IN THE MATTER OF	*	**BEFORE THE**
PATRICIA A. NEWTON, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D23551		**Case Number: 2014-0308**

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ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel A of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of Patricia A. Newton, M.D., (the "Respondent"), license number D23551, to practice medicine in the State of Maryland. The Disciplinary Panel takes such action pursuant to its authority under Md. Code Ann., State Govt § 10-226(c)(2009 Repl. Vol. & 2013 Supp.) concluding that the public health, safety or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS

Based on information received by, and made known to the Disciplinary Panel, and the investigatory information obtained by, received by and made known to and available to the Disciplinary Panel, including the instances described below, the Disciplinary Panel has reason to believe that the following facts are true:[1]

1. At all times relevant hereto, the Respondent is and was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on April 19, 1979. Her license is scheduled to expire on September 30, 2015.

[1] The statements regarding the Respondent's conduct are intended to provide the Respondent with notice of the basis of the suspension. They are not intended as, and do not necessarily represent a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this matter.

2. The Respondent is board-certified by the American Board of Psychiatry and Neurology. The Respondent is not board-certified in the sub-specialty of pain medicine by any Board recognized by the American Board of Medical Specialties.

3. The Respondent is a solo practitioner who practices psychiatry in Baltimore City. The Respondent does not hold any hospital privileges.

4. For the past several years, the Respondent has also practiced pain management. According to the Respondent, two-thirds of her patient population have psychiatric issues and one-third have a combination of psychiatric and pain disorder issues.

5. The Board initiated an investigation of the Respondent after receiving an anonymous complaint that was "prompted by arrest of a young woman with 'a needle in her arm and 500 oxycodone tablets.'" The complaint alleged that the Respondent had prescribed the oxycodone, a Schedule II Controlled Dangerous Substance ("CDS"), to the young woman. Patient A,[2] below.

6. The police report of the incident revealed that Patient A had been found unconscious in a hospital emergency room bathroom with a syringe in her arm containing a substance believed to be heroin. Patient A had in her possession over 350 tablets of medication in 21 bottles, many of which contained multiple types of medications, 40 syringes, a rubber strap, a substance suspected to be marijuana and a large amount of cash. The labels on the medication bottles indicated that all of the medication was prescribed by the Respondent. Most of

[2] Names of patients and other individuals are confidential. The names will be provided to the Respondent upon request.

the pills in Patient A's possession were CDS, including alprazolam (Schedule IV), dextroaphetamine (Schedule II), OxyContin (Schedule II), hydromorphone (Schedule II) and methadone (Schedule II).

7. In furtherance of the Board's investigation, Board staff conducted an unannounced office visit and acquired by subpoena medical records of ten patients to whom the Respondent had prescribed CDS. Board staff also interviewed the Respondent and requested that she provide a summary of her care of the patients whose records had been subpoenaed. The Board referred the case for review to an expert in pain medicine (the "Expert"). The results of the Board's investigative findings are set forth below.

I. On-Site Visit of the Respondent's Medical Office

8. On April 23, 2014, Board staff conducted an unannounced visit to the Respondent's medical office and served her with a subpoena for ten patient records.

9. The Respondent's office was cluttered with stacks of papers and boxes covering the desks, tables, chairs, sofa and floor. A storage room was unlocked and it contained an unlocked cabinet with numerous sample psychiatric medications and nine bottles of expired medication, four of which were CDS. The Respondent explained that before she changes a patient's medication, the patient is required to return to her office the unused portion. The Respondent stores the unused portion in the event she resumes prescribing that medication to the patient. When later interviewed by Board staff, the Respondent stated that all of the bottles observed by Board staff had been brought to her office by

patients earlier that day, but she did not have time to dispose of them because she was the only person in the office.

10. Board staff observed a bottle labeled "Methadone" prescribed to Patient C, below, on a shelf in the storage room. The Respondent stated that Patient C had returned the methadone to her that day because he had experienced side effects. The Respondent stated that she does not store CDS in her office and disposes of unused CDS returned to her by patients by flushing them down the toilet. Regarding Patient C's methadone, the Respondent stated that she had not had time to properly secure the methadone in a locked cabinet or flush it.

11. Board staff noted that at the time of the on-site visit, a patient was present in the Respondent's office who could have potentially entered the unlocked storage room.

12. On April 25, 2014, Board staff returned a medical record to the Respondent at her request. Three patients were in the waiting room when Board staff arrived. While in the Respondent's office, Board staff noticed a paper prescription signed by the Respondent on the desk in the patient therapy room. A patient's name was written on the prescription; however, the body of the prescription and date were blank. The door to this room was open and the Respondent was on the phone in an adjacent office with her back to the waiting room.

II. The Respondent's Interview

13. On May 19, 2014, the Respondent was interviewed under oath by Board staff.

14. With regard to her practice of pain management, the Respondent stated that she had taken a pain management course at an American Psychiatric Association

meeting in or around mid-2013, where she learned the need to enter into "pain treatment agreements" with patients. The Respondent further stated that she had taken "sixteen hours of pain management with the American Academy of Pain Medicine" in March 2014, and that she was planning to take an on-line 35-hour course in July 2014.

15. The Respondent stated that most of her pain management patients have pain treatment agreements in their charts.

16. The Respondent told Board staff that she will replace medication only once when a patient reported to have lost the medication. The Respondent further stated that she that she will discharge a patient if, after counseling the patient three times about medication misuse, the patient then reports to have lost medication or has a positive toxicology screen.

17. Referring to a patient (Patient A, below) who initially presented having been prescribed Suboxone for substance abuse, from which the Respondent weaned her and then prescribed CDS, the Respondent stated that it is "inhumane not to treat a patient if they have a legitimate chronic pain condition, whether or not they've had a substance abuse disorder..." The Respondent acknowledged that these patients "require close monitoring."

III. Summary of Expert Opinion

18. In furtherance of its investigation, Disciplinary Panel A sought the opinion of an expert in Pain Medicine (the "Expert") to review pertinent documents and provide an expert opinion regarding the Respondent's professional competence and conduct.

19. After review, the Expert concluded that the Respondent engaged in ongoing unprofessional conduct in the practice of medicine in violation of her professional obligation to do no harm.

20. The Expert further opined that as demonstrated in all ten patient records, the Respondent is not professionally competent to practice pain medicine as a result of a clear and consistent deficit of skill, knowledge and judgment with regard to the management of patients for whom she is prescribing opioid medications.

21. Finally, the Expert opined that the Respondent's conduct raises 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.

22. In support of his opinion, the Expert noted numerous deficiencies in the Respondent's prescribing practices for all ten patients which included, but were not limited to, the following:

    a. The Respondent consistently failed to document adequate assessment of the patient prior to initiating or continuing opioid treatment. In many instances, the Respondent failed to conduct an adequate physical examination;

    b. The Respondent failed to use risk assessment tools;

    c. The Respondent prescribed two short-acting opioids such as Percocet and oxycodone concurrently;

    d. In many instances, the Respondent continued to prescribe opioids to patients despite evidence of abuse, addiction and/or diversion;

e. The Respondent failed to utilize adjunctive therapies and failed to assess routinely the "Four A's" of pain medicine. The "Four A's refer to domains of pain to be addressed and documented as follows: Analgesia; Activities; Adverse Effects and Aberrant Drug-Related Behaviors;

f. The Respondent failed to adhere to the Universal Precautions for writing prescriptions for opioids in such a way as to protect the public health, especially as it relates to the risk for addiction, opiate misuse/abuse/diversion and overdose. The Universal Precautions provide a systematic, reproducible method for safe and appropriate use of chronic opioid therapy and include:

i. Diagnosis with appropriate differential;

ii. Psychological assessment including risk of addictive

iii. Informed consent;

iv. Treatment Agreement;

v. Pre- and post-intervention assessment of pain level and function;

vi. Appropriate trial of opioid therapy with adjunctive medication;

vii. Reassessment of pain score and level of function;

viii. Regular assessment of the "Four A's" of pain medicine;

ix. Periodic review of pain diagnosis and comorbid conditions, including addictive disorders; and

x. Documentation.

IV. Patient-Specific Allegations

Patient A

23. Patient A, a female in her forties, initially presented to the Respondent on July 10, 2012, for treatment of depression, anxiety and chronic pain. Patient A's past medical history included: Attention Deficit Disorder; juvenile arthritis; Crohn's Disease; thoracic outlet syndrome; kidney stones and recurrent pneumonia.

24. In the Respondent's summary of care, she noted that when Patient A first presented, her medication regimen included Suboxone which had been prescribed by one of Patient A's previous physicians to treat opioid dependency.

25. The Respondent weaned Patient A off of Suboxone and despite having noted severe psychological issues, prescribed OxyContin 60 mg b.i.d. (twice a day) and oxycodone 30 mg t.i.d. (three times a day) for breakthrough pain.

26. In August 2012, although Patient A reported that her pain was not "grossly improved," the Respondent continued to prescribed opioid medications.

27. During the course of Patient A's treatment, the Respondent added Dilaudid, morphine sulfate, and Duragesic patches at various times to her medication regimen.

28. The Respondent failed to conduct adequate physical examinations when altering Patient A's regimen.

29. Although Patient A admitted to over-medicating and taking her medications early, the Respondent provided to her post-dated prescriptions. When Patient A reported on more than one occasion that her medication had been stolen, the Respondent wrote prescription refills.

30. After Patient A was found unconscious in the hospital emergency room bathroom, a drug screen conducted by the hospital revealed that Patient A tested positive for methadone. When interviewed by Board staff, the Respondent acknowledged that she had prescribed methadone to treat Patient A's pain "for a brief period of time." The Respondent failed to document that she had prescribed methadone to Patient A.

31. The Respondent failed to document an adequate assessment of Patient A prior to initiating high dose opioid treatment. The Respondent did not attempt to control Patient A's pain at lower doses after she weaned Patient A off of Suboxone, failed to adequately monitor Patient A during treatment and despite being aware of the incident at the hospital, continued to prescribed high dosages of opioids to Patient A.

Patient B

32. Patient B, a female in her fifties, initially presented to the Respondent in 1993. Patient B's past medical history includes: bipolar illness; seizure disorder; bilateral knee pain status post bilateral knee replacement and obesity. In 2014, the Respondent documented that Patient B admitted to buying street methadone and abusing it.

33. The Respondent received information from various sources that Patient B was opiate-dependent and had documented Patient B's drug-seeking behavior on several instances. Nonetheless, during Patient B's course of treatment, the Respondent consistently prescribed at various times combinations of Percocet,

oxycodone in increasing dosages, morphine sulfate, morphine and Duragesic patches.

34. In February 2013, a nurse from a local hospital called the Respondent to advise her that Patient B had fallen twice and the nurse was concerned she was taking too much medication. In October 2013, Patient B reportedly was taken to a hospital emergency room after falling asleep at a pharmacy waiting for her prescriptions to be filled. When the Respondent saw Patient B shortly after that incident, Patient B requested increased pain medications. The Respondent declined Patient B's request, documenting "[Patient B] is back to her old ways of drug seeking behavior." Nonetheless, the Respondent continued to prescribe opioids to Patient B.

35. In February 2014, the Respondent documented that Patient B had admitted that she had "sold her meds to buy methadone" and requested the Respondent to increase her medication. The Respondent refused her request to increase the dosage but continued to prescribe opioids to her.

36. The Respondent failed to document an adequate assessment of Patient B prior to initiating and continuing opioid treatment. The Respondent did not use a risk assessment tool nor were adjunctive therapies considered or used. The Respondent failed to conduct an adequate physical examination or pain history and failed to document any drug testing. The Respondent continued to prescribe opioids to Patient B despite documented issues of opioid misuse and concerns regarding Patient B's functionality.

Patient C

37. Patient C, a male in his fifties, initially presented to the Respondent in September 2008. His medical history includes: traumatic brain injury and Post-Traumatic Stress Disorder, which occurred when Patient B served in the military; migraines; chronic back pain and a history of drug abuse.

38. In October 2008, the Respondent discontinued Patient B's Darvocet and started Percocet.

39. In November 2008, the Respondent documented that Patient B had "increased his use of pain meds without medical supervision." The Respondent then increased the dosage of Patient B's Percocet.

40. During the course of Patient C's treatment, the Respondent stopped and started at various times OxyContin 40 mg, OxyContin 60 mg, Dilaudid, and methadone.

41. The Respondent documented on several occasions that Patient C was non-compliant, but continued to prescribe opioids.

42. Contained in Patient C's chart is a March 2013 Statement of Probable Cause from the District Court of Baltimore County in which it is reported that a search of Patient C incident to arrest after threatening two individuals with a shotgun, revealed "drug paraphernalia that is used to ingest (snort) and smoke Controlled Dangerous Substance." Patient C was also described as having a caplet of alprazolam concealed in a tube hanging from a key ring.

43. The Respondent continued to prescribe opioids to Patient C notwithstanding the police report and later documented concerns that Patient C was taking too many pills and running short of his monthly prescription.

44. The Respondent failed to document an adequate assessment of Patient C before initiating and continuing opioid treatment. The Respondent failed to use a risk assessment tool, failed to perform routine assessments of the etiology of Patient C's pain, failed to use adjunctive therapy and failed to consistently assess the Four A's of pain.

Patient D

45. Patient D, a male in his sixties, initially presented to the Respondent in 1997 for a disability assessment. Patient D's diagnoses included: major depressive disorder; chronic low back pain secondary to multiple gunshot wounds and degenerative disc disease.

46. In or around 2004, the Respondent began prescribing Percocet to Patient D.

47. In 2005, the Respondent documented that Patient D was using cocaine, but was not abusing painkillers. Later in 2005, the Respondent documented that Patient D admitted to using some street drugs. The Respondent advised him to go to Narcotics Anonymous ("NA") and detoxify.

48. In 2013, the Respondent prescribed to Patient D a regimen of Percocet, oxycodone and anti-depressants.

49. The Respondent documented several instances in which Patient D had bought drugs off the street; in December 2013, she documented that Patient D admitted to relapsing on cocaine. The Respondent instructed Patient D to stay in NA and refilled his prescriptions for Percocet and oxycodone with a two-month follow-up.

50. The Respondent failed to document an adequate assessment of Patient D prior to initiating and continuing opioid treatment. The Respondent failed to assess

the Four A's of pain and failed to utilized adjunctive therapies. The Respondent failed to conduct toxicology screening and continued to prescribe opioids despite Patient D's documented issues with abuse and diversion.

Patient E

51. Patient E, a female in her forties, initially presented to the Respondent in 2010. The Respondent diagnosed her, *inter alia,* with major depressive disorder, anxiety, endometriosis, hypertension, chronic headaches and chronic upper and lower back pain with radiculopathy.

52. In December 2011, Patient E reported that she was taking extra pain medication because her pain had worsened. Despite not having conducted a pain assessment, the Respondent began a trial of Dilaudid and oxycodone.

53. In September 2012, Patient E admitted to taking more pain medication than the Respondent had prescribed. The Respondent supplemented Patient E's medication regimen with a one-week supply of Percocet.

54. In October 2012, the Respondent documented that she had advised Patient E that "she was not being compliant with her treatment regimen as directed by taking extra meds to cover her."

55. Through the end of the review period, April 2014, the Respondent continued Patient E on a regimen of oxycodone (for break-through pain), Percocet 10/325, two tablets every eight hours and Xanax.

56. The Respondent failed to document an adequate assessment of Patient E prior to initiating and continuing opioid treatment. The Respondent failed to assess the Four A's of pain and failed to utilized adjunctive therapies. The Respondent

failed to conduct toxicology screening and continued to prescribe opioids despite documented evidence of Patient E's misuse.

Patient F

57. Patient F, a male in his forties, initially presented to the Respondent in June 2010, with complaints of panic, anxiety and stress related to his business. Patient F reported that he had undergone right ACL repair in 2004 and repair of a right dislocated bicep in 2005. Patient F also reported that his then-current medication regimen included Percocet, dosage unspecified.

58. The Respondent failed to conduct a physical examination of Patient F at his first visit or thereafter.

59. At Patient F's second visit, in August 2010, the Respondent documented that she "increase[d] pain meds to Percocet 10/325 mg 2 tablets Q [every] 8 hours for pain PRN and observe response." The Respondent failed to assess Patient F's pain or explain her treatment rationale.

60. In June 2012, the Respondent documented that Patient F had undergone knee surgery and "feels great!" with pain "nothing like it once was in the past." The Respondent continued Patient F on Percocet despite his report of reduced pain.

61. In November 2013, the Respondent documented that Patient F's knee pain had returned and that his "need to ↑ meds is not good." The Respondent discontinued Patient F's Percocet and began OxyContin 60 mg (one tablet every 12 hours) and oxycodone (one tablet every 6 hours for breakthrough pain).

62. The Respondent failed to document an adequate assessment of Patient F prior to initiating and continuing opioid treatment. The Respondent failed to assess

the Four A's of pain and failed to utilized adjunctive therapies. The Respondent failed to conduct toxicology screening.

Patient G

63. Patient G, a female in her seventies, had been seen by the Respondent in the late 1980s for depression and pain. The Respondent did not prescribe opioids to Patient G at this time.

64. Patient G returned to the Respondent in April 2009 for pain management. The Respondent failed to conduct a physical examination or pain assessment; however, she began prescribing Percocet 5/325 (two tablets every eight hours) to Patient G.

65. By March 2011, the Respondent had added another short-acting opioid, oxycodone, to Patient G's regimen for break-through pain.

66. In April 2012, the Respondent added Dilaudid to Patient G's medication regimen and continued Percocet based on Patient G's report of increased pain.

67. The Respondent failed to document an adequate assessment of Patient G prior to initiating and continuing opioid treatment. The Respondent failed to assess the Four A's of pain and failed to utilized adjunctive therapies. The Respondent failed to conduct toxicology screening.

Patient H

68. Patient H, a female in her forties, initially presented to the Respondent in August 2013, with a history of headaches, neck pain and insomnia. The Respondent diagnosed Patient H with Major Depression.

69. The Respondent documented Patient H's medication regimen as including oxycodone 5 mg b.i.d. and Opana 30 mg b.i.d.

70. At Patient H's first visit and in the absence of a physical examination and risk assessment, the Respondent started OxyContin 60 mg b.i.d. and oxycodone 30 mg t.i.d.

71. At Patient H's second visit at the end of August 2013, the Respondent increased Patient H's OxyContin 60 mg to every eight hours and her oxycodone to every six hours.

72. During Patient H's course of treatment the Respondent stopped and started OxyContin, replacing it with methadone. In October 2013, the Respondent added Duragesic patches to Patient H's regimen.

73. The Respondent failed to document an adequate assessment of Patient H prior to initiating and continuing opioid treatment. The Respondent failed to assess the Four A's of pain and failed to utilized adjunctive therapies. The Respondent failed to conduct toxicology screening.

Patient I

74. Patient I, a female in her forties, initially presented to the Respondent in January 2013. Patient I's past medical history included depression and anxiety, back pain and gout. The Respondent diagnosed Patient I with Major Depression and Anxiety.

75. The Respondent did not document that Patient I was on an opioid regimen when she first presented. At Patient I's first visit, however, the Respondent prescribed Percocet and oxycodone. The Respondent failed to perform an adequate

physical examination or risk assessment prior to initiating or continuing opioid therapy.

76. In February 2013, the Respondent increased Patient I's dosage of oxycodone from 10 mg t.i.d. to 30 mg t.i.d.. The Respondent documented that Patient I had had some relief from pain, but that it worsened at night and disturbed her sleep.

77. In February 2014, the Respondent discontinued Patient I's Percocet due to concerns of excessive Tylenol and started a trial of morphine sulfate.

78. In April 2014, the Respondent discontinued Patient I's morphine and restarted Percocet, citing Patient I's inability to tolerate morphine.

79. The Respondent failed to document an adequate assessment of Patient I prior to initiating and continuing opioid treatment. The Respondent failed to assess the Four A's of pain and failed to utilized adjunctive therapies. The Respondent failed to conduct toxicology screening.

Patient J

80. Patient J, a male in his forties, initially presented to the Respondent in October 2011. The Respondent diagnosed him with Adjustment Disorder with Anxiety, and chronic pain syndrome.

81. The Respondent noted that two weeks earlier Patient J's previous physician had prescribed him Percocet, one tablet t.i.d., which Patient J felt did not work. The Respondent documented that Patient J said he "needed to be on two tablets before it works." The Respondent doubled Patient J's dosage of Percocet in the absence of an adequate physical examination or risk assessment. The Respondent also started Flexeril, a muscle relaxant.

82. In December 2011, the Respondent documented that Patient J was emotionally labile during the office visit and that grief over the death of relative had developed into frank depression. The Respondent discontinued Patient J's Percocet and started OxyContin 60 mg t.i.d. and oxycodone 30 mg. t.i.d.

83. Sometime between December 2011 and May 2012, the Respondent had changed Patient J's OxyContin regimen from 60 mg t.i.d. to 80 mg b.i.d. The Respondent failed to document her treatment rationale for doing so, but in May 2012, restarted Patient J's dosage to OxyContin 60 mg t.i.d noting that Patient J did not like OxyContin 80 mg.

84. In March 2013, Patient J's insurance company had notified the Respondent that Patient J had received Percocet from another physician. The Respondent documented that she was going to send a note to Patient J advising him that he would be discharged if this occurred again; however, a note is not present in Patient J's file, nor did the Respondent document that she discussed this issue with Patient J in later visits.

85. In August 2013, the Respondent once again increased Patient J's OxyContin to 80 mg in the morning and evening, noting his increased pain.

86. The Respondent failed to document an adequate assessment of Patient J prior to initiating and continuing opioid treatment. The Respondent failed to assess the Four A's of pain and failed to utilized adjunctive therapies. The Respondent failed to conduct toxicology screening.

CONCLUSION OF LAW

Based on the foregoing facts, Disciplinary Panel A concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226 (c) (2) (i) (2009 Repl. Vol. & 2013 Supp.).

ORDER

Based on the foregoing, it is, by a majority of the quorum of Disciplinary Panel A,

ORDERED that pursuant to the authority vested by Md. Code Ann., State Gov't § 10-226(c)(2), the Respondent's license to practice medicine in the State of Maryland be and is hereby **SUMMARILY SUSPENDED**; and be it further

ORDERED that a post-deprivation hearing in accordance with Code Regs. Md. 10.32.02.09B (7) (c), D and E on the Summary Suspension has been scheduled for **September 10, 2014, at 2:15 p.m.,** at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and be it further

ORDERED that at the conclusion of the **SUMMARY SUSPENSION** hearing held before Disciplinary Panel A, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request, before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031-1301; and be it further

ORDERED that on presentation of this Order, the Respondent **SHALL SURRENDER** to the Board's Compliance Analyst, the following items:

(1) the Respondent's original Maryland License D23551; and

(2) the Respondent's current renewal certificate; and be it further

ORDERED that a copy of this Order of Summary Suspension shall be filed with the Board in accordance with Md. Code Ann., Health Occ. § 14-407 (2009 Repl. Vol. & 2013 Supp.); and be it further

ORDERED that this is a Final Order of the Board and, as such, is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't §§ 10-611 *et seq.*

August 27, 2014
Date

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