

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2023-044

In the Matter of

VICTOR FERZOCO, M.D.

**CONSENT ORDER**

Pursuant to G.L. c. 30A, § 10, Victor Ferzoco, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket No. 18-081.

**Findings of Fact**

1. The Respondent graduated from the Tufts University School of Medicine in 1991. He is certified by the American Board of Internal Medicine. He has been licensed to practice medicine in Massachusetts under certificate number 78147 since 1983. He has privileges at Faulkner Hospital and Brigham and Women's Hospital.

**Patient A**

2. Patient A is a female born in 1960.
3. The Respondent began his treatment of Patient A in April 2014.

4. The Respondent's care of Patient A continued for over five years.
5. Patient A had a history of right arm weakness; adhesive capsulitis of shoulder; anxiety; chronic back pain; disc disease; and uncomplicated opioid dependence.
6. At her first visit, the Respondent noted Patient A was taking oxycodone, equivalent to 60 ME (Morphine mg Equivalent)/day with the stated goal of tapering her dose. The Respondent also noted Patient A was on Ativan and Flexeril.
7. Based on Patient A's presentation, the Respondent could have considered consultation with a pain specialist and mental health specialist.
8. The Respondent did not document that he discussed the risks and drug interactions of the above three medicines that can potentially cause Central Nervous System (CNS) depression.
9. The Respondent did not consistently document prescriptions, quantities of pills, or refills in subsequent notes until June 10, 2015, when the records changed to a new electronic medical record system.
10. During treatment, the Respondent prescribed oxycodone in high doses and relied on escalating her oxycodone dose for pain control.
11. The Respondent did not prescribe non-steroidal anti-inflammatory drugs (NSAIDs) and prescribed gabapentin late in her treatment.
12. The Respondent did not attempt to wean the oxycodone, except when required by insurance regulations.
13. The Respondent referred Patient A to neurosurgeons and orthopedic surgeons, but did not refer her to pain specialists or psychiatrists.
14. The Respondent did not properly document her toxicology screen results.

15. The aspects of the Respondent's treatment of Patient A, outlined above, departed from the standard of care.

Patient B

16. Patient B is a female born in 1973.
17. The Respondent began treating Patient B in 2010.
18. The Respondent treated Patient B for over eight years.
19. Patient B had a history that included chronic back pain; radiculopathy; depressive disorder; anxiety; fibromyalgia; and bipolar disorder.
20. The Respondent prescribed Patient B opioids which were not indicated at the onset of her treatment. Subsequently, doses of opioids were increased during her treatment.
21. The Respondent recommended a referral to a pain specialist in November 2018, but there was no documentation if Patient B ever was seen by the pain specialist.
22. The Respondent prescribed opioids in combination with Xanax, despite known interactions and despite some aberrant urine toxicology screens.
23. The Respondent continued to prescribe opioids and Xanax despite some missed or canceled appointments and a lapse of over 7 months between appointments.
24. Documentation of prescriptions was inconsistent until May 2015, when the electronic medical record changed to a new system.
25. The Respondent treated Patient B with multiple medicines and higher than typically needed doses of Adderall.
26. The Respondent did not document one of Patient B's medications correctly. Buspirone was not prescribed from December 12, 2016 to August 23, 2018 although it was on

her medication list and identified as an active medication. This medication was prescribed by another provider. Patient C stopped taking this medication in 2018.

27. The aspects of the Respondent's treatment of Patient B, outlined above, departed from the standard of care.

#### Patient C

28. Patient C was a male born in 1965.

29. The Respondent began treating Patient C in September 2008.

30. The Respondent treated Patient C for over ten years.

31. Patient C had a history that included: depressive disorder; insomnia; lumbosacral neuritis or radiculitis; lower back pain; lumbar degenerative disc disease; cervical disc disease; chronic shoulder pain; knee pain; and migraines.

32. The Respondent prescribed Patient C oxycodone and diazepam on his first visit. Subsequent urine toxicology had shown he was not taking these medicines as stated.

33. The Respondent tripled Patient C's oxycodone dose over the treatment course in an effort to effectively treat his pain. Patient C was originally prescribed oxycodone by another provider, and was taking the medication, when he first saw the Respondent.

34. Patient C had a remote history, approximately 10-15 years before he first saw the Respondent, of Operating Under the Influence and Cocaine use. This was not initially disclosed by Patient C when he first saw the Respondent.

35. Patient C's parole officer called and left a message with concerns about his past drug use.

36. Patient C had depression and was being seen by a psychiatrist at one point during his treatment course with the Respondent.

37. Patient C reported that he took his wife's Adderall unknowingly on three occasions. He reported that this was due to an error with his pill box and his wife's pill box.

38. Patient C reported two episodes of falling while under the Respondent's care.

39. Patient C was involved in a motorcycle accident and a motor vehicle accident while under the Respondent's care.

40. Patient C reported some symptoms to the Respondent such as being tired in the morning that could have been related to his medications. The Respondent tried adjusting the timing and dosages of Patient C's medications in response.

41. The Respondent did not wean Patient C from his medications or refer Patient C to a psychiatrist.

41. During the Respondent's treatment of Patient C, there was prescribing with multiple refills, lags in appointments, and lags in necessary toxicology screens.

42. The aspects of the Respondent's treatment of Patient C, outlined above, departed from the standard of care.

#### Patient D

43. Patient D is a female born in 1958.

44. The Respondent began treating Patient D in 2007.

45. The Respondent treated Patient D for over eleven years.

46. The Respondent prescribed high doses of opioids, in potentially dangerous combinations with other potentially habit-forming medications.

47. The Respondent did not timely respond to red flags such as a history of substance abuse and taking her friend's medicine.

48. The Respondent's treatment was not based on her urine toxicology results.

49. The Respondent did not adequately monitor her, with an interval between visits as long as nine months. During this interval, the Respondent continued to refill medications, and prescribed codeine cough syrups over the phone.

50. The Respondent kept incomplete medication records and prescribed multiple refills.

51. The Respondent did not refer her to a psychiatrist, despite symptoms that could have been consistent with ongoing symptomatic chronic depression, and possibly impacted her pain.

52. The aspects of the Respondent's treatment of Patient D, outlined above, departed from the standard of care.

#### Patient E

53. Patient E is a female who was born in 1955.

54. The Respondent first treated Patient E in 2007.

55. The Respondent treated Patient E for over eleven years.

56. The Respondent prescribed Patient E high doses of opioids, in combination with high doses of clonazepam, butalbital and muscle relaxants. These medications required close monitoring, which was not done.

57. From August 31, 2007 to December 17, 2018, there were only 20 visits recorded. The longest interval between visits was sixteen months.

58. Despite the number of visits, the Respondent continued to prescribe Patient E medicines, and adjusted her opioids, clonazepam, butalbital and muscle relaxants over the telephone.

59. The Respondent prescribed Patient E codeine cough syrups over the telephone.

60. The Respondent did not adequately address possible red flag violations over many years, including lost or stolen medicines, some requests for early refills, multiple ER visits and obtaining medicine from another prescriber.

61. The Respondent failed to adequately address pharmacy concerns of medication misuse as well as insurance warnings requiring more limited prescriptions for Patient E.

62. There were few urine toxicology screens recorded, but the Respondent did not thoroughly address negative results and continued to prescribe.

63. The Respondent referred her to neurosurgeons and orthopedic surgeons, but it was not always clear if there was follow-through with these visits.

64. The Respondent did not refer Patient E to a neurologist, despite allowing her to become dependent on butalbital.

65. The aspects of the Respondent's treatment of Patient E, outlined above, departed from the standard of care.

#### Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, eighth par. (c) and 243 CMR 1.03(5)(a)3 by engaging in conduct that places into question the Respondent's competence to practice medicine including practicing medicine with negligence on repeated occasions.

#### Sanction and Order

The Respondent's license is hereby indefinitely suspended. The indefinite suspension will be stayed upon the Respondent's entry into a standard five-year Probation Agreement. In addition to the standard terms, (including but not limited to, practice pursuant to a Board-approved practice plan with a Board-approved practice monitor), the Probation Agreement must include the Respondent's agreement:

- to undergo, and submit to the results of, a practice audit by LifeGuard within 90 days of the approved Consent Order;
- to document remediation of all deficiencies identified by LifeGuard.

The audit shall be of patients seen since January 2022 and who were prescribed opioids and benzodiazepines by the Respondent.

This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

#### Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel, the Respondent, and the Respondent's counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order and Probation Agreement with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at

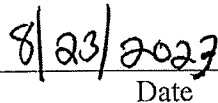


which he practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated for the duration of this suspension and subsequent Probation Agreement. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

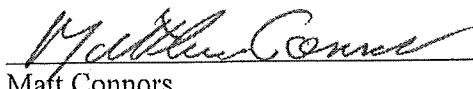
The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

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Victor, Ferzoco, M.D.  
Licensee



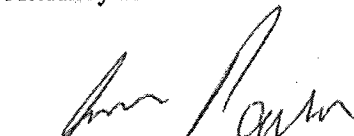
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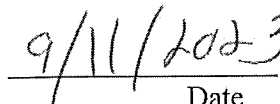
Matt Connors  
Attorney for the Licensee



Date



James Paikos  
Complaint Counsel



Date

So ORDERED by the Board of Registration in Medicine this 2<sup>nd</sup> day of November,  
twenty 23.

A handwritten signature in dark ink, appearing to read 'Julian N. Robinson', written over a horizontal line.

Julian N. Robinson, M.D.  
Board Chair