COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2012-015

In the Matter of	)
ARSHIA SIDDIQUI, M.D.	)

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Arshia Siddiqui, 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 No. 11-288.

Findings of Fact

1. The Respondent was born on June 26, 1975. She graduated from the Dow Medical College, Karachi University in 1999. She is certified by the American Board of Medical Specialties in Internal Medicine and Pediatrics. She has been licensed to practice medicine in Massachusetts under certificate number 227181 since 2006.

2. On November 24, 2011, the Respondent began working at the Massachusetts General Hospital (MGH) Chelsea HealthCare Center as an Assistant in Pediatrics and Internal Medicine. The Respondent has privileges at MGH.

3. From August 2010 until July 22, 2011, the Respondent was employed at Fallon Clinic (now known as Reliant Medical Group) in Shrewsbury, Massachusetts.

4. In August 2010, the Respondent was hired as the site director to work full time at ReadyMED, a busy urgent care center that is part of the Fallon system.

5. In January 2011, the Respondent's work responsibilities significantly increased when the prior chair of urgent care at Fallon left that position.

6. For the period from January through July 22, 2011, ReadyMED was typically staffed by two clinicians for each weekday eight-hour shift and weekend twelve-hour shift, one physician and one nurse practitioner or physician assistant. On some occasions, due to a shortage of available coverage, the Respondent covered shifts as the sole clinician at ReadyMED.

7. For the period from January through July 22, 2011, the ReadyMed physicians were the Respondent and one other part-time Fallon staff physician. There were also several physician moonlighters.

8. The Respondent notified Fallon that there was insufficient staff to cover the shifts described in paragraph 6 above.

9. Each prescriber had two paper prescription pads that were kept in a locked cabinet. The prescriptions were not pre-numbered and were not pre-signed. The prescribers had keys to the locked cabinet.

10. The prescription pads were rarely used. Most ReadyMED prescriptions were generated electronically.

11. ReadyMED providers entered information about patients into electronic medical records through a computer system used by Fallon. It was the practice at ReadyMED to enter information about patients into the computer system contemporaneously.

12. On July 15, 2008, the Respondent's current primary care physician ("PCP") began prescribing the Respondent Adderall, 30 mg, two times a day. Adderall is a Schedule II medication. The PCP wrote the prescriptions consistent with the Respondent's prior diagnosis and treatment for ADHD.

13. The Respondent's PCP continued to prescribe Adderall in the amount noted in paragraph 12 to the Respondent through February 11, 2011.

14. Her office staff mailed prescriptions for Adderall to the Respondent when the Respondent called to request them.

15. In or about February 2011, her office staff told the Respondent that the Respondent was due for a physical examination, and that they would issue no further Adderall refills until she did so.

16. The Respondent did not appear at her PCP's office between December 2, 2009 and August 2011.

17. The Respondent did not make an appointment for a physical examination with any Fallon provider.

18. Between April 2011 and June 19, 2011, the Respondent wrote three prescriptions for Adderall in the same dosage and quantity that her PCP had been writing for her. On each occasion, the Respondent went into the locked file cabinet at ReadyMED and stole a prescription from a staff physician's prescription pad. She forged the staff physician's name to the prescriptions.

19. The staff physician was the Respondent's subordinate.

20. The staff physician was never the Respondent's treating physician.

21. The staff physician was not aware that the Respondent had taken any prescriptions from her prescription pad.

22. Using the forged prescriptions, on April 8, 2011, May 15, 2011, and June 19, 2011, the Respondent obtained Adderall from Target Pharmacies in Framingham and Westborough.

23. In or about July 2011, the Respondent went into the locked cabinet at ReadyMED and stole at least two additional prescriptions from the same staff physician's prescription pad.

24. The Respondent wrote a prescription, dated July 19, 2011, for Adderall 15 mg, dispense 120 tabs, using a stolen prescription. The Respondent forged the staff physician's signature onto the prescription.

25. On July 22, 2011, the Respondent went to a Target Pharmacy in Framingham and attempted to fill the prescription for Adderall identified in paragraph 24.

26. The pharmacist told the Respondent he would not fill the prescription as written because the name of the medication was spelled incorrectly. The Respondent took the prescription back from the pharmacist, corrected the spelling on the same prescription and brought it back to the pharmacy to be filled. The pharmacist again noticed an apparent error on this prescription. Since the prescription did not note that the Respondent was to take two pills a day, the prescription appeared to have been for a two-month supply of Adderall.

27. The pharmacist called ReadyMED to have the prescription corrected.

28. The ReadyMED medical assistant who spoke to the pharmacist checked ReadyMED's computer system and did not see any prescription listed. All prescriptions should be listed in the computer.

29. The ReadyMED medical assistant asked the pharmacist for a copy which he faxed to ReadyMED.

30. The ReadyMED medical assistant then telephoned the staff physician who had supposedly written and signed the prescription.

31. The staff physician, who was out of state on July 22, 2011, denied knowing anything about this matter and denied having written the prescription.

32. The ReadyMED medical assistant alerted Fallon management about this issue.

33. When the Respondent returned to the pharmacy, the pharmacist told the Respondent that he had faxed the earlier prescription back to ReadyMED to the doctor in whose name it was written.

34. The Respondent left the pharmacy and called ReadyMED. She asked the ReadyMED medical assistant who had received the faxed prescription from the pharmacy to shred it.

35. The Respondent then used her home computer to remotely access her own electronic medical record at Fallon. She altered her medical record to close the matter.

36. The Respondent returned to the pharmacy early that evening with a prescription, dated July 22, 2011, for Adderall 15 mg, 2 tabs, twice a day, dispense 120 tabs, using a stolen prescription. The Respondent had again forged the staff physician's signature onto the prescription.

37. Using the forged prescription, on the evening of July 22, 2011, the Respondent obtained 120 tablets of Adderall from the Target Pharmacy in Framingham.

38. On the evening of July 22, 2011, the Chief Medical Officer of Fallon telephoned the Respondent and informed her that she was aware of the fact that the Respondent had written a prescription to herself and had signed a colleague's name to that prescription.

39. The Respondent stated that she had written a prescription in her name for use by another individual. The Respondent knew this statement was incorrect.

40. Fallon conducted an investigation and discovered that the Respondent had forged four months worth of Adderall prescriptions.

41. Fallon's Chief Medical Officer advised the Respondent that she was aware of the Respondent's actions regarding the forged prescriptions for Adderall and told the Respondent that the Respondent was being terminated from her position.

42. Fallon terminated the Respondent for cause, effective July 22, 2011.

43. Following the recommendation of Fallon's Chief Medical Officer, the Respondent met with Physician Health Services ("PHS") in July 2011.

44. After assessing the Respondent, PHS concluded that the nature of the behaviors for which the Respondent contacted PHS did not appear to be health related and therefore PHS did not recommend monitoring at that time.

45. Following her termination from Fallon on July 22, 2011, the Respondent called her PCP and met with her on August 2, 2011. The Respondent told her PCP that she had a lapse of judgment and had self-prescribed Adderall. The Respondent then returned to her PCP for a physical examination on August 30, 2011.

Conclusions of Law

A. The Respondent has violated G.L. c. 112, § 5, ninth par. (b) and 243 CMR 1.03(5)(a)2 by committing offenses against a provision of the laws of the Commonwealth relating to the practice of medicine, or a rule or regulation adopted thereunder—to wit: G.L. c. 94C, § 19(a), which requires that physicians issue prescriptions for controlled substances for legitimate purpose and in the usual course of the physician's medical practice.

B. The Respondent has violated G.L. c. 112, § 5, ninth par. (b) and 243 CMR 1.03(5)(a)2 by committing offenses against a provision of the laws of the Commonwealth relating to the practice of medicine, or a rule or regulation adopted thereunder—to wit: G.L. c. 94C, § 33(b), which provides that no person shall utter a false prescription for a controlled substance, nor knowingly or intentionally acquire or obtain possession of a controlled substance by means of forgery, fraud, deception or subterfuge, including but not limited to the forgery or falsification of a prescription.

C. 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 gross misconduct in the practice of medicine and practicing medicine fraudulently.

D. The Respondent has violated G.L. c. 112, § 5, ninth par. (c) and 243 CMR 1.03(5)(a)10 by practicing medicine deceitfully, or engaging in conduct that has the capacity to deceive or defraud.

E. The Respondent has violated 243 CMR 1.03(5)(a)18 by committing misconduct in the practice of medicine.

F. 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 suspended, said suspension to be immediately stayed upon the Respondent's entry into a five year Probation Agreement. The terms of said Probation Agreement shall include, but not be limited to the Respondent's compliance with all recommendations made by Physician Health Services ("PHS") including that she complete the coaching sessions she has already begun. Coaching must continue for at least one (1) year and further if recommended by her coach. Further provisions of the Probation Agreement shall include Board approval of a work site monitor. In addition, the Respondent must complete five (5) hours of CMEs in ethics/professionalism. Said CMEs must be Board approved and must be taken in addition to those required for the renewal of the Respondent's license. These additional CMEs must be completed within two (2) years of the date on which the Board approves the Consent Order. The Probation Agreement may include any other terms and conditions the Board deems appropriate.

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 s/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 suspension and probation. 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.

Signed by Arshia Siddiqui — 3/25/12
Arshia Siddiqui — Date
Licensee

Signed by W. Scott Liebert — March 30, 2012
W. Scott Liebert — Date
Attorney for the Licensee

Signed by Pamela J. Meister — April 2, 2012
Pamela J. Meister — Date
Complaint Counsel

So ORDERED by the Board of Registration in Medicine this 16th day of May, 2012 .

Signed by Peter Paige, M.D.
Peter Paige, M.D.
Chairman