

July 2016 Public Board Actions List

Georgia Composite Medical Board
Attn: **Mr. Reginald Hawthorne**, Public Records Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303-3465
PH: (404) 463-8903
FX: (404) 656-9723
Email: reginald.hawthorne@dch.ga.gov

The Board issued **five** public orders in July 2016. To view each Board order, click on the licensee's name below.

1. Joe Mario Herrera, M.D.

064822
Physician
Public Consent Order

2. Harvey Bowen Leslie, M.D.

027597
Physician
Final Decision

3. Ronald Craig Mclean, M.D.

030163
Physician
Order of Completion

4. Daniel Tesfaye, M.D.

067614
Physician
Public Consent Order

5. Douglas Ray White, M.D.

029557
Physician
Public Board Order Terminating Probation

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:

JOE MARIO HERRERA, M.D.,
License No. 64822,
Respondent.

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GEORGIA COMPOSITE
MEDICAL BOARD

JUL 07 2016

DOCKET NUMBER:
2012 0001

PUBLIC CONSENT ORDER

By agreement of the Georgia Composite Medical Board ("Board") and JOE MARIO HERRERA, M.D. ("Respondent"), the following disposition of the matter is entered into pursuant to the provisions of O.C.G.A. § 50-13-13 (a) (4), as amended.

FINDINGS OF FACT

1.

Respondent is licensed to practice medicine in the State of Georgia and was licensed as such at all times relevant to the matters stated herein. Respondent is also licensed as a physician in the State of Florida.

2.

On or about August 18, 2015, a Final Order was entered by the Florida Board of Medicine in the matter of *Department of Health vs. Joe M. Herrera, M.D.*, DOH Case No. 2011-19533. An Administrative Complaint alleged that Respondent committed medical malpractice regarding his medical care and treatment of three (3) patients particularly as related to his prescribing of controlled substances. A Settlement Agreement was entered into between Respondent and the Department of Health, which was adopted in the Final Order, and which included the below listed sanctions. The Final Order and Settlement Agreement

("Florida Order") imposed sanctions including a reprimand, fine, administrative costs, completion of continuing education, probation for one year, and permanent restrictions. Under the Florida Order, Respondent was permanently restricted from ownership or practice in a pain management clinic, treatment of chronic, non-malignant pain, and the prescribing of Schedule I through IV controlled substances except in a hospital or ambulatory surgery center setting.

3.

Respondent admits the above findings of fact and waives any further findings of fact with respect to the above-styled matter.

CONCLUSIONS OF LAW

Respondent's conduct and disciplinary action in another state constitutes sufficient grounds for the imposition of discipline upon his license to practice medicine in the State of Georgia pursuant to O.C.G.A. Chs. 1 and 34, T. 43, as amended. Respondent waives any further conclusions of law with respect to the above-styled matter.

ORDER

The Georgia Composite Medical Board, having considered the particular facts and circumstances of the case, hereby orders, and Respondent hereby agrees, to the following:

1.

Respondent must fully comply with the Florida Order. If any reports are required under the Florida Order, they shall also be submitted to the Board. Evidence of satisfaction of the continuing education required under the Florida Order shall be submitted to the Board

within thirty (30) days of the effective date of this Order or completion of the continuing education, whichever is later. If Respondent's license is suspended in Florida for failure to comply with the Florida Order, Respondent's Georgia license shall be summarily suspended, pending further proceedings.

2.

Respondent's practice in the State of Georgia shall be permanently restricted as follows:

(1) Respondent may not own, operate or be employed by a pain management clinic;

(2) Respondent may not treat any patient for "chronic pain" as defined by O.C.G.A §43-34-282 and in Board Rule 360-3-.06; and

(3) Except for practice in a hospital setting or ambulatory surgery center setting, Respondent shall be permanently restricted from the prescribing of Schedule I through IV controlled substances.

3.

This Consent Order shall constitute a public reprimand of Respondent by the Board.

4.

Respondent shall abide by all State and Federal laws regulating his practice of medicine or relating to drugs, the Rules and Regulations of the Georgia Composite Medical Board and the terms of this Consent Order and the Florida Order. If Respondent shall fail to abide by such laws, rules or terms, or if it should appear from reports submitted to the Board that Respondent is otherwise unable to practice with reasonable skill and safety to patients, Respondent's license shall be subject to further discipline, including revocation, upon substantiation thereof after notice and hearing, and if revoked, the Board in its discretion may

determine that the license should be permanently revoked and not subject to reinstatement. Respondent further agrees that any violation of the Consent Order shall be deemed to be sufficient to authorize the Board to order summary suspension of Respondent's license, pending further proceedings, pursuant to the provisions of the Georgia Administrative Procedure Act, O.C.G.A. § 50-13-18(c)(1), or any other statute authorizing emergency action, but Respondent understands that Respondent shall be entitled to an expedited hearing to substantiate such violation(s), if the Board exercises such right.

5.

Respondent understands that pursuant to O.C.G.A. Title 43, Chapter 34A the contents of this Order and the Florida Order shall be placed on Respondent's Physician Profile. Furthermore, by executing this Consent Order, Respondent hereby agrees to permit the Board to update the Physician Profile reflecting the orders. Respondent also understands and agrees that the Board will report this Order, once docketed, to the local DEA and/or Georgia Drugs and Narcotics Agency.

6.

Approval of this Consent Order by the Georgia Composite Medical Board shall in no way be construed as condoning the Respondent's conduct, and shall not be construed as a waiver of any of the lawful rights possessed by the Board. **This Consent Order shall not become effective until approved and docketed by the Georgia Composite Medical Board.**

7.

Respondent acknowledges that he has read this Consent Order and understands its contents. Respondent understands that he has a right to a hearing, and freely, knowingly, and

voluntarily waives that right. Respondent understands that the Consent Order will not become effective until approved and docketed by the Georgia Composite Medical Board. Respondent further understands that the Board shall have the authority to review the investigative file and all relevant evidence in considering the Consent Order. Respondent further understands that the Consent Order, once approved, and its dissemination shall constitute a public record evidencing disciplinary action. However, if the Consent Order is not approved, it shall not constitute an admission against interest in the proceeding, or prejudice the right of the Board to adjudicate the matter. Respondent consents to the terms and conditions contained herein.

Approved, this 7th day of July, 2016.

GEORGIA COMPOSITE MEDICAL BOARD

John S. Antalis, MD

BY: _____

~~ALICE HOUSE, M.D.~~ John S. Antalis, MD
Chairperson

ATTEST: _____

Robert Jeffery
ROBERT JEFFERY
Executive Director

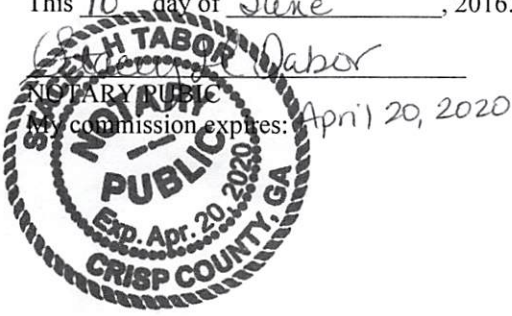
CONSENTED TO:

Joe Mario Herrera

JOE MARIO HERRERA, M.D.
Respondent



[As to Respondent's signature:]
Sworn to and subscribed before me
This 10 day of June, 2016.



**BEFORE THE GEORGIA COMPOSITE BOARD OF MEDICAL
STATE OF GEORGIA**

GEORGIA COMPOSITE MEDICAL BOARD,)
)
 Petitioner,)
)
 v.)
)
 HARVEY B. LESLIE, MD)
 License no. #: 27597)
)
)
 Respondent.)

GEORGIA COMPOSITE
MEDICAL BOARD

JUL 22 2016

DOCKET NUMBER: 2016001

FINAL DECISION

The above-styled matter came before the Georgia Composite Medical Board on July 7, 2016, for agency review of an Initial Decision issued on May 4, 2016, by Ronit Walker, Administrative Law Judge. Appearing on behalf of the Board was J. David Stubins, Senior Assistant Attorney General, and appearing on behalf of Harvey B. Leslie, M.D. ("Respondent") was Colette Resnik Steel. Respondent, Dr. Leslie, was also present.

The Board received Respondent's application for agency review hearing on or about June 3, 2016, within thirty days after service of the Initial Decision. Thereafter, on or about June 13, 2016, the Board entered an Order Extending Time For and Scheduling Review, whereby the review hearing was scheduled for July 7, 2016.

After conducting the agency review hearing, review of the whole record, and receipt and consideration of arguments, the Board hereby enters this Final Decision.

FINDINGS OF FACT

The Findings of Fact entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

ORDER

Based on the foregoing, and consistent with the recommendations of the Administrative Law Judge as to disciplinary sanctions against the Respondent's license to practice medicine in the State of Georgia, the Respondent's medical license shall, effective upon docketing of this order, be limited indefinitely to the extent that he may not prescribe controlled substances as defined in 21 U.S.C Sec. 812, until such time as he has taken and passed the Mercer Prescription Course. Upon the successful completion of that course, Respondent may petition the Board, requesting that it reconsider his prescription privileges.

This is the FINAL DECISION of the Board as a matter of law under O.C.G.A. Sections §§ 50-13-17 and 50-13-41.

THIS THE 22ND DAY OF JULY, 2016.



(BOARD SEAL)

GEORGIA COMPOSITE MEDICAL BOARD

BY: *John S. Antalis, MD*

JOHN S. ANTALIS, MD
Chairperson

ATTEST: *Robert Jeffrey*
ROBERT JEFFERY, MBA
Executive Director

II. Findings of Fact

A. Background

1.

Respondent holds a license to practice as a physician in the State of Georgia, and has held such certificate at all times relevant to the issues presented for hearing. (Statement of Matters Asserted ¶ 1; Transcript at p. 217 (hereinafter T.)).

2.

Respondent is a solo practitioner in Decatur, Georgia. (T. 181). He estimates that he treats more than 50% of his patients for pain management. (T. 218-19).

3.

The American Board of Anesthesiology provides board certification in the subspecialty of pain management. (T. 89-91). Respondent is not board certified in pain management. He holds a diplomate from the American Academy of Pain Management and is a member of the American Society of Interventional Pain Physicians. (T. 181-82).

4.

In 2010, the Board determined that Respondent had hired unlicensed individuals to provide physical therapy to his patients and sanctioned Respondent's license, ordering him to cease and desist from this practice. (T. 217-18).

5.

Following the imposition of this sanction, the Board issued subpoenas for the complete medical records of several patients treated by Respondent. Respondent provided records to the Board. (Exhibits P-2, P-3, P-6).

6.

After receiving the records that Respondent provided, the Board contacted peer reviewer Barry Neil Straus, M.D., and requested that he review the records that Respondent submitted for two patients—D.P. and C.T.—to determine whether Respondent’s treatment conformed to the minimum standards of acceptable and prevailing medical practice in the State of Georgia. (T. 22).

7.

Based on his review of the subpoenaed records for patients D.P. and C.T., Dr. Straus concluded that Respondent’s diagnosis, treatment and recordkeeping for these patients did not meet the minimum standards of acceptable and prevailing medical practice. (T. 22-39; Exhibits P-2, P-3).

8.

On July 7, 2015, the Board issued a Statement of Matters Asserted charging that Respondent’s diagnosis, treatment and recordkeeping for patients D.P. and C.T. failed to conform to the minimum standards of acceptable and prevailing medical practice. (Statement of Matters Asserted ¶ 3).

9.

During an administrative hearing, the Board presented expert testimony from Dr. Straus, who had evaluated the records provided by Respondent (the “subpoenaed records”). (See T. 7-82; Exhibits P-2, P-3). Respondent presented rebuttal expert testimony from Thomas T. Simopoulos, M.D. Dr. Simopoulos reviewed what Respondent identified as the complete records for patients D.P. and C.T. (the “expanded records”). The expanded records included

documents that had not been provided to the Board in response to the issued subpoenas.³ (See T. 84-172, 182-83; Exhibits R-3, R-4).

B. Patient D.P.

10.

From August 2007 through April 2011, Respondent treated D.P. for cervical disk degeneration. (T. 66, 106; Exhibits P-2, R-3). Respondent's records reflect that D.P., a female in her sixties, had a history of lower back and neck pain. She also suffered from multiple other medical problems, including hypertension, diabetes and chronic obstructive pulmonary disease. (T. 23-24, 103-05, 183-84, 192; Exhibits P-2, R-3).

11.

During the course of treatment, Respondent obtained orthopedic records from D.P.'s previous physicians. (T. 58, 108; Exhibit R-3). The records indicated that D.P. had an established "C-6/7 disk herniation." Prior to being treated by Respondent, she had received epidural steroid injections and been placed on opioid therapy. (T. 108-09; Exhibit R-3). Controlled substances, such as opioids, have a high potential for abuse. (T. 11).

³ The Board objected to the admission of the expanded records, as Respondent had failed to provide a number of documents within the records in response to the Board's subpoenas. When responding to a request or subpoena for patient records, Respondent testified that he typically includes the patient's history, examinations performed and progress notes, while excluding information placed in the folder's side pocket—such as insurance information and referrals. Respondent conceded that any referrals should have been included in the subpoenaed records, but explained that he had not personally prepared the records in response to the subpoenas. (T. 219-20; see also Exhibits R-3 & R-4). As the Board did not have any grounds to challenge the authenticity of the expanded records, and had received them for review approximately a week prior to the hearing, they were admitted into evidence. However, the undersigned notes that multiple additional documents, beyond insurance information and referrals, were omitted from the subpoenaed records. For example, all of D.P.'s examination notes from August 2007 to September 2008 were not submitted in response to the subpoena, but do appear in the expanded record. (Compare Exhibit P-2 with Exhibit R-3). The majority of D.P.'s and C.T.'s physical therapy notes also were not provided to the Board in the subpoenaed records. (Compare Exhibits P-2, P-3 with Exhibits R-3 and R-4).

12.

Respondent met with D.P. once a month. D.P. reported her pain level as fluctuating between 7 and 9 on a scale of 1-10, 10 being the most acute pain level. (Exhibits P-2, R-3).

13.

Also during the course of treatment, Respondent prescribed the following medications: Percocet, which contains Oxycodone, 10mg four times daily; Soma, 350mg four times daily; Tramadol, four times daily; and Ambien and Xanidine for nightly use. (T. 23-24; Exhibits P-2, R-3).

14.

In addition to medication, D.P. engaged in physical therapy at least once a month during all but eight months of treatment.⁴ (T. 71, 73; Exhibit R-3). According to the notes from the physical therapy sessions, D.P. reported that her pain level ranged from 4 to 10. In the last two years of treatment, D.P. reported her pain level as ranging from 7 to 9. (Exhibit R-3).

15.

Respondent treated D.P with nerve-block injections on at least three occasions.⁵ (T. 71; Exhibit R-3). Respondent also referred D.P. to specialists in order to treat health issues other than pain management. (T. 72).

16.

On March 21, 2011, Respondent issued a total of ten prescriptions to D.P. including the prescriptions for Soma, Ambien, Tramadol, and Percocet. (T. 198; Exhibit R-3). Shortly thereafter, a member of Respondent's staff placed a note in D.P.'s file stating the following: "Just got Rx on 3/21/2011. Pt. family has called several times asking us why is she on all these

⁴ There were no records of physical therapy for the following months: March, April, July, August, November, and December 2008; and January and February 2009. (Exhibits P-2, R-3).

⁵ Nerve block injections were administered on December 9, 2008, October 27, 2009, and January 1, 2009.

Rx. States she's always crying. Started wetting her clothes and acts out." The note did not include the names or contact information of the family members who had contacted Respondent. (Exhibits P-2, R-3). Respondent did not contact D.P.'s family regarding the message and D.P.'s records do not reflect that Respondent addressed the reported issues with D.P. (T. 195; Exhibits P-2, R-3). Other than this note, the records for D.P. contain no other evidence or warnings of either drug-use aberrancies or a history of drug abuse. (T. 70-71, 112-13; Exhibits P-2, R-3).

17.

D.P.'s last visit with Respondent was on April 6, 2011. At that time, Respondent referred D.P. to a physician whose offices were located near her home in Carrollton, Georgia. (T. 194; Exhibits P-2, R-3).

Testimony of Dr. Straus

18.

Dr. Straus has been a physician for approximately thirty-six years, and licensed in Georgia since 1985. He holds a B.A. from Rensselaer Polytechnic Institute, an M.D. from Albany Medical College, and a J.D. from Georgia State University. Dr. Straus is board certified by the American Board of Anesthesiology, with a subspecialty in pain medication. He has exclusively practiced in the field of pain medicine since 1990, and serves on the Medical Association of Georgia's Task Force on Prescription Drug Monitoring. From 1991 to 2013, Dr. Straus was the Medical Director of the North Georgia Pain Clinic in Atlanta, Georgia. He currently operates a practice with two other anesthesiologists to provide pain medicine and interventional pain management in the northern Atlanta area. Dr. Strauss has published articles, lectured and provided expert testimony in the field of pain management, and has been a peer reviewer for the Board since 2003. (T. 7-9, 40-41; Exhibit P-1).

19.

Based upon his review of the subpoenaed records, Dr. Straus testified that Respondent's care for D.P. fell below minimum standards. According to Dr. Straus, a physician should not continue to prescribe pain medication unless a patient experiences a 30 percent reduction in pain. D.P.'s repeated reports of 9 or 10 on the pain scale would indicate either that the medication was proving to be ineffective, or that she was abusing/not taking her medication. (T. 76-77). However, Dr. Straus did note that, while D.P.'s prescribed medications were "not optimal," they remained "within the lines so long as the patient had a good diagnosis and had shown other things hadn't been a problem and there was [sic] no other issues." (T. 24).

20.

Dr. Straus also testified that Respondent did not provide the minimum standard of care because he failed to respond in any way to the concerns raised by D.P.'s family, as recorded on the note dated March 21, 2011. The minimum standard of care would require physicians to respond to such concerns, just as they would address the aberrant results of a drug test. At the very least, a physician would need to discuss the matter with the patient. (T. 24-25).

21.

Additionally, Dr. Straus testified that Respondent's recordkeeping for his treatment of D.P. was "pretty terrible," falling below the minimum standards of acceptable and prevailing medical practice. Dr. Straus stated that he could not determine from the notes how D.P. was responding to the medications provided or to the procedures performed. As a specific example, one note, made during D.P.'s exam on October 5, 2009, stated that D.P. was complaining of "pain level 8/10" and had been "coughing up blood since Sunday." Dr. Straus asserted that a pain level of 8 indicated that pain medication was not working, and that coughing up blood "normally would

need some type of workup.” However, he testified that D.P.’s records did not reflect that any follow-up occurred on these two issues. (T. 26; Exhibits P-2, R-3).

Testimony of Dr. Simopoulos

22.

Dr. Simopoulos has been practicing medicine for approximately twenty years. He holds a B.A. and M.A. in biochemistry from Brandeis University, and earned his M.D. from the University of Massachusetts Medical School. He completed a residency in anesthesiology and a fellowship in pain management, and has practiced pain management since 2003. Dr. Simopoulos is board certified by the American Board of Anesthesiology, with a subspecialty in pain medication. He is employed as the director of interventional pain services at Beth Israel Deaconess Medical Center in Boston, and also serves as an assistant professor at Harvard Medical School. Dr. Simopoulos is on the editorial board of the American Society of Interventional Pain Physicians, and has both lectured and written extensively in this field. (T. 84-92; Exhibit R-1). Dr. Simopoulos has never practiced in Georgia, nor is he licensed in Georgia. (T. 146).

23.

Dr. Simopoulos testified that he reviewed both the subpoenaed and expanded records. After this review, Dr. Simopoulos concluded that Respondent’s treatment of D.P. fell “within the usual course of medical care” for the period between 2007 and 2011, while also meeting the standard of care recognized nationally for patients with chronic pain. (T. 110-11).

24.

Dr. Simopoulos maintained that D.P.’s prescribed medications were appropriate, reasonable and medically necessary. As an initial matter, D.P.’s co-existing conditions made surgery a significant risk, thereby making pain management medication the more appropriate treatment.

(T. 109). In his view Respondent prescribed “typical doses” of the medications, with D.P. only receiving “minor dose increases.”⁶ (T. 110-11, 124). Dr. Simopoulos agreed that if a patient’s condition improved, the standard of care would call for physicians to reduce the level of opioids. However, if conditions are chronic, “opioids tend to at best stay stable, or increase because people are getting older, the conditions don’t improve for the most part, and there’s also the factor of tolerance.” (T. 153-54). Dr. Simopoulos also noted that, in addition to medication, Respondent attempted “reasonable” alternative modalities when treating D.P., including physical therapy and injections. (T. 111-12).

25.

Dr. Simopoulos further testified that D.P.’s consistent reports of acute pain levels over time did not necessarily indicate that the medications were ineffective. Rather, patients often report their pain levels as the level they feel while they are not on medications, concerned that reporting lower levels will result in drug therapy ceasing altogether. (T. 122-23). In 2007, the prevailing standard of care was to believe a patient’s self-report regarding her level of pain. (T. 122).

26.

As for record-keeping, Dr. Simopoulos testified that Respondent would not be expected to note “a whole lot of physical exam findings,” given that he saw D.P. monthly and chronic pain tends to stay stable. (T. 115-16, 151-52). Looking specifically at the examination documents from May 8, 2009, Dr. Simopoulos stated that these notes met the minimum standard, as the records show “there’s at least a documented complaint[, a physical examination and assessment and a plan.” (T. 119-20). However, Dr. Simopoulos conceded that he could not decipher several of the May 8 notations at all. Also, although Respondent did not find any deficits during the

⁶ At one point in his testimony, Dr. Simopoulos stated that “the recipe” for D.P.’s medication, “wasn’t quite right,” but did not elaborate further. However, he maintained that the medication regimen nonetheless was “reasonable.” (T. 111).

examination, Dr. Simopoulos observed that “we don’t know exactly what [Respondent] evaluated.” (T. 117-18).

27.

Dr. Simopoulos agreed that a physician who prescribes alternative modalities like physical therapy and interventional medicine should make notations as to the patient’s responses to these treatments. He did not recall seeing any such notations in D.P.’s records for the physical therapy or injections. (T. 153).

Testimony of Respondent

28.

Respondent testified that he obtained D.P.’s prior orthopedic records and conducted a “full history and physical” during her initial visit in August 2007. (T. 183-85). He asserted that he evaluates patients every time he sees them. (T. 194, 200).

29.

Respondent conceded that he did not make any calls to D.P.’s family after receiving the note detailing their concerns about D.P.’s medication. According to Respondent, the note did not provide a phone number; further, he did not want to violate HIPAA by discussing D.P.’s treatment with third parties. (T. 195). Although he could not recall whether he discussed the note with D.P. during her next visit, he admitted that the records did not reflect any such discussion. (T. 221). Rather, during D.P.’s next visit on April 6, 2011, Respondent referred her to another physician who was geographically closer, reasoning that, “if the family is calling, maybe she needs more intimate care.” (T. 196, 198-200).

30.

Regarding record-keeping of D.P.'s treatment, Respondent testified that he primarily placed copies of the prescriptions in the files, rather than writing them down in the progress notes. (T. 189). He conceded that he "might not write a lot of detail" in his examination notes, but that "you find how detailed the patient's treatment is by what prescriptions is (sic) written for the patient." (T. 194). As to the note that D.P. was "coughing up blood," Respondent testified that he referred D.P. to an ear, nose and throat specialist, and documented the referral.⁷ (T. 192, 200).

C. Patient C.T.

31.

From 2009 to 2012, Respondent treated patient C.T. for pain management. (T. 230; Exhibits P-3, R-4). Respondent's records reflect that C.T. was a forty five year old female with low back pain and other significant medical issues, including a history of ovarian cancer, disk degeneration and lumbosacral radiculitis. (T. 73, 127, 204).

32.

In early December of 2009, Respondent wrote C.T. a prescription for Lortab, 10mg four times daily. (T. 29; Exhibits P-3, R-4). On December 23, 2009, Respondent prescribed Soma, a muscle relaxant, 350mg four times daily. (T. 29; Exhibit R-4). A few weeks later, on January 7, 2010, Respondent added Oxycontin, 40mg two times daily, to C.T.'s regimen, essentially tripling the amount of narcotics being prescribed. (T. 29). Eventually, Respondent also prescribed Xanax. (T. 30).

⁷ Both the subpoenaed records and the expanded records include a referral, dated October 13, 2009, to a health provider in Carrollton, Georgia, for "evaluation and treatment." However, it does not indicate the reason for this referral. (See Exhibits P-2, R-3).

33.

Lortab, Oxycontin and Xanax are controlled substances. (T. 30). The Drug Enforcement Administration (“DEA”) ranks these substances from I through V, with schedule I controlled substances having the highest risk for abuse. (T. 11).⁸ Narcotics also have a high rate of “diversion,” in that patients with prescriptions for controlled substances will sell their medications to third parties. (T. 15).

34.

In order to prescribe controlled substances, a physician has to obtain a license from the Drug Enforcement Administration (“DEA”). (T. 10-11). Given the potential for abuse, physicians must exercise caution in prescribing controlled substances, taking care to treat patients with appropriate medications and using multiple modalities. (T. 10-12). Further, a physician should monitor a patient for possible abuse or addiction by mandating that the patient undergo drug testing and responding to an aberrant result. (T. 17-19).

35.

Approximately a year after her initial appointment, Respondent began to administer drug screening to C.T. (T. 35). The majority of the screens reflected “aberrant results,” indicating that for over fourteen months C.T. did not take her medication appropriately. (T. 32-39).

⁸ In addition to the schedules for controlled substances issued by the federal government in 21 U.S.C. § 812, Georgia also regulates controlled substances. See, e.g., O.C.G.A. § 16-13-26(1)(A)(xiv) (listing oxycodone as a Schedule II controlled substance). O.C.G.A. § 16-13-28(a)(1) identifies alprazolam, also known as Xanax, as a Schedule IV substance.

Testimony of Dr. Straus

36.

In Dr. Straus's opinion, Respondent's diagnosis, treatment and recordkeeping for C.T. all fell below minimum standards. (T. 23, 28-35).

37.

Dr. Straus testified that C.T.'s physical examinations and diagnostic testing did not justify "the prescriptions and treatment in this case" (T. 31-32).⁹ He acknowledged that Respondent did order C.T. to undergo a nerve conduction study, which would assist a physician in making a diagnosis. (T. 74-75). However, he opined that the results of this study still did not justify the prescribed medication: "[T]here was no history she had tried multiple other medications, she was started on the highest possible dose of hydrocodone . . . along with a drug for muscle spasms with no documentation that there were muscle spasms." (T. 30, 81).¹⁰ Moreover, although C.T.'s expanded medical records reflect that Respondent attempted other modalities in addition to the use of controlled substances to address C.T.'s pain, including physical therapy, non-narcotic medications, and lumbar and sacroiliac joint injections, the records do not document her response to these modalities. (T. 31, 73, 204; Exhibits P-3, R-4).

38.

At the beginning of C.T.'s treatment, Respondent and C.T. both signed a pain management agreement, explicitly providing that C.T. would not use illegal drugs. The pain management agreement also stated that if Respondent determined C.T. was using illegal drugs, he could cease prescribing opioids. (Exhibits P-3; R-4).

⁹ Well after prescribing controlled substances Respondent ordered Magnetic Resonance Imaging, the results of which were "essentially normal." (T. 28, 32).

¹⁰ In Dr. Straus's opinion, Lortab, Soma, Oxycontin and Xanax constitute an "abuse sort of combination." (T. 30).

39.

Dr. Straus reviewed the results of C.T.'s drug screens. On December 10, 2010, C.T.'s drug screen was negative, reflecting that she had taken none of the prescribed medication the week before testing, an "aberrant result." (T. 32). Respondent continued to prescribe pain medication. (T. 33).

40.

On January 15, 2011, C.T.'s drug screening again indicated she was negative for Oxycontin. (T. 33). The minimum standards of acceptable and prevailing medical practice would mandate that Respondent discuss the negative drug screen with C.T. to make sure that she was not consuming more medication than prescribed and then running out of medication. (T. 35-36). Dr. Straus did not find any records indicating that Respondent discussed the results of this screening with C.T. (T. 33).

41.

Dr. Straus testified that if a physician suspects a patient is abusing his or her medication, the physician must make a referral to an addiction counselor. (T.18). A physician should either terminate treatment, or refuse to prescribe additional medication, until information is received from the counselor. (T. 18-19).

42.

On April 15, 2011, the drug screening demonstrated that the prescribed medications were being taken appropriately. (T. 33).

43.

On May 13, 2011, the drug screening demonstrated that C.T. had cocaine in her system, but indicated she was negative for hydrocodone – thus testing positive for an illegal drug and negative for the prescribed medication. Dr. Straus testified that at a minimum Respondent should have referred C.T. to an addiction specialist, informing her that he would not continue to prescribe pain medication unless C.T. demonstrated that she was taking steps to deal with her addiction. (T. 36). He also should have documented his response to the aberrant screenings, including an explanation as to why he did not terminate care. (T. 38).¹¹ According to Dr. Straus, the records do not indicate there was any discussion between Respondent and C.T. about the results of the May 13, 2011, screening, nor did Respondent document the reasons that he did not terminate treatment. (T. 33, 38).

44.

In July 2011, C.T. tested positive for amphetamines, but records do not indicate Respondent discussed these results with C.T. (T. 33-34). After another positive test for illegal drugs or a negative screen for medication, Dr. Straus asserted that at a minimum, Respondent should have terminated care. (T. 36-37).

45.

The next four drug screens, through January 2012, demonstrated that C.T. had ingested numerous illegal controlled substances including cocaine, amphetamines, and ecstasy. C.T. also tested positive for methadone. (T. 34-35). In February 2012, the drug screen reflected C.T. tested positive for cocaine, amphetamines, and methadone. (T. 35). The screens provided solid

¹¹ After C.T. tested positive for an illegal substance and negative for her prescribed medication, Dr. Straus believes that the vast majority of physicians in Georgia would have discharged C.T. from care. (T. 33, 36). In fact, Dr. Straus does not know “anyone in the state who doesn’t terminate [when a drug screen reflects] cocaine.” (T. 38).

evidence that C.T. had both cocaine and methadone in her system, indicating that that she was selling her prescription medication for cocaine. (T. 39).

46.

As pain management standards are “evolving,” Dr. Straus acknowledged that the treatment with controlled substances has been “controversial,” with difficulties arising both from under-treatment and over-treatment. (T. 43).

47.

Subsequent to Respondent’s treatment of C.T., the Board promulgated Ga. Comp. R. & Regs. r. 360-3-.06(2). Rule 360-3-.06(2) (2012) specifically addressed pain management, issuing protocols for physicians who prescribe controlled substances. (T. 48-49).¹²

¹² In part, this regulation provided that the minimum standards of practice include, but are not limited to the following:

- (c) When initially prescribing a controlled substance for the treatment of pain or chronic pain, a physician shall have a medical history of the patient, a physical examination of the patient shall have been conducted, and informed consent shall have been obtained.

...

- (d) When a physician is treating a patient with controlled substances for pain or chronic pain for a condition that is not terminal, the physician shall obtain or make a diligent effort to obtain any prior diagnostic records relative to the condition for which the controlled substances are being prescribed and shall obtain or make a diligent effort to obtain any prior pain treatment records. The records obtained from prior treating physicians shall be maintained by the prescribing physician with the physician’s medical records for a period of at least ten (10) years. If the physician has made a diligent effort and is unable to obtain prior diagnostic records, then the physician must order appropriate tests to document the condition requiring treatment for pain or chronic pain. If the physician has made a diligent effort and the prior pain treatment records are not available, then the physician must document the efforts made to obtain the records and shall maintain the documentation of the efforts in his/her patient record.
- (e) When a physician determines that a patient for whom he is prescribing controlled scheduled substances is abusing the medication, then the physician shall make an appropriate referral for treatment for substance abuse.
- (f) When prescribing a Schedule II or III controlled substance for 90 (ninety) days or greater for the treatment of chronic pain arising from conditions that are not terminal, a physician must have a written treatment agreement with the patient and shall require the patient to have a clinical visit at least once every three (3) months to evaluate the patient’s response

48.

Notwithstanding that the Board promulgated Rule 360-3-.06(2) after Respondent had treated C.T., Dr. Straus testified that standards of care are not limited “to what is specifically spelled out in the Board rules.” (T. 79). The standard of care “depends on what sort of reasonable physicians practicing nationwide do as a minimum standard of care.” (T. 79). General minimum standards of acceptable and prevailing practice mandate a prescription “has to be for a legitimate medical reason in the normal course of medical practice.” (T. 51). Dr. Straus did not find anything in the record indicating that Respondent met the standard of care; the records demonstrated that he had failed to “appropriately” treat C.T. (T. 81). Additionally, given the lack of documentation that there was any discussion between C.T. and Respondent regarding the results of her drug screens, Dr. Straus also concluded that Respondent’s recordkeeping for C.T. failed to conform to the minimum standards of acceptable and prevailing medical practice in Georgia. (T. 23; P-3).

Testimony of Dr. Simopoulos

49.

Dr. Simopoulos reviewed both C.T.’s subpoenaed and expanded medical records. (T. 126). According to Dr. Simopoulos, “[t]here’s no mathematical formula” regarding opioid therapy, and dosing is dependent on a physician’s judgment. Some physicians begin treatment using higher

to treatment, compliance with the therapeutic regimen through monitoring appropriate for that patient, and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances. The physician shall respond to any abnormal result of any monitoring and such response shall be recorded in the patient’s record. Exceptions to the requirement of a clinical visit once every three (3) months may be made for hardship in certain cases and such hardship must be well documented in the patient record. When a physician determines that a new medical condition exists that is beyond their scope of training, he/she shall make a referral to the appropriate practitioner.

....

dosages. (T. 97). Considering C.T.'s medical history and the fact that Respondent had used multiple modalities to treat her pain, Dr. Simopoulos concluded that Respondent's treatment met minimum standards of care. (T. 127-131).¹³

50.

Regarding C.T.'s aberrant drug screens, Dr. Simopoulos noted that "in 2009, if we look at the opioid guidelines, they didn't say what we should absolutely do with these results" (T. 136). He has observed "dramatic variability in [physicians'] approaches to [aberrant screens]." (T. 99). In Dr. Simopoulos's experience, there are some physicians who believe that if treatment is terminated after aberrant screening, a patient may be even more likely to abuse illegal substances. (T. 141, 143). Dr. Simopoulos agreed that in light of clear evidence of abuse at some point a physician should decline to continue to prescribe controlled substances; in his personal medical practice he has terminated opioid treatment for a patient after four negative screens. (T. 142-43).

51.

During his review of the expanded records, Dr. Simopoulos found documentation that Respondent had referred C.T. to New Beginnings Today, a drug rehabilitation facility. (T. 140, 155). He would have expected Respondent to have conducted a follow-up from the referral, but there was no evidence that Respondent had any further discussion with C.T. regarding rehabilitation. (T. 156). Even if termination in this case was not mandated under minimum standards of acceptable and prevailing medical practice, Dr. Simopoulos agreed with the Board's expert that Respondent should have documented his responses to the aberrant screens in C.T.'s medical record. (T. 143). Respondent's failure to adequately document the record fell below minimum standards. (T. 127, 167-68).

¹³ The expanded records contained the majority of C.T.'s physical therapy notes. (Compare Exhibits P-3, R-4).

Testimony of Respondent

52.

Respondent acknowledged that he had signed a pain management agreement with C.T. Despite the pain management agreement's statement that he could cease opioid therapy if a patient used illegal drugs, Respondent testified that as long as a patient had medication in his or her system he would continue to treat the patient because he didn't want to "abandon" his patients. (T. 212).

53.

In the instant case, Respondent did not terminate C.T.'s treatment because he does not "believe in throwing people away." (T. 226). Moreover, he did not think C.T. was abusing drugs, just that "she was having fun with illicit drugs" (T. 226).

54.

In response to an aberrant screen, Respondent's protocol would be to discuss these results with a patient. (T. 209).

55.

Respondent acknowledged he had "a tendency not to write that much in the chart . . . a lot of times I don't write it in the chart." (T. 209). Based on the poor quality of his recordkeeping, at the hearing Respondent was unable to accurately assess C.T.'s treatment. Regarding C.T.'s drug screens, he initially erred in testifying that she had only used illegal drugs "maybe six or eight months, I don't know if it was a year, it didn't go on that long, she was off and she wasn't on drugs any more." (T. 213). Despite the fact that C.T. continually tested positive for illegal drug use, Respondent asserted he "got her off [drugs] and she did fine." (T. 213).

56.

In addition, Respondent was unable to recall the circumstances under which he referred C.T. to New Beginnings Today for rehabilitation, "since it's not documented in the chart, I can't — you know, I don't want to say what I did and didn't do." (T. 211).

57.

Currently, his practice has begun to take more stringent measures to prevent the abuse of prescription medication. Respondent now checks to see if patients receive controlled substances from other sources, or divert their prescriptions for financial gain. He will work with a patient abusing illegal drugs to ensure that they are receiving treatment for addiction. (T. 233-34).

Testimony of C.T.

58.

C.T. testified on Respondent's behalf. Due to a variety of circumstances, she has suffered from chronic pain for most of her life. (T. 175). She now has end-stage ovarian cancer and is in hospice care. (T. 178).

59.

C.T. described Respondent as "a wonderful doctor. . . ." (T. 177). He was an "attentive" physician, asking "all the time" whether or not an administered treatment was effective. (T. 177-79). She left his practice only when she had to move away from the Atlanta area. (T. 179).

III. Conclusions of Law

1.

The Board bears the burden of proof in this matter. Ga. Comp. R. & Regs. r. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21(4).

2.

Professional licensing boards may discipline a licensee upon a finding by a majority of the entire board that the licensee has engaged in unprofessional conduct that fails to conform to the minimal reasonable standards of acceptable and prevailing practice or engaged in conduct that has violated a statute, law, or any rule or regulation of this state. O.C.G.A. § 43-1-19(a)(6), (8).

3.

Under O.C.G.A. § 43-34-8(a), the Board has the authority to discipline a physician upon a finding that the licensee has:

- (7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or failure to conform to, the minimum standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimum standards of acceptable and prevailing medical practice or by rule of the board;

...

- (10) Violated or attempted to violate a law, rule, or regulation of this state, any other state, the board, the United States, or any other lawful authority without regard to whether the violation is criminally punishable, which law, rule, or regulation relates to or in part regulates the practice of medicine, when the licensee or applicant knows or should know that such action is violative of such law, rule, or regulation; or violated a lawful

order of the board, previously entered by the board in a disciplinary hearing;

...

- (19) Failed to maintain appropriate medical or other records as required by board rule;

....

4.

Pursuant to Ga. Comp. R. & Regs. r. 360-3-.02, unprofessional conduct includes:

- (1) Prescribing controlled substances for a known or suspected habitual drug abuser or other substance abuser in the absence of substantial justification.

...

- (7) Failing to maintain appropriate patient records whenever Schedule II, III, IV or V controlled substances are prescribed. Appropriate records, at a minimum, shall contain the following:

- (a) The patient's name and address;
- (b) The date, drug name, drug quantity and patient's diagnosis necessitating the Schedule II, III, IV or V controlled substances prescription; and
- (c) Records concerning the patient's history.

...

- (16) Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response.

...

- (18) Any other practice determined to be below the minimal standards of acceptable and prevailing practice.

5.

If the Board finds cause for discipline, it may deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician. O.C.G.A. § 43-34-8(b)(1), see also O.C.G.A. § 43-1-19(d).

A. Patient D.P.

6.

The Board proved, by a preponderance of the evidence, that Respondent's treatment and recordkeeping failed to meet the minimum standards of acceptable and prevailing medical practice in violation of O.C.G.A. §§ 43-1-19, 43-34-8, and Ga. Comp. R. & Regs. 360-3-.02.¹⁴

7.

Respondent failed to follow up on the information contained in the note dated March 21, 2011, which indicated that D.P.'s family was concerned about her medication and had witnessed the patient crying, wetting her clothes, and acting out. Regardless of whether Respondent could have or should have contacted the family, he was required, at a minimum, to have addressed these concerns with D.P. personally, as they related directly to her safe use of controlled substances. However, the records do not indicate that such a discussion took place before or during D.P.'s next visit on April 6, 2011, nor does Respondent recall any such discussion. Furthermore, although Respondent did not prescribe any medications on April 6, 2011, and thereafter referred D.P. to a physician closer to her home, Respondent has not offered any explanation as to why those actions would otherwise absolve him of his responsibility to address

¹⁴ Respondent's treatment of D.P. and C.T. already had ended before Ga. Comp. R. & Regs. 360-3-.06, setting forth specific protocols for the treatment of pain and chronic pain, would have been in effect. However, Respondent was still required to meet "the minimum standards of acceptable and prevailing medical practice" as noted in O.C.G.A. § 43-34-8(a)(7).

the information he had received with D.P. and document the matter in his records. Respondent's failure to do so potentially put D.P.'s health at risk, and thereby fell short of the prevailing medical standards. O.C.G.A. § 43-34-8(a)(7), Ga. Comp. R. & Regs. r. 360-3-.02(18).¹⁵

8.

Respondent also failed to meet the minimum standards while maintaining D.P.'s medical records, as required by O.C.G.A. § 43-34-8(a)(19) and Ga. Comp. R. & Regs. r. 360-3-.02(16). As Respondent's own expert conceded, the poor legibility of Respondent's handwritten notes made it difficult to determine what evaluations, if any, were actually performed. This fact was highlighted at the hearing, when Dr. Simopoulos was unable to understand the notes made during the May 9, 2009, examination. However, even if the illegible notes properly documented D.P.'s complaint and the various assessments performed, Respondent failed to adequately document D.P.'s responses to ongoing treatment. Although Respondent testified that he included copies of prescriptions in the record for that purpose, the prescription copies, by themselves, provide no information on exactly how the medications are affecting Respondent, nor do they address the effect of physical therapy or injections.

9.

The Board did not present persuasive evidence that Respondent's diagnosis fell short of prevailing standards. As noted by Dr. Straus, Respondent had obtained orthopedic records from D.P.'s previous physicians indicating that she had an established disk herniation. Prior to being

¹⁵ In its written arguments submitted post-hearing, the Board argues that D.P.'s records from her previous physician raised concerns about her diversion and abuse of prescription drugs. (See Petitioner's Closing Statement, filed March 17, 2016). The Board referenced such records while cross-examining Respondent about D.P.'s records from Dr. John C. Earle. (T. 222-23). A failure to acknowledge such concerns potentially could violate Ga. Comp. R. & Regs. r. 360-3-.02(1). However, the Board did not prove this allegation; Dr. Straus, who reviewed Dr. Earle's records as part of the subpoenaed records, testified that nothing in the record indicated that D.P. had a history of drug abuse. (See T. 70-71; Exhibit P-2). Respondent's expert arrived at the same conclusion. (See T. 112-13).

treated by Respondent, D.P. had received epidural steroid injections and been placed on opioid therapy for this condition.

10.

Neither did the Board demonstrate that Respondent's conduct fell below minimum standards by prescribing controlled substances for D.P.'s pain. The Board's expert, Dr. Straus, testified that DP.'s repeated reports of 9 or 10 on the pain scale indicated that she was not receiving the 30 percent pain reduction necessary to justify further prescriptions. However, this Court finds persuasive Dr. Simopoulos's testimony that medication for D.P.'s chronic pain should have remained stable, with minor increases for factors such as age or tolerance. Dr. Straus also conceded that D.P.'s medications were "within the lines so long as the patient had a good diagnosis and had shown other things hadn't been a problem and there was [sic] no other issues." Thus, as the record shows that D.P. received consistent doses of pain medications with only slight adjustments over five years, this Court declines to conclude that Respondent's treatment regarding pain medication fell below the minimum standard of care.

B. Patient C.T.

11.

In C.T.'s case, the Board also proved, by a preponderance of the evidence, that Respondent's treatment and recordkeeping failed to meet the minimum standards of acceptable and prevailing medical practice, and he thereby engaged in unprofessional conduct or a practice harmful to the public in violation of O.C.G.A. §§ 43-1-19, 43-34-8, and Ga. Comp. R. & Regs. 360-3-.02.

12.

Under Ga. Comp. R. & Regs. r. 360-3-.02, a physician engages in unprofessional conduct by prescribing controlled substances for a known or suspected habitual drug abuser in the absence of substantial justification. Over the course of fourteen months, C.T.'s urine screens were positive for cocaine, amphetamines, ecstasy and methadone. Either Respondent failed to recognize and address the signs of abuse and diversion of controlled substances, or he deliberately ignored them.

13.

Respondent's failure to address C.T.'s misuse of her medication also constituted unprofessional conduct under O.C.G.A. § 43-34-8(a). Even if Respondent did not want to "throw away" his patient, he certainly took inadequate measures to ensure that her health and welfare were protected. Respondent's records do not indicate that he and C.T. discussed her illegal drug use and/or her failure to take her medication appropriately. There was no evidence that he ever followed up with C.T. to determine whether she was receiving drug-abuse treatment, or an explanation as to why Respondent did not terminate treatment. His testimony at the hearing that he thought she was merely was having "fun" is further evidence that he failed to appropriately consider the impact of illegal drugs on a patient who had a number of serious health conditions. Respondent's failure to do so potentially put C.T.'s health at risk, thereby falling short of prevailing medical standards. O.C.G.A. § 43-34-8(a)(7), Ga. Comp. R. & Regs. r. 360-3-.02(18).

14.

Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment and response is unprofessional conduct under Ga. Comp. R. & Regs. r. 360-3-.02(16). Respondent's records for C.T. were wholly inadequate, likely exacerbating Respondent's substandard treatment. As demonstrated during the hearing, given the poor quality of his notes Respondent could not detail C.T.'s history, or her responses to any treatment provided. Dr. Straus, Dr. Simopoulos, and even Respondent himself, provided clear evidence that Respondent's recordkeeping fell below the minimum standards of acceptable and prevailing medical practice.

15.

Although Respondent's treatment and recordkeeping fell below minimum standards, the Board did not prove that his diagnosis was substandard. Given C.T.'s medical history and the nerve conduction study, Respondent had an adequate basis to make a diagnosis in her case.

IV. Decision

Based on the aforementioned Findings of Fact, the Board has proven by a preponderance of the evidence that on multiple occasions Respondent engaged in unprofessional conduct that failed to conform to the minimum standards of acceptable and prevailing medical practice in violation of O.C.G.A. §§ 43-1-19, 43-34-8, and Ga. Comp. R. & Regs. r. 360-3-.02.

Pursuant to O.C.G.A. § 43-34-8(b)(1), if the Board finds cause for discipline, it may deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician. See also O.C.G.A. § 43-1-19(d). In determining an appropriate sanction, the undersigned considers the fact that the Board previously has sanctioned Respondent. However, while the Board presented substantial evidence that Respondent's treatment and recordkeeping for D.P. and C.T. did not

meet minimum standards, the evidence also suggests that his actions reflect inadequate training rather than deliberate misconduct. Further, particularly in light of her current medical condition, C.T.'s testimony that Respondent was a "wonderful" and "attentive" doctor who expressed concern about her condition also weighs in his favor.

Accordingly the undersigned **RECOMMENDS** that Respondent's license be limited indefinitely in that he may not prescribe controlled substances, as defined under 21 U.S.C. § 812, until he has fulfilled any conditions imposed upon him by the Board, including obtaining Continuing Medical Education as directed and approved by the Board.

SO ORDERED, this 4 day of May, 2016.



RONIT WALKER
Administrative Law Judge

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:

RONALD CRAIG MCLEAN, M.D.,
License No. 30163,
Respondent.

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GEORGIA COMPOSITE
MEDICAL BOARD

JUL 11 2016

DOCKET NUMBER:
2016 0029

ORDER OF COMPLETION

1.

The Georgia Composite Medical Board ("Board") entered a Public Consent Order in the above-styled matter on or about January 7, 2016, Docket No. 20160029, which publicly reprimanded Respondent and placed terms and conditions on Respondent's license to practice medicine in the State of Georgia. The Public Consent Order required Respondent to successfully complete a mini-residency program in the appropriate prescribing of controlled substances, and to pay a fine and administrative fees.

2.

On or about July 5, 2016, the Board received a petition from the Respondent to terminate the Public Consent Order, indicating he has complied with the Public Consent Order by paying the fine and administrative fees and completing the required prescribing course.

3.

On or about July 7, 2016, the Board reviewed the petition and Respondent's compliance with the terms thereof and determined Respondent has complied with the terms and conditions of the Public Consent Order.

Based on the foregoing, the Board hereby issues this Order of Completion as Respondent has completed the requirements of the Public Consent Order.

SO ORDERED, this 11th day of July, 2016.

GEORGIA COMPOSITE MEDICAL BOARD



BY:

John S. Antalis, M.D.
JOHN ANTALIS, M.D.
Chairperson

ATTEST:

Robert J. Perry, MBA
ROBERT J. PERRY, MBA
Executive Director

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:
DANIEL TESHAYE, M.D.,
License No. 67614,

Respondent.

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GEORGIA COMPOSITE
MEDICAL BOARD

JUL 14 2016

DOCKET NUMBER:
1016 0025

PUBLIC CONSENT ORDER

By agreement of the Georgia Composite Medical Board (“Board”) and DANIEL TESHAYE, M.D. (“Respondent”), the following disposition of this matter is entered into pursuant to the provisions of O.C.G.A. §50-13-18, 43-34-8, and/or §43-1-19.

FINDINGS OF FACT

1.

Respondent is licensed to practice medicine as a physician in the State of Georgia and was so licensed at all times relative to the matters herein.

2.

On or about October 8, 2015, Respondent, a neurologist, voluntarily reported to the Board that he had engaged in a professional boundary violation with a patient, had stopped working, sought evaluation, and entered treatment for professional sexual boundary issues. One female patient alleged that on two office visits, Respondent inappropriately hugged, touched, and attempted to kiss her. Respondent acknowledged an inappropriate hug/embrace. Criminal charges were filed against Respondent for the inappropriate touching of the patient, the disposition of which is more fully set forth in Paragraph 5 on page 2.

3.

When Respondent was placed on administrative leave by his employer in or about

October 2015, he completed a 24 hour CME course on Maintaining Proper Boundaries through Vanderbilt University Medical Center and entered a treatment program for professional boundary issues.

4.

Respondent was in treatment from on or about December 10, 2015 to on or about January 21, 2016. Upon completion of treatment, recommendations were made to Respondent concerning continuation of continuing care and/or monitoring and certain practices to employ in order to practice medicine safely.

5.

On or about May 23, 2016, Respondent entered a plea, without admitting guilt, to one count of misdemeanor sexual battery, receiving First Offender treatment. Respondent was placed on probation for one year, with terms and conditions, and was required to pay a \$1,000.00 fine.

6.

On or about May 17, 2016, Respondent indicated to the Board his desire to return to the practice of medicine. In connection therewith, on or about June 9, 2016, Respondent personally met with a Board committee.

7.

Respondent admits the above findings of fact and waives any further findings of fact with respect to the above styled matter.

CONCLUSIONS OF LAW

Respondent's conduct and the above Findings of Fact constitute sufficient grounds for the imposition of sanctions and/or conditions upon Respondent's license to practice medicine in the State of Georgia pursuant to O.C.G.A. §§43-34-8 and 43-1-19.

ORDER

The Georgia Composite Medical Board, having considered all the particular facts and circumstances of this case, hereby orders, and the Respondent hereby agrees that Respondent's license shall be placed on a period of probation until further order of the Board subject to the following terms and conditions:

1.

- (a) Individual Therapy. Respondent shall participate in weekly individual therapy with a Board approved provider (“therapist”) with experience in family relationship issues, underlying feelings of trauma, sexual compulsivity, and professional boundary violations. Any change in therapist shall be preapproved by the Board.
- (b) Group Meetings. Respondent shall obtain a sponsor and attend and participate in weekly group meetings, such as SA, SLAA, and SAA which are focused on sexual addiction, accountability and relapse prevention, but can also include meetings such as Caduceus or other similar support groups acceptable to the Board.
- (c) Polygraph Examination. Every six (6) months, beginning no later than ninety (90) days after returning to the practice of medicine, Respondent shall, at his own expense, obtain polygraph examinations from a provider acceptable to the Board. The examinations shall focus on Respondent’s sexual behavior, particularly in the workplace. Respondent shall cause the results of all examinations to be provided directly to the Board from the examiner.
- (d) Supervision and Monitoring. Respondent shall designate an acceptable workplace supervising (“supervising”) physician who will supervise his work and an acceptable treating

("monitoring") physician with whom he will continue psychiatric care, including treatment for Respondent's medical condition(s), and who will monitor any medications prescribed to Respondent.

- (e) Copies of Order to Providers. Respondent shall provide a docketed copy of this Consent Order to both the supervising and the monitoring physicians and to his therapist. The physicians and therapist shall each sign a statement to be submitted to the Board within 10 days of the effective date of this Order as evidence of having read and understood the same and having agreed to serve as Respondent's supervising and monitoring physicians and therapist. Respondent shall obtain prior written Board approval through the Medical or Executive Director for any change in supervising and monitoring physicians or therapist.
- (f) Quarterly Reports. Respondent shall submit or cause to be submitted quarterly reports from his supervising and monitoring physicians and his therapist regarding his performance and mental/physical condition by March 31, June 30, September 30 and December 31 of each calendar year, including a report on any medication being prescribed to Respondent. Failure to submit or have such reports submitted in a timely manner shall be considered a violation of the Consent Order. It is expected that the supervising and monitoring physicians and therapist shall be in communication with each other and will immediately report any change in Respondent's behavior that would render Respondent unable to practice medicine with reasonable skill and safety to patients. By executing the Consent Order, Respondent specifically consents to such supervising and monitoring physicians or any other facility where Respondent obtains medical treatment reporting upon Respondent's condition, notwithstanding any privilege provided by state or federal law. Respondent shall obtain prior

Board approval through the Medical or Executive Director for any change in the supervising or monitoring physician.

- (g) Use of Chaperone. For all patient visits with female patients, Respondent shall utilize a female chaperone during the entire visit. Respondent shall ensure the chaperone documents her presence by signing the office note for each visit. Within ten (10) days of the effective date of this Order or, if a new chaperone is employed, prior to beginning employment, Respondent shall provide the chaperone with a copy of this Order and submit a notarized statement to the Board evidencing that the chaperone has received and read this Order. Should Respondent become employed by a hospital and treat patients in the hospital, he shall obtain a letter from the CEO or Administrator of the hospital confirming that he has provided the hospital with a docketed copy of this Order and that the hospital will arrange for a female chaperone to accompany Respondent for all inpatient visits.
- (h) Further Evaluation. At any time during the period of probation, the Board shall also have the authority to order Respondent to undergo a physical or mental evaluation by a physician designated by the Board. Respondent shall execute such releases as may be required for the Board to obtain the results of such evaluations.
- (i) Criminal Probation. Respondent shall notify the Board forthwith of any changes to or termination of his criminal probation.
- (j) Periods of Residency Outside Georgia or Periods When Not Actively Practicing Medicine. In the event that Respondent should leave Georgia to reside or practice outside of Georgia for periods longer than thirty (30) consecutive days, Respondent shall notify the Board in writing of the dates of departure and return. Periods of residency or practice outside of Georgia as well as periods when Respondent is not actively engaged in practicing as a

physician will not apply toward the reduction of Respondent's probation period, except as authorized by the Board.

- (k) Employment/ Residency Change. Respondent shall notify the Board in writing of his practice location within ten (10) days of beginning practice. Respondent shall advise the Board of any change in address of record or employment status within 10 days of the change.
- (l) Abide By Laws, Rules and Terms. Respondent shall abide by all State and Federal laws regulating the practice of medicine or relating to drugs, the Rules and Regulations of the Georgia Composite Medical Board and the terms of this Consent Order. If Respondent shall fail to abide by such laws, rules or terms, or if it should appear from reports submitted to the Board that Respondent is otherwise unable to practice medicine with reasonable skill and safety to patients, or should Respondent violate the criminal laws of the State, including any term of monitoring, if any, Respondent's license shall be subject to further discipline, including revocation, upon substantiation thereof after notice and hearing, and if revoked, the Board in its discretion may determine that the license should be permanently revoked and not subject to reinstatement. **Respondent further agrees that any violation of this Consent Order shall be deemed to be sufficient to authorize the Board to order summary suspension of Respondent's license, pending further proceedings, pursuant to the provisions of the Georgia Administrative Procedure Act, O.C.G.A. § 50-13-18(c)(1), or any other statute authorizing emergency action, but Respondent understands that he shall be entitled to an expedited hearing to substantiate such violation(s), if the Board exercises such right.**

- (m) Modification. Respondent agrees that he shall not be eligible to petition to modify any portion of this Consent Order for a period of two (2) years from the effective date of this Order. Any petition submitted by Respondent for modification after the two (2) year period shall include letters of support from Respondent's therapist, sponsor, monitoring physician and supervising physician. Any decision to grant or deny the petition shall be in the Board's discretion and Respondent shall not be entitled to a hearing under the Georgia Administrative Procedure Act but may appear before the Board at his request.
- (n) Termination of Probation. Respondent shall not be eligible to petition for termination of probation until three (3) years from the effective date of this Consent Order. At such time, Respondent may petition for termination of probation by certifying under oath before a notary public that he has complied with all conditions of probation and by providing documentation supporting discharge from probation, including, but not limited to, written statements from Respondent's supervising and monitoring physicians and therapist as to whether they agree with terminating probation. The Board shall review and evaluate the practice of Respondent prior to terminating the probation period. At such time, the Board shall be authorized, but is not required, to terminate probation. If the Board denies Respondent's petition for termination of probation, Respondent may petition for termination of probation on an annual basis thereafter. In any event, the Consent Order shall remain in effect pending a final determination by the Board and notification that the probation period has terminated.

2.

Respondent understands that pursuant to O.C.G.A. Title 43, Chapter 34A, the contents of this Consent Order shall be placed on Respondent's Physician Profile. Furthermore, by

executing this Consent Order, Respondent hereby agrees to permit the Board to update the Physician's Profile reflecting this Consent Order.

3.

Approval of this Consent Order by the Georgia Composite Medical Board shall in no way be construed as condoning the Respondent's conduct and shall not be construed as a waiver of any of the lawful rights possessed by the Board. **The Board reserves the right to initiate disciplinary action for any conduct not related to the conduct described in the findings of fact within this Order.**

4.

Respondent acknowledges that he is represented by counsel and that he has read this Consent Order and understands its contents. Respondent understands that he has a right to a hearing before the Board, and freely, knowingly, and voluntarily waives that right. Respondent understands that the Consent Order will not become effective until approved and docketed by the Georgia Composite Medical Board. Respondent further understands and agrees that the Board shall have the authority to review the application file and all relevant evidence in considering the Consent Order. Respondent further understands that the Consent Order, once approved, shall constitute a public record that may be disseminated as a disciplinary action of the Board. However, if the Consent Order is not approved, it shall not constitute an admission against interest in the proceeding, or prejudice the right of the Board to adjudicate the matter. Respondent consents to the terms and conditions contained herein.

Approved, this 14th day of July, 2016.

GEORGIA COMPOSITE MEDICAL BOARD

(BOARD SEAL)



John S. Antalis, M.D.

BY:

JOHN ANTALIS, M.D.
Chairperson

Robert Jeffery

ATTEST:

ROBERT JEFFERY
Executive Director

CONSENTED TO:

Daniel Tesfaye

DANIEL TESFAYE, M.D.
Respondent

[As to Respondent's signature:]
Sworn to and subscribed before me
This 12th day of July 2016.

Frances C. Dorfman

NOTARY PUBLIC
My Commission Expires:



BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:

DOUGLAS WHITE, M.D.,
License No. 29557,
Respondent.

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GEORGIA COMPOSITE
MEDICAL BOARD

JUL 11 2016

DOCKET NUMBER:
10100043

PUBLIC BOARD ORDER TERMINATING PROBATION

1.

The Georgia Composite Medical Board ("Board") entered a Public Consent Order ("Order") in the above-styled matter on or about March 1, 2012, Docket No. 10100043, which placed Respondent's license to practice medicine in the State of Georgia on a period of probation, subject to terms and conditions. The Board on or about December 1, 2015 entered an Amendment to Public Consent Order, Docket No. 10100043, lifting the restriction of working with midlevel providers.

2.

On or about June 13, 2016, the Board received a petition from the Respondent to terminate probation. The Board reviewed the petition and Respondent's compliance with the terms of the Order and determined Respondent has complied with the terms and conditions of probation.

Based on the foregoing, the Board hereby terminates the probation of Respondent's license. Respondent's license is returned to unrestricted status and is in good standing.

SO ORDERED, this 11th day of July, 2016.

GEORGIA COMPOSITE MEDICAL BOARD

(BOARD SEAL)



BY:

John S. Antalis, M.D.

JOHN ANTALIS, M.D.
Chairperson

ATTEST:

Robert Jeffery
ROBERT JEFFERY, MBA
Executive Director