COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2025-041

In the Matter of

THOMAS A. FRY, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Thomas A. Fry, 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. 20-152.

Findings of Fact

1. The Respondent graduated from the University of Massachusetts Medical School in 2000. In 2003, he was licensed to practice medicine in Massachusetts under certificate number 218006. Dr Fry was first certified by the American Board of Internal Medicine in 2004 and recertified in 2025. He is affiliated with Massachusetts General Hospital (MGH).

2. From 2010 to 2017, the Respondent was a primary care physician (PCP) at MGH's West Medical Group located in Waltham.

3. Since 2017, the Respondent has been a PCP at MGH's Concierge Medicine practice in Boston.

Patient SG

4. From 2012 to April 2013, the Respondent prescribed [redacted] to Patient SG for his [redacted].

5. In April 2013, Patient SG recovered from his [redacted] and stopped taking [redacted].

6. In January 2015, Patient SG [redacted] and contacted the Respondent by telephone. The Respondent restarted prescribing [redacted] without an in person visit.

7. From January 2015 to May 2018, the Respondent steadily increased the number of [redacted] that he prescribed to Patient SG.

8. From [redacted] 2016, to [redacted], 2017, the Respondent did not have in person visits with Patient SG.

9. The Respondent failed to meet the standard of care in his treatment of Patient SG when he:

a. Failed to have regular in person visits;

b. Failed to perform [redacted]

c. Failed to utilize [redacted] after the initial [redacted] was executed in August 2015; and

d. Failed to routinely document discussions related to [redacted] treatment, [redacted] [redacted] or [redacted] in the medical record.

Patient RL

10. In 2020, the Respondent prescribed [redacted] to Patient RL for [redacted] on a monthly basis based on the patient's report that [redacted] was previously prescribed by another provider.

11. The Respondent failed to meet the standard of care in his treatment of Patient RL when he:

a. Failed to utilize [redacted];

b. Failed to perform [redacted];

c. Failed to document that he performed appropriate [redacted] assessments; and

d. Failed to document discussions regarding Patient RL's complaints of [redacted].

Patient DC

12. From 2018 to 2022, the Respondent treated Patient DC for [redacted].

13. The Respondent prescribed [redacted] to Patient DC for her [redacted] based on the patient's report that [redacted] was previously prescribed by other providers.

14. The Respondent also prescribed [redacted] and [redacted] to Patient DC for [redacted] based on the patient's report that these medications were previously prescribed by other providers.

15. From July 2018 to December 2022, the Respondent prescribed [redacted] for Patient DC for suspected [redacted] without performing cultures.

16. The Respondent failed to meet the standard of care in his treatment of Patient DC when he:

a. Prescribed concomitant [redacted] and [redacted];

b. Inappropriately prescribed [redacted];

c. Inappropriately prescribed [redacted] without culture testing;

d. Failed to perform [redacted];

[1] [redacted] is a [redacted] associated with dependency and an increased risk of rebound headaches.

e. Failed to utilize [redacted]; and

f. Failed to routinely document discussions related to [redacted] treatment in the medical record.

Patient LV

17. The Respondent treated Patient LV from 2019 to 2021.

18. On [redacted], 2019, the Respondent spoke by telephone with Patient LV. The Respondent's telephone note documented Patient LV was having more trouble with [redacted] and that Patient LV emailed and wanted "[redacted]" as she gets too many side effects from [redacted].

19. The Respondent prescribed [redacted] to treat Patient LV's [redacted].

20. The Respondent failed to meet the standard of care when he failed to document a diagnostic workup or accepted [redacted] diagnostic criteria to support a diagnosis of [redacted] prior to prescribing [redacted] for Patient LV.

Patient LL

21. Since 2005, the Respondent has prescribed brand name [redacted] and [redacted] to Patient LL to treat [redacted] based on the patient's report that these medications were previously prescribed by another provider.

22. The Respondent failed to meet the standard of care in his treatment of Patient LL when he:

a. Prescribed concomitant [redacted] and [redacted];

b. Failed to perform [redacted];

c. Failed to document that he performed appropriate [redacted]

d. Failed to document that he discussed [redacted] alternatives; and

e. Failed to attempt [redacted] Patient LL from the [redacted]

Mitigation

23. Since being notified of the Board matter,

a. the Respondent has decreased his number of chronic pain management patients;

b. Any chronic pain management patient is co-managed with a Board-certified pain management specialist;

c. the Respondent personally checks the Massachusetts Prescription Monitoring data rather than allowing delegates to do so; and

d. the Respondent has completed continuing medical education classes regarding safe opioid prescribing.

Conclusions of Law

A. The Respondent has violated G.L. c. 112, § 5, eighth 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 violated 243 CMR 2.07(13)(a)by violating a rule or regulation of the Board, to wit: (1) failure to maintain medical records in violation of 243 CMR 2.07(13)(a).

Sanction and Order

The Respondent's license is hereby **REPRIMANDED**. The Respondent is ORDERED to successfully complete the following additional CME courses and provide proof of successful completion within 90 days of the approval of this consent order:

- CPEP medical records course: https://www.cpepdoc.org/cpep-courses/medical-records keeping seminar-2/ and
- CPEP prescribing course: https://cpepdoc.org/cpep-courses/r1rescribing-controlled-drugs/ .

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, the Respondent, and the Respondent's counsel 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 in the year following the date of imposition of 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.

Thomas A. Fry, M.D.
Licensee

9/23/2025
Date

Jennifer Herlihy
Attorney for the Licensee

9/23/2025
Date

Tracy Morong
Complaint Counsel

9/23/25
Date

So ORDERED by the Board of Registration in Medicine this 9th day of October, 2025.

Booker T. Bush, M.D.
Board Chair

On October 9, 2025 in accordance with the Board's authority and statutory mandate, the Board voted to approve the Consent Order reprimanding Dr. Thomas Fry's license to practice medicine, and requiring him to successfully complete Continuing Medical Education credits as specified in the Consent Order. Said sanctions are imposed on Dr. Arcoleo's license under certificate number 218006.

Board Members Voting Affirmatively

- Booker T. Bush, M.D., Physician Member, Chair
- Frank O'Donnell, Esq., Public Member, Vice Chair
- Sandeep Singh Jubbal, M.D., Physician Member, Secretary
- Jason Qu, M.D., Physician Member
- Yvonne Y. Cheung, MD, MPH, MBA, Physician Member
- Aviva Lee-Parritz, M.D., Physician Member

Board Members Voting to Oppose: None

Board Members Recused: None

Board Members Absent: None

EFFECTIVE DATE OF ORDER

The Consent Order is effective as of October 9, 2025.

Date Issued: October 9, 2025

George Zachos, Executive Director
Board of Registration in Medicine