

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2013-057

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In the Matter of )  
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JOHN GEORGE, M.D. )  
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**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 John George, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice, as set forth herein in resolution of investigative Docket Nos. 09-380, 09-442, 10-054, 10-069, and 11-154.

**Biographical Information**

1. The Respondent was born on July 19, 1970. He graduated from the Medical College at the University of Kerala, Trivandrum, Kerala, India in 1996. He is certified by the American Board of Internal Medicine. He has been licensed to practice medicine in Massachusetts under certificate number 220351 since 2004. He is affiliated with Southcoast Hospitals Group – St. Luke’s Campus, in New Bedford, Massachusetts.

2. The Respondent was placed on probation for allegations of boundary violations in In the Matter of John George, M.D., Board of Registration in Medicine, Adjudicatory Case No. 2007-069 (Consent Order, December 19, 2007). He was subject to probationary terms and

conditions, including, but not limited to, weekly counseling and implementing a chaperone policy for all female patient encounters.

#### Factual Allegations

3. Patient A, a 44-year-old female, initially presented herself to the Respondent in July 2009 with complaints of back pain.

4. The Respondent prescribed Flexeril, a muscle relaxant, to Patient A.

5. Patient A returned to the Respondent's office approximately four (4) days later, and requested a different pain medication, specifically Percocet.

6. The Respondent refused to prescribe Percocet to Patient A; the Respondent instead prescribed Motrin and Ultram.

7. Patient A telephoned the Respondent's office and complained that the medications he prescribed to her were not working.

8. Patient A returned to the Respondent's office a few days later, complaining that the Motrin and Ultram were not relieving her pain symptoms.

9. The Respondent told Patient A that she would have to leave his office.

10. After leaving the Respondent's office, Patient A presented herself to St. Luke's Hospital, where she was diagnosed as having a urinary tract infection. She was discharged from St. Luke's with prescriptions for antibiotics and for Percocet.

11. The Respondent's medical record relating to Patient A do not contain a detailed history of Patient A's complaints of pain, and make no reference to an evaluation of the source of the patient's complaint.

12. The Respondent's medical record relating to Patient A also does not contain any reference to Patient A's request for Percocet, his recommendation to take Motrin and/or Ultram,

or of any telephone calls that Patient A had placed to his office in between her office visits referenced above.

13. The Respondent's care and treatment of Patient A is below the standard of care.

14. Patient B was a 28-year-old female who first presented herself to the Respondent in October 2008.

15. Patient B suffered from opiate addiction, and sought care and treatment from the Respondent for her addiction.

16. The Respondent treated Patient B by enrolling her into his twelve week Suboxone treatment program, which includes random urine screens for opiates during the course of the Suboxone treatment program.

17. On four separate occasions between November 3, 2008 and November 25, 2008, Patient B tested positive for the presence of oxycodone, a drug that was not prescribed to her by the Respondent.

18. The Respondent warned Patient B that if she had a fifth positive urine screen, he would terminate her from his Suboxone treatment program.

19. Patient B tested positive for the presence of oxycodone on December 1, 2008, at which time the Respondent terminated Patient B from his Suboxone treatment program, but continued to treat Patient B as her primary care physician.

20. On December 1, 2008, the Respondent prescribed Klonopin to Patient B, but did not record the prescription in her medical record, nor did he record his clinical reasoning for issuing the prescription.

21. Patient B re-entered the Respondent's Suboxone treatment program on March 12, 2009.

22. On March 19, 2009, the Respondent increased the dose of Patient B's Klonopin, and on May 5, 2009, the Respondent switched Patient B's medication from Klonopin to Xanax.

23. The Respondent did not document in Patient B's record his clinical reasoning for switching Patient B's medication in Patient B's medical record.

24. On three separate occasions in March 2009, Patient B tested positive for oxycodone; the Respondent dismissed her from his Suboxone treatment program on May 19, 2009.

25. The Respondent continued to act as Patient B's primary care provider following her second dismissal from the Respondent's Suboxone treatment program.

26. The Respondent continued to prescribe Xanax and other prescription medications to Patient B through October 14, 2009, which was Patient B's last office visit with the Respondent.

27. Patient B died on October 17, 2009 of an accidental overdose of a variety of prescription and illicit drugs.

28. The Respondent did not document his clinical reasoning for choosing to prescribe benzodiazepines to Patient B, and did not document a thorough workup of the source of Patient B's depression or her complex system of co-morbidities, in Patient B's medical record.

29. The Respondent's record keeping relating to Patient B fall below the standard of care.

30. Patient C, a 42-year-old female, first presented herself to the Respondent in 2008 for management of lupus erythematosus, obesity, obstructive sleep apnea, irritable bowel syndrome, emphysema, osteoarthritis, and acid reflux.

31. Patient C presented herself to the Respondent's office on January 18, 2010 for the

purpose of obtaining a regular refill of her morphine prescription.

32. In accordance with the Respondent's policy for obtaining refill prescriptions, Patient C presented the Respondent's receptionist with an empty pill bottle, indicating which prescription needed to be refilled.

33. Prior to Patient C's January 18, 2009 office visit, the Respondent typically refilled Patient C's Percocet prescription biweekly.

34. At Patient C's office visit immediately prior to her January 18, 2009 office visit, the Respondent instead wrote a prescription for a one month supply of Percocet.

35. At her January 18, 2009 office visit, Patient C inadvertently presented the empty pill bottle for her new Percocet prescription, although that prescription was not due for a refill.

36. The Respondent interpreted Patient C's empty Percocet bottle as an indication that Patient C had consumed too many Percocet, or was otherwise seeking excess opiates from the Respondent, and he therefore discharged Patient C from his practice; however, the Respondent refilled Patient C's morphine prescription, which was due for a refill.

37. Upon leaving the Respondent's office, Patient C presented herself to the Hawthorne Walk-In Medical Center, where she received emergent care for her management of her multiple co-morbidities.

38. The Respondent's abrupt termination of Patient C, in light of his recent change in the frequency of Percocet prescriptions, and in light of the complexities of Patient C's multiple systemic conditions, is below the standard of care.

39. The Respondent's medical records of Patient C do not document comprehensive evaluations and do not document his clinical reasoning behind each prescription issued or the patient's tolerance/reactions to each medication.

40. Patient D, a 40-year old female, first presented herself to the Respondent in 2006, for management of lumbar disc disease and spondylolysis.

41. Patient D has a remote history of opiate dependence, and attended several detoxification programs for opiate and heroin abuse.

42. In 2006, Patient D received prescriptions for Kadian, which is a slow release morphine, from a pain clinic.

43. In 2007, the Respondent referred Patient D to an orthopedic surgeon who prescribed Vicodin to Patient D.

44. In January 2008, the Respondent attempted to refer Patient D to the pain clinic she previously went to, but that pain clinic would not accept Patient D as a patient.

45. In April 2008, Patient D complained of right arm pain, and a subsequent MRI revealed extensive abnormalities; the Respondent prescribed oxycodone and suggested physical therapy.

46. A physiatrist recommended that Patient D receive cortisone injections, but Patient D refused to receive them.

47. Through February and March 2009, the Respondent continued to prescribe oxycodone.

48. The Respondent gave Patient D random urine screens between October 2007 and June 2009, and those results were negative for the presence of non-prescribed substances.

49. The Respondent wrote "Do Not Drive" on the oxycodone prescriptions for Patient D.

50. Patient D was involved in two separate motor vehicle accidents on May 21, 2009 and on May 23, 2009, the second motor vehicle accident resulting in Patient D undergoing a

splenectomy.

51. Patient D's mother accompanied Patient D to her several office visits with the Respondent and attempted to speak with the Respondent to voice her concern that the Respondent's continued prescribing of opiates to her daughter was detrimental to her recovery from opiate addiction.

52. The Respondent refused to speak with Patient D's mother, stating that he could not discuss her daughter's care with the mother due to the confidentiality provisions of HIPAA.

53. The Respondent's refusal to accept, passively, potentially relevant information from Patient D's mother, and then continue to prescribe opiates to Patient D, in concert with his knowledge of Patient D's motor vehicle accident, is below the standard of care.

54. The Respondent's medical records for Patient D between March 2009 and June 2009 do not contain notes reflecting the Respondent's clinical reasoning for prescriptions he issued to Patient D during that period of time, which is below the standard of care.

55. The Respondent's medical records for Patient D do not contain accurate detail relative to the dose and quantity of medicines prescribed to Patient D.

56. The Respondent's failure to accurately document Patient D's medical record is below the standard of care.

57. The Respondent voluntarily attended and completed an assessment program at the University of San Diego known as the Physician Assessment and Clinical Education Program (PACE or PACE Assessment).

58. The PACE Assessment is a two-phase program which assesses, among other areas, a participant's base of medical knowledge, clinical interactions in both live and simulated patient encounters, computer-based examinations, analyzes a participant's office-based practice,

medical record keeping, and personal interactions with staff and patients.

59. The Respondent graduated from PACE with a passing grade, but with the following recommendations to improve his practice, including: obtain a practice monitor to assist the Respondent in improving his chart notes; and complete courses in medical record keeping and in patient/staff communication.

60. In mitigation, the Respondent has cooperated with the Board throughout the course of its investigation, has taken steps to improve documentation in his medical records, and has taken steps to complete the recommendations made by PACE, including incorporating recommended suggestions into his daily practice, and actively researching appropriate continuing education courses.

#### Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, ninth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.



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,

Candace Lapidus Sloane, MD

Candace Lapidus Sloane, M.D.  
Board Chair

Date: December 4, 2013