THE COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. Division of Administrative Law Appeals

Board of Registration in Medicine,
Petitioner

v. Docket No. RM-18-0066

Eugene C. Jagella, M.D.,
Respondent

Appearance for Petitioner:

Karen A. Robinson, Esq.
Complaint Counsel
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Appearance for Respondent:

Eugene C. Jagella, M.D., pro se
951 South Market Street #22
South Williamsport, PA 17702

Administrative Magistrate:

Edward B. McGrath, Esq.
Chief Administrative Magistrate

SUMMARY OF RECOMMENDED DECISION

While I believe that the Respondent was acting in what he thought was the best interests of his patients, I recommend that the Board affirm the Order of Temporary Suspension and impose other discipline it believes appropriate, because the Petitioner proved the allegations contained in the statement of allegations and proved that the Respondent was an immediate and serious threat to the public health, safety, or welfare.

RECOMMENDED DECISION

On January 25, 2018, the Petitioner, Board of Registration in Medicine ("Board"/"BORIM"), issued a statement of allegations, pursuant to G. L. c. 112, § 5 and 243 CMR §1.03(5)(a)(11), an Order of Temporary Suspension, and an Order of

Reference to the Division of Administrative Law Appeals ("DALA") regarding the Respondent, Dr. Eugene C. Jagella. The Board charged in its Statement of Allegations that the Respondent engaged in conduct that called into question his competence to practice medicine, including practicing medicine "with gross negligence on a particular occasion or negligence on repeated occasions." It also alleged that the Respondent engaged in conduct that undermined the public confidence in the integrity of the medical profession and that the Respondent violated 243 CMR 2.07 (13)(a) which requires that a physician maintain a medical record which is adequate to enable the licensee to provide proper diagnosis and treatment. The Order of Temporary Suspension stated that: "The Board has determined that the health safety and welfare of the public necessitate said suspension."

On February 6, 2018, DALA acknowledged receipt of the action and, on February 12, 2018, I issued a notice of hearing on the Motion for Summary Suspension of the Respondent's medical license for February 16, 2018. On February 16, 2018, I allowed the Respondent's motion to extend time to file his response to the Statement of Allegations and to hold a pre-hearing conference on March 14, 2018. The Respondent filed his Answer to the Statement of Allegations on March 2, 2018 and I held the pre-hearing conference on March 14, 2018.

The evidentiary hearing on both the summary suspension and the statement of allegations was scheduled for May 16 and 17, 2018. The parties conducted discovery. The Respondent filed a motion to continue the hearing, which I allowed. The parties prepared pre-hearing memoranda. I marked the Petitioner's Pre-hearing Memorandum "A" for identification and the Respondent's "B." The Respondent filed a supplemental pre-hearing memorandum before the second day of the hearing, which I marked "BB."

The parties presented their evidence at the evidentiary hearing held on June 8 and 20, 2018. The Respondent was represented by counsel during the pre-hearing proceedings and represented himself at the hearing.

The hearing was conducted at the offices of the Division of Administrative Law Appeals, One Congress Street, 11th Floor, Boston, MA. The Petitioner produced four witnesses. The Petitioner called Robert Bouton, an investigator for the Board of Registration in Medicine, Tarsha Huftalen, N.P., Melinda Raboin, M.D., and the Respondent. The Respondent called eleven witnesses and he testified on his own behalf. The Respondent's witnesses included Patients B and C and some of his other patients. The hearing was stenographically recorded and I refer to the transcript in this decision as "Tr. page." At the hearing, I marked nineteen items offered by the Petitioner as exhibits (Ex. 1-19). I also marked nine (9) items offered by the Respondent as exhibits (Ex. 20-28).

I granted the parties until August 26, 2018 to submit written closing arguments and they both took advantage of that opportunity. I marked the Respondent's closing argument "C" and the Petitioner's "D." When I received the latter of these submissions on August 20, 2018, I closed the record. On October 17, 2018, the Respondent submitted a letter accompanied by a news article concerning former Governor of Pennsylvania Ed Rendell. To the extent that this was a motion to re-open the record pursuant to 801 CMR 1.01(7)(k), it is denied. Even if the information contained in the submission were true, what Governor Rendell thought about treating opioid addicts is not probative on the issues before me. I have marked the letter and the attachment "E" for identification. On April 22, 2019, the Petitioner submitted another letter and newspaper article. These items

concerned federal criminal prosecutions of individuals not involved in this matter. The record is closed and the information contained in these submissions is not probative. I will not consider it. I have marked them "F." For similar reasons, I denied the Respondent's Motion to Admit Newly Discovered Relevant Evidence dated May 31, 2019 and which I marked "G." The article submitted with the motion states on page 2 that "Policies should allow clinicians to account for each patient's circumstances in making clinical decisions" and that is not disputed. The issue confronting me arises from the treatment of certain patients on specific occasions and the article does not address the specifics of the Respondent's care of his patients and it was published after the incidents described in the statement of allegations occurred.

FINDINGS OF FACT

Based upon the evidence presented, the reasonable inferences from it, and my assessment of the witnesses' credibility, I make the following findings of fact:

1. In April 2017, the Board received a statutory complaint alleging that one of the Respondent's patients was receiving a significant amount of narcotics from the Respondent. (Bouton Test. Tr. 30)
2. The complaint was lodged by a nurse practitioner named Tarsha Huftalen. (Huftalen Test. Tr. 42)
3. Huftalen began her career as a registered nurse at Massachusetts General Hospital in neurology/neurosurgery. She then went to Regis College and obtained her master's degree in nursing. She worked at Dana-Farber Cancer Institute in experimental medicine for about a year and a half and then began working at Franklin Pain and Wellness Center, where she has served as the

clinical director for five-and-a half-years and supervises the nurse practitioners. (Huftalen Test. Tr. 41)

4. Huftalen's experience includes treating patients who require pain medication, including opiate and non-opiate pain medication, and patients suffering from addiction. (Huftalen Test. Tr. 42)

5. Huftalen saw a patient for an initial consultation whom she believed was on a very high dose of opiate pain medication. (Huftalen Test. Tr. 43)

6. This patient is identified as Patient F in this action. (Huftalen Test. Tr. 44)

7. The Respondent referred Patient F to Huftalen. (Huftalen Test. Tr. 46)

8. Huftalen was concerned because the patient was on 60 milligrams of oxycodone every two hours and 40 milligrams of methadone a day. The patient was also prescribed Phenergan, and Valium. (Huftalen Test. Tr. 45)

9. Huftalen believed that this was a "recipe for death." She expressed her concerns to Patient F and documented them in a pain management note dated March 31, 2017 and addressed to the Respondent. (Huftalen Test. Tr. 46, Pet. Ex. 10 pp.125-127)

10. Huftalen wrote in her assessment and plan set out in the pain management note, that:

> I had an extensive conversation with Patient F regarding the doses of her opiates. She is on an excess amount, which could be in some cases considered quite inappropriate dosing. I would recommend that she be weaned off these medications....

(Ex. 10 p. 126-127)

11. Huftalen did not receive a response from the Respondent. (Huftalen Test. Tr. 48)

12. Huftalen sent an email to the Board of Registration in Medicine expressing her concern on March 31, 2017. (Ex. 16)

13. Huftalen sent the report to the Board of Registration in Medicine, because she believed that the CDC guidelines indicate that pain treatment of patients with non-terminal illness should not exceed 90 morphine equivalents, and the morphine equivalents of just the oxycodone Patient F was receiving "far exceeded that." (Huftalen Test. Tr. 54)

14. The Board assigned an investigator, Robert Michael Bouton, to investigate the complaint. (Bouton Test. Tr. 30)

15. Bouton reviewed the Respondent's file at the Board and found that the Respondent had been the subject of a report made by Milford Regional Medical Center after it changed his admitting privileges. This occurred after the Respondent allegedly ordered a test performed on a 92 year old female patient that showed possible signs of an infection and the Respondent failed to follow up. In addition, the Respondent, according to the report, admitted a patient to the telemetry ward for full review contrary to the patient's signed "comfort care only" form. After the Respondent provided a written response, the information was forwarded to the Board's data repository committee and the complaints were closed. (Bouton Test. Tr. 32)

16. Bouton's review of the Respondent's file revealed two complaints lodged in 2014. One concerned a patient who alleged that the Respondent dropped him as a patient, because the patient had too many issues. The other was brought by another patient's family who claimed that the Respondent took too long to

report the results of an MRI and make a diagnosis. These complaints were forwarded to the Board's complaint committee. The Respondent filed his response to each complaint and the complaint committee closed the cases. (Bouton Test. Tr. 33)

17. Bouton then ran the Respondent's name through the Prescription Monitoring Program, also known as the MassPAT system. (Bouton Test. Tr. 36)

18. According to MassPAT, Patients A through F were prescribed drugs that were contraindicated or received high amounts of narcotic medications. (Bouton Test. Tr. 37)

19. Bouton requested complete copies of Patients A through F's medical records from the Respondent. (Bouton Test. Tr. 37)

20. The Respondent complied with that request and certified that the records he was supplying comprised "the full and complete medical record in my possession." (Bouton Tr. 38, Exs. 5 - 10 p. 1)

21. Bouton reviewed the records and forwarded them for an expert review. (Bouton Tr. 38)

22. Bouton sent the medical records of Patients A through F to Melinda Raboin, M.D. for her review and Dr. Raboin prepared a report, which is marked Pet. Ex. 13. (Raboin Test. Tr. 71, Ex. 13)

23. Dr. Raboin is a graduate of Tufts University Medical School. She did her residency at UMass Medical Center in Worcester. Dr. Raboin is licensed to practice medicine in Massachusetts and is board certified in Family Medicine. (Raboin Test. Tr. 58)

24. Family medicine treats patients of all ages, while internal medicine treats adults only. (Raboin Test. Tr. 59)

25. Dr. Raboin works at Clean Slate Center. It is a treatment center for opiate and alcohol abuse. (Raboin Test. Tr. 59)

26. Dr. Raboin was in a traditional family practice for most of her career and is on the faculty at the University of Massachusetts Medical School, where she works with students on an international trip. She is a member of the American Academy of Family Practice. (Raboin Test. Tr. 60)

27. Dr. Raboin spends 70 percent of her day treating patients and, since August of 2017, she has been treating addicts exclusively, including heroin and cocaine addicts. (Raboin Test. Tr. 61)

28. The standard of care for pain management and narcotic-prescribing is the same for family medicine physicians and internal medicine physicians. (Raboin Test. Tr. 62)

29. Opiates, also called narcotics, act mostly on the "mu receptor" to modulate pain. They can cause euphoria. Benzodiazepine act on a different receptor mostly called the GABA receptor and they mostly modulate symptoms of anxiety. They are both sedatives, when prescribed together, they have an additive effect, Each also can be addicting. (Raboin Test. Tr. 63)

30. Methadone is considered an opiate. (Raboin Test. Tr. 63)

31. Combinations of multiple opiates are additive, because they add onto the same receptor. (Raboin Test. Tr. 64)

32. When prescribing medication to someone with chronic pain the standard of care is to exhaust all other options, including physical therapy, injections and surgery, then start with medications other than opiates. There are non-narcotic options that should be tried. (Raboin Test. Tr. 67)

33. Selective serotonin reuptake inhibitors ("SSRI") are non-narcotic and are most often known for treating depression or anxiety, but sometimes can be used to co-modulate pain. (Raboin Test. Tr. 67).

34. A physician must review the patient's medical records and corroborate the patient's history then gradually increase the prescription depending on the patient's response to the medication. The physician should review the patient's progress to determine if a tolerance or addiction is developing. (Raboin Test. Tr. 69)

35. Drug screens are always useful, but how often a physician has them done depends on the patient and situation. (Raboin Test. Tr. 70)

36. It is standard of care to meet with patients with some regularity when prescribing narcotics. The physician must assess for side effects, complications and compliance. (Raboin Test. Tr. 120)

37. The Respondent's treatment of patients A through F did not meet the standard of care. (Raboin Test. Tr. 72)

Patient A

38. The Respondent started treating Patient A when the Patient was 52 and complaining of influenza. Patient A told the Respondent that he had chronic pain from herniated disc surgery. The Respondent did not review Patient A's

prior medical records and did not consider surgery. (Raboin Test. Tr. 118-119)

39. Patient A had a history of alcoholism and a sister who died of a drug overdose. These are relative contraindications for prescribing opiates. (Raboin Test. Tr. 121)

40. The Respondent did not consider other non-opioid treatments for Patient A and he did not meet regularly with Patient A before refilling his narcotics prescriptions. (Raboin Test. Tr. 120)

41. The opiates were not effective as there is evidence in the medical records that doses escalated over time, but Patient A continued to be in severe pain. (Raboin Test. Tr. 121).

42. The Respondent failed to have regular visits and examinations with Patient A, and failed to employ regular urine drug screens or pill counts. Express Scripts sent a letter to the Respondent expressing concern about Patient A's prescriptions. (Raboin Test. Tr. 124, 127, Ex. 5 p. 343)

43. The Respondent admits that he should have performed urinary drug screens on Patient A. (Res. Test. Tr. 260)

44. When Patient A began treating with the Respondent, Patient A was taking 60 Vicodin tablets a month. In 2017, Patient A was still in severe pain and taking oxycodone 15 milligrams 800 tablets per month. (Raboin Test, Tr. 129)

45. Morphine equivalents is a method to translate the strength of different drugs so as to calculate a standard measurement of their strength. (Raboin Test. Tr. 130)

46. When Patient A stopped treating with the Respondent, he was taking more than the recommended dose in terms of morphine equivalents. (Raboin Test. Tr. 130)

47. The Respondent's treatment of Patient A failed to meet the standard of care. (Raboin Report Ex. 13 p. 13)

Patient B

48. In June 2016, the Respondent saw Patient B for chronic back and shoulder pain and depression. (Raboin Test. Tr. 137)

49. The Respondent did not document Patient B's prior psychiatric medications. (Raboin Test. Tr. 137)

50. The Respondent quickly increased Patient B's prescriptions of oxycodone and, while there was an initial response, there was a poor pattern of pain control and the prescription was be increased again. There was poor monitoring with drug screens. (Raboin Test. Tr. 137-138).

51. The Respondent prescribed oxycodone and OxyContin together, and substantially increased the daily dose of narcotics over time. (Raboin Test. Tr. 139).

52. In two months, Patient B went from 5 milligrams a day to over 200 milligrams a day. That was excessive. (Raboin Test. Tr. 140-141).

53. Raboin noted that, before Patient B started treating with the Respondent, his pain medication had been reduced, but the Respondent failed to obtain the medical records to establish why the medication had been reduced before he

started increasing Patient B's pain medication. Failing to obtain Patient B's prior medical records violated the standard of care. (Ex. 13 p. 13)

54. The Respondent treated Patient B's depression with Xanax. Prescribing Xanax along with other narcotics was below the standard of care, because Xanax is a benzodiazepine. It can be addicting and combining it with the other narcotics increases the risks of sedation and addiction. The standard of care would have been to start with SSRIs or NSRIs (Norepinephrine Serotonin reuptake inhibitors)[1] first. (Raboin Test. Tr. 141)

55. Patient B was caused to become tolerant to very high doses of narcotics that were not giving him benefit. He was exposed to sedation and the overprescribing made it harder to control his postoperative pain when he had back surgery. (Raboin Test. Tr. 142)

56. In January of 2017, Patient B's OxyContin and Oxycodone were cut back to once a day reduce sedation. (Ex. 13 p. 13)

57. The Respondent did not document regular drug screens for Patient B. (Raboin Test. Tr. 142)

58. The Respondent's care of Patient B was below the standard of care.

Patient C

59. The Respondent first treated Patient C on May 28, 2004 and noted that Patient C had a medical history including active IV heroin use. (Ex. 13 p. 8)

60. Patient C was a 31-year-old man with a history of heroin addiction and mental illness when the Respondent started treating him. (Raboin Test. Tr. 97)

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4008300/

61. The Respondent treated Patient C for chronic pain. The use of narcotics was contraindicated because of his history of heroin addiction. (Raboin Test. Tr. 98)

62. The Respondent prescribed Patient C opiates, allegedly to keep Patient C from using heroin. That is always contraindicated. It will do nothing to get the patient to stop using heroin. (Raboin Test. Tr. 101)

63. Patient C needed specialty care in an addiction clinic. While the Respondent discussed a referral to detox with Patient C, but he never made the referral and instead enabled Patient C's addiction. (Raboin Test. Tr. 103)

64. The Respondent supplied methadone to Patient C while Patient C was receiving outpatient treatment from a clinic. (Raboin Test. Tr. 104)

65. On September 3, 2010, the Respondent prescribed methadone because Patient C complained of low back pain that was not helped by Ultram. Patient C promised to only take small amounts, but asked for more methadone on October 5, 2010 and October 23, 2010. The Respondent agreed to provide the prescriptions. (Raboin's Report Ex. 13 p. 9)

66. The Respondent did not believe he had to perform drug screens on Patient C, because Patient C lived with his elderly grandmother who "watches him like a hawk." (Resp. Test Tr. 180)

67. The Respondent's treatment of Patient C violated the standard of care. (Raboin's Report Pet. Ex. 13 p. 12)

Patient D

68. Patient D was 64 years old when the Respondent began treating her for chronic back pain. She was already on methadone. (Raboin Test. Tr. 148)

69. Patient D's methadone dosage was 50 milligrams a day, but it was no longer controlling her pain. The Respondent increased her methadone dosage and added oxycodone without exploring other treatment options. Her pain did not improve. (Raboin Test. Tr. 148-149)

70. Despite the increase in medication, Patient's D's pain was not adequately controlled. (Raboin Test. Tr. 152).

71. Patient D developed a tolerance to the medication and Patient D reported falling asleep during the day and had respiratory difficulties requiring a visit to an emergency room. The Respondent did not document performing random drug screens for Patient D. (Raboin Test. Tr. 153-154, 156)

72. According to the Respondent, Patient D reported that she had been seen by Dr. McCormick earlier. She had been sleeping poorly at night and reported sleeping better since getting a new mask for her BIPAP. (Ex. 8 p. 154)

73. According to the Respondent, the emergency room staff noted that Patient D's "Evaluation (was) negative and she was sent home." (Ex. 8 p. 154).

74. Dr. Raboin testified that on that occasion sedation was a "possibility which should be entertained." (Raboin Test. Tr. 158)

75. The Respondent's care of Patient D was below the standard of care.

Patient E

76. The Respondent began treating Patient E on August 15, 2006. Patient E was a 33-year-old-male complaining of knee, arm, and ankle pain along with hypertension. (Rabbin Test. Tr. 160)

77. Patient E's prior treating physician started him on oxycodone. (Patient E Test. Tr. 348)

78. Patient E tried over-the-counter pain medications. Motrin helped him the most, but according to Patient E he is on dialysis because the Motrin caused kidney failure. (Patient E Test. Tr. 348)

79. The Respondent prescribed Lyrica for Patient E, but the insurer would not pay for it. (Patient E Test. Tr. 348)

80. Although the Respondent did not have any past medical records concerning Patient E, he started Patient E on Percocet.[2] (Raboin Test. Tr. 160)

81. The Respondent did not perform a drug screen on Patient E, and he had no face-to-face contact with Patient E for almost 2 years, but the narcotic pain medication continued. Although Patient E continued to complain of severe pain no other therapies were suggested. There was a request for a pain specialist but there is no medical record of a follow-up. (Raboin Test. Tr. 161)

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[2] Percocet is acetaminophen/oxycodone. https://www.pdr.net/drug-summary/Percocet-acetaminophen-oxycodone-2483.1051.

82. The Respondent also prescribed both benzodiazepines and narcotics for Patient E, but failed to document the justification for prescribing both. (Raboin Test. Tr. 161-162)

83. In some situations, it is acceptable to prescribe benzodiazepines for anxiety, but not exclusively without trying other medications and it is not acceptable to use it continuously without other adjuvant medication. (Raboin Test. Tr. 169)

84. Treatment notes concerning Patient E document his development of tolerances to the pain medication. The Respondent received a letter from CVS/caremark expressing concern about Patient E's prescriptions. (Raboin Test. Tr. 164, 165-166, Ex. 9 p. 137)

85. The Respondent did not perform regular drug screens on Patient E. (Raboin Test. Tr. 167)

86. The Respondent's treatment of Patient E did not meet the standard of care.

Patient F

87. The Respondent began treating Patient F in 2011, when she was 31. Patient F was already taking methadone and oxycodone for chronic pain related to a motor vehicle accident. She was also taking clonazepam for anxiety, and reported a history of metastatic breast cancer and multiple sclerosis. (Raboin Test. Tr. 74)

88. The medical records provided by the Respondent concerning Patient F did not document the motor vehicle accident, the diagnosis of breast cancer, or the diagnosis of multiple sclerosis. (Raboin Test. Tr. 74)

89. The medical record concerning Patient F documented an opiate use disorder. (Raboin Test. Tr. 81)

90. On December 4, 2012, Patient F told the Respondent that she had been incarcerated for six months for a driver's license/probation issue and not a drug charge. (Ex. 10 p. 36)

91. On September 6, 2013, Patient F reported that she took methadone and Dilaudid and had a history of opiate abuse. (Ex. 10 p. 219)

92. On March 13, 2017, the Respondent noted a medical record that documented Patient F's history of intravenous drug abuse. Patient F told the Respondent that her ex-husband alleged that during a bitter divorce. The Respondent wrote "I have accepted her explanation and will be expunging that history from her record." (Ex. 10 p. 6, Raboin Test Tr. 77-78)

93. Expunging the medical record violated the standard of care, because the addiction disease process includes denial and lying. (Raboin Test. Tr. 95)

94. The Respondent did not regularly screen Patient F for illicit or non-prescribed drugs. (Raboin Test. Tr. 81)

95. The Respondent's treatment of Patient F violated the standard of care.

Mitigation

96. For the most part, when the Respondent's patients told him that they needed early refills of their opiate prescriptions, he agreed because he believed it was the humane and compassionate thing to do. (Res. Test. Tr. 316)

97. The Respondent's practice has focused on the neediest patients in his community, and he travels to treat patients unable to visit his office. (Exs. 20 and 22, Saluk Test. Tr. 235 -236)

98. The Respondent believes that each patient should be treated individually and that the physician should review how the patient is functioning to determine whether or not the patient is getting the correct dose of pain medication. (Resp. Test. Tr. 323)

99. The Respondent believes that it is up to the primary care doctor to decide whether or not a certain course of treatment is appropriate. (Resp. Test. Tr. 289)

100. The Respondent does not think he violated "some sort of rule in the amount of medication [he] was prescribing ...because again [doctors] have the option of using [their] clinical judgment." (Resp. Test. Tr. 325-326)

101. The Respondent's only motivation for prescribing the pain medication was to help his patients. (Resp. Test. Tr. 289)

ANALYSIS

The Legislature has granted the Board the authority to investigate and, when appropriate, discipline doctors. G.L. c. 112, § 5. To carry out its legislative mandate, the Board has adopted regulations. Those regulations provide that the Board may discipline a physician for:

> conduct which places into question the physician's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, ... or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions, for violation of any rule or regulation of the Board and Misconduct in the practice of medicine.

243 CMR 1.03 (5)(a)3. The regulations also provide that: "The Board may suspend or refuse to renew a license pending a hearing on the question of revocation if the health, safety or welfare of the public necessitates such summary action." 243 CMR 1.03(11). I note that "the Board 'has long viewed with the utmost seriousness any physician's inability or failure to faithfully discharge' his 'grave responsibility' for issuing prescriptions for controlled substances.'" *Matter of Okrassa,* Adjud. Case No. 02-50 Final Dec. and Order of Bd. of Reg. in Medicine, July 16, 2003 Recommended Dec., May 7, 2003, DALA Docket No. RM-02-1349 (citations omitted).

The case before me addresses allegations pertaining to Patients A through F. The Board has the burden of establishing the allegations set forth in the Statement of Allegations and supporting the Order of Temporary Suspension by a preponderance of the evidence. *See Craven v. State Ethics Commission,* 390 Mass. 191, 200 (1983) (preponderance of evidence generally standard applied at administrative proceedings); *Randall v. Bd. of Reg. in Medicine,* SJ-2014-0475 slip op. at 3 (June 9, 2015) (due process requires preponderance of evidence for summary suspension). To meet this burden, the Board must produce sufficient evidence that "it is made to appear more likely or probable - in the sense that actual belief in its truth, derived from the evidence, exists in the mind or minds of the tribunal, notwithstanding any doubt that may linger there." *Sargent v. Massachusetts Acc. Co.*, 307 Mass. 246, 250, 29 N.E.2d 825, 827 (1940). A fact is proved by a preponderance of the evidence if the tribunal has "a firm and abiding conviction in the truth of" the proposition advanced by the Board. *Stepakoff v. Kantar,* 393 Mass. 836, 843, 473 N.E.2d 1131, 1136 (1985). After a careful review of all of the

evidence in this case, I have concluded that the Board has met its burden of proof with respect to each of the counts set forth in the Statement of Allegations.

A. Misconduct in the practice of medicine

Pursuant to G.L. c. 112, § 5, eighth para. (h) 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 his competence to practice medicine, including, but not limited to gross incompetence, gross negligence on a particular occasion or negligence on repeated occasions. *See Bd. of Reg. in Medicine v. Nasif,* Adjud. Case No. 2016-013 Bd. of Reg. in Medicine Final Dec. and Order dated Oct. 12, 2017, Recommended Dec. at 12 dated May 11, 2017 (Div. Adm. Law App. Docket No. RM-16-163). Physicians must meet the standard of care, which is "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession." *Brune v. Belinkoff,* 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968). The standard of care is the level of care and skill that physicians in the same specialty commonly possess. *Palandijan v. Foster,* 446 Mass. 100, 104-05, 842 N.E.2d 916, 920-21 (2006); *McCarthy v. Boston City Hospital,* 358 Mass. 639, 643, 266 N.E.2d 292, 295 (1971).

The Petitioner in this case proved by a preponderance of the evidence that the Respondent practiced medicine with negligence on repeated occasions. I found Dr. Raboin's expert testimony and the opinions contained in her report, Ex. 13, persuasive. In particular, the Respondent's failure to obtain his patient's prior medical records and his failure to conduct regular drug screens were violations of the standard of care for patients to whom he prescribed opiates. In addition, I note that the Respondent failed to conduct regular visits and examinations of his patients, and failed to properly consider non-opioid

treatment. Dr. Raboin's testimony and report convinced me that this conduct was below the standard of care.

For the most part, the Respondent does not dispute that he performed as Dr. Raboin testified, but he argued that, as the primary care physician, he was free to determine the best care for each of his patients. The standard of care does leave room for physicians to make choices between alternative treatment approaches, but those choices must be reasonable and within the standard of care. *See Barret v. Hight*, 353 Mass. 268, 276-277, 230 N.E.2d 808, 814 (1967) (discussing limits of reasonable decision); *Bd. of Reg. in Medicine v. Hughes*, Adjud. Case No. 2014-052 Bd. of Reg. in Medicine Final Dec. and Order dated Jun. 2, 2016, Recommended Dec. at 10 dated Mar. 30, 2016 (Div. Adm. Law App. Docket No. RM-14-810).

Based upon the evidence before me, I find that many of the Respondent's choices were not reasonable. For example, failing to review Patient A's prior medical records concerning his herniated disc surgery and prescribing opiates without performing regular examinations was below the standard of care. (Findings 38-40). In addition, relying on Patient C's grandmother and not performing regular drug screens on Patient C, because "she watches [the patient] like a hawk" was not reasonable. (Finding 66). The Respondent himself testified that he should have conducted more drug screens. (Finding 43). The fact that the Respondent continued prescribing narcotic pain medication for Patient E without examining him for two years was another violation of the standard of care. (Findings 81 and 82).

While the Respondent called several witnesses, none of their testimony rebutted Dr. Raboin's expert opinion concerning the standard of care or the Respondent's breach

of it. Dr. Crimaldi did not have any knowledge of the Respondent's treatment of Patients A through F or of any of the Respondent's chronic pain patients and he did not opine as to the quality of their care. Nor did I find the testimony of the nurse practitioners and licensed practical nurse offered by the Respondent relevant to the Respondent's care of Patients A through F. First, they did not testify concerning the Respondent's treatment of Patients A through F. Second, as nurse practitioners and licensed practical nurses, I would not have given any weight to their testimony concerning the standard of care applicable to physicians had they been asked. In addition, I did not find the testimony of the Respondent's patients persuasive as to the standard of care or the Respondent's breach of it when he treated Patients A through F. I find that they did not have the necessary training or experience to understand the standard of care. I also find, based upon their testimony and my observations of them testifying, that their relationship with the Respondent called into question their ability to objectively assess his conduct.

B. Failure to maintain an adequate medical record

The Petitioner proved by a preponderance of the evidence that the Respondent violated 243 CMR 2.07(13)(a) by "failing to maintain a medical record for each patient which is adequate to enable the licensee to provide proper diagnosis and treatment..." I was persuaded by Dr. Raboin's testimony concerning the Respondent's deficient record keeping. In particular, the Respondent's decision to change Patient F's medical history by "expunging" references to her intravenous drug abuse, because Patient F told him that her ex-husband had lied about it was a violation of 243 CMR 2.07(13)(a). (Finding 93) In addition, the failure to document drug screens and to follow up with Patient C about a referral to detox violated 243 CMR 2.07(13)(a). (Finding 63)

C. The Respondent's conduct undermined public confidence in the medical profession

> Conduct which undermines public confidence in the integrity of the medical profession is an independently sufficient ground for the board to sanction a physician. Such conduct is not limited to that outlined in G.L. c. 112, § 5 (1994 ed.). The board has broad authority to 'protect the image of the medical profession' and is not limited to disciplining conduct involving direct patient care, criminal activity, or deceit.

Sugarman v. Bd. of Reg. in Medicine, 422 Mass. 338, 343, 662 N.E.2d 1020, 1024 (1996). I find that the Respondent's failure to respond to the questions raised about his treatment of Patient F by Ms. Huftalen and to address the concerns raised by his patients' pharmacies and insurers (Findings 11, 42, 84), constituted conduct which undermines the public confidence in the medical profession. I also find that agreeing to expunge a reference to intravenous drug use in Patient F's medical record (Finding 93) constituted conduct that undermines the public confidence in the medical profession. *See Raymond v. Bd of Reg. in Medicine*, 387 Mass. 708, 712-13, 443 N.E.2d 391, 394-95 (1982) (Board may protect public confidence in integrity of profession); *Levy v. Bd. of Reg. in Medicine*, 378 Mass. 519, 529, 329 N.E.2d 1036, 1042 (1979) (protect public esteem of profession).

D. Summary suspension

The Board may suspend a physician's license to practice medicine pending a hearing on the question of revocation if the health, safety or welfare of the public necessitates such summary action. In this case, I was convinced by a preponderance of the evidence that the Respondent's violation of the standard of care on repeated occasions was a threat to his patients' safety. *See Kobrin v. Bd. of Reg. in Medicine*, 444 Mass. 837, 842 n. 5 (2005) (summary suspension appropriate when patient safety directly jeopardized). I was not persuaded that Patient D was sedated because of an opioid overdose at the

emergency room, as Dr. Raboin testified that was a "possibility" (Finding 74). There was, however, lots of other evidence in the record establishing that the Respondent's conduct placed his patients' safety at risk. For example, I found persuasive Dr. Raboin's testimony concerning the building of tolerances to opioids and the additive nature of the drugs and her objection to the persistent manner in which the Respondent increased the opioid dosage given to the six patients at issue. (Findings 29, 31, 54 and 55).

E. Mitigation

I was convinced by the evidence offered by the Respondent, including his testimony, that the Respondent cares about his patients and he acted in what he believed were their best interests. I was also convinced that his service to the neediest in his community is a credit to the medical profession, but these facts are not a defense to the allegations against him. I recommend that the Board consider these facts in mitigation as it sees fit when it considers the matter. *See Keigan v. Bd. of Reg. in Medicine*, 399 Mass. 719, 722, 506 N.E.2d 866, 869 (1987) (consideration of mitigating factors).

CONCLUSION

For the reasons stated above I recommend that the Board affirm the summary suspension of the Respondent's license to practice medicine and, in accordance with the statement of allegations, while noting that the Respondent has not practiced since his license was suspended and the mitigating factors referred to above, I recommend that the Board impose the sanctions it deems appropriate.

Division of Administrative Law Appeals

Edward B. McGrath
Chief Administrative Magistrate

DATED: June 4, 2019