COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2013-036

In the Matter of

TIMOTHY R. OMAN, 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 Timothy R. Oman, 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. 11-112.

Biographical Information

1. The Respondent was born on July 21, 1955. He graduated from the University of Virginia School of Medicine in 1981. He is certified in Family Medicine by the American Board of Medical Specialties. He has been licensed to practice medicine in Massachusetts under certificate number 75178 since 1991.

2. The Respondent has practiced family medicine at Lahey Hamilton-Wenham Family Practice ("Lahey-Hamilton") in South Hamilton since 1995. He is currently the medical

director at Lahey-Hamilton. He has privileges at Lahey Clinic and Northeast Hospital Corporation, and an affiliation with Tufts – New England Medical Center.

Factual Allegations

Patient A

3. Patient A was a patient at Lahey-Hamilton from 1984, when Patient A was seven years old, until his death in 2010, when he was thirty-three years old.

4. As of July 2001, Patient A had reported problems with depression, anxiety and insomnia to providers at Lahey-Hamilton.

5. On September 5, 2001, Patient A was admitted to Beverly Hospital, requesting detoxification from alcohol.

6. The Respondent became Patient A's primary care physician (PCP) in 2002.

7. In early January 2002, the Respondent treated Patient A. The Respondent noted that Patient A was misusing alcohol.

8. In May 2002, Patient A reported to Lahey-Hamilton providers that he had been suffering with back pain. He did not identify any trauma or injury that led to the pain.

9. Patient A's back pain, depression, anxiety and insomnia were ongoing concerns during the course of his care with the Respondent.

10. The Respondent prescribed narcotic medications for Patient A's back pain during the course of his physician-patient relationship with Patient A.

11. The narcotic medications the Respondent prescribed to Patient A were opioids that included, at various times, hydrocodone, methadone, oxycodone, and Vicoprofen.

12. Methadone has a more stable, prolonged half-life than the other opioids identified in paragraph 11, above. Patients who take methadone are at risk for central nervous system depression and respiratory depression.

13. The Respondent prescribed benzodiazepines for Patient A's anxiety during the course of his physician-patient relationship with Patient A.

14. The benzodiazepines the Respondent prescribed to Patient A included, at various times, alprozolam, clonazepam, diazepam, and temazepam.

15. Opioids and benzodiazepines taken together can potentiate the effect of each individual drug. The combined use of opioids and benzodiazepines can result in respiratory suppression and somnolence.

16. In November 2004, the Respondent counseled Patient A about drug seeking behavior, and the development of physical and psychological tolerances to narcotics and benzodiazepines. The Respondent further educated Patient A about issues of tolerance and dependence with regard to taking narcotics for pain and benzodiazepines for anxiety.

17. In December 2006, Patient A was admitted to Beverly Hospital's emergency room following a single vehicle, single-occupant car accident. Patient A's urine toxicology results showed the presence of benzodiazepines, cocaine and opiates in his urine.

18. On or about January 5, 2007, Patient A was scheduled for plastic surgery to fix the nasal fractures he received in the December 2006 car accident. The plastic surgeon commented in her note that Patient A appeared smelling strongly of alcohol.

19. On or about January 5, 2007, Patient A's plastic surgery was cancelled because he took Xanax (alprazolam) and oxycodone prior to the scheduled surgery.

20. On or about October 30, 2008, the Respondent prescribed methadone and Valium (diazepam) to Patient A.

21. On or about December 29, 2008, Patient A told the Respondent that he was experiencing significant drowsiness from taking methadone. The Respondent suggested that Patient A cut back his diazepam, a benzodiazepine, or his tramadol, a narcotic-like pain reliever, as those two medications, when combined with methadone, could cause drowsiness.

22. On or about October 26, 2009, Patient A was living with his parents. Patient A told the Respondent that Patient A's parents had found a syringe in his room, which he claimed his girlfriend used for her insulin. Patient A denied using any illicit drugs.

23. At the October 26, 2009 office visit, the Respondent advised Patient A that he would contact Lahey Behavioral Medicine to arrange an appointment for counseling concerning Patient A's depression and anxiety.

24. On or about October 27, 2009 to November 2, 2009, Patient A was admitted to Beverly Hospital's psychiatric unit for abuse of prescribed medication and illicit drug use. While there, he underwent a medical narcotic detoxification with Suboxone.

25. Patient A's psychiatrist at Beverly Hospital contacted the Respondent about substituting methadone in place of other narcotics to address Patient A's back pain and opioid dependence.

26. On or about November 2, 2009, Patient A told the Respondent that he had been using intravenous heroin for about six months.

27. On or about November 2, 2009, the Respondent restarted Patient A on methadone.

28. The Respondent continued to prescribe benzodiazepines to Patient A.

29. On or about December 8, 2009, Patient A was admitted to Beverly Hospital for respiratory arrest secondary to medication use.

30. While at Beverly Hospital, Patient A refused to enter chemical dependence treatment.

31. Patient A was discharged from Beverly Hospital on or about December 9, 2009.

32. On or about December 9, 2009, the Beverly Hospital psychiatrist who consulted on this matter called the Respondent and informed him about Patient A's status. He recommended that the Respondent taper and discontinue Patient A's methadone and clonazepam.

33. The Beverly Hospital psychiatrist indicated in a consult note that the patient having both medications in such large amounts was an extremely dangerous situation. The Respondent reviewed the consult note.

34. On or about December 9, 2009, the Respondent agreed to taper and discontinue both the methadone and the clonazepam.

35. On or about December 17, 2009, the Respondent saw Patient A at Lahey-Hamilton in follow up for the hospitalization. The Respondent told Patient A that continuing Patient A on medications without counseling and intensive therapy was not appropriate. The Respondent recommended that Patient A follow up with a Methadone clinic and provided him with telephone numbers for two such clinics.

36. At the December 17, 2009 office visit, Patient A asked the Respondent to continue prescribing the medications until he was able to receive appropriate mental health care. The Respondent agreed to temporarily prescribe methadone and clonazepam to Patient A, but said he would only prescribe one week's worth of medication at a time. The Respondent recommended that Patient A follow up with a methadone outpatient program and gave Patient A

telephone numbers for two programs. Patient A stated that he had no insurance and would apply for insurance.

37. At the December 17, 2009 office visit, the Respondent told Patient A that Patient A was to stay in phone contact at a minimum on a weekly basis to ensure that he was pursuing appropriate mental health follow up.

38. The Respondent's records contain no indication that Patient A sought mental health counseling following the December 17, 2009 office visit with the Respondent.

39. On or about March or April, 2010, Patient A called the Respondent to say he had been accosted and had his money and methadone prescription stolen. The Respondent prescribed a fourteen-day supply of methadone for Patient A.

40. On or about June 4, 2010, Patient A saw the Respondent at Lahey-Hamilton. Patient A said that his girlfriend had her purse stolen and that the purse contained Patient A's methadone and Klonopin medications. The Respondent advised Patient A that he needed to be extremely careful with regard to other narcotics medications given his previous history. The Respondent gave Patient A prescriptions for one-week supplies of alprazolam and hydrocodone with acetaminophen.

41. On or about June 29, 2010, Patient A's father called Lahey-Hamilton, reporting that Patient A had taken 117 methadone pills in two to three days and was drunk on drugs. Lahey-Hamilton staff advised Patient A's father that Patient A should be taken to a hospital.

42. On or about July 1, 2010, Patient A called Lahey-Hamilton requesting to speak only to the Respondent. Patient A said that his family had gone on a rampage and thrown out all his medications. Lahey-Hamilton staff noted that Patient A sounded like he had taken too much medication.

43. On or about July 2, 2010, Patient A met with the Respondent at Lahey-Hamilton. Patient A appeared somnolent. Patient A denied using street drugs. The Respondent gave Patient A Vicoprofen in light of his being off methadone and potentially developing withdrawal from narcotics. The Respondent again urged Patient A to begin counseling with regards to his anxiety and to meet with psychiatry regarding appropriate treatment of his anxiety in concert with his chronic back pain.

44. The Respondent called Lahey Behavioral Health to request an appointment for Patient A. The Respondent told Patient A to follow up with Lahey Behavioral Health to obtain mental health counseling.

45. The Respondent's medical records do not reflect that Patient A ever made an appointment with, or obtained counseling from, Lahey Behavioral Health.

46. The Respondent continued to prescribe narcotics and benzodiazepines to Patient A despite Patient A's failure to obtain mental health treatment.

47. The Respondent never performed drug screens on Patient A.

48. On or about September 20, 2010, Patient A was admitted to Bayridge Hospital with agitated behavior and bizarre thoughts.

49. While Patient A was at Bayridge Hospital, he underwent a detoxification for methadone and benzodiazepines.

50. A Bayridge Hospital psychiatrist warned Patient A about the lethality of combining opiates and benzodiazepines.

51. That same Bayridge Hospital psychiatrist had a conversation with the Respondent concerning Patient A's use of opiates and benzodiazepines.

52. The Respondent agreed with the taper of the opiates and benzodiazepines and also agreed not to prescribe any further addictive substances to Patient A. The Respondent understood that Patient A was to be referred to a Suboxone clinic upon discharge from Bayridge Hospital.

53. Patient A was discharged from Bayridge Hospital on or about September 28, 2010. Because of a lack of insurance, Patient A was not able to complete a referral to a Suboxone clinic. The Respondent referred Patient A to a Suboxone clinic.

54. Following the conversation with the Bayridge Hospital psychiatrist, on or about September 28, 2010, the Respondent wrote a prescription to Patient A for one week's worth of methadone 10 mg, one every four hours as needed for pain. The Respondent also wrote a prescription to Patient A for alprazolam 2 mg one q.i.d. for anxiety with arrangements to make an appointment within the next week to discuss the overall treatment plan.

55. On or about October 1, 2010, Patient A saw the Respondent at Lahey-Hamilton. The Respondent gave Patient A a prescription for methadone 10 mg, two every 6 hours as needed for pain. The Respondent changed Patient A's benzodiazepine to Klonopin (clonazepam) 2 mg q.i.d.

56. At the October 1, 2010 visit, the Respondent gave Patient A the telephone number of a Suboxone clinic. The Respondent also noted his plans to get Patient A into routine therapy.

57. In the early morning of October 2, 2010 Patient A's parents found him unresponsive at home. Patient A was taken by ambulance to Beverly Hospital and pronounced dead at 2:51 a.m.

58. The medical examiner who performed an autopsy on Patient A concluded that Patient A died from methadone intoxication.

59. The Respondent's treatment of Patient A fell below the standard of appropriate medical care in that:

a. The Respondent failed to adequately treat Patient A's substance abuse despite a documented longstanding history of Patient A's high risk behaviors and medical complications, including respiratory arrest in 2009;

b. The Respondent continued to prescribe narcotics and benzodiazepines to Patient A when there were contraindications not to prescribe these medications;

c. The Respondent failed to perform appropriate monitoring of Patient A's chronic narcotics and benzodiazepines prescriptions, including failing to perform drug screens;

d. The Respondent's prescribing showed a lack of adequate understanding of the interaction between methadone and benzodiazepines, despite communication from another physician about the dangers of combining narcotics, particularly methadone, with benzodiazepines;

e. The Respondent failed to respond adequately to multiple red flags including multiple lost and stolen prescriptions, active heroin abuse, concerns from family members about prescription drug abuse, dangerous complications of substance abuse including respiratory arrest, and multiple hospitalizations for mental health and substance abuse related illness; and

f. The Respondent failed to stop prescribing narcotics and benzodiazepines when it became obvious that Patient A had not followed through with the Respondent's recommendations for addiction and mental health treatment.

Patient B

60. The Respondent was Patient B's PCP at Lahey-Hamilton as of January 1, 2009.

61. Patient B had a well documented history of chronic pain from cervical disk disease, dating from approximately 2003.

62. Patient B did not have a documented history of substance abuse.

63. The Respondent treated Patient B with chronic opiates, including combinations of methadone and oxycontin, both of which are long-acting opiates.

64. At the same time, the Respondent also treated Patient B with oxycodone, a short-acting opiate.

65. At the same time, the Respondent also treated Patient B with benzodiazepines.

66. The Respondent failed to record the specific rationale for treating Patient B with multiple long acting opiates in combination with benzodiazepines.

67. The Respondent continued to treat Patient B with a combination of long-acting opiates, short-acting opiates, and benzodiazepines after the death of Patient A.

68. The Respondent failed to document that he monitored Patient B for compliance through the use of drug screens or pill counts.

69. The Respondent's treatment of Patient B fell below the standard of appropriate medical care in that:

a. The Respondent prescribed combinations of long-acting opiates and benzodiazepines without a specifically documented reason for doing so;

b. The Respondent continued to prescribe combinations of opiates and benzodiazepines to Patient B after being advised by at least one other physician about the dangers of such prescribing;

c. The Respondent failed to document that he monitored Patient B's compliance with narcotics prescribing.

70. The Respondent has taken a number of actions in order to improve the management of patients with chronic pain in his practice at Lahey-Hamilton. Among these actions are the following:

a. The Respondent's office adopted the Controlled Medicine Agreement, which includes reinforcement of routine drug testing, pill counts, single prescribers and limitations of prescriptions.

b. The Respondent has become involved in efforts to set up a more uniform opioid policy at the Lahey Clinic for use in outpatient management.

c. The Respondent and his partner have established an intra-office practice for cross-consultation involving patients on chronic pain medication.

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 by practicing with 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: August 14, 2013

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