COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2013-038

In the Matter of	)
TZVETAN TZVETANOV, 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 Tzvetan Tzvetanov, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket numbers associated with this order to show cause **are** Docket Nos. 11-458 and 12-154

Biographical Information

1. The Respondent was born on June 13, 1964. In 1988, he graduated from the Charles University Faculty of Medicine in Prague, Czech Republic. He has been licensed to practice medicine in Massachusetts since 2000, under certificate 204641. He is board-certified in Internal Medicine.

2. The Respondent owns a solo practice in North Andover, Massachusetts. He is affiliated with Lawrence General Hospital, Holy Family Hospital and Medical Center, and Anna Jacques Hospital.

Factual Allegations

Patient A

3. The Respondent was Patient A's primary care physician as of February 2002, when Patient A was thirty-one years old, until January 24, 2011, when the Respondent discharged Patient A from his practice.

4. As of February 2002, the Respondent was prescribing methadone to Patient A for chronic pain management, following a cervical neck fusion in 2000.

5. The Respondent continued to prescribe methadone to Patient A during most of the course of his treatment.

6. In July 2003 and in June 2009, the Respondent diagnosed Patient A as suffering from depression. He did not document the basis for the diagnosis or what the treatment would be.

7. At various times in 2005, 2006 and 2008, the Respondent issued prescriptions for mirtazepine to Patient A, without documenting why this was prescribed.

8. At various times, the Respondent issued prescriptions for trileptal and clonidine, without documenting why this was prescribed.

9. The Respondent did not document Patient A's response to mirtazepine, trileptal or clonidine, all of which have the potential to cause morbidity.

10. In January 2010, the Respondent noted that Patient A had chronic pain syndrome and was functioning very well. Patient A was compliant and not abusing his medication at that visit.

11. In April 2010, the Respondent advised Patient A that, unless Patient A tapered off methadone, the Respondent would no longer provide him with medical care.

12. In June 2010, the Respondent noted that Patient A had been successfully weaned off methadone.

13. The Respondent continued to prescribe methadone to Patient A throughout 2010.

14. From April 2010 to January 20, 2011, the monthly distribution of 10 mg methadone prescribed by the Respondent to Patient A went from 450 pills to 165 pills.

15. In December 2010, Patient A complained of severe neck pain with diminished range of motion.

16. When the Respondent examined Patient A on December 21, 2010, he noted, "Severe muscle spasm in the neck that the patient cannot turn the head to left or right, even slight movement of the upper extremities reproduces the neck pain. He does have severe muscle spasm and contracture."

17. The Respondent diagnosed a neck contusion but did not reference the mechanism of the contusion.

18. The Respondent's records do not show that he performed a neurologic examination, or that he considered the possibility of spinal cord injury or nerve root injury.

19. The Respondent sent Patient A to a pain clinic and ordered an MRI of Patient A's spine.

20. The Respondent noted that the MRI yielded no evidence suggesting further treatment with methadone.

21. The Respondent continued to treat Patient A with methadone.

22. In fact, the MRI report revealed moderate to severe neuroforaminal stenosis at the C3-4 and C4-5 levels.

23. On January 19, 2011, the Respondent met with Patient A. The Respondent noted that, "The patient is still in significant pain"

24. The Respondent noted that Patient A would continue with the pain clinic and would see a spinal surgeon.

25. The Respondent prescribed methadone, 10 mg #165, to Patient A on or about January 19, 2011, confirming that Patient A will continue with the Pain Clinic and see the spinal surgeon.

26. The Respondent did not document why he prescribed methadone to Patient A.

27. On January 24, 2011, the Respondent wrote to Patient A stating that he would no longer be providing further medical care to him.

28. The Respondent said that he discharged Patient A from his practice because Patient A repeatedly violated his pain agreement.

29. The Respondent's records do not reflect that Patient A violated his pain agreement.

30. The Respondent's records do not contain any documented actions by Patient A that warranted his discharge from the Respondent's practice.

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

a) The Respondent failed to adequately document the basis for the diagnosis and treatment of Patient A's depression and pain;

b) The Respondent failed to document the reason he prescribed mirtazepine, trileptal and clonidine;

c) The Respondent did not assess Patient A's response from the use of mirtazepine, trileptal and clonidine; and

d) The Respondent acted unprofessionally in prescribing methadone to Patient A in January 2011, and discharging Patient A from his practice shortly thereafter.

Patient B

32. The Respondent became Patient B's primary care physician on February 14, 2011, when Patient B was sixty-two years old.

33. At the February 14, 2011 visit, the Respondent noted that Patient B's history included tobacco abuse and hyperlipidemia, which are risk factors for peripheral vascular problems.

34. The Respondent's documented examination failed to comment on Patient B's peripheral vascular status.

35. On February 14, 2011, Patient B's history was negative for diabetes.

36. On March 15, 2011, Patient B saw the Respondent for a fungal rash. The Respondent also documented an elevated glucose of 113, and triglycerides of 401.

37. Elevated glucose, elevated triglycerides and fungal rash are consistent with pre-diabetes, and should have led the Respondent to obtain a hemoglobin A1c or glucose tolerance test.

38. The Respondent next saw Patient B on August 2, 2011. The Respondent drew blood on that day.

39. Blood results obtained on August 5, 2011, show an A1c of 8.0, which is diagnostic for diabetes.

40. The Respondent's records do not show that the Respondent notified Patient B about the A1c results.

41. The Respondent prescribed metformin 500 mg tablets to Patient B on August 19, 2011.

42. While the Respondent's record does indicate that he counseled Patient B at most visits that he should follow a low-fat, low-cholesterol diet, exercise, lose weight, and quit smoking, there is no record that the Respondent counseled Patient B about his diabetes at any time in 2011.

43. On December 8, 2011, Patient B visited the Respondent's office for lab work. Blood results showed a glucose level of 168.

44. Although there is some indication that Respondent saw Patient B on December 12, 2011, there are no office notes concerning this visit.

45. Although the Respondent recalled seeing Patient B on February 3, 2012, there are no office notes concerning this visit.

46. The Respondent did not discuss Patient B's diabetes during the February 3, 2012 office visit.

47. Patient B submitted a urine sample for testing on February 3, 2012. The urine result showed 3+ for glucose, which is indicative of diabetes.

48. The Respondent failed to communicate the urine lab results to Patient B, despite multiple requests to do so in February 2012.

49. On March 2, 2012, Patient B's son called the Respondent's office and reported that, on March 1, 2012, Patient B had gone to the emergency department of a local hospital. Patient B's blood sugar was 513.

50. The Respondent's son questioned how the Respondent could have taken blood and urine samples without discovering that Patient B was diabetic.

51. The Respondent told Patient B's son that he would not discuss Patient B's treatment without permission from Patient B.

52. On February 14, 2011, Patient B had given the Respondent written permission to communicate with Patient B's son about Patient B's medical condition.

53. On March 8, 2012, Patient B visited the Respondent. Patient B had a non-fasting blood sugar of 438.

54. The Respondent's office notes dated March 8, 2012, noted that the Respondent had last seen Patient B in August 2011.

55. The Respondent noted that Patient B "is just diagnosed with type-II full-blown diabetes which progressed quite quickly in the last six months."

56. The Respondent told Patient B that he had full-blown diabetes and needed to be treated aggressively.

57. The Respondent noted that Patient B was taking glyburide 5 mg daily.

58. Glyburide is a medication used to treat Type 2 diabetes.

59. There were no notes showing when glyburide therapy began.

60. The Respondent started Patient B on glucovanse at the March 8, 2012 visit.

61. The Respondent did not note that he had provided any information to Patient B concerning how to monitor his glucose levels, or what signs to watch for.

62. The Respondent did not perform a urine screen for microalbuminuria, an important prognostic marker for renal disease.

63. The Respondent did not refer Patient B to an ophthalmologist to determine whether there were any microvascular complications.

64. Patient B transferred to a new primary care physician after the March 8, 2012 visit with the Respondent.

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

a. The Respondent failed to recognize or follow-up on the March 2011 abnormal laboratory results, which were indicators of pre-diabetes;

b. The Respondent inadequately followed-up on Patient B's August 2011 A1c of 8.0, in that there is no record that the Respondent communicated the results to Patient B, communicated any urgency in regards to scheduling an office visit, made any follow-up notes, or advised Patient B about treatment;

c. The Respondent failed to adequately treat Patient B as a result of the March 2012 office visit, in that the Respondent provided no instructions to Patient B concerning glucose monitoring, and did not make appropriate referrals to specialists;

d. The Respondent repeatedly failed to adequately document his treatment of Patient B; and,

e. The Respondent failed to adequately communicate with Patient B and Patient B's son, who was authorized to receive Patient B's medical information.

66. In June 2012, the Respondent implemented a new electronic medical record system that uses Athena-based medical assessment software.

67. The software generates prescriptions that are sent electronically to the patient's pharmacy, and the prescriptions are documented in the patient's medical record.

68. The Respondent now has a medical software system which receives and routes clinical information for easier use and access.

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 practicing medicine 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

SENT CERTIFIED MAIL 8/15/13 mq