IN THE MATTER OF	*	**BEFORE THE**
GARY J. SPROUSE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D32036	*	**Case Number: 7714-0004**

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AMENDED FINAL DECISION AND ORDER

PROCEDURAL HISTORY

On January 24, 2011, the Maryland State Board of Physicians ("Board") charged Gary J. Sprouse, M.D., a board-certified physician in internal medicine, with violating Sections 14-404(a)(2), (3)(i) and (ii), (11), (22), and (40) of the Health Occupations Article. In 2013, after a contested case hearing, Dr. Sprouse's license was suspended and he was ordered to take multiple courses, including one in pain management. On September 10, 2013, the Board issued an order ("Probation Order"), terminating Dr. Sprouse's suspension and placing him on probation for three years. A condition of probation required Dr. Sprouse to comply with the Maryland Medical Practice Act.[1] The Probation Order also subjected Dr. Sprouse to a peer review at the discretion of the Board.

In 2014, in accordance with the Probation Order's terms, the Board subpoenaed ten medical records from Dr. Sprouse for a peer review. Two peer reviewers evaluated the records. Both peer reviewers found that Dr. Sprouse's treatment failed to meet the standard of quality medical care for eight of ten chronic pain patients.[2] On January 15, 2015, Disciplinary Panel B

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[1] Md. Code Ann. Health Occ. §§ 14-101 – 14-702.

[2] On July 30, 2014, based on an unrelated investigation, the Board reprimanded Dr. Sprouse for violation of § 14-404(a)(22) (failure to meet the appropriate standards of quality medical care) with regard to three patients. *In the Matter of Gary J. Sprouse, M.D.*, Board Case No. 2010-0629.

charged Dr. Sprouse with violating the Probation Order by failing to comply with Health Occ. § 14-404(a)(22) (failure to meet the appropriate standards of quality medical care).[3]

Dr. Sprouse received a three-day evidentiary hearing before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings. At the hearing, the State and Dr. Sprouse jointly introduced the medical records for the eight patients at issue, Patients 1, 3-6, and 8-10. The State introduced its peer review reports and presented testimony from one of the peer reviewers, Ira Kornbluth, M.D., who was accepted as an expert in physical medicine and rehabilitation and pain medicine. Dr. Sprouse testified on his own behalf and presented testimony from Patient 1, Patient 5, and Marcia D. Wolf, M.D., who was accepted as an expert in physical medicine and rehabilitation and pain medicine.

The ALJ issued a proposed decision on October 28, 2015, concluding that Dr. Sprouse failed to meet appropriate standards for delivery of quality medical care for all eight patients. As a sanction, the ALJ recommended a reprimand and 18 months of probation with conditions including random audits of Dr. Sprouse's controlled dangerous substance ("CDS") prescribing and that he comply with the Maryland Medical Practice Act. The ALJ also recommended that Dr. Sprouse be ordered to terminate his pain management practice (ceasing to treat patients with Schedule II CDS) except for patients with terminal cancer whom he treats in nursing homes. Dr. Sprouse filed exceptions. The State filed a response in opposition to Dr. Sprouse's exceptions. Board Disciplinary Panel A (the "Panel") held an exceptions hearing on February 10, 2016.

FINDINGS OF FACT

The Panel adopts the ALJ's Proposed Findings of Fact. The ALJ's Proposed Findings of Fact (pages 6-20, numbered paragraphs 1-110) are incorporated by reference into the body of

[3] In this Order, a violation of § 14-404(a)(22) may also be referred to as a violation of the standard of care.

this document as if set forth in full.[4] *See* attached ALJ Proposed Decision, Exhibit 1. The Findings of Fact were proven by the preponderance of the evidence. Dr. Sprouse did not take exception to the ALJ's Proposed Findings of Fact.

DISCUSSION AND EXCEPTIONS

Review Period

The eight patients at issue in this case were each a patient of Dr. Sprouse prior to Dr. Sprouse's suspension. To determine whether Dr. Sprouse violated the Probation Order, the Panel forwarded to peer reviewers Dr. Sprouse's patient treatment records starting from September 10, 2013, and ending April 30, 2014 (the "Review Period"). To the extent the patients' medical histories and Dr. Sprouse's treatment of the patients prior to September 10, 2013 should inform his treatment during the Review Period, the medical history and/or prior treatment are relevant and discussed in this Order only for those purposes.

Excessively High Doses of Opioids

The ALJ found that there was insufficient justification for Dr. Sprouse's opioid prescribing dosage levels for Patients 1, 3, 6, and 10 and insufficient description of the characteristics of the pain complaints to support his opioid prescribing for Patients 8 and 9. The Panel adopts the ALJ's assessment of these patients described on the first full paragraph of page 27 through page 30 of the Proposed Decision. For those patients, the State's expert, Dr. Kornbluth opined that the high opioid doses were not justified, and described Dr. Sprouse's prescribing as "inordinately high," "excessive," "unjustifiable," irresponsibly high" and "inexcusably and unjustifiably high."

[4] Except as indicated in this Order, the Panel does not adopt the discussion section of ALJ Proposed Decision.

For example, Patient 1 suffered from abdominal pain due to endometriosis, migraines, back pain, and neck pain due to cervical disc herniation. Dr. Sprouse prescribed 120 mg of oxycodone per day, 120 mg of Oxycontin per day, and, on an as needed basis, Dilaudid up to 12 mg per day. Dr. Kornbluth testified that in order to justify prescribing such high doses of Oxycontin, oxycodone, and Dilaudid, the patient would have had to have multiple surgeries, cancer, or failed attempts at lower doses, none of which was documented for Patient 1. According to Dr. Kornbluth these doses were "excessive[.] [M]uch more than a reasonable provider would prescribe for same or seminal condition and . . . doses . . . that were beyond the scope of normal prescribing." The Panel accepts Dr. Kornbluth's opinion.

Another example is Dr. Sprouse's treatment of Patient 3, a 52-year-old woman, who had pain-related diagnoses of chronic abdominal pain due to gastritis or adhesions from endometriosis, back pain, neck pain, migraines, and rotator cuff tendonitis. Dr. Sprouse treated Patient 3's pain with 360 mg MS Contin (morphine) per day and 240 mg oxycodone per day. Dr. Kornbluth testified that these high doses of pain medications were unjustifiable based on the patient's medical work-up and that the prescribing violated the standard of care. Dr. Sprouse reviewed an MRI of the cervical spine injury to assess the patient's neck pain, but Dr. Kornbluth stated that the imaging findings did not justify the level of medication that Dr. Sprouse prescribed. The Panel agrees with Dr. Kornbluth's assessment.

A third example concerns Patient 6, a 41-year-old woman who had diagnoses of trigeminal neuralgia, fibromyalgia, lower back pain, and hip pain. Dr. Sprouse treated Patient 6 with 300 mg of MS Contin per day and 180 mg of oxycodone per day. Dr. Kornbluth testified that this amount of pain medication was unreasonable and not justified for this patient's condition. Dr. Kornbluth noted that the diagnostic imaging studies and blood test results did not

support the prescriptions Dr. Sprouse wrote. In other words, there was no objective evidence to justify the high dosages of opioids. The Panel agrees.

In his exceptions, Dr. Sprouse suggests that the Panel should adopt Dr. Wolf's opinion regarding the standard of care. The Panel declines to do so. Dr. Wolf testified that as long as the treatment record shows the patient has intractable pain and the physician obtained a medical history, performed a physical examination, evaluated the patient's circumstances, and monitored the patient's progress, the physician has acted within the standard of care. Dr. Kornbluth, however, testified that there must be sufficient justification in the treatment record to prescribe high doses of opioid pain medication and that a physician's prescribing falls below the standard of care if it is not justified based on the patient's diagnosis and symptoms. The Panel accepts Dr. Kornbluth's testimony and rejects the testimony of Dr. Wolf. The Panel finds that Dr. Sprouse violated § 14-404(a)(22) of the Health Occupations Article by prescribing unjustifiably high doses of opioids for the patients' specific symptoms and diagnoses.

Prescribing Benzodiazepines and Opioids Simultaneously

For Patients 3, 5, and 9, Dr. Sprouse prescribed a benzodiazepine (a class of medication used to treat anxiety) while simultaneously prescribing opioids for pain during the Review Period. Dr. Kornbluth stated that prescribing benzodiazepines and opioids together should be avoided because both have a depressing effect on the central nervous system. Both benzodiazepines and opioids can depress a patient's breathing, and taking them together significantly increases the likelihood of respiratory failure. Dr. Kornbluth testified that they should only be used together in limited circumstances, for short periods, and in low doses. For example, he stated that they may be prescribed for considerable muscle spasms or episodes of overwhelming anxiety, but, even for those limited uses, the prescribing of opioids and

benzodiazepines together should still only be prescribed for a short period and in the lowest possible doses. The Guidelines of the American Academy of Pain Medicine ("AAPM") reflect Dr. Kornbluth's opinion on limiting prescribing benzodiazepines and opioids simultaneously:

> Fear of inducing respiratory depression is often cited as a factor that limits the use of opioids in pain management. While respiratory depression can occur with patients taking opioids, this risk can generally be minimized if certain precautions are followed. For instance, concomitant use of other neuro-depressive drugs, such as benzodiazepines and alcohol, should be viewed with great caution, since the combination of these drugs have been shown to increase the risk of serious adverse events.

See Joint Exhibit 11.

For Patient 3, Dr. Sprouse prescribed 360 mg per day of MS Contin (an opioid), 240 mg per day of oxycodone (an opioid), and 40 mg per day of Valium (a benzodiazepine). For Patient 5, Dr. Sprouse, prescribed 80 mg of Methadone (an opioid) per day, 180 mg of Oxycodone per day and 3 mg of Xanax per day (a benzodiazepine). For Patient 9, Dr. Sprouse prescribed 180 mg per day of MS Contin, 120 mg per day of Oxycodone, and 8 mg per day of Xanax. As discussed above, these opioid prescriptions were excessive. Patients 3, 5, and 9 did not report any muscle spasms and were not prescribed the benzodiazepines for acute episodes of anxiety, rather, Dr. Sprouse prescribed the benzodiazepines and opioids for general chronic anxiety issues and chronic pain, respectively. Dr. Sprouse's medical notes did not indicate any awareness of the risks involved in combining the opioids and benzodiazepines, nor did the notes indicate any concern regarding the dosage level of the medications. The Board finds that Dr. Sprouse violated § 14-404(a)(22) of the Health Occupations Article by his prescribing benzodiazepines and opioids for Patients 3, 5, and 9 during the Review Period.

Dr. Sprouse additionally ignored respiratory symptoms for Patient 3 and failed to minimize the risks of prescribing both types of medications simultaneously. In 2013, Patient 3 exhibited symptoms of depressed respiration. At three separate visits in early 2013, Patient 3

stated that she had passed out multiple times and had shortness of breath and light headedness. Dr. Sprouse's notes did not document the possibility that these symptoms were related to her taking opioids and benzodiazepines together or that her respiratory difficulties could become worse by continuing the regimen. During the Review Period, Dr. Sprouse did not adjust his prescribing or make any changes to address Patient 3's warning signs of respiratory distress. Dr. Sprouse also did not document whether he considered changing Patient 3's prescriptions based on these symptoms.

Even Dr. Sprouse's expert, Dr. Wolf, does not dispute the risks of prescribing benzodiazepines with opioids, and agreed that the combination of drugs has the potential to compromise patient safety. But, in his exceptions, Dr. Sprouse points to Dr. Wolf's testimony that she believed that Dr. Sprouse was aware of the dangers and appropriately monitored the prescribing. The weight of the evidence does not support Dr. Wolf's testimony. The Panel accepts Dr. Kornbluth's opinion that Dr. Sprouse violated the standard of care by his opioid and benzodiazepine prescribing for Patients 3, 5, and 9. The Panel finds that this violation alone is sufficient to justify the sanctions issued in this case.

Frequency of Office Visits

Dr. Sprouse saw the eight patients at issue for appointments on a bi-monthly basis (once every two months). The ALJ concluded that bi-monthly visits were appropriate for six of the eight patients, but the standard of care required monthly visits for Patients 8 and 9. The State did not file exceptions to the ALJ's findings that bi-monthly visits were adequate for six of the patients and, thus, the Panel will not disturb the ALJ's conclusion on those six patients. The Panel will, however, discuss the frequency of office visits for Patients 8 and 9.

Patient 8, a 64-year-old male, suffered from chronic pain, including back pain, neuropathy (nerve damage), and kidney stones. He also suffered from several psychiatric conditions, including bipolar disorder, anxiety, panic attacks, and agoraphobia. In a 2013 visit, Patient 8 relayed a psychotic episode where he had hallucinations in which he saw a horse in his closet, his children go into a bubble, and his microphone stand turn into a bird.

In addition to his complicated psychiatric and pain conditions, Patient 8 also demonstrated that he was at risk for abuse or diversion of his medications. In January 2013, Patient 8 submitted to a drug screen, which tested negative for oxycodone and hydrocodone, medications he was prescribed by Dr. Sprouse. The absences of these medications in Patient 8's system indicated the possibility of diversion or misuse of these opioids. Patient 8's office notes contain no explanation for the drug test results. At the hearing, however, Dr. Sprouse speculated that the patient had been prohibited from taking those drugs after a visit to an emergency room following his psychotic episode. Dr. Sprouse also testified that Patient 8's psychiatric conditions resulted in poor impulse control, putting him at risk for excessive opioid use.

Patient 8's severe psychiatric conditions, poor impulse control, and negative drug screen indicated that he required frequent monitoring and visits. The Panel concludes that the bi-monthly office visits were inadequate and that the standard of care for Patient 8 required more frequent visits and monitoring.

Patient 9, a 61-year-old female, had back pain, knee pain, hip pain, and cervical neck pain. The patient also had bunion surgery, total right hip replacement, osteoarthritic changes to the lumbar spine (a breakdown of the cartilage of the joints and discs in the neck and lower back), and degenerative joint disease of her left hip and both knees.

Patient 9 exhibited several red flags before the Review Period, indicating that she should have been seen by Dr. Sprouse more frequently than on a bi-monthly basis during the Review Period. The medical records indicate that on four occasions Patient 9 claimed that her medications were stolen, which the ALJ described as problematic. On one occasion, Dr. Sprouse noted his concern that the physical examination findings were inconsistent with the symptoms Patient 9 described. On two other occasions, Patient 9 took more pain medicine than prescribed, including once finishing a thirty-day supply of oxycodone in twelve days. Dr. Sprouse's notes also described Patient 9 as "self dosing" and reported another instance when she ran out of pain medicine eight days early. While on two occasions Dr. Sprouse threatened to discharge the patient and refer her to a pain management specialist, he did not do so.

The Panel finds that the incidents listed above were red flags. Alleging stolen medications on multiple occasions, finishing medications early, and physical examinations that do not comport with the patient's complaints all indicate risks that necessitate close monitoring and frequent appointments. Based on these red flags, the Panel finds that the bi-monthly office visits for Patient 9 during the Review Period were too infrequent and did not meet the standard of care.

In his exceptions, Dr. Sprouse claims that the ALJ arbitrarily required more stringent follow-up intervals for Patients 8 and 9. He cites Dr. Wolf's testimony that bi-monthly checkups were sufficient. However, Dr. Wolf's testimony is not persuasive. Dr. Wolf provided no justification for her opinion nor did she address Patient 8's complex psychiatric conditions or negative drug test or Patient 9's numerous red flags. The Panel concludes that the bi-monthly visits with Dr. Sprouse did not meet the standard of care for Patients 8 and 9. The Panel finds that this violation alone is sufficient to justify the sanctions issued in this case.

Random Drug Screenings

As discussed above, Dr. Sprouse prescribed excessively high opioid doses to his patients. Dr. Sprouse prescribed oxycodone 30 mg tablets to many of his patients in large quantities. Oxycodone has a high "street value" and, therefore, high diversion potential. Drug screenings are ordered for chronic pain patients to determine whether they are abusing or diverting their medications. The charges allege that Dr. Sprouse failed to order sufficient drug screenings for Patients 3, 4, 5, 8, and 10.

The State's peer reviewers' reports and Dr. Kornbluth's testimony established that, for these patients, the standard of care required drug screening at least every three months. While not a description of the standard of care, the AAPM guidelines echo Dr. Kornbluth's opinion that compliance monitoring should include periodic drug screenings and describe compliance monitoring as "a critical aspect of chronic opioid prescribing." Dr. Sprouse testified that his goal is to order drug tests once a year. For Patient 3, Dr. Sprouse did not order a single drug screen between September 2008 and the end of the Review Period in April 2014. For Patients 4 and 10, Dr. Sprouse did not order any drug screenings between 2009 and the end of the Review Period. At the end of the Review Period, Dr. Sprouse did not ordered a drug screen for Patient 8 for 15 months and had not ordered a drug screen for Patient 5 for 14 months. As stated earlier, the lack of drug screenings prior to the Review Period provides the context, but the Panel's conclusions on whether he violated the probation order are based on his failure to require drug screenings during the Review Period.

The Panel finds that Dr. Sprouse failed to order drug testing with sufficient frequency and did not increase the frequency of drug screenings in response to patients exhibiting risk factors and warning signs.

In addition, several of these patients exhibited "red flags," specifically prior failed drug tests, indicating that Dr. Sprouse should have ordered additional drug screenings during the Review Period.

For example, Patient 4 was a 62-year-old male whose pain conditions included thigh pain, ankle pain, low back pain, and hip pain. He also suffered from psychiatric conditions, including bipolar disorder. Dr. Sprouse ordered drug screenings for Patient 4 on November 25, 2008 and July 16, 2009. The July 2009 drug screen tested positive for Valium, a benzodiazepine never ordered by Dr. Sprouse, and as explained above, a drug that could have dangerous outcomes when taken concurrently with opioids. The drug screen also tested below the minimum of 300 ng/ml for Methadone,[5] although Dr. Sprouse had prescribed Methadone. In August, 2009, Dr. Sprouse informed Patient 4 in writing that he would no longer treat him for his chronic pain conditions and referred the patient to abuse and addiction treatment and pain management programs.

Six months later, however, Dr. Sprouse treated Patient 4 at a rehabilitation center after Patient 4's ankle surgery. He resumed prescribing the patient methadone and additionally prescribed Dilaudid (an opioid). Dr. Sprouse failed to order any drug screenings at any point after Patient 4 resumed taking opioid medications, and Dr. Sprouse continued prescribing those medications for Patient 4's ankle, hip, and back pain without ordering any drug screens despite the failed drug test in 2009 and the patient's discharge from the practice. The Panel concludes that Dr. Sprouse failed to meet the standard of care for Patient 4 based on his failure to order any drug screenings during the Review Period, especially in light of Patient 4's violation in his earlier drug test.

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[5] The lab deemed Patient 4's drug test a violation because it was below the threshold for a positive test.

Regarding Patient 8, Dr. Sprouse prescribed him oxycodone and hydrocodone for back pain. As stated above, Patient 8's most recent drug screen, in January 2013, was negative for oxycodone and hydrocodone. And, while Dr. Sprouse speculated at the hearing that the patient had been prohibited from taking those drugs after a visit to the emergency room, he did not document in the patient's medical records that he explored this possibility. Further, as indicated above, Dr. Sprouse identified Patient 8 as someone at risk for non-compliance because, as Dr. Sprouse testified, Patient 8's psychiatric conditions gave him limited control over his impulses. The Panel finds that, based on the foregoing risks for non-compliance, Dr. Sprouse did not meet the standard of care by his failure to conduct any drug screens for Patient 8 during the Review Period.

Dr. Sprouse argues in his exceptions that, while he admitted that his goal is to order drug testing every year, he uses his clinical judgment based on his knowledge of his patients and only orders random drug testing on a patient who he believes is misusing drugs. He cites Dr. Wolf's testimony that there are no mandatory time periods for drug screenings. The Panel finds Dr. Wolf's and Dr. Sprouse's testimony unconvincing. The Panel finds that Dr. Sprouse's insufficient drug screenings for these patients failed to meet the standard of care. The Panel finds that this violation alone is sufficient to justify the sanctions issued in this case.

Referral to Pain Management Specialist

The ALJ found that all eight patients should have been referred to a pain management specialist. Both experts testified that primary care physicians may provide chronic pain management, so long as they act within the standard of care. Dr. Kornbluth opined that Dr. Sprouse should have referred these specific patients to pain management specialists because the patients were on high doses of opioids for many years, had complex medical conditions, and had

co-morbid conditions. The AAPM's statement regarding referral to a specialist describes a similar standard:

> **Consultation as needed**: Consultation with a Pain Medicine or other specialist may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem. The management of pain in patients with a history of addiction or comorbid psychiatric disorder requires special consideration.

Patients 3, 4, and 8 had psychiatric co-morbidities of bi-polar disorder and anxiety or depression. Several patients had orthopedic issues related to their pain complaints. Patient 6 had diabetes, morbid obesity, asthma, and sleep apnea, in addition to pain from trigeminal neuralgia, temporomandibular joint disorder, fibromyalgia and low back pain. Nearly all of the patients had multiple concurrent conditions contributing to their pain.

In his exceptions, Dr. Sprouse argues that referral to a pain specialist is never required. He cites the AAPM, which states that consultation may be provided "as needed," and Dr. Wolf's testimony which states that a physician is never required to refer a patient to a pain management specialist. The Panel agrees that the referral to a pain management specialist is not required in all cases, but finds the standard of care may require a physician to refer a patient to a specialist in certain circumstances. The circumstances of these eight patients required referrals to pain management specialists. Dr. Sprouse's failure to refer these particular patients to a pain management specialist violated the standard of care.

DR. SPROUSE'S ADDITIONAL EXCEPTIONS

AAPM and the Standard of Care

Dr. Sprouse claims that the ALJ adopted the AAPM's guidelines as the standard of care. The ALJ, however, explicitly disclaimed doing so, stating: "I do not suggest that the Board should adopt the AAPM's statement as the standard of care in this case." The ALJ considered AAPM's guidelines as guidance to determine whether there was support for the expert

testimony. Indeed, Dr. Sprouse himself uses the AAPM's statement in this way, quoting it in his exceptions to bolster his expert's testimony. The Panel likewise considers the AAPM's guidelines as supportive of the State's expert witness testimony, but does not adopt the AAPM's guidelines as the standard of care.[6]

Expert Opinions

Dr. Sprouse argues that the proposed decision is biased and arbitrary because, according to Dr. Sprouse, the ALJ ignored the testimony of his expert, Dr. Wolf, and focused solely on the statements of the State's expert, Dr. Kornbluth.[7] Dr. Sprouse's argument is devoid of merit. The ALJ addressed Dr. Wolf's opinions throughout the Proposed Decision.

"When two experts offer conflicting opinions, the trier of fact must evaluate the testimony of both experts and decide which opinion, if either, to accept." *Blaker v. State Board of Chiropractic Examiners*, 123 Md. App. 243, 259 (1998). In considering Dr. Wolf's conclusions regarding the standard of care, the Panel rejects her testimony. Dr. Wolf's opinions were not sufficiently founded on the specific facts for the patients at issue and her reasoning was unconvincing.

CONCLUSIONS OF LAW

The Panel concludes that Dr. Sprouse violated the September 10, 2013, Probation Order, which required Dr. Sprouse to comply with the Maryland Medical Practice Act, Health Occ. §§ 14-101 – 14-702. Dr. Sprouse failed to comply with the Medical Practice Act because he failed

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[6]The Panel also declines to consider Dr. Sprouse's request to take judicial notice of the book "Responsible Opioid Prescribing: A Clinician's Guide" by Scott M. Fishman, M.D. This publication was not admitted into evidence.

[7] Dr. Sprouse also states that the ALJ ignored his testimony, but fails to specify what testimony was ignored, and the Panel will not speculate. Dr. Sprouse does not challenge any specific Findings of Fact and Dr. Sprouse was not qualified as an expert. Nevertheless, the Panel considered Dr. Sprouse's testimony in full.

to meet the appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22).

SANCTION

Under the 2013 Probation Order, the Panel may impose any further sanctions authorized under Health Occ. §§ 14-404(a) and 14-405.1 for a violation of the Probation Order. Providing patients with safe and effective treatment for chronic pain is essential, especially considering the dangers involved with opioid abuse and addiction. The Panel notes that Dr. Sprouse has expressed a willingness to learn from his mistakes and has asked for the Panel's guidance to help him improve his pain management practice. As such, the Panel will impose a sanction that allows Dr. Sprouse to practice pain management while learning from specialists in the field.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, by an affirmative vote of a majority of a quorum of Disciplinary Panel A, hereby

ORDERED that the probation and the terms and conditions of Dr. Sprouse's 2013 Probation Order are hereby terminated; and it is further

ORDERED that Gary J. Sprouse, M.D. is **REPRIMANDED**; and it is further

ORDERED that Dr. Sprouse is placed on **PROBATION** for a minimum period of **18 MONTHS**.[8] During the probationary period, Dr. Sprouse shall fully and satisfactorily comply with the following probationary terms and conditions:

1. Dr. Sprouse's medical practice shall be supervised by two Panel-approved physician peer supervisors licensed in Maryland; one supervisor specializing in pain

[8] If Dr. Sprouse's license expires while he is on probation, the probationary period and any probationary conditions will be tolled. COMAR 10.32.02.05C(3).

management and one specializing in psychiatry with experience in treating psychiatric conditions concomitant with pain conditions;

A. As part of the approval process, Dr. Sprouse shall submit to the Panel, **WITHIN 30 DAYS**, the names and professional credentials of the physician supervisors that he proposes to supervise his practice;

B. Dr. Sprouse shall provide the panel-approved supervisors with this Final Decision and Order, prior Board Orders dated July 22, 2013 and July 30, 2014, and whatever other written materials the Panel deems appropriate;

C. Dr. Sprouse shall ensure that the supervising physicians notify the Board in writing of their acceptance of the peer supervisor role;

D. The supervisors shall be available to Dr. Sprouse for consultations on any patient, shall have access to Dr. Sprouse's patients' records, and shall maintain the confidentiality of all medical records and patient information;

E. Each supervisor shall hold face-to-face meetings with Dr. Sprouse at least **ONCE A MONTH**. At these meetings, the pain management specialist supervisor shall review a random sample of at least ten cases or 100% of chronic pain patients seen since the last meeting, whichever is less. At these meetings, the psychiatry specialist supervisor shall evaluate a random sample of at least ten cases or 100% of chronic pain patients with psychiatric co-morbidities seen since the last meeting, whichever is less. The supervisors shall evaluate Dr. Sprouse's practice for compliance with quality of care standards;

F. Additionally, Dr. Sprouse shall ensure that the supervisors provide the Panel with **QUARTERLY REPORTS** concerning Dr. Sprouse's pain prescribing. The reports should state the number and types of cases reviewed, medical issues discussed, and the supervisor's assessment of Dr. Sprouse's progress and his compliance with the quality of care standard.

G. Dr. Sprouse is solely responsible for ensuring that the supervisors submit the required quarterly reports. If there are indications that Dr. Sprouse poses a risk to patients, the supervisor shall immediately report his or her concerns to the Panel;

H. In the event that the supervisors discontinue supervising Dr. Sprouse for any reason, Dr. Sprouse shall immediately notify the Board and submit a replacement candidate to serve as his supervisor under the terms specified above;

I. A report from either supervising physician that the Panel deems as unsatisfactory progress may constitute a violation of Probation and this Order;

2. Beginning on July 25, 2016, Dr. Sprouse is prohibited from prescribing opioids to chronic pain patients, until the supervisors in the preceding condition have been approved by the Panel, with limited exceptions. Dr. Sprouse may prescribe opioids for palliative care to patients with terminal cancer whom Dr. Sprouse treats in nursing homes. Dr. Sprouse may also prescribe opioids for acute pain, not to exceed a period of 72 hours, and prescriptions may not be renewed or refilled;

3. The Panel will issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program on a quarterly basis requesting Dr. Sprouse's CDS prescriptions written from the beginning of each quarter;

4. Dr. Sprouse shall not petition the Panel for early termination of his probation;

5. Dr. Sprouse shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

ORDERED that, after a minimum of 18 months, Dr. Sprouse may submit a written petition to the Panel requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or the Panel. Dr. Sprouse may be required to appear before the Board or the Panel to discuss his petition for termination. The Board or the Panel will grant the petition to terminate the probation if the Board or the Panel determines that the Dr. Sprouse has satisfactorily complied with the probationary terms and conditions, and, based on the reports from his two supervisors, deems that his opioid prescribing is in compliance with the standard of quality medical care, and there are no pending complaints related to the charges; and it is further

ORDERED that Dr. Sprouse is responsible for all costs incurred in fulfilling the terms and conditions of this Final Decision and Order; and it is further

ORDERED that if the Board or the Panel determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before the Board or the Panel if there is no genuine dispute as to a material fact, that Dr. Sprouse has failed to comply with any term or condition of probation or this Final Decision and Order, the Board or the Panel may

reprimand Dr. Sprouse, place Dr. Sprouse on probation with appropriate terms and conditions, suspend or revoke Dr. Sprouse's license to practice medicine in Maryland, or impose a civil monetary fine in addition to a sanction; and it is further

ORDERED that, unless stated otherwise in the order, any time period prescribed in this Final Decision and Order begins when the Final Decision and Order goes into effect. The Final Decision and Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of the Panel; and it is further

ORDERED that this is a public document.

July 11, 2016
Date

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

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Sprouse has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within thirty (30) days from the date of mailing of this Final Decision and Order. The cover letter accompanying this Final Decision and Order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Sprouse files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201

STATE BOARD OF PHYSICIANS	*	**BEFORE ROBERT F. BARRY,**
V.	*	**AN ADMINISTRATIVE LAW JUDGE**
GARY J. SPROUSE, M.D.,	*	**OF THE MARYLAND OFFICE**
RESPONDENT	*	**OF ADMINISTRATIVE HEARINGS**
LICENSE No. D32036	*	**OAH CASE No.: DHMH-MBP-71-15-12178**
	*	**SBP CASE No.: 7714-0004**

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
FINDINGS OF FACT
DISCUSSION
CONCLUSIONS OF LAW
PROPOSED DISPOSITION
NOTICE OF RIGHT TO FILE EXCEPTIONS

STATEMENT OF THE CASE

On January 24, 2011, the State Board of Physicians (Board) charged Gary J. Sprouse, M.D. (Respondent) with violating several sub-sections of the Maryland Medical Practice Act. The charges included an allegation that the Respondent had failed to meet appropriate standards for the delivery of quality medical care in connection with his prescribing of opioids for the treatment of chronic pain.

On July 22, 2013, following a hearing before an administrative law judge and the completion of the Board's exceptions process, the Board suspended the Respondent's license to practice medicine until he completed Board-approved courses in pain management and two other topics.

On September 10, 2013, the Board terminated the suspension and placed the Respondent on probation for a minimum of three years. While on probation, the Respondent was subject to peer review at the discretion of the Board and required to comply with the Maryland Medical Practice Act.

On January 15, 2015, following peer review of the Respondent's treatment of ten patients, the Board, by one of its disciplinary panels, charged the Respondent with violating the terms of the probation. Specifically, the Board alleged that the Respondent failed to meet appropriate standards for the delivery of quality medical care in connection with his prescribing of opioids and non-opioids for the treatment of chronic pain for eight of the patients reviewed. Md. Code Ann., Health Occ. § 14-404(a)(22) (Supp. 2015). The Board forwarded the charges to an administrative prosecutor within the Office of the Attorney General.

On April 10, 2015, the Board transmitted this matter to the Office of Administrative Hearings (OAH) with a delegation to issue proposed findings of fact, proposed conclusions of law, and a proposed disposition.

After an in-person scheduling conference on April 29, 2015 and a pre-hearing conference on June 30, 2015, I conducted a hearing at the OAH on July 28, 2015 through July 30, 2015. Md. Code Ann., Health Occ. § 14-405(a) (2014). Janet Klein Brown, Assistant Attorney General, Administrative Prosecutor, Health Occupations Prosecution and Litigation Division, represented the State. Conrad W. Varner, of Varner & Goundry, represented the Respondent, who was present throughout the hearing.

The contested-case provisions of the Administrative Procedure Act, the Board's Rules of Procedure, and the OAH Rules of Procedure govern procedure in this matter. Md. Code Ann., State

Gov't §§ 10-201 through 10-226 (2014); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUES

(1) Did the Respondent fail to meet appropriate standards for the delivery of quality medical care in connection with his prescribing of opioids and non-opioids for the treatment of chronic pain?

(2) If so, what sanction should be imposed on the Respondent's license to practice medicine?

SUMMARY OF THE EVIDENCE

Exhibits

The parties offered the following joint exhibits, which were admitted as evidence:

JOINT #1 - Medical records, Patient 1 ([redacted]) (GJS10027 - GJS10301)[1]

. . .

JOINT #3 - Medical records, Patient 3 [redacted] (GJS10686 - GJS10968)

JOINT #4 - Medical records, Patient 4 ([redacted]) (GJS10969 - GJS11160)

JOINT #5 - Medical records, Patient 5 [redacted] (GJS11161 - GJS11337)

JOINT #6 - Medical records, Patient 6 [redacted] (GJS11338 - GJS11654)

. . .

JOINT #8 - Medical records, Patient 8 ([redacted]) (GJS11702 - GJS11849)

JOINT #9 - Medical records, Patient 9 ([redacted]) (GJS11850 - GJS12228)

JOINT #10 - Medical records, Patient 10 ([redacted]) (GJS12229 - GJS12424)

JOINT #11 - Respondent's Supplemental Response to the Peer Reviews, with a Statement from the American Academy of Pain Medicine on the Use of Opioids for the Treatment of Chronic Pain (2013)

[1] In my decision, I used the initial J. (for JOINT) to signify the medical records.

The State, except as noted, offered the following exhibits, which were admitted as evidence:

STATE #1 - (not offered)

STATE #2 - Consent Order, June 26, 1996

STATE #3 - Final Decision and Order, July 22, 2013;

STATE #4 - Order Terminating Suspension and Imposing Probation, September 10, 2013

STATE #5 - Final Decision and Order, July 30, 2014; Proposed Decision, November 8, 2012

STATE #6 - Charges of Violation of Probation of Order of September 10, 2013, January 15, 2015

STATE #7 - Confidential Patient Identification List

STATE #8 - (A) - Rite Aid Pharmacy: Prescriber Activity Report - September 10, 2013 through March 20, 2014;

Rite Aid Pharmacy: Customer Profile Reports - September 10, 2013 through March 20, 2014, for Patients 1 ([redacted]), 3 ([redacted]) 4 ([redacted]), 5 ([redacted]), 6 ([redacted]) and 9 ([redacted])

(B) - CVS/Caremark: Patient Profile Record - September 10, 2013 through February 26, 2014, for Patient 8 ([redacted])

(C) - Walgreens: Prescriber Profile;

Walgreens: Patient Profiles for Patients 3 ([redacted]), 4 ([redacted]), 6 ([redacted]), 8 ([redacted]), 9 ([redacted]), and 10 ([redacted])

STATE #9 - Peer Review - Ira Kornbluth, M.D.

STATE #10 - *Curriculum Vitae,* Ira Kornbluth, M.D.

STATE #11 - Letter from Ira Kornbluth, M.D. to the Administrative Prosecutor, June 11, 2015

STATE #12 - Peer Review- Jeffrey A. Schneider, M.D.

STATE #13 - *Curriculum Vitae,* Jeffrey A. Schneider, M.D.

STATE #14 - Letter from Jeffrey A. Schneider, M.D. to the Administrative Prosecutor, June 11, 2015

The Respondent, except as noted, offered the following exhibits, which were admitted as evidence:

RESP #1 - *Curriculum Vitae,* Respondent

RESP #2 - *Curriculum Vitae,* Marcia D. Wolf, MD.

RESP #3 - Letter (Expert Report) from Marcia D. Wolf, M.D. to the Respondent's attorney, March 16, 2015

RESP #4 - Letter (Addendum to Expert Report) from Marcia D. Wolf, M.D. to the Respondent's attorney, May 30, 2015

RESP #5 - (not offered)

RESP #6 - (not offered)

RESP #7 - (not offered)

RESP #8 - Abstract - "Using Urine Drug Testing to Support Healthy Boundaries in Clinical Care," Journal of Opioid Management, January-February 2015

RESP #9 - (not offered)

RESP #10 - (not offered)

RESP #11 - (not offered)

RESP #12 - (not offered)

RESP #13 - Final Report, Calloway Labs, Patient # 10 ([redacted]), date sample provided March 18, 2009

RESP #14 - Consent for Chronic Narcotic Therapy, Patient 10 [redacted]

Testimony

Ira Kornbluth, M.D., who was accepted as an expert in physical medicine and rehabilitation and in pain medicine, testified for the State.

The Respondent testified on his own behalf. He also presented testimony from the following witnesses: Marcia D. Wolf, M.D., who was accepted as an expert in physical medicine and rehabilitation and in pain medicine; Patient 1 ([redacted]); and Patient 5 ([redacted]).

FINDINGS OF FACT

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

1. The Respondent has been licensed to practice medicine in Maryland since 1985 under license number D32036.

2. At all times relevant to this case, the Respondent maintained an office for the practice of internal medicine at Queen Anne's Medical Center in Chester, Maryland. While his medical license was suspended in August and September 2013, the Respondent completed Board-approved courses in pain management at a symposium sponsored by Massachusetts General Hospital and Harvard Medical School.

3. Dr. Kornbluth, who was initially engaged as one of the peer reviewers, has been licensed to practice medicine since 2004; he is board-certified in physical medicine and rehabilitation and pain management. He has his own medical practice, SMART Pain Management.

4. Dr. Wolf, who has been licensed to practice medicine since approximately 1992, is board-certified in physical medicine and rehabilitation and pain medicine. Since 2000, Dr. Wolf has been the Medical Director of the MidAtlantic Pain Medicine Center.

Patient 1 ([redacted])

5. Patient 1 [redacted] is a forty-eight-year-old, married woman, who has three children; she works occasionally cleaning houses or caring for children.

6. Patient 1 has been treated by the Respondent or by other doctors or nurse practitioners in the Respondent's office since 2001. Her diagnoses have included degenerative disc disease of her lumbar spine, L4-5 and L5-S1, with relatively mild symptoms, migraine headaches, and a herniated cervical disk. (J.10258-59; J.10294-96; J.10297-98).

7. The Respondent initially treated Patient 1's cervical spine pain with prednisone, an anti-inflammatory corticosteroid; Percocet, a combination of acetaminophen and an opioid, Oxycodone; and Flexeril, a muscle relaxant. The Respondent also recommended physical therapy and massage. (J.10141; J.10154).

8. The Respondent treated Patient 1's migraine headaches with occasional injections of morphine during office visits and Phenergan. (J.101249).

9. On April 24, 2007, Patient 1 signed a chronic opioid therapy agreement. (J.10194-97).

10. As of September 7, 2007, the Respondent was treating Patient 1's cervical spine pain with Percocet and Flexeril and treating her migraine headaches with Dilaudid (hydromorphone, an opioid) and Imitrex. (J.10130-31).

11. As of July 29, 2008, the Respondent was treating Patient 1's cervical neck pain with an opioid, OxyContin, 40 mg, 1 tab, every 12 hours; Percocet 10/325, 2 tabs, every six hours, as needed; and Flexeril. (J.10125). The Respondent was also prescribing Dilaudid, 4 mg, 1 tab, as needed, for migraine headaches. (J.10125).

12. Since at least September 8, 2010, Patient 1 has declined to have surgery for her herniated cervical disk. (J.10109).

13. Since at least January 3, 2011, the Respondent has treated treating Patient 1's cervical neck pain with OxyContin, 60 mg, 1 tab, every 12 hours; and Oxycodone, 15 mg, 2 tabs,

four times a day; and Flexeril. The Respondent has also prescribed Dilaudid, 4 mg, 1 tab, as needed; and Imitrex, for migraine headaches. (J.10105).

14. During the period under review, the Respondent saw Patient 1 for office visits on September 23, 2013, November 5, 2013, January 6, 2014, and March 4, 2014. (J.10038-39; J.10036-37; J.10035; J.10033-34).

15. On May 18, 2007, February 17, 2009, March 13, 2009, and March 4, 2014, Patient 1 provided specimens for random drug testing. (J.10040; J.10215; J.10226-27; J.10230-31; J.10210-11).

Patient 3 [redacted]

16. Patient 3 [redacted] is a fifty-two-year-old, unemployed woman; she has been treated by the Respondent for approximately fifteen years.

17. Patient 3's diagnoses have included chronic abdominal pain from gastritis or adhesions from endometriosis, back pain, neck pain, and rotator cuff tendonitis. Patient 3 also has bipolar disorder and post-traumatic stress disorder related to being sexually abused as a child; she has severe anxiety and agoraphobia.

18. On May 7, 2007, Patient 3 signed a chronic opioid therapy agreement. (J.10861-64).

19. As of July 8, 2008, the Respondent was treating Patient 3's abdominal pain with morphine, 100 mg, 1 tab, three times per day; and Percocet 10/325 mg, 1 tab, every four hours, as needed. The Respondent was also prescribing Valium, 10 mg, 1 tab, four times per day, as needed. (J.10847).

20. In 2008, the Respondent routinely gave Patient 3 injections of morphine during office visits. (J.10940-56).

21. As of February 9, 2009, the Respondent was treating Patient 3's abdominal pain and lower back pain with MS Contin (morphine), 100 mg, 1 tab, three times per day; and Percocet 10/325 mg, 1 tab, every four hours, as needed. The Respondent was also prescribing Valium, a benzodiazepine, 10 mg, 1 tab, four times per day as needed. (J.10834).

22. As of January 3, 2011, the Respondent was treating Patient 3's abdominal pain, lower back pain, and shoulder pain with MS Contin, 60 mg, 2 tabs, three times per day; and Oxycodone, 30 mg, 2 tabs, four times a day. The Respondent was also prescribing Valium, 10 mg, 1 tab, four times per day; Imitrex; anti-depressants; and a mood stabilizer. (J.10692-93).

23. On May 9, 2013, Patient 3 underwent a MRI of her cervical spine for neck pain with radiculopathy to the shoulders. The MRI showed degenerative disc disease mostly at C5-C6 and C6-C7 with broad-based bulging and posterior osteophytes. The radiologist noted multilevel degenerative changes with areas of foraminal narrowing, mostly on right at C3-C4 and bilaterally at C5-C6, as well as lateral recess narrowing and mild canal stenosis at C5-C6 and C6-C7. (J.10896).

24. As of April 3, 2014, the Respondent was treating Patient 3's abdominal pain, lower back pain, and neck pain with MS Contin, 60 mg, 2 tabs, three times per day; Oxycodone, 30 mg, 2 tabs, four times a day; he was also prescribing Valium, 10 mg, 1 tab, four times per day; Imitrex; and Zoloft. (J.10692-93).

25. During the period under review, the Respondent saw Patient 3 for office visits on October 14, 2013, December 10, 2013, January 2, 2014, February 6, 2014, and April 3, 2014. (J.10701-02; J.10698-10700; J.10696-97; J.10694-95; J.10692-93).

26. On July 3, 2007 and September 22, 2008, Patient 3 provided specimens for random drug testing. (J.10893; J.10881-82).

Patient 4 ([redacted])

27. Patient 4 ([redacted]), a man, died in May 2014 from cancer at the age of sixty-two.

28. The Respondent treated Patient 4 for approximately ten years.

29. Patient 4's diagnoses included left thigh and ankle pain, low back pain, hip pain, hiatal hernia, bipolar disorder, and aortic valve replacement.

30. The Respondent prescribed methadone for Patient 4 to treat low back pain since at least October 8, 2004. (J.10996).

31. Methadone, a non-opioid that is used off-label to treat pain, can cause QTc changes in a person's heart rhythm. (STATE #12).

32. The Respondent referred Patient 4 for an ECG in October 2007 and October 2008. (J.1148-49).

33. On May 2, 2007, Patient 4 signed a chronic opioid therapy agreement. (J.11095-97).

34. On November 25, 2008 and July 16, 2009, Patient 4 provided urine specimens for random drug testing. (J.11108-10).

35. The urine sample provided on July 16, 2009 was positive for Valium, which the patient was not prescribed and technically negative for methadone, which the patient was prescribed, because it showed 299 ng/ml of methadone, with a cutoff of 300 ng/ml of methadone. (J.11105). On August 4, 2009, the Respondent discharged Patient 4 from the pain management part of his practice. (J.11093).

36. In April 2011, Patient 4 fractured his ankle, and, in July 2011, he had surgery on his right hip, which included installation of a pin. (J.10985-87). Patient 4 received physical therapy after the surgery on his hip. (J.11021).

37. After being treated by the Respondent in a rehabilitation center where the Respondent worked, Patient 4 returned to the pain management part of the Respondent's practice. (J. 11024).

38. As of January 24, 2012, the Respondent was treating Patient 4 for low back pain and the ankle fracture. The Respondent prescribed methadone, 10 mg, four tabs, three times per day; and Dilaudid, 8 mg, 1 tab, every six hours. (J.11024-25).

39. As of April 4, 2013, Patient 4 had ankle pain and hip pain. He rated his pain with medication as 8 on a bad day and 3 on a good day, and he used a cane to assist with walking. (J.11002).

40. On September 27, 2013, the Respondent gave Patient 4 and injection of cortisone into his right hip. (J.10981).

41. On October 24, 2013, Patient 4 had an MRI of his right hip, which showed no avascular necrosis or significant degenerative changes. (J.10994).

42. On November 11, 2013, Patient 4 had surgery to remove a surgical pin from his right hip. (J.10988-10990).

43. As of April 16, 2014, the Respondent was treating Patient 4's hip pain, thigh pain, ankle pain, and low back pain with methadone, 10 mg, 4 tabs, three times per day; and Dilaudid, 8 mg, 1 tab, five times a day. The Respondent was also prescribing an anti-depressant and a mood stabilizer. (J.10975-76).

44. During the period under review, the Respondent saw Patient 4 for office visits on September 19, 2013, September 27, 2013, October 7, 2013, January 6, 2014, and April 16, 2014. (J.10983-84; J.10981-82; J.10979-80; J.10977-78; J.10975-76).

Patient 5 [redacted]

45. Patient 5 ([redacted], is a thirty-one-year-old man, who is self-employed as a contractor, building new homes and performing home improvements. He performs strenuous physical labor on a daily basis.

46. On or about March 23, 2006, Patient 5 was seriously injured in a motor vehicle accident, which involved the patient driving under the influence of alcohol. He was treated at the Shock Trauma Center at the University of Maryland Medical Center for multiple injuries, including a fractured cervical vertebrae, transverse process fractures of three lumbar vertebrae, a fractured left scapular, and a fractured left femur. (J.11316-17; 11327-34; J.11247).

47. When he was first seen in the Respondent's office, Patient 5 was prescribed OxyContin and Percocet for back pain. Patient 5 was referred for physical therapy and occupational therapy. (J.11247).

48. Patient 5 saw a physical therapist for a few months, but stopped because of the expense. (J.11242).

49. On December 13, 2006, another doctor in the Respondent's office recommended that Patient 5 consult with a pain management specialist. (J.11237).

50. As of April 10, 2007, the Respondent prescribed methadone instead of OxyContin for Patient 5 based on the cost of the medications and Patient 5's lack of health insurance. (J.11234).

51. On May 4, 2007, Patient 5 signed a chronic opioid therapy agreement. (J.1276-79).

52. As of July 24, 2007, the Respondent was treating Patient 5's back pain with methadone, 10 mg, 7 tabs per day, and Oxycodone, 15 mg, 1 tab, five times per day, as needed. (J.11231).

53. As of March 5, 2014, the Respondent was treating Patient 5's back pain with methadone, 10 mg, 8 tabs per day; and Oxycodone, 30 mg, 1 tab, six times per day. The Respondent was also prescribing Xanax, a benzodiazepine, 1 mg, 1 tab, three times per day, as needed, for anxiety. (J.11166).

54. On October 22, 2010 and March 1, 2013, Patient 5 provided specimens for drug testing. (J.11210).

55. During the period under review, the Respondent saw Patient 4 for office visits on September 18, 2013, November 14, 2013, January 9, 2014, and March 15, 2014. (J.11166; J.11168; J.11170; J.11172).

Patient 6 [redacted]

56. Patient 6, [redacted] is a forty-one-year-old woman, who has been the Respondent's patient since at least 2003. (J.11652).

57. Patient 6's diagnoses have included trigeminal neuralgia, lower back pain, temporomandibular joint disorder, obesity, bilateral hip pain, and fibromyalgia.

58. In March 2008, the Respondent referred Patient 6 for a physical therapy assessment for cervical-thoracic pain. (J.11640).

59. An MRI of Patient 6's lumbar spine conducted on September 2, 2008 showed no diagnostic abnormality. (J.11603).

60. As of November 14, 2008, the Respondent was treating Patient 6's low back pain with MS Contin, 60 mg, 1 tab, three times a day; and Oxycodone, 30 mg, 1 or 2 tabs, four times a day. (J.11503).

61. On September 28, 2009, Patient 6 complained of neck pain. The Respondent planned to obtain a MRI of Patient 6's neck, to prescribe Lyrica, a non-opioid used for nerve

pain, and to refer her to physical therapy. (J.11486). Due to insurance issues and Patient 6's lack of cooperation, Patient 6 has not had a MRI of her neck.

62. On November 3, 2010, the Respondent diagnosed Patient 6 with fibromyalgia and prescribed Lyrica and a TENS, a medical devise for nerve stimulation. As of November 13, 2010, the Respondent was treating Patient 6's low back and neck pain with MS Contin, 60 mg, 1 tab, three times a day; and Oxycodone, 30 mg, 1 tab, every four hours. (J.11460-61).

63. Between January 11, 2011 and April 14, 2014, Patient 6 has consistently complained of pain from various sources. On December 12, 2011, she described pain that was 10 out of 10 on a pain scale and which kept her from getting out of bed. (J.11423).

64. On November 27, 2012, Patient 6 complained of facial pain, for which she was taking Lyrica, and hip, shoulder, and back pain. (J.11385-86).

65. On February 19, 2014, the Respondent treated Patient 6's hip pain with injections of a steroidal anti-inflammatory medication. (J.11347).

66. As of April 14, 2014, the Respondent was treating Patient 6's low back pain, bilateral hip pain, and fibromyalgia with MS Contin, 100 mg, 1 tab, three times a day; and Oxycodone, 30 mg, 1 tab, every four hours. (J.11344-45).

67. On October 22, 2008 and February 17, 2014, Patient 6 signed a chronic opioid therapy agreement. (J. 11561-64; J.11357-60).

68. On October 22, 2008 and February 17, 2014, Patient 6 submitted specimens for random drug testing. (J.11356; J.11584-85).

69. During the period under review, the Respondent saw Patient 6 for office visits on September 17, 2013, December 11, 2013, February 17, 2014, February 19, 2014, and April 14, 2014. (J.11353-55; J.11351-52; J.11349-50; J.11347-48; J.11344-46).

Patient 8 [redacted]

70. Patient 8 [redacted] is a sixty-four-year-old man, who has been the Respondent's patient since at least 2005.

71. Patient 8's diagnoses have included lower back pain, kidney stones, and peripheral neuropathy. Patient 8 has also been diagnosed with anxiety and bipolar disorder. (Other than the results of an electroneuromyographic (EMG) examination of Patient 8's left arm, there are no diagnostic test reports in the medical records.)

72. In 2005, the Respondent prescribed Duragesic, an opioid (fentanyl) skin patch that delivers pain medication through the skin; and Oxycodone for Patient 8. (J. 11822-23).

73. As of September 19, 2006, the Respondent was treating Patient 8's low back pain with Duragesic, 50 mcg/hr, every three days; and hydromorphone-acetaminophen 10/325, 1 tab, four times a day. He was also prescribing Ativan, a benzodiazepine, 1 mg, 1 tab, five times a day. (J.11801).

74. On May 23, 2007, Patient 8 signed a chronic opioid therapy agreement. (J.11816-19).

75. As of August 8, 2012, the Respondent was treating Patient 8's low back pain with Duragesic, 50 mcg/hr, every two days; and hydromorphone-acetaminophen 10/325, 1 tab, four times a day; and Oxycodone, 30 mg, 1 tab, four times a day. He was also prescribing Ativan, a benzodiazepine, 1 mg, 1 tab, five times a day. (J.11801).

76. On January 16, 2013, Patient 8 provided a specimen for drug testing. (J.11716). The specimen tested negative for Oxycodone and showed a low level of fentanyl. Patient 8 recently had been in an emergency room with hallucinations. (J.11725-26). The Respondent has enlisted Patient 8's wife to assist with Patient 8's compliance with his medications.

77. As of March 10, 2014, the Respondent was treating Patient 8's low back pain and peripheral neuropathy with Duragesic, 75 mcg/hr, one per day; Oxycodone, 30 mg, 1 tab, four times per day; and hydrocodone-acetaminophen, 10/325 mg, 1 tab, four times per day. He was also prescribing Xanax, 2 mg, 1 tab, four times per day. (J.11708-09).

78. During the period under review, the Respondent saw Patient 8 for office visits on September 23, 2013, November 18, 2013, January 13, 2014, February 19, 2014, and April 14, 2014. (J.11353-55; J.11351-52); J.11349-50; J.11347-48; J.11344-46).

Patient 9 [redacted]

79. Patient 9 [redacted] is a sixty-one-year-old woman, who has been the Respondent's patient since at least 1991.

80. Patient 9's diagnoses have included cervical neck pain, bunion surgery, osteoarthritic changes to the lumbar spine, degenerative joint disease of her left hip and both knees, and a total right hip replacement in 2008.

81. Patient 9 had a physical therapy assessment for cervical pain in 1995, but she did not return for treatment. (J.12223-25).

82. A MRI of Patient 9's cervical spine conducted on April 16, 1996 showed degenerative disk disease with posterior spondylotic changes at C5-6 and C6-7. (J.12194).

83. A diagnostic evaluation of Patient 9's lumbar spine conducted on May 1, 1996 showed some mild narrowing at L5-S1 suggesting some degenerative disk change. (J.12193).

84. The Respondent has treated Patient 9 with opioid pain medication since at least 1996. The medications have included Percocet, morphine, Dilaudid, and Duragesic patch. There are several references in Patient 9's medical records of her reporting that her medications were

stolen, a sign of possible medication misuse or diversion. (*e.g.* J.11897; J.11912; J.11953; J.12056).

85. The Respondent has prescribed Xanax for Patient 9 since at least 1993. (J.12145).

86. In 2006, the Respondent expressed his concern to Patient 9 about her use of pain medication and the fact that her physical examination was not consistent with her description of her symptoms. (J.12118-22).

87. In January 2008, the Respondent was treating Patient 9's right hip pain with MS Contin, 60 mg, 1 tab, four times a day; and a Duragesic patch. The orthopedic surgeon who eventually performed the right hip replacement on Patient 9 was concerned about the "inappropriate" levels of pain medication prescribed for Patient 9, and insisted that she wean down on the medications before surgery and attempt to stop medications post-surgery. (J.12198-J.12200).

88. As of December 3, 2010, after Patient 9's hip replacement, the Respondent was not prescribing opioid pain medication for Patient 9. She was prescribed Suboxone, an opioid antagonist, by another doctor. (J.11936).

89. As of September 14, 2011, the Respondent was treating Patient 9's low back and neck pain with Percocet, 1 tab, four times per day; Butrans (bupronephrine, an opioid antagonist); and a non-steroidal anti-inflammatory. He was also prescribing Xanax, 2 mg, 2 tabs, twice per day. (J.11912).

90. On December 19, 2011, the Respondent injected Patient 9's left knee with a steroid. He also prescribed Oxycodone, 30 mg, 1 tab, four times a day, as needed. (J.11903-J.11904).

91. On February 22, 2012, Patient 9 reported that she had been in a "near-accident" and possibly suffered whiplash. She had used a thirty-day supply of Oxycodone, 15 mg, in twelve days. The Respondent refused to write a prescription for additional Oxycodone and threatened to refer Patient 9 to pain management. (J.11892).

92. On June 7, 2012, Patient 9 complained of severe back pain and she had again taken more pain medication than she had been prescribed. The Respondent again threatened to refer Patient 9 to pain management. (J.11883)

93. As of June 7, 2012, the Respondent was treating Patient 9's pain with Dilaudid, 4 mg, 1 tab, four times per day; and Oxycodone, 30 mg, 1 tab, four times per day. He was also prescribing Xanax, 2 mg, 2 tabs, twice per day. (J.11883).

94. As of June 11, 2013, the Respondent was treating Patient 9's pain with MS Contin, 60 mg, 1 tab, three times per day; and Oxycodone, 30 mg, 1 tab, four times per day. He was also prescribing Xanax, 2 mg, 2 tabs, twice per day. (J.11876).

95. As of March 5, 2014, the Respondent was treating Patient 9's pain with MS Contin, 60 mg, 1 tab, three times a day; and Oxycodone, 30 mg, 1 tab, four times per day. He was also prescribing Xanax, 2 mg, 1 tab, four times per day. (J.11856-57).

96,. On January 6, 2003 and May 7, 2007, Patient 9 signed a chronic opioid therapy agreement. (J.12158-59; J.12153-56).

97. On November 12, 2002, June 29, 2007, September 23, 2008, and November 12, 2013, Patient 9 submitted specimens for drug testing. (J.12171; J.12170; J.12164-65; J.11864-65).

98. During the period under review, the Respondent saw Patient 9 for office visits on September 16, 2013, November 12, 2013, January 9, 2014, and March 5, 2014. (J.111862-63; J.11860-61; J.11858-59; J.11856-57).

Patient 10 (redacted)

99. Patient 10 (redacted) is a sixty-four-year-old woman, who has been the Respondent's patient since at least 1994.

100. As of July 27, 2007, the Respondent was treating Patient 10's back pain with OxyContin, 80 mg, 1 tab, three times a day; OxyContin, 40 mg, 1 tab, twice a day; and Percocet, 1 tab, four times a day. He also prescribed Valium, 10 mg, 1 tab, twice a day. (J.12324).

101. As of October 10, 2010, Patient 10 was diagnosed with major depression, low back pain, and osteoarthritis of her knees. As of that date, the Respondent was prescribing OxyContin, 80 mg, 2 tabs, twice a day; and Oxycodone, 30 mg, 1 tab, four times a day. He also prescribed Valium, 10 mg, 1 tab, three times a day; and bupropion XL, an atypical anti-depressant, 300 mg, 1 tab per day. (J.12297-98).

102. In 2010-2011, the Respondent treated Patient 10's knee pain with Simvisca shots; he also referred her to a chiropractor for her back pain. (J.12292-96; J.12274-75).

103. A MRI of Patient 10's lumbar spine performed on March 28, 2013 showed multi-level degenerative changes of the spine. (J.12407-08).

104. A MRI of Patient 10's knees performed on March 28, 2013 showed advanced arthritic changes in both knees. (J.12409-10).

105. A MRI of Patient 10's pelvis performed on March 28, 2013 showed moderate degenerative changes in Patient 10's left hip. (J.12415).

106. In 2013, Patient 10 had a total left hip replacement. (J.12251).

107. As of March 19, 2014, the Respondent was treating Patient 10's low back pain and knee pain with OxyContin, 80 mg, two tabs, twice per day; and Oxycodone, 30 mg, 1 tab, five times per day. He was also prescribing Valium, 10 mg, 1 tab three times per day. (J.12235-36).

108. On March 18, 2009, Patient 10 provided a specimen for drug testing. (RESP #13).

109. During the period under review, the Respondent saw Patient 10 for office visits on September 19, 2013, November 25, 2013, February 5, 2014, and March 19, 2014. (J.12235-36; 12237-38; 12239-40; 12241-42).

110. On April 9, 2014, Patient 10 had a right total knee arthroplasty (replacement).

DISCUSSION

The Board alleged that the Respondent failed to meet appropriate standards as determined by appropriate peer review for delivery of quality medical care in connection with his prescribing of opioids and non-opioids to eight patients for the treatment of chronic pain. Md. Code Ann., Health Occ. § 14-404(a)(22) (Supp. 2015). The Board's charges against the Respondent are based, in part, upon peer reviews of the medical records of those eight patients: Patient 1, Patients 3-6, and Patients 8-10. The Board generally alleged that the Respondent: (a) failed to provide sufficient justification in the treatment record, including assessment of pain complaints through medical history, physical examination, and diagnostic studies that support prescribing high doses of opioids on a chronic basis; (b) prescribed high doses of opioids, potent controlled dangerous substances (CDS) with high misuse and diversion potential, in large quantities, on a chronic basis, without adequate compliance monitoring and at inappropriate follow-up intervals; (c) prescribed medications with opioid potentiating effects, such as benzodiazepines, to patients for whom he has prescribed large quantities of opioids, which compromises patient safety, and

without an explanation of the rationale for such use on a chronic basis; and (d) failed to recommend and refer patients requiring high doses of controlled substances over many years to a pain specialist for consultation and/or treatment. Allegation (a) likely applies to all eight patients, but the Board listed it in its patient-specific charges only as to Patients 1, 3, 6, 8, 9, and 10, although in regards to Patients 8 and 9, the Board specifically alleged that the Respondent prescribed high doses of opioids without identifying the specific characteristics of the patients' pain; the part of allegation (b) related to inappropriate follow-up intervals and allegation (d) apply to all eight patients. The part of allegation (b) related to inadequate compliance monitoring (drug testing) applies to Patients 3, 4, 5, 8, and 10; and allegation (c) applies to Patients 3, 5, and 9. The Board also alleged that the Respondent violated a standard of care because he failed to obtain a yearly ECG of Patient 4 to assess QTc changes in the heart rhythm based on Respondent's concomitant prescribing of high dose methadone in a patient who has a history of cardiac disease. Finally, the Board alleged that the Respondent violated standards of care related to Patient 10 because he failed to obtain a chronic opioid treatment agreement with her and failed to document the characteristics of her pain.

The record in this case, frankly, is less than ideal in that it contains little evidence of an established, objective standard of care for the treatment of non-cancer chronic pain with opioids and non-opioids. Neither party presented much in the way of medical literature to establish the applicable standard of care. Instead, the State's expert, Dr. Kornbluth, testified as to his understanding of the standard of care, relying mainly on his own practice, and the Respondent's expert, Dr. Wolf, testified that the applicable standard of care for the treatment of chronic pain essentially relies on each physician's clinical judgment, guided by the physician's experience and a consensus drawn from medical research that was not specific to the treatment of non-

cancer chronic pain. (RESP #3). Neither Dr. Kornbluth nor Dr. Wolf presented a very thoughtful explanation of the standard of care for chronic pain; each advocated for their party's position, but did not provide much objective information concerning the applicable standard of care. Dr. Wolf testified that physicians in Maryland are attempting to develop a standard of care for the treatment of chronic pain and that other states have developed very specific requirements for such treatment, but she did not explain the content of those standards. (T.537-538). The parties also each referred to a book by David Fishman, M.D., "Responsible Opioid Prescribing," but neither party submitted it into evidence.

The only written standard of care in the record is a statement from the American Academy of Pain Medicine (AAPM), entitled "Use of Opioids for the Treatment of Chronic Pain," which was provided to the Board by the Respondent but admitted as a joint exhibit.[2] The AAPM's statement contains a standard of care that is less rigorous than the standard testified to by Dr. Kornbluth, but which does set forth some objective standards that even Dr. Wolf should be able to support. It is important to note that the standard of care for the treatment of chronic pain contains elements that are more universal precautions or best practices, some of which are not related to patient care, but to public health concerns about the diversion of opioids for sale or recreational use, and the risk of overdose and addiction associated with such use.

The standard of care suggested by the AAPM is as follows:

> **Opioids should be prescribed only after a thorough evaluation of the patient, consideration of alternatives, development of a treatment plan tailored to the needs of the patient and minimization of adverse effects, and on-going monitoring and documentation.**

[2] The State offered into evidence two final orders of the Board and one proposed decision of an administrative law judge related to the Respondent. The final order of July 30, 2014, which was admitted as part of STATE #5, referred to and adopted findings of fact in a proposed decision that set forth a standard of care for prescribing opioids for chronic pain. Unfortunately, the State did not submit that relevant proposed decision, but instead offered, also as part of STATE #5, a proposed decision related to the Board's final order of July 22, 2013. That proposed decision contained a very outdated standard of care for prescribing opioids for chronic pain that was not helpful to my decision.

AAPM believes that guidelines for prescribing opioids should be an extension of the basic principles of good professional practice.

Evaluation of the patient: Evaluation should initially include a pain history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous treatments, a drug history, and an assessment of coexisting diseases or conditions. When appropriate, the patient should undergo a baseline drug screening.

Treatment plan: Treatment planning should be tailored to both the individual and the presenting problem. Consideration should be given to different treatment modalities, such as an interventional approach, a formal pain rehabilitation program, the use of physical medicine and psychological and behavioral strategies, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. If a trial of opioids is selected, the physician should ensure that the patient or the patient's guardian is informed of the risks and benefits of COT [chronic opioid therapy] and the conditions under which opioids will be prescribed. AAPM has recently updated its guidance for the proper consent for the use of opioids. A trial of opioids implies setting expectations that the medications will be prescribed for a short period of time. Continued use will be contingent upon demonstrated improvement in analgesia, physical function and quality of life – the absence of significant adverse events and maladaptive behaviors.

Consultation as needed: Consultation with a pain medicine or other specialist may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem. The management of pain in patients with a history of addiction or a comorbid psychiatric disorder requires special consideration.

Periodic review of treatment efficacy: Review of treatment efficacy should occur frequently to assess the functional status of the patient, continued analgesia, adverse effects, quality of life, and indications of medication misuse. Monitoring of compliance is a critical aspect of chronic opioid prescribing, using such tools as random urine drug screening, pill counts, and where available, review of prescription monitoring data base reports. Close follow-up and reexamination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life as a result of opioid use.

Documentation: Documentation is essential for supporting the evaluation, the reason for opioid prescribing, the overall pain management treatment plan, any consultations received, and periodic review of the status of the patient.

(JOINT #11).

For this decision, I have used the AAPM's statement as guidance on the standard of care for prescribing opioids and methadone for the treatment of chronic pain because it contained the best evidence in the record of an objective standard. I do not suggest that the Board should adopt the AAPM's statement as the standard of care in this State.

Sufficient justification in the treatment record to support prescribing high doses of opioids on a chronic basis

The Board alleged that the Respondent failed to provide sufficient justification in the treatment record, including assessment of pain complaints through medical history, physical examination, and diagnostic studies that support prescribing high doses of opioids on a chronic basis. As to the specific patients, the Board alleged that the Respondent: prescribed inordinately high doses of opioids for Patient 1 without medical justification; prescribed inordinately high doses of opioids for Patient 3 with no obvious pathology and without medical justification; failed to document significant identifiable pathology and a diagnosis prior to prescribing opioids for Patient 6 that would justify the use; prescribed high doses of opioids without clearly identifying the characteristics of Patient 8's pain complaints; failed to document the specific characteristics of Patient 9's pain complaints that support prescribing high doses of opioids; and prescribed excessively high doses of opioids to Patient 10 without medical justification. The language of some of the patient-specific charges seemingly modifies the basic charge that the Respondent prescribed too much pain medication for too long a time to these six patients. For example, the Board alleged that the Patients 3 and 6 did not have obvious or identifiable pathology to justify the high doses of opioids prescribed by the Respondent and that the Respondent failed to identify the characteristics of the pain experienced by Patients 8 and 9 that would justify prescribing high doses of opioids. In my discussion, I will address these patient-specific allegations, but I will focus on the general allegation that the Respondent did not have sufficient justification in the

treatment record to support his prescribing high doses of opioids and methadone on a chronic basis.

Based primarily on the AAPM's standard of care for chronic pain, as supplemented by the opinions of Dr. Kornbluth and Dr. Wolf, I conclude that the Respondent failed to justify his prescribing very high doses of opioids and non-opioids on a chronic basis to at least the six patients included in the specific charges. Dr. Kornbluth testified, specifically as to Patient 1, but equally applicable to the other five patients, and consistent with the AAPM's guidelines, that pursuant to the standard of care for the treatment of chronic pain with opioids, there should be "sufficient justification in the treatment record including thorough history, examination to support the level of opioids that were prescribed." (T. 90). He also testified: "For this level of medication, one would have had to have failed lower doses . . . have generally multiple surgeries and/or cancer to justify this level of opioid prescribed, severe misalignment of a joint or other profound pathology . . . ." (T. 90-91). Dr. Kornbluth described the levels of opioids prescribed by the Respondent as "inordinately high," (T.91), "excessive," (T.92), "unjustifiable," (T.106), "irresponsibly high," (T.135, 137), "inexcusably and unjustifiably high," (T.148). Dr. Kornbluth further testified that in assessing a patient's pain a physician would want to "understand the pain condition, where the pain is, how intense the pain is, the character of the pain, whether it's more of a . . . burning sharp pain or more of a dull achy pain, what makes it better, what makes it worse, how long has . . . the pain been in existence, whether it's getting better or whether it's getting worse, what the patient has done previously to treat the pain and the effects of prior treatments, what the patient is interested in for pain control." (T. 79-80).

Dr. Kornbluth conceded that these six patients had pain-generating conditions, but he maintained that despite these conditions, the Respondent had failed to provide sufficient

justification in the treatment record to support prescribing the high doses of opioids on a chronic basis. The Respondent questioned the basic concept of "high dose," arguing that a patient's tolerance of the pain medication – the need for a larger dose to obtain pain relief – must be considered, and that as long as the patient is getting pain relief, is functional, and not having unacceptable side effects, there is no established dose that is too high. Dr. Wolf indicated that there is no common standard with regard to an appropriate twenty-four hour dose of opioid medication. (RESP #3). Dr. Kornbluth testified, with hesitancy, that some physicians and health-care regulators consider an opioid dose that is equivalent to a morphine dose of 100 mg to be a high dose. The Respondent cited a standard of a 160 mg morphine equivalent dose, (JOINT #11), and Dr. Wolf testified that the concept of morphine equivalence is not an exact science, but that a high opioid dose would be a 300 mg morphine equivalent dose. The parties did not translate the opioid doses prescribed for the eight patients under review into morphine equivalents, but Dr. Kornbluth testified and Dr. Wolf acknowledged that at least some of the eight patients at issue in this case were receiving opioid doses of at least 500 mg morphine equivalents. (T.273-274; T.491). In reaching my conclusions concerning the doses of pain medication prescribed by the Respondent, I relied extensively on Dr. Kornbluth's descriptions of the doses of opioids prescribed by the Respondent. It was clear to me that the dosages prescribed by the Respondent appeared to shock Dr. Kornbluth, an experienced pain management doctor, and Dr. Wolf conceded that the Respondent was prescribing high doses of pain medication; she only balked at describing them as excessively high. (T.49).

Ultimately, on this record I concur with the State and Dr. Kornbluth's opinion that the high opioid and non-opioid doses prescribed by the Respondent on a long-term basis to the six patients under review cannot be justified pursuant to the applicable standard of care based on the

patients' conditions. The patients all had conditions that generate pain, but no condition so severe as to justify the long-term, in some cases decades-long, use of high opioid and non-opioid doses of medication. The patients' medical records do not reflect that any of them had the profound pathology that Dr. Kornbluth testified might justify such high doses of pain medication over such a long period of time.

Patient 1, for example, has chronic pain from a herniated cervical disk and intermittent pain from migraines. Patient 1 has declined surgery on her neck and she has practiced some yoga to alleviate pain. Patient 1 testified at the hearing and she presented as a physically fit woman who has a relatively reasonable level of functioning: she indicated that she can care for her children, clean her house, and do occasional child care for money. Since at least January 3, 2011, the Respondent has treated Patient 1's cervical neck pain, in part, with OxyContin 60 mg, 1 tab, every 12 hours; and another opioid, Oxycodone, 15 mg, 2 tabs, four times a day. The Respondent also prescribed, in part, Dilaudid, 4 mg, 1 tab, as needed, for Patient 1's migraines. The Respondent testified, pursuant to his general practice, that he prescribed the OxyContin (an extended-release version of Oxycodone) as a long-acting pain medication, in conjunction with the Oxycodone, a short-acting pain medication for breakthrough pain. The short-acting pain medication is designed to be taken as needed when the long-acting pain medication is insufficient. The Respondent's patients, however, such as Patient 1, seem to take all of the long-acting and short-acting pain medication every day. The Respondent seemingly made no effort to determine how Patient 1 (or any of his other patients) was using the Oxycodone and whether she could use less Oxycodone. Patient 1 also was prescribed Dilaudid every month even though, according to the Respondent, she only used the Dilaudid as needed for migraines, which recently have not been a significant problem for Patient 1. On this record, I have to concur with Dr.

Kornbluth that Patient 1 has been on an inordinately high level of opioids, at least 240 mg of Oxycodone per day plus whatever Dilaudid she uses, for a long period of time for neck pain and occasional migraines. The Patient's ability to function and the absence of side effects do not justify this dosage level or, as discussed below concerning referrals to a pain management specialist, the Respondent's reliance on opioids as the primary treatment for chronic pain.

I also concur with Dr. Kornbluth's opinion that the Respondent has prescribed inordinately high doses of opioids for Patient 3 without medical justification. Since at least January 3, 2011, the Respondent has treated Patient 3's abdominal pain, back pain, neck pain, and shoulder pain with morphine, 60 mg, 2 tabs, three times per day; and Oxycodone, 30 mg, 2 tabs, four times per day. The source of Patient 3's abdominal pain has been diagnosed as gastritis or, possibly, adhesions from endometriosis. Patient 3 has had a long-standing diagnosis of lower back pain, and, as shown on an MRI of her cervical spine, she has degenerative disc disease mostly at C5-C6 and C6-C7 with broad-based bulging and posterior osteophytes. Patient 3 clearly has pain generators, but the amount of her long-acting pain medication – 360 mg of morphine – itself is well above what even Dr. Wolf defined as a high dose of opioids. When the 240 mg of Oxycodone is added to the morphine, the amount of the pain medication prescribed by the Respondent for Patient 3 for abdominal, back, and neck pain is simply unreasonable.

I also concur with Dr. Kornbluth's opinion that the Respondent has prescribed inordinately high doses of opioids for Patient 6 without medical justification. Patient 6's diagnoses include a history of trigeminal neuralgia, which has not recently been symptomatic, fibromyalgia, and lower back and bilateral hip pain. The Respondent has prescribed Lyrica, a non-opioid, for Patient 6's fibromyalgia, but he has also prescribed opioids for all of the patient's pain. The diagnostic test in the medical records, however, showed no abnormality in Patient 6's

lumbar spine and the patient has not cooperated with obtaining other diagnostic tests. The Respondent has treated Patient 6's pain with MS Contin, 100 mg, 1 tab, three times a day; and Oxycodone, 30 mg, 1 tab, six times a day. The amount of Patient 6's long-acting pain medication – 300 mg of morphine – itself is equal to what even Dr. Wolf defined as a high dose of opioids. When the 180 mg of Oxycodone is added to the morphine, the amount of the pain medication prescribed by the Respondent for Patient 6 for fibromyalgia and back and hip pain, without significant diagnostic conformation of a pain source, is again simply unreasonable because these diagnoses do not support such a prescription regimen.

The Board charged the Respondent with violating this standard of care because he prescribed high doses of opioids without clearly identifying the characteristics of Patient 8's and Patient 9's pain complaints that support prescribing high doses of opioids. This is a variation on the charge of prescribing high doses of pain medication without sufficient justification in that it adds the failure to characterize the patients' pain. I concur with Dr. Kornbluth's opinion as to Patient 8 and Patient 9. Patient 8 has been diagnosed with lower back pain, but there is no diagnostic test of the patient's lumbar spine in the medical records and no significant description of his pain. Patient 8 has also been diagnosed with kidney stones and peripheral neuropathy, but again there is no significant description of his pain in the medical records. It is very difficult to discern from the medical records why Patient 8, a difficult patient with a serious mental illness, is on high doses of fentanyl, hydromorphone, and Oxycodone. Patient 9 has been diagnosed with neck, back, hip, and knee pain; she had a total hip replacement in 2008 and she was weaned off of her pain medication. The Respondent, however, based on Patient 9's complaints of low back pain and neck pain, neither of which is well-supported by diagnostic imaging, started prescribing

opioids to Patient 9 again, starting in 2011. It is this most recent prescribing, which continued through the review period that supports this charge against the Respondent.

As to Patient 10, the Board charged with violating the standard of care because he prescribed high doses of opioids without justification and separately because he failed to clearly identifying the characteristics Patient 10's pain. The Respondent's treatment of Patient 10 presents the closest call on whether the Respondent violated this standard of care. As of July 27, 2007, the Respondent was treating Patient 10's back pain with 320 mg of OxyContin and Percocet. The medical records do not contain any contemporaneous diagnostic tests to support that level of pain medication. Later, in 2010-2011, the Respondent treated Patient 10's knee pain with Simvisca shots, and referred her to a chiropractor for her back pain. A MRI of Patient 10's lumbar spine performed on March 28, 2013 showed multi-level degenerative changes of the spine; a MRI of Patient 10's knees performed on March 28, 2013 showed advanced arthritic changes in both knees, and a MRI of Patient 10's pelvis performed on March 28, 2013 showed moderate degenerative changes in Patient 10's left hip. In 2013, Patient 10 had a total left hip replacement. Obviously, in 2013, there was better diagnostic support for the Respondent's prescribing of high doses of opioids to Patient 10. As of March 19, 2014, the Respondent was treating Patient 10's low back pain and knee pain (for which Patient 10 had a right total knee replacement in April 2014) with 320 mg of OxyContin and 150 mg of Oxycodone. Ultimately, I accept Dr. Kornbluth's opinion that these levels of opioids are not justified even for someone with these specific pain generators.

I do not find, however, that the Respondent failed to document the characteristics of Patient 10's pain complaints. Patient 10 had pain from degenerative joint disease, which is self-

explanatory, and I doubt that any further description of her pain would have served any clinical purpose.

Referral to a pain management specialist

As to all eight patients, the Board, using slightly different language each time, charged that the Respondent violated the applicable standard of care by not referring the patient to a pain management specialist. For Patients 1, 3, and 10, the Board noted that the Respondent had treated the patient with opioids for at least ten years. Dr. Kornbluth testified that "[c]hronic pain specialists have more advanced training in the management [and] evaluation of chronic pain and oftentimes and most times they have more developed mechanisms to assess compliance and other alternatives to patients beyond just the use of medications." (T.78). Both Dr. Kornbluth and Dr. Wolf testified that pain management (or pain medicine) is a recognized medical specialty, in which specially trained physicians treat pain through a variety of modalities, which include the prescription of opioids.

Dr. Wolf inexplicably testified that the Respondent did not violate the standard of care on this issue because: "[t]the record made it clear that he's either referred or has attempted to refer patients to pain management specialists." (T.333). There is simply no support in the record for Dr. Wolf's assertion. The Respondent claimed in a summary of treatment that he referred Patient 3 to pain management with a Dr. Barnett in 2008, (J.10691), but there is no confirmation of that assertion in the medical records. Patient 5 was referred to pain management after his release from the hospital following his motor vehicle accident, but that referral was made by the Respondent's colleague. The Respondent threatened to refer Patient 9 to a pain management specialist, but only in response to her misuse of her prescribed medications. I find no evidence that the Respondent ever referred any of the eight patients under review for meaningful consultation with

or comprehensive treatment by a pain management specialist. The Respondent's defense of his failure to refer patients to a pain management specialist was a rambling statement that most of his referrals to pain management were for specific procedures, such as an injection or a diagnostic test, and which then segued into a discussion of referrals for mental health treatment. (T.605-607). It was telling that Patient 1 testified that she thought the Respondent was a pain management specialist, (T.426), and the Respondent himself, especially with his critique of the courses in pain he took during his suspension, seems to consider himself a pain management specialist. But the Respondent seems to lack a basic understanding of what a pain management specialist could do for his patients. He failed to consider that a pain management specialist could provide a more comprehensive approach to pain management, one that did not rely primarily on high doses of opioids or methadone for long periods of time. Most significantly, the Respondent did not consider, as testified to by Dr. Kornbluth, that a pain management specialist would wean the patients down from their high doses of opioids and methadone. (T.125). Even the standard of care urged by the AAPM recognizes that consultation with a pain medicine may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem, and encourages the use of different treatment modalities, including an interventional approach, such as injections; the use of physical medicine, such as physical therapy; a formal pain rehabilitation program, involving, in part, weaning off of opioids; and psychological and behavioral strategies. (JOINT #11). The Respondent has sporadically included different treatment modalities, but the medical records establish that his primary treatment for chronic pain is large doses of pain medication for an undetermined length of time, with no plan to wean patients off of the medication or to consistently use other treatment modes.

On this record, I conclude that the applicable standard of care required the Respondent, a primary care physician, to refer each of the eight patients under review to a pain management specialist, and that the Respondent violated this standard of care as to each patient. I believe this to be the Respondent's most egregious violation of the standard of care for treating his chronic pain patients, one which alone warrants significant sanctions. The Respondent, despite some success in making at least Patient 1 and Patient 5 reasonably functional, has also made them and his other patients dependent on opioids or methadone, without the viable alternatives that could be offered in a more comprehensive approach to treating pain.

Monthly Office Visit

As to all eight patients, the Board, using slightly different language each time, charged that the Respondent violated the applicable standard of care by not seeing each patient for an office visit at least monthly. The Board charged that: the Respondent failed to: see Patient 1, a 48 year old patient with multiple co-morbidities and using high doses of opioids, at least monthly; consistently see Patient 3, a 51 year old patient with complex medical and mental health issues, using high doses of opioids, and with a very high risk of abuse, overdose, suicide and/or diversion, at least monthly; closely monitor and consistently see Patient 4, a 62 year old patient with a cardiac history, who is receiving high amounts of methadone which creates a risk of cardiac and/or respiratory consequences, at least monthly; see Patient 5, a 30 year old male with a history of alcohol and opioid dependence for whom Respondent is prescribing high doses of opioids, stimulants, and benzodiazepines, at least monthly; see Patient 6, a 39 year old female for whom Respondent is prescribing very high doses of opioids, at least monthly; see Patient 8, a 62 year old male with a history of noncompliance for short term follow-up of monthly visits; see Patient 9, a 59 year old female for whom he is prescribing high doses of opioids, every month;

and to see Patient 10, a 62 year old female on excessively high doses of opioids for 10 years, at least monthly.

On the record in this case, I find that the Board failed to prove that there is an applicable standard of care that required the Respondent to see each chronic pain patient for an office visit at least monthly. Dr. Kornbluth testified that monthly follow-ups were required so that the patients were "closely monitored to make sure that medications were being taken appropriately." (T. 118). He also testified that close monitoring was especially important for patients with comorbidities, including psychiatric or addiction comorbidities. (T.172). Dr. Kornbluth conceded, however, that there is no set interval for the time between visits for a stable non-cancer chronic pain patient: "There is no set interval. However the standard of care is such that patients on these levels of medications need to be frequently assessed and the standard of care is such that they should be assessed every month or more often. There's no set written interval. The literature is taken that they, to my knowledge, have to be seen monthly. It's proper and good medical care to do that." (T.160). Dr. Kornbluth did not cite to any specific medical literature to support his testimony. The Board's other peer reviewer, Jeffrey A. Schneider, M.D., also endorsed an interval of one month between office visits to assess compliance with the medications and to document the patient's analgesia (pain relief), activities of daily living (functioning), adverse side effects, and aberrant drug-using behaviors. (BOARD #12). Dr. Schneider also did not cite any specific medical literature to support his opinion.

Dr. Wolf testified that there is no standard of care for how often a non-cancer chronic pain patient must be seen for an office visit, and that the interval for office visits is based on the physician's clinical knowledge of the patient. (T.337). She emphasized that the eight patients

under review were long-term patients of the Respondent whose medical issues and medication doses were stable. (T.337).

On this record, I conclude that the applicable standard of care is less rigid than asserted by the Board in that it requires a physician, either a primary care physician or a pain management specialist, to exercise clinical judgment and to see a patient on chronic opioid therapy for non-cancer pain at appropriate follow-up intervals to assess compliance with the medications and to document the patient's pain relief, functioning, adverse side effects, and aberrant drug-using behaviors. For some patients, especially new patients, a monthly follow-up might be required; however, each of the eight patients reviewed was a long-term patient of the Respondent on stable doses of opioid medication, with no recent significant changes in symptoms or pain relief or functioning, and, with the notable exceptions of Patient 8 and Patient 9, no recent indications of aberrant behavior. For these particular patients, with the exception of Patient 8 and Patient 9, the two-month follow-up interval employed by the Respondent constitutes a reasonable exercise of his clinical judgment, and is consistent with a standard of care that requires appropriate monitoring of patients on chronic opioid therapy. Patient 8 has bipolar disorder and he has lost or misused his pain medication, and he had an episode of psychosis in January 2013. The Respondent testified that he relied on Patient 8's wife to assist in monitoring Patient 8. Patient 9, over a long period of time, exhibited problematic behavior concerning her pain medication by reporting that it was stolen and by taking more pain medication than the Respondent had prescribed. Patient 8 and Patient 9 are the kind of patients that need to be seen at least monthly. The Board, as a matter of setting forth universal precautions concerning patients on chronic opioid therapy could impose a monthly visit requirement, but that standard is not required for proper patient care for six of the eight patients under review. With the exception of Patient 8 and

Patient 9, the Respondent did not violate the applicable standard related to the frequency of follow-up visits for his patients on chronic opioid therapy.

Random drug testing

As to Patients 3, 4, 5, 8, and 10, the Board charged that the Respondent violated the applicable standard of care by not conducting adequate compliance monitoring through random drug testing. One purpose of random drug testing is to confirm that the patient is taking the prescribed medication. This is important for the patient, but it also serves a public health purpose because it shows that the patient is not diverting the medications, some of which have a significant street value as a recreational drug. Another purpose of random drug testing is to confirm that the patient is not taking medication that was not prescribed or illegal medications. Dr. Kornbluth testified that the Respondent failed to comply with the applicable standard of care by not performing random drug testing on these five patients during the period subject to peer review – September 2013 through early April 2014. According to Dr. Kornbluth, random drug testing should be performed on patients on high doses of opioid medication "every three months or perhaps more often." (T.161). Dr. Kornbluth conceded that, according to one authoritative source, "Responsible Opioid Prescribing," by David Fishman, M.D., the frequency of random drug testing is left to the physician's clinical judgment. (T.191-192). Dr. Kornbluth also conceded that he could not cite any medical literature "to suggest that there is a difference in outcome with regards to abuse, diversion, addiction and medications if drug testing is done every three months versus every six months." (T.213).

Dr. Wolf testified that there is no established standard as to the frequency of drug testing because it is a clinical decision to be made based on the individual patient. (T. 331). The Respondent testified that although his goal is to conduct a random drug test on each patient once

a year, he also exercises clinical judgment based on his knowledge of his patients and often does not perform a random drug test on a patient that he does not suspect is misusing the medications. The Respondent also cited the cost of the random drug tests and cited medical literature that suggested that random drug testing does not result in better patient outcomes.

On this record, I conclude that the applicable standard of care is less rigid than asserted by the Board in that it requires a physician, either a primary care physician or a pain management specialist, to exercise clinical judgment and to conduct random drug testing of a patient on chronic opiate therapy for non-cancer pain at appropriate intervals to assess compliance with the medications. As a universal precaution, however, the standard of care for a long-term patient on chronic opiate therapy for non-cancer pain requires at least an annual random drug test, although a semi-annual drug test is probably better. Even the Respondent, who largely disparaged random drug testing, testified that his goal is an annual random drug test for each of his chronic pain patients.

According to the medical records Patient 3 last provided a specimen for random drug testing on September 22, 2008, (J.10893; J.10703-04)[3]; Patient 4 last provided a specimen for random drug testing on July 16, 2009, (J.11104-10); Patient 5 last provided a specimen for random drug testing on March 1, 2013, (J.11175); and Patient 8 last provided a specimen for drug testing on January 16, 2013. (J.11716). There is no record of Patient 10 providing a specimen for random drug testing during her treatment by the Respondent. It is obvious from the medical records that the Respondent has not taken seriously the use of random drug testing for his chronic pain patients. As to these five patients, the Respondent violated even the more

[3] In her supplemental report and testimony, Dr. Wolf referred to a random drug test of Patient 3 that was conducted on August 27, 2014. I have not considered this drug test because it was conducted after the period subject to peer review.

relaxed standard of care of an annual random drug test that I have found to be the applicable standard based on the record in this case.

Prescribing benzodiazepines for patients on chronic opioid therapy

As to Patients 3, 5, and 9, the Board charged the Respondent with violating a standard of care that required him to refrain from prescribing high doses of opioids in conjunction with prescribing benzodiazepines, such as Valium and Xanax, with opioid potentiating effects, without justification. Dr. Kornbluth testified that medications with opioid potentiating effects, such as benzodiazepines, should generally be avoided for patients on chronic opioid therapy because benzodiazepines, like opioids, can have a depressant effect on the central nervous system, which compromises patient safety. According to Dr. Kornbluth, benzodiazepines can be used safely to treat conditions such as muscle spasm or anxiety, for a short period of time at the lowest possible dose to achieve the desired effect. (T.75-77). Dr. Wolf testified that the Respondent did not violate this applicable standard of care because he was aware of the potential for a combination of opioids and benzodiazepines to compromise patient safety, he had a rationale for prescribing benzodiazepines on a long-term basis, and he was monitoring the patients. (T.333).

The Respondent testified that as a primary care physician he has to treat many conditions in his patients, including concomitant physical and mental health diagnoses. He asserted that he is aware of the risk of respiratory depression associated with the use of opioids and benzodiazepines, and that he monitored his patients for that risk.

The AAPM document entitled "Use of Opioids for the Treatment of Chronic Pain" provides a statement concerning the concomitant use of opioids and benzodiazepines:

> While respiratory depression can occur with patients taking opioids, the risk can generally be minimized if certain precautions are followed. For instance,

> concomitant use of other neuro-depressive drugs, such as benzodiazepines and alcohol, should be viewed with great caution, since the combination of these drugs has been shown to increase the risk of serious adverse events. . . . Finally, patients do not develop complete tolerance to the respiratory depressant effects of opioids and the risk of respiratory depression increases as dose increases, regardless of how long one is on opioids.

(JOINT #11).

On this record, I conclude that the applicable standard of care requires a physician prescribing high doses of opioids in conjunction with prescribing benzodiazepines, to exercise extreme caution due to the risk of adverse events, including death, related to respiratory depression. I further conclude that the Respondent violated this standard of care based on his concomitant prescribing of high doses of opioids and benzodiazepines on a chronic basis without sufficient justification and with no plan to wean the patients down from their doses of either the opioids or benzodiazepines. Patient 3 has been prescribed opioids and Valium since at least 2008; Patient 5 has been prescribed Xanax and Oxycodone since at least March 2014; and Patient 9 has been prescribed opioids and Xanax for over twenty years. The evidence in this record indicates that patients do not develop a tolerance for the respiratory depressive effects of opioids and benzodiazepines, and therefore remain at risk of respiratory depression. The Respondent has not exhibited reasonable caution in his concomitant use of opioids and benzodiazepines for his chronic pain patients.

Obtaining an annual ECG to assess QTc changes in the heart rhythm of Patient 4 who was prescribed methadone and who had a history of cardiac disease

As to Patient 4, the Board charged the Respondent with violating a standard of care that required him to obtain a yearly ECG to assess QTc changes in the heart rhythm based on the Respondent's concomitant prescribing of high dose methadone and his history of cardiac disease. The basis for this charge appears to be Dr. Schneider's peer review report, in which he wrote:

"With regards to the concomitant use of high dose methadone and fluoxetine in a patient with cardiac disease, ECG should be considered yearly for QTc changes." (BOARD #12). Dr. Kornbluth did not mention in his peer review report anything about a yearly ECG to assess QTc changes in the heart rhythm, but he did adopt the Board's charges against the Respondent. (BOARD #10 and BOARD #11). At the hearing, Dr. Kornbluth testified that the use of methadone was risky for a patient with a cardiac history, including a replacement of the aortic valves, but he did not testify to a standard of care that required the Respondent to obtain a yearly ECG of Patient 4. (T.109). I am not convinced on this record that the Board proved that there is a standard of care that required the Respondent to obtain a yearly ECG to assess QTc changes in Patient 4's heart rhythm. The strongest statement on this issue was made by the non-testifying peer reviewer, and that statement was not supported by any other compelling evidence.

Failing to obtain a signed consent for chronic narcotic therapy agreement from Patient 10

As to Patient 10, the Board charged the Respondent with violating a standard of care that required him to obtain a signed consent for chronic narcotic therapy agreement from every patient for whom he was prescribing opioids on a chronic basis. The Respondent testified that he had a chronic narcotic therapy agreement with all of his chronic pain patients, including Patient 10, but could not produce a copy of Patient 10's agreement (other than one signed after the review period) because of a problem with his office's computers that caused him to lose some older written medical records. On this record, I credit the Respondent's testimony that, pursuant to his long-standing practice, evidenced by chronic opioid therapy agreements with all of the other seven patients, that Patient 10 had signed such an agreement before the review period. I concur with the Respondent's position that the absence of evidence of Patient 10's chronic

opioid therapy agreement is not convincing evidence of its absence, at least at one time, from the patient's medical records.

Sanction

The State asked that I recommend that the Board reprimand the Respondent, and issue a new order of probation, with a term of eighteen months. As a condition of that probation, with an exception for patients with terminal cancer that the Respondent treats in nursing homes, the State proposed that the Respondent be ordered to terminate the pain management part of his medical practice – he shall not treat patients on an on-going basis with Schedule II controlled dangerous substances. Also, as a condition of that probation, the Respondent shall be subject to random audits to review his prescribing of controlled dangerous substances, and he shall comply with the Medical Practice Act. The Respondent argued essentially for another chance to continue to treat chronic pain patients because he claimed that the Board, in its prior orders, had not provided him with sufficient guidance or consistent standards of care for the treatment of chronic pain patients. The medical records, however, indicate that the Respondent's prescription practices concerning opioids and methadone have been problematic for a long time. Most notably, the orthopedic surgeon who operated on Patient 9's hip insisted that she be weaned down on her pain medications pre-surgery and off of her pain medications post-surgery. It was also obvious from the Board's orders in the Respondent's earlier disciplinary cases that the Board was concerned about the Respondent's prescribing practices. The State correctly argued that the Respondent appeared to learn very little from his earlier disciplinary proceedings or from the courses he took in 2013 on pain management. The Respondent was on notice that while he was on probation he was required to be familiar with and to comply with the standard of care for treating chronic pain.

Disciplinary proceedings against a physician are not intended to punish the offender but rather to protect the public. *McDonnell v. Comm'n on Medical Discipline*, 301 Md. 426, 436 (1984). The sanction requested by the State is within the regulatory guidelines of COMAR 10.32.02.09A(3) and COMAR 10.32.02.10B and the conditions of probation proposed by the State are reasonably related to the Respondent's offenses. COMAR 10.32.02.09A(5). I concur with the State' recommendations, most forcefully in its recommendation that the Respondent be prohibited from continuing his non-cancer chronic pain practice.

CONCLUSIONS OF LAW

Based on the above Findings of Fact and Discussion, I conclude that the Respondent violated the Probation Order of September 10, 2013 by failing to comply with section 14-404(a)(22) of the Medical Practice Act in the following twenty-four ways:

- failed to provide sufficient justification in the treatment record to support prescribing high doses of opioids on a chronic basis to Patients 1, 3-6, and 10;
- failed to sufficiently characterize Patient 8's and Patient 9's pain to justify prescribing high doses of pain medication;
- failed to refer Patients 1, 3-6, and 8-10 to a pain management specialist;
- failed to see Patient 8 and patient 9 for a monthly office visit;
- failed to conduct annual random drug testing on Patients 3-5, 8, and 10.

I further conclude that the Respondent did not violate the Probation Order of September 10, 2013 by failing to comply with section 14-404(a)(22) of the Medical Practice Act in the following nine ways:

- failed to characterize Patient 10's pain;
- failed to see Patients 1, 3-6, and 10 for a monthly office visit;

- failed to obtain an annual ECG to assess QTc changes in the heart rhythm of a Patient 4, who was on methadone and who had cardiac disease
- failed to obtain a signed consent for chronic narcotic therapy agreement from Patient 10

I further conclude that, as a result, the Board may discipline the Respondent. Md. Code Ann., Health Occ. § 14-404(a) (Supp. 2015).

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board against the Respondent for violation of section 14-404(a) (22) be **UPHELD,** in part. I further **PROPOSE** that the Board reprimand the Respondent, and issue a new order of probation, with a term of eighteen months. As a condition of that probation, with an exception for patients with terminal cancer that the Respondent treats in nursing homes, the Respondent shall be ordered to terminate the pain management part of his medical practice – he shall not treat patients on an on-going basis with Schedule II controlled dangerous substances. Also, as a condition of that probation, the Respondent shall be subject to random audits to review his prescribing of controlled dangerous substances, and he shall comply with the Medical Practice Act.

October 28, 2015
Date Ruling Issued

Robert F. Barry
Administrative Law Judge

RFB/kkc
#158299

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: Christine A. Farrelly, Executive Director, 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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