

COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Board of Registration in Medicine

Adjudicatory Case No. 2024-004

In the Matter of

MARK E. ALLARA, M.D.

**CONSENT ORDER**

Pursuant to G.L. c. 30A, § 10, Mark E. Allara, 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. 19-071 and 23-045.

**Findings of Fact**

1. The Respondent is Board-certified in family medicine. He graduated from the Columbia University College of Physicians & Surgeons in 1994. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 82135 since 1995. He works at Middleton Family Practice and Congenial Healthcare, LLC in Middleton.

**Patient A**

2. In December of 2015, Patient A, then a **G.L. c. 4, § 7(26)(c)** female, began treating with the Respondent as her primary care provider (PCP).

*Benzodiazepines*

3. On January 7, 2016, Patient A presented to the Respondent complaining of **G.L. c. 4, § 7(26)(c)** The Respondent prescribed diazepam (Valium), a schedule IV benzodiazepine, 10mg twice per day prn “temporarily.”

a. The Respondent’s review of systems (ROS) noted, in part: “Psych: no depression, anxiety . . . .”

4. On August 2, 2016, the Respondent’s assessment and plan (A/P) for <sup>G.L. c. 4, § 7(26)(c)</sup> stated “**G.L. c. 4, § 7(26)(c)** will use valium prn temporarily.”

5. The Respondent continued to refill Patient A’s diazepam prescription without documenting additional <sup>G.L. c. 4, § 7(26)(c)</sup> symptoms until the summer of 2018.

6. On July 12, 2018, the Respondent diagnosed Patient A with “Primary insomnia” and prescribed zolpidem (Ambien), a sedative, 10mg once per day and clonazepam (Klonopin), another schedule IV benzodiazepine, 1mg twice per day.

7. On August 1, 2018, Patient A presented to the Respondent’s colleague. The A/P noted that Patient A “did not tolerate Ambien, taking pain med approx. 4 x day at work, clonazepam is new 2-3x day, discussed avoiding use at work.”

8. On October 22, 2018, Patient A presented to the Respondent’s colleague. Patient A reported **G.L. c. 4, § 7(26)(c)** and headache and requested an early Klonopin refill. Patient A reported that she took “a few doses but it ‘sedated’ her too much.” Patient A and the Respondent’s colleague discussed concerns “with all of the medications she is on” and discussed emergency room evaluation for withdrawal. The Klonopin refill was denied.

9. On November 5, 2018, Patient A was treated at <sup>G.L. c. 4, § 7(26)(c)</sup> Hospital for substance abuse and intoxication.

10. **G.L. c. 4, § 7(26)(c)**

11. On December 4, 2018, Patient A presented to the Respondent for follow-up.
- a. The Respondent listed clonazepam as an allergy causing moderate confusion.
  - b. The history of present illness (HPI) reported “discharged at 30 days in-patient [for] detox of clonazepam.”

*Opioids*

12. On December 7, 2015, the Respondent conducted a full physical examination of Patient A. The Respondent prescribed Patient A Percocet, a schedule II opioid, 5mg/325mg four times per day.

- a. The Respondent’s ROS noted, in part: “Musculoskeletal: no muscle aches or weakness and no arthralgias/joint pain, back pain, or swelling in the extremities.”

13. Between December 7, 2015 and September 19, 2016, the Respondent continued to prescribe Patient A Percocet without consistent documentation, examination, and evaluation of Patient A’s pain. The Respondent eventually increased Patient A’s Percocet prescription to 5mg/325mg every four hours, or six times per day on September 19, 2016, when Patient A presented for a motor vehicle accident from the prior **G.L. c. 4, § 7(26)(c)**

- a. The Respondent’s diagnosis of “unspecified osteoarthritis” is inconsistent with his HPI, ROS, and A/P.
- b. The Respondent’s diagnosis of “low back pain” is inconsistent with his HPI, ROS, and A/P.

14. On December 9, 2016, Patient A presented to the Respondent for “arthritis flare – knee gave out other day and patient fell, hands and feet are swollen.”

- a. The Respondent's HPI, ROS, and physical exam did not note any pain or swelling.
- b. The Respondent's A/P continued to list "Pain – due to recent car accident," "Arthritis," and "Low back pain."

15. On May 10, 2017, Patient A presented to the Respondent for "worsening bilat hand knee and left hip pain for past 2 weeks, having trouble with ambulation."

16. On June 6, 2017, Patient A presented to the Respondent's colleague. Patient A reported that she "fell down 3 steps and landed on concrete – left side chest painful hurts to breathe." Patient A reported her Percocet use for arthritis. Patient A was instructed to follow up with an x-ray.

17. On August 16, 2017, Patient A presented to the Respondent for follow-up. The Respondent increased Patient A's Percocet prescription to 5mg/325mg 1-2 tablets every four hours, or up to 12 tablets per day.

- a. The HPI continued to note "worsening bilat hand knee and left hip pain for past 2 weeks, having trouble with ambulation" and "arthritis flare recently."
- b. The Respondent's physical exam did not report any pain, weakness, aches, or swelling.

18. On November 29, 2017, Patient A presented to the Respondent for follow-up. The Respondent's A/P noted that Patient A needed a total knee replacement. The Respondent amended Patient A's Percocet prescription to 10mg/325mg every six hours, or four times per day.

- a. The HPI continued to note "worsening bilat hand knee and left hip pain for past 2 weeks, having trouble with ambulation."

- b. The Respondent's ROS and physical exam did not report any pain, weakness, aches, or swelling.
19. On January 30, 2018, Patient A presented to the Respondent for follow-up after recent hospitalization for **G.L. c. 4, § 7(26)(c)**. The Respondent prescribed oxycodone, another schedule II opioid, 10mg every four hours, or six times per day.
20. On February 14, 2018, the Respondent conducted a full annual physical examination of Patient A. The Respondent continued Patient A's prescriptions for diazepam and oxycodone and prescribed gabapentin 100mg three times per day.
- a. The Respondent's ROS and physical exam did not report any pain, weakness, aches, or swelling.
  - b. The Respondent's ROS did not report any positive psychiatric symptoms.
  - c. The Respondent did not document his rationale for prescribing gabapentin.
21. On April 27, 2018, Patient A presented to the Respondent for follow-up. The Respondent increased Patient A's gabapentin prescription to 300mg three times per day.
22. On May 7, 2018, Patient A presented to the Respondent's colleague for "Pain in left hand and wrist, fingers numb." Patient A reported that she was in a "MVA <sup>G.L. c. 4, § 7</sup> weeks ago." X-rays were ordered.
23. On May 18, 2018, Patient A presented to the Respondent for hand swelling. The HPI and ROS are continued from the May 7, 2019 visit note. The Respondent administered a Kenalog injection into the left wrist.
24. On June 22, 2018, Patient A presented to the Respondent for follow-up. The HPI continued to report Patient A's hand and wrist swelling from the May 7, 2019 visit note,

including “was in MVA<sup>G.L.</sup> weeks ago.” The HPI reported “worsening knee pain.” The Respondent’s A/P for multiple joint pain indicated a referral to ortho. The Respondent increased Patient A’s oxycodone prescription to 10mg every three hours, or eight times per day.

25. On November<sup>G.L. c. 4</sup> 2018, Patient A was treated at<sup>G.L. c. 4, § 7(26)(c)</sup> Hospital for substance abuse and intoxication.

26. **G.L. c. 4, § 7(26)(c)**

27. On December 4, 2018, Patient A presented to the Respondent for follow-up. Oxycodone is removed from Patient A’s medication list. The Respondent continued Patient A’s gabapentin prescription. The December 4, 2018 visit note is devoid of discussion of Patient A’s past or current pain.

28. Between December 2018 and December 2019, Patient A continued to present to the Respondent. The Respondent’s notes indicated that Patient A required a total knee replacement and needed to avoid opioids and benzodiazepines. The Respondent maintained Patient A’s prescription for gabapentin, eventually increasing the dose to 900mg three times per day on April 10, 2019.

29. On December 10, 2019, Patient A presented to the Respondent for “severe right leg pain getting worse.” The December 20, 2019 note reported that the Respondent prescribed Percocet 5mg/325mg three times per day on December 10, 2019.

30. On January 29, 2020, Patient A presented to the Respondent for follow-up. The HPI reported “new onset R pain on leg 6 weeks ago intensifying over past few days” with a plan for an epidural injection with another physician and notation of a buprenorphine patch.

31. The Respondent failed to meet the standard of care when prescribing controlled substances to Patient A when he:

- a. Failed to document discussions about the risks and benefits of high risk medications; and
- b. Failed to document his rationale for changing medications, dosages, and frequency of use.

#### Patient B

32. In February of 2015, Patient B, then a 60-year-old female, was an established patient of the Respondent.

33. Lorazepam is a schedule IV benzodiazepine FDA-approved to treat anxiety.

34. Between February 6, 2015 and March 6, 2017, the Respondent prescribed lorazepam to Patient B without a correlating diagnosis or associated documented symptoms.

35. On March 6, 2017, the Respondent listed Patient B's diagnoses of anxiety and depression for the first time.

36. Fioricet (butalbital/acetaminophen/caffeine) is FDA-approved to acutely treat only tension-type headaches in adults.

37. Between February 6, 2015 and February 6, 2018, the Respondent prescribed Fioricet to Patient B without a correlating diagnosis or associated documented symptoms.

38. On February 6, 2018, the Respondent listed Patient B's diagnosis of migraine for the first time and listed the onset to be December 1, 2017.

39. The Respondent continued to prescribe Patient B lorazepam and butalbital through 2022.

40. On January 3, 2022, Patient B refilled her butalbital prescription from the Respondent. Patient B received 60 tablets, a 15-day supply.

41. On January 6, 2022, Patient B presented to the **G.L. c. 4, § 7(26)(c)** Emergency Department for a **G.L. c. 4, § 7(26)(c)** evaluation. **G.L. c. 4, § 7(26)(c)**

42. On January 25, 2022, Patient B presented to the Respondent for follow-up. The Respondent's HPI noted **G.L. c. 4, § 7(26)(c)**

43. The Respondent continued to prescribe Patient B lorazepam and butalbital through 2023.

44. Patient B refilled her butalbital prescription from the Respondent on January 8 and January 24, 2023. Patient B received 60 tablets upon each refill.

45. On January 28, 2023, Patient B presented to the **G.L. c. 4, § 7(26)(c)** Emergency Department for a fall. **G.L. c. 4, § 7(26)(c)**

46. The Respondent failed to meet the standard of care when prescribing controlled substances to Patient B when he:

- a. Failed to document, evaluate, and manage a diagnosis of anxiety; and
- b. Failed to document, evaluate, and manage a diagnosis of headache.

47. The Respondent completed 8 CME credits in a Pain Medicine Knowledge Self-Assessment in December 2023. The Respondent also completed 3 CME credits in Pain Management and Opioids: Balancing Risks and Benefits in July 2023.

### Conclusions of Law

A. The Respondent engaged in conduct which 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 in violation of G.L. c. 112 §5, eighth par. (c) and 243 CMR 1.03(5)(a)(3).

B. The Respondent failed to maintain a medical record for each patient that is complete, timely, legible, and adequate to enable a licensee or any other health care provider to provide proper diagnosis and treatment in violation of 243 CMR 1.03(5)(a)(11), to wit: 243 CMR 2.07(13)(a).

### Sanction and Order

The Respondent's license is hereby REPRIMANDED. This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

### Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel and the Respondent are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

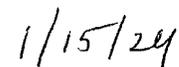
As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

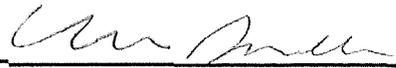
The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order 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 the Respondent 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 within one year following this reprimand. 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.

  
\_\_\_\_\_  
Mark E. Allara, M.D.  
Licensee

  
\_\_\_\_\_  
Date

  
\_\_\_\_\_

Chad Brouillard, Esq.  
Counsel for Licensee

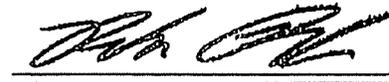
1/17/24  
Date

  
\_\_\_\_\_

Rachel N. Shute, Esq.  
Complaint Counsel

1/24/24  
Date

So ORDERED by the Board of Registration in Medicine this 25th day of January,  
20 24.

  
\_\_\_\_\_

Booker T. Bush, M.D.  
Acting Chair