations in exchange for CDS prescriptions.

[2] Schedule II CDS.

14. On or about April 24, 2009, the Board received a fifth complaint ("complaint #5") from a pharmacist stating that many of the Respondent's patients were prescribed "large amounts of Methadone, Oxycodone[3] 15mg, Oxycodone 30mg 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.[4]

15. In furtherance of its investigation, the Board subpoenaed patient records and transmitted 13 randomly selected patient records and related documents for a formal peer review of the Respondent's medical practice. Two physicians specializing in internal medicine reviewed the 13 patient records. Both reviewers concurred that the Respondent failed to meet standard of quality medical care with regard to 10 of the 13 patients reviewed.

16. Based upon the peer review reports, the Board concluded that the public health, safety or welfare imperatively required emergency action. As a result, on August 5, 2010 the Board issued an Order for Summary Suspension of the Respondent's license to practice medicine. A show cause hearing was scheduled for August 11, 2010 and then rescheduled for August 25, 2010 at the Respondent's request.

17. On August 26, 2010, the Board issued an order (the "August 26, 2010 Order") staying the summary suspension of the Respondent's license to practice medicine conditioned on the following requirements:

a. [The Respondent] shall practice internal medicine only;

[3] Schedule II CDS.
[4] Schedule II CDS

b. [The Respondent] shall not accept nor shall he treat any patients for pain management;

c. [The Respondent] shall in no case prescribe any Schedule I, II, III, or IV Controlled Dangerous Substance, except in emergency cases involving acute pain, and in these cases for no more than a total of 48 hours, and [The Respondent] shall not prescribe these substances for chronic pain.

18. The Board subsequently received information that the Respondent prescribed Ultram, a centrally acting opioid analgesic, to patients, and in quantities exceeding the recommended dose, in violation of the August 26, 2010 Order.

19. On September 22, 2010, the Board voted to vacate its August 26, 2010 Order staying the Order for Summary Suspension of the Respondent's Medical License, and re-impose the summary suspension. A show cause hearing was held on October 13, 2010.

20. On October 14, 2010, the Board issued an order ("October 14, 2010 Order") finding that the Respondent "failed to comply with the conditions of the Board's August 26, 2010 order, as described in the order, dated September 23." Further, the Board found that the order vacating the stay of the summary suspension should continue, and that the "summary suspension continues to be imperatively required in order to protect the public health, safety, and welfare."

21. On October 18 and 19, 2010, an evidentiary hearing on the summary suspension of the Respondent's license was held before Administrative Law Judge James Power.

22. On November 16, 2010, ALJ Power issues a Proposed Decision, in which he concluded that "the health, welfare and safety of the public imperatively requires the Board to issue an order to suspend the respondent's license." ALJ Power proposed that the summary suspension of the Respondent's license be upheld.

23. The Respondent did not file exceptions to ALJ Power's Proposed Decision. The Board's Final Order is pending. However, the summary suspension issue will become moot upon the Board's approval of this Consent Order, and will therefore be vacated.

II. NEW COMPLAINTS

24. The Board received four additional complaints against the Respondent regarding his prescribing practices.

25. On November 30, 2009, the Board received a sixth complaint ("complaint #6") from a former patient ("Patient U," infra) of the Respondent's alleging that the Respondent prescribed her Suboxone[5] for treatment of her substance abuse without conducting urine drug testing, referring her to a behavior health and counseling program and often, without seeing her regularly before refilling her prescription. As a result, Patient U also alleged that her insurance company denied coverage of her medication.

26. On May 13, 2010, the Board received a seventh complaint ("complaint #7") from the Vice President of Medical Affairs at Facility A alleging that the Respondent is practicing below the standard of care as it relates to pain management. The complainant stated that "many members of the medical staff believe that [the

[5] Suboxone is a narcotic medication indicated for the treatment of opioid dependence, is available only by prescription, and must be taken under a doctor's care, as prescribed.

Respondent] contributes significantly to the prescription drug misuse which is pervasive in [Cecil] county."

27. On June 9, 2010 and July 20, 2010, the Board received two additional complaints ("complaint #8" and "complaint #9") from the grandparents and mother, respectively, of a deceased 21-year-old patient ("Patient R," *infra*) whom the Respondent treated. Patient R died of a Methadone overdose. The complainants alleged the Respondent was aware of Patient R's drug addiction and her history of multiple drug overdoses, but he continued to prescribe Methadone, Vicodin, Percocet and Xanax, despite their requests that he not do so.

28. The Board staff subpoenaed Patient R's medical record on June 29, 2010 and September 1, 2010. The Respondent failed to comply with the Board's request.

29. On September 7, 2010, Board staff went to the Respondent's office with a third subpoena for medical and billing records. Board staff observed two of the Respondent's employees actively working on Patient R's medical record, and initially refused to provide the medical record to Board staff.

30. Board staff also observed that two of the three examination rooms in the Respondent's office were being used to house medical records. One of the Respondent's employees informed Board staff that the records were being "made pretty and prepared for an anticipated chart audit by the Board."

31. Board staff interviewed another employee, who was also a patient, at the Respondent's practice ("Patient L," *infra*), who stated that she recently stopped working for the Respondent because she and other employees were instructed by the Respondent to work without pay to "fix the charts."

32. Patient L stated that the Respondent instructed his employees to make sure everything was in order in the patient charts beginning in January 2009. According to Patient L, the Respondent instructed his employees to make sure all progress notes were present and signed, and to make sure all pill counts and drug screens appeared as though they were completed.

33. Patient L also stated that the Respondent's employees, including Patient L, wrote the progress notes prior to the patients being seen and prepared prescriptions for the Respondent to sign.

34. According to Patient L, the Respondent's employees, many of whom were also patients in his pain management practice, had access to his prescription pads.

35. On September 24, 2010, Board staff sent 20 patient records ("Patients L through EE") to be reviewed by an expert in pain management.

36. The expert in pain management concluded that with respect to all 20 patient records that he reviewed, the Respondent engaged in unprofessional and immoral conduct in the practice of medicine; is professionally incompetent to practice medicine; and prescribed drugs for illegitimate medical purposes.

III. GENERAL INVESTIGATIVE FINDINGS

37. 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. And, in fact, the Respondent's patients did exhibit such consequences. He failed to deliver quality medical care to 10 out of 13 cases reviewed.

38. The patients reviewed complained of chronic pain. 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 implementing a clear pain management plan or comprehensive strategy to address the patients' medical needs or drug use.

39. The Respondent prescribed potent narcotics without performing a thorough examination, assessing the etiology of their pain, exhausting alternate therapies and modalities, and establishing a clear need for such medications.

40. 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 a 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.

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

42. 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.

43. 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.

44. Notwithstanding his policy that "in rare cases of drug diversion being is proven [*sic*], discharge from care is compulsory with no further prescriptions not withstanding [*sic*] the withdrawal symptoms," the Respondent consistently disregarded evidence of drug abuse and diversion and continued to prescribe narcotics to those patients.

45. Furthermore, 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.

46. There were many instances in the records reviewed 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. The Respondent discharged only one of the patients reviewed after multiple inconsistent urine toxicology screens over a period of several months. Further, the Respondent discharged the patient from his practice with a two-month supply of narcotics, violating his own policy.

47. 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. For example and as set forth below, the Respondent failed to appropriately monitor and address a patient's (identified below as "Patient B") elevated blood pressure.[6] In addition, the Respondent failed to monitor a patient's (identified below as "Patient J") prostate health and PSA[7], which is minimally required, given the Respondent's prescription of testosterone to treat Patient J's erectile dysfunction.

III. PATIENT SPECIFIC FINDINGS

Examples of the above investigative findings are set forth in the following patient specific findings. These summaries are not intended as, and do not represent, a

[6] The names of the patients and other individuals referred to herein are confidential. The Respondent may obtain the names from the Administrative Prosecutor.
[7] Prostate Specific Antigen test.

complete description of the evidence with respect to the Respondent's conduct in this matter.

Patient A

48. 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.

49. The Respondent did not order any radiological studies at the time of Patient A's initial assessment.

50. There are no previous records regarding Patient A's motor vehicle accident in his chart.

51. 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 "dirty" or abnormal.

52. After Patient A's first appointment, the Respondent prescribed Methadone 40mg, Oxycodone 15mg and Ativan[8] 1mg 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.

53. 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.

[8] Schedule IV benzodiazepine.

54. 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.

55. The Respondent diagnosed Patient A with chronic low back pain, not otherwise specified, and sacroiliac joint pain.

56. 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 why X-rays were not done.

57. 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.

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

59. The Respondent failed to offer any medications other than narcotics.

60. The Respondent continued to increase Patient A's dosages of Oxycodone and Methadone without medical indication and never attempted to titrate down the drug dosage.

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

62. Patient A's chart contains a photocopy of a prescription for Methadone 40mg 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 made to ensure that the individual who picked up the prescription was indeed Patient A.

63. 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 metabolites, 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.

Patient B

64. 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 fracture of the right ankle. According to Patient B's chart, she had two follow-up visits with an orthopaedist for the metatarsal fracture.

65. 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.

66. Despite an incomplete evaluation, the Respondent immediately prescribed Lorcet[9] 10/650mg QID and MS Contin[10] 30mg BID to Patient B.[11]

67. 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?"

68. 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 100mg TID and Oxycodone 15mg QID.

69. In January 2008, the Respondent added Xanax[12] to Patient B's medication regimen. He initially prescribed 0.25mg TID and by August 2008, the Respondent was prescribing 0.25mg q4h (every four hours) with two refills.

70. The Respondent ordered X-rays of Patient B's right ankle, tibia and fibula in February 2008 and of her left ankle and left foot in July 2008.

71. 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.

72. 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.

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[9] Schedule II CDS.
[10] Schedule II CDS.
[11] QID indicates that a medication should be taken four times a day. BID indicates that a medication should be taken two times a day.
[12] Schedule IV benzodiazepine.

73. Laboratory tests were done once in April 2008 and the Respondent prescribed Lovastatin to treat Patient B's high cholesterol. The Respondent did not follow-up on Patient B's high cholesterol.

74. The Respondent failed to attempt other treatment modalities by referring Patient B to an orthopaedist or to physical therapy.

75. 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.

76. The Respondent failed to address and document Patient B's possible substance abuse.

77. 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 work.

Patient C

78. 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.

79. 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 substances, 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."

80. In January 2004, the Respondent received an anonymous telephone call from "a concerned friend" of Patient C. The individual stated that "[Patient C] is abusing medication. He is extremely intoxicated taking these drugs. [The friend] is concerned that they will find [Patient C] dead."

81. 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[13].

82. 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 physician and therefore the Respondent would not dispense any medications. However, several days after Patient C's telephone calls, the Respondent prescribed Lorcet 10/650mg QID for Patient C.

83. 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

[13] A Schedule II CDS.

abuse counselor and AA." Without any evidence that Patient C complied with those conditions, the Respondent continued to prescribe narcotics for Patient C.

84. Patient C's chart reflects that he entered into a substance abuse treatment program in 2005, although it is unclear whether he completed it. According to the Respondent's progress notes, Patient C continued to drink alcohol.

85. A 2006 prescription profile for Patient C indicated that he was taking Hydrocodone with acetaminophen[14]. The Respondent noted on the document that he was not prescribing this medication 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.

86. 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.

87. 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[15] and Morphine, and positive for cocaine.

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

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[14] Schedule II CDS.
[15] Schedule II CDS.

89. 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.

90. 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 him at regular intervals.

91. 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 100mg and 120 tablets of Oxycodone 15mg to Patient C.

92. 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.

Patient E[16]

93. 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.

94. 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

[16] The State has elected not to proceed with regard to Patient D in the Order for Summary Suspension dated August 26, 2010.

injections, however, there are no further notes after April 2003 in Patient E's chart regarding his treatment with the pain management practice.

95. 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.

96. 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.

97. All subsequent care was with the Respondent.

98. In February 2004, Patient E signed a pain management contract, informed consent for narcotics, and the Respondent's Policy for Pain Treatment.

99. The Respondent saw Patient E at regular monthly intervals and prescribed various narcotics (Methadone), anti-anxiety medications (Xanax), and anti-depressants.

100. The Respondent tested Patient E for medication compliance one time, in August 2005.

101. 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.

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

103. Patient E's record reflects that he suffered cardiogenic 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 medications. At the time, the Respondent had been prescribing Methadone and Xanax for Patient E.

104. 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.

105. Patient E's death certificate identified narcotic (methadone and morphine) and ethanol intoxication as the cause of death.

106. Throughout his treatment of Patient E, the Respondent never addressed or documented addressing Patient E's drug abuse.

107. 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.

108. The only care that the Respondent provided was to prescribe narcotics to Patient E.

109. 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.

Patient F

110. 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.

111. 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").

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

113. 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.

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

115. 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.

116. The Respondent prescribed Xanax and various narcotics (Avinza[17], Percocet, Fentanyl[18]) for Patient F for a number of years. In addition, the Respondent prescribed Lyrica and Depakote to treat Patient F's headaches. Without documenting

[17] Morphine Sulfate, extended release capsules.
[18] Schedule II CDS, a potent narcotic analgesic with rapid onset and short duration of action.

his rationale, the Respondent resorted to increasing dosages of narcotic analgesics, tranquilizers, and sleep-producing agents.

117. The Respondent continued to provide higher dosages of the medications at Patient F's request and ultimately prescribed Fentanyl.

118. 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.

119. 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.

120. Patient F entered a substance abuse treatment program in 2007.

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

Patient G

122. Patient G was a 40 year-old male when he began seeing the Respondent in June 2005 for shoulder, knee and hand pain.[19] 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

[19] Patient G's first appointment with the Respondent was in December 2003, but he did not see the Respondent regularly for pain management until June 2005.

Respondent diagnosed Patient G with seronegative rheumatoid arthritis based on his family history.

123. 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.

124. 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.

125. 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.

126. Between May 2005 and March 2008, Patient G had 10 x-rays and MRIs 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.

127. 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.

128. By December 2008, the Respondent was prescribing Dilaudid[20] and Oxycontin, in addition to a muscle relaxant to treat Patient G's pain.

129. In 2008, the Respondent prescribed Prednisone and Methotrexate to treat Patient G's polyarthritis. The Respondent failed to perform a comprehensive

[20] A Schedule II CDS.

evaluation, including laboratory testing, of Patient G to determine whether he met the criterion for a diagnosis of rheumatoid arthritis.

130. 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.[21]

131. The Respondent failed to refer Patient G to a rheumatologist for evaluation and treatment before prescribing Oxycontin and Dilaudid.[22]

Patient H

132. 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 approximate eight-year history with chronic low back pain and bipolar disorder.

133. 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.

134. 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 1mg BID PRN for her pain.[23]

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[21] Patient G's chart includes a November 2007 prescription for a blood work ("CBC with manual differential") but there are no laboratory results in the chart, and no follow-up in the Respondent's progress notes.

[22] In November and December 2007, the Respondent noted "rheumatology consult" in Patient G's progress notes, but there is no evidence in Patient G's chart that the referral was ever made. The Respondent did note that Patent G wished to wait until January 2008 for the consultation, but there is no follow-up in the progress notes.

[23] TID indicates that a medication should be taken three times a day. PRN indicates that a medication should be taken "when necessary."

135. Also at her first appointment, Patient H signed an acknowledgment of the Respondent's Pain Management Policy (the "policy"). The policy states, in pertinent part:

> 4) Because of high addiction potential use of Percocet, Oxycontin and Xanax will be kept to a minimum. Percocet and Oxycontin will not be prescribed at the same time.
>
> 5) Narcotics will be prescribed to new patients only if old records are available to verify previous treatments, barring some exceptions. A prescription for 10-20 pills by Emergency Room [*sic*] is not a reason to continue it.
>
> ...
>
> 7) Expect Urine and Blood Drug Screen [*sic*] from time to time. A pill count during every visit (and between office visits in rare situations). Please bring unused pills in original containers during all visits to document that you are in total control of your pain pills and nerve pills.
>
> ...
>
> 10) In case of side effects and/or in-effectiveness [*sic*] of a particular medicine, it must be reported within 2 days and the unused pills in original containers must be brought to the office for us to prescribe alternative medicine.
>
> ...
>
> 15) In rare cases of drug diversion being is proven [*sic*], discharge from care is compulsory with no further prescriptions not withstanding [*sic*] the withdrawal symptoms. Absence of prescribed medications and presence of street drugs and/or unprescribed medications in the Urine or Blood Screening is considered to be a proof [*sic*] of Drug Diversion by Law Enforcement Agencies and by DEA.

136. The Respondent saw Patient H on a monthly basis for refills of her potent narcotics prescriptions.

137. 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.

138. 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.

139. 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.

140. 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.

141. The Respondent's notes of Patient H's November 12, 2007 appointment state "discharged with one month worth medicines for repeated violation of the contract."

142. Patient H's chart contains a copy of the prescriptions, dated November 12, 2007. Patient H's chart also contains a second set of prescriptions for the same medications, but dated December 12, 2007. On the December prescriptions the Respondent wrote, "Pt given 1 month prescriptions; She is being discharged. She is

going to someone else and her ride is waiting so no evaluation could be done. Will send records when requested."

143. In violation of his own drug policy and his agreement with Patient H, the Respondent provided Patient H with more than a month's prescriptions for Oxycontin and Lortab.

144. The Respondent prescribed opioids 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.

145. In the eight months that the Respondent treated Patient H, he failed to conduct a comprehensive evaluation of Patient H's pain and failed to request Patient H's past medical records. The Respondent prescribed narcotics to Patient H without following his own drug policy.

Patient I

146. 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.

147. 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.[24] The Respondent did not have Patient I sign a pain management contract.

148. The Respondent did not order X-rays, nor did he request Patient I's prior treatment records.

149. The Respondent diagnosed Patient I with Chronic Pain Syndrome secondary to Carpel Tunnel Syndrome.

150. 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.

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

152. 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.

153. 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.

154. Results of a follow-up toxicology screen on October 17, 2005 were also inconsistent and indicated possible diversion of narcotics. Patient I tested negative for Morphine, which was prescribed by the Respondent. The Respondent failed to

[24] QAM indicates that medication should be taken once a day, in the morning.

discuss or document discussing Patient I's inconsistent drug test results at her next appointment or anytime thereafter.

155. In May 2006, Patient I ran out of Xanax and was seen in a hospital emergency room with a seizure.

156. 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.

157. 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.

158. There are several notes in Patient I's chart stating that she ran out of her medications prior to her next scheduled appointment.

159. The Respondent failed to prescribed less addictive medications to Patient I for a minor hand injury that had been previously managed conservatively by an orthopaedist.

160. 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.

161. 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.

Patient J

162. 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.[25] The Respondent diagnosed Patient J with Failed Back Surgery Syndrome with Radiculopathy.

163. The Respondent established a goal of maintaining Patient J in a state that would allow him to continue working.

164. 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 (Opoids) [*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.

165. 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.

[25] Transcutaneous Electrical Nerve Stimulation unit or a "TENS unit" is a pocket size, portable, battery-operated device that sends electrical impulses to certain parts of the body to block pain signals.

166. 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.

167. 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.

168. 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.

169. 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.

Patient K

170. 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.

171. 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.

172. 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.

173. 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.

174. The Respondent failed to order x-rays or other radiologic imaging studies and failed to refer Patient K for physical therapy. The Respondent also failed to document his reasons for not ordering the imaging studies and not referring 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.

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

176. The Respondent's actions, including but not limited to; his pattern of excessive and unjustifiable prescribing of narcotic analgesics, specifically, Schedule II

opioid analgesics, to patients; his failure to perform appropriate and comprehensive evaluation of the patients prior to prescribing large amounts of narcotic analgesics to them; his failure to implement a clear pain management plan or comprehensive strategy for the long term prescribing of narcotic analgesics; his failure to attempt other treatment modalities or therapies prior to his long term prescribing of addictive narcotic analgesics to patients; his failure to abide by the provisions of his own pain management contract and opioid prescribing policy with the patients; his failure to recognize and address his patients' abuse and/or diversion of the narcotic analgesics he prescribed; and his failure to provide adequate care of his patients' health conditions, other than chronic pain constitute, in whole or in part failure to meet appropriate standards for the delivery of quality medical or care, in violation of H.O. § 14-404(a)(22).

Patients L – EE

Pursuant to a subpoena issued by the Board, the Board obtained the medical records of 20 patients ("Patients L – EE") who were treated by the Respondent. The medical records were forwarded to an expert witness specializing in pain management, who was appointed by the Board.

177. On or about September 28, 2010, the expert issued a report of his findings with respect to the medical records of Patients L – EE. The expert concluded that the Respondent engaged in unprofessional conduct in the practice of medicine when he:

a. Failed to comply with two Board subpoenas for medical records;

b. Instructed his staff to alter medical records to make them "ready for the Board" by making sure all progress notes were completed and signed, making sure that drug screens were reflected as completed, and by correcting pill counts so that they added up to the correct number;

c. Instructed his staff to write progress notes in medical records as if they were written by the Respondent; and

d. Treated six of his employees for pain management without monitoring their access to his prescription pad.

178. The expert further opined that the Respondent is professionally incompetent with respect to his practice of pain management. According to The expert's review of 20 medical records, the Respondent consistently prescribed long-term, high-dose opioid medications in the absence of medical necessity and/or therapeutic rationale. In addition, the Respondent failed to substantiate medical diagnoses for which these medications were being prescribed, failed to consistently monitor for medication compliance, failed to follow-up on abnormal test results when he did monitor for medication compliance, and consistently disregarded evidence of drug abuse and diversion while continuing to prescribe narcotics.

179. The expert stated that the Respondent failed to integrate historical information, physical examination findings, and laboratory findings to develop an appropriate assessment or plan of care that considered the risks and benefits of using narcotics and other potent sedative hypnotics to treat his patients. Further, the Respondent failed to adequately investigate the patients' complaints, motivation and/or compliance. The expert stated that the Respondent never formulated a

complete assessment and plan based on relevant information, which is especially problematic given his treatment of young patients with a history of narcotic abuse.

180. The expert stated that the Respondent exhibited a pattern of escalating the dosages of narcotics and other potent sedative hypnotics, even in the case of a patient (Patient R) with a recent history of overdose that resulted in severe medical complications.

181. According to his review of 20 medical records, the expert concluded that the Respondent prescribed drugs for illegitimate purposes.

182. The expert made the following patient-specific findings:

Patient N

183. Patient N, a female born in 1978, began seeing the Respondent in October 2006 when her previous pain management physician closed his practice abruptly. She was both a patient and an employee of the Respondent.

184. Although Patient N filled out her patient registration form in October 2006, her medical record does not contain any progress records prior to November 16, 2009. However, Patient N's medical record does include results of laboratory studies prior to November 2009, including one inconsistent[26] urine drug screen from June 28, 2010.

185. According to Patient N's medical record, which the Respondent provided in response to a Board subpoena, her first documented visit with the Respondent

[26] A drug screen is inconsistent when the patient tests positive for a medication that is not prescribed or tests negative for a medication that is prescribed.

occurred on November 16, 2009.[27] At that time the Respondent prescribed Oxycodone 30mg 1 tablet PO QID PRN #120 and Methadone 10mg 3 tablets PO QID #360 "for chronic pain".

186. There are no previous medical records or pharmacy profiles to substantiate the medical necessity of these medications and dosages.

187. There are no reports or diagnostic imaging studies in Patient N's medical record.

188. There was no urine drug screen completed at Patient N's initial visit.

Patient R

189. Patient R, a female born in 1988, began seeing the Respondent in February 2008. Patient R had a history of depression, anxiety and prescription narcotic abuse. Patient R had left her addiction treatment program, where she was receiving Methadone, and began taking Suboxone prescribed by the Respondent.

190. At Patient R's initial visit, the Respondent failed to document Patient R's symptoms of withdrawal, if any, before prescribing Suboxone. Further, the Respondent failed to obtain a urine drug screen at her initial visit.

191. At Patient R's initial visit, the Respondent documented a diagnosis of fibromyalgia syndrome, but did not prescribe any medications to treat Patient R for fibromyalgia until nearly three months later.

192. In Patient R's medical record, the Respondent documented two instances when she ran out of pain medication but was denied early refills. The

[27] Based on Patient N's medical record, it appears that she began seeing the Respondent prior to November 2009; however, the Respondent failed to provide any documentation of visits prior to November 2009.

Respondent wrote in his summary of care that "such infractions are to be expected in view of her past medical history."

193. In August 2009, the Respondent discontinued Suboxone and began prescribing Methadone to treat Patient R's alleged increasing pain.

194. There are no progress notes in Patient R's medical record for July 2009, only a copy of a prescription for Suboxone.

195. The Respondent's progress notes from Patient R's June 2009 visit do not indicate that she was experiencing any pain or discomfort.[28] However, the Respondent's August 2009 progress note appears to state that Patient R had "tenderness at many different places including all 18 spots of FMS and tender all along tensa fasciae latae Rt."

196. The Respondent continued to increase Patient R's dosage of Methadone, without any supportive documentation in the medical record.

197. The Respondent's follow-up notes in Patient R's medical record are grossly incomplete.

198. Multiple inconsistencies are noted on the urine drug screenings, including positive results for marijuana and benzodiazepines. The Respondent obtained four urine drug screens but did not document what clinical changes, if any, were made in light of the inconsistent results.

199. In April 2010, Patient R was admitted to Facility A for an overdose (Tylenol, morphine, or benzodiazepines) with respiratory failure and rhabdomyolysis with acute renal failure.

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[28] The Respondent checked the boxes next to "Chr. Pain Syndrome" and "Chr. LBP NOS" at each monthly appointment but did not provide further documentation to substantiate prescribing highly addictive narcotics to a patient who was recovering from opioid dependency.

200. Once her condition stabilized, Patient R was transferred to Facility B. Patient R denied that her overdose was a suicide attempt and stated that she inadvertently took her medicine twice. Patient R was diagnosed with Depressive Disorder NOS, opioid dependence, possible benzodiazepine dependence, and Anxiety Disorder NOS.

201. On May 7, 2010, approximately ten days after being discharged from Facility B, Patient R followed-up with the Respondent. At that time, the Respondent wrote Patient R a prescription for Dilaudid 4mg #42 with Patient R's aunt as the custodian of the medication.[29] A urine drug screen was positive for benzodiazepines, marijuana, Oxycodone, and opiates, but according to the medical record, the Respondent failed to address this with Patient R.

202. On May 10, 2010, Patient R requested Xanax and the Respondent prescribed Xanax 1mg QID PRN #4 with five refills.[30]

203. On May 13, 2010, the Respondent prescribed Methadone 10mg three tablets PO QID #360 and Lorcet 10/325 one tablet PO QID #180. The Respondent increased these medications from the previous prescriptions on April 2, 2010, without explanation and without implementing safety measures to ensure against another possible overdose.

204. The Respondent died of a Methadone overdose on May 17, 2010.

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[29] According to Patient R's family, this individual was not Patient R's aunt, but rather, her friend. There is no indication that this friend acted as the custodian of Patient R's medication.

[30] A handwritten note on the prescription stated, "4 tablets per day only one day supply with additional five refills. This way patient will be good for 6 days. She has a severe problem of O.D. Every day she will pick up one day's supply #4." Patient R's medical record also contains a copy of a prescription dated May 10, 2010 for Xanax 1mg 1 tablet QID PRN #40 with three refills. The words, "not sent" are written next to the prescription but there is no date or signature. In addition, the Respondent wrote a note on a copy of a March 10, 2009 prescription that stated, "Patient tricked us. Told the patient to see a psychiatrist. We will just give her Suboxone and 'no xanax [sic].'"

Patient T

205. Patient T, a male born in 1980, began seeing the Respondent in February 2006 for Suboxone treatment of chronic opioid dependency. According to Patient T's medical record, which the Respondent provided in response to a subpoena the Board issued, he had a history of heroin addiction and had received substance abuse treatment.

206. According to Patient T's medical record, a urine drug screen obtained by the Respondent on September 22, 2009 was positive for morphine, barbiturates, and cocaine metabolites. The Respondent documented only "NA meetings" on Patient T's September 2009 progress note, and continued prescribing Suboxone.

207. Urine drug screens on July 2, 2010 and August 28, 2009 were also inconsistent with Patient T's drug regimen.

208. Patient T's medical record also contains an unsigned, undated note on stationery bearing the name "Melissa," which states "Anonymous call [Patient T] Xanax Suboxone to 13 yr old calling Police + DEA." There is no further documentation of this anonymous call.

209. Medical documentation was absent in many of Patient T's follow-up visits. For instance, on December 16, 2009, the Respondent failed to document that he obtained a history from Patient T.

210. The physical examination that is documented on December 16, 2009 consists only of weight, blood pressure and heart rate, and was obtained by ancillary medical staff.

211. Under "assessment", the Respondent documented only "opioid dependency" and wrote "see copies of scripts" as the plan.

Patient U

212. Patient U, a female born in 1978, began seeing the Respondent in December 2008 for substance abuse treatment with Suboxone. The Respondent also prescribed Seroquel for Patient U.

213. On the initial history form, Patient U disclosed that she was taking "illegal street drugs." Despite this information, the Respondent failed to obtain a urine drug screen on this visit or any subsequent patient visits.

214. Prior to prescribing Suboxone for Patient U, the Respondent failed to assess her withdrawal symptoms using the Clinical Opioid Withdrawal Scale ("COWS") or any other method.

215. The Respondent failed to obtain a pharmacy profile or previous treatment records prior to initiating Patient U's treatment with Suboxone, or at any time during the ten months that he treated her.

216. The Respondent's actions, as described above, constitute a violation of the following provisions of the Act: Is guilty of immoral conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(i); Is guilty of unprofessional conduct in the practice or medicine, in violation of H.O. § 14-404(a)(3)(ii); Is professionally, physically or mentally incompetent, in violation of H.O. § 14-404(a)(4); Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of H.O. § 14-404(a)(22); and sells,

prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes, in violation of H.O. § 14-404(a)(27).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated the following provisions of the Act: Is guilty of immoral conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(i); Is guilty of unprofessional conduct in the practice or medicine, in violation of H.O. § 14-404(a)(3)(ii); Is professionally, physically or mentally incompetent, in violation of H.O. § 14-404(a)(4); Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of H.O. § 14-404(a)(22); and sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes, in violation of H.O. § 14-404(a)(27).

In addition, in light of the revocation that the parties have agreed to in this case, the Board will terminate its order of summary suspension issued on August 5, 2010, for the sole reason that that summary suspension has now become moot.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 3rd day of May, 2011, by a quorum of the Board considering this case:

ORDERED that the Respondent's license to practice medicine in the State of Maryland is **PERMANENTLY REVOKED**; and it is further

ORDERED that the Respondent may not apply for licensure or reinstatement of his medical license to the Board or any successor agency; and it is further

ORDERED that the Summary Suspension of the Respondent's license to practice medicine in Maryland is **TERMINATED**, for the sole reason that the Summary Suspension has become moot at this time because the Respondent's license has been revoked; and it is further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 et seq. (2009 Repl. Vol. and 2010 Supp.)

5/20/11
Date

John Papavasiliou, Deputy Director
Maryland Board of Physicians

CONSENT

I, Dinesh Shah, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree to be bound by the foregoing Consent Order and its terms, conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

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 as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

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

4/7/11
Date

Dinesh Shah, M.D.
Respondent

Read and approved:

4/13/11
Date

Jamie A. Cheret, Esq.
Co-Counsel for the Respondent

4/13/11
Date

Ali Kalarestaghi, Esq.
Co-Counsel for the Respondent

NOTARY

STATE OF ~~MARYLAND~~ DELAWARE

CITY/COUNTY OF NEW CASTLE:

I HEREBY CERTIFY that on this 8th day of APRIL, 2011, before me, a Notary Public of the foregoing State personally appeared Dinesh Shah, M.D. License Number D23334, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Notary Public

My Commission Expires: MAY 29th 2011

NICOLE RENE BOGGS
Notary Public
State of Delaware
My Commission Expires on May 29, 2011