IN THE MATTER OF	*	BEFORE THE
PATRICIA NEWTON, M.D.	*	MARYLAND STATE BOARD
Respondent	*	OF PHYSICIANS
License No. D23551	*	Board Case No. 2014-0308

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

FINAL DECISION AND ORDER

At issue in this case is Patricia Newton, M.D.'s pain management practice, specifically her prescribing of opioids to treat her patients' complaints of pain.

On August 27, 2014, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") summarily suspended Dr. Newton's license to practice medicine in Maryland. On September 11, 2014, after a show cause hearing before Board Panel A, the summary suspension was continued.

On September 12, 2014, Dr. Newton was charged with unprofessional conduct in the practice of medicine, *see* Md. Code Ann., Health Occ. § 14-404(a)(3)(ii); and professional incompetence, *see* Health Occ. § 14-404(a)(4).

On February 18, 19, and 20, 2015, an evidentiary hearing was held before an administrative law judge ("ALJ") of the Office of Administrative Hearings. On May 14, 2015, the ALJ issued a Proposed Decision recommending the summary suspension be upheld; the charges be upheld; Dr. Newton be reprimanded; Dr. Newton cease her pain management practice; Dr. Newton issue a letter, approved by the Board, informing her patients of the cessation of her pain management practice; Dr. Newton be placed on probation for three years; and the Board maintain the right to monitor her medication prescribing practices. Neither Dr. Newton nor the State filed exceptions.

FINDINGS OF FACT

Board Disciplinary Panel B adopts the ALJ's proposed findings of fact (1-100), pages 5 through 21 of the ALJ's Proposed Decision. The ALJ's proposed findings of fact are incorporated by reference into the body of this document as if set forth in full. The ALJ's Proposed Decision is attached as **Exhibit 1.**

Board Panel B also adopts and incorporates by reference the ALJ's discussion, pages 21 through 54 of the ALJ's Proposed Decision.

The findings of fact were proven by the preponderance of the evidence.

CONCLUSIONS OF LAW

Based upon the findings of fact, Board Panel B concludes that Dr. Newton is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); and is professionally incompetent, in violation of Health Occ. § 14-404(a)(4). Board Panel B also concludes that the public health, safety, or welfare imperatively required emergency action, *see* State Gov't § 10-226(c)(2), warranting the summary suspension of Dr. Newton's medical license on August 27, 2014. Board Panel B adopts and incorporates by reference the ALJ's Proposed Conclusions of Law set forth on pages 56-57 of the ALJ's Proposed Decision.

Sanction

The Board adopts the sanction proposed by the ALJ, which is set forth on page 57 in the ALJ's Proposed Decision.

ORDER

It is, by an affirmative vote of a majority of a quorum of Board Disciplinary Panel B, hereby

ORDERED that Dr. Newton is **REPRIMANDED;** and it is further

ORDERED that Dr. Newton may not practice pain management; and it is further

ORDERED that Dr. Newton shall issue a letter to her patients informing the patients of the cessation of her pain management practice. The letter shall be submitted to the Board for approval within **30 days** of this order; and it is further

ORDERED that the summary suspension of Dr. Newton's medical license is **TERMINATED;** and it is further

ORDERED that Dr. Newton is placed on **PROBATION** for **THREE YEARS;** and it is further

ORDERED that the Board maintains the right to monitor Dr. Newton's medication prescribing practices; and it is further

ORDERED that, if Dr. Newton violates any condition of this order, the Board or a Board panel, after notice and a show cause hearing before the Board or Board panel if there is no genuine dispute as to the material facts or after an evidentiary hearing before the Office of Administrative Hearings if there is a genuine dispute as to the material facts, may further sanction Dr. Newton, which may include a reprimand, further probation, or the suspension or revocation of Dr. Newton's medical license; and it is further

ORDERED that this is a public document.

7/29/2015
Date

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

NOTICE OF RIGHT TO APPEAL

Pursuant to § 14-408(a) of the Health Occupations Article, Dr. Newton has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review must be filed within 30 days from the date this Final Decision and Order is mailed. The petition for judicial review must be made as directed in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222, and Maryland Rules 7-201 *et seq.*

If Dr. Newton petitions for judicial review, the Board is a party and should be served with the court's process. In addition, Dr. Newton should send a copy of his petition for judicial review to the Board's counsel, David Wagner, Assistant Attorney General, Office of the Attorney General, 300 W. Preston Street, Suite 302, Baltimore, Maryland 21201. The administrative prosecutor is not involved in the circuit court process and does not need to be served or copied on pleadings filed in circuit court.

Exhibit 1

MARYLAND BOARD OF	*	**BEFORE SUSAN A. SINROD,**
PHYSICIANS	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
PATRICIA NEWTON, M.D.,	*	**OF ADMINISTRATIVE HEARINGS**
RESPONDENT	*	
LICENSE No.: D23551	*	**OAH No.: DHMH-MBP-71-14-41234**
	*	**DHMH-MBP-72-14-39927**

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PROPOSED DECISION

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

STATEMENT OF THE CASE

On August 27, 2014, a disciplinary panel of the Maryland State Board of Physicians (Board) summarily suspended the medical license of Patricia Newton, M.D. (Respondent). On September 11, 2014, the disciplinary panel determined, after a show cause hearing, that the summary suspension would be continued. On September 12, 2014, the Board issued charges against the Respondent under the Maryland Medical Practice Act. Md. Code Ann., Health Occ. §§ 14-101 through 14-507, and 14-601 through 14-608 (2014).[1] Specifically, the Board alleged that the Respondent violated section 14-404(a)(3)(ii) of the Act due to unprofessional conduct in the practice of medicine, and section 14-404(a)(4) due to being professionally incompetent. Md. Code Ann., Health Occ. §§14-404(a)(3)(ii) and 14-404(a)(4). The Board forwarded the charges

[1] All references to the Health Occupations Article are to the 2014 volume.

to the Office of the Attorney General for prosecution. The Board delegated both disciplinary matters to the Office of Administrative Hearings (OAH), and I consolidated the cases for hearing.

I conducted a scheduling conference on November 20, 2014 and a prehearing conference on January 15, 2015. I conducted the hearing on February 18, 19 and 20 at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (2014); Code of Maryland Regulations (COMAR) 10.32.02.04. Victoria H. Pepper, Assistant Attorney General and Administrative Prosecutor, represented the State of Maryland (State). Clothilda G. Harvey, Esquire, represented the Respondent, who was present.

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

ISSUES

1. Did the Board establish that the Respondent's use of her license presented a substantial likelihood of risk of serious harm to the public health, safety or welfare, justifying summary suspension of her license?

2. Did the Respondent violate section 14-404(a)(3)(ii) of the Medical Practice Act due to unprofessional conduct in the practice of medicine?

3. Did the Respondent violate section 14-404(a)(4) of the Medical Practice Act due to professional incompetence?

4. If a violation of either section of the Medical Practice Act is proven, what sanctions are appropriate?

SUMMARY OF THE EVIDENCE

Exhibits

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

State's Ex. #1- Complaint, dated October 7, 2013

State's Ex. #2- Medical Records for Patient A's [redacted] Center

State's Ex. #3- [redacted]

State's Ex. #4- Memorandum of Unannounced Office Visit, dated April 24, 2014

State's Ex. #5(a)- Certification of Medical Records of Patient A, dated April 23, 2014, with medical records and Respondent's Summary attached

(b)- Certification of Medical Records of Patient A, dated May 28, 2014, with medical records attached

State's Ex. #6(a)- Certification of Medical Records of Patient B, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient B, dated May 28, 2014, with medical records attached

State's Ex. #7- Certification of Medical Records of Patient C, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient C, dated May 28, 2014, with medical records attached

State's Ex. #8(a)- Certification of Medical Records of Patient D, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient D, dated May 28, 2014, with medical records attached

State's Ex. #9(a)- Certification of Medical Records of Patient E, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient E, dated May 28, 2014, with medical records attached

State's Ex. #10(a)- Certification of Medical Records of Patient F, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient F, dated May 28, 2014, with medical records attached

State's Ex. #11(a)- Certification of Medical Records of Patient G, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient G, dated May 28, 2014, with medical records attached

State's Ex. #12(a)- Certification of Medical Records of Patient H, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient H, dated May 28, 2014, with medical records attached

State's Ex. #13(a)- Certification of Medical Records of Patient I, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient I, dated May 28, 2014, with medical records attached

State's Ex. #14(a)- Certification of Medical Records of Patient J, dated April 23, 2014, with Respondent's Patient Summary and medical records attached

(b)- Certification of Medical Records of Patient J, dated May 28, 2014, with medical records attached

State's Ex. #15- Transcript of Interview with the Respondent, dated May 19, 2014

State's Ex. #16- *Curriculum Vitae* of Paul Wayne Davies, M.D., undated

State's Ex. #17- Expert Report of Paul Wayne Davies, M.D., dated August 8, 2014

State's Ex. #18- Order for Summary Suspension of License to Practice Medicine, dated August 27, 2014

State's Ex. #19- Order Continuing Summary Suspension, dated September 11, 2014

State's Ex. #20- Charges Under the Maryland Medical Practice Act, dated September 12, 2014

The Respondent submitted the following exhibit, which was admitted into evidence:

Resp. Ex. #1- Transcript of hearing before the Board, dated September 10, 2014

Testimony

The following witnesses testified on behalf of the State:

1. Paul Wayne Davies, M.D., accepted as an expert witness in Pain Management and the diagnosis and treatment of adults with acute and chronic pain.
2. Noreen Noppinger, Compliance Analyst

The Respondent testified in her own behalf, and presented testimony of:

1. Patient A.

PROPOSED FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence:[2]

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland.

2. The Respondent was originally licensed to practice medicine on April 19, 1979. Her license is scheduled to expire on September 30, 2015.

3. The Respondent is board-certified by the American Board of Psychiatry and Neurology.

4. The Respondent is not board-certified in Pain Management.

5. Until the Board summarily suspended the Respondent's license to practice medicine, she maintained an office for the practice of Psychiatry. The Respondent also treated one-third of her patients in the area of Pain Management.

6. An opioid is a narcotic medication used to treat acute or chronic pain. A short-acting opioid causes a fast, sudden, euphoric effect that lasts for approximately four to six hours, and also carries with it significant withdrawal symptoms. There is a high risk of addiction to a

[2] Findings of fact numbers one through four were stipulated by the parties.

short-acting opioid. It is often used for breakthrough pain in conjunction with a long-acting opioid. The effects of a long-acting opioid are spread over a longer period of time; one does not experience the sudden euphoria and significant withdrawal symptoms.

7. On October 7, 2013, the Board received an anonymous complaint following the arrest of a woman (Patient A). The Complaint stated that on [redacted], the woman was found with a needle in her arm and 500 Oxycodone pills in her possession that the Respondent prescribed.

8. The police report of the incident stated that hospital staff at [redacted] Medical Center found Patient A in a restroom, with a syringe in her arm. Upon securing her belongings, hospital security found a large number of syringes and prescription medication that had been prescribed by the Respondent. Patient A's bag contained 21 prescription bottles, some containing multiple medications, forty syringes, a rubber strap, a substance that was suspected to be marijuana, a large amount of cash, and the following controlled dangerous substances:

-60 pills and 7 pieces, Alprazolam, a schedule IV controlled dangerous substance.
-161 pills and 8 pieces, Dextroamphetamine, a schedule II controlled dangerous substance.
-31 pills, Oxycontin, a schedule II controlled dangerous substance
-63 pills, Oxycodone, a schedule II controlled dangerous substance.
-30 pills and 5 pieces, Hydromorphone, a schedule II controlled dangerous substance.
-4 pills, Methadone, a schedule II controlled dangerous substance. (3 of these pills were located in a knotted plastic baggie)
-9 pills, Methylphenidate, a schedule II controlled dangerous substance. (Located in [a] prescription bottle for Oxycodone)
-175 pills, non scheduled prescription medication
-12 pills, unidentified
-0.4 grams, greenish brown leafy substance, suspected [marijuana], a schedule I controlled dangerous substance. (Located in a small plastic baggie)
-25 syringes and 27 needles, stored throughout her bag
-$820.00 in cash found crumpled in an inside pocket of her bag.

....

All the prescriptions were written by [the Respondent]...

State's Ex. #3.

9. On April 23, 2014, Doreen Noppinger, Compliance Analyst with the Board, together with another Compliance Analyst, conducted an unannounced visit at the Respondent's medical practice office to serve a subpoena for medical records and to make an initial contact with the Respondent.

10. Ms. Noppinger and the other Compliance Analyst (Compliance Analysts) looked around the Respondent's office, because the information in the Complaint characterized the Respondent's office as a "mess." State's Ex. #1.

11. The Compliance Analysts found a partially open door to a storage room with a bottle of Methadone on a shelf. A patient had returned the Methadone that day and the Respondent had not yet had the chance to dispose of it or lock it away. The room had many boxes and it was difficult to enter. The storage room had a metal cabinet with a key hanging off of it, and the cabinet contained expired prescription bottles of medication and sample medications.

12. The Compliance Analysts found the Respondent's office to be messy, with piles of papers stacked on the floor, sofas, chairs and table tops. There was a water stain on the ceiling tile.

13. The Respondent was very cooperative and retrieved the subpoenaed medical records for the Compliance Analysts.

Patient A

14. The Respondent first began treating Patient A in July 2012 for depression, anxiety and chronic pain. Patient A suffered from multiple medical conditions that caused her chronic pain. She had been sexually assaulted by a doctor when she was a teenager. She suffered from

attention deficit disorder, post-traumatic stress disorder, arthritis, osteoporosis, Crohn's Disease and other medical conditions.

15. When Patient A first came to the Respondent on July 10, 2012, she completed a Medical History Record and the Respondent conducted a mental status examination. Patient A was on Suboxone, a medication that is used to treat opiate dependence. The Respondent did not prescribe any narcotic medication on that date due to the presence of Suboxone.

16. After weaning Patient A off of the Suboxone, the Respondent began to prescribe narcotic medication.

17. On July 19, 2012, which was Patient A's second visit to the Respondent, the Respondent prescribed her Oxycodone. Oxycodone is a short-acting, Schedule II opioid which has a high risk of addiction and dependence. The Respondent also prescribed Oxycontin, which is the long-acting version of Oxycodone.

18. On August 14, 2012, the Patient was having an anxiety attack when she visited the Respondent. She reported pain from a mass in her back, poor sleeping habits and anxiety. The Respondent continued the prescriptions of Oxycontin and Oxycodone.

19. On September 14, 2012, the Respondent reviewed the results of an MRI that had been conducted on the Patient. The Patient was found to have pain from a fatty mass, or lipoma, and was wearing a boot due to a fracture. On that day, the Respondent noted that Patient A's "pain and depression are in good control on her current regimen...." State's Ex. #5. The Respondent ordered that the Oxycontin and Oxycodone be continued, and she added Dilaudid, another short-acting opioid, for breakthrough pain.

20. The Respondent continued to prescribe these medications through March 2013, and on April 2, 2013, the Respondent increased Patient A's dosage of Dilaudid.

21. On August 26, 2013, the Patient reported that she thought she lost her Oxycontin so she took extra Oxycodone and Dilaudid. The Respondent agreed to prescribe a refill of the Dilaudid early, and counseled Patient A regarding compliance with her medication regimen.

22. On September 18, 2013, Patient A came to see the Respondent on an emergency basis. She was anxious and distraught. She had just been released from Anne Arundel County Medical Center, and she reported that neither her medications nor $400.00 cash had been returned to her by the hospital. Her medications could not be refilled until September 24, 2013. The Respondent prescribed Dilaudid and Morphine to hold her over until her medications could be refilled, and the Respondent gave her pre-dated prescriptions for September 24, 2013. The Respondent had Patient A sign a consent form so that the Respondent could review the medical records from the hospital, and counseled her regarding use of her pain medication.

23. On November 9, 2013, Patient A admitted to the Respondent that she had been overmedicating and taking her medications early. The Respondent counseled her and told her that her prescriptions would not be filled early. The Respondent wrote pre-dated prescriptions for a two-month supply, but required that Patient A come to the office in December to obtain the December refill prescription.

24. On January 7, 2014, the Respondent ordered refills of Patient A's prescriptions even though she reported that her medications had been stolen. She did not have a police report but she had a complaint number. The Respondent prescribed refills and stated that she would observe Patient A for compliance.

25. On February 1, 2014, Patient A reported that her insurance refused to allow her to fill Oxycontin or patches of any kind. She had therefore been without any long acting medication for approximately one month, and she was in severe pain. The Respondent gave her

an extra prescription for Dilaudid to hold her over. The Respondent's noted in her record of this visit stated that she would discuss the situation with Patient A's pharmacist.

Patient B

26. The Respondent began to treat Patient B in 1993. She suffered from bipolar disorder and also had a seizure disorder and a mood disorder. After being discharged from care, she returned to the Respondent for regular treatment in 2001. She presented as obese, with severe pain in her knees. She also suffered from depression.

27. When Patient B returned to the Respondent for regular treatment, she admitted that she bought street Methadone for her pain. She also had been "doctor shopping" to acquire pain medication. As a result, a group of Patient B's doctors consulted and agreed that the Respondent would be the one to handle Patient B's treatment for depression and pain.

28. On July 9, 2011, the Respondent found Patient B to be "drug-seeking." Regardless, the Respondent prescribed Percocet, a short-acting narcotic which is a combination of Tylenol and Oxycodone.

29. On September 20, 2011, the Respondent noted that Patient B was "stable despite drug-seeking behavior." State's Ex. #6(a), p. 582.

30. While still under the Respondent's care, Patient B again engaged in drug-seeking behavior, and the Respondent increased the frequency of her appointments to every three to four weeks, and counseled her regarding noncompliance with her medication.

31. On February 2, 2012, Patient B had been going to Narcotics Anonymous (NA) meetings and had not been abusing drugs. She reported to the Respondent that she was still having "drug dreams," so the Respondent discussed relapse prevention with her. She was having knee pain. The Respondent, noting that she did not want to induce drug dependency, but added

Oxycodone to Patient B's medication regimen, because she had such a high drug tolerance and needed help with breakthrough pain.

32. On May 2, 2012, Patient B told the Respondent that she had "some somatic complaints" and "some increase in pain." State's Ex. #6(a) p. 574. The Respondent increased the dosage of Oxycodone.

33. On July 30, 2012, the Respondent prescribed Percocet and Oxycodone, as well as Duragesic, a long-acting narcotic patch, for Patient B.

34. On September 27, 2012, Patient B came to the Respondent's office with slurred speech. She had not yet obtained an x-ray that the Respondent previously requested on a swollen and sore foot. Ex. 6(a) p. 569, 70. Patient B admitted that she had taken extra Xanax. The Respondent advised against this behavior, but continued the opioid prescriptions.

35. At some point prior to February 25, 2013, the Respondent received a call from a nurse practitioner from Union Memorial Hospital who reported that Patient B had fallen twice while there. The nurse practitioner inquired whether Patient B had been overmedicated. On February 25, 2013, the Respondent discussed this with Patient B, who denied that she had abused the narcotics and said she tripped on a rug. Despite the fact that the Respondent was unsure about the veracity of Patient B's account, the Respondent continued all of Patient B's medications unchanged.

36. On July 25, 2013, Patient B signed a Therapy Agreement for Pain Management (Pain Management Agreement), wherein she agreed not to share or sell her medication, that early refills would not be given, that medications will not be replaced if lost or stolen, and that if stolen, a police report must be filed. The Pain Management Agreement also informed Patient B that failure to adhere to the policies contained therein would result in cessation of pain therapy with controlled dangerous substances.

37. On October 19, 2013, Patient B requested that her medications be increased. The Respondent felt that Patient B had returned to her drug-seeking behavior. The Respondent refused to increase the medication without documentation and "surgical reassessment" but continued the same opioid prescriptions and told Patient B to return in three weeks.

38. On January 15, 2014, Patient B's mother informed the Respondent that she did not think Patient B was taking her medication properly. The Respondent noted that she was unsure if Patient B was being compliant, but continued her medications, and noted that seeing Patient B monthly gives greater control of use and abuse of the medications.

39. On February 26, 2014, Patient B requested that the Respondent increase her medication but the Respondent refused to do so. Patient B admitted that several years prior she sold her medications to buy Methadone off the street. The Respondent counseled her regarding noncompliance with her pain medication, because her tendency to abuse her prescriptions had been a problem.

40. On March 25, 2014, the Respondent suspected that Patient B was again abusing her medication. Patient B admitted that before coming to the Respondent's office, she took all of her pain medication at once. Patient B admitted to abusing Percocet and the Respondent discontinued that prescription, and counseled Patient B that if her behavior continued the Respondent would discharge her from care. However, the Respondent continued the prescription of Oxycodone and Morphine Sulfate, which the Respondent had added to Patient B's medication regime in July 2013.

41. On April 23, 2014, Patient B came to see the Respondent one day earlier than scheduled and said that she had been out of medication for four days. The Respondent talked to Patient B about abusing her medication, and warned that if her dishonest and abusive behavior

regarding her medications continued, her medication would be discontinued. However, the Respondent renewed the prescription for pain medication.

42. Prior to prescribing narcotic medication to Patient B, and during her treatment of Patient B when Patient B returned to her care in 2001, the Respondent did not perform and document a physical examination, did not conduct a mental status examination and did not consider the universal precautions for the prescription of pain medication.

Patient C

43. Patient C had been under the Respondent's care since 2008. He had a history of mental issues including traumatic brain injury and post-traumatic stress disorder, as well as other somatic and mental health disorders. He had a history of abuse of narcotics, cocaine and alcohol. He was in the Special Forces in the military and was being treated by the Veterans Administration (VA) for his somatic conditions.

44. When Patient C first came to the Respondent in September 2008, he completed a Medical History Record.

45. On November 19, 2008, Patient C told the Respondent that he increased the use of his pain medication without medical advice or supervision due to an increase in pain. Patient C told the Respondent that he was in a great deal of pain and not sleeping well. The Respondent counseled him regarding noncompliance with his medication, and increased his dosage of Percocet.

46. On December 19, 2008, Patient C reported to the Respondent that he was in excruciating back pain and his pain medication was not working. The Respondent ordered an MRI of his back and increased his Percocet dosage. The Respondent reviewed the MRI results.

47. The Respondent saw Patient C monthly in 2009 and during that period he was stable on his medication with no remarkable incidents. However, on June 2, 2010, Patient C

reported that he was taking extra Percocet. The Respondent was concerned about the extra Tylenol that he was taking as a result. She discontinued his Percocet prescription, counseled him about compliance with his medication, and began a trial of Oxycontin.

48. On July 2, 2010, Patient C reported that he could not tolerate the Oxycontin; it caused him to break out in hives. The Respondent discontinued the Oxycontin and began a trial of Dilaudid for his pain.

49. On July 24, 2010, Patient C admitted that he drank alcohol while on his pain medication and that he took extra Dilaudid. The Respondent had also received a call from Patient C's landlady who told her that Patient C was drinking alcohol and selling his pain medication. Patient C denied selling his pain medication. The Respondent discontinued the Dilaudid and placed Patient C back on Percocet and counseled him regarding drinking while on his medication. She also informed Patient C that if the drinking continued she would discontinue the pain medication.

50. On November 26, 2011, Patient C went to see the Respondent two weeks prior to his scheduled appointment. He reported that he increased his medication on his own, and now he sought a refill because he was running low. The Respondent confronted him with this noncompliance, and told him that he was already taking the maximum dosage. The Respondent also reported that Patient C "apparently has been abusing these meds for some time in this way and trying to hustle his sister for her pain meds, which she has refused but told me about today when discussing this issue with him." State's Ex. #7(a), p. 1039. The Respondent refused to increase Patient C's Percocet.

51. On November 1, 2012, the Respondent signed a Pain Management Agreement.

52. On December 31, 2012, the Respondent again counseled Patient C about taking his medications early. She continued his current medication regimen.

53. On March 4, 2013, Patient C was arrested for assault with a deadly weapon. While searching Patient C incident to this arrest, police found drug paraphernalia that is used to snort and smoke a controlled dangerous substance. Police also found a caplet of Alprazolam, a controlled substance, in a tube hanging from a key ring.

54. In March 2013 following the arrest incident, and in April and May 2013, the Respondent continued the same medication regimen for Patient C.

55. On August 17, 2013, Patient C again took his medications too early, and the Respondent counseled him about compliance issues. She prescribed refills of his medications for one month.

56. On October 18, 2013, the Respondent prescribed refills for Patient C's pain medication for a two-month supply. Patient C's son had taken over monitoring his medications, and Patient C had been doing well and had been compliant.

57. Prior to prescribing narcotics to Patient C, and throughout her treatment of Patient C, the Respondent did not perform and document a physical examination, did not conduct a mental status examination, and did not consider universal precautions for the prescription of pain medication.

Patient D

58. Patient D had been in the Respondent's care since 1997. He originally came to the Respondent for a Social Security disability assessment. He presented suffering from Major Depressive Disorder and chronic lower back pain. Earlier in his life he experienced multiple gunshot wounds, and re-injured his back in 1999. He suffered from degenerative joint disease. The Respondent discharged him from care at some point, and he returned to her in December 2002.

59. When Patient D first came to the Respondent in 1997, he completed a Medical History record.

60. Patient D had a history of abusing alcohol and illegal drugs, including cocaine. The Respondent had been prescribing him Percocet for his pain. On multiple occasions, the Respondent advised him to enroll in a drug treatment program.

61. On December 20, 2006, Patient D was arrested on suspicion of buying narcotics on the street. He was also charged with possession of an illegal firearm and was incarcerated for 30 days. The drug charges were ultimately dismissed. The Respondent continued his pain medication, and advised him to enter drug rehabilitation.

62. On May 14, 2007, Patient D reported to the Respondent that he was still making excuses about his abuse of drugs. The Respondent prescribed refills of his pain medication.

63. On July 14, 2007, Patient D reported that he was no longer abusing street drugs and had enrolled in Baltimore Behavioral Health for rehabilitation. In 2007 and 2008 he moved to Philadelphia to a halfway house and had been drug-free. On February 4, 2008, he came back to Baltimore for a weekend and started using drugs again after being clean for seven months. The Respondent continued his pain medication.

64. Starting in April 2008, Patient D began living in Richmond, Virginia but would return to Baltimore for his appointments with the Respondent. He was drug-free and attending NA. He remained drug and alcohol free and continued to see the Respondent every two months

65. On March 29, 2012, Patient D ran out of his medications early. The Respondent prescribed refills for his pain medication.

66. On May 3, 2013, Patient D reported that his pain was in good control. The Respondent wrote three months' worth of pre-dated prescriptions, but only actually gave him a prescription for one-month at a time. The Respondent required that Patient D return to her office

monthly to pick up that month's prescription; the Respondent met with Patient D every other month.

67. On December 2, 2013, Patient D admitted to relapsing and using cocaine one time. The Respondent prescribed the same medications and referred Patient D to rehabilitation.

68. The Respondent did not conduct and document a physical examination of Patient D prior to initiating narcotic medication when he returned to her care in 2002. During her treatment of Patient D, she did not utilize a structured risk assessment tool, or conduct urine drug screening to monitor his use of street drugs. Further, the Respondent did not consider the universal precautions.

Patient E

69. Patient E had been the Respondent's patient since July 2010. She had been diagnosed with major depression and anxiety, and suffered from pain from multiple somatic conditions, including chronic headaches, back pain, Endometriosis and Carpal Tunnel Syndrome. The Respondent initially prescribed her Percocet, and later substituted Oxycontin.

70. When Patient E first saw the Respondent on July 13, 2010, she completed a Medical History Record. The Respondent also conducted a mental status examination.

71. On December 21, 2011, Patient E reported that she had taken extra pain medication. The Respondent counseled her regarding medication noncompliance. The Respondent prescribed a trial of Dilaudid as well as Oxycodone for breakthrough pain.

72. On February 7, 2012, Patient E reported that she took extra Oxycodone. The Respondent counseled her regarding noncompliance. She had stopped taking Dilaudid, and the Respondent instructed her to return to use of the Dilaudid, and only take Oxycodone for breakthrough pain.

73. On September 14, 2012, Patient E came to the Respondent on an unscheduled visit and reported that she had taken a few extra pain pills. The Respondent counseled her about this and gave her a one week supply of Percocet in addition to the pain medication that she was already taking.

74. On October 16, 2012, the Respondent noted that Patient E had not been compliant with her medication; she was taking extra pills. The Respondent required Patient E to sign a Pain Management Agreement in order to continue therapy. The Respondent discontinued the Dilaudid, continued the Oxycodone for breakthrough pain, and prescribed Percocet for chronic pain. Then, the Respondent told Patient E to return in two months.

Patient F

75. Patient F initially came to the Respondent in June 2010. He presented with pins in his knees and back, anxiety and stress. He had prior knee surgery and had a dislocated bicep repaired. He also had chronic low back pain.

76. When Patient F first saw the Respondent on June 22, 2010, he completed a Medical History Record. The Respondent conducted a mental status examination.

77. On August 13, 2010, the Respondent increased Patient F's pain medication. She prescribed Percocet. Patient F did not report increased pain during that visit. The Respondent noted that "[s]omatic complaints persist in terms of muscles and joints from the work." State's Ex. #1(a), p. 2257.

78. On January 29, 2011, Patient F came to see the Respondent without a scheduled appointment. The Respondent gave Patient F a new pain medication prescription because he reported that he was cleaning out his truck, and accidently threw away his medication. The Respondent told Patient F to keep his regular appointment on February 7, 2011, and continued to see him monthly thereafter.

79. On June 4, 2012, the Respondent continued Patient F's medication despite his report that his pain was reduced.

80. On September 28, 2012, Patient F signed a Pain Management Agreement.

Patient G

81. Patient G had been in the Respondent's care since 1987 for depression and chronic pain. The Respondent treated her through 1995, and again beginning in 2009. She had chronic hip and knee pain, GERD, Diabetes and Hypertension.

82. When Patient G returned to the Respondent's care on April 3, 2009, she completed a Medical History Record. The Respondent conducted a mental status examination.

83. On March 3, 2011, Patient G reported to the Respondent that she was experiencing increased pain. She had been taking Percocet. The Respondent added Oxycodone, another short-acting narcotic, to Patient G's pain medication regimen.

84. On April 9, 2012, Patient G reported significant pain. At that time the Respondent had already been prescribing Percocet for Patient G. On that day, the Respondent added Dilaudid to Patient G's medication regimen.

Patient H

85. Patient H had been under the Respondent's care since August 3, 2013. She presented with daily headaches and neck pain. The Respondent diagnosed Patient H with Major Depression.

86. When Patient H first saw the Respondent on August 3, 2013, she completed a Medical History Record. The Respondent conducted a mental status examination.

87. On August 3, 2013, the Respondent prescribed Oxycodone and Oxycontin, at a dose that was significantly higher than the doses of pain medication that she had been previously prescribed by another doctor.

88. On August 29, 2013, Patient H reported to the Respondent that she had significant pain that day. The Respondent increased her Oxycontin and Oxycodone.

89. On September 24, 2013, Patient H told the Respondent that she had not found any relief with Oxycontin. The Respondent discontinued the Oxycontin and prescribed a trial of Methadone.

90. On October 19, 2013, Patient H reported to the Respondent that the Methadone had helped her pain but she did not tolerate it well. The Respondent restarted Oxycodone and added Duragesic patches.

Patient I

91. Patient I first saw the Respondent on January 2, 2013. She had a history of depression and anxiety. She had been involved in a motor vehicle accident and experienced back pain.

92. On Patient I's first visit to the Respondent on January 2, 2013, she completed a Medical History Record, and the Respondent conducted a mental status examination. The Respondent prescribed Percocet and Oxycodone, two short-acting narcotics.

93. On February 1, 2013, the Respondent increased Patient I's Oxycodone.

94. On May 1, 2013, Patient I signed a Pain Management Agreement.

95. On October 19, 2013, Patient I reported that her pain was in good control. The Respondent reduced her dosage of Percocet.

96. On February 22, 2014, the Respondent discontinued Percocet because there was concern that Patient I was getting too much Tylenol, and because she was taking two short-acting pain medications. The Respondent instead prescribed a trial of Morphine Sulfate and increased the dosage of Oxycodone for breakthrough pain.

Patient J

97. Patient J first went to see the Respondent in October 2011. His complaints included depression and chronic back and hip pain.

98. On Patient I's initial visit on October 10, 2011, he completed a Medical History Record, and the Respondent conducted a mental status examination. The Respondent increased Patient I's dose of Percocet from that which another doctor had prescribed.

99. On March 30, 2013, the Respondent received a note from Patient J's insurance company stating that two weeks prior, Patient J had gone to another doctor and received a prescription for Percocet.

100. On August 8, 2013, the Respondent increased Patient J's Oxycontin and continued his Oxycodone.

DISCUSSION

The Board

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

Under the Administrative Procedure Act, the Board may exercise the following authority to summarily suspend a physician's license:

§ 10-226. Licenses – Special provisions

(a) Definitions.

(1) In this section the following words have the meanings indicated.

(2) "License" means all or any part of permission that:
(i) is required by law to be obtained from a unit;
(ii) is not required only for revenue purposes; and
(iii) is in any form, including:
1. an approval;
2. a certificate;
3. a charter;
4. a permit; or
5. a registration.

(3) "Unit" means an officer or unit that is authorized by law to:
(i) adopt regulations subject to Subtitle 1 of this title; or
(ii) adjudicate contested cases under this subtitle.

. . .

(c) Revocation or suspension.

(1) Except as provided in paragraph (2) of this subsection, a unit may not revoke or suspend a license unless the unit first gives the licensee:
(i) written notice of the facts that warrant suspension or revocation; and
(ii) an opportunity to be heard.

(2) A unit may order summarily the suspension of a license if the unit:
(i) finds that the public health, safety, or welfare imperatively requires emergency action; and
(ii) promptly gives the licensee:
1. written notice of the suspension, the finding, and the reasons that support the finding; and
2. an opportunity to be heard.

Md. Code Ann., State Gov't § 10-226(a), (c) (2014).

In addition, under the Health Occupations Article, the Board may "reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

. . . .

(3) Is guilty of:

. . . .

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

. . . .

(4) Is professionally, physically, or mentally incompetent[.]

Md. Code Ann., Health Occ. § 14-404(a)(3)(ii) and (4) (2014).

Summary Suspension

On August 27, 2014, the Board summarily suspended the Respondent's medical license. The Board took this action after receiving the Complaint regarding the arrest of Patient A, who was found in a hospital bathroom with a needle in her arm and 500 Oxycodone pills in her possession that had been prescribed by the Respondent. State's Ex. #1. The police report of the incident stated that hospital staff found Patient A in a restroom, unresponsive, with a syringe in her arm. State's Ex. #3. Upon securing her belongings, hospital security found a large number of syringes and prescription medication that had been prescribed by the Respondent. State's Ex. #3.

On April 23, 2014, the Board conducted an unannounced visit at the Respondent's medical office to serve a subpoena of medical records in furtherance of its investigation of the matters alleged in the Complaint. As set forth in the Findings of Fact, the Board found the Respondent's office cluttered with papers and boxes upon desks, tables, chairs and the floor. In an unlocked storage room there was an unlocked cabinet with sample psychiatric medication and expired controlled dangerous substances. *See also,* testimony of Doreen Noppinger, Tr. 164-188. There was also a bottle of Methadone on a shelf in the storage room.

After interviewing the Respondent and reviewing the subpoenaed medical records, the Board referred the results of its investigation to a Pain Management expert (Expert). State's Ex. #17. The Expert concluded that the Respondent engaged in unprofessional conduct in the practice of medicine and was not professionally competent to practice Pain Management. The Expert further concluded that the Respondent's conduct posed a "substantial likelihood of serious risk to the public health, safety or welfare of patients due to her lack of training and clinical judgment to treat complex patients seeking care for pain management." State's Ex. #17. The Expert cited

multiple reasons for this conclusion, including the Respondent's failure to document adequate assessments of patients prior to proceeding with opioid treatment, failure to use risk assessment tools, prescription of two short-acting narcotics simultaneously, and continuation of opioid treatment despite evidence of abuse, addiction and diversion. The Expert also cited the Respondent's failure to utilize adjunctive therapies, failure to adhere to universal precautions for the prescription of opioid medication, and failure to routinely assess the "Four As" (analgesia, activity, addictive behavior and aberrant behavior) of prescription pain medication.[3]

I agree with the State that, given all of the information that the Board had before it, which included the Expert's report, the disarray of the Respondent's office, the narcotic medication located in an unlocked room and an unlocked cabinet, and the matters contained in the Complaint and police report, the Board necessarily imposed the summary suspension. The Respondent testified that she only had a part-time secretary. Tr. 200. Therefore, if no one was in the office except the Respondent and her patients, the patients in the Respondent's waiting room could have entered the unlocked storage room and taken the narcotics while the Respondent was with another patient. Further, given the circumstances upon which the police found Patient A, with an alarming amount of narcotics in her possession that the Respondent prescribed, the Board had significant facts before it to justify its conclusion that summary suspension was necessary. The Board is not required to wait until someone is harmed before imposing a suspension if the risk of harm is substantial, which it appeared to be at the time of the summary suspension. Given the information before the Board, the Board justifiably concluded that there was a substantial risk of harm to public health, safety and welfare if it were to allow the Respondent to continue in her practice pending full investigation, the issuance of charges and a hearing. I conclude that the summary suspension was appropriate.

[3] This will be discussed and explained further below.

Charges under the Maryland Medical Practice Act

The Board filed charges on September 12, 2014, alleging that the Respondent was in violation of Section 14-404(a)(3)(ii) of the Health Occupations Article due to unprofessional conduct in the practice of medicine, and Section 14-404(a)(4) due to professional incompetence. The State presented the testimony of Paul Wayne Davies, M.D., who was accepted as an expert witness in Pain Management and the diagnosis and treatment of adults with acute and chronic pain.

Much of Dr. Davies' testimony centered on his opinion that the Respondent deviated from the standard of care of pain management. The Board did not bring charges against the Respondent under Section 14-404(a)(22) of the Health Occupations Article for a failure to meet appropriate standards for the delivery of quality medical care, which would have required a peer review. Although it could appear that the Board may have charged the Respondent in this manner in order to avoid peer review, the Respondent did not raise this argument at the hearing, nor did she challenge the State's case on due process grounds. Further, my analysis of the evidence in its entirety led me to conclude that the Respondent's actions, in her treatment of the majority of the ten patients at issue, constituted misconduct in the practice of medicine, and in some instances, professional incompetence.

Dr. Davies testified that the standard of care is to use one short-acting or one long-acting opioid, or a combination of one of each simultaneously to treat pain. Tr. 22. There is no benefit to mixing two short-acting opioids, and the risk of dependence, addiction and abuse poses more harm than benefit. Tr. 22. He explained that when assessing a patient for a pain management regimen, a physician should obtain a thorough history of the pain, conduct a thorough physical examination, and follow up through diagnostic testing, review of previous medical records, and the utilization of a risk assessment tool. Tr. 23, 24. The physical examination could be targeted to the anatomical area of the pain complaint, in addition to neuromuscular and neurological examinations. Tr. 24.

Further, Dr. Davies explained that the physician should constantly monitor and evaluate the patient's progress and side effects, and assess whether or not the positive effects of the medication outweigh any negative effects. Tr. 25. The standard for monitoring a narcotics regimen is the assessment of the "Four As," which are "analgesia,[4] activity, addictive behavior and aberrant behavior." Tr. 25. Also, urine drug screens should be performed to ensure that the patient is taking the medication and dosage that he is prescribed, so as to prevent negative drug interactions. Tr. 25, 26. For psychiatric patients, even closer monitoring may be necessary. If a physician finds that a patient is abusing or diverting narcotic medication, this creates a red flag, and the benefit of the medication needs to be balanced against the risk to the patient and society that could result from such abuse. Tr. 26, 27.

According to Dr. Davies, "universal precautions" are a list of steps that a physician should take when treating patients with narcotic medication. Tr. 27. These universal precautions include ten steps: 1) Make a diagnosis with appropriate differential and consideration of prior substance abuse and psychiatric illness; 2) Psychological assessment including risk of addictive disorders; 3) Informed consent, or educating the patient about opioid benefits and risks; 4) Execution of a treatment agreement, setting forth both the expectations and the obligations of the patient and physician regarding opioids; 5) Pre- and post-intervention assessment of pain level and function; 6) Appropriate trial of opioid therapy with and without adjunctive medication, including the consideration of subjective complaints as well as objective clinical findings; 7) Regular reassessment of pain score and level of function; 8) Regular assessment of the Four As of pain medicine; 9) Periodic review of pain diagnosis and comorbid conditions including addictive disorders; and 10) Careful and complete documentation. State's Ex. #17, citing Gourlay DL, Heit

[4] Analgesia is defined as the loss of the ability to feel pain while conscious. http://www.merriam-webster.com/dictionary/analgesia.

HA, Lmahrezi A. *Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain. Pain Med 2005,* March-April 6(2): 107-12. Dr. Davies defined "adjunctive medication" as medication used to treat pain that is non-narcotic. Tr. 27. He explained that the World Health Organization has a "step-wise approach to how one treats pain," beginning with non-narcotic treatments such as non-narcotic pain medication and other non-narcotic treatments. Tr. 27, 28. I found Dr. Davies to be credible and knowledgeable, and he explained the standard of care for Pain Management in a clear, understandable manner.

The State argued that the overwhelming evidence in this case established that the Respondent's pain management practices constituted a substantial risk of harm to patients, in that the Respondent prescribed excessive quantities of opioids, which are addictive, including multiple short-acting opioids at the same time. Further, the State argued that the Respondent failed to act within the standard of care of a reasonably competent physician because she failed to conduct adequate physical examinations, failed to conduct urine screening, failed to monitor and assess the Four As of pain medication and did not monitor patients closely enough through sufficient follow-up visits.

The Respondent argued that nothing in the Maryland Medical Practice Act allows the Board to enter her office and walk around and take pictures. Therefore, any evidence that resulted from that unlawful entry is the "fruit of the poisonous tree" and should not be considered. Further, she argued that the Board should not have taken her original patient records when it executed its subpoena on April 23, 2014. The Respondent conceded that her documentation was not as detailed as it should have been. However, she disagreed that she failed to closely monitor her patients and failed to address noncompliance issues. She took the position that her records established that she addressed compliance issues as they arose, and continued to prescribe opioids in situations where there had been medication noncompliance because the noncompliance ceased. Further she argued

that even though she did not have a checklist for monitoring the Four As, her notes indicated that she regularly did so. The Respondent requested that the charges be amended to a failure to keep adequate medical records under Section 14-404(a)(40) of the Health Occupations article.

The Board's right to enter medical premises in furtherance of an investigation, and/or to enforce its duties is clearly set forth in Section 14-206(d) of the Health Occupations Article, as follows, in pertinent part:

> **Right to enter**
> (d)(1) If the entry is necessary to carry out a duty under this title, the Board's executive director or other duly authorized agent or investigator of the Board may enter at any reasonable hour:
> (i) A place of business of a licensed physician; or
> (ii) Public premises.
> (2) A person may not deny or interfere with an entry under this subsection.

Further, the Board may issue subpoenas in connection with any investigation. Md. Code Ann., Health Occ., § 14-206(a) (2014) and § 14-401.1(i) (2014); *See also,* COMAR 10.32.02.03C. There is no requirement that the Board obtain copies, rather than originals of a physician's records. I conclude, therefore, that the Respondent's arguments regarding the subpoena for records and entry into her medical practice office has no merit.

Patient A

According to Dr. Davies' report, the Respondent failed to document adequate assessment of Patient A prior to beginning treatment with narcotic medications. Also, she failed to use a risk assessment tool, and she began Patient A on a high dose of narcotics without attempting to control the pain at lower doses.

At the hearing, Dr. Davies opined that the Respondent, by continuing to prescribe Oxycodone, Oxycontin and Dilaudid to Patient A, did not follow an adequate treatment protocol. Tr. 33. It was too much medication for any patient. He noted that the Respondent never conducted

an adequate physical examination of Patient A, did not adequately monitor her progress, or follow the Four As or universal precautions. Tr. 33, 34. According to Dr. Davies, it is a red flag for abuse or diversion when a patient reports that medication was stolen. Therefore, it is "good practice" to investigate the matter further, and to decline to replace the prescriptions until there is a police report to confirm such a theft. Tr. 34. Additionally, a patient's need to refill a prescription early raises a similar red flag. Tr. 35. Given the red flags that were apparent in Patient A's records, and given her psychiatric and physical ailments, Dr. Davies opined that it was not reasonable to continue to prescribe narcotics, and the Respondent's treatment of Patient A constituted a substantial likelihood of the risk of serious harm to Patient A and public health, safety and welfare. Tr. 35, 37. At any rate, Dr. Davies testified that the Respondent should have monitored Patient A by office visits every few weeks, monthly at least, and only should only have prescribed a small amount of narcotics at one time, rather than a one or two month supply. Tr. 37, 102-103.

On cross-examination, Dr. Davies answered questions regarding whether his opinion of the Respondent's treatment protocol would have changed if there was documentation of the existence of other health factors, such as pain from pancreatitis on April 2, 2013, when the Respondent increased the dosage of Dilaudid for Patient A. Similarly, the question was posed as to whether his opinion would change, for example, on January 7, 2014, if there was documentation that the Respondent actually spoke to a police officer when Patient A reported that her medications were stolen. Tr. 148. Dr. Davies testified, and throughout his testimony he made this point several times, that it is possible that there was simply a lack of documentation setting forth the actual circumstances. Tr. 111, 112. Further, some of the Respondent's patient records were typewritten, and some were handwritten. Those that were handwritten were difficult, if not impossible to read. Tr. 112, 113, 143, 144. The Respondent did, in fact, testify that she spoke to the police officer regarding this incident and verified that Patient A did file a complaint reporting the stolen

medication. Tr. 297, 298. Regardless, Dr. Davies' point was that it is the standard of care to have the appropriate documentation, such as the police report, in the medical records, before continuing to prescribe narcotics. Tr. 149, 150.

On the subject of non-compliance with narcotic medication, Dr. Davies explained that when a patient has a compliance issue, it should be documented with an "opioid contract violation" that the patient must sign acknowledging the violation. Tr. 121, 138. Further, Dr. Davies noted that where there are compliance issues, that particular patient should be seen more often than in two month increments. Tr. 138. The noncompliant patient needs to be monitored much more closely. Tr. 138. That way, the Respondent would have had the option of terminating or canceling the patient if violations continued to occur. Tr. 121, 122.

Patient A testified on behalf of the Respondent. She insisted that the reason she had syringes when confronted by the police at [redacted] Medical Center was for the injection of vitamin B-12. Tr. 286, 287. She denied that she was unconscious. Tr. 287. She denied ever having used heroin. Tr. 294.

The Respondent testified that when she sees a new patient, the patient completes an intake form that lists symptoms and major complaints as well as family history. Tr. 215. She then does a "cursory physical examination" which includes vital signs and examination of any area about which the patient has a complaint. Tr. 215. The Respondent indicated that she did conduct a physical examination of Patient A, and a one-page record of that physical examination would normally be present in the patient's medical records. However, the record of the physical examination of Patient A was missing from the file when the Board returned her medical records. Tr. 215. She denied that a risk assessment checklist was necessary, because she compiles a very detailed medical history, which is her way of conducting a risk assessment, and is part of her routine evaluation of a patient. Tr. 216. Patient A's records do reflect that the Respondent compiled a detailed history. State's Ex.

#5(a), p. 390-393. The Respondent's handwritten history is difficult to read. She also obtained Patient A's prior medical records.

The Respondent testified that she initially prescribed Oxycodone and Oxycontin to Patient A in doses that were lower than that which she had been prescribed in the past. Tr. 229. She noted that prescribing the medication PRN, or as needed, is not appropriate with psychiatric patients because they will abuse the medication by taking it rather than utilizing other coping skills that they learn through therapy. Tr. 229, 230. She explained further that psychiatric medications and pain medications, while not being associated with the same receptors, can act to block each other's effects. Tr. 232. Therefore, pain medication must be prescribed at a dose that will provide some relief, given that psychiatric medications may have an interactive effect. Tr. 232, 233.

The Respondent explained that she scheduled Patient A's visits no more frequently than one or two months apart because there was an insurance cap on the number of psychiatric visits that she could attend. Tr. 234. Further, Patient A had multiple appointments with her primary care physician and surgeons, which was why, on August 14, 2012, she told Patient A to return in two months despite the high doses of opioid medications that she was taking. Tr. 238, 256.

In response to Dr. Davies' opinion that she failed to use adjunctive relief with Patient A, the Respondent explained that her initial evaluation of Patient A revealed that Patient A was allergic to NSAIDs[5] such as Ibuprofen and Celebrex. Tr. 241. Further, Patient A had been on opioid medication for a long time, and, although acknowledging that adjunctive therapy was critical, insurance would not pay for other adjunctive therapies such as acupuncture. Tr. 241, 242. Therefore, the Respondent felt as though she was "stuck." Tr. 242.

Although the Respondent conceded that she does not utilize an opioid violation form, she testified that she makes her patients aware that if there are three incidents of non-compliance, she

[5] Nonsteroidal anti-inflammatory drugs.

will no longer treat the non-compliant patient. Tr. 246, 247. Further, she said that the patient's Pain Management Agreement informs a patient of the consequences for noncompliance. Tr. 247. There is no Pain Management Agreement in Patient A's records. The Respondent addressed her decision to give Patient A pre-dated prescription refills for two months on November 9, 2013 when Patient A admitted to over-medicating. Again, she had upcoming medical appointments, the holidays were approaching, and the Respondent was going to be out of town. Therefore, the Respondent wrote two prescriptions, but only gave one to Patient A on November 9, 2013. She was required to return to the Respondent's office in December when the Respondent would be away to pick up the prescription for that month. Tr. 296, 297.

In response to Dr. Davies' opinion that on April 2, 2013, when she increased Patient A's dose of Dilaudid, the Respondent stated that at that time, Patient A was having acute pain other than her chronic ongoing pain, so she increased the Dilaudid for a short period of time. Tr. 258, 259. The Respondent testified regarding her written plan for several other visits with Patient A, where she prescribed a hold-over prescription or determined not to see Patient A for a two month period, and generally, those determinations were related to insurance matters, or the inability to schedule appointments due to travel plans of either Patient A or the Respondent. Tr. 300-302.

Patient A completed a Medical History Record, and the Respondent completed a mental status examination and took copious notes of the Respondent's complaints and history on her first visit. State's Ex. #5(a). However, while I can read certain words within those notes, I cannot read them with enough sufficiency to decipher the contents. State's Ex. #5(a), p. 390-394. There is no evidence of any physical examination in Patient A's records.

From September 2013 through January 2014, Patient A once reported her medications stolen, once reported them lost, and once admitted that she had been over-medicating and taking her medications early. The Respondent did counsel her regarding noncompliance on those occasions,

but did refill her prescriptions, and sometimes for a two or three month period. I found the Respondent's testimony to be credible that Patient A was not actually given the prescription for more than one month; she was required to come to the office to pick up the prescription for the second month. Although prescribing in that manner may have prevented Patient A from getting an early refill of her prescription, the Respondent did not monitor her or meet with her each time she came to pick up that prescription. Patient A had a track record for noncompliance, especially during that period, and I found Dr. Davies' explanation of the protocol mandated by the standard of care in a pain management practice to be convincing that, at that point, the Respondent should have declined to refill the prescriptions, especially after three incidents that were red flags for abuse.

There is no evidence in Patient A's record that the Respondent formally monitored the Four As of pain management, or regularly considered the universal precautions that are part of the standard of care for pain management. However, I agree with the Respondent that scattered throughout her notes, there are times when she comments on matters to which the universal precautions relate. Further, I am mindful of the fact that most of the Respondent's patients are referred to her and being followed by other doctors. While her notes may show signs of consideration of some of the characteristics that comprise the standard of care, it was not done on a structured, organized basis, and her records do not display these considerations on a regular basis. Further, there is no evidence that she conducted urine screening to monitor Patient A.

The Respondent argued, and Dr. Davies agreed, that the treatment of psychiatric patients for pain takes on additional components. However, after taking all of the evidence regarding Patient A into consideration, and for the reasons set forth above, I conclude that the State has established that the Respondent's treatment of Patient A constituted misconduct in the practice of medicine and professional incompetence.

Patient B

Dr. Davies testified that he was concerned about the Respondent's medication regimen for Patient B. Tr. 40. On July 30, 2012, the Respondent prescribed both Percocet and Oxycodone, which, according to Dr. Davies, are essentially the same drug, and they are both short-acting. Tr. 40. Because the short-acting drugs have a "high peak and a quicker trough," the risk of dependency is greater. Tr. 40, 41. Further, since they are basically the same medication, both with a high street value, diversion can be an issue. Tr. 41. Dr. Davies did not find an adequate treatment rationale for this narcotic treatment. Tr. 41. He opined that with all of the red flags that Patient B exhibited for the abuse of narcotics, the Respondent failed to adequately monitor Patient B through drug testing, and did not provide an adequate treatment rationale for her prescribed medication regimen. Tr. 44, 45. Dr. Davies maintained that the Respondent's treatment of Patient B was not consistent with the standard practice for a reasonable competent physician, because she failed to assess Patient B before initiating narcotic treatment, did not use a risk assessment tool, and did not do urine drug screening or provide "adequate continuing care." Tr. 45. He further opined that the Respondent's treatment of Patient B constituted a substantial likelihood of serious harm to Patient B, public health, welfare and safety. Tr. 45. Dr. Davies' report noted his disagreement with the Respondent's treatment of Patient B, because there were no "adequate legible pain history and physical exam documented," and no drug testing or adjunctive therapies were utilized. State's Ex. #17. Despite Patient B's known and continuing substance abuse, the Respondent continued to prescribe opioid medications. State's Ex. #17.

The Respondent testified that she continued Patient B's narcotic prescriptions despite her abuse of the narcotics and drug-seeking behavior, in consultation with the methadone program in which Patient B participated. Tr. 306, 309, 310. She justified giving Patient B two short-acting narcotics, those being Percocet and Oxycodone, so that the Respondent "can keep her flatlined on

her narcotic blood level and not have her increase any kind of oral medication." Tr. 309. That was why she prescribed the Duragesic long-acting patch, so that Patient B would not misuse her oral medications. Tr. 309. The Respondent countered Dr. Davies' testimony that she failed to use risk assessment tools with Patient B; Patient B had been her Patient for 20 years and the Respondent knew her well. The Respondent said that she continually confronted Patient B about her abusive behavior, and denied her requests to increase medication. Tr. 316. The Respondent was aware that Patient B was at risk and was the type to "test," which was a behavioral issue that the Respondent was aware of and dealing with. Tr. 316. The Respondent stated that Patient B was going to a methadone program every day, and to a therapist from that program weekly. Therefore, closer and more frequent monitoring was unnecessary. Tr. 317. According to the Respondent, Patient B probably could not have seen her more often because she was paying out of pocket. Tr. 317.

The evidence established that throughout the Respondent's most recent treatment of Patient B, between 2011 and 2014, Patient B abused and was noncompliant with her medication on multiple occasions. Although the Respondent did refuse to increase the dosage of medication when Patient B requested it, she did continue to prescribe the narcotic medication despite her frequent noncompliance. Although the Respondent did have her sign a Pain Management Agreement, the Respondent did not follow through with the consequences set forth therein, because she continued to prescribe the narcotics despite the continuing noncompliance.

There is no evidence in Patient B's records that the Respondent conducted a physical examination or a mental status examination. Nor is there any evidence that Patient B completed a Medical History Record at the onset of the most recent period of time that the Respondent treated her. The Respondent did obtain some of Patient B's medical records. The documentation regarding Patient B does not reflect that the Respondent regularly monitored the Four As or consider the universal precautions with Patient B. If she had, the evidence reflected that Patient B's pain

management protocol would likely have been different. I am mindful of the fact that a psychiatrist's relationship with her patients is different than that of other physicians; there is a closer, more personal relationship. However, after considering all of the evidence pertaining to Patient B, I conclude that the Respondent's treatment constituted misconduct in the practice of medicine, and exhibited professional incompetence, in violation of Section 14-404(a)(3)(ii) and (f) of the Health Occupations Article.

Patient C

Dr. Davies opined that the Respondent failed to properly monitor Patient C with drug testing or assess his pain. Tr. 46. She did not attempt adjunctive therapy. Tr. 47. Given Patient C's non-compliance issues, and considering the paraphernalia found in Patient C's possession when he was arrested on March 4, 2013, it was Dr. Davies' opinion that a reasonably competent physician would have weaned Patient C off of the narcotic medication. However, the Respondent instead increased his dosage of Oxycontin. Tr. 49. Dr. Davies stated that by doing so, she placed Patient C and the safety of the public at risk, because Patient C exhibited signs of addiction and diversion. Tr. 51. According to Dr. Davies, the Respondent should not have increased Patient C's dosage of Percocet on November 19, 2008, based only upon Patient C's subjective statements that his pain had increased. Instead, the Respondent should have conducted an appropriate evaluation of Patient C to develop a treatment rationale for the increase, especially since Patient B had increased his medication on his own, without medical advice or supervision. Tr. 47. In his report, Dr. Davies also noted the Respondent's failure to assess the Four As of pain medication. State's Ex. #17.

The Respondent explained why she increased Patient C's dosage of Percocet on November 2, 2008 despite his noncompliance with his medication regime. He brought his sister with him to his appointment, who had been monitoring Patient C and who had reported his noncompliance to the Respondent. Additionally, he had not been sleeping well. She made an objective determination

to increase his pain medication. Tr. 319, 320. When asked if she used assessment tools, she said that she conducted a mental status assessment, and worked in conjunction with Patient C's primary care doctors at the VA who agreed that the Respondent would manage his pain medication. Tr. 322, 323.

The Respondent testified that she knew much more about Patient C's arrest than what was in her records. Tr. 323. Patient C's landlord had called her and apologized for getting Patient C arrested, because the landlord's boyfriend had been storing controlled substances in Patient C's bedroom. Tr. 324. The judge in Patient C's criminal case mandated that he stay in treatment, and that he see the Respondent at least once monthly. The Respondent reported to the court after every visit. Tr. 324, 325. The Respondent therefore argued that the red flags to which Dr. Davies referred concerning this incident were not red flags at all. Tr. 325, 326.

The Respondent testified that she could not do adjunctive therapy with Patient C because he had a metal plate in his head. Tr. 329. It is unclear what she meant by that, but she said that many other types of therapy had been attempted by the VA. Tr. 329. The Respondent also explained that in 2013, Patient C's son was monitoring his medication, and Patient C had migraine headaches, blurred vision and pain. Therefore, his risk of diversion was very low considering the amount of distress that he was in. Tr. 331. 332.

I found Dr. Davies' testimony to be convincing that the Respondent did not act within the standard of care when she continued prescribing narcotic medication to Patient C given his compliance issues. She did counsel him often regarding his noncompliance, but also enabled his noncompliance by continuing to prescribe those medications without consequence. I understand the Respondent's intent and desire to adequately address Patient C's pain. Considering Patient C's long history of treatment with the VA, I believed the Respondent, and Patient C's records corroborate, that adjunctive therapy had already been attempted. Tr. 329, 330. Patient C's VA medical records

were part of the record and it is clear that the VA followed him regularly and conducted regular laboratory tests. State's Ex. #7(a), p. 1170-1280. However, even if Patient C's arrest was not what it appeared to be, his frequent noncompliance with his medication regime should have prompted some kind of action designed to quell further noncompliance. Patient C signed a Pain Agreement on November 1, 2012, but the Respondent did not adhere to its contents when Patient C was noncompliant multiple times thereafter and she continued to prescribe his medications. There was no evidence of any physical examination or mental status examination in Patient C's records, but the VA was monitoring his physical ailments and the reasons for his pain. Nevertheless, considering Patient C's frequent noncompliance, it does not appear that the Respondent monitored the Four As of pain medication or consider the universal precautions. For all of these reasons, I conclude that the State established that the Respondent's treatment of Patient C constituted misconduct in the practice of medicine and professional incompetence.

Patient D

Dr. Davies' report stated that the Respondent failed to document an adequate assessment prior to prescribing ongoing narcotic treatment for Patient D. She failed to use a risk assessment tool. State's Ex. #17. There was no adequate, legible pain history or physical examination. The Respondent prescribed narcotics "despite obvious narcotics issues." Moreover, his report stated that the Respondent failed to use adjunctive therapies and assess the Four As of pain medicine. In his testimony, Dr. Davies added that prescribing narcotics to Patient D, who had other drug issues, was like "offering a beer to an alcoholic." Tr. 52. He noted that in situations such as this, a very "tight" treatment plan is required, with a medication such as Suboxone, which helps address addiction. Tr. 52, 53. It was Dr. Davies' opinion that on May 3, 2013, when the Respondent prescribed a three-month supply of pain medication, such a large amount of medication given to a Patient with street drug abuse issues creates a risk that the medication could be diverted and abused. Dr. Davies

maintained that Patient D should have been monitored much more closely. Tr. 55. On December 5, 2013, Patient D reported that he relapsed one time. Dr. Davies opined that this was a major red flag, and that "any physician would have discontinued prescribing narcotics, period. Some physicians would have continued care with appropriate therapy and extremely close monitoring." Tr. 55.

The Respondent testified that despite Patient D's history of drug abuse, he also had six unremoved bullets in his leg and he had pain that needed to be dealt with. He had a legitimate medical condition. Tr. 336. He needed to be in drug rehabilitation, but his pain could not be ignored. Tr. 336. Adjunctive therapy had been tried before by the VA. Tr. 337, 339. She could have stopped his medication when he relapsed, but he was still in pain and needed to be treated. Tr. 342. The Respondent denied that she gave him a prescription for two or three months' worth of medication at any time; even though she wrote pre-dated prescriptions she required him to come to her office monthly to pick up that month's prescription. She saw him every other month. Tr. 339, 344. She asserted that she did screen Patient D for cocaine after he relapsed in December 2013, and the results were negative. Tr. 346. Also, his primary care physician was screening him in Virginia. Tr. 346.

With this particular patient, the records do not reflect that he abused the pain medication that the Respondent prescribed, with the exception of March 12, 2012 when he finished his medications a few days early. State's Ex. #8(a), p. 1452. I found the Respondent to be credible that she still felt it necessary to treat his pain, and that she did not give him two or three months' supply of medication at any one time; she required him to come to her office to pick up his prescriptions each month, and she met with him every other month. On December 2, 2013, when Patient D admitted that he had relapsed, the Respondent's report said that she would screen for cocaine on the next visit. Although she testified that she did so, there was no evidence of that in the Respondent's records for Patient D.

I found the Respondent's explanation of her treatment of Patient D to be reasonable. She did not give him two or three months' worth of prescriptions at one time. She only saw him every other month because he lived in Richmond. He only had one incident of finishing his medication early; otherwise, his addiction problem was with cocaine, not the narcotics that she prescribed. However, there was no evidence that the Respondent conducted a physical examination upon Patient D. Throughout the Respondent's notes that memorialized her appointments with Patient D, she mentioned his use of cocaine and the effects that it was having on his life as well as his ultimate efforts with drug rehabilitation. Nevertheless, it does not appear that she utilized any structured risk assessment tools, or considered the universal precautions when deciding to prescribe narcotic medication. There is no evidence that she conducted drug-screening, which, in this particular case, was necessary to monitor his use of street drugs. For these reasons, I conclude that the State has established that the Respondent's treatment of Patient D constituted misconduct in the practice of medicine, but I cannot conclude that the treatment rose to the level of professional incompetence.

Patient E

Dr. Davies' report stated that the Respondent failed to document adequate assessment prior to initiating narcotic treatment for Patient E, failed to use a risk assessment tool, her records lacked a legible pain history and a physical examination, and failed to use drug testing in her treatment of Patient E. Further, his report stated that the Respondent prescribed narcotics despite Patient E's non-compliance, failed to utilize adjunctive therapies and failed to assess the Four As of pain medication. State's Ex. #17.

In his testimony, Dr. Davies discussed the Respondent's note on October 16, 2012, that indicated that Patient E had not been compliant with her medication. State's Ex. #9, p. 1669. He opined that a reasonably competent physician would have had the patient sign documentation acknowledging the noncompliance, would have monitored the patient closely, every two to four

weeks, and would have considered weaning her off of the medication. Tr. 61. The Respondent did have her sign a Pain Management Agreement; however, the Respondent told Patient E to return to see her in two months. Dr. Davies said that this implied that the Respondent gave Patient E a prescription for two months' worth of pain medication, and Dr. Davies was concerned that the Respondent did not monitor Patient E adequately. Tr. 61, 62. Further, Dr. Davies opined that the Respondent's treatment of Patient E was not consistent with the standard of practice for a reasonably competent physician, because of inadequate monitoring when significant red flags existed. Tr. 62.

The Respondent testified that Patient E initially came to her with recent laboratory reports. Tr. 349. There are, in fact, some laboratory results, in Patient E's records, which were from tests conducted not long before Patient E saw the Respondent for the first time. State's Ex. #9(a), p.1836-1838, 1850. The Respondent stated that Patient E had already attempted adjunctive therapy, as evidenced by her past medical records. Tr. 350. She had been on non-opioid medication with little results. Tr. 350, 351. The Respondent explained that adjunctive therapy was not indicated at that time, because Patient E was about to have surgery. Tr. 362. The Respondent prescribed Dilaudid and Oxycodone on December 21, 2011, knowing that Patient E had taken some extra medication, because she was scheduled for a surgical procedure, her pain had increased, she was suffering from psychological distress, and the Respondent wanted to "manage her pain on an acute basis" until her surgical procedure. Tr. 351. 352. The Respondent maintained that she assesses a patient's pain by interviewing and observing the patient. Tr. 352, 353. She always assesses a patient's ability to cope with pain by the mental status examination. Tr. 353.

When a patient violates a Pain Management Agreement, the Respondent testified that depending on the patient, she will determine if they are to sign an acknowledgment of a

violation. Tr. 355. However, she usually just writes the violation in the chart. Tr. 355. She does not discharge a patient for violating a treatment agreement once. She will counsel the patient, because her patients do have legitimate physical and psychological pain Tr. 356. The Respondent said that on October 16, 2012, the Respondent counseled Patient E regarding noncompliance; she was going to her primary care physician in 48 hours and the Respondent gave her a handwritten note to ask the doctor to obtain blood work and a urine screen. Tr. 361. There is not a copy of that note or any laboratory results from that period of time in Patient E's records.

Between December 21, 2011 and October 16, 2012, the Respondent noted that Patient E was noncompliant with her medication four times. On all of those occasions, she took extra medication and therefore, finished her prescription early. The Respondent noted the noncompliance and counseled Patient E, but did nothing to curb the noncompliance, and kept prescribing the medication. I found Dr. Davies' testimony to be convincing that, with so many incidents of noncompliance, the Respondent should have monitored Patient E more closely. Further, despite the noncompliance, the Respondent continued to prescribe narcotic medication. This posed a risk to the patient as well as the public. There was no evidence of any physical examination in Patient E's records, nor any evidence of the use of pain assessment tools or consideration of the universal precautions. The Respondent said that she assessed Patient E's pain and ability to cope through the mental status examination. However, the mental status examination contained very little information. It is a checklist that is divided into six sections: "Appearance & Behavior, Speech, Emotions, Thought, Perception, Sensorium & Intellect." State's Ex. #9(a), p. 1705. Each section contains a sub-list. For example under "emotions" it lists "mood, affect, variability, intensity, lability, appropriateness." Each item on each list has a checked box next to it, presumably because the Respondent analyzed each one. The only thing

that the Respondent wrote on the document, other than checking the boxes, was, next to Appearance & Behavior, she wrote "sad," and next to Emotions, she wrote "depressed & anxious." State's Ex. 9(a), p. 1705. The mental status examination displayed the Respondent's cursory impression of Patient E's mental status. It did not address risks for addiction, any of the Four As or universal precautions.

After considering all of the evidence regarding Patient E, I conclude that the Respondent did not conduct the appropriate assessments, and she allowed Patient E to continue her medication despite frequent noncompliance. While it is possible that the lack of evidence is the result of inadequate documentation, I can only analyze this matter based upon the evidence that was before me. Therefore, I can only conclude, with regard to Patient E, that the Respondent's treatment of Patient E constituted misconduct in the practice of medicine and professional incompetence.

Patient F

Dr. Davies' report about Patient F stated that the Respondent failed to document adequate assessment of Patient F's pain before initiating narcotic treatment. State's Ex. #17. She did not utilize a risk assessment tool, and did not conduct a physical examination. She did not document any drug tests. The report also said that she failed to utilize adjunctive therapies and assess the Four As of pain medicine.

Dr. Davies added in his testimony that the Respondent did not document any adequate treatment rationale for increasing Patient F's Percocet on August 13, 2010. Regarding Patient F's visit on January 29, 2013 when he reported that he accidentally threw away his medication, Dr. Davies explained that this was a red flag for abuse, addiction or diversion, and it is not "standard practice to replace a prescription." Tr. 64. On June 4, 2012, when Patient F reported reduced pain, Dr. Davies noted that a competent physician would have reduced the dose of

Percocet. Tr. 64. Dr. Davies found that the Respondent's treatment of Patient F was not consistent with the standard practice for a reasonably competent physician, and constituted a substantial likelihood of risk to the patient, public health, welfare and safety, because of the reasons stated in his report, and because of the risk of addiction and diversion. Tr. 65, 66.

The Respondent testified that Patient F had a physical examination two days prior to his first visit. Tr. 373. On August 13, 2010, she increased his Percocet. The Respondent explained that she did so because his MRI revealed torn ligaments and degenerative disease in his back. He had been on non-opioid pain medication. She increased the Percocet because he complained of limping and pain when he sat. Tr. 374. Neither the pain nor the MRI results are documented in the Respondent's note for that visit.

The Respondent stated that Patient F's previous medical records indicated that he had already been involved in adjunctive treatment, including physical therapy. Tr. 374, 375. She gave him new prescriptions on January 29, 2011 when he reported that he accidentally threw away his pain medication, because he had no prior history of substance abuse. Tr. 376. On June 4, 2012, when he reported reduced pain, the Respondent stated that she did not reduce his dosage of Percocet because she spoke with his surgeon, and the surgeon told her that he should be maintained on his medication. Tr. 377.

Dr. Davies' testimony that it was not standard practice to replace a prescription upon one incident of lost or stolen medication was contrary to earlier testimony, where he stated that some practitioners would continue care, albeit, in a more "tightly monitored environment." Tr. 43; *See also*, Tr. 55. Patient F did not have a prior history of red flags for abuse or diversion, and the Respondent had him keep his regular appointment which was only nine days later. State's Ex. #10(a), p. 2253. Then, she continued to monitor him monthly. Therefore, I cannot conclude that the Respondent deviated from the standard of care as set forth by Dr. Davies when she continued

his medication after this one incident. The Respondent testified that Patient F had a physical examination just 48 hour prior to his initial meeting with her; however, there is no documentation of that physical examination in Patient F's record. Regardless, I believed the Respondent's testimony that she did not lower Patient F's dosage of Percocet on June 4, 2012, because she spoke to his surgeon who told her that he should be maintained on the medication. The only medical records in Patient F's file are those from his surgeon, James York, M.D., and the only medication that he prescribed to Patient E was Naprosyn. While I agree, after considering Dr. Davies' testimony that that the Respondent could have better documented any risk assessments and treatment rationales that she considered, including the Four As and universal precautions, I cannot conclude that the evidence established that, with regard to Patient F, the Respondent's treatment of Patient F constituted misconduct in the practice of medicine or professional incompetence.

Patient G

Dr. Davies' report regarding Patient G stated that the Respondent failed to adequately assess pain before beginning a narcotic regimen, failed to use a risk assessment tool, did not conduct a physical examination or conduct drug testing. She failed to utilize adjunctive therapies and assess the Four As of pain medication. State's Ex. #17.

Dr. Davies testified that the Respondent did not have an adequate treatment rationale to increase Patient G's dosage of Percocet on March 18, 2010, to a level that was double the dosage. Tr. 68. On March 3, 2011, the Respondent prescribed Percocet and Oxycodone, two Oxycodone based short-acting medications, which have "so much abuse potential," and is a red flag for diversion. Tr. 68. Dr. Davies noted that again, on April 9, 2012, the Respondent continued Percocet and added Dilaudid, two short-acting narcotics, with no adequate treatment rationale for doing so. Tr. 68, 69.

The Respondent testified that she assessed Patient G's risk by noting that she had no history of alcohol or drug abuse. Tr. 383. She maintained that Patient G had a physical examination by another doctor one day before she initially saw the Respondent. Tr. 383. Patient G had already been on non- narcotic medication, physical therapy and other adjunctive treatments. Tr. 383, 384. The Respondent's rationale for prescribing two short-acting narcotics on March 3, 2011, was to increase the Oxycodone without increasing the Tylenol which is contained in the Percocet. Tr. 384. She added the Oxycodone to give her "the equivalent of 15 milligrams rather than 10 milligrams." Tr. 384, 385. The Respondent justified the increase in Patient G's Percocet on March 18, 2010, because Patient G reported that her pain had intensified. Tr. 387.

I am convinced by Dr. Davies' opinion, and the Respondent conceded, that the prescription of two short-acting narcotics simultaneously deviated from the standard of care. The Respondent's initial report when Patient G first came to her on August 21, 1987, was thorough, and it does appear that the Respondent conducted an assessment of Patient G's pain, and her mental capacity to cope with physical and psychological pain. State's Ex. #11(a) p. 2553, 2554. The Respondent documented that she would only consider narcotic medication after review of prior medical records, and that she would monitor Patient G closely "in the initial phases of [the medication] to ascertain any level of suicidiality." State's Ex. #11(a), p. 2554. However, there is no documentation of any physical examination just prior to Patient G's return to the Respondent on April 3, 2009, by either the Respondent or another physician. Patient G did complain of increased pain on March 18, 2010 when the Respondent increased the Percocet dosage. State's Ex. #11(a), p. 2337. Her prior medical records documented that Patient G had gone through adjunctive therapy such as a TENS machine and physical therapy. Other than the one incident where the Respondent increased Patient G's pain medication based only on her

subjective complaint of pain, and her prescription of two short-acting narcotics on March 3, 2011, there is no additional evidence of misconduct or incompetence. I conclude, with regard to Patient G, the Respondent's actions constituted misconduct in the practice of medicine, but did not rise to the level of professional incompetence.

Patient H

Dr. Davies testified that there was no adequate physical examination or treatment rationale for the Respondent to prescribe Oxycodone and Oxycontin to Patient H on her initial visit on August 3, 2013.[6] Tr. 71. He noted that the dosages were a significant increase compared to her previous dosages of Oxycodone and Opana. Tr. 71. He also opined that she did not conduct an adequate physical examination or have an adequate treatment rationale for increasing the dosage of Oxycontin and Oxycodone on August 29, 2013 based upon Patient H's complaints of significant pain. Tr. 72. Similarly, Dr. Davies found no adequate physical examination or treatment rationale for discontinuing Oxycontin and substituting a trial of Methadone when Patient H complained that the Oxycontin had not provided her any relief. Tr. 72, 73. Last, Dr. Davies testified that on October 19, 2013, after Patient H reported that she did not tolerate the Methadone well even though it helped her pain, the Respondent did not conduct an adequate physical examination or have an adequate treatment rationale for restarting Oxycodone and adding Duragesic patches. Tr. 73, 74. In Dr. Davies' opinion, the Respondent's treatment of Patient H was not consistent with the standard of practice for a reasonably competent physician, because she did not conduct an adequate initial evaluation or a physical examination, she did not utilize a risk assessment tool or urine drug screens, and she did not assess the Four As of pain medication or consider universal precautions. Tr. 74. Further, her treatment constituted a

[6]The dates to which Dr. Davies' report referred in his discussion of Patient H do not correspond with any of the medical records admitted into evidence regarding Patient H. Therefore, I considered only Dr. Davies' testimony in my consideration of the State's evidence pertaining to Patient H.

substantial likelihood of serious harm to Patient H, or public health, safety and welfare. Tr. 75, 75.

The Respondent testified that she assessed Patient H's pain by doing an initial cursory examination which included an assessment of range of motion, deep tendon reflexes, and observation of Patient H while ambulating. At the time, Patient H reported that she was having a migraine headache. Tr. 396. The Respondent's rationale for starting Methadone on September 24, 2013 was that Patient H had not responded to other long or short-acting medications, and Methadone is a "very effective pain killer and less likely to be abused by patients because of its very long half-life." Tr. 398. The Respondent explained that Patient H had been on pain medication for many years and had developed a tolerance; thus, the way to address that was to switch the class of medication that she was on to one with a longer half-life. Tr. 398. Sometimes that involves raising the dosage. The Respondent stated that she did not utilize adjunctive treatment because Patient H had already been through adjunctive care and had already been on narcotics for a long time. Tr. 399. She had been on non-narcotic pain medications and in physical therapy. Tr. 400. The Respondent countered Dr. Davies' testimony that her treatment plan posed a risk to Patient H or the public, because Patient H did not have a history of abuse or deterrence, and the Respondent assessed her physical and psychological symptoms and her level of activity. Tr. 400, 401.

The Respondent documented Patient H's history of pain and pain medication during her initial visit on August 3, 2013. State's Ex. #12(a), p. 2625. There were laboratory reports from February 2013 in Patient H's file. Only part of the Respondent's initial note about Patient H is legible, but I can read that it discussed prior adjunctive therapy including acupuncture and physical therapy. State's Ex. #13(a), p. 2628. It appears from Patient H's record that Patient H came to the Respondent because of depression, in addition to head and neck pain. The

Respondent saw Patient H monthly until the end of 2013, and after that, every other month. The Respondent started and discontinued different pain medications based on Patient H's reports of discomfort. There is no record of a physical examination of Patient H. However, Dr. Davies' testimony regarding Patient H was very general, and there were no red flags for abuse or diversion. The Respondent's records reflect that she started and discontinued medication in attempt to arrive at a successful medication regimen for a patient that already had a high tolerance for pain medication. Dr. Davies did not suggest that a physical examination is required for each medication change under these circumstances, and such a protocol would not be logical or reasonable. While perhaps the Respondent should have conducted a physical examination on Patient H's initial visit, I cannot conclude that the evidence established misconduct in the practice of medicine or professional incompetence with regard to Patient H.

Patient I

Dr. Davies' report on Patient I stated that on January 2, 2013, Patient I's first visit, there was inadequate documentation of risk assessment tools, no physical examination and no drug screening. Further, the Respondent prescribed two short-acting narcotics which was not routine, and failed to utilize adjunctive therapies or assess the Four As of pain medication. State's Ex. #17.

In addition, Dr. Davies testified that there was no rationale that would warrant the initiation of opioid treatment on Patient I. Tr. 76. Nor did the Respondent conduct a physical examination that would warrant increasing Oxycodone on February 1, 2013. Tr. 77. Further, Dr. Davies testified that on February 24, 2014[7] when the Respondent discontinued Percocet, started a trial of Morphine Sulfate, and increased the Oxycodone, that was a significant increase in the opioids without an adequate physical examination or treatment protocol. Tr. 77, 78.

[7] The date of this visit was actually February 22, 2014.

However, he conceded that if there are concerns about too much Tylenol, changing to Morphine could be a reasonably competent plan. Tr. 78. Nevertheless, Dr. Davies opined that normally, a physician would instead increase the Oxycodone if Percocet was being discontinued. Tr. 78. He did not explain why. Dr. Davies felt that the Respondent's treatment of Patient I did not meet the standard of practice for a reasonably competent physician due to lack of appropriate physical examinations, failure to use assessment tools, a lack of urine drug screening before starting or continuing narcotics, and a lack of assessment of the Four As of pain medication or universal precautions. Tr. 79. Further, Dr. Davies opined that due to the high doses of narcotics that the Respondent prescribed to Patient I that did not significantly improve her pain, the Respondent's treatment of Patient I caused a substantial likelihood of serious harm to Patient I. Tr. 79.

The Respondent testified that Patient I had no past history of drug or alcohol abuse. She came to the Respondent with documented medical illnesses, and with laboratory reports. The Respondent said that she had the report of a prior physical examination, and nothing that the Respondent reviewed led her to believe that Patient I would be engaging in any "aberrant behavior that would cause her to be a risk." Tr. 407.

There are no prior medical reports or laboratory reports in Patient I's records. Patient I completed a Medical History Record, but that is the only evidence of Patient I's medical history. She signed a Pain Management Agreement on May 1, 2013. The Respondent's report of Patient I's initial visit is barely legible, but it is extensive, and does appear to note Patient I's neck pain and limited range of motion. State's ex. #13(a), p. 2695. Again, it appears that the Respondent was merely trying to adjust Patient I's pain regimen to a protocol that was successful in the treatment of her pain. There was no evidence of red flags for abuse. Regardless, the lack of documentation of any prior medical history, laboratory results or physical examination by the Respondent is concerning based on Dr. Davies' testimony. I conclude that the evidence

established that the Respondent's treatment of Patient I constituted misconduct in the practice of medicine for those reasons, but did not rise to the level of professional incompetence.

Patient J

Dr. Davies testified that there was no adequate physical examination or treatment protocol to warrant the increase Patient J's medications on his initial visit. Tr. 81. The subjective complaints of Patient J alone were not sufficient justification. Tr. 81. Dr. Davies noted that the Respondent continued to prescribe opioids to Patient J throughout the period that she treated him, despite receiving notice from his insurance company on March 30, 2013 that informed her that Patient J had received a Percoset prescription from another doctor. Tr. 82, 83. For all of the same reasons, including lack of a physical examination, lack of an adequate treatment rationale, failure to monitor the Four As of pain medication and failure to use universal precautions, Dr. Davies opined that the Respondent's treatment of Patient J did not meet the standard of practice for a reasonably competent physician, and her treatment constituted a likelihood of serious harm to the patient or public health, safety and welfare. Tr. 83, 84.

The Respondent denied that she initially increased Patient J's medication simply because he requested it. Tr. 412. She increased it because he had significant pain in his lower back, radiating down the left side, and he was obese. Tr. 412. She did not believe that even increasing the medication to that level would have been sufficient. Tr. 412. He was likely not receiving adequate treatment prior to coming to see her. Tr. 413. The Respondent noted that she addressed the Four As by noting and observing that he had no history of alcoholism or drug abuse, no history of aberrant behavior, and no side effects from the narcotics. Tr. 414.

Regarding her receipt of the notice from the insurance company on March 30, 2013, the Respondent added that actually, Patient J had been injured and he went to the emergency room where they gave him additional Percocet for pain from the injury. Tr. 416. Regardless, the

Respondent counseled Patient J not to fill such a prescription without notifying her first. Tr. 416. On August 8, 2013, Patient J was injured again in a similar manner, and she changed his prescription of Oxycontin to a lower dose taken more frequently, based on her observation that he could barely walk. Tr. 417, 418.

The Respondent disputed Dr. Davies' testimony that the she failed to monitor the Four As of pain medication or use universal precautions. She conceded that she did not document these considerations well. Tr. 426. She explained that she documented her treatment without thinking that someone else would be reading them. Tr. 426. She maintained, however, that in her notes, her observations regarding the Four As are scattered throughout. Tr. 426.

The Respondent did document that she would discontinue Patient J's medication if there were any further incidents such as the report from the insurance company on March 30, 2013 that he had received Percocet from another doctor. State's Ex. #14(a), p. 2746. I found the Respondent to be credible that this occurred because Patient J was injured and went to the emergency room. However, there is no documentation in Patient J's records regarding an emergency room visit in the vicinity of March 30, 2013. Therefore, I agree with Dr. Davies' concern regarding this incident because the Respondent continued to prescribe narcotic medication. Even though the Respondent's testimony rebutted Dr. Davies' impression about that incident, the Respondent's documentation was lacking, and Dr. Davies' concern was legitimate. Patient J's file contains prior medical records that establish his history of back problems, including an orthopedic report from only six days prior to his initial appointment with the Respondent. State's Ex. #14(a), p. 2892. He also completed a Medical History Record upon his initial visit to the Respondent. State's Ex. #14(a), p. 2907. The Respondent's notes from his initial visit, while barely legible, do discuss his pain, the fact that he was already on Percocet that

had not been effective, and that non-narcotic medication had been attempted. State's Ex. #14(a), p. 2904.

Dr. Davies' testimony was convincing that a continued, regular assessment of the Four As of pain medication is necessary when treating for pain. The Respondent mentioned Patient J's pain level in most of her treatment notes, and, of course, her concentration centered on his psychiatric well-being. Nevertheless, I must conclude that the Respondent's documentation is deficient with regard to regular, regimented assessment of the considerations necessary in the standard of care of pain management, and even though the Respondent may have continually conducted these assessments, her documentation did not reflect that. There were records of physical examinations prior to Patient J's initial visit to the Respondent; however, there were no records of any physical examination just prior to, or during the Respondent's treatment of Patient J. For all of these, reasons, I conclude that the Respondent's treatment of Patient J constituted misconduct in the practice of medicine, but did not rise to the level of professional incompetence

I found the Respondent's testimony to be candid and credible. She conceded that she only recently discovered that prescription of two short-acting narcotics at the same time deviated from the standard of care. Tr. 250. She agreed that her documentation was inadequate. Tr. 471. She conceded that she needed additional education if she were to continue a pain medication practice. Tr. 427. I am persuaded that she cared very much about her patients, and sincerely wanted to take the necessary measures to treat their pain. On May 19, 2014, when she was interviewed by the Board, she agreed that a patient who has a substance abuse problem must be closely monitored, but nevertheless felt it to be inhumane to refuse to treat a patient "if they have a legitimate chronic pain condition." State's Ex. #15, p. 39, 40. Dr. Davies agreed with that statement, but countered by stating that treatment of such a patient with narcotics can create a greater problem. Tr. 87. From the testimony before me, I can deduce that there is a fine line to walk in weighing all of these

factors. There is no evidence in the record that would remotely indicate that the Respondent committed any act that was intended to place a patient or the public at risk.

The Respondent conceded that her pain medication practices may not fall within the standard of care for pain patients who do not have psychiatric conditions, although she believed her treatment did fall within the standard of care for psychiatric patients. Nevertheless, she has determined that she will cease her pain management practice. She conceded that she would need additional medical education to feel comfortable that she would never end up in this situation with the Board again. Tr. 427. Regardless, she is willing to forfeit that part of her practice, and treat her patients for psychiatric issues only. Tr. 427.

The Respondent testified that when she received her medical records back from the Board, some of the checklists that documented the cursory physical examinations that she conducted, and some laboratory reports and Pain Management Agreements were missing. Tr. 440, 441. She would not speculate as to who took them or where they were. Tr. 441. She maintained that she did have adequate documentation of physical examinations but they were missing. Tr. 471. However, she conceded that her progress notes and other correspondence were indeed deficient. Tr. 473, 474.

I do not believe that the Respondent lied when she testified that some medical records were missing, nor do I believe that those records were produced by the Respondent and subsequently removed by the Board or anyone else. There is not one report of a physical examination in any of the ten patient records. I find that it is more likely than not that, given the Board's description of the disorganization of the Respondent's office, and based on my review of somewhat disorganized, incomplete patient records, the Respondent never produced that documentation to the Board, if it even existed at all.

Sanctions

The State argued that, pursuant to COMAR 10.32.02.09B, there are both aggravating and mitigating factors that may be considered in imposing a sanction against the Respondent. The State acknowledged that the Respondent was cooperative with the Board's investigation, and also, that she has never before been disciplined by the Board. COMAR 10.32.02.09B(5)(a) and (c). The State argued further that the Respondent's actions caused the potential for harm, and were part of a course of detrimental conduct. COMAR 10.32.02.09B(6(c) and (d). The State requested that I recommend that the Respondent be reprimanded, that she verify that she has terminated the pain management portion of her practice, that she notify her patients by a letter, approved by the Board, that she has terminated her pain management practice, and that the Board, or a panel of the Board reserves the right to monitor, at its discretion, the Respondent's prescribing practices. The State requested that this include the ability to obtain pharmacy runs to ensure that no non-psychiatric opioids are being prescribed. Further the State requested that the Respondent be placed on probation for three years, and that the Board, or a panel of the Board may, in its discretion, conduct a peer review of the Respondent's patients. The State also argued that I recommend that the summary suspension be upheld, due to the substantial risk of harm to Patients that existed as a result of the Respondent's actions in prescribing excessive quantities of addictive opioids without adequate physical examinations, urine screening, follow-up visits and treatment rationale.

The Respondent has already determined to give up the Pain Management portion of her practice. She objected, however, to the Board being able to monitor her psychiatric patients, because her psychiatric care was not at issue. She conceded that her documentation was not sufficient, and that she may have needed more education regarding pain management. Therefore, she argued, that her full disclosure to the Board, her implementation of remedial

measures, that being, voluntarily giving up her pain management practice, and the fact that, if any misconduct is found, it was not premeditated, all should serve to further mitigate the evidence in this case.

In its closing argument, the State acknowledged that if the Respondent ceased her pain management practice, then the Board's primary concern would be addressed. Tr. 481. I give the Respondent credit for her candor and admission as to her deficiencies. I agree with the Board that cessation of her pain management practice, a three-year probation period, reprimand, notification of the termination of her pain management practice to her patients by a letter approved by the Board, and the right to monitor the Respondent's pharmaceutical prescribing practices are all appropriate. These sanctions provide the checks and balances that I deem to be necessary following my review of the evidence in this case. I disagree that discretionary peer review of the Respondent's psychiatric patients is warranted, because her psychiatric treatment was not, and never has been an issue for cause or concern.

PROPOSED CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Discussion, I conclude, as a matter of law, that the summary suspension imposed on August 27, 2014 and continued on September 11, 2014 should be upheld, because the Board reasonably believed that the Respondent's pain management practice constituted a risk to public health, safety and welfare. Md. Code Ann., State Gov., § 10-226(c)(2) (2014). I further conclude that the Respondent's treatment of Patients A, B, C, D, E, G, I and J constituted misconduct in the practice of medicine, in violation of Section 14-404(a)(3)(ii) (2014) of the Health Occupations Article. I further conclude that the Respondent's treatment of Patients A, B, C, and E constituted professional incompetence in violation of Section 14-404(a)(4) (2014) of the Health Occupations Article. As a result, I conclude that the Board may discipline the Respondent for the cited violations. COMAR

10.32.02.09A and B. Last, I conclude that the Respondent's treatment of Patients F and H did not violate the Medical Practice Act.

PROPOSED DISPOSITION

I **PROPOSE** that summary suspension that the Board imposed on August 27, 2014 and continued on September 11, 2014 be **UPHELD**; and

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

I **PROPOSE** that the Respondent be reprimanded and placed on probation for three years, that she cease her pain management practice and issue a letter, approved by the Board, informing her patients of the cessation of her pain management practice, and that the Board maintain the right to monitor the Respondent's medication prescribing practices.

May 14, 2015
Date Decision Issued

Susan A. Sinrod
Susan A. Sinrod
Administrative Law Judge

SAS/cj
#156089

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions to this proposed decision with the disciplinary panel of the Board of Physicians and request a hearing on the exceptions. The exceptions must be written and be filed within fifteen (15) working days from the date of the proposed order. COMAR 10.32.02.05B(1). The exceptions and request for hearing must be addressed to the disciplinary panel of the Board of Physicians, 4201 Patterson Avenue, Baltimore, MD, 21215-2299, Attn: Geneva Goode, Administrative Aide to Supervisor, Compliance Administration. A copy of the exceptions should be mailed to the opposing attorney. The opposing party will have fifteen (15) days from the filing of any written exceptions to file a response. *Id.* The response must be addressed as above. *Id.* The Office of Administrative Hearings is not a party to any review process.

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