

COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss.

Division of Administrative Law Appeals

Board of Registration in Medicine,
Petitioner,

v.

Docket No.: RM-14-16

Randall Bock, M.D.
Respondent.

Appearance for Petitioner:

Stephen C. Hootor, Esq.
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Appearance for Respondent:

A. Douglas Matthews, Esq.
P.O. Box 1237
Westport, MA 02790

Administrative Magistrate:

Kenneth J. Forton, Esq.

SUMMARY OF RECOMMENDATION

The Board has proven that Respondent made a false representation in his 2013 request to renew his medical license, *see* G.L. c. 112, § 5, ninth par. (a); 243 CMR 1.03(5)(a)(1), and that he violated G.L. c. 94C, § 19(b) by refilling his office Suboxone supply from his patients' subsequent prescriptions. However, the Board did not prove that Respondent's addiction treatment program fell below the standard of care. It also did not prove that Respondent's behavior towards five of his patients violated the Board's Disruptive Physician Behavior Policy.

RECOMMENDED DECISION

On January 22, 2014, the Petitioner, Board of Registration in Medicine, issued a Statement of Allegations ordering the Respondent, Randall Bock, M.D., to show cause why he should not be disciplined for engaging in conduct that places into question his competence to practice medicine, for engaging in conduct that undermines the public confidence in the integrity of the medical profession during his treatment of five patients, Patients A through E, and for fraudulently procuring the renewal of his certificate of registration. The Statement of Allegations relied specifically upon the Board's Policy 01-01, regarding "Disruptive Physician Behavior." This policy defines "disruptive behavior" as "a style of interaction . . . that interferes with patient care," states that such behavior "has a deleterious effect upon the health care system and increases the risk of patient harm," and warns that disruptive behavior that "compromises the quality of medical care or patient safety" "could be grounds for Board discipline." The Board also alleged that Dr. Bock's "Suboxone tapering" program and the manner in which he prescribed Suboxone to his patients fell below the standard of care. Additionally, the Statement of Allegations ordered Dr. Bock to show cause why he should not be disciplined for failing to disclose on his 2013 license renewal application the Massachusetts Attorney General's civil investigation into his MassHealth billing practices.

On January 22, 2014, the Board referred the matter to the Division of Administrative Law Appeals, and issued an order to impound the case and an order to use pseudonyms. Dr. Bock answered the Statement of Allegations on February 10, 2014, and amended his answer on February 18, 2014.

Also on January 22, 2014, the Board issued an Order of Temporary Suspension, effectively suspending Dr. Bock immediately. On January 28, 2014, Dr. Bock appealed the summary suspension. On October 30, 2014, DALA upheld the Board's summary suspension, pending the outcome of a final hearing on the merits of the Statement of Allegations. *Board of Registration in Medicine v. Bock*, Docket No. RM-14-16 (DALA, Oct. 30, 2014; adopted by Board, Feb. 19, 2015). Dr. Bock appealed the summary suspension to a single justice of the Supreme Judicial Court under G.L. c. 112, § 64 and G.L. c. 30A, §§ 14, 15. On October 14, 2016, the single justice, determining that DALA had applied an incorrect evidentiary standard in its recommended decision on summary suspension, remanded the case to the Board for recommitment to DALA to apply the correct evidentiary standard. *See Bock v. Board of Registration in Medicine*, Docket No. SJ-2015-0095, Decision on Joint Motion for an Order of Remand (October 11, 2016). Thereafter, on February 23, 2017, the Board recommitted the case to DALA to apply the correct evidentiary standard (preponderance of the evidence, rather than substantial evidence) in the summary suspension appeal. On March 6, 2017, Dr. Bock filed an Opposition to the Board's Order of Recommitment. During a status conference held on October 31, 2017, Dr. Bock ultimately waived his right to a hearing on the Board's summary suspension order, and elected instead to accept summary suspension and proceed to a hearing on the merits of the Board's Statement of Allegations.

I held an evidentiary hearing at the Division of Administrative Law Appeals (DALA), One Congress Street, 11th Floor, Boston, Massachusetts on the following dates: March 6, March 20, March 23, March 27, and April 11, 2018. Twenty-eight exhibits were entered into evidence during the hearing. (Exs. 1-28.) Six witnesses testified:

Olivera Bogunovic-Sotelo, M.D. (Board's expert), Patient D, Dr. Randall Bock, Dr. Alan Wartenberg (Dr. Bock's expert), Anne McCarthy (former employee of Dr. Bock), and Juliane Balliro, Esq. (Dr. Bock's former attorney). Following the hearing, I admitted Dr. Alan Wartenberg's curriculum vitae as Exhibit 29 and the Board of Registration in Medicine's Full License Renewal Instructions as Exhibit 30.

The record closed on June 20, 2018, after the parties filed their closing briefs.

FINDINGS OF FACT

Based on the testimony and exhibits presented, I make the following findings of fact:

1. Dr. Randall Bock was born in 1956. He earned his Bachelor of Science degree from Yale University. He received his medical degree from the University of Rochester School of Medicine and Dentistry in 1981. Dr. Bock has been licensed to practice medicine in Massachusetts since 1984. He is not board certified. Dr. Bock maintained a solo practice in Revere, Massachusetts. He had admitting privileges at Lawrence Memorial Hospital of Medford. (Ex. 16; Bock III: 113-14, 130-38.)¹
2. Dr. Bock completed his internship at St. Raphael Hospital in New Haven, Connecticut. From 1982 to 1983, he worked in general medicine at a clinic in West Virginia. He started a psychiatry residency at MassGeneral Hospital in 1983, but left after four months. Following this, Dr. Bock worked at out-patient clinics and various ambulatory clinical practices in Lynn, Danvers, and Saugus. (Bock III: 114-21, 130-31.)
3. In 1988, Dr. Bock rented space in Revere where he ran his own private practice with two medical assistants. In 1989, the building came up for sale pursuant to

¹ Citations to the hearing transcripts will use the following format: [Name of Witness] [Transcript Volume]: [Page Number(s)].

foreclosure. Dr. Bock purchased the building. He practiced in Revere for 27 years as a family practitioner. (Bock III: 131-33.)

4. From 1989 to 2005, Dr. Bock noticed an increase in the number of patients in his practice seeking opiate addiction treatment. After taking the Drug Enforcement Administration's (DEA) required eight-hour course at the Boston University School of Medicine, he started prescribing Suboxone in 2005 or 2006. (Bock III: 136-43.)

5. Suboxone, or buprenorphine, is a schedule III controlled substance. It has been approved by the Food and Drug Administration for use in the treatment of opioid addiction. Individual physicians may prescribe Suboxone in their offices if they receive a waiver from the DEA. (Ex. 26; Bock III: 166.)

6. Methadone is a schedule II controlled substance. Methadone can be prescribed only in federally-regulated addiction treatment programs. An individual physician may prescribe methadone for the treatment of opioid addiction if he or she registers with the DEA to run a narcotic treatment program. (Ex. 26; Bogunovic-Sotelo II: 64-65.)

7. The "disease model" of treatment perceives addiction as a chronic illness. According to this model, an addiction patient may be in remission but needs continual monitoring. People who become addicted to substances experience permanent changes in the brain that affect their reward and decision-making systems. As a result, it is difficult for addicted patients to make rational decisions. (Bogunovic-Sotelo II: 27-32.)

8. The "behavior model" of treatment perceives people who are addicted to narcotics as being able to overcome their addiction and train themselves to change their behaviors. (Ex. 24; Bock IV: 274-78, 285-86.)

Dr. Bock's Addiction Treatment Program

9. Dr. Bock's addiction treatment program initially consisted of "Suboxone tapering" over the course of six months. Tapering involves starting the patient at a higher dose of Suboxone and then gradually weaning the patient off of the medication. Later, Dr. Bock changed the target goal, tapering his patients in four to five months. (Bock III: 144-52, 160.)

10. Dr. Bock did not offer Suboxone or methadone maintenance. The only treatment he provided was Suboxone tapering. He did not expect the tapering treatment to work on everyone, but offered it to patients who wanted to try this approach. (Bock III: 141-42, 144-50; Bock IV: 268-71.)

11. He instructed his staff to inform patients about his program and answer questions. Dr. Bock did not necessarily make his patients aware that there were other programs that would put them on maintenance. He assumed that they knew what other programs were offered. Dr. Bock stated, "Nobody *didn't* know about maintenance." His Suboxone tapering program was one option of treatment for opiate-addicted patients. (Bock III: 144-50.)

12. When a patient called the office, the office staff would explain to them that Dr. Bock offered a four-month tapering program. If the patient wanted a maintenance program, the staff had a list of other programs in the area to recommend. (Bock IV: 303-04; McCarthy V: 391-94.)

13. Before starting Suboxone treatment, Dr. Bock required patients to sign a disclosure and agreement form. This form described the treatment as a gradual tapering from Suboxone. It also stated that the treatment of the underlying emotional component of a drug-use problem will involve "hard questions and no-nonsense probing." Patients were informed that they could withdraw from the program at any time without penalty. In order to stay in the program, Dr. Bock required patients to show up for appointments, avoid illicit drug usage, and provide witnessed drug screens. Dr. Bock wrote:

My words can be strong and plain and my persistence painful. If you do find yourself hurt or offended, I am sorry. My intent is not hurtfulness or disrespect. It is to try to get you to speak the truth to yourself. . . . I know of no other way to help you defeat drugs and the surrounding behaviors on a permanent basis.

(Ex. 21.)

14. Dr. Bock instructed his patients to watch a series of videos regarding his addiction treatment recovery program and his own theory of addiction. (Bock IV: 266-67, 300-02, 305-07.)

15. His office manager at the time, Anne McCarthy, did not instruct the patients to watch these videos in advance or when they arrived for an appointment. (McCarthy V: 396-97.)

16. In his videos, Dr. Bock explained that Suboxone is used to treat addiction. He warned that Suboxone is a narcotic itself, potentially addictive, and lethal in high doses. (Ex. 25.)

17. Dr. Bock stated that narcotic usage is something that can be undone, and that calling it a disease takes away personal responsibility for actions. He also stated that the length and success of the detoxification program depends on individual motivation.

He mentioned that not everyone finds success with his tapering program and that methadone clinics were an alternative. (Ex. 25.)

18. Suboxone comes in 2-milligram and 8-milligram pills. (Bock III: 180-81.)

19. Before a patient started treatment, Dr. Bock would initially write him a prescription for five 8-milligram pills. He instructed patients to bring these pills to their first day of treatment, where he would determine the appropriate dosage. After two days, Dr. Bock would write a prescription for additional pills. (Bock III: 172-74; 180-82.)

20. Dr. Bock's addiction treatment program consisted of three phases, or "days." On "Day 0," Dr. Bock would meet a patient for an initial, half hour appointment. In the first phase, on "Day 1," the patient was supposed to come to the appointment in withdrawal, whereupon Dr. Bock would start the Suboxone treatment. The initiation of the treatment would take most of the day, during which Dr. Bock would judge the appropriate dosage. The second phase, "Day 2," was a stabilization period. The third phase of the program, for the rest of the four to six months, was the gradual tapering of Suboxone. At every visit, Dr. Bock would assess a patient's clinical opiate withdrawal scale (COWS). (Bock III: 171-73, 211.)

21. In a partial, unpublished manuscript entitled "The Drug Whisperer," Dr. Bock described his tapering treatment program. Dr. Bock wrote the first three chapters of the manuscript, which are in evidence, and supervised the drafting of the subsequent chapters, which are not in evidence. In the initial chapters, he debated the "disease model" versus "behavior model" of addiction, and stated that some people can be motivated enough to enroll in a treatment plan to help them stop drug use completely. (Exs. 24, 25.)

22. Dr. Bock's own theory of addiction includes mental and physiological components, although he does not refer to it as a disease. He believes that people who have an addiction suffer from compulsion, which affects their choices and actions. Under the influence of drugs, Dr. Bock acknowledges that there are also physiological symptoms, such as withdrawal. He believes that someone with an opiate addiction can achieve complete withdrawal and total abstinence. (Bock IV: 279-89.)

Addiction Treatment Standard of Care

23. The standard of care in opiate addiction treatment is how a reasonable and prudent physician would treat a particular patient at a particular time. Several different addiction treatments that would fall under this standard of care, including abstinence-based treatment, methadone/Suboxone maintenance, and Suboxone tapering. Narcotics Anonymous, similar to Alcoholics Anonymous, is a program that encourages complete abstinence. Physicians regularly recommend Narcotics Anonymous meetings as part of opiate addiction treatment. (Wartenberg IV: 349-50, 354-55, 377-78.)

24. The treatment of opiate addiction is not an exact science. A practitioner must determine which treatment is appropriate and effective for each patient based on the patient's drug use history, treatment history, and personal circumstances. Even if a particular detox program does not result in success, it may be appropriate in order to determine the effectiveness of a treatment plan, as long as it is properly administered and monitored and does not harm the patient. (Wartenberg IV: 360, 380-83.)

25. Not all addiction medicine practitioners offer all possible addiction treatments, nor are they required to under the standard of care. (Wartenberg IV: 347-50, 368-69.)

Attorney General's Investigation

26. Shortly after Dr. Bock started his Suboxone treatment practice, a colleague suggested to him that he charge an administrative fee for the initial/intake visit for patients on MassHealth. Dr. Bock began charging a \$185 "administrative fee." (Bock III: 140-43; McCarthy V: 406.)

27. A complaint against charging the fee was filed by an unknown person, and the Massachusetts Attorney General ultimately investigated Dr. Bock's practice of charging the extra \$185 fee. As a result of the investigation and ensuing civil action against him, Dr. Bock discontinued this practice. He reimbursed the affected patients if he could find them. (Ex. 15; Bock III: 187.)

28. Dr. Bock entered into an Assurance of Discontinuance with the Attorney General on April 19, 2012. As part of this assurance, Dr. Bock agreed to stop his practice of charging an "administrative fee" for MassHealth members seeking Suboxone treatment. (Ex. 15.)

29. During this investigation, Dr. Bock was represented by Attorney Julianne Balliro. (Bock III: 188-89; Balliro V: 412.)

30. Dr. Bock did not inform the Board about the Attorney General's investigation or Assurance of Discontinuance at any time after April 2012. (Ex. 16.)

31. In July 2013, Dr. Bock filled out an application to renew his medical license. Question 18C asks: "Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association." Dr. Bock checked "yes" to this question. (Ex. 16.)

32. The Board's "Full License Renewal Instructions" provide that "[i]f you answer 'Yes' to any part of question 18, you must also complete Form R. At a later date, you will be asked to submit copies of supporting documentation." (Ex. 30.)

33. Dr. Bock understood that a "yes" answer required a narrative explanation. Before filing his license renewal form, he consulted Attorney Balliro for help with phrasing this explanation. (Ex. 16; Bock III: 187-94.)

34. Attorney Balliro does not recall the details of her telephone conversation with Dr. Bock. (Balliro V: 412-416.)

35. In the end, Dr. Bock did *not* list the Attorney General's investigation on his 2013 renewal application. Dr. Bock's Form R, attached to his 2013 renewal application, lists only investigations by the Board regarding complaints from addiction treatment patients. (Ex. 16; Bock III: 187-94; Bock IV: 330-31.)

Patient A

36. Dr. Bock saw Patient A for an initial visit on July 13, 2011. At the time of the visit, Patient A was 51 years old. Patient A reported that he had been using heroin for a few years. He tested positive for opiates at the time of the appointment. He had not been working for the last fifteen years due to several surgeries, and was receiving workers' compensation. Dr. Bock noted that Patient A had a history of arrests, including driving under the influence and "help[ing] drug dealer out," and had engaged in shoplifting. (Ex. 2.)

37. Patient A did not return to Dr. Bock's office after the first visit. (Exs. 1, 2.)

38. During the single appointment, Dr. Bock suggested to Patient A that if he was performing outdoor work at home, including mending his fence, he should consider performing other types of constructive work. (Ex. 2; Bock III: 201-04.)

39. During Dr. Bock's examination of Patient A, he touched him on his side and told him to get more exercise. He also tapped the side of Patient A's head and glasses, telling him he had to be smarter about what he was doing. Dr. Bock did not poke him in the head from behind. (Bock III: 205, 209-11.)

40. Patient A described himself to Dr. Bock as lazy. Dr. Bock noted this statement in his medical record. (Ex. 2; Bock III: 221.)

41. At the appointment, Dr. Bock compared addiction to pornography and pantomimed masturbation. In the course of his explanation, he also mouthed the word "pussy." (Ex. 1; Bock III: 208-09.)

42. On August 19, 2011, Patient A filed a complaint against Dr. Bock with the Board of Registration in Medicine. He made several allegations, including that Dr. Bock had assaulted him by taking his reading glasses out of his pocket and throwing them onto the counter, poking him in the head, and poking him in the side, calling him fat. He alleged that Dr. Bock had demeaned him for receiving workers' compensation. Patient A alleged that Dr. Bock made other humiliating, abusive, and offensive comments, with profanity. (Ex. 1.)

43. Dr. Bock refuted many of the allegations in the complaint. (Bock III: 199-211.)

44. Following Patient A's complaint, Dr. Bock started asking his patients' permission to record their initial visits. (Bock III: 243.)

45. Patient A did not testify at the hearing.

Patient B

46. Dr. Bock saw Patient B a number of times for opiate addiction. (Ex. 3; Bock III: 215.)

47. On June 15, 2012, Patient B filed a complaint against Dr. Bock with the Board of Registration in Medicine. Patient B alleged that Dr. Bock was rude and disrespectful to him and that he called Patient B a "retard." (Ex. 3.)

48. Dr. Bock denied the allegation that he made a derogatory comment about Patient B's MassHealth insurance. Most of Dr. Bock's patients were on MassHealth insurance. (Bock III: 216-17.)

49. Patient B also reported that Dr. Bock gave patients Suboxone pills in his office, then had them give him a number of Suboxone pills from their prescription so that he could give them to the next patient who saw him for treatment. (Ex. 3; Bock III: 176-84, 218-19.)

50. Dr. Bock had a supply of Suboxone in his office, which he received as free samples from a pharmaceutical company. The free samples consisted of thirty 8-milligram pills. He used that supply when patients failed to show up on "Day 1" with their prescription of Suboxone. In those cases, Dr. Bock would give them Suboxone from his office supply. This practice diminished his office supply of Suboxone. (Bock III: 219, 170-80.)

51. When Dr. Bock was about to run out of his Suboxone supply, he was unable to replenish the sample from the pharmaceutical company. In order to replenish his supply, Dr. Bock started his practice of patients "returning" pills to Dr. Bock from

their own prescriptions. He continued this method of replenishing his Suboxone supply until Patient B filed a complaint against him. Following that complaint, he discontinued this method of prescribing Suboxone. (Bock III: 170-83, 218-19.)

52. Patient B did not testify at the hearing.

Patient C

53. On May 17, 2013, Dr. Bock gave Patient C a physical examination for immigration purposes. (Ex. 4.)

54. Dr. Bock charged a \$180 or \$190 base fee for the immigration physical. He charged extra for additional services, such as immunizations. Dr. Bock's staff communicated the pricing to patients. He did not handle these phone calls and did not communicate with Patient C about payment. (Bock III: 227-33.)

55. Patient C wrote a check for the full cost of the physical, which was \$250.00. When her check bounced, Dr. Bock instructed one of his staff members to call her to ask for payment. He did not instruct his staff member to tell Patient C that he would call the police or immigration to arrest her. His normal practice for bounced checks was to file a criminal complaint. Eventually, Patient C's husband came to the office to pay the amount due in cash. (Bock III: 231-37.)

56. On June 11, 2013, Patient C filed a complaint against Dr. Bock with the Board. She complained that Dr. Bock threatened to call the police when her check bounced. (Ex. 4.)

57. Patient C did not testify at the hearing.

Patient D

58. Patient D testified at the hearing. She began treatment with Dr. Bock for opiate addiction on September 18, 2013. She had five appointments with him. (Ex. 6; Patient D III: 83.)

59. Patient D saw Dr. Bock because he was the only opiate addiction practitioner in the area with an available appointment. At that time, she was on a waiting list for another program. When space became available at MassGeneral Hospital in Revere, Patient D transferred to its Suboxone maintenance program. At the time of the hearing, she was in a MassGeneral program. (Patient D III: 89-90, 108.)

60. Dr. Bock recorded Patient D's first visit with her permission. At one point, he asked her to lie on the floor face down. As Patient D was getting on the floor, Dr. Bock stopped her, stating that the instruction was to show her that she should not do things just because someone tells her to. (Exs. 7, 8; Patient D III: 84, 109-10.)

61. Patient D perceived Dr. Bock as rude, arrogant, and mean. He commented on her yellow teeth. She alleged that this comment and others undermined her confidence. (Patient D III: 85-86.)

62. During one of her appointments, Patient D overheard Dr. Bock yelling at another patient and trying to take pictures of his arm. (Ex. 5.)

63. Patient D also complained that Dr. Bock would zap fruit flies with an electric bug killer during her appointments. At certain times of the year, Dr. Bock admitted that there were a few more fruit flies in the office, as there was a store next door that sold fresh fruit. (Patient D III: 84-85; Bock III: 156-58.)

64. During one visit, Patient D observed that a bathroom had not been cleaned and was out of order. Another bathroom was available for use in the office. (Patient D III: 88.)

65. Dr. Bock's office staff was responsible for cleaning the office. The examination rooms were cleaned after every patient. An outside cleaning company was hired for more extensive maintenance. (McCarthy V: 390.)

Patient E

66. On November 5, 2013, Dr. Bock saw Patient E. She had recently moved to the area from California. She was seeking a primary care physician and a referral to a rheumatologist for her lupus. She also complained of a sore on her lip. (Exs. 10, 12.)

67. Dr. Bock's habit was to come into the room and wash his hands. He usually shook hands with people. (Bock III: 242-244.)

68. Patient E complained of anxiety. Dr. Bock responded by characterizing anxiety as a "fight or flight" response and used a "lion and mouse" analogy. In the recorded visit, he told Patient E that "if you can make your situation more like the lion, then you're going to be less nervous." Being "like the mouse" was feeling that "things are happening to you." The way that he described his outlook on anxiety was unintentionally confusing. (Exs. 11, 12.)

69. Dr. Bock recommended "exercise, controlling your weight, . . . getting back to work, those are all constructive things that bring you so you are kind of more in a position where you can measure and gauge things." (Exs. 11, 12.)

70. Dr. Bock compared Patient E's lupus to a "life speed bump." (Exs. 11, 12.)

71. Patient E did not have her medical records at her visit. It would have taken a few weeks to transfer them from her previous out-of-state doctor. Dr. Bock wanted to determine the type of treatment she needed before referring her to a specialist for her lupus or anything else. At the time of the visit, Patient E was not experiencing a flare-up of her lupus requiring immediate care by a specialist. (Bock III: 250-51.)

72. Patient E filed a complaint with the Board regarding Dr. Bock. It was not dated. She did not return for a follow-up visit. (Ex. 9.)

73. Patient E did not testify at the hearing.

Board Policy

74. In June 2001, the Board adopted its "Disruptive Physician Behavior" Policy 01-01, based on guidelines published by the American Medical Association (AMA) and the Joint Commission on Accreditation of Healthcare Organizations. This policy states, in relevant part:

Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are now recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. In order to more clearly delineate conduct that is unacceptable, the AMA has adopted the definition of disruptive behavior set forth above. The AMA distinguishes this behavior from criticism that is offered in good faith with the aim of improving patient care.

(Ex. 18.)

Expert Witnesses

75. Dr. Olivera Bogunovic-Sotelo received her medical degree in 1992 from the University of Belgrade, where she also received a master's degree in public health. She is board certified in adult psychiatry, with a sub-specialty in geriatric psychiatry. She

completed her residency in general psychiatry at SUNY Buffalo. She also completed a fellowship in geriatric psychiatry at New York University, from 2000 to 2001, and a fellowship in addiction psychiatry at MassGeneral Hospital in Boston, from 2001 to 2002. (Ex. 28; Bogunovic-Sotelo II: 14-15, 19.)

76. She has worked as a physician/psychiatrist at McLean Hospital since November 2006, where she also serves as the Medical Director. Eighty percent of her work is clinical. She also moonlights at Cape Cod Hospital and operates a small, private practice for patients with substance abuse and psychiatric disorders. She works as an assistant professor at Harvard Medical School and has taught at SUNY Buffalo. (Bogunovic-Sotelo II: 13-16.)

77. Dr. Bogunovic-Sotelo trains other practitioners in the DEA's required eight-hour course. Most of the course focuses on prescribing and initiating Suboxone treatment. (Bogunovic-Sotelo II: 58-60.)

78. In preparation for the hearing, Dr. Bogunovic-Sotelo reviewed only exhibits pertaining to Dr. Bock's unpublished manuscript and his Suboxone videos. She did not review any of his patients' medical records. (Bogunovic-Sotelo II: 20-21.)

79. According to Dr. Bogunovic-Sotelo, the ideal approach to addiction treatment is multidisciplinary. In addition to medication, different forms of therapy are necessary for a successful outcome, including cognitive-behavioral, supportive psychotherapy, and other kinds of behavioral therapy, based on each patient's clinical picture. (Bogunovic-Sotelo II: 22-26, 33-34, 66.)

80. Dr. Alan Wartenberg received his medical degree in 1972 from the Medical College of Wisconsin. He is board certified in internal medicine by the

American College of Physicians and certified in addiction medicine by the American Board of Addiction Medicine. The American Board of Addiction Medicine is a professional organization for physicians interested in the treatment of addictive disorders. Dr. Wartenberg completed a rotating internship at Harvard and the University of California, Los Angeles from 1972 to 1973. He completed his residency in internal medicine at a hospital affiliated with the Medical College of Wisconsin. He is licensed to practice in Massachusetts. Dr. Wartenberg retired from practice two years ago. (Ex. 29; Wartenberg IV: 342-45.)

81. Dr. Wartenberg served as the medical director of the Faulkner Hospital's addiction recovery program from 1991 to 2004. He ran a private practice in North Kingston, Rhode Island from 2003 to 2012. He also worked at an out-patient opiate treatment program in Providence, Rhode Island. (Ex. 29; Wartenberg IV: 343-44.)

82. Dr. Wartenberg's own practice included methadone and Suboxone maintenance. (Wartenberg IV: 373-76.)

83. He wrote an opinion report in January 2014 in preparation for Dr. Bock's summary suspension case. In preparation of that report and his testimony at this hearing, he reviewed Dr. Bock's consent form and Suboxone videos. He did not review patient medical records. (Wartenberg IV: 346-47, 362-64.)

CONCLUSION AND RECOMMENDATION

The Board has not proven by a preponderance of the evidence that Dr. Bock engaged in disruptive conduct during his treatment of Patients A through E or that he provided substandard care in his Suboxone tapering program. However, the Board has proven that Dr. Bock fraudulently procured his renewal of certification because he failed

to disclose the Attorney General's investigation in his 2013 license renewal application. Additionally, from approximately 2006 until 2012, Dr. Bock's Suboxone prescription practice was in violation of G.L. c. 94C, § 19(b), which prohibits the use of prescriptions to obtain controlled substances for general dispensing to patients.

Statutory Basis for Discipline

In Massachusetts, physicians may be disciplined for "misconduct in the practice of medicine." 243 CMR 1.03(5)(a)(18). Doctors are also prohibited from engaging in conduct which places into "question the physician's competence to practice medicine," including gross misconduct in the practice of medicine. G.L. c. 112, § 5(e); 243 CMR 1.03(5)(a)(3). The Supreme Judicial Court defined the term "misconduct" in *Hellman v. Board of Registration in Medicine*, 404 Mass. 800, 804 (1989):

"Misconduct" in general, is improper conduct or wrong behavior, but as used in speech and in law it implies that the conduct complained of was willed and intentional. It is more than that conduct which comes about by reason of error of judgment or lack of diligence. It involves intentional wrongdoing or lack of concern for one's conduct. Whether or not an act constitutes misconduct must be determined from the facts surrounding the act, the nature of the act, and the intention of the actor.

A physician may be disciplined for misconduct during diagnosis or treatment of a patient or for misconduct "in carrying out his professional activities." *Forziati v. Bd. of Registration in Medicine*, 333 Mass. 125, 130 (1955).

Additionally, the Board may discipline a physician who lacks "good moral character" or has engaged in conduct that undermines the public confidence in the integrity of the medical profession. G.L. c. 112 § 2; see *Sugarman v. Bd. of Registration in Medicine*, 422 Mass. 338, 342 (1996) (disclosed confidential medical information to the media); *Alsabati v. Bd. of Registration in Medicine*, 404 Mass. 547, 551 (1989).

(committed plagiarism nearly ten years earlier); *Raymond v. Bd. of Registration in Medicine*, 387 Mass. 708, 712 (1982) (convicted of illegal arms dealing). Such disciplinary action "is reasonably related to promotion of the public health, welfare, and safety." *Raymond*, 387 Mass. at 713.

The Board may also discipline physicians for violating a Board rule or regulation. G.L. c. 112, § 5(h); 243 CMR 1.03(5)(a)(11). In 2001, the Board issued a "Disruptive Physician Behavior" policy, providing that behaviors such as rude or offensive comments and intimidation of patients and staff are detrimental to patient care. Board of Registration in Medicine, Policy 01-01, *Disruptive Physician Policy* (adopted June 13, 2001). It is unclear whether violating a Board policy constitutes violation of a Board rule or regulation. I do not directly address that issue in this decision because I conclude that Dr. Bock did not violate the Board's policy.

Standard of Care

All physicians must meet the standard of care, which is "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession." *Brune v. Belinkoff*, 354 Mass. 102, 109 (1968). The standard of care is the level of care and skill that physicians in the same specialty commonly possess. *Palandjian v. Foster*, 446 Mass. 100, 105 (2006); *McCarthy v. Boston City Hospital*, 358 Mass. 639, 643 (1971). Evidence that other physicians may have treated a patient differently does not prove negligence on its own, unless such treatment does not coincide with accepted medical practice. *Grassis v. Retik*, 25 Mass. App. Ct. 595, 602 (1988). Physicians may be required to choose one treatment from other medically appropriate

with the support of a group like Narcotics Anonymous, are all within the standard of care as long as the treatment choice is tailored to the patient.

Suboxone Tapering Program

The Board alleges that the manner in which Dr. Bock prescribes Suboxone is below the standard of care. Particularly, it contends that Dr. Bock's addiction treatment program falls below the standard of care because he does not believe that opiate addiction is a disease but a choice and can be changed through discourse and personal reflection. The Board argues, and Dr. Bogunovic-Sotelo opined, that any treatment program that eschews the widely-held opinion that addiction is a disease would not fall within the standard of care. Dr. Bock's unpublished manuscript certainly debates the "disease-model" and "behavior-model" schools of thought. However, in Dr. Bock's testimony, he did not deny the physiological component of addiction, especially symptoms of withdrawal. Further, his addiction treatment program did not consist merely of discourse with his patients, but offered a Suboxone treatment plan.

Dr. Bock offered a four to five month Suboxone tapering program for his patients. He instructed his staff to explain the program to potential patients. He also had patients sign a consent form that informed them of the nature of the program, Dr. Bock's "hard ball" approach, and the option to withdraw at any time. He testified that his intent was to help patients recover from drug addiction, in part by Suboxone tapering and in part by identifying and changing their underlying behaviors. Both expert witnesses agreed that a combination of medication and behavioral therapy was appropriate. Dr. Bogunovic-Sotelo also opined that some patients can tolerate tapering/detoxification and future abstinence as long as they continue with a therapy or self-help group. (Bogunovic-Sotelo

II: 37, 44-45). She stated that these programs are an appropriate form of treatment as long as they follow a disease-model theory of addiction. According to Dr. Wartenberg, treatments such as methadone/Suboxone maintenance, tapering programs of varying lengths, and complete abstinence programs, such as Narcotics Anonymous, meet the standard of care for opiate addiction treatment. In this case, a tapering program like Dr. Bock's, with a goal of total abstinence, falls within the standard of care.

Although Dr. Bogunovic-Sotelo criticized Dr. Bock for believing that all patients could be successful on his tapering program, and for adhering to a "behavior model" of addiction, Dr. Bock testified that he did not believe that every patient would resolve opiate addiction in his tapering program. The evidence does not show that he made any representation to potential patients that he would offer any treatment other than Suboxone tapering. While his office staff may not have volunteered information about maintenance programs to every patient that called, Dr. Bock's Suboxone videos mention maintenance programs. Although the Board's expert concluded that Dr. Bock failed to consider that his tapering program could have a dangerous effect on some of his patients, his Suboxone videos warn of the potentially addictive effects of Suboxone and possibility of lethal overdose. The videos also explain that not every patient is successful on a Suboxone tapering program.

The fact that Dr. Bock does not call addiction a "disease" did not affect the way that he treated patients, and neither did the fact that there are not many physicians offering such a program. His tapering program was successful for many of his patients. In order to determine whether Dr. Bock's Suboxone treatment program met the standard of care, I must assess his practice with patients, not his thoughts or philosophy or the

relative uniqueness of his approach. However, in terms of whether Dr. Bock considered opiate addiction a disease or a choice, I find that he has an appropriately nuanced view of the subject, in light of the medical community's still limited and evolving knowledge of drug addiction and how to treat it.

For the reasons stated, I conclude that Dr. Bock's Suboxone tapering program fell within the standard of care for patients seeking treatment for opiate addiction.

Disruptive Behavior

In June 2001, the Board published a new disruptive physician policy. This policy provides that "[b]ehaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are now recognized as detrimental to patient care." However, it also provides that "criticism that is offered in good faith with the aim of improving patient care" does not violate the policy.

The Board alleges that Dr. Bock's interactions with Patients A through E constituted disruptive behavior, specifically "making personal observations of the patient's socio-economic status and confronting patients with his unfiltered personal and political opinions." I find that, although Dr. Bock's methods and analogies were unconventional, his behavior was not so disruptive as to be detrimental to patient care. While Dr. Bock's approach was unorthodox and, at times, heavy-handed, his intent was not to insult or demean his patients but to treat them for opiate addiction and their other health problems. I find Dr. Bock's testimony at the hearing credible. Further, I give his live testimony more weight than the written complaints of Patient's A, B, C, and E, who did not testify at the hearing. Any criticism that he offered in the course of treating the complaining patients was in good faith with the aim of improving their care.

Patient A:

The Board alleges that at Patient A's initial visit, Dr. Bock poked him, took his reading glasses out of his pocket, called him fat, and demeaned him for receiving workers' compensation. Patient A also complained that Dr. Bock made offensive comments with foul language. Patient A did not return after this visit.

Although the Board's Statement of Allegations states that Dr. Bock called him lazy, Patient A's written complaint did not mention this. Dr. Bock credibly testified that Patient A described himself as lazy, and he noted this in Patient A's medical record. Dr. Bock testified that what he noted in the medical record also reflected what Patient A had told him about his shoplifting and driving under the influence. Patient A did not testify at the hearing.

The Board argues that Dr. Bock called Patient A fat and poked him in the side. Dr. Bock credibly testified that during his physical examination of Patient A, he touched Patient A's side and suggested that he exercise more. While Patient A could reasonably infer that Dr. Bock was commenting on his weight, I conclude that Dr. Bock's comment was offered in the course of treatment to improve Patient A's health, and not as a demeaning insult. Dr. Bock also denied taking Patient A's glasses out of his pocket and throwing them on the counter. However, he admitted that he did tap Patient A's glasses and side of his head, telling him that he needed to be smarter about what he was doing.

Dr. Bock also admitted that in the course of his explanation he made a masturbatory gesture and mouthed the word "pussy" while comparing drug addiction to pornography. These actions were not necessary to treat Patient A, but it is clear from the testimony that Dr. Bock was nervously and probably inaccurately attempting to speak to

Patient A at his level. Dr. Bock denied the use of any other foul language or offensive comments.

For the reasons stated, I find that Dr. Bock did not exhibit disruptive behavior towards Patient A.

Patient B:

Patient B was treated by Dr. Bock a number of times for opiate addiction. The Board alleges that Dr. Bock was rude and disrespectful to Patient B during Patient B's treatment. Patient B did not testify at hearing. Dr. Bock denied that he was rude and disrespectful. He denied demeaning Patient B after quizzing him about the Suboxone videos or calling him a "retard." Dr. Bock also stated that he would never make a derogatory comment about Patient B's insurance because most of his patients had MassHealth insurance. Instead, he testified that he cautioned Patient B against wasting his trust fund. I find that through these personal comments, Dr. Bock was likely trying to provide the "strong and plain" approach that was a part of his addiction treatment plan. I give more weight to Dr. Bock's credible live testimony than to Patient B's written complaint.

For the reasons stated, I find that Dr. Bock did not exhibit disruptive behavior towards Patient B.

Patient C:

Patient C saw Dr. Bock for an immigration physical examination. Following the exam, her check bounced. The Board alleges that Dr. Bock made threats to Patient C about reporting her bounced check to the police and was discourteous during the

examination. Neither Patient C nor any member of Dr. Bock's staff who may have had contact with Patient C testified at the hearing.

The Board argues that Patient C was not aware before her visit that there would be an extra charge for immunizations or tests. Although the Statement of Allegations noted that Dr. Bock was abrupt and discourteous to Patient C during her physical, Patient C did not make this allegation in her complaint. Dr. Bock testified that his staff had contact with Patient C following the bounced check and he did not direct them to threaten Patient C with calling the police or reporting her to immigration authorities. There is no evidence about what was said to Patient C, although Dr. Bock testified that it was his regular practice to file a criminal complaint for bounced checks. This is a drastic measure, but Dr. Bock explained that it was much easier for him to file the complaint and not involve a collection agency.

I find the record evidence insufficient to determine whether Dr. Bock's behavior towards Patient C was disruptive or threatening, amounting to a violation of the Board's disruptive physician policy. I conclude that the Board has not proven by a preponderance of the evidence that Dr. Bock's conduct was disruptive.

Patient D:

Patient D was treated for opiate addiction by Dr. Bock over the course of five appointments. She testified at hearing that Dr. Bock was rude, arrogant, and mean. She also stated that he had made derogatory and humiliating comments to her about her appearance, particularly her teeth.

Dr. Bock recorded his first visit with Patient A, with her permission. At that visit, Dr. Bock explained his theory of addiction and his method of treatment. At one point in

the visit, he asked her to lie face down on the floor. As Patient D was getting on the floor, he told her that he had not been serious and that he was illustrating a point. I find that the recording of the initial appointment does not demonstrate conduct amounting to disruptive behavior. Although a number of Dr. Bock's comments were insensitive at times, given Patient D's life history, I find that he offered these comments and criticism in good faith, with the goal of treating her addiction.

Patient D also alleged that Dr. Bock's office was dirty and that there were fruit flies that he zapped with an electric bug killer during her appointments. Dr. Bock's office manager credibly testified that the examination rooms were cleaned after every patient. Dr. Bock explained that there was a store next door that sold fruit, and during certain seasons, some fruit flies would get into his office. During one appointment, the waiting room bathroom was out of order and unclean, but another bathroom was available for use.

Dr. Bock did not exhibit disruptive behavior towards Patient D.

Patient E:

Patient E saw Dr. Bock for an initial visit because she was looking for a new primary care physician after moving to Massachusetts. She did not return for a subsequent appointment. Patient E alleged that, overall, Dr. Bock had a poor bedside manner. As an example, she stated that Dr. Bock demonstrated how viruses were spread by coughing into his hands and then threw his hands in the direction of her and her boyfriend. While Patient E did not observe him washing his hands before her appointment, Dr. Bock testified that it was his regular practice to wash his hands before and after seeing each patient. Patient E also complained that Dr. Bock used a lion and

mouse analogy to talk about anxiety. During Patient E's recorded office visit, Dr. Bock advised her to take more control of her life, like a lion, instead of feeling hopeless and victimized, like a mouse. Patient E did not testify at the hearing.

Although Patient E wrote that she was "horrified" by Dr. Bock's comments, I find that the comments she specified were not "rude, loud or offensive." Patient E did not complain that she felt intimidated by his behavior. Although Dr. Bock's analogies and explanations were confusing, I do not find that his comments or behavior detrimentally affected Patient E's care.

Inasmuch as the Board argues that Dr. Bock's analogy about anxiety or his failure to refer Patient E to a specialist for her pre-existing lupus after her first visit constituted disruptive behavior, this is a standard of care issue. However, the Board did not provide evidence regarding the standard of care for treating chronic illness showing that Dr. Bock's analogy or non-referral fell below the standard.

The Board also alleges that Dr. Bock failed to refer Patient E to a rheumatologist after she requested one for her pre-existing lupus. I find Dr. Bock credible in his testimony that he did not have Patient E's medical records and wanted to see them before referring her. He did not observe, and Patient E did not inform him, that she was experiencing a lupus flare-up or other lupus-connected emergency. Further, neither of the expert witnesses addressed this issue. Without an expert opinion on Dr. Bock's medical judgment with respect to this patient, I cannot determine when, or if, physicians are obligated to refer their patients to a specialist merely because the patient requests the referral, even without medical records or a medical evaluation.

For the reasons stated, I find that Dr. Bock did not exhibit disruptive behavior towards Patient B.

Suboxone Prescription Practice

The prescription of substances such as Suboxone is controlled by G.L. c. 94C, § 19(b), which provides: "No prescription shall be issued in order for a practitioner to obtain controlled substances for supplying the practitioner for the purpose of general dispensing to patients."

Dr. Bock had an office supply of Suboxone pills from a pharmaceutical company's sample. He used this supply to accommodate patients who showed up to their appointments without their initial prescription of Suboxone and were in withdrawal. Once his supply began to dwindle and Dr. Bock realized that the sample supply would not be replenished, he had patients return any Suboxone pills that were "advanced" to them from their second Suboxone prescription.

The Board argues that this practice violated the statute. At the hearing, Dr. Bock admitted to this practice. However, he testified that he discontinued this practice in 2012, after Patient B filed a complaint. There is no evidence that he continued the practice after 2012. I find that Dr. Bock's method of restocking an office supply of Suboxone violated Section 19(b) until 2012, when he stopped.

Attorney General Investigation and License Renewal

When Dr. Bock started his Suboxone practice or shortly after, he charged his patients an "administrative fee" of \$185.00 for their initial visits. Dr. Bock was a MassHealth provider. This administrative fee for Suboxone treatment patients was money he received in addition to MassHealth reimbursement. Based on a patient

complaint, the Massachusetts Attorney General investigated Dr. Bock and determined that his practice of charging an administrative fee was in violation of G.L. c. 93A, § 2; G.L. c. 118E, §§ 42, 36; and 130 CMR 450.203(A) ("No provider may solicit, charge, receive, or accept any money, gift, or other consideration from a member, or from any other person, for any item or medical service for which payment is available under MassHealth, in addition to, instead of, or as an advance or deposit against the amounts paid or payable by the MassHealth agency for such item or service,") and 42 C.F.R. § 447.15. Dr. Bock was represented by Attorney Juliane Balliro in this matter. In April 2012, Dr. Bock entered into an Assurance of Discontinuance with the Attorney General. He agreed that he would cease his practice of charging an administrative fee to any MassHealth member seeking Suboxone treatment.

G.L. c. 112, § 5, ninth par. (a) gives the Board authority to discipline a physician for fraudulently procuring a certificate of registration. The Board's regulation, at 243 CMR 1.03(5)(a)(1), provides that a physician may be disciplined for "[f]raudulent procurement of his or her certificate of registration or its renewal." The Board alleges that Dr. Bock fraudulently procured his license renewal because he failed to report properly the Attorney General's investigation in his July 2013 license renewal form.

The Board contends that Dr. Bock falsely answered Question 18C in the negative. Question 18C asks whether the licensee has been the subject of an investigation by any governmental authority. While the evidence shows that Dr. Bock did answer "yes" to Question 18C, he failed to disclose the Attorney General's investigation specifically anywhere in his renewal form. Dr. Bock claimed that he did not list the investigation based upon advice from Attorney Balliro. However, Attorney Balliro could not recollect

the details of the conversation at the hearing and did not remember telling Dr. Bock not to list the investigation. Therefore, I cannot rely on her testimony, and there is no evidence she advised non-disclosure of the investigation other than Dr. Bock's self-serving recollection. Moreover, even if Ms. Balliro had advised Dr. Bock not to disclose the investigation, relying on her poor legal advice would not have absolved him of the violation.

The license renewal instructions, presumably available to Dr. Bock at the time he filled out his online form, require that a "yes" answer to Question 18C be accompanied by "Form R." While Dr. Bock submitted a Form R with his 2013 renewal application, he listed only Board investigations into patient complaints, and not the Attorney General's investigation. Based on the evidence, I find that Dr. Bock failed to report an investigation by a governmental authority on his 2013 license renewal form because he did not include the Attorney General's investigation on his Form R.

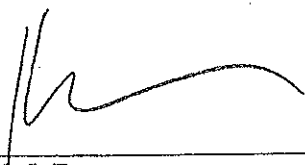
CONCLUSION

Based on the evidence presented at the hearing, the Board has not proven by a preponderance of the evidence that Dr. Bock committed misconduct or gross misconduct in the practice of medicine. Although reasonable minds could differ on what the "best" treatment for opiate addicted patients would be, the Board did not prove that Dr. Bock's treatment violated the standard of care. Additionally, the Board did not provide sufficient evidence that Dr. Bock's conduct towards Patients A through E was "disruptive" under its 2013 policy. Rather, the record establishes that Dr. Bock's actions were intended to help his patients overcome opiate addiction. His methodology involved some tough talk, and some unorthodox analogies, but nothing rising to the level of disruptive behavior.

I do find that Dr. Bock's practice of inappropriately "refilling" his office supply of Suboxone from patients' prescriptions violated G.L. c. 94C, § 19(b). I also find that Dr. Bock failed to report the Attorney General's investigation on his 2013 license renewal form.

Therefore, based on the foregoing reasons, I recommend that the Board impose appropriate discipline on Dr. Bock as to the two violations found here.

DIVISION OF ADMINISTRATIVE LAW APPEALS



Kenneth J. Forton
Administrative Magistrate

DATED: **JUL 16 2018**