COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2013-057

In the Matter of

JOHN GEORGE, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, John George, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket Nos. 09-380, 09-442, 10-054, 10-069, and 11-154.

Findings of Fact

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.

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 erythematosis, 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, 2009 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.

Conclusion of Law

A. The Respondent has violated G.L. c. 112, § 5, ninth 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.

B. The Respondent has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982).

Sanction and Order

The Respondent's license is hereby indefinitely suspended, with leave to petition the Board for an immediate stay of said suspension upon entry into a five (5) year Probation Agreement, which shall include provisions that (1) the Respondent comply with all recommendations made by PACE, to wit: obtain a Board-approved practice monitor to assist the Respondent in improving his chart notes, complete a Board-approved medical record keeping

course, and complete a Board-approved communication course to address patient and staff communication issues; (2) the Respondent submit a Board-approved practice plan that includes monitoring of all practice settings by a Board-approved monitor, who shall be board-certified in internal medicine and possess an active, unrestricted license to practice medicine in Massachusetts; (3) the monitor engage in weekly case reviews with the Respondent and provide monthly reports to the Board, which reports shall focus on the accuracy and completeness of the Respondent's medical record documentation, rationale for clinical decision making and any other areas relating to medical record documentation as recommended or noted by PACE; and (4) that the Respondent shall continue the use of Board-approved chaperones for all female patient encounters.

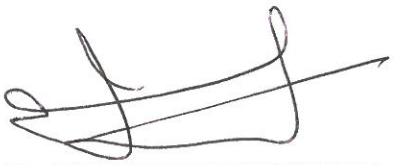
The Respondent may petition the Board to terminate the Probation Agreement following one year of demonstrated compliance with its terms and conditions.

Execution of this Consent Order

The Respondent shall provide a complete copy of this Consent Order and Probation Agreement with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of

Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated for the duration of this stayed suspension. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

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



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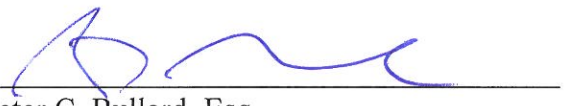
John George, M.D.
Licensee

Date



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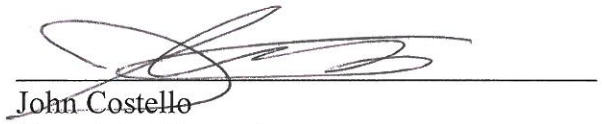
Peter C. Bullard, Esq.
Attorney for the Licensee

Date



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John Costello
Complaint Counsel

Date

So ORDERED by the Board of Registration in Medicine this 4th day of December, 2013.

Candace Lapidus Sloane, MD

Candace Lapidus Sloane, M.D.
Board Chair

SENT CERTIFIED MAIL 12/5/13 mg