IN THE MATTER OF	*	**BEFORE THE**
JAMES L. HOOPER, M.D.	*	**MARYLAND STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
LICENSE NO.: D08910	*	**CASE NO: 2009-0891**

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ORDER OF SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

The Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license to practice medicine in the State of Maryland of James L. Hooper, M.D. (the "Respondent") (D.O.B. 05/24/31) license number D08910.

The Board takes such action pursuant to its authority under Md. State Govt. Code Ann. ("S.G.") § 10-226(c)(2) (2009 Repl. Vol.), concluding that the public health, safety or welfare imperatively requires emergency action. The Board bases its conclusion on the following investigative findings originating with a complaint by several pharmacists in Tennessee that Respondent was prescribing controlled dangerous substances ("CDS") for patients who were traveling six or seven hours to see him in his office in Maryland and then returning to their area of residence in Tennessee to fill the prescriptions. The patients did not appear to be in pain, paid cash for their prescriptions, and often presented in a pair or group.

INVESTIGATIVE FINDINGS[1]

Based on the investigatory information obtained by the Board, including the

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

instances described below, the Board has reason to believe that the following facts are true:

I. Background of Licensee

1. At all times relevant hereto, Respondent was and is licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on November 24, 1970, under license number D008910.

2. On or about September 2010, Respondent last renewed his license which will expire on September 30, 2012.

3. Respondent was initially licensed to practice medicine in West Virginia in 2003, which license expired on June 30, 2010.

4. Respondent was initially licensed to practice medicine in the District of Columbia in 1963, which license is now inactive.

5. Respondent's self-designated practice areas are General Practice, Family Medicine, Physical Medicine and Rehabilitation, Pain Medicine.

6. Respondent is not board-certified in any specialty area recognized by the American Board of Medical Specialties.

7. Respondent does not hold any hospital privileges at this time.

8. From 1966 to 1990, Respondent practiced medicine with a multi-specialty medical practice in Montgomery County.[2]

9. From 1990 to 1998, Respondent practiced medicine in Fort Myers,

[2] According to Respondent's CV, Respondent was associated with this medical group in Maryland, beginning in 1966; however, according to records of the Board, Respondent was not licensed until November 1970.

Virginia, providing acute minor illness care.

10. From 1998 to 2000, Respondent practiced family medicine in Riyadh, Saudi Arabia.

11. From 2000 to 2009, Respondent practiced part-time at a women's clinic in Maryland which provides non-surgical and surgical abortion services and gynecological services.

12. From 2006 to present, Respondent has been employed by a seven day a week walk-in clinic in Maryland, where he practices part-time.

13. From 2008 to 2010, Respondent practiced rehabilitation and pain management with a specialty group in Maryland.

14. From 2009 to present, Respondent has maintained an office in his residence in Finksburg, Maryland for the part-time practice of "pain management." Respondent does not have any employees at this practice location.

II. Complaints and Initial Investigation

15. On December 17, 2009, the Board received an telephone complaint from a pharmacist at a large national chain pharmacy, Pharmacy A,[3] in northern Tennessee regarding five patients who regularly present with prescriptions for CDS written by Respondent for residents of Virginia and Tennessee. When contacted by the pharmacist, Respondent reported that he works from his home in Finksburg, Maryland.

16. On January 29, 2010, the Board received a facsimile from a pharmacist at a different large national chain pharmacy, Pharmacy B, in northern Tennessee

[3] The names of the specific pharmacies are available to Respondent upon request to the administrative prosecutor.

containing copies of prescriptions for CDS written by Respondent for four patients, two of whom are subsequently identified in this Order as Patient B[4] and Patient G, who reside in Tennessee and who came into the pharmacy together.

17. On April 5, 2010, the Board received a telephone call from a different pharmacist at Pharmacy A in northern Tennessee regarding Respondent's writing prescriptions for residents of Tennessee. The pharmacist reported that when he calls Respondent to verify the prescriptions, Respondent is "very combative."

18. On April 14, 2010, the Board received a telephone call from a different pharmacist at Pharmacy B in Westminster, Maryland stating that patients from out-of-state were presenting prescriptions written by Respondent and requesting they be filled in Maryland. She reported "a car full of people" coming together with one person coming into the pharmacy and another person following about 15 minutes later.

19. On April 15, 2010, Board staff interviewed three of the Tennessee pharmacists who had filed complaints who provided the following information: the patients reside in Kentucky, Virginia, or Tennessee; each patient presented with three to four prescriptions, mainly for Schedule II CDS; the patients did not appear to be in any pain; the patients often paid for their medication with cash; the patients often came in groups or came into the pharmacy one at a time, within minutes of each other, to get their prescriptions filled; and when Respondent is contacted to verify the prescriptions, he is abrasive.

20. On April 30, 2010, the Board received from the Tennessee Controlled

[4] Patient names are confidential and are not included in this Order. Respondent may obtain a Confidential Patient Identification List from the Administrative Prosecutor.

Substance Monitoring Program of the Board of Pharmacy, a computer printout for CDS, including morphine sulfate and Xanax, written by Respondent and five other prescribers for Patient E and copies of prescriptions written for Patient A.

21. On May 22, 2009, the pharmacist sent, by facsimile, copies of seven prescriptions for two patients, subsequently identified as Patient F and Patient G, written by Respondent. All the prescriptions were post-dated for May 23, 2009, all were written on prescription forms from women's clinic where Respondent had been employed, and all were for CDS.

22. Thereafter, the Board issued subpoenas to Pharmacy A and Pharmacy B for a printout of all CDS prescribed by Respondent from January 1, 2008 to present. The Board received print-outs from each of these pharmacies.

23. The computer printouts from the large chain pharmacies indicate that Respondent has been providing prescpritions for CDS for patients who live outside of Maryland, specifically in the area of Bristol, Tennessee and Bristol, Virginia. Based on these surveys, the Board randomly selected the names of 18 individuals to further investigate Respondent's prescribing practices.

III. Investigation of Respondent

24. On June 15, 2010, the Board hand-delivered a subpoena to Respondent at Respondent's home office for "a complete copy of any and all medical records" for 18 enumerated patients. Board staff asked Respondent to notify them when they could return to obtain the records.

25. On June 16, 2010, Board staff returned to Respondent's home office and received from Respondent the original medical records for 15 of the 18 patients.

Respondent stated that he did not recall one of the patients, one of the patients he treats at the pain management practice in Baltimore County,[5] and he may have treated the third patient at the walk-in clinic. Respondent also submitted to Board staff signed affirmations that he was providing "any and all records" in his possession pertaining to the care and treatment of each of the 15 patients.

26. The "medical records" contained copies of prescriptions, email correspondence from patients, copies of money orders from patients, and several pages of medical records from prior evaluating or treating physicians.

27. Board staff created photocopies of the 15 records and on June 18, 2010, the Board returned all of the original records to Respondent.

28. On Thursday, June 24, 2010, Respondent called the Board in the morning and stated that he received the records but that a folder was missing that contained all his medical notes on the 15 patients. Board staff explained that every document which they obtained from Respondent on June 16, 2010 had been returned to him and that the Board had not received a folder of medical notes.

29. On Thursday, June 24, 2010, Respondent called the Board in the afternoon and stated that he found the folder and was sending it to the Board by registered mail. Respondent requested that the Board make a copy and send him the originals.

30. On Monday, June 28, 2010, the Board received a folder containing approximately 15 examination forms which were completed by circling certain

[5] The Board obtained this patient's medical records from the medical office where Respondent has been employed.

information and adding some handwritten comments and were signed by Respondent. On the back of each form, Respondent listed dates of follow-up contacts, using "PC" for phone contact, and "F-F" for face-to-face contact, and three or four narrow lines of text for each visit.

31. On August 31, 2010, in response to the complaints, the Board received Respondent's typed "review of patient charts," which was drafted on or about August 2, 2010. At the bottom of all 15 summaries, Respondent added the same hand-written statement: "Patient made progressive improvement in pain level and remained alert and oriented. Patient had no adverse effects from pain medication."

IV. Background on Respondent's "Pain Management" Practice

32. In an interview with Board staff on August 17, 2010, Respondent stated that he is not board-certified by any specialty board. He stated that his specialties are family practice and urgent care. He stated that he had done some pain management with a rehabilitation and pain management group practice in Maryland, where he had worked part-time for several years.[6] Respondent left the women's clinic approximately a year ago.

33. Respondent stated that since April or May 2009, he sees approximately 25 or 30 patients, one to three patients a week, privately, for pain management on referral from an internet company based in Florida that refers patients to doctors for pain management. Initially, Respondent saw a few patients at the women's clinic, "after hours," and thereafter he began to see patients at his home. Respondent stated that

[6] Respondent took a "leave of absence" from this position when the Board initiated the investigation in this case.

he was contacted by the internet company in 2009 and does not know how they selected him. Respondent stated that the process involves his being contacted by the internet company and asked to schedule a patient. The internet company then "emails" him the patient's medical records. Respondent sees the patient at his home office, examines the patient, and "treats accordingly." Respondent stated his agreement with the internet company is that the patients who are referred to him have chronic pain from injury or post-operative surgery and that he would "only see the patients once or twice and they would get a local doctor to treat them. Or, in the alternative, if the patient wants to continue treatment, they could come make their own arrangements to see me." Respondent acknowledged that most of the time he continues to see the patients. Respondent was informed that the patients would be from "out-of-state" and noted that the referrals he received have been from Virginia, Maryland, Tennessee or Pennsylvania, with approximately five patients from Maryland.[7] Respondent stated that in addition to the referrals from the internet company, he has patients that came to him "by word-of-mouth," but that since approximately February 2010, he has only taken one or two new patients. Respondent stated that many of his patients are husband/wife or live together, and some of his patients come to appointments together.

34. Respondent stated that he considers the records of prior care that he received from the internet company to be "pretty complete." Respondent did not know if the internet company verified the records. Respondent described his home office as containing a desk, a stethoscope, blood pressure cuff, scale and examination table.

[7] According to the company's website, there are 21 states where the company can supply referrals with additional states "coming soon."

Respondent keeps his medical records at home, but prior to creating his home office, he carried the patient records in his briefcase to the women's clinic.

35. Respondent's unwritten agreement with the internet company is that they would send him $125 per patient, with payment every three months. Respondent also receives a payment directly from the patient, either by cash, check or money order. Respondent charges the patient $150 for the initial visit and $60 for subsequent visits. Respondent stated that most of the patients do not have insurance. Respondent stated that his follow-up visits are every three months; however, "recently I've told patients I have to see them every month." Respondent explained this change because he intends to "give up this practice by the first of the year," when his malpractice insurance ends and he does not plan to renew it. Respondent stated that when he saw patients every three months, he would speak with them by telephone every month. Respondent then mailed the prescriptions to the patient, "post-dating" the prescriptions.

36. Respondent acknowledged that he does not ask patients to complete a pain questionnaire, does not keep a pain log, does not use a pain agreement, and does not do urine surveillance. Respondent uses an examination form that he obtained from the group pain management practice where he had been employed.

V. Discussion of Patients A through O[8]

37. Respondent's documentation of all of the initial and subsequent patient visits was submitted to the Board under separate cover approximately 12 days after Respondent submitted what he represented were complete medical records pursuant to

[8] The deficiencies that are described in this Order pertain to 15 patients, Patients A - 0.

the Board's subpoena.

38. A review of Respondent's medical records show that Respondent's initial visit with each of these 15 patients was between April 21, 2009 and October 26, 2009. The patients are both male and female with ages ranging between 28 and 48 at the time of the initial visit, with an average age just under 30. All of the patients reside in Tennessee, close to the Virginia border; or in Virginia, close to the Tennessee border.

39. The majority of the patients claimed they had some kind of prior traumatic injury resulting from a motor vehicle accident (MVA) or a fall. Respondent's records contain medical records from prior evaluating and treating physicians; however, the majority of these reports were only a few pages of one or two office visits and reports of an MRI but generally were not close in time to the date of the initial visit with Respondent. There is no indication in Respondent's records that he communicated with any of the prior evaluating or treating physicians or that Respondent requested additional medical records from these physicians.

40. Respondent did not document the age or date of birth for any of the patients.[9] Respondent documented pulse, blood pressure, weight and height. For some, but not all, of the patients, Respondent documented range of motion of the neck, trunk, posture or shoulder. In all of the records, Respondent documented a brief phrase for the history, such as "MVA" or "fall twisted right knee 10 years ago" or "LBP (lower back pain) rad (radiating) right." For all of the records, Respondent circled the phrase

[9] Age at time of initial visit was obtained from documents from other providers contained in Respondent's records.

"HPI, PMH, FHSH, ROS[10], medication hx, allergy hx reviewed for decision making purposes," but Respondent did not document any specific positive findings. In all of the records, certain types of routine counseling and patient education were circled, such as "options of tx," "dosage of medications," "recurring nature of pain," or "home exercise program." In some of the medical records, Respondent added specific recommendations such as "soft cervical collar" or "Stretching/walking." In all of the records, Respondent circled "current medication" but did not document what the current medications were or who was prescribing them.

41. In all of the records, Respondent documented that "patient agrees not to get pain meds from another dr – no ETOH." In some of the records, Respondent listed the medications he was prescribing on the initial evaluation form, in other records there were copies of prescriptions he had written.

42. In most of the records, Respondent prescribed CDS, such as MS Contin,[11] Norco[12], Lortab,[13] Oxycontin,[14] Percocet,[15] Methadone,[16] Xanax,[17] and Valium[18]. These

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[10] These initials stand for history of present illness, past medical history, family history and social history, and review of systems.

[11] MS Contin is a brand of a time-released formulation of morphine sulfate, usually taken every twelve hours for chronic pain. Due to its strength, it is typically prescribed to cancer patients and victims of severe but non-cognitive-damaging trauma.

[12] Norco, a trade name for a hydrocodone-acetaminophen compound.

[13] Lortab is a brand name of hyrdocodone.

[14] Oxycontin is a brand name of oxycodone.

[15] Percocet is a brand name of oxycodone.

[16] Methadone is a synthetic opioid.

[17] Xanax is a benzodiazepine used to treat anxiety or panic disorders.

[18] Valium is a benzodiazepine used to treat anxiety, muscle spasms, and seizures.

substances are commonly considered to be substances of abuse and have a significant "street value."

43. The only social history which Respondent documented on all of the patients is: "Patient is a non-smoker."

44. Respondent described family history as "negative" for all of the patients except one (Patient O), wherein he stated that the patient has two children who are diabetic.

45. In almost all of the records, Respondent recommended that the patients return to the office in three months. Respondent would then briefly document monthly phone contacts with the patient, followed by a face-to-face visit. For some of the patients, Respondent only had face-to-face visits every three or four months, even though on every contact, either telephone or face-to-face, Respondent prescribed CDS. In most of the records, Respondent kept carbon copies of the prescriptions that he gave to or mailed to the patients.

46. Respondent received email communications from patients which he printed and maintained in the medical records.[19] The emails were often requests for specific CDS, early refills on CDS, or for increases in dosage of CDS.

47. Respondent was paid in cash by all of the patients, many of whom used a money order or check, which Respondent kept copies of and maintained in the medical records.

48. The last contacts that Respondent documented in the records was mid-

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[19] Respondent's email address contains the word "paincity."

June 2010, since that is the time that the Board issued the subpoena for Respondent's records; therefore, it is not known if Respondent is currently treating any or all of the patients whose records were reviewed.

49. In Respondent's "Review of Patient Charts" which he created on or about August 11, 2010, after being notified of the investigation and which he submitted to the Board on August 31, 2010, Respondent provided dates of final contact for the following patients:

a. Patient B – 5/25/10, patient did not return, no contact from patient

b. Patient E – 4/17/10, patient arrested

c. Patient F – 7/15/10, patient moving to North Carolina

d. Patient H – 3/24/10, Respondent terminated her because receiving same medication from another physician in VA

e. Patient I - 6/23/10, no reason given

f. Patient M – 6/14/10, patient did not return, no contact from patient

g. Patient N – 6/29/10, Respondent terminated him because he was receiving suboxone for opioid dependence, records sent to a pain management physician in W.VA

VI. Findings Pertaining to Patients A through O

50. Based on a review of the investigative file, including Respondent's records of treatment, Respondent's conduct as described below constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, imperatively requiring suspension of Respondent's license to practice medicine in that he:

a. Failed to perform or document any physical examination, other than obtaining vital signs, on some of the patients prior to initiating prescribing

CDS such as opioids or sedative-hypnotics;

b. Failed to perform complete assessments and physical examinations, including a full history of the nature of the pain, location, duration, onset, relieving and exacerbating factors, and any psychological components on all 15 patients;

c. Failed to develop a differential diagnosis and a process to evaluate the differential for the potential causes of the patients' pain to determine the etiology of the pain and attempt to formulate a rational treatment plan to address objective physical findings;

d. Failed to develop an assessment and a plan of care for patients that included medical necessity and therapeutic rationale for the prescribing of CDS;

e. Failed to verify with a prescribing physician or dispensing pharmacy the patients' "current medications," prior to prescribing CDS;

f. Repetitively prescribed Schedule II opioids, such as MS Contin 60 mg, Norco10/325 (oxycodone/acetaminophen), Roxicet 5/325 mg., Lidoderm patch, Oxycontin 40 mg., Lortab10/325 mg.(hydrocodone), Methadone 10 mg., and Soma 350 mg., and sedative hypnotics, such as Xanax and Valium 10 mg, which are common substances of abuse, without appropriate safeguards;

g. Failed to utilize common anti-diversion safeguards such as pain contracts, pharmacy profiles, urine or salvia testing, drug counts, or failed to confirm patient compliance by the same methods;

h. Failed to recognize common signs of addiction and diversion and aberrant behavior such as requests for certain CDS by name, asking for increases in the number or strength of CDS, attempts to obtain CDS from other doctors, requesting frequent early renewals of CDS, reports of lost or stolen prescriptions;

i. Failed to periodically re-evaluate and review the need for CDS, or to develop a plan to reduce or eliminate the need for CDS;

j. Initiated or discontinued CDS without documenting a medical rationale;

k. Failed to refer patients to appropriate specialists;

l. Failed to develop non-medicinal approaches to pain management and refer patients for other modalities of treatment, such as physical therapy,

occupational therapy, acupuncture, massage, heat/ice;

m. Failed to obtain consultation with addiction specialists;

n. Failed to personally examine the patients prior to mailing them prescriptions for CDS; and

o. Dated prescriptions for CDS in advance of the date he was actually writing the prescriptions.

VII. Additional Deficiencies in Regard to Certain Patients (A, C, E, F, G, H, J, K, L, N, O [20]

Patient A

51. On October 26, 2009, Respondent initially saw Patient A, then a 39 year old female who resided in Tennessee, with complaint of chronic cervical pain, post MVA. A prior evaluating physician recommended facet joint injections or epidural, and physical therapy.

52. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, imperatively requiring suspension of Respondent's license to practice medicine in that he:

a. Failed to communicate with the prior physician to determine the results of the facet joint injections or epidural and physical therapy;

b. Failed to respond appropriately to Patient A's request for additional medication; and

c. Failed to respond appropriately to Patient A obtaining medication from another physician.

Patient C

[20] Not all of the 15 patients are discussed separately in this Order, since many of the deficiencies as described above are common to the review of all of the cases.

53. Contained in Respondent's records, was a "New Client Registration" form the internet company, dated April 9, 2009. In response to the question in the questionnaire regarding which medication he was requesting, Patient C[21] stated, "hydrocodone 10/325."

54. Respondent prescribed MS Contin, Soma, Xanax, and Norco.

55. On September 15, 2009, Respondent discontinued MS Contin, and substituted Lidoderm patch, oxycodone, oxycontin, and continued Xanax and Soma, which Respondent continued to prescribe through May 30, 2010.

56. Also contained in Respondent's records, was correspondence on October 4, 2009, to Respondent from a pharmacy benefit manager, informing Respondent that Patient C has had pain medications prescribed by him and at least two other physicians and has filled prescriptions in at least three different pharmacies in the previous three month period. Respondent did not fax back his comments and suggestions, as requested.

57. On February 1, 2010, Patient C sent an email to Respondent requesting an increase in Oxycodone from 3 tablets to 4 tablets a day, which Respondent subsequently did.

58. On May 28 and 29, 2010, Respondent documented that Patient C called and reported that her husband did not receive his prescription and described possible symptoms of withdrawal. Respondent sent additional prescriptions.

59. Respondent's conduct as described above, in addition to the failures

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[21] Patient C is married to Patient L.

described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Failed to respond appropriately to notification from Patient C's pharmacy benefits manager about Patient C filling prescriptions from multiple physicians at multiple pharmacies;

b. Failed to recognize and respond appropriately to Patient C's aberrant drug –related behaviors such as requesting early refills, running out of medications early, and receiving narcotic medications from multiple providers;

c. Agreed to increase the number of tablets of Oxycodone which Patient C received each month without proper investigation into the medical necessity for the increases; and

d. Failed to obtain an adequate social history to determine Patient C's contact with street drug culture or current living situations.

Patient E

60. On September 23, 2009, Respondent initially saw Patient E,[22] then a 32 year old female who resided in Tennessee, with complaint of post-operative chronic pain.

61. Respondent monthly prescribed MS Contin, Xanax, Soma and Oxycodone.

62. In October 2009, Respondent received emails from Patient E, requesting him to mail her "scripts." In January 2010, Respondent received emails from patient E reporting a break-in and her medications being stolen and frequent emails in January, February and March with reports of familial upset and requests for more prescriptions.

63. April 17, 2010 was Respondent's last contact with Patient E. Respondent

[22] Patient E resided with Patient D.

refilled Xanax, Oxycodone, and MS Contin.

64. On April 19, 2010, Respondent received a telephone call from North Carolina Police reporting that Patient E had been arrested. Respondent informed the police that he had written prescriptions for Patient E.

65. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Failed to recognize and respond appropriately to Patient E's aberrant drug –related behaviors such as multiple emails to Respondent requesting early refills and reporting lost/stolen prescriptions;

b. Failed to discuss medication safety and security; and

c. Failed to obtain an adequate social history.

Patient F

66. Respondent's records of Patient F contain copies of prescriptions of another patient and copies of a driving license of a different patient.

67. Respondent failed to properly maintain medical records.

Patient G

68. Respondent's records contain a copy of a referral from the internet company stating that in the past she was approved for "HYDRO 10/500 #90." Respondent prescribed MS Contin 60 mg, Roxicet 5/325 mg, Valium 10 mg, and Soma.

69. Respondent continued monthly to refill these medications.

70. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm

to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Prescribed larger does of opioids than Patient G was currently taking without documenting a therapeutic rationale.

Patient H

71. On October 4, 2009, Respondent received an email from Patient H stating that she had increased her does of MS Contin to twice daily, without authorization, and on the same date. Patient increased dosages of morphine sulfate after she wrote him stating that higher doses seem to work better to control her pain.

72. On March 22, 2010, Respondent documented that he received a call from a Pharmacy A stating that Patient H was getting the same narcotic medication from another physician in McLean, Virginia. Respondent received a telephone call from North Carolina Police questioning a prescription for this patient.

73. On March 24, 2010, Respondent notified Patient H that he was terminating her care.

74. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Increased the frequency of Patient H's medication after receiving her email stating that higher doses work better, without an examination; and

b. In October 2009, failed to recognize and respond appropriately to Patient H's aberrant drug-seeking behavior such as increasing doses without authorization and requesting early refills.

Patient J

75. In addition to prescribing CDS, on one occasion, Respondent prescribed birth control pills (bcp) and on another occasion prescribed an antibiotic for Patient J.

76. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Prescribed bcp and antibiotics, without adequate history and physical examination.

Patient K

77. After the initial visit, Respondent did not document any examination or contact with Patient K, either face-to-face or telephone, although Respondent wrote multiple prescriptions for MS Contin, Xanax, and Lortab.

78. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Wrote prescriptions for CDS without ever examining Patient K.

Patient L

79. In addition to prescriptions for Phentermine,[23] which Patient L[24] had taken

[23] Phentermine, similar to amphetamine, is an appetite suppressant used to help reduce weight in obese patients when used short-term and combined with exercise, diet, and behavioral modification. It should not be used with individuals who have a history of substance abuse.

[24] Patient L is married to Patient C.

previously, and Lortab, Respondent ordered an MRI. There is no report of the MRI in Respondent's records or any follow-up with Patient L.

80. Respondent later switched Patient L to oxycodone and continued to prescribe Phentermine.

81. On May 24, 2010, Respondent documented a telephone contact from Patient L wherein he stated he twisted his right knee and had increased pain. Respondent wrote and sent Patient L a prescription for oxycodone, even though he had written a prescription for a 30 day supply of oxycodone on May 1, 2010.

82. On May 28 and 29, Respondent documented a telephone contact from Patient L wherein he described sweats, nausea, vomiting, and diarrhea. Respondent documented, "did not receive meds. symptoms of withdrawal." On May 30, 2010, at a face-to-face visit, Respondent documented "withdrawal symptoms."

83. On June 10, 2010, Respondent received an email from Patient L's wife, Patient C, requesting her husband's prescription for Phentermine, which Respondent mailed, even though he had sent a prescription for Phentermine on May 24, 2010.

84. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, imperatively requiring suspension of Respondent's license to practice medicine in that he:

a. Prescribed Phentermine without obtaining a history of Patient L's use of Phentermine and without proper follow-up of adverse effects or pill counts;

b. Failed to follow-up on his recommendation that Patient L have an MRI; and

c. Failed to properly respond to Patient L's symptoms of withdrawal.

Patient N

85. On July 18, 2009, Respondent initially saw Patient N, a resident of southern Virginia, who presented with complaint of left knee pain, possible ACL tear and lower back pain radiating down the left leg. Respondent prescribed Soma, MS Contin, and Norco.

86. Respondent received handwritten letters from Patient N requesting Respondent to date prescriptions in advance and to increase the quantity of oxycodone.

87. On June 1, 2010, Respondent documented that he received a call from a pharmacy that reported that Patient N is on suboxone from another physician and provided Respondent with the name and number of the physician.

88. On June 2, 2010, Respondent documented that he sent a letter to Patient N, terminating his care of him. Respondent's records contain a copy of a prescription with Respondent's handwriting giving Patient N 30 days notice and stating he will no longer treat him for pain management because he has been under the care of another doctor.

89. On June 4, 2010, Respondent documented that he discussed Patient N with the prescribing physician, a psychiatrist.

90. Respondent's records contain a copy of correspondence from Patient N requesting that Respondent "take him back" as a patient and which included correspondence from Patient's N's treating psychiatrist, addressed to "whom it may concern" stating that Patient N is under his care for his psychiatric medications but he will no longer prescribe Suboxone for him.

91. On June 23, 2010, Respondent prescribed Soma.

92. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Failed to perform regular urine drug screens to discover misuse of CDS.

Patient O

93. In October 2009, Respondent ordered an MRI of the cervical and thoracic spine and an x-ray of the heel.

94. Respondent's conduct as described above, in addition to the failures described in paragraph 50, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare by Respondent, requiring suspension of Respondent's license to practice medicine in that he:

a. Failed to follow-up on recommendation for MRI and x-ray.

VIII. Summary Regarding Summary Suspension

95. The above investigative facts regarding Respondent's prescribing of CDS in regard to Patients A through O, constitutes a substantial likelihood of a risk of serious harm to the public health, safety, or welfare, imperatively requiring suspension of Respondent's license to practice medicine under State Govt. Code Ann. § 10-226(c)(2) and Code Md. Regs. tit. 10, § 32.02.05B.

CONCLUSIONS OF LAW

Based upon the foregoing Investigative Findings, the Board concludes that the public health, safety, or welfare imperatively requires emergency action, and that

pursuant to Md. State Govt. Code Ann. § 10-226(c)(2) (2009 Repl. Vol.), Respondent's license must be immediately suspended.

ORDER

Based on the foregoing Investigative Findings and Conclusions of Law;

IT IS THIS 17th day of November 2010, by an affirmative vote of a majority of the quorum of the Maryland Board of Physicians;

ORDERED that pursuant to the authority vested in the Board by Md. State Govt. Code Ann. § 10-226(c)(2), Respondent's license to practice medicine in the State of Maryland be and is hereby **SUMMARILY SUSPENDED;** and be it further

ORDERED that a pre-deprivation hearing on the **SUMMARY SUSPENSION** in accordance with Code Md. Regs. tit. § 32.02.05 B (6) was held on **Wednesday November 17, 2010 at 1:30 p.m.** at the Maryland Board of Physicians, room 109, 4201 Patterson Avenue, Baltimore, Maryland 21215; and be it further

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

ORDERED that on presentation of this Order, Respondent **SHALL SURRENDER** to Board staff the following items:

(1) Respondent's original Maryland license D08910;

(2) Respondent's current renewal certificate;

(3) Respondent's current Federal DEA certificate of Registration # BH4289028, exp. 10/31/10;

(4) Respondent's current Maryland Controlled Substance Registration # M13259, exp. 9/30/12;

(5) All prescribed substances in his possession and/or practice, including all controlled dangerous substances, other than substances, which have been prescribed by a licensed physician for Respondent;

(6) All Medical Assistance prescription forms in his possession and/or practice;

(7) All prescription forms and pads in his possession and/or practice; and

(8) All prescription pads on which his name and DEA number are imprinted; and be it further

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

ORDERED that this is a Final Order of the Board, and as such, is a **PUBLIC DOCUMENT** pursuant to Md. State Govt Code Ann. § 10-611 *et seq.*

17 November 2010
Date

Paul T. Elder, M.D.
Chairman