Individual Information
Medical

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William Richard Deagle

Address	Halifax, Nova Scotia, B3M 3
License Number	DR-33863
License Type	Physician
License Status	Active - Restricted
License Method	Canadian Exam
License First Issued	July 14, 1994
Last Renewal Date	June 01, 2005
Last Expiration Date	May 31, 2007

Board or Program Actions

Board	Action	Description	Action Issued	Action Ended
Medical	Formal Complaint-Charges with DOAH	Formal Complaint filed with Office of Administrative Courts.	05/23/2006	
	Stipulation in Abeyance	Dr. Deagle left the state and moved to Canada. Interim Stipulation placed in abeyance but the underlying cases are still pending final resolution.	07/30/2004	
	Stipulation	Stipulation for Interim Agreement of Practice includes practice restrictions/prescription log and practice monitoring. Please note that this is not the final resolution of the pending matters.	04/20/2004	07/30/2004
	Summary Suspension	pursuant to 24-4-104(4), CRS	03/22/2004	04/20/2004

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(Definition of Board or Program Actions)

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OFFICE OF
ADMINISTRATIVE COURTS

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS

STATE OF COLORADO

Case No. ME 2006-0003

FORMAL COMPLAINT OF THE ATTORNEY GENERAL, NOTICE TO SET, NOTICE OF HEARING, AND NOTICE OF DUTY TO ANSWER AND ELECTION NOT TO MEDIATE

IN THE MATTER OF THE DISCIPLINARY PROCEEDING REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF WILLIAM DEAGLE, M.D., LICENSE NO. 33863,

Respondent.

FORMAL COMPLAINT

The Colorado State Board of Medical Examiners ("Board"), Inquiry Panel A ("Panel"), by the Colorado Attorney General, makes this formal complaint ("complaint") against William Deagle, M. D. ("Respondent"), pursuant to §§12-36-117(1) and § 12-36-118(5), C.R.S.

JURISDICTION AND BACKGROUND

1. The Board and the Panel possess jurisdiction over Respondent and the subject matter of these proceedings as set forth in the Colorado Medical Practice Act, §§ 12-36-101 to 137, C.R.S., and the State Administrative Procedure Act, §§ 24-4-101 to 108, C.R.S.

2. Respondent was licensed to practice medicine in Colorado on July 14, 1994 and was issued license number 33863 which he has held continuously since that date.

3. On March 16, 2004 the Panel summarily suspended Respondent's license to practice medicine pursuant to § 24-4-104(4) C.R.S., because the public health, safety or welfare imperatively required emergency action.

4. On April 20, 2004, Respondent entered into a Stipulation for Interim Agreement of Practice ("Interim Stipulation"). The interim stipulation imposed restrictions on Respondent's practice of medicine in lieu of summary suspension.

5. At all times relevant to this complaint, Respondent held himself out to the public as a family practitioner who also practiced pain management.

6. At all times relevant to the complaint, Respondent practiced medicine in Colorado.

PATIENT ONE

7. On or about October 24, 2002, Respondent entered into a physician/patient relationship with Patient One.

8. Patient One's chief complaint was leg pain originating from an accident in 1997.

9. On or about October 24, 2002, Respondent knew or should have known that Patient One had a history of depression.

10. On or about October 24, 2002, Respondent knew or should have known that Patient One was seeing Dr. Joseph Mendozza for psychiatric care.

11. On or about October 24, 2002, Respondent knew or should have known that Patient One was taking Percocet, Effexor, Klonopin, and Risperdal.

12. On or about October 24, 2002, Patient One signed a Pain Management Agreement.

13. On or about October 24, 2002, Respondent prescribed Oxycontin to Patient One without adequate clinical justification.

14. Alternatively to the allegations in paragraph 13, Respondent did not adequately document Patient One's medical records with his clinical justification for prescribing Patient One Oxycontin.

15. On or about October 24, 2002, Respondent prescribed Oxy IR to Patient One without adequate clinical justification.

16. Alternatively to the allegations in paragraph 15, Respondent did not adequately document Patient One's medical records with his clinical justification for prescribing Patient One Oxy IR.

17. On more than one occasion, Respondent prescribed Patient One Oxycontin prior to the time his other prescription was scheduled to run out.

18. On or about October 31, 2002, Respondent prescribed Patient One 120 Oxycontin, to be taken 1-2 every twelve hours.

19. On or about November 5, 2002, Respondent prescribed Patient One 120 Oyxcontin.

20. On or about November 8, 2002, Patient One was admitted to Aurora South Medical Center because he overdosed on several medications including, but not limited to, Oxycontin.

21. On or about November 13, 2002, Patient One was transferred to Exempla West Pines ("West Pines") for in-patient rehabilitation.

22. On or about November 13, 2002, Patient One was placed on a mental health hold.

23. While at West Pines, Patient One reported taking more than the prescribed amounts of Oxycontin.

24. Patient One was discharged from West Pines on or about November 18, 2002.

25. Respondent knew or should have known that Patient One had a history of polysubstance abuse and dependence.

26. Respondent knew or should have known that Patient One was chronically suicidal.

27. Respondent knew or should have known that Patient One was bipolar.

28. Respondent knew or should have known that Patient One had a family history of bipolar disorder.

29. On or about November 18, 2002, Respondent knew or should have known that West Pines recommended that Dr. Mendozza manage Patient One's psychiatric medications and that Respondent manage Patient One's other medications.

30. On or about November 18, 2002, Respondent knew or should have known that West Pines recommended that Patient One attend an intensive outpatient substance abuse program.

31. Respondent saw Patient One on or about November 19, 2002, and he ordered physical therapy for Patient One.

32. On or about November 19, 2002, Respondent prescribed Percocet, Klonopin, Risperdal, and Seroquel to Patient One.

33. On or about November 19, 2002, Respondent knew or should have known that Patient One needed drug and alcohol rehabilitation.

34. On or about January 6, 2003, Respondent restarted Patient One on Oxycontin and Oxy IR, and discontinued the Percocet.

35. On or about January 6, 2003, Respondent knew or should have known that Patient One used marijuana.

36. On or about January 29, 2003, Respondent knew or should have known that Patient One had not started physical therapy.

37. On or about February 12, 2003 Respondent knew or should have known that Patient One stopped taking his medications.

38. On or about February 26, 2003 Respondent knew or should have known that Patient One had not started physical therapy.

39. On or about March 17, 2003, Respondent ordered a toxicology screen on Patient One that was completed on or about March 24, 2003.

40. Respondent knew or should have known that Patient One's March 17, 2003 toxicology report was positive for cannabinoids, low for prescribed benzodiazepines, and prescribed opiates ranged from levels of low to "not detected."

41. Respondent did not adequately document Patient One's medical records with the results of Patient One's March 17, 2003 toxicology report.

42. On or about March 24, 2003, Respondent ordered a toxicology screen for Patient One that was completed on or about March 28, 2003.

43. Respondent knew or should have known that Patient One's March 24, 2003 toxicology report was positive for cannabinoids, and levels of prescribed opiates were low.

44. Respondent did not adequately document Patient One's patient records with the results of Patient One's March 24, 2003 toxicology report.

45. On or about April 9, 2003, Respondent ordered a toxicology screen on Patient One that was completed on or about April 14, 2003.

46. Respondent knew or should have known that Patient One's April 9, 2003 toxicology report was positive for cannabinoids and cocaine, low for prescribed benzodiazepines, and levels of prescribed opiates ranged from low to "not detected."

47. Respondent did not adequately document Patient One's patient records with the results of Patient One's April 9, 2003 toxicology report.

48. As of April 16, 2003, Respondent continued to treat Patient One with Oyxcontin and Oxy IR.

49. On or about April 16, 2003, Patient One reported using marijuana and denied using cocaine.

50. Respondent did not counsel Patient One regarding his marijuana use.

51. Alternatively to the allegations in paragraph 50, Respondent did not adequately document in Patient One's medical records, that he counseled Patient One regarding his marijuana use.

52. On or about April 16, 2003, Respondent ordered a toxicology screen on Patient One that was completed on or about April 21, 2003.

53. Respondent knew or should have known that Patient One's April 16, 2003 toxicology report was positive for cannabinoids, prescribed benzodiazepines were low and prescribed opiates ranged from a level of low to "not detected."

54. Respondent did not adequately document Patient One's medical records with the results of Patient One's April 16, 2003 toxicology report.

55. On or about May 1, 2003 Respondent recommended that Patient One be admitted to the hospital for depression and a suicide risk evaluation.

56. Respondent did not notify Dr. Mendozza that he recommended that Patient One be admitted to the hospital for depression and a suicide risk evaluation.

57. Alternatively, Respondent did not adequately document Patient One's medical records to reflect that he notified Dr. Mendozza that Patient One was depressed and required a suicide risk evaluation.

58. On or about May 1, 2003, Respondent planned to taper Patient One's Oyxcontin because Patient One broke the terms of the pain management contract.

59. As of May 13, 2003, Respondent continued to treat Patient One with Oyxcontin and Oxy IR.

60. As of May 13, 2003, Respondent knew or should have known that Patient One had not been attending physical therapy regularly.

61. On or about May 13, 2003 Patient One reported that he was not suicidal.

62. On or about May 13, 2003 Patient One reported that he was clean of drugs.

63. On or about May 13, 2003, Respondent prescribed Patient One 120 Oxycontin.

64. On or about May 13, 2003, Respondent prescribed Patient One 120 Oxy IR.

65. On or about May 13, 2003, Respondent ordered a toxicology screen for Patient One that was completed on or about May 16, 2003.

66. Respondent knew or should have known that Patient One's May 13, 2003 toxicology screen showed that levels of prescribed benzodiazepines and opiates ranged from low to "not detected."

67. Respondent did not adequately document Patient One's patient records with the results of Patient One's May 13, 2003 toxicology report.

68. Respondent knew or should have known that on or about May 17, 2003, Patient One attempted suicide by overdosing.

69. Respondent knew or should have known that Patient One's May 17, 2003 toxicology screen indicated that Respondent had benzodiazepines, opiates, cocaine and marijuana in his system.

70. Respondent knew or should have known that on or about June 25, 2003, Patient One was admitted to Arapahoe House for residential drug rehabilitation treatment.

71. Respondent saw Patient One on or about September 2, 2003 and prescribed Oxycontin and Oxy IR to Patient One.

72. Respondent did not adequately document in Patient One's medical records that Patient One had attempted suicide, had overdosed, and/or that he had spent the last several months in drug rehabilitation treatment.

73. On or about September 2, 2003, Respondent ordered a toxicology screen for Patient One that was completed on or about September 10, 2003.

74. Respondent knew or should have known that Patient One's September 2, 2003 toxicology report was positive for cannabinoids, and levels of prescribed benzodiazepines and opiates levels ranged from low to "not detected."

75. Respondent did not adequately document Patient One's medical records with the results of Patient One's September 2, 2003 toxicology report.

76. On or about September 12, 2003 Respondent ordered a toxicology screen for Patient One that was completed on or about September 17, 2003.

77. Respondent knew or should have known that Patient One's September 12, 2003 toxicology report was positive for cocaine and cannabinoids, and prescribed levels of opiates and benzodiazepines ranged from a level of low to "not detected."

78. Respondent did not adequately document Patient One's medical records with the results of Patient One's September 12, 2003 toxicology report.

79. On or about September 29, 2003, Respondent increased Patient One's dosage for Oxycontin without clinical justification.

80. Alternatively to the allegations in paragraph 79, Respondent did not adequately document Patient One's medical records to reflect his clinical justification for increasing Patient One's dosage for Oxycontin.

81. On or about October 2, 2003 Respondent concluded that Patient One should go to drug rehabilitation or Respondent would taper Patient One's pain medications and discharge him as a patient.

82. On or about October 2, 2003, Respondent ordered a toxicology screen for Patient One that was completed on or about October 10, 2003.

83. Respondent knew or should have known that Patient One's October 2, 2003 toxicology report was positive for cannabinoids, and prescribed levels of opiates were low, and prescribed levels of benzodiazepines were not detected.

84. Respondent did not adequately document Patient One's medical records with the results of Patient One's October 2, 2003 toxicology report.

85. On or about October 24, 2003, Respondent prescribed refilled Patient One's prescriptions for Oxycontin and Oxy IR.

86. On or about October 27, 2003, Respondent knew or should have known that Patient One's psychiatrist stopped prescribing him Klonopin.

87. On or about October 27, 2003, Respondent prescribed Patient One Xanax.

88. On or about December 2, 2003, Patient One told Respondent his medications were stolen.

89. On or about December 2, 2003, Respondent replaced Patient One's Oxycontin and Oxy IR.

90. On or about December 11, 2003, Respondent ordered a toxicology screen for Patient One that was completed on or about December 16, 2003.

91. Respondent knew or should have known that Patient One's December 11, 2003 toxicology screen was positive for cannabinoids, prescribed levels of benzodiazepines ranged from low to "not detected," and prescribed levels of opiates were low.

92. Respondent did not adequately document Patient One's patient records with the results of Patient One's December 11, 2003 toxicology report.

93. On or about January 7, 2004, Respondent knew or should have known that Patient One stopped taking his Oxycontin.

94. On or about January 12, 2004, Respondent prescribed Oxycontin, Oxy IR and Xanax to Patient One.

95. On or about February 2, 2004, Respondent discontinued Patient One's prescription of Oxy IR and started Patient One on Actiq without clinical justification.

96. Alternatively to the allegations in paragraph 95, Respondent did not adequately document Patient One's medical records with the clinical justification for prescribing Actiq to Patient One.

97. On February 2, 2004, Respondent knew or should have known that Patient One was to start doing regular drug screens through the substance abuse program.

98. On February 8, 2004, Patient One died from an overdose of a combination of prescription medications.

Unprofessional Conduct: Patient One

99. Respondent's evaluation and/or treatment of Patient One did not meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by § 12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent did not properly manage Patient One's use of medications;

b. Respondent did not adequately assess Patient One's functionality in conjunction with his prescribing of narcotics;

c. Respondent prescribed medications to Patient One prior to the time the previous prescriptions should have ran out;

d. Respondent did not adequately assess, monitor and/or document Patient One's mental status during his course of treatment of Patient One;

e. Respondent did not get appropriate consultations for Patient One's addictions;

f. Respondent did not enforce the terms of the Pain Management Agreement with Patient One; and

g. Respondent prescribed medications to Patient One without considering the drug interactions between the medications.

100. Respondent violated § 12-36-117(1)(cc) C.R.S., by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on Patient One's records for one or more of the following reasons:

a. Respondent did not adequately document Patient's One's use of medications;

b. Respondent did not adequately document Patient One's functionality in conjunction with his prescribing of narcotics;

c. Respondent did not adequately document his efforts to follow-up with Patient One's mental health providers; and

d. Respondent did not adequately document follow-up with Patient One after receiving the results of Patient One's toxicology reports.

PATIENT TWO

101. Respondent was Patient Two's primary care physician.

102. In August 1999, Patient Two suffered a work injury.

103. In April 2000, Patient Two underwent, and Respondent received a report of, an Independent Medical Examination.

104. On or about August 31, 1999, Respondent diagnosed Patient Two with cervical spine strain and right levator scapula tendonitis.

105. From August 1999 to March 2001, Respondent prescribed Vicodin to Patient Two on a routine basis.

106. On or about April 27, 2000, Respondent knew or should have known that Respondent had overused Vicodin in the past.

107. On or about April 27, 2000, Respondent knew or should have known that Patient Two had a narcotics addiction.

108. On or about April 27, 2000, Respondent knew or should have known that Patient Two had asked other providers for early refills on her medications.

109. On more than one occasion, Respondent prescribed Vicodin to Patient Two prior to the time her previous prescription should have run out.

110. On or about July 3, 2000, Respondent knew or should have known that Patient Two's left shoulder was normal, and her right shoulder revealed mild tendinosis without rotator cuff tear.

111. On or about March 9, 2001, Respondent discontinued Patient Two's use of Vicodin, and began prescribing Oxycontin and Oxy IR, without clinical justification.

112. Alternatively to the allegations in paragraph 111, Respondent did not adequately document Patient Two's medical records with the clinical justification for prescribing her Oxycontin and Oxy IR.

113. From approximately March 2001 to April 2002, Respondent prescribed Patient Two the following dosages of Oxycontin:

a. March 9, 2001 – 40 mg. I BID, #60;

b. March 21, 2001 - #60;

c. May 18, 2001 – 80 mg I Q12, #60;

d. June 7, 2001 - #60;

e. June 28, 2001 - #60;

f. July 12, 2001 – 80 mg #60;

g. July 30, 2001 - #60;

h. August 12, 2001 - #60 (refill of July 30, 2001);

i. September 4, 2001 - 80 mg I Q 12H #60;

j. September 20, 2001 - #60;

k. October 1, 2001 - #60;

l. October 17, 2001 - 80 mg I-II Q12, #120;

m. November 27, 2001 - #90;

n. December 19, 2001 - #90;

o. January 16, 2002 - #90;

p. January 28, 2002 – 80 mg. I a.m. II HS #50;

q. February 11, 2002 - #90

r. February 25, 2002 80 mg. tablets I a.m. and II Q HS #90;

s. March 13, 2002 - # 90; and

t. April 4, 2002 – 80 mg I a.m. and II Q HS #90.

114. On multiple occasions from March 2001 to April 2002, Respondent prescribed Patient Two Oxycontin prior to the date the previous prescription were scheduled to run out.

115. Alternatively to the allegations in paragraph 114, Respondent did not adequately document Patient Two's medical records with the clinical justification for prescribing Oxycontin to Patient Two prior to date the previous prescription was scheduled to run out.

116. On or about May 25, 2001, Respondent was aware that Patient Two reported that she could fall asleep standing up.

117. On or about June 12, 2001, Respondent was aware that Patient Two reported falling asleep in the bathroom.

118. On or about September 4, 2001, Patient Two signed an Informed Consent on the use of Opiod Medications.

119. On or about October 1, 2001, Respondent was aware that Patient Two reported being tired all of the time.

120. Respondent knew or should have known that Patient Two was overusing the prescribed narcotics.

121. On or about February 11, 2002, Respondent prescribed Patient Two Actiq without clinical justification.

122. Alternatively to the allegations in paragraph 121, Respondent did not adequately document Patient Two's medical records with the clinical justification for prescribing Actiq to Patient Two.

123. Respondent did not perform any urine drug screens on Patient Two.

124. Alternatively to the allegations in paragraph 123, Respondent did not adequately document Patient Two's medical records to reflect that urine drug screens were performed.

125. Patient Two died on April 26, 2002.

Unprofessional Conduct: Patient Two

126. Respondent's evaluation and/or treatment of Patient Two did not meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by § 12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent did not properly manage Patient Two's use of medications;

b. Respondent did not adequately assess Patient Two's functionality in conjunction with his prescribing of narcotics;

c. Respondent prescribed medications to Patient Two prior to the time the previous prescription should have run out;

d. Respondent did not get appropriate consultations for Patient Two's addictions;

e. Respondent did not enforce the terms of the Informed Consent on the Use of Opiod Medications with Patient Two;

f. Respondent prescribed drugs to Patient Two without considering the drug interactions between the medications; and

g. Respondent did not conduct an adequate number of urinalyses on Patient Two throughout the course of treatment.

127. Respondent violated § 12-36-117(1)(cc) C.R.S. by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on Patient Two's records for one or more of the following reasons:

a. Respondent did not adequately document Patient Two's use of narcotics.

b. Respondent did not adequately document Patient Two's functionality in conjunction with his prescribing of narcotics;

c. Respondent did not adequately document Patient Two's medical and social history, and/or recommendations and treatment by other providers;

d. Respondent did not adequately document that Patient Two exhibited symptoms of being physically and/or mentally addicted to narcotics; and

e. Respondent did not document an accurate or adequate substance use or abuse history for Patient Two.

PATIENT THREE

128. Respondent entered a physician/patient relationship with Patient Three on or about February 23, 2000.

129. Patient Three sought treatment from Respondent for pain relief, including but not limited to foot pain.

130. On or about October 25, 2000, Respondent first prescribed Percocet, and Methadone to Patient Three.

131. From May 2001 through December 2001, Respondent prescribed Oxy IR to Patient Three without adequate clinical justification.

132. Alternatively to the allegations in paragraph 131, Respondent did not adequately document Patient Three's medical records with his clinical justification for prescribing Patient Three Oxy IR.

133. From May 2001 through February 2004, Respondent prescribed Patient Three varying strengths of Oxycontin without adequate clinical justification.

134. Alternatively to the allegations in paragraph 133, Respondent did not document Patient Three's medical records with adequate clinical justification for prescribing Patient Three varying strengths of Oxycontin.

135. On more than one occasion, Respondent prescribed Patient Three Oxycontin prior to the date her previous prescription for Oxycontin should have run out.

136. Respondent knew or should have known that Patient Three was taking more than the prescribed amounts of Oxycontin.

137. On or about July 24, 2001, Respondent knew or should have known that Patient Three reported that while on Oxycontin, she had headaches and blurred vision.

138. On or about July 24, 2001, Respondent prescribed Patient Three Oxycontin and Oxy IR.

139. On or about February 14, 2002, Respondent knew or should have known that Patient Three reported increased activity.

140. On or about February 14, 2002, Respondent began prescribing Patient Three Actiq, without adequate clinical justification.

141. Alternatively to the allegations in paragraph 140, Respondent did not document Patient Three's medical records with adequate clinical justification for prescribing Patient Three Actiq.

142. Respondent prescribed Actiq to Patient Three from February 2002 until February 2004, without clinical justification.

143. Alternatively to the allegations in Paragraph 142, Respondent did not adequately document his clinical justification for prescribing Actiq to Patient Three from February 2002 to February 2004.

144. On more than one occasion Respondent prescribed Actiq to Patient Three prior to the time her previous prescription for Actiq should have run out.

145. Respondent knew or should have known that Patient Three was using more than the prescribed amounts of Actiq.

146. On or about June 16, 2002 Respondent knew or should have known that Patient Three was excessively tired.

147. On or about September 13, 2002, Respondent signed an Informed Consent on the Use of Pain Control with Opiod Medicine.

148. On or about November 5, 2002, Respondent knew or should have known that Patient Three was overusing Actiq.

149. On or about December 5, 2002, Respondent planned for Patient Three to see a psychiatrist.

150. From January 2003 to October 2003, Respondent prescribed Duragesic patches to Patient Three.

151. On or about March 25, 2003 Respondent ordered a urinalysis for Patient Three.

152. Respondent did not adequately document the results of Patient Three's March 25, 2003 urinalysis.

153. On or about April 9, 2003, Respondent knew or should have known that Patient Three was having "spells" with an increased need for Actiq.

154. On or about April 15, 2003 Respondent knew or should have known that Patient Three was overusing Actiq.

155. On or about April 15, 2003, Respondent knew or should have known that Patient Three suffered from severe depression.

156. On or about April 15, 2003, Respondent prescribed Patient Three six boxes of Actiq.

157. On or about April 29, 2003, Respondent prescribed Patient Three five boxes of 1200 ug Actiq.

158. On or about June 16, 2003, Respondent knew or should have known that Patient Three needed to be evaluated by a psychiatrist for depression and panic disorder.

159. On or about July 2, 2003, Respondent knew or should have known that Patient Three reported being very tired and sleepy.

160. On or about July 23, 2003, Respondent prescribed Patient Three six boxes of 800 ug Actiq.

161. On or about July 30, 2003, Patient Three asked Respondent to prescribe her more Actiq.

162. On or about July 30, 2003, Respondent prescribed Patient Three six boxes of 400 ug Actiq.

163. On or about September 26, 2003, Respondent knew or should have known that Jody Goodwine, a Licensed Professional Counselor, was treating Patient Three.

164. Respondent did not adequately consult with Ms. Goodwine regarding Patient Three's treatment.

165. Alternatively to the allegations in paragraph 164, Respondent did not adequately document Patient Three's medical records with information regarding any consultations with Ms. Goodwine.

166. On or about December 8, 2003, Respondent restarted Patient Three on Oxycontin without clinical justification.

167. Alternatively to the allegations in paragraph 166, Respondent did not adequately document in Patient Three's medical records the clinical justification for restarting her on Oxycontin.

168. On or about January 4, 2004, Respondent knew or should have known that Patient Three's husband was concerned with Patient Three's Actiq use.

169. On or about January 5, 2004, Respondent knew or should have known that Patient Three reported being a drug addict.

170. On or about January 21, 2004, Respondent knew or should have known that Patient Three reported being a drug addict.

171. On or about February 9, 2004, Respondent knew or should have known that Patient Three reported being a drug addict.

172. On or about February 9, 2004, Respondent prescribed Patient Three more Actiq, without clinical justification.

173. Alternatively to the allegations in paragraph 172, Respondent did not adequately document in Patient Three's medical records his clinical justification for prescribing her Actiq.

174. On or about February 16, 2004, Respondent knew or should have known that Patient Three tried to renew her Actiq prescription early.

175. On or about February 19, 2004, Respondent knew or should have known that Patient Three was addicted to her pain medication.

176. On or about February 19, 2004, Respondent knew or should have known that Patient Three needed drug rehabilitation treatment.

177. On or about February 19, 2004, Patient Three entered drug rehabilitation.

Unprofessional Conduct: Patient Three

178. Respondent's evaluation and/or treatment of Patient Three did not meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by § 12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent did not properly manage Patient Three's use of medications;

b. Respondent did not adequately assess Patient Three's functionality in conjunction with his prescribing of narcotics;

c. Respondent prescribed medications to Patient Three prior to the time the previous prescription should have run out;

d. Respondent did not adequately assess, monitor and/or document Patient Three's mental status during his course of treatment of Patient Three;

e. Respondent did not get appropriate consultations for Patient Three's addictions;

f. Respondent did not enforce the terms of the Informed Consent of the Use of Pain Control with Opiod Medicine with Patient Three;

g. Respondent prescribed drugs to Patient Three without considering the drug interactions between the medications; and

h. Respondent did not conduct an adequate number of urinalyses on Patient Three throughout the course of treatment.

179. Respondent's documentation of Patient Three's care was in violation of § 12-36-117(1)(cc) C.R.S., falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records for one or more of the following reasons:

a. Respondent did not adequately document Patient Three's functionality in conjunction with his prescribing of narcotics;

b. Respondent did not adequately document Patient Three's mental health status;

c. Respondent did not adequately document an adequate rationale for increasing dosages of narcotic therapy for Patient Three;

d. Respondent did not adequately document the extent to which Patient Three became physically and/or mentally addicted to narcotics;

e. Respondent did not adequately summarize the evaluations performed by one or more specialist for Patient Three; and

f. Respondent did not adequately document the concerns of addiction from Patient Three's family.

PATIENT FOUR

180. Respondent treated Patient Four on or about April 26, 1999, following Patient Four's second motor vehicle accident.

181. Throughout the course of treatment, Respondent treated Patient Four for multiple issues including, but not limited to, chronic pain.

182. Respondent knew, or should have known, that Patient Four had a history of alcohol and cocaine abuse.

183. Respondent did not perform a urine drug screen on Patient Four before prescribing narcotics to him.

184. On or about July 20, 1999, Respondent knew or should have known that Patient Four requested detoxification.

185. In July 1999, Respondent knew or should have known that Patient Four was overusing his medications

186. In July 1999, Respondent knew or should have known that Patient Four was going through withdrawal.

187. On or about July 28, 1999, Respondent planned to discontinue the use of narcotics to treat Patient Four if he continued to improve over the following six to twelve weeks.

188. On or about August 6, 1999, Respondent continued treating Patient Four with narcotics.

189. On or about August 6, 1999, Respondent planned to dispense Patient Four's narcotics on a daily basis so he would not exceed the required number of pills.

190. On or about August 19, 1999, Respondent gave Patient Four 20 extra Lorcet for emergencies.

191. From September 1999 to January 2004, Respondent prescribed Xanax and/or Klonopin to Patient Four.

192. On more than one occasion, Respondent prescribed both Xanax and Klonopin to Patient Four during the same time period.

193. On more than one occasion, Respondent prescribed Xanax and/or Klonopin to Patient Four prior to the time his other prescriptions were scheduled to run out.

194. Respondent changed Patient Four's dosages and/or frequencies of Xanax and Klonopin without clinical justification.

195. Alternatively to the allegations in paragraph 194, Respondent did not adequately document why he changed Patient Four's dosages and/or frequencies of Xanax and Klonopin

196. On or about September 20, 1999, Respondent concluded that Patient Four was overusing narcotics.

197. On or about September 20, 1999, Respondent concluded that all of Patient Four's prescriptions must include a release of medications on a daily basis.

198. On or about September 24, 1999, Respondent knew or should have known that Patient Four tended to overuse his narcotics.

199. On or about September 24, 1999, Respondent concluded that Patient Four's narcotics should be reduced.

200. On or about October 8, 1999, Respondent prescribed Patient Four 140 Norco tablets (10 daily).

201. On or about October 8, 1999, Respondent prescribed Patient Four 20 extra Norco tablets for emergencies.

202. On or about December 24, 1999 Respondent knew or should have known that Patient Four had taken 20 Norco in one day.

203. Between approximately January 2000 and January 2004, Respondent prescribed varying dosages of Oxycontin to Patient Four without clinical justification.

204. Alternatively, Respondent did not adequately document Patient Four's medical records with his clinical justification for prescribing varying dosages of Oxycontin to Patient Four.

205. On more than one occasion, Respondent prescribed Patient Four Oxycontin prior to the time his other prescription was scheduled to run out.

206. Between January 2000 and January 2004, Respondent prescribed Oxy IR and/or Oxyfast to Patient Four.

207. On or about February 3, 2000, Respondent reported to Rodick Services Vocational Rehabilitation that Patient Four was making significant progress reducing his use of narcotics.

208. On or about March 3, 2000, Respondent knew or should have known that Patient Four was overusing his pain medications.

209. On or about April 24, 2000, Respondent concluded that Patient Four overused his medications.

210. On or about June 9, 2000, Respondent knew or should have known that Patient Four needed treatment for opiate drug dependency.

211. On or about July 7, 2000, Respondent concluded that Patient Four had overused his pain medications.

212. On or about July 13, 2000, Respondent concluded that Patient Four had overused his pain medications.

213. On or about March 20, 2001, Respondent knew or should have known that Patient Four reported having cotton mouth, black outs, and slurred speech.

214. On or about July 23, 2001, Respondent first prescribed Patient Four Methadone.

215. From approximately July 2001 to February 2002, Respondent prescribed Patient Four Methadone without clinical justification.

216. Alternatively to the allegations in paragraph 215, Respondent did not adequately document Patient Four's medical records with his clinical justification for prescribing Methadone to Patient Four.

217. On or about August 27, 2001, Respondent concluded that Patient Four used more medications than he was scheduled to use.

218. On or about September 5, 2001, Patient Four signed an Informed Consent for the Use of Pain Control with Opiod Medications.

219. On or about November 14, 2001, Patient Four reported that some of his medications were accidentally destroyed with a coffee accident.

220. On or about November 14, 2001, Respondent prescribed Patient Four Oxycontin and Alprazolam.

221. On or about December 12, 2001, Patient Four signed a Physician-Patient Contract for Opioid Medications.

222. On or about January 15, 2002 Patient Four reported that he was doing housework, cleaning and cooking.

223. On or about January 29, 2002, Respondent concluded that Patient Four had taken additional pain medications.

224. On or about February 6, 2002, Patient Four reported doing less at work and less housework.

225. On or about February 28, 2002, Respondent first prescribed Actiq to Patient Four.

226. From about February 2002 through January 2004, Respondent prescribed Patient Four Actiq without adequate clinical justification.

227. Alternatively to the allegations in paragraph 226, Respondent did not adequately document Patient Four's medical records with his clinical justification for prescribing Actiq to Patient Four.

228. On more than once occasion Respondent prescribed Actiq to Patient Four prior to the time his previous prescription was scheduled to run out.

229. On or about March 13, 2002, Respondent knew or should have known that Patient Four was not maintaining activity.

230. On or about April 3, 2002 Respondent knew or should have known that Patient Four had a seizure the prior evening.

231. On or about April 3, 2002, Respondent's plan was for Patient Four's wife to control all of Patient Four's medications.

232. On or about May 28, 2002, Respondent first prescribed Duragesic to Patient Four.

233. Between May 2002 and January 2004, Respondent prescribed Duragesic patches to Patient Four without clinical justification.

234. Alternatively to the allegations in paragraph 233, Respondent did not adequately document Patient Four's medical records with his clinical justification for prescribing Duragesic to Patient Four.

235. On or about June 3, 2002, Respondent knew or should have known that Patient Four had a hard time coming down from his medications.

236. On or about June 24, 2002, Respondent knew or should have known that Patient Four was off of all Actiq and Fentanyl patches.

237. On or about July 29, 2002, Patient Four signed an Informed Consent on use of Pain Control with Opiod Medicines.

238. On or about August 13, 2002, Respondent restarted Patient Four on Actiq without adequate clinical justification.

239. Alternatively to the allegations in paragraph 238, Respondent did not document Patient Four's medical records with his clinical justification for restarting him on Actiq.

240. On or about September 30, 2002, Respondent knew or should have known that Patient Four overused his Actiq.

241. On or about September 30, 2002, Respondent warned Patient Four to stick to the prescribed dosages of Actiq.

242. On or about October 15, 2002, Respondent knew or should have known that Patient Four was having trouble controlling his use of Actiq.

243. On or about November 5, 2002, Respondent concluded that Patient Four overused the Actiq.

244. On or about November 7, 2002, Respondent concluded that Patient Four had good pain control.

245. On or about November 11, 2002, Respondent prescribed five boxes of Actiq to Patient Four.

246. On or about December 19, 2002, Respondent knew or should have known that Patient Four wanted his medications adjusted.

247. On or about December 19, 2002, Respondent prescribed Patient Four eight boxes of 800 ug Actiq.

248. On or about February 3, 2003, Respondent knew or should have known that Patient Four had withdrawal symptoms.

249. On or about March 25, 2003, Respondent ordered a drug test for Patient Four.

250. Respondent did not document the results of Patient Four's March 2003 drug test.

251. On or about April 9, 2003, Respondent knew or should have known that the Denver Veteran's Administration Medical Center ("VA") was considering outpatient rehabilitation for Patient Four.

252. Respondent did not follow up with the VA regarding outpatient rehabilitation for Patient Four.

253. Alternatively to the allegations in paragraph 252, Respondent did not document in Patient Four's medical records whether Patient Four followed up with the VA.

254. On or about June 4, 2003, Respondent knew or should have known that Respondent's routine drug test was negative.

255. On or about August 11, 2003, Respondent knew or should have known that Patient Four increased the use of his medications.

256. On or about August 11, 2003, Respondent knew or should have known that Patient Four had seizures from medication withdrawals.

257. On or about December 4, 2003, Respondent concluded that Patient Four used a lot of his Alprazolan.

258. On or about January 31, 2004, Respondent knew or should have known that Patient Four was admitted to the VA for benzodiazepine withdrawal.

259. On or about February 6, 2004, Respondent knew or should have known that Patient Four was moved to a psychiatric unit at the VA for further management of his multiple psychiatric issues.

260. Respondent knew or should have known that Patient Four's mother was concerned about Patient Four's narcotics use.

261. Respondent knew or should have known that his wife called Patient Four's mother and told her not to call Respondent's office again.

262. Respondent knew or should have known that Patient Four spent about eight months in the VA for drug rehabilitation and psychiatric issues.

Unprofessional Conduct: Patient Four

263. Respondent's evaluation and/or treatment of Patient Four did not meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by § 12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent did not properly manage Patient Four's use of medications;

b. Respondent did not adequately assess Patient Four's functionality in conjunction with his prescribing of narcotics;

c. Respondent prescribed medications to Patient Four prior to the time the previous prescription should have ran out;

d. Respondent did not adequately assess, monitor and/or document Patient Four's mental status during his course of treatment of Patient Four;

e. Respondent did not get appropriate consultations for Patient Four's addictions;

f. Respondent did not enforce the Informed Consent on Use of Pain Control with Opiod Medications;

g. Respondent prescribed drugs to Patient Four without considering the drug interactions between the medications; and

h. Respondent did not conduct an adequate number of urinalyses on Patient Four throughout the course of treatment.

264. Respondent's documentation of Patient Four's care was in violation of § 12-36-117(1)(cc) C.R.S., falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records for one or more of the following reasons:

a. Respondent did not adequately document Patient Four's mental health;

b. Respondent did not adequately document Patient Four's functionality in conjunction with his prescribing of narcotics;

c. Respondent did not adequately document Patient Four's medical and social history, and/or recommendations and treatment by other providers;

d. Respondent did not adequately document that Patient Four became physically and/or mentally addicted to narcotics;

e. Respondent did not document an accurate or adequate substance use or abuse history for Patient Four;

f. Respondent did not adequately document corroboration of Patient Four's history and/or phone contact with other providers, and/or did not document corroboration of any kind;

g. Respondent did not adequately document the justification for the drugs prescribed to Patient Four and/or the increases in narcotics prescribed to Patient Four; and

h. Respondent did not adequately summarize the evaluations performed by one or more specialist for Patient Four.

PATIENT FIVE

265. On or about May 25, 2001, Respondent entered a physician/patient relationship with Patient Five.

266. Patient Five's primary complaint was back pain.

267. Respondent did not take a detailed medical and/or social history, including, but not limited to, past substance use and abuse, on Patient Five.

268. Alternatively to the allegations in Paragraph 267, Respondent did not adequately document Patient Five's medical records to reflect that he took a detailed medical and/or social history, including, but not limited to, past substance use and abuse on Patient Five.

269. On or about May 25, 2001, Respondent prescribed Patient Five Oxycontin, Oxy IR, Xanax, Vioxx, and Zanaflex.

270. Respondent did not have adequate clinical justification for prescribing narcotics to Patient Five.

271. Alternatively to the allegations in paragraph 270, Respondent did not adequately document in Patient Five's medical records, his clinical justification for prescribing narcotics to Patient Five.

272. From May 2001 to October 2001, Respondent prescribed Oxycontin to Patient Five, without clinical justification.

273. Alternatively to the allegations in paragraph 272, Respondent did not adequately document Patient Five's medical records with his clinical justification for prescribing Oxycontin to Patient Five.

274. On more than one occasion, Respondent prescribed Patient Five Oxycontin before his previous prescription was scheduled to run out.

275. From May 2001 to October 2001, Respondent prescribed Oxy IR to Patient Five, without clinical justification.

276. Alternatively to the allegations in paragraph 275, Respondent did not adequately document Patient Five's medical records with his clinical justification for prescribing Oxy IR to Patient Five.

277. Respondent did not document and/or assess Patient Five's level of functionality in conjunction with narcotic usage.

278. On or about September 12, 2001, Patient Five signed an Informed Consent on the Use of Pain Control with Opioid Medications.

279. On or about October 1, 2001, Respondent knew or should have known that Patient Five had withdrawal symptoms.

280. Around October to November of 2001, Patient Five began drug rehabilitation treatment at a methadone clinic.

281. On or about November 20, 2001 Respondent prescribed Patient Five Methadone.

282. On or about December 20, 2001 Respondent prescribed Patient Five Methadone.

283. On or about February 12, 2002, Respondent discontinued Patient Five's use of Methadone, and prescribed Patient Five Oxycontin and Actiq, without clinical justification.

284. Alternatively to the allegations in paragraph 283, Respondent did not adequately document his clinical justification for discontinuing Patient Five's use of Methadone, and prescribing Patient Five Oxycontin and Actiq.

285. Patient Five terminated care with Respondent some time after February 12, 2002.

286. Respondent did not administer any drug screens to Patient Five.

287. Respondent knew or should have known that Patient Five was overusing the prescribed narcotics.

Unprofessional Conduct: Patient Five

288. Respondent's evaluation and/or treatment of Patient Five did not meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by § 12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent did not properly manage Patient Five's use of medications;

b. Respondent prescribed medications to Patient Five prior to the time the previous prescription should have ran out;

c. Respondent did not get appropriate consultations for Patient Five's addictions;

d. Respondent did not enforce the terms of the Informed Consent on the Use of Pain Control with Opiod Medications;

e. Respondent prescribed drugs to Patient Five without considering the drug interactions between the medications; and

f. Respondent did not conduct an adequate number of urinalyses on Patient Five throughout the course of treatment.

289. Respondent violated § 12-36-117(1)(cc) C.R.S. by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on Patient Five's records for one or more of the following reasons:

a. Respondent did not adequately document Patient Five's use of narcotics;

b. Respondent did not adequately document Patient Five's functionality in conjunction with his prescribing of narcotics;

c. Respondent did not adequately document Patient Five's medical and/or social history;

d. Respondent did not adequately document that Patient Five exhibited symptoms of being physically and/or mentally addicted to narcotics; and

e. Respondent did not document an accurate or adequate substance use or abuse history for Patient Five.

PATIENT SIX

290. On or about May 30, 2001, Respondent entered a physician/patient relationship with Patient Six.

291. Patient Six sought treatment from Respondent primarily for migraines and minor back pain.

292. On or about May 30, 2001 Respondent prescribed Patient Six Oxycontin, Oxy IR, Sonata and Xanax without clinical justification.

293. Alternatively to the allegations in paragraph 292, Respondent did not adequately document his clinical justification for prescribing Patient Six Oxycontin, Oxy IR, Sonata and Xanax.

294. Respondent did not adequately utilize other treatment modalities for Patient Six during the course of Patient Six's treatment.

295. Respondent did not adequately inquire into Patient Six's medical and/or social history, including, but not limited to, past substance use and abuse, before prescribing narcotics to Patient Six.

296. On more than one occasion, Respondent prescribed medications to Patient Six before the previous prescriptions were scheduled to run out.

297. On or about September 6, 2001, Patient Six signed an Informed Consent on the Use of Pain Control with Opiod Medications.

298. In September 2001, Respondent knew or should have known that starting Patient Six on long-term narcotic use would exacerbate her headaches and create opioid dependence.

299. In September 2001, Respondent knew or should have known that Patient Six had MRI and cervical spine films that were read as normal.

300. Respondent did not administer urine screens to Patient Six during the course of treatment with narcotics.

301. Respondent knew or should have known that Patient Six was overusing the prescribed narcotics.

302. Respondent knew or should have known that Patient Six went through drug rehabilitation at home.

Unprofessional Conduct: Patient Six

303. Respondent's evaluation and/or treatment of Patient Six did not meet generally accepted standards of medical practice and, thus, constituted unprofessional conduct as defined by § 12-36-117(1)(p), C.R.S. for one or more of the following reasons:

a. Respondent did not properly manage Patient Six's use of medications;

b. Respondent prescribed medications to Patient Six prior to the time the previous prescription should have ran out;

c. Respondent did not get appropriate consultations for Patient Six's addictions;

d. Respondent did not enforce the terms of the Informed Consent on the Use of Pain Control with Opiod Medications;

e. Respondent prescribed drugs to Patient Six without considering the drug interactions between the medications;

f. Respondent did not employ more conservative treatment prior to prescribing narcotics for Patient Six; and

g. Respondent did not conduct an adequate number of urinalyses on Patient Six throughout the course of treatment.

304. Respondent violated § 12-36-117(1)(cc) C.R.S. by falsifying or repeatedly making incorrect essential entries or repeatedly failing to make essential entries on Patient Six's records for one or more of the following reasons:

a. Respondent did not adequately document Patient Six's use of narcotics;

b. Respondent did not adequately document Patient Six's functionality in conjunction with his prescribing of narcotics;

c. Respondent did not adequately document Patient Six's medical and/or social history;

d. Respondent did not document that Patient Six exhibited symptoms of being physically and/or mentally addicted to narcotics; and

e. Respondent did not document an accurate or adequate substance use or abuse history for Patient Six.

NOTICE TO SET

YOU ARE HEREBY NOTIFIED that the attorney for Inquiry Panel A of the Colorado State Board of Medical Examiners will appear **July 14, 2006** in the Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202 for the purpose of obtaining a date for the hearing of the Formal Complaint of the Attorney General served herewith. You are invited to appear in person or by counsel. If you cannot be present personally or through counsel, you may contact the setting clerk at the Office of Administrative Courts (303) 866-2000 on the aforementioned date and time to participate in the setting. If you do not appear in person or by counsel, you will be notified in writing of the hearing date, time and place.

NOTICE OF HEARING

YOU ARE HEREBY NOTIFIED that pursuant to § 12-36-118, C.R.S., and §§ 24-4-104 and 105, C.R.S., a hearing on the attached Formal Complaint of the Attorney General will be held before an administrative law judge, on a date to be set, for the purpose of

At the hearing, you shall have the right to appear in person, to be represented by legal counsel at your own expense, to cross-examine any witness, to rebut any evidence presented by the complainant, and to present evidence in your own defense.

The Panel's statement with regard to an option to engage in mediation is attached for your review and signature.

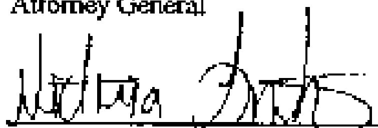
NOTICE OF DUTY TO ANSWER

YOU ARE HEREBY NOTIFIED that, pursuant to § 24-4-105(2)(b), C.R.S., you are hereby required to file a written answer to the below Formal Complaint with the Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202, within 30 days after the mailing of this Notice to Set, Notice of Hearing and Notice of Charges. You must also mail a copy of such answer to the Panel's attorney, Victoria Lovato, Assistant Attorney General, Office of the Attorney General, 1525 Sherman Street, 5th Floor, Denver, Colorado 80203.

If you fail to file your written answer within the applicable time period, an order entering a default decision may be issued against you for the relief requested in the Formal Complaint, without further notice, or such other penalties which may be provided for by law, without further notice.

Dated: May 23, 2006

JOHN W. SUTHERS
Attorney General



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