THE COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. **Division of Administrative Law Appeals**

Board of Registration in Medicine,
Petitioner

v.

Docket No. RM-16-350

Robert B. Shepherd, D.O.,
Respondent

Appearance for Petitioner:

John Costello, Esq.
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Appearance for Respondent:

Andrew L. Hyams, Esq.
Jeremy Y. Weltman, Esq.
Kerstein, Coren & Lichenstein, LLP
60 Walnut Street
Wellesley, MA 02481

Administrative Magistrate

James P. Rooney

Summary

Board of Registration in Medicine's motion for summary suspension of doctor for prescribing outside the usual course of his practice to a fiancé and a girlfriend denied for lack of proof that his judgment was so poor that his continued practice represents an immediate threat to public health.

RECOMMENDED DECISION ON SUMMARY SUSPENSION

On July 26, 2016, the Board of Registration in Medicine issued a statement of allegations against Robert B. Shepherd, D.O., alleging, among other things, that he improperly prescribed medication to two women he was dating.

On the same day, the Board, acting in accordance with 243 CMR 1.03(11)(a) summarily suspended Dr. Shepherd's license to practice medicine, deeming that he poses an "immediate and serious threat to the public health, safety, and welfare."[1] The Board relied on a motion by complaint counsel seeking the doctor's suspension and an attached affidavit of Board investigator Robert M. Bouton describing the prescriptions Dr. Shepherd issued to his two girlfriends and a number of encounters he had with the police in 2015 and 2016. While the motion does not state the specific grounds for the Board's contention that Dr. Shepherd is an immediate threat to the public health, its position here is that the events described in Investigator Bouton's affidavit demonstrate a pattern of poor judgment inconsistent with his continued practice of medicine. Dr. Shepherd appeared at the Board meeting at which the motion to suspend was considered and answered questions posed by Board members. He also presented affidavit from Female A, who he is dating, and Female C, a friend of hers.

The Board referred this matter to the Division of Administrative Law Appeals on July 27, 2016. I scheduled a hearing on the summary suspension for August 5, 2016, but gave the doctor an opportunity to attend a prehearing conference on that date instead. Dr. Shepherd chose to appear for a prehearing conference. At the conference, I granted his request to resolve the summary suspension motion on the papers. Following the

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[1] The motion to suspend Dr. Shepherd mentions both 243 C.M.R. § 1.03(11)(a), which allows the Board to suspend a doctor it deems to be an immediate and serious threat to the public health based solely on affidavits presented to it, and 243 C.M.R. § 1.03(11)(b), which allows the Board to suspend a doctor who "may be a serious threat to the public health," in which case it may give the doctor three days to file affidavits. It is not entirely clear under which of these provision the Board acted. Doctor Shepherd maintains that he asked for an additional three days before the Board heard the motion and that his request was denied. I assume, then, that it is more likely that the Board acted under 243 C.M.R. § 1.03(11)(a).

conference, the Board submitted a supplemental affidavit from Investigator Bouton setting forth his recollection of Dr. Shepherd's responses to the Board. Dr. Shepherd relied on the two affidavits previously submitted to the Board and affidavits he submitted with his answer to the Statement of Allegations, including his own affidavit, an affidavit of Female E (his former fiancé), affidavits from two doctors with whom he has practiced, and an affidavit of Carol A. Warfield, M.D., a professor at Harvard Medical School who has worked as a pain management doctor, concerning the propriety of his prescriptions to Female A stated as a hypothetical. Both parties submitted briefs; Dr. Shepherd also submitted proposed findings of fact.

Findings of Fact

Based on the documentary record and reasonable inferences I draw from it, I make the following findings of fact:

1. Robert Shepherd was born in 1958 and graduated from the New England College of Osteopathic Medicine in 1987. He has been licensed to practice in Massachusetts since 1990. He is board certified in family medicine and has worked at Athol Memorial Hospital and Heywood Hospital as an emergency room doctor and a hospitalist. (Statement of Allegations and Shepherd affidavit Ex. A.) Dr. Shepherd has completed training in opioid prescribing by taking online courses offered by Boston University. (Bouton supp. affidavit.)

Prescriptions to Female E

2. Dr. Shepherd was engaged to Female E between 2011 and 2014. During that time he wrote her four prescriptions for painkillers, each without refills. Female E's dentist

extracted a tooth on May 23, 2013. Thereafter, she developed a "dry socket,"[2] causing her pain that she described as "almost to the point of being intolerable." On June 7, 2013, Dr. Shepherd wrote her a prescription for 40 pills of hydrocodone with acetaminophen.[3] (Bouton, Shepherd, and Female E affidavits.)

3. On October 19, 2013, Female E cracked a tooth when she bit down on her tongue ring. She did not have a regular dentist at the time because she was having trouble finding a dentist who would accept Mass Health insurance. On that Saturday, Dr. Shepherd wrote her a prescription for 20 pills of oxycodone HCL with acetaminophen[4] to ease her pain. Female E eventually found a dentist, but could not obtain an appointment earlier than November 9, 2013. By Saturday, October 26, 2013, she had used up the medication Dr. Shepherd had prescribed one week before and had yet to locate a dentist.

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[2] A "dry socket" is a painful condition that may develop after tooth extraction. "The socket is the hole in the bone where the tooth has been removed. After a tooth is pulled, a blood clot forms in the socket to protect the bone and nerves underneath. Sometimes that clot can become dislodged or dissolve a couple of days after the extraction. That leaves the bone and nerve exposed to air, food, fluid, and anything else that enters the mouth. This can lead to infection and severe pain that can last for 5 or 6 days." http://www.webmd.com/oral-health/guide/dry-socket-symptoms-and-treatment#1.

[3] Hydrocodone with acetaminophen is a "combination medication [that] is used to relieve moderate to severe pain. It contains a narcotic pain reliever (hydrocodone) and a non-narcotic pain reliever (acetaminophen)." http://www.webmd.com/drugs/2/drug-251/hydrocodone-acetaminophen-oral/details. Hydrocodone with acetaminophen was listed as a Schedule III drug by the Drug Enforcement Agency until October 6, 2014, when it was re-listed as a Schedule II drug. https://www.deadiversion.usdoj.gov/fed_regs/rules/2014/fr0822.htm.

[4] Oxycodone HCL with acetaminophen is a "combination medication [that] is used to help relieve moderate to severe pain. It contains a narcotic pain reliever (oxycodone) and a non-narcotic pain reliever (acetaminophen)." http://www.webmd.com/drugs/2/drug-2796-5352/oxycodone-acetaminophen-oral/oxycodone-acetaminophen---oral/details. Oxycodone is a Schedule II drug. 21 C.F.R. § 1308.12(b)(1)(xiii).

On that day, Dr. Shepherd prescribed her 40 pills of hydrocodone with acetaminophen. (Bouton, Shepherd, and Female E affidavits.)

4. On February 7, 2014, Female E fell on her tail bone while snowboarding. By that night, she was experiencing increasingly intense pain. Instead of going to the emergency room, she called Dr. Shepherd, who agreed to write her a prescription for 10 pills of hydrocodone with acetaminophen. He told her she would not need the medication for more than a couple of days. Her pain subsided in a few days to the point that she did not need any further pain medication. (Bouton, Shepherd, and Female E affidavits.)

Prescriptions to Female A

5. Dr. Shepherd has been dating Female A on and off since at least January 2015 when she moved in with him. She moved out sometime in August 2015 and moved back in with him in October or November 2015. She still lives with Dr. Shepherd. (Female A affidavit.)

6. Female A is 29 years old. She was assaulted by an ex-boyfriend in 2009 and was prescribed oxycontin while she was hospitalized. Thereafter, she started using heroin. She describes herself as presently in recovery. She insists that "[s]ince I met [Dr. Shepherd in 2014] I have never kept heroin in [his] house. I have used once in the house since I have been living there." She concealed this use from Dr. Shepherd until she prepared her affidavit. (Female A affidavit.)

7. Throughout the period in which Female A has lived with Dr. Shepherd, the doctor has believed that she was not using heroin and was "working on staying clean." (Shepherd affidavit.) He has attempted to take steps to prevent her from using heroin. For example, when he gives her money for grocery shopping, he insists that she show

him the grocery list and, once she returns from the store, he has her show him the grocery receipt and the change she received to make sure she has not spent any of the money on drugs. (Female A affidavit.) He also asked her to leave his house after she had seen her old boyfriend. He maintains that he did so because of his "belief that [the ex-boyfriend] was an active drug user who would attempt to influence Female A to begin using heroin again." (Shepherd affidavit.)

8. Prior to dating Dr. Shepherd, Female A's primary care physician was a Dr. Matthews in Athol. She has bi-polar disorder; Dr. Matthews prescribed her Klonopin.[5] She left Dr. Matthews' practice because:

> At some time I discovered that a person named Stephanie was working for Dr. Matthew[s] spread rumors about me and my medical history to people who knew me and were not aware of my medical issues. Dr. Matthew[s] was completely unaware of this activity, but I was embarrassed to go to him and intimidated by Stephanie and so I stopped going to see him.

(Female A affidavit.) Dr. Shepherd was aware that Female A suffered from anxiety and bi-polar disorder. He encouraged her to seek treatment from a mental health professional. (Bouton supp. affidavit.)

9. Female A asked Dr. Shepherd to write her a prescription for Klonopin. (Female A affidavit.) He agreed to do so because Female A:

> had reported to me that she had been taking Klonopin in a 1-2 mg. dose for some time to treat her anxiety, as had been regularly prescribed by her then treating physician – Dr. Matthew[s]. . . . However, due to an issue that had arisen between her and the treating physician's staff, she felt as though she could not return to refill her Klonopin prescription. Instead, she asked me if I could write her a prescription for the Klonopin until she could find another doctor.

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[5] Klonopin (clonazepam) "works by calming your brain and nerves. It belongs to a class of drugs called benzodiazepines." http://www.webmd.com/drugs/2/drug-920-6006/klonopin-oral/clonazepam---oral/details. Klonopin is a Schedule IV drug. 21 C.F.R. § 1312.14 (c)(11).

(Shepherd affidavit.)

10. Dr. Shepherd wrote the following prescriptions for Klonopin for Female A:

Date Written	Dose	Quantity
January 5, 2015	1 mg.	60
January 26, 2015	1 mg.	60
April 27, 2015	1 mg.	60
June 3, 2015	1 mg.	60
June 30, 2015	2 mg.	60
July 27, 2015	2 mg.	60
August 22, 2015	2 mg.	60
September 25, 2105	2 mg.	90
January 12, 2016	2 mg.	90
February 16, 2106	2 mg.	90

(Bouton affidavit and Bouton affidavit Ex. 8.) The prescriptions were written on Heywood Hospital prescription forms. (Bouton affidavit Ex. 8.) The doctor did not authorize any refills of these prescriptions. He insists that he "only prescribed the numbers of pills necessary after fully discussing her symptoms and general history of her use of the medications with her." (Shepherd affidavit.) He increased her dosage in late September 2015 because she was experiencing additional stress. Dr. Shepherd is aware that taking a benzodiazepine and heroin together can cause respiratory arrest. (Bouton supp. affidavit.)

11. For a hypothetical individual who suffers from anxiety and is a recovering heroin user who is not currently using heroin and was prescribed the same dosages of Klonopin Dr. Shepherd prescribed to Female A, Dr. Warfield opined:

> Although it was inappropriate for Dr. S[hepherd] to prescribe for [Female A] since they did not have a doctor-patient relationship, Dr. S[hepherd] did not put [Female A]'s health at risk as he prescribed medication which had been given by her previous doctor, for a diagnosis (anxiety) for which it was indicated, and titrated the dose up very slowly over a period of months and was able to observe any side effects such as excessive sedation.

(Warfield affidavit.) She also stated:

> . . . [T]here are no guidelines or standards which require [urine drug] screens for patients who are prescribed benzodiazepines and even opioids, these screenings are not mandatory. Therefore, aside from the lack of a doctor-patient relationship, I do not think that it was outside the standard of care for Dr. S[hepherd] not to stop prescribing the medication due to concern for diversion.

Id.

12. Dr. Shepherd also twice prescribed Lomotil[6] to Female A: 30 pills on April 27, 2015 and 10 pills on October 19, 2015. (Bouton affidavit and Bouton affidavit Ex. 8.) Dr. Shepherd stated that as to the October prescription:

> I recall that [Female A] was displaying symptoms consistent with gastrointestinal flu, including intensive bouts of diarrhea. Instead of heading to the Emergency Room, she asked if I could provided her with something. Since she was living with me, and I felt like I could certainly assess her symptoms if they were negatively affected following taking the Lomotil, I prescribed her only enough to get her through a few days.

(Shepherd affidavit.) Dr. Shepherd is aware that diarrhea can occur during heroin withdrawal. (Bouton supp. affidavit.)

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[6] Lomotil (diphenoxylateHCL/atropine sulfate) "is used to treat diarrhea. It helps to decrease the number and frequency of bowel movements. It works by slowing the movement of the intestines. Diphenoxylate is similar to narcotic pain relievers, but it acts mainly to slow the gut. Atropine belongs to a class of drugs known as anticholinergics, which help to dry up body fluids and also slow gut movement." http://www.webmd.com/drugs/2/drug-6876/lomotil-oral/details. Lomotil is a Schedule V drug. 21 C.F.R. § 1308.15(c)(4).

Burglary of Dr. Shepherd's House

13. While he has been dating Female A, Dr. Shepherd has had numerous encounters with the police and emergency personnel. During the evening of September 6, 2015, Dr. Shepherd returned to his home in Rutland, Massachusetts after working a double shift. He saw a car parked in his driveway and a man, whom he recognized, leaving his house. The man said he was looking for Female A; when the doctor responded that Female A no longer lived there, he left. The next morning, he noticed "a gouge in [his] wall under the under the railing of [his] stairs," which led him to check to see if anything was missing. He determined that 10 of the 80 registered firearms he owns were missing, along with two small lockboxes, and a $3,000 coin collection. He reported the burglary to the police. He also spoke to Female A, who told him the man seen at his house had stolen the weapons to pay off money he owed in a drug deal made with a member of a street gang known as the Latin Kings. Dr. Shepherd provided this information to the police, who charged a suspect later that month. (Shepherd and Bouton affidavits; police reports at Bouton affidavit Ex. 3.)

Overdose of Female A's Cousin

14. On February 19, 2016, Dr. Shepherd drove Female A to her cousin's apartment in Gardner, Massachusetts in order to show the cousin, Female B, her freshly-done nails. Dr. Shepherd waited in the car while Female A entered the apartment. Female A returned immediately, telling the doctor that she had found Female B unresponsive on the floor. Dr. Shepherd ran to the apartment, asked others present if Female B had taken anything, and had someone call 911 while he performed rescue breathing. When paramedics arrived, he told them he thought that Female B had overdosed. The

paramedics administered two doses of Narcan, which revived Female B. (Shepherd and Bouton affidavits; police report at Bouton affidavit Ex. 4.)

Dr. Shepherd's Auto Accident

15. On April 6, 2016, Dr. Shepherd was backing his Dodge Ram Quad Cab out of his driveway when he hit a woman who was jogging by, scraping her leg. The Rutland police cited him for negligent operation of a vehicle. Dr. Shepherd failed to appear for a court date on the charge and an arrest warrant was issued. Rutland police arrested him on the warrant on July 18, 2016. The following day, he appeared in East Brookfield District Court and claimed that he had not received notice of the original hearing. The court placed him on probation, required him to complete a safe driver program, and charged him $600 in court costs. (Shepherd and Bouton affidavits; police report at Bouton affidavit Ex. 5.)

Female C Overdose at Dr. Shepherd's House

16. In April 2016, Dr. Shepherd agreed to allow Female C to live in his house. Female C had been involuntarily committed for heroin abuse, and as a result had lost custody of her daughter, who was then living with Female C's mother. Because Female C was not allowed to see her daughter, her mother asked Dr. Shepherd, who was a friend, if he would allow Female C to stay in one of his spare bedrooms. Female C had similar conversation with Female A in which Female A suggested she come live with Dr. Shepherd. Dr. Shepherd agreed on condition Female C not use drugs or alcohol and she look for a job. On June 16, 2016, Dr. Shepherd and Female A left the house to run an errand. In the now empty house, Female C became anxious about losing her one year old child, went to a heroin stash she kept secret from Dr. Shepherd, and overdosed. Dr.

Shepherd and Female A returned to find Female C unresponsive on the floor. Female A called 911, as Dr. Shepherd had told her to do. Rutland EMTs responded and revived Female C by administering Narcan. The Rutland police recovered six empty baggies, a used needle, and a spoon with a brown sticky substance suspected to be heroin. (Shepherd, Bouton, and Female C affidavits; police report at Bouton affidavit Ex. 6.)

Dr. Shepherd's Vehicle Stopped by the Police

17. On June 24, 2016, Dr. Shepherd drove Female A and another woman, Female D, to an apartment in Gardner. Female A told Dr. Shepherd that she intended to look at a mattress she was interested in purchasing and that someone who lived there owed her money for cigarettes she had purchased for him. Dr. Shepherd parked his car in the apartment's parking lot and waited there for ten minutes while the two woman went into the apartment. When they returned, he drove away. The Gardner police were watching this apartment building because it had been the subject of complaints of drug sales. When Dr. Shepherd drove off, the police stopped him and told him his car was being stopped because of an expired inspection sticker and a broken tail light. The police asked all three of the car's occupants to get out of the car, and then interviewed them separately. The police told Dr. Shepherd that the apartment was a known drug sale location; the doctor disclaimed any knowledge of this. He was also asked if his female passengers used heroin. If he was asked to identify Female D, the police reports do not mention this.[7] Female D told the police that she was a daily heroin user. The officers who interviewed Female A thought they saw fresh track marks on her arm. Dr. Shepherd

[7] Board Counsel maintains that an unredacted copy of the police report would show that the person identified in the redacted report as Female D was described as Female A's sister. The unredacted report is not before me, and hence I make no findings about it.

has never seen fresh track marks on her arm. The officers did not find any evidence of narcotics possession or use, and therefore let everyone go. They issued a written warning to Dr. Shepherd for his motor vehicle violations. He had those fixed within a few days. (Shepherd and Bouton affidavits; police report at Bouton affidavit Ex. 7.)

Arrest of Female D at Dr. Shepherd's House

18. On June 30, 2016, the Massachusetts State Police went to Dr. Shepherd's home to execute an arrest warrant for Female D concerning a probation violation on a larceny charge. Dr. Shepherd was not aware that Female D was in his house. The police found Female D in Dr. Shepherd's bedroom and arrested her. (Shepherd and Bouton affidavits; police report at Bouton affidavit Ex. 9.)

Dr. Shepherd's Conversation with Board Staff

19. In February 1997, Dr. Shepherd received a speeding ticket. Any prior arrests he might have had came up in a conversation between Dr. Shepherd and a Board staff member. (Bouton affidavit.)

Prior Board Investigations of Dr. Shepherd

20. The Board of Registration in Medicine twice in the past investigated complaints made against Dr. Shepherd. In November 2003, a complaint was filed about a "do-not-resuscitate" order signed by Dr. Shepherd concerning a nursing home patient. Her son doubted that she had agreed to it. Dr. Shepherd responded that he had discussed this topic with her when she was admitted to the facility, and that at the time she wished to be on "do-not-resuscitate" status. The Board ended the investigation in February 2004 without taking any disciplinary action. (Bouton affidavit Ex. 1.)

21. In August 2004, the Board received a complaint that Dr. Shepherd had failed to forward a patient's records to her new doctor after Dr. Shepherd closed his private practice. Dr. Shepherd responded that his previous receptionist had misplaced the request and that, once he received the complaint, he had sent the patient's records to her new doctor. The Board closed its investigation in October 2004 without taking any disciplinary action. (Bouton affidavit Ex. 2.)

Hospital Complaint Records Regarding Dr. Shepherd

22. Various complaints have been filed about Dr. Shepherd at the two hospitals where he works. The complaints at Athol Memorial Hospital concern delays and diagnoses in the emergency room. There is no indication in the Athol Memorial Hospital's files that it took any disciplinary action against Dr. Shepherd. (Bouton affidavit Ex. 12.) The complaints made at Heywood Hospital similarly concern emergency room delays, diagnoses, and treatment.[8] Again, there is no indication that the hospital has taken any disciplinary action against Dr. Shepherd. (Bouton affidavit Ex. 13.) None of the complaints allege improper prescription practices.

23. The Board, after voting 4-2, issued an order of temporary suspension on July 26, 2016. (Dr. Shepherd's brief Ex. B.) It stated, "[t]he "Board has determined that, based upon the information set forth in the Motion for Summary Suspensions and Affidavit, the health, safety, and welfare to the public necessitates said suspension." (Order of Temporary Suspension, July 26, 2016.)

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[8] One of the complaints at Heywood Hospital alleges that Dr. Shepherd brought prostitutes into the hospital. The file shows that the police were alerted. There is no indication, however, as to what any investigation by the hospital determined. (Bouton affidavit Ex. 13.) There is also no evidence as to whether the Board has investigated this matter. Because there is no evidence in the record to verify this scandalous allegation, I do not consider it.

Discussion

When the Board of Registration in Medicine summarily suspends a physician under 243 C.M.R. § 1.03(11)(a), it has the burden to prove at a hearing on the suspension that, by a preponderance of the evidence, the physician is an immediate and serious threat to the public health, safety, or welfare. *See Randall v. Board of Registration in Medicine*, SJ-2014-0475, Memorandum of Decision (Cordy, J., June 9, 2015.)

Board counsel asserts that the various incidents described in Investigator Bouton's affidavit demonstrate that Dr. Shepherd's judgment is so poor that his continued practice represents an immediate and serious threat to the public health, safety, and welfare. Poor judgment in the practice of medicine, or poor judgment generally, is not a listed ground for discipline in the Board's regulations. Those regulations list charges potentially related to Dr. Shepherd's judgment here, such as gross incompetence in the practice of medicine, violation of a Department rule, and misconduct in the practice of medicine. *See* 243 C.M.R. § 1.03(5)(a)3, 11, and 18. The regulations, however, also note that the Board's ability to discipline is not limited to the types of violations specifically listed; other grounds may be established though adjudication. 310 C.M.R. § 1.03(5)(b). The Board has, in at least one instance, summarily suspended a doctor, in part, for bad judgment. It adopted a magistrate's decision that this doctor had "consistently displayed poor judgment and decision-making through his conduct during his treatment of patients." *Board of Registration in Medicine v. Bock*, Docket No. RM-14-16, Decision at 21 (Mass. Div. of Admin. Law App., Oct. 30, 2014; adopted by Board, Feb. 19, 2015).

Before turning to whether the Board has demonstrated that Dr. Shepherd has shown such poor judgment that his medical license should be suspended until the merits of the Statement of Allegations are resolved, I note that this matter is being decided on the papers and that this has consequences for the decision. Had the parties presented witnesses at a hearing, I could have made credibility calls. But because I have before me only affidavits or unsworn statements in police and other reports, I am not in a position to make witness credibility calls absent some compelling independent proof of the veracity of a particular version of the facts.

This means that some of the factual allegations concerning the doctor cannot be resolved in this decision. Most significantly, the Board accuses Dr. Shepherd of lying to the police about Female D's identity, and thus covering up that she had an arrest warrant outstanding. Investigator Bouton recites in his affidavit that when Dr. Shepherd was stopped by the Gardner police on June 24, 2016, while Female D was in his car, the doctor told the police, incorrectly, that Female D was Female A's sister. One week later, the report the State Police made when arresting Female D at Dr. Shepherd's house recites that "[t]wice Dr. Shepherd was stopped by the police with Female D in his vehicle and covered up Female D's identity to prevent her arrest." (Bouton affidavit Ex. 9.) Dr. Shepherd denies knowing that Female D had an outstanding arrest warrant when his car was stopped by the Gardner police and denies falsely identifying her as Female A's sister. I note that the redacted Gardner police reports do not describe Female D as Female A's sister or say that Dr. Shepherd told the police anything about Female D's identity. (Bouton affidavit Ex. 7.) There is no evidence in the record that the doctor was stopped a second time by the police before Female D's arrest.

Investigator Bouton's affidavit also recites that Dr. Shepherd told the Rutland police who came to investigate the burglary of his house that Female A used heroin and that he said the same thing to the Gardner police when they stopped his car. Dr. Shepherd denies this, and maintains that he said only that Female A was a recovering heroin user. This dispute is potentially relevant to the accusations concerning Dr. Shepherd's prescribing to Female A, but I cannot resolve it at this juncture.

Investigator Bouton also states that Dr. Shepherd falsely told a Board staff member that he had not been arrested prior to his arrest for missing the court date for his negligent vehicle operation charge. Dr. Shepherd maintains he said that he had not had as much as a speeding ticket since the 1990s, thereby acknowledging that he had a speeding ticket in the 1990s. This accusation of lying to the Board involves a factual dispute whose resolution requires an evaluation of credibility, and thus cannot be resolved on the papers.

What remains are a myriad of charges. I turn first to the allegations concerning Dr. Shepherd's prior Board cases and the complaints filed with the hospitals where he now works. The Board cases from 2003 and 2004 are of no apparent relevance to whether Dr. Shepherd's continued medical practice more than ten years later presents an immediate thereat to public health. The Board thought so little of them at the time that it took no action. It may choose to revive those investigations now, but it has yet to do so.

The complaints made at his current hospitals are potentially more relevant, but the documents from these hospitals do not show that they imposed any discipline on Dr. Shepherd. Furthermore, there is no indication in Mr. Bouton's affidavit or elsewhere that the Board has completed an investigation of any of these complaints to substantiate them,

and is now relying on any of them in particular. Board counsel states that the Board is currently investigating these complaints. Investigations not yet complete, and for which no verified details are provided, are not a valid basis for summarily suspending Dr. Shepherd.

Dr. Shepherd's person life is more problematic. In the space of ten months, a woman living with him overdosed on heroin at his house, anther woman was arrested there, as was he, and his car was stopped by the police after he had parked outside an apartment the police knew to be a drug sale location. In addition, he was present when another woman overdosed on heroin and his house was burglarized by someone known to his ex-heroin addict girlfriend, who stole from the doctor in order to pay off a large drug debt to a criminal gang.

There is less here than meets the eye, however. I first examine the doctor's own arrest, which stemmed from an accident in his driveway in which he struck a jogger who was running by and was charged with negligent operation of a vehicle. Such a driving error would not be sufficient to show that his medical license should be summarily suspended. His later failure to appear in court for the hearing on the negligent operation of a vehicle charge is more troubling, but at present there is no evidence other than that the doctor did not know of the hearing and thus missed it, which led to his arrest. This is an insufficient basis for summarily suspending him.

Most of the remaining incidents during that ten-month period are, in one way or another, related to Dr. Shepherd's relationship with Female A, who both he and she describe as a recovering heroin addict. Dating a recovering drug addict may be an unwise personal choice, but how the mere fact of a dating relationship demonstrates a

lack of judgment related to the practice of medicine has not been shown. However, one consequence of this particular dating relationship was that the doctor ended up in various situations involving illegal drugs: two heroin overdoses, a traffic stop near a drug sale location, an arrest in his house of a fugitive, and the burglary of his home by someone seeking to pay off a drug debt.

The doctor can hardly be faulted that someone learned of his gun collection and broke into his house to steal it. As for the heroin overdoses, there does not appear to be anything untoward about the doctor's involvement when Female B overdosed in her own apartment. Female A found Female B, and alerted the doctor who then took apparently appropriate steps in response. As for the overdose of Female C in the doctor's house, Dr. Shepherd took on the responsibility to look after this young woman, who was the daughter of someone he knew, as she tried to stay off of drugs in order to be allowed to regain custody of her child. There is no evidence, so far, that the doctor enabled any drug use on her part or knew that she had secreted in his house the heroin she took when she overdosed. Again, the doctor seems to have acted appropriately when confronted with the overdose.

The arrest of Female D in his house is more mystifying, but the main problem with his actions concerning this woman is whether he knowingly concealed her identity from the police, and thus allowed her to avoid arrest one week earlier on an outstanding warrant. As I have pointed out already, I cannot resolve this question on the papers because the facts are in dispute and resolving them would require an evaluation of witness credibility.

Finally, Dr. Shepherd's decision to drive Female A to what the police had reason to believe was a drug sale location does not mean that the doctor had any similar knowledge. There is no evidence that he had prior knowledge, and hence no reason to believe that his willingness to drive Female A to this apartment shows that his judgment is so impaired that he should be summarily suspended from the practice of medicine.

That leaves the allegations related to Dr. Shepherd's prescriptions to his former fiancé and his current girlfriend. Dr. Shepherd concedes that he failed to follow acceptable medical practice when he dispensed these prescriptions because they were to non-patients outside the usual course of his medical practice and he did not maintain medical records when he prescribed. He contests only the Board's argument that his behavior in dispensing these prescriptions warrants summary suspension.

Regarding the four prescriptions for pain relievers Dr. Shepherd wrote for Female E in 2013 and 2014, the Board offers little beyond the uncontested fact that the doctor on four occasions prescribed narcotic pain relievers to her. The sum total of Board counsel's argument is that Dr. Shepherd "prescribed Schedule II and III medications to a non-patient, and for whom he did not keep medical records." (Board brief at 13.)

The Board does not contest that Female E was in severe pain on each of these four occasions – three from dental pain and one from a snowboarding accident – other than to suggest that the existence of the snowboarding accident should have been supported by more than Female E's affidavit alone. Nor has the Board presented evidence that the type or quantity of medication was inappropriate under the circumstances. Thus, Dr. Shepherd's assertion that he prescribed a short course of pain medication in each instance for a legitimate medical purpose has not been challenged.

I note that the Board's regulations bar doctors:

> "[e]xcept in an emergency, . . . from prescribing Schedule II controlled substances to a member of his immediate family, including a spouse (or equivalent), parent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling, or other relative permanently residing in the same residence as the licensee.

243 C.M.R. § 2.07(19). The Board's *Prescribing Practices Policy and Guidelines* that applied then also "suggest[ed] that physicians consider refraining form prescribing all controlled substances for family members and significant others in non-emergency situations." Policy at 34 (amended November 17, 2010).

Neither the regulation nor the policy absolutely bans prescribing Schedule II narcotics to a non-relative, such as a fiancé, as Dr. Shepherd did here on one occasion. It does suggest that physcicians consider refraining from prescribing any controlled substances, which would include Schedule II and III painkillers, to a significant other, such as Female E. Dr. Shepherd did prescribe such painkillers to Female E, but absent some evidence that the prescriptions he wrote violated some applicable standard, the Policy's mere suggestion that such prescriptions be avoided hardly shows that the doctor's continued practice presents an immediate danger to public health.

Prior Board decisions sanctioning doctors for improperly prescribing painkillers have resulted in sanctions that have varied with the level of the offense. A doctor who, over a six month period, prescribed Vicodin (then Schedule III) and Percocet (Schedule II) without a legitimate medical purpose to a female friend with whom he maintained a "social relationship" was reprimanded and fined. *Matter of Ossiani*, Docket No. RM-15-64 (Board decision, June 2, 2016). On the other hand, a doctor who prescribed high doses of multiple narcotics to thirteen patients without supported diagnoses, and despite

evidence of drug diversion or overdosing, had his license revoked. *Matter of Maurukas,* Adjudicatory Case No. 2007-067 (Consent Order, Nov. 21, 2007.) As the matter presently stands, it appears that Dr. Shepherd prescribed, on four discrete instances, narcotic painkillers to his fiancé outside the course of his usual practice and without creating medical records. This is a violation, but it is more similar to the one for which the Board issued a reprimand rather than the one in which it revoked a license. This is not dispositive, because it is conceivable that a doctor's practices may initially seem to present an immediate threat to the public health, although, on further examination, they warrant a sanction far less than less license revocation. Still, the fact that the likely penalty for this particular violation will fall far short of revocation underscores the absence of proof that Dr. Shepherd's prescribing painkillers to Female E shows that he presents an immediate danger to public health warranting summary suspension of his license.

Turning to the prescriptions to Female A, the main prescription was for Klonopin, a Schedule IV drug. He also twice prescribed Lomotil, a Schedule V drug. The version of the Board's *Prescribing Practices Policy and Guidelines* that went into effect on October 8, 2015 states that "Schedule IV drugs have a low potential for abuse relative to the substances in Schedule III, but may lead to physical or psychological dependence" and that "Schedule V drugs have a low potential for abuse relative to the substances in Schedule IV but may lead to some physical dependence or psychological dependence." Both the current and the 2010 version of the Policy, which applied when Dr. Shepherd began prescribing to Female A, suggest that physicians not prescribe controlled substances to significant others, but, as noted above, do not ban such prescriptions.

According to Dr. Shepherd, he prescribed Lomotil to Female A when she experienced diarrhea as a consequence of having the flu. Investigator Bouton reported that Dr. Shepherd acknowledged to the Board that diarrhea could be a symptom of heroin withdrawal. The possibility was thus raised that Dr. Shepherd ignored or misdiagnosed drug withdrawal symptoms of Female A. This is significant, but in the absence of cross-examination of the doctor, there is nothing in the record from which I can conclude that a long-experienced doctor failed to recognize the difference between the effects of the flu and heroin withdrawal. Thus, there appears to have been a legitimate medical purpose for this prescription.[9] Nonetheless, he still prescribed outside his normal medical practice to a non-patient and he did not prepare a medical record. While these are violations, prior Board practice does not tend to suggest that they are violations sufficient to demonstrate that a physician's license must be summarily suspended for them. A doctor who, over a seven year period, ordered drugs for himself and his wife, including Lomotil, without preparing any medical records was reprimanded and fined by the Board. *See Matter of Miller*, Adjudicatory Case No. 2014-048 (Board decision, Dec. 3, 2014.) Dr. Shepherd's prescription of Lomotil was no worse than Dr. Miller's. There is no evident reason to impose a harsher sanction right now.

In examining whether the prescription for Klonopin shows that Dr. Shepherd presents an immediate danger to public health, I look at both general issues in the way he handled this prescription and concerns particular to prescribing Klonopin to a recovering heroin user. Dr. Shepherd appears to have begun prescribing Klonopin to Female A at

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[9] Dr. Shepherd does not address in his affidavit the other time that he prescribed Lomotil to Female A. This demonstrates one of the reasons the Board requires doctors to keep records of their prescriptions.

around the time she moved in with him. She had a regular doctor then, Dr. Matthews, who had been prescribing her Klonopin. She told Dr. Shepherd that she could not go back to this doctor because one of his staff members was spreading rumors about her. There is no indication that Dr. Shepherd urged Female A to inform Dr. Matthews that his staff person was engaged in inappropriate behavior or that he considered doing so himself. Had Dr. Matthews been notified, it is possible the situation could have been resolved in a fashion that would have allowed Female A to comfortably remain with her treating physician.

Even assuming that she did not want to press the matter, as she stated in her ffidavit, and wished to find a new doctor instead, Dr. Shepherd simply took her word that Dr. Matthews had been prescribing her Klonopin at a certain dosage level. He did not check the Prescription Monitoring Program to determine both what medications Female A had been prescribed and to comply with 105 C.M.R. §700.012 (h)(1)(c), which requires that the program be checked before a doctor first prescribes a benzodiazepine. Nor did he check with Dr. Matthews to see why he had been prescribing her Klonopin. Dr. Shepherd stated in his affidavit that he thought the prescription was for anxiety; Female A, in her affidavit, says she thought it was for bi-polar disorder. Dr. Warfield, in her affidavit, opines that the medication and dosage were appropriate for the treatment of anxiety, but does not opine as to whether it was appropriate for someone who also has bipolar disorder. Dr. Shepherd, who knew Female A had both conditions, should have at least cleared up with Dr. Matthews what the prescription was for.

Eeven assuming it might have been permissible to prescribe to Female A for a short time while she looked for a new doctor, there is no evidence that she sought a new

doctor, that Dr. Shepherd urged her to do so (beyond merely encouraging her to seek treatment from a mental health professional), or that he ever put a time limit on how long he would prescribe for her. The prescription information Investigator Bouton obtained showed that Dr. Shepherd continued to prescribe Klonopin to Female A for one year, including for a time during which they were not living together.[10] No explanation has been offered for the length of time Dr. Shepherd continued to prescribe to Female A. Dr. Shepherd's actions thus show numerous judgment errors in his initial and continued prescription of Klonopin to Female A, as well as violation of the regulation on checking the Prescription Monitoring Program.

Despite the numerous problems with Dr. Shepherd's handling of the Klonopin prescription, Dr. Shepherd has presented evidence of that the Board has imposed sanctions for similar conduct that would seem inconsistent with summary suspension. The Board, for example, reprimanded and fined a doctor who, over a two year period, handed out free samples of Klonopin to his live-in girlfriend, and prescribed various Schedule VI drugs to his ex-wife and two friends, all outside his normal medical practice. *See Matter of Beckhardt*, Adjudicatory Case No. 2008-027 (Board decision, Aug. 6, 2008). The Board's attitude may have changed since 2008, and neither party pointed me toward any later Board cases regarding the failure to access the Prescription Monitoring

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[10] Board counsel, in his brief, notes that there appears to be a gap in the autumn of 2015 in which Dr. Shepherd stopped prescribing Klonopin to Female A. He asserts that "[a]bruply stopping benzodiazepine intake can cause dangerous seizures and/or greatly increase the risk of death." Dr. Shepherd does not address any possible period during which he stopped prescribing Klonopin to Female A. This is not altogether surprising because the charge against him focuses on his prescribing to Female A at all, not on any time that he stopped prescribing. Moreover, I cannot consider counsel's claim about the impact of stopping Klonopin because it is not supported by expert testimony or other appropriate evidence.

Program. Still, it was the Board's burden to prove that Dr. Shepherd's conduct warrants summary suspension. It has not offered such proof as far as his general handling of the Klonopin prescription is concerned.

There is more to the prescription at issue here because it was to a woman who Dr. Shepherd described as a recovering heroin addict. Board counsel hints that it matters whether Female A was using heroin while she was taking Klonopin. Dr. Shepherd seems to acknowledge that the legitimacy of prescribing Klonopin to Female A turns on whether she was a recovering addict or an active heroin user, because his counsel repeatedly emphasized that the doctor, throughout the time he prescribed to her, believed she was not using heroin. The only evidence pertinent to the conseuences of prescribing Klonopin to a heroin user comes from Investigator Bouton's supplemental affidavit in which he recites that Dr. Shepherd, when questioned by the Board, agreed that taking a benzodiazepine and heroin together can cause respiratory arrest.[11] How that should impact whether or how a doctor prescribes Klonopin to someone who purports to be a recovering heroin addict is not explained anywhere in the record. The only evidence on this question comes from Dr. Warfield, who opined that a doctor prescribing Klonopin to a purportedly recovering heroin user was not required by the standard of care to perform

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[11] M.G.L. c. 94C, § 24A(2)(c) includes a legislative finding relative to benzodiazepine prescriptions to drug addicts. It provides that:

> The department may require participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of benzodiazepines or any other schedule IV or V prescription drug, which is commonly abused and may lead to physical or psychological dependence or which causes patients with a history of substance dependence to experience significant addictive symptoms.

Although potentially relevant, neither party presented argument concerning this legislative finding.

routine drug screenings. Thus, as significant as the risk evidently is in this situation, without some proof as to how the doctor should have handled the risk, the Board has not presented evidence sufficient to demonstrate that he should be suspended summarily from all practice.

However, a distinction must be made between Dr. Shepherd's hospital practice, about which no complaints have been filed regarding his prescription practices, and his treatment of his girlfriend outside of his regular practice. According to the 2015 version of the Board's *Prescribing Practices Policies and Guidelines*:

> Treating patients for drug dependency usually requires specialized knowledge beyond the substance abuse training that is received in medical school. Physicians should not undertake to treat patients for addiction unless they have sufficient training to do so. Where the treating physician lacks specialized knowledge, patients should be referred to an addiction medicine specialist or to another qualified physician.

Policy at iv. While this provision deals only with treating for drug dependency, it suggests that a physician faced with an issue of drug dependency acknowledge when he is out of his depth and transfer care to someone with specialized knowledge.

Dr. Shepherd says he believed throughout his relationship with Female A that she was a recovering, not an active, heroin user. While his belief may have been sincere and his efforts to make sure Female A was not using heroin were commendable, such as checking her receipts to see that the money he gave her was actually used to buy groceries, there is evidence that he was out of his depth and failed to realize it.

He recognized that if Female A was spending time with active heroin users that this increased the risk that she would begin to use again. Thus, when he learned that she had spent some time with an old boyfriend who was an active user, he asked her to leave his house. He does not seem to have been as quick to recognize other signs Female A

was keeping company that might have suggested a risk of renewed drug use. The evidence shows that her cousin who overdosed was an active drug user; her friend Female C was only a partly recovering heroin addict who overdosed at the doctor's house; her acquaintance who burglarized Dr. Shepherd's house was heavily involved in the drug trade; and she visited at least one drug sale location with Female D who was a daily heroin user.[12] Although these facts may not have been known to Dr. Shepherd beforehand, they should have been known by him once the overdoses, the burglary, and the traffic stop occurred. None of this new information seems to have affected the way the doctor handled his continued issuance of prescriptions to Female A. Nor did they cause him to ask her again to leave his house. Female A's affidavit supports his contention that he did not know she was using, but she admits to using once in his house and concealing this from him. What she does not say is whether she used heroin while she was dating him and when she was outside his house. This is hardly a ringing endorsement of Dr. Shepherd's handling of the situation.

Given Dr. Shepherd's evident lapses in attentiveness when dealing with a girlfriend who may or may not have been using heroin, the evidence supports summarily suspending him from prescribing to his girlfriend (or any other female acquaintances with drug problems) outside the normal course of his hospital practice. I recommend

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[12] It is not clear if or when Dr. Shepherd knew that Female D used heroin. Still, whatever Dr. Shepherd thought when Female A asked him to drive her and Female D to an apartment in Gardner to look at a mattress she was interested in purchasing, scepticism should have been the response once he learned that the apartment was thought by the police to be a drug sale location.

that, beyond this sanction, the summary suspension motion be denied.

DIVISION OF ADMINISTRATIVE LAW APPEALS,

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James P. Rooney
First Administrative Magistrate

Dated: October 14, 2016