IN THE MATTER OF	*	**BEFORE THE MARYLAND**
Tristan J. Shockley, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D68884	*	**Case Number: 2014-0979**

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CONSENT ORDER

On September 24, 2015, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Tristan J. Shockley, M.D. (the "Respondent"), License Number D68884, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("Health Occ. II")§ 14-404(a) (2014 Repl. Vol.).

The pertinent provision of the Act provides:

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> ...
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]

On December 16, 2015, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

I. FINDINGS OF FACT

Disciplinary Panel B finds:

BACKGROUND

1. At all times relevant to these charges, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about March 24, 2009, and he is presently licensed through September 30, 2017.

2. The Respondent is board-certified in Physical Medicine and Rehabilitation.

3. At all times relevant to these charges, the Respondent practiced physical medicine and rehabilitation in private practices located in Laurel and Hyattsville, Maryland.[1]

4. On or about June 27, 2013, the Board issued to the Respondent an Advisory Letter and Notice of Re-Review based on an investigation conducted relating to allegations that the Respondent was overprescribing controlled dangerous substances ("CDS"). The Board notified the Respondent the reviewers had opined he had failed to meet standards of quality medical care in five of twelve records reviewed, and provided the Respondent with the reports in which the reviewers had opined that among other deviations in care, the Respondent had failed to "take reasonable precautions to attempt to prevent opioid misuse, abuse and/or diversion." Examples raised by the reviewers included several "red flags" such as early refill requests, inconsistent urine toxicology screens (positive urine toxicology screens for non-prescribed controlled substances including illicit substances such as cocaine and marijuana), and patients with negative results for drugs prescribed which raised concerns for diversion of the opioids. One of the reviewers noted, "There

[1] In order to maintain confidentiality, facility and patient names will not be used in this document, but will be provided to the Respondent on request.

were concerning findings on drug testing but this did not translate into closer monitoring or a clear change in treatment..." The Board notified the Respondent that although the investigation would be closed, based on the concerns raised by the peer reviewers, a peer review of his practice was to be conducted in one year.

5. By letter dated August 15, 2014, the Board notified the Respondent of its investigation (re-review noted in the June 2013 Advisory Letter), subpoenaed 10 patient records and requested that the Respondent submit summaries of care for all 10 patients.

6. By letter dated August 21, 2014, the Respondent's attorney requested a 10 day extension of time to submit the summaries of care.

7. The Board transmitted the 10 patient records and other relevant documents for peer review to two peer reviewers board-certified in physical medicine and rehabilitation (the "reviewers").

8. On or about April 6, 2015, the reviewers submitted their respective reports to the Board, which are set forth in pertinent part below.

9. By letter dated April 8, 2015, the Board sent to the Respondent copies of the peer review reports providing him an opportunity to respond to the opinions of the reviewers.

10. By letter dated April 23, 2015, the Respondent submitted a supplemental response to the peer review reports.

PATIENT-RELATED FINDINGS

PATIENT 1

11. On or about July 29, 2013, Patient 1, a male in his 50s, presented to the Respondent with a chief complaint of low back pain. The Respondent diagnosed Patient

1 with lumbar degenerative disc disease, lumbosacral spondylosis, lumbago and enthesopathy of the hip region.

12. During this initial visit and continuing through July 31, 2014, the Respondent prescribed Oxycodone[2] 15 mg on approximately a monthly basis (between 40 to 120 tablets monthly).[3]

13. During Patient 1's initial visit, the Respondent obtained a urine toxicology screen, which tested positive for cocaine.

14. On August 7, 2013, the Respondent documented he counseled Patient 1 for 15 minutes, and he (Patient 1) denied the cocaine use. The Respondent prescribed Oxycodone for him, and repeated the urine toxicology screen.

15. On August 30, 2013, the Respondent documented Patient 1's urine toxicology screen from August 7, 2013 was "consistent", even though Patient 1 tested negative for Oxycodone, which had been prescribed for him PRN. The Respondent documented that Patient 1 "ran out of medication." The Respondent continued to prescribe opioids to Patient 1. The Respondent's note on this date reads:

> We discussed urine drug screen again today. No more illicit drugs noted. He reports that he ran out of his medication. Again I expressed the concern for him to follow the treatment regimen. Repeat urine drug screen was done on today's visit.

16. Patient 1's September 30 and October 28, 2013 urine drug screens were consistent with his prescribed medications.

17. On November 25, 2013, the Respondent provided Patient 1 with a 6-week supply

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[2] Oxycodone, an opioid, is a Schedule II CDS.

[3] On November 25, 2013 and July 31, 2014, the Respondent prescribed 120 tablets for a six-week supply. On April 7, 2014 and June 4, 2014, the Respondent prescribed 120 tablets for a four-week supply.

of Oxycodone (120 tablets) as Patient 1 reported he would be away for a "holiday."

18. On January 8, 2014, Patient 1's urine again tested negative for any prescribed medications, yet the Respondent documented that the results were "consistent." The Respondent continued to prescribe opioids for Patient 1.

19. On February 5, 2014, the Respondent obtained a urine drug screen from Patient 1 that was consistent with the opioids he was prescribing.

20. On July 31, 2014, the Respondent documented that he prescribed Patient 1 a 6- week supply of medication (120 tablets).

21. On July 31, 2014, after Patient 1 had left the office, a pharmacist who had been filling Patient 1's prescriptions contacted the Respondent to notify him that Patient 1 had been receiving multiple opioid prescriptions from other prescribers. The Respondent reviewed Maryland's Prescription Drug Monitoring Program through "CRISP"[4] that had become accessible to providers in December 2013. CRISP revealed that multiple providers had prescribed opioids to Patient 1. The Respondent documented that he would be treating Patient 1 on his next visit with non-opioid management.

22. The Respondent failed to meet standards of quality medical care for Patient 1 for reasons including but not limited to the following:

a. The Respondent failed to adequately recognize and/or take action regarding Patient 1's abuse and/or diversion of prescribed opioids despite several red flags; and/or

b. The Respondent provided Patient 1 a 6-week supply of opioids on two occasions despite his inconsistent urine toxicology screen results.

[4] CRISP stands for Chesapeake Regional Information System for Our Patients.

PATIENT 2

23. On September 30, 2013, Patient 2, a female in her 40s, presented to the Respondent with complaints of neck, hand, feet, shoulder and back pain. The Respondent's assessment of Patient 2 included myalgia and myositis, lumbago, lumbosacral spondylosis, an unspecified disorder of the bursae and tendons in the shoulder, pain in the leg joint, and enthesopathy of her hip. She was previously known to the Respondent from another practice.

24. Beginning at the initial visit on September 30, 2013, through August 5, 2014, the Respondent prescribed on a monthly basis, methadone 10 mg, every 8 hours,[5] 150 tablets of oxycodone 15 mg (1-2 every six hours as needed), Lyrica[6] and Robaxin.[7]

25. According to Patient 2's medication list, she was also on Adderall 30 mg once daily.[8] Most, but not all months through August 5, 2014, the Respondent prescribed this Schedule II stimulant. According to the Respondent, the patient had a childhood diagnosis of ADHD and had been on Adderall since childhood.

26. On October 28, 2013 the Respondent documented that he provided Patient 2 with "enough" to get to her November 16, 2013 psychiatric appointment.[9]

27. On May 12, 2014, the Respondent documented that Patient 2 had an appointment with a psychiatrist "who she hopes will continue to prescribe her Adderall."

28. On July 9, 2014, the Respondent documented that Patient 2 again saw a psychiatrist who refused to prescribe Adderall to a patient on pain medication. Although

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[5] A Schedule II opioid used in the management of severe pain.
[6] Used in the treatment of fibromyalgia and anxiety.
[7] A central muscle relaxant.
[8] A Schedule II psychostimulant used in the treatment of ADHD, narcolepsy and obesity.
[9] He failed to document whether Patient 2 had seen the psychiatrist, and if so whether, he had prescribed the Adderall as requested.

the Respondent advised Patient 2 to wean off of the Adderall, and documented July 9 would be her last prescription, he continued prescribing to her on August 5, 2014.

29. During Patient 2's initial visit on September 30, 2013, the Respondent ordered an initial urine toxicology screen that tested positive for morphine, which had not been prescribed to Patient 2. Patient 2 acknowledged she had tried morphine without being prescribed that medication. The Respondent continued to prescribe opioids to Patient 2 despite the inconsistent urine toxicology screen. The Respondent documented that the results of the drug screen collected on September 30 were seen and discussed on the October 28, 2013 visit. Respondent's note of this date reads: "repeat urine drug screen was done today. We discussed the importance of following the treatment regimen and not taking non prescribed medications. "

30. On or about October 23, 2013, the Respondent received a request from the Sheriff's Office in St. Mary's County for Patient 2's health records and identification of the medications the Respondent had been prescribing for her.

31. On October 28, 2013, the Respondent ordered a urine toxicology screen, and it tested positive for fentanyl,[10] which had not been prescribed to Patient 2. Additionally, a drug that was prescribed (pregabalin),[11] was not detected. The Respondent continued to prescribe opioids to Patient 2 despite the inconsistent urine toxicology screen. The Respondent documented that he counseled Patient 2 on this date.

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[10] Schedule II CDS.

[11] This is the generic name for Lyrica.

32. On or about November 27, 2013, the Respondent documented that he had received a "request" from the St. Mary's County Sheriff's Department. Patient 2 told the Respondent she had been arrested, but that the arrest was a "misunderstanding."[12]

33. On November 27, 2013, Patient 2's urine toxicology screen tested positive for marijuana.

34. On December 23, 2013, the Respondent counseled Patient 2 regarding the positive marijuana result and recommended she follow up with her psychiatrist. The Respondent's note read: "She was counseled on the use of marijuana. Medication management agreement was reviewed on today's visit. I expressed that it is very important to see and be followed by a psychiatrist." Patient 2 stated that she smoked marijuana for her anxiety. The Respondent continued to prescribe opioids to Patient 2 despite the inconsistent urine toxicology screen.

35. Patient 2's record contains an undated letter from the Respondent noting that on several occasions he had discussed with Patient 2 her marijuana use.

36. The Respondent failed to meet standards of quality medical care for Patient 2 for reasons including but not limited to the following:

a. The Respondent prescribed excessive high dose short-acting narcotics over a period of time with inadequate pathology or findings on physical examination; and/or

b. The Respondent continued to prescribe opioids despite inconsistent urine toxicology screens including but not limited to one for marijuana, and two for opioids that he had not prescribed (morphine and fentanyl).

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[12] On February 19, 2014, the Respondent documented "She reports that she is relieved because her court case went in her favor. She reports the charges were dropped. A review of public records shows that Patient 2 was indicted in two drug related offenses; one indictment was filed in August 2013, and the second indictment in October 2013. Patient 2 pled guilty to one count of the August 23, 2013 indictment (manufacturing CDS) on January 24, 2014, and was sentenced to probation.

II. CONCLUSION OF LAW

Based on the foregoing Findings of Fact, the Disciplinary Panel B concludes as a matter of law that the Respondent's actions and inactions constitute violations of Health Occ. § 14-404(a) (22).

III. ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the Respondent is **REPRIMANDED;** and it is further

ORDERED that after **ONE (1) YEAR,** the Board or its agents or designees shall conduct a chart and/or peer review of the Respondent's medical practice. An unsatisfactory review may constitute a violation of this Consent Order; and it is further

ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

ORDERED that if the Respondent fails to comply with any of the terms of this Consent Order, a Disciplinary Panel of the Board, in its discretion, after notice and an opportunity for a show cause hearing before a Disciplinary Panel or an evidentiary hearing if material facts are disputed at the Office of Administrative Hearings, may impose additional sanctions authorized under the Medical Practice Act, including a reprimand, suspension, probation, revocation and/or a monetary fine; and it is further

ORDERED that the Respondent is responsible for all costs incurred in

fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014).

01/12/2016
Date

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

CONSENT

I, Tristan J. Shockley, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by Disciplinary Panel B of the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of a disciplinary panel of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of a disciplinary panel of the Board that I might have filed after any such hearing.

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

12/26/2015
Date

Tristan Shockley
Tristan J. Shockley, M.D.

Reviewed and Approved by:

Conrad W. Varner, Esquire

STATE OF MARYLAND

CITY/COUNTY OF:

I HEREBY CERTIFY that on this 26th day of December, 2016, before me, a Notary Public of the State and County aforesaid, personally appeared Tristan J. Shockley, M.D. and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: January 28, 2017

BOBBY GENE MIDDLETON JR.
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires January 28, 2017