

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2023-044

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In the Matter of)
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VICTOR FERZOCO, M.D.)
_____)

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that VICTOR FERZOCO, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 18-081.

Biographical Information

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.

Factual Allegations

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.

Legal Basis for Proposed Relief

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.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The

Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,

A handwritten signature in black ink, appearing to read 'JNR', followed by a horizontal line.

Julian N. Robinson, M.D.
Board Chair

Date: November 2, 2023