BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

FRANK L. LAMP, M.D., RESPONDENT

FILE Nos. 02-10-557 & 02-11-664

****

CONSENT AGREEMENT

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COMES NOW the Iowa Board of Medicine (Board) and Frank L. Lamp, M.D., (Respondent), and on June 28, 2013, hereby enter into this Consent Agreement to resolve this matter.

1. Respondent was issued Iowa medical license no. 27191 on July 1, 1989.

2. Respondent's Iowa medical license is active and will next expire on November 1, 2013.

3. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.

4. Respondent is an Iowa-licensed physician who practices family medicine in Grundy Center, Iowa.

5. **New Disciplinary Charges:** On November 15, 2012, the Board charged Respondent with inappropriately prescribing controlled substances, particularly methadone, to patients with known substance abuse histories between 2009 and 2011 and performing an inappropriate and/or medically unnecessary physical examination on a young female patient in his clinic in Grundy Center, Iowa, on August 10, 2011. A hearing was held on March 21, 2013.

6. **Findings of Fact, Conclusions of Law, Decision and Order**: On April 18, 2013, the Board issued a Findings of Fact, Conclusions of Law, Decision and Order. The Board concluded that Respondent violated the laws and rules governing the practice of medicine when he inappropriately prescribed controlled substances, particularly methadone, to patients with known substance abuse histories between 2009 and 2011. The Board also concluded that Respondent's physical examination of a young female patient in his clinic on August 10, 2011, was inappropriate, not because it was unethical, but because it was performed incompetently. The Board concluded that Respondent did not have sufficient medical justification for his decision to perform a breast examination. Under the terms of the April 18, 2013, Findings of Fact, Conclusions of Law, Decision and Order, the Board issued Respondent a Citation and Warning and ordered him to pay a $2,500 civil penalty. The Board prohibited Respondent from purchasing, procuring, possessing, administering or dispensing controlled substances. The Board ordered Respondent to complete a Board-approved clinical competency evaluation and a Board-approved professional boundaries evaluation. The Board ordered Respondent to have a Board-approved female healthcare

professional chaperone continually present at all times while treating all patients under the age of 18 years old and while providing breast and/or pelvic examinations for any female patient. Finally, the Board placed Respondent on indefinite probation subject to a Board-approved practice monitoring plan and Board monitoring.

7. **Voluntary Surrender of License:** In lieu of compliance with the terms and conditions of the April 18, 2013, Findings of Fact, Conclusions of Law, Decision and Order, Respondent agrees to voluntarily surrender his Iowa medical license effective June 1, 2013, to resolve this matter.

8. Respondent voluntarily submits this Consent Agreement to the Board for consideration.

9. Respondent agrees that the State's counsel may present this Consent Agreement to the Board for consideration.

10. By entering into this Order, Respondent voluntarily waives any rights to a contested case hearing on the allegations in the Statement of Charges, and waives any objections to the terms of this Order.

11. This Order constitutes the resolution of a contested case proceeding.

12. Respondent understands that the Board is required by Federal law to report this Order to the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank.

13. The Order becomes a public record available for inspection and copying upon execution in accordance with the requirements of Iowa Code Chapters 17A, 22 and 272C.

14. This Order is subject to approval of the Board. If the Board fails to approve this Order it shall be of no force or effect to either party.

15. The Board's approval of this Order shall constitute a **Final Order** of the Board.

Frank L. Lamp MD
Frank L. Lamp, M.D., Respondent

Stacy A. Fogt

NOTARIAL SEAL IOWA
STACY A. FOGT
Commission Number 709323
My Comm. Exp. 4-9-2016

Subscribed and sworn to before me on May 13, 2013.

Notary Public, State of Iowa.

This Order is approved by the Board on June 28, 2013.

Gregory B. Hoversten D.O.
Gregory B. Hoversten, D.O., Chairman
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686

BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

FRANK L. LAMP, M.D., RESPONDENT

FILE NOS. 02-10-557, 02-11-664

****

FINDINGS OF FACT, CONCLUSIONS OF LAW, DECISION AND ORDER

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On November 15, 2012, the Iowa Board of Medicine (Board) filed a Statement of Charges charging Frank L. Lamp, M.D. (Respondent) with five counts:

Count I: Professional Incompetency, in violation of Iowa Code sections 147.55(2); 148.6(2)(g) and (i), 272C.10(2) and 653 IAC 23.1(2)"a"-"f";

Count II: Inappropriate Prescribing, in violation of Iowa Code section 148.6(2)(i) and 653 IAC 23.1(7);

Count III: Improper Pain Management, in violation of Iowa Code section 148.6(2)(i) and 653 IAC 13.2;

Count IV: Violating the Laws and Rules Governing the Practice of Medicine, in violation of Iowa Code section 148.6(2)(c) and 653 IAC 23.1(10);

Count V: Unethical or Unprofessional Conduct, in violation of Iowa Code section 147.55(3), 148.2(g), 272C.10(3) and 653 IAC 23.1(4).

The hearing was held on March 21, 2013 before the following Board members: Joyce Vista-Wayne, M.D.; Michael Thompson, D.O.; Carole Frier, D.O.; Analisa Haberman, M.D.; Monsignor Frank Bognanno and Ann Gales, public members.

Respondent was represented by attorney Kevin D. Engels. Assistant Attorney General Theresa O'Connell Weeg represented the state. The hearing was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(l) and 653 IAC 25.18(12). The hearing was recorded by a certified court reporter. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing and was instructed to prepare a written decision for Board review, in accordance with their deliberations.

THE RECORD

The record includes the Notice of Hearing and Statement of Charges; Continuance Order; Amended Prehearing Conference Order; ALJ Ruling on Motion to Continue and Initial Prehearing Conference Scheduling Order; Amended Hearing Order; Respondent and State Witness Lists; Respondent and State Exhibit Lists; Respondent's Objections to State Exhibits, State Response, ALJ Order Overruling Respondent's Exhibits; ALJ Order Sustaining Respondent's Objection to State Exhibit 67; testimony of Joan Schuller, KP, James Machamer, SK, Tom Pattee, D.O.; Jeff Gronstal; DM; Respondent; State Exhibits 1-66 and Respondent Exhibits 1-7.

FINDINGS OF FACT

Licensing, Disciplinary, and Practice History

1. Respondent was initially issued Iowa medical license number 27191 on July 1, 1989. Respondent's medical license is active and will next expire on November 1, 2013. At all times relevant to this Decision and Order, Respondent was practicing family medicine in a solo practice in Grundy Center, Iowa. Respondent employed two nurses, a receptionist, and a billing clerk. (State Exhibit 8; Testimony of Respondent, Sara Hook, R.N.)

2. On March 19, 1997, Respondent and the Board entered into a Combined Statement of Charges and Informal Settlement. Respondent admitted that he was unable to practice medicine safely and skillfully due to substance abuse. Respondent's medical license was indefinitely suspended, and he agreed not to apply for reinstatement until he had successfully completed a Board-approved inpatient chemical dependency program. (State Exhibit 1)

Respondent completed a Board-approved inpatient chemical dependency treatment program on May 6, 1997. Following discharge, the treatment program recommended that Respondent refrain from using all mood altering substances and that he continue his attendance of Alcoholics Anonymous (AA) and Sexual Addicts Anonymous (SAA). Respondent was also referred for individual and group therapy for his mental health issues, which included post-traumatic stress disorder secondary to childhood sexual trauma, major depression, depersonalization, and codependency. (State Exhibit 2)

In March 1998, Respondent's therapist referred him for inpatient treatment for his sexual addiction and other mental health issues. On April 2, 1998, Respondent completed this inpatient treatment and was discharged with staff approval. His prognosis was listed as poor, however, because he declined to attend the recommended extended care program. Respondent explained that he was unable to afford the monthly cost of the extended care program and chose to resume treatment with his therapist and psychiatrist in Iowa. (State Exhibit 2)

3. The Board reinstated Respondent's medical license on August 23, 2000. The Board found that Respondent had been diagnosed with significant mental health disorders in the course of his treatment for substance abuse. The Board found that Respondent had been diligent in pursuing treatment for his mental health issues, appeared stable in his recovery, and had the support of his physician and therapist in seeking reinstatement. Respondent's license was placed on probation for a period of five years, subject to conditions relating to substance abuse and sexual addiction. In part, the initial probationary conditions included the following restrictions:

- Respondent shall not treat patients under the age of 15; and
- Respondent shall have a female chaperone present in the examination room when treating female patients.

(State Exhibit 2)

On January 18, 2001, the Board approved an Amended Order that removed the prohibition on treating patients under the age of 15 and modified the chaperone requirement to apply only when Respondent examined and treated patients under the age of eighteen. The Board approved chaperone was required to timely document his or her continuous physical presence in the medical record for each patient under age eighteen. (State Exhibit 3)

On July 27, 2001, the Board approved a Third Amended Order. The Third Amended Order required Respondent to have a female chaperone while treating all patients under the age of eighteen and required the supervising nurse to provide quarterly written reports to the Board verifying Respondent's compliance with the restrictions in the order. (State Exhibit 5) Respondent was discharged from probation effective August 23, 2005. (State Exhibit 6)

Allegations of Inappropriate Prescribing/Operating OTP Without A License

4. Opioid Treatment Programs (OTP) are highly regulated and must be licensed by the Iowa Department of Public Health (IDPH).[1] In October 2010, the IDPH notified the Board that it had received a formal complaint that Respondent was prescribing methadone in the treatment of opioid addicted patients without being licensed as an OTP. The IDPH reported that Respondent was treating five patients who had dropped out of a licensed OTP. Respondent was treating four of the patients with methadone and one of the patients with another narcotic. Respondent had admitted that he knew that these patients had been enrolled in an OTP prior to coming to him for treatment. Respondent advised the IDPH investigator that he was prescribing methadone for chronic pain and denied that he was prescribing methadone for drug treatment purposes. The IDPH asked the Board to provide an opinion as to whether Respondent's practices are acceptable. (Testimony of Jeff Gronstal; State Exhibits 25, 28-30)

5. Board Investigator James Machamer was assigned to investigate the complaint concerning Respondent's prescribing practices. Mr. Machamer conducted interviews and obtained written statements, patient treatment records, Respondent's narcotic dispensing records, and information from the Iowa Prescription Monitoring Program (PMP).[2] Mr. Machamer also prepared several investigative reports. Mr. Machamer's

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[1] See Iowa Code chapter 125 and 641 IAC 155.35. *"Opioid treatment"* means the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. This term encompasses detoxification treatment, short-term detoxification treatment, long-term detoxification treatment, maintenance treatment, comprehensive maintenance treatment, and interim maintenance treatment. *"Opioid treatment program"* or *"OTP"* means a program or practitioner engaged in opioid treatment or interim maintenance treatment. 641 IAC 155.35(1).

[2] The Prescription Monitoring Program (PMP) database is a centralized database of reportable controlled substance prescriptions (Schedule II, II, and IV) dispensed to patients by a pharmacy pursuant to a

initial focus was on the five patients (RB, SP, CB, JF, RS) identified in the complaint made to the IDPH. The investigation later expanded to include additional patients that Respondent was also treating with methadone. (Testimony of James Machamer; State Exhibits 21-24; 25-27; 37-41; 45-58)

6. Thomas Pattee, D.O. is the Medical Director for Cedar Valley Recovery Services (CVRS), an Opioid Treatment Program (OTP) with locations in Cedar Falls and Marion, Iowa. Dr. Pattee is also a family physician in private practice. Dr. Pattee filed the IDPH complaint against Respondent after learning that Respondent was treating former patients of the CVRS OTP with methadone, which is an opioid agonist treatment medication. (Testimony of Thomas Pattee, D.O.; State Exhibits 29-31)

As the CVRS Medical Director, Dr. Pattee is responsible for initial intake and for approving patients to enter the OTP. CVRS does not treat chronic pain and may only accept patients who have an opioid dependency, although there may be some question of overlap. Dr. Pattee acknowledged that physicians in private practice are permitted to prescribe methadone to treat chronic pain. In his own private practice, however, Dr. Pattee tends to minimize the use of opioids to treat chronic pain. Prior to accepting patients into the OTP or into his private practice, Dr. Pattee consults the PMP to review the patient's use of opioids and other narcotic pain medications. (Testimony of Thomas Pattee, D.O.; James Machamer; State Exhibits 25, 31)

The use of methadone in an OTP is strictly controlled by federal regulations. There is a thorough screening process, mandated starting doses, and required attendance at the treatment program. Patients are required to earn the right to take their methadone home with them. Dr. Pattee explained that methadone has a long half-life, accumulates slowly, and stays in the patient's system for a long time, which can lead to respiratory distress, particularly when combined with other medications. There is always a potential for overdose because even with an adequate and verified history of the patient's medications, it is difficult to determine the patient's tolerance level. For this reason, patients in the OTP may only be given an initial starting dose of 30 mg. An additional dose of 10 mg may be given only after the patient is observed in the clinic for a period of two hours and is still exhibiting signs and symptoms of withdrawal. There

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prescriber authorized prescription. The PMP was established by state statute and rule in 2009 for the collection and maintenance of PMP information and for the provision of that information to authorized individuals, including health care providers, for use in the treatment of their patients. 657 IAC 37.2; Iowa Code section 124.551-124.558.

is also a risk of drug diversion or taking more than the amount prescribed if the patient is given multiple doses of methadone to take home for later use and if the patient is not followed with drug screens. (Testimony of Thomas Pattee, D.O.)

Methadone is a relatively inexpensive medication. At an OTP, however, patients pay an all-inclusive program cost, which includes all of their medication, labs, counseling, and the administrative costs of the program. Services are provided on a per diem cash basis. Many of CVRS' clients are uninsured or undersinsured, and CVRS does not bill insurance companies. When patients fall behind in making payment they are given a short term window to catch up on payment. If they are unable to do so, the patient is given a tapered dose of methadone. Dr. Pattee had heard that the cost of obtaining methadone through the OTP may be as much as ten times the cost of filling a methadone prescription at a local pharmacy. Dr. Pattee believed that patients may have been leaving CVRS and seeking methadone from Respondent because of lower costs and because they were unhappy with the restrictions imposed on their methadone use at CVRS. (Testimony of Thomas Pattee, D.O.)

7. On June 16, 2011, the IDPH issued a notification to Respondent to Cease and Desist providing substance abuse treatment services. The IDPH's Notification to Cease and Desist was based on Respondent's treatment of the following five patients who left the CVRS OTP and sought treatment from Respondent:

a) RS was admitted to the CVRS on October 27, 2008. According to Dr. Pattee, RS presented to CVRS with a history of methamphetamine abuse, alcohol dependency, nicotine dependency and self-treatment with sedatives for withdrawal symptoms. He was five years post lumbar surgery and was using escalating amounts of Percocet and Oxycontin. RS had broken his contract with his previous provider. He had been evaluated and treated for possible depression. RS had not reported any chronic pain to CVRS. RS left CVRS on April 9, 2010. (Testimony of Thomas Pattee, D.O.; State Exhibit 37)

On April 7, 2010 (two days prior to leaving CVRS), Respondent gave RS a prescription for 240 tablets of methadone 10 mg, with instructions to take 8 tablets daily. Respondent's subjective note for that date states that RS "presents seeking a refill on Methadone, Alprazolam, and Prozac" and that "he does not have insurance and is looking for another doctor who will take him." The subjective note also states that RS had lumbar back surgery in 2002. Respondent's assessment for the patient states:

"Chronic pain syndrome." Respondent also noted that the patient had been getting his methadone at the methadone clinic in Cedar Falls and that the methadone was costing Respondent over $300 a month while it would cost $25 for the same prescription at the local pharmacy. Respondent further noted that he refilled the patient's methadone 80 mg and will see the patient back for monthly refills. (State Exhibit 57)

On August 18, 2010, Respondent increased the methadone dosage for RS to 10 tablets a day. After the Cease and Desist was issued on June 16, 2011, Respondent stopped prescribing methadone for RS. He gave RS a prescription for Vicodin for pain and withdrawal, along with Lorazepam. On July 5, 2011, Respondent prescribed MS Contin 30 mg, 1 p.o.t.i.d. #90 after RS reported that his pain control was not nearly as good with the Vicodin as it had been with the methadone. Respondent was still treating RS when the Board investigator interviewed him on August 24, 2011. (Testimony of Thomas Pattee, D.O.; Respondent; State Exhibits 34, 37, 38, 57, 58)

b) SP was admitted to CVRS on February 4, 2010. According to Dr. Pattee, SP had a history of three prior inpatient treatments but had always relapsed. SP reported no issues related to chronic pain and had no significant physical findings at CVRS. On or about April 13, 2010, someone called CVRS to report that SP had sold his take home methadone to a person who was hospitalized with an overdose. SP was questioned but only admitted giving a friend 5-10 mg of methadone. On April 14, 2010, SP was administratively discharged from CVRS after he brought in fake urine, admitted using Vicodin, and refused a urine test. (Testimony of Thomas Pattee; D.O.; State Exhibit 37)

Respondent saw SP as a patient on June 8, 2010. Respondent's subjective note for SP states, in part, that he:

- was recently enrolled in a methadone program in Cedar Falls for chronic pain syndrome but had to stop because it was too expensive;
- has a seizure disorder and chronic anxiety/panic attacks but could no longer afford his psychiatrist because he did not have insurance;
- started using Vicodin at age 16 due to chronic pain from motor vehicle accidents and has recently been in a treatment program;
- is requesting help today with methadone for chronic pain syndrome/musculoskeletal pain and Alprazalom for anxiety/panic attacks; and
- had his dad with him who notes that SP has been buying opiates off the street to deal with the pain or possibly to prevent withdrawal symptoms.

(State Exhibit 52) Respondent's assessment of the patient lists Anxiety, Seizure Disorder, and Opiate Dependence. The assessment also states that they spoke about opiate dependence for about 30 minutes, that SP was committed to stopping opiate abuse, and that Respondent was willing to prescribe methadone for chronic pain syndrome. Respondent notes that the methadone will be inexpensive for their limited income and that he would give the patient "the benefit of the doubt" and give him a prescription for methadone that day. SP's dad was in the room and agreed to manage SP's medications on a daily basis. Respondent further noted that the dad had no money so Respondent allowed them to put SP's medications on Respondent's charge account at the local pharmacy, and "they will pay the next month." On June 8, 2010 and again on July 8, 2010, Respondent gave SP a prescription for 240 tablets of 10mg methadone, 8 tablets daily. Respondent also prescribed Alprazalom 1mg for the patient's anxiety. Respondent reported that he last saw SP on July 10, 2010. (Testimony of Thomas Pattee, D.O.; Respondent; State Exhibits 37, 38, 52, 56)

At hearing, Respondent testified that SP was kicked out of the methadone clinic for inability to pay. Respondent testified that his "heart went out" to SP and his dad. Respondent testified that he prescribed methadone for chronic pain, although he knew that SP had a substance abuse problem. SP eventually stopped coming to Respondent for treatment. Respondent wrote off SP's entire bill and personally paid for SP's medications through his own account at the local pharmacy. Respondent called SP's dad and found out that SP had gone back on the streets. (Respondent testimony; State Exhibits 34, 38)

On October 27, 2010, SP was admitted to the hospital for opiate withdrawal after he had been using IV Morphine and other street drugs. A commitment order was obtained to send SP to inpatient treatment. (State Exhibit 55)

c) CB was admitted to CVRS on July 12, 2008 and was last treated by CVRS on June 15, 2009. CB was initially referred to CVRS by a court order. CB had a longstanding history of opioid abuse as well as a history of depression, traumatic life experiences, anxiety, and an unsuccessful suicide attempt. CB's physical examination at CVRS was described as "fairly nonfocal with the exception of some surgical scars on his left ankle and significant tooth decay." CB self-reported a history of lumbar fractures, bilateral ankle fractures and closed head injury. (State Exhibit 37; Testimony of Thomas Pattee, D.O.)

On June 17, 2010, Respondent gave CB a prescription for 270 tablets of 10 mg methadone, 9 per day. Respondent's subjective note for CB states that he has been taking methadone for chronic pain for the last 2 years, that an industrial accident in 1998 left him with severe back pain, that a botched hernia repair led to nerve damage and neuropathic pain, and that he also has pain from a severe left leg fracture 5 years earlier. CB reported that he had been getting his methadone at a Waterloo clinic but "is not taking it for prevention of withdrawal as much for pain." CB told Respondent that he wanted to get his medications from a regular pharmacy to decrease his financial outlay. Respondent's assessment of CB states "Chronic pain syndrome, "Refill Methadone," "Will follow him back appropriately in a month." After the Cease and Desist, Respondent stopped prescribing methadone for CB and prescribed Oxycodone, MS Contin, and Diazepam instead. (Testimony of Thomas Pattee, D.O.; Respondent; State Exhibits 34, 37, 47, 48)

d) JF was initially admitted to CVRS on February 22, 2008 and was re-admitted on November 17, 2009, with his last treatment on June 16, 2010. JF had reported a history of IV oxycontin and heroin use, alcoholism, and OWIs. JF did not complain of chronic pain. (Testimony of Thomas Pattee, D.O.; State Exhibit 37)

On June 9, 2010, Respondent wrote JF a prescription for 300 tablets of 10 mg methadone, 10 per day. Respondent's subjective note states that JF reported taking 100 mg Methadone daily since November 2009 for chronic pain syndrome and reported that he started using Vicodin in his teens to treat pain from severe ankle injuries suffered in motor vehicle accident. JF also reported taking medication for Bipolar Disorder and ADHD in the past. Respondent's last methadone prescription for JF was issued on May 2, 2011, with two refills. This was before Cease and Desist was issued. JF refilled the May 2, 2011 prescription after the IDPH issued its Notification to Cease and Desist. Respondent saw JF again on July 29, 2011 but refused to refill his methadone prescription. (Testimony of Thomas Pattee, D.O.; Respondent; State Exhibits 37, 38, 49-51: Respondent Exhibit 6)

e) RB was admitted to CVRS on July 11, 2008 after a three week incarceration. RB admitted years of methamphetamine, sedative, and marijuana use. RB also admitted multiple previous treatments, prior outpatient services through CVRS, a history of Bipolar Disorder, multiple psychiatric hospitalizations, and possible ADHD. RB was on disability. RB had no documented, known chronic pain issues at CVRS although he reported having had hip and knee discomfort, with no specific diagnosis.

While at CVRS, RB was under psychiatric care and receiving psychiatric medications. At hearing, Dr. Pattee explained that when a patient is being treated for opiate dependency and also has a co-morbid psychiatric condition like Bipolar Disorder, it is essential to treat both of the patient's diagnoses or the likelihood of successful treatment of either condition is substantially diminished. CVRS coordinates its services with the physicians who are treating the same patient for their co-morbid conditions. RB was last treated at CVRS on June 21, 2010. (Testimony of Thomas Pattee, D.O.; State Exhibit 37)

On June 22, 2010, Respondent prescribed 120 tablets of 10 mg methadone, 8 per day for RB. Respondent's subjective note for RB indicates that RB reported a history of two motor vehicle accidents and compression fractures in his back from falling out of a tree. RB requested a prescription for pain medications and told Respondent that he had been on methadone several times for chronic pain with good effect. Respondent documents that RB has a history using street drugs and "injecting" but his veins are shot. Respondent does not document RB's current use of medications or any information from the PMP. Respondent did not request a urinalysis. Respondent's assessment of RB was "**Chronic pain syndrome**. I'm going to prescribe Methadone for him. After talking with him about dosing, I'm going to start with 80 mg a day but I've cautioned him to start with 10 mg and in four hours double it, and 4 hours later add 20 more etc. to make certain he is able to tolerate that dose. We'll see him back in 2 weeks. He has agreed to drug test if we ask him to."(State Exhibit 45)

Respondent testified that this was the only time that he provided treatment to RB. After his first appointment, RB made a few phone calls to Respondent that made it clear he was a drug seeker rather than a chronic pain patient. Respondent declined to see RB anymore. (Testimony of Thomas Pattee, D.O.; Respondent; State Exhibits 34, 37, 38, 45-46)

8. The record also includes documentation of Respondent's treatment of several additional patients, including two more patients who received methadone prescriptions from Respondent after they left the methadone treatment program at CVRS. (State Exhibits 25, 26, 40; Testimony of Thomas Pattee, D.O.; Respondent; DM)

a) DM was first seen at CVRS in January 2007 following a court committal for chemical dependency evaluation. DM was Respondent's patient and had been receiving Oxycodone, 360 mg, which was being tapered. DM also reported prior treatment by another physician for back pain and also reported having gastric bypass

surgery and losing significant weight. CVRS started DM on methadone. Dr. Pattee advised Respondent that he recommended no short-acting opioids and a comprehensive pain evaluation for DM. DM was still involved with CVRS in January 2008, and it is unclear when he left CVRS. (Testimony of Thomas Pattee, D.O.; State Exhibit 40)

On February 25, 2009, Respondent prescribed 210 tablets of 10 mg methadone, 7 per day for DM. Respondent's subjective note on that date states, in part, that DM presented with several problems, including stomach pain off and on over the last couple of months with intermittent vomiting and black, tarry stools for two weeks. The subjective note also indicates that RB reported that he had been receiving a stable dose of methadone, 65 mg a day, for over a year from a doctor in Waterloo. RB reported he was taking the methadone for chronic pain and that he recently attempted to go down to 60 mg but the pain was such that he had to go back to 65 mg. DM reported a surgical history of gastric bypass, three laminectomies, and a right ankle tendon repair. DM also reported that he had been in a treatment program for opiate dependence in December 2006 and in methadone treatment in January 2007. DM also reported depression. Respondent's assessment for DM states: **Chronic pain syndrome.** I have agreed to prescribe his Methadone for him at 6.5-10 mg tablets daily." Respondent also referred DM for an EGD and gave him Prilosec and Nexium. Respondent did not perform an abdominal or rectal exam. (State Exhibit 59, pp. 358-359; Respondent testimony)

DM testified at hearing and reported that Respondent is treating him for back pain that he suffers as a result of back surgeries. As of the date of the hearing, Respondent continues to prescribe methadone for DM. His current dose is 10 mg methadone, 3 tablets a day. DM testified that methadone has provided him with pain relief, without the side effects he experienced when taking other narcotics. DM also testified that in the past he has tried injections, physical therapy, exercise, and a pain clinic. (Testimony of DM; State Exhibits 26, 40, 59, 60)

b) AG was admitted to the CVRS in March 2010. She had a 25 year history of using opioids, as well as generalized anxiety disorder, poly-substance abuse, and possible hyper-pain syndrome postop knee and hip replacement. CVRS initiated AG on methadone treatment for substance use disorder. AG's last treatment at CVRS was in August 2010, and she started receiving methadone from Respondent in September 2010. The Board was not provided any medical records for AG. (Testimony of Thomas Pattee, D.O.; State Exhibit 40)

c) RR was admitted to CVRS on July 7, 2009. RR had a 20 year history of using intravenous opioids, with morphine as her drug of choice. RR admitted cocaine, methamphetamine, and sedative use within the past six months. RR did not follow up with CVRS following a court hearing in March 2010. (Testimony of Thomas Pattee, D.O.; State Exhibit 40)

Respondent started prescribing methadone for RR on June 22, 2010. Respondent's subjective note for the patient states "she would like to get a prescription for Methadone for chronic pain and cluster headaches." RR reported that another physician had started her on methadone about 14 years earlier for cluster headaches and that she has had "2 rather progressive surgeries for cluster headaches with only minimal success." RR reported that she was on disability due to her crippling headaches. RR admitted a history of marijuana, morphine, and methamphetamine use. Respondent's assessment of RR was "Chronic pain syndrome. I will prescribe Methadone for this young woman. We'll see her back in a month. She has agreed to drug testing if I ask her." Respondent's plan of treatment was for methadone 10mg, 8 tablets daily #240. Respondent continued to prescribe this same dose of methadone for RR through March 8, 2011. (State Exhibits 61-62)

Respondent reports that he fired RR as a patient on April 7, 2011 after a drug screen came back as positive for methamphetamine, benzodiazepenes, and methadone. He provided her one last prescription of methadone with an eight day supply. (Respondent testimony; State Exhibit 38)

d) Respondent started treating AA with methadone on June 14, 2010. Respondent's subjective note states that AA "is a 31 year old who presents in tears today noting she has been using opiates essentially since about age 18 when she starting taking them for pain suffered from motor vehicle accidents." AA reported that she had been in drug treatment the prior year but relapsed. AA told Respondent that she wants to stop using opiates and get on a regular methadone dose and get her life together. She had previously taken methadone that she obtained on the street. AA reported chronic pain in her low back, back and neck from a severe whiplash injury. She reported that she had tried multiple NSAIDs, heat, massage, muscle relaxants but the only medications that work for her are opiates.

Respondent's assessment of AA states, in part:

> **Chronic pain syndrome**. My heart goes out to this young woman. I believe she is truly interested in getting her life together. I'm going to start her on Methadone and we'll do it as follows: She's going to take Methadone 10 mg tablets, initially start with 2, then 6 hours later if she's having cravings, she'll take 2 more and 6 hours later, she'll take 2 more until we get an idea of how much Methadone per day it will take to prevent cravings.
>
> I will give her 40- 10 mg tablets. I have cautioned her very carefully that she can hurt herself with Methadone if she overdoses…I'm figuring it will probably take about 60-80 mg per day to help her not be sick with withdrawal….
>
> She has agreed to random drug testing and has agreed to only get controlled substances from my office. She understands that I will check her compliance on the Iowa Pharmacy Board PMP program.

On June 18, 2010, Respondent saw AA again and his subjective note states that she used the methadone as directed and the 80 mg per day dose was about the right dose. Respondent gave AA a prescription for 10 mg methadone, 8 tablets daily, #240. Respondent provided the same prescription to AA from July–October 2010. On November 16, 2010, Respondent gave AA a prescription for 10 mg methadone, 8 tablets daily#248 with two refills. On February 10, 2011, Respondent gave AA a prescription for 10 mg methadone, 8 tablets daily#248 with one refill. Respondent continued to prescribe methadone for AA through at least August 10, 2011. (State Exhibits 63, 44)

Dr. Thomas Pattee testified that, in his opinion, Respondent's assessment of AA indicates that he is treating her for opiate withdrawal, not for chronic pain. Dr. Pattee described Respondent's treatment plan for the patient as "quite reckless." (Testimony of Thomas Pattee, D.O.)

Respondent testified that he thought he was prescribing correctly and "did not know any better. " In medical school he received no training in prescribing narcotics. Respondent is no longer seeing this patient. Respondent did not believe that his methadone prescriptions for AA after June 16, 2011 violated the Cease and Desist Order

because AA was not one of the five patients identified to him by IDPH in connection with the Cease and Desist. (Respondent testimony)

9. The Board asked a peer review committee (committee), which consisted of two Iowa licensed family practice physicians, to review Respondent's care of 16 patients, including the 5 patients identified in the initial complaint to IDPH. The committee issued its written report on September 28, 2012. In its report, the committee stated its belief that Respondent was "caring and had good intentions" for his patients. Nevertheless, the committee concluded that Respondent's prescriptions of methadone for 5 patients (RB, CB, SP, RS, and AA) failed to conform to the minimum standard of care for physicians in Iowa. Specifically, the committee found that Respondent "failed to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician in Iowa acting in the same or similar circumstances." (State Exhibit 44)

The committee explained that when prescribing methadone to treat chronic pain in patients who have been in an OTP or who are seeking methadone for pain complaints:

- It was Respondent's responsibility to document the existence, location, and severity of the pain in the individual medical records at both the initial evaluation and at subsequent visits. Respondent failed to adequately document the diagnoses and etiologies of chronic pain through current evaluations or through review of prior assessments;
- A prudent physician would obtain previous medical records with results of diagnostic tests and treatments to confirm the history and truthfulness of patients. Respondent should have confirmed justification for his initial methadone dosing by reviewing the patient's medical records. There were several cases where Respondent prescribed relatively high doses of methadone at the initial visit, which could have had disastrous consequences if the patient was taking lower doses of methadone than claimed;
- Respondent either knew or should have known that the patients taking methadone had been receiving medication from an Opiate Treatment Program (OTP). Many of the methadone patients acknowledged a prior or current history of illicit drug use, which is an indication of potential abuse or diversion. However, Respondent did not routinely obtain drug screens at his initial encounter with these patients and seldom documented any review of the patients' PMP at initial or follow up visits. A physician would be expected to

periodically review the patients' PMP. Methadone dispensed by an OTP does not appear on the PMP, which may also impact the prescribing physician's decision making process;

- None of Respondent's medical charts reflect an attempt by Respondent to wean the patient to the lowest effective dose. The committee was concerned that Respondent's escalation of methadone for RB and AA reflected a pattern of use that was consistent with using methadone for addiction treatment;
- The FDA approved labeling for methadone does not mention a contraindication with regards to the concomitant use of benzodiazepines. However, a prudent physician would monitor these patients closely and add a non-benzodiazepine such as an SSRI for the treatment of anxiety. Respondent's drug of choice for patients with anxiety is Alprazalom, which has a particularly high abuse potential among the benzodiazepines.

(State Exhibits 42-44, 45-48, 52-58, 63-64)

The peer review committee also identified "concerns" with respect to Respondent's care of the following patients:

- For DM, Respondent's record fails to state any information regarding the previous prescriber and fails to specify the location or details of the patient's pain. There is no record of prior evaluations or of Respondent checking the PMP; and
- For RR, there was no attempt to identify or obtain records from previous providers, the PMP was not checked, and there was no drug screen at the initial visit. When RR had a positive drug screen for abuse of methamphetamine on 4/7/11, she was appropriately given one last methadone prescription with a tapering dose schedule.

(State Exhibits 44, 59-62)

Respondent does not dispute the peer review committee's conclusions, with one exception. Respondent disputed the conclusion that he violated the IDPH Cease and Desist Order by prescribing methadone for JF and AA. (Respondent testimony)

10. Respondent was criminally charged in Grundy County District Court with three counts related to allegations that he operated an Opioid Treatment Program without a license and that he violated the IDPH Cease and Desist Order. Respondent's trial was scheduled to commence on March 14, 2013. On March 18, 2013, an Order was entered dismissing one of the charges at the state's request. Also on March 18, 2013, an Order was entered dismissing the remaining two counts on Respondent's motion for acquittal. According to Respondent, the state moved to dismiss the charges in the first case because he had shown that he did not prescribe methadone for JF after the Cease and Desist Notification was issued. Respondent testified that charges were dismissed in the other two cases because the court determined that he fell within the physician in private practice exception to Iowa Code chapter 125. The court's orders do not specify the reasons for the dismissals. (Testimony of Respondent; Respondent Exhibit 5)

11. Respondent denies prescribing methadone for the purpose of treating patients for their opiate addiction. Respondent maintains that all of the methadone that he prescribed was for the treatment of chronic pain. Respondent admits that he had no training whatsoever in prescribing narcotics prior to 2011, when he was required to complete continuing medical education in chronic pain management in order to renew his license. On February 7, 2012, Respondent was awarded 7.25 credits for completing a continuing medical educational activity entitled: "Responsible Opioid Prescribing: A Physician's Guide." Respondent testified that this opened his eyes to a more appropriate way to prescribe opiates. Respondent also reported completing 14 online courses through Medscape and doing a lot of extra reading on opiates, especially methadone, since renewing his license in 2011. Respondent reports that from June to November 2012 he issued 25% fewer narcotic prescriptions than he issued from June to November 2011. Respondent testified that he no longer prescribes methadone as a first choice and now prescribes slower, more cautious doses due to methadone's potentially lethal consequences. (Testimony of Respondent; Respondent Exhibit 4)

Respondent agrees that he did not obtain sufficient prior medical records for patients before prescribing methadone for chronic pain. He further agrees that he should not have accepted at face value what patients told him. Respondent defended his actions, at least in part, by pointing out that many of his patients were uninsured or under insured and could not afford MRIs, CT scans, or pain clinics. He stated that when there is no money and no insurance, sometimes the only appropriate treatment is to relieve pain and suffering to allow a patient not to miss work and to function in their daily lives. (Testimony of Respondent; Respondent Exhibit 4)

Respondent submitted a number of letters of support from patients as well as a 12 page petition of support signed by his patients. (Respondent Exhibits 2-3) He also submitted records for several patients that he refused to treat with methadone because he determined that they were seeking opioid treatment rather than treatment for chronic pain. (Respondent testimony; Respondent Exhibit 4)

Allegations of Inappropriate Examination of a 17 year old Female Patient

12. On or about November 11, 2011, KP told her high school health teacher that Respondent had given her a breast and pelvic examination that made her feel uncomfortable. KP's report was prompted by the teacher's lecture about what students should expect during a standard physical examination. KP reported that the breast exam went on longer than necessary and that the whole experience felt "creepy." The teacher knew about Respondent's disciplinary history, and she encouraged KP to file a complaint with the Board. The teacher showed KP the Board's website and printed out the information on the website about Respondent's past discipline. The teacher spoke to the student's mother, who was hesitant to file a complaint but told the teacher that they would not be returning to Respondent. The teacher later notified the Grundy County Attorney, the Department of Human Services, and the Board of KP's report to her. (Testimony of JS; KP; James Machamer; State Exhibits 8-12)

The teacher's report was referred to Board Investigator James Machamer for investigation. Mr. Machamer prepared an investigative report and a Supplemental Investigative Report. Mr. Machamer spoke to KP's health teacher, a Grundy Center police officer, KP, KP's mother, SK, and Respondent. Mr. Machamer also obtained copies of KP's medical records from the Grundy County Hospital and from Respondent's office. Later, Mr. Machamer re-interviewed KP and also interviewed Respondent's nurse. (State Exhibits 8-20; 66Testimony of James Machamer)

13. Respondent treated KP on just two occasions, once in the emergency room and once at his office. On July 30, 2011, KP went to the Grundy County Hospital Emergency Room for treatment of a foot laceration that she received on a river tubing trip with her mother and SK (who was initially identified as a family friend). KP testified that she also told Respondent that she was having pain in her right side and asked him if he had any suggestions for her. (Testimony of KP; Respondent; James Machamer; State Exhibits 8, 13)

KP's mother and SK were both present with KP while Respondent sutured KP's foot. During this emergency room visit, Respondent asked KP if she smoked and if she drank alcohol. KP admitted that she did. Respondent also asked KP about her sexual activity and her use of condoms. During their investigative interviews, KP and SK both told James Machamer that Respondent lectured KP on how long sperm can live in the body. KP, KP's mother, and SK all found Respondent's comments about sexual activity and sperm to be weird/odd and out of place, although none of them said anything to Respondent at the time. (KP, SK, James Machamer testimony; State Exhibits 8, 18)

At hearing, Respondent testified that he gives a "public service announcement" to all of the teenagers that he treats. In addition to sexual issues, Respondent's "public service announcement" covers tobacco, alcohol, and seat belt use. Respondent testified that he tells all teenagers that there is "1 egg among 500 million sperm per ejaculate" and that they should wear condoms and not trust birth control pills. Respondent further testified that every single teenage girl in America needs to know that sperm swim out of the fallopian tube and all over the abdominal cavity. Respondent admits he gave KP his "public service announcement" in the emergency room but testified that he spent more time on tobacco and alcohol than sexual matters because KP was a smoker and because he believed she had been drinking beer that day. Respondent's record of KP's emergency room visit does not include any documentation that he gave KP a public service announcement. (Respondent testimony; State Exhibits 13, 20)

In the medical record, Respondent documented that KP had a laceration of her left foot, laceration of her left third toe, and right hip pain. He documented that KP was to have her sutures out at his office on August 10th. He also documented that he gave KP a prescription for 50 tablets of Vicodin 5/500, 1 or 2 every four hours, prn for pain. (State Exhibit 13)

14. On Saturday, August 6, 2011, KP went to the Grundy County Hospital Emergency Room complaining of a generalized abdominal pain that started five days earlier. In the previous two days, the pain had increased and was concentrated in the right upper quadrant. KP described the pain as "sharp, colicky" pain that took her breath away. KP reported that she had been taking Vicodin, as needed. The hospital called KP's mother for consent to treat her. The emergency room record indicates that the attending physician considered the following as possible causes of her pain: appendicitis, cholecystitis (inflammation of the gall bladder), or the Vicodin that she was taking for her foot laceration. The attending physician ordered a CT scan of KP's

abdomen and pelvis, urinalysis (HCG), and blood tests, all of which were normal. The attending physician recommended clear liquids and bed rest. KP was also advised to take Miralax and Prilosec OTC and to follow up with Respondent on Monday. (State Exhibit 14)

Respondent was listed on the emergency room record as KP's primary physician, although she had only seen Respondent on one occasion. At hearing, KP explained that her family had recently moved, and she did not have a family physician at this time. (State Exhibit 14; Testimony of KP)

15. On August 10, 2011, KP went to Respondent's office by herself for the scheduled appointment to have her sutures removed. KP was 17 years old at the time of this appointment. Respondent's clinical record for the visit states:

> [KP] presents for suture removal from the ER. She is also requesting help with what she calls "right hip pain" but it turns out to be right low abdominal/suprapubic pain. She also has right upper quadrant pain, and actually had a CT scan in the ER recently with no definitive diagnosis reached. The ER doctor did not do a pelvic exam...She has had a PAP smear in the past, and was on birth control pills in the past but not recently. She is sexually active, and uses condoms 100% of the time.

KP told the Board's investigator that she had a history of cervical cancer and had pelvic examinations every three months during and after the treatments. (State Exhibit 8, p. 33) At hearing, KP recalled that she told Respondent about having had an abnormal PAP smear and that she had to have a PAP smear every three months. KP testified that she discontinued the regular PAP smears after she moved. (KP testimony)

Respondent did not document KP's history of abnormal PAP smears or the date of her last PAP smear in his clinical note of the visit. (State Exhibit 15; Respondent Exhibit 7) When he was interviewed on December 12, 2011, Respondent did not know when KP had her last gynecological exam and he did not mention her abnormal PAP smear. (State Exhibit 20) In a letter to the Board dated February 12, 2013 and in his testimony at hearing, Respondent stated that KP told him that she had an abnormal PAP smear, cervical dysplasia, and a cone procedure. Respondent further testified that he asked KP when she had her last PAP smear and she told him that it had been over a year. (Respondent testimony; State Exhibit 15; Respondent Exhibit 4)

Respondent testified that he suspected that KP had a pelvic infection. With her history, he decided that he should perform a complete "well woman" examination, including a 100% skin cancer screening, breast exam, pelvic exam, and PAP smear. Respondent testified that he does not use a chaperone for breast exams because that was how he was trained in residency. Respondent testified that KP's breast exam was one minute or less on both sides and was normal. (Testimony of Respondent; Respondent Exhibit 4)

Respondent's clinical note documents that he:

- performed a breast exam, pelvic exam, and PAP smear;
- did not do a full formal derm exam but what skin was seen during the limited exam appeared normal;
- believed KP had Fitz-Hugh Curtis syndrome[3] and cervicitis;
- decided to treat KP with an intramuscular injection of Rocephin and a prescription for Azithromycin; and
- addressed the usual public service announcement including tobacco, seat belts, alcohol, and sexuality.

Respondent did not document any vital signs for KP, did not take any cultures, and did not order any blood work. Respondent testified that cultures and blood work were not necessary because KP obviously had cervicitis and either chlamydia or gonorrhea. Respondent testified that KP had incredible cervical tenderness and winced and cried out when during his bi-manual examination. However, neither KP nor Respondent's nurse, Sara Hook, recalled that the pelvic examination had been painful for KP. (Testimony of KP, Sara Hook, R.N.; Respondent; State Exhibit 15, pp. 57-58; Respondent Exhibit 7)

Respondent testified that he treated KP with the Rocephin injection and oral antibiotics and then made arrangements for her sexual partner to come in and be treated. Respondent could not recall when he got the name of KP's sexual partner but believes it was at the time of her examination. (State Exhibit 15, pp. 57-58; Respondent Exhibit 7; Testimony of Respondent)

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[3] In his letter to the Board, Respondent explained that Fitz-Hugh Curtis syndrome is a chlamydia infection that causes local pain in the pelvis and distant pain in the upper right quadrant by infecting the liver capsule. (Respondent Exhibit 4)

KP recalled Respondent telling her that he thought she had a sexually transmitted disease, probably chlamydia or gonorrhea, but KP did not recall ever being told that she had Fitz-Hugh Curtis syndrome. (KP testimony)

16. In her initial interview with the Board's investigator on November 29, 2011, KP reported that:

- a nurse was not present in the room when Respondent performed the breast exam, pelvic exam, and PAP smear;
- she felt like the breast exam was "intense," went on "much too long" and seemed like it "lasted forever." KP estimated that the breast exam took 5-6 minutes;
- Respondent left the room after the breast exam to get the items he needed for the pelvic exam and PAP smear;
- During the pelvic examination, Respondent commented "you have a nice looking Pandora." This comment surprised her and made her very uncomfortable, but she did not say anything to him;
- After the pelvic exam, Respondent left the room while KP got dressed. Respondent later returned to the room to give her an injection in the buttocks and to write a prescription for additional medication;
- When she went home, she did a "Google" search of the word "Pandora" and found out it could be used to describe female body parts;
- She told her mother what occurred and tried to "laugh it off," but she was unable to get past the comment.

(State Exhibit 8; Testimony of James Machamer)

In his February 12, 2013 letter to the Board, Respondent states that his nurse, Sara Hook, was in the room for KP's entire pelvic examination and that he may have told KP that she had a "normal perineum." (Respondent Exhibit 4) James Machamer re-interviewed KP on April 2, 2012, and she did not think that she could have misheard the comment "normal perineum" as "nice Pandora." KP could not recall anyone else in the room with her during the breast or pelvic exam. She told Mr. Machamer that if someone else had been in the room she might not have been as uncomfortable with Respondent. KP described the breast exam in detail and testified that after examining her right breast with both hands, Respondent moved his right hand to her left breast and simultaneously held both breasts at the same time before moving both hands to the

left breast. KP told Mr. Machamer that following this experience with Respondent, she has problems trusting doctors and has been reluctant to see a doctor when it has been necessary. (State Exhibit 66; Testimony of James Machamer)

17. KP's testimony at hearing was not entirely consistent with her prior interview. KP testified, in part, that:

- the breast exam took too long and seemed like forever. When switching from her right to left breast Respondent had his hands on both breasts at the same time, which had never happened in her prior breast exams. When asked for an estimate of how long the breast exam took, she replied no more than 5 minutes and no less than 1 minute, probably between 1 and 5 minutes;
- a nurse gave her the gown to change into for the pelvic exam;
- she didn't remember if a nurse had been in the room with her during the pelvic exam. KP testified that there was no nurse present for the breast exam and she was "pretty sure" but not positive that there was no nurse for the pelvic exam;
- the nurse was in and out of the room so much that it was possible the nurse was there for the pelvic exam and KP did not realize it because she was so preoccupied;
- she felt that if a nurse had been present she would have spoken up if she heard Respondent tell her that she had a "nice-looking Pandora;"
- the word "Pandora" stuck in her head and she could not imagine a physician telling her she had a "nice-looking" anything. She googled "Pandora" when she got home and found out it was originally a Greek word for female parts. She told her mom and they kind of laughed it off;
- she never heard the word "perineum" before and did not think that Respondent said "perineum" rather than "Pandora."

KP testified that she was in a sexual relationship with SK, who was much older. Her mother did not know about the relationship at the time of KP's appointment with Respondent. Sometime after her appointment, KP told SK that he should probably get checked by a doctor. (Testimony of KP)

18. Although he admits rarely using a chaperone for breast exams, Respondent has consistently maintained that he always has a nurse present for pelvic exams. Respondent was certain that his nurse was present for KP's pelvic examination and PAP smear. (State Exhibits 15, 20; Respondent Exhibit 4; Testimony of Respondent)

Sara Hook, R.N. has worked for Respondent for two years. Ms. Hook testified that either she or another nurse is always present when Respondent performs a pelvic examination, but they do not document their presence in the patient record. Ms. Hook described Respondent's routine for pelvic examinations, including his usual comments to patients. She testified that Respondent leaves the room while the patient undresses. She usually gets the supplies for the pelvic exam and PAP smear if the room was not previously set up for these procedures. Ms. Hook stands on Respondent's left side where the patient should be able to see her. Respondent would sometimes comment to a patient that they have a "normal looking perineum" or a "perfectly normal looking perineum." Ms. Hook testified that she has never heard Respondent use the word "Pandora." Ms. Hook denied that Respondent ever told her what to say to the Board's investigator or in her testimony at hearing.[4] (Testimony of Sara Hook, R.N.)

Ms. Hook also testified that:

- she remembered that KP complained of pelvic pain when she came in for removal of her sutures;
- she would have taken KP to the examination room but would not have stayed with KP for the entire appointment;
- she would have re-entered the room for the pelvic examination and would have left afterward;

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[4] James Machamer interviewed Respondent at his office on December 12, 2011. Mr. Machamer questioned Respondent about his use of a chaperone during pelvic examinations, and Respondent told him "Every single time without exception." According to Mr. Machamer, Respondent suddenly rose from his chair and stepped out into the hall, closing the door behind him. Respondent spoke to a female that Mr. Machamer could not see, who Respondent later identified as his nurse. Respondent reentered his office, stating "That's what I thought too, okay, thanks." Respondent then offered to bring his nurse in to speak to Mr. Machamer. Mr. Machamer believed that Respondent wanted his nurse to verify that she was present for KP's exam. Mr. Machamer did not speak to Respondent's nurse at that time because he felt the nurse was "tainted" by Respondent's inquiry. (State Exhibit 20; Testimony of James Machamer) On December 14, 2011, Respondent sent the Board a complaint concerning Mr. Machamer's conduct during the interview. (Respondent Exhibit 4). On April 2, 2012, Mr. Machamer conducted a telephone interview of Respondent's nurse, Sara Hook. Ms. Hook admitted that she spoke to the Respondent in the hallway the day of his interview by Mr. Machamer. Ms. Hook told Machamer that Respondent asked her "about a patient or significant other-no a patient." Ms. Hook recalled that Respondent asked her for KP's name. Ms. Hook told Machamer that she was prompted to come down the hallway because Respondent called her on his office intercom. (State Exhibit 66; Machamer testimony) At hearing, Ms. Hook testified that Respondent asked her if she remembered the name of KP's significant other, and told him it was SK. Ms. Hook had never met KP before she was treated by Respondent but she knew SK because he was a friend of her brother's. (Testimony of Sara Hook, R.N.)

- she would have given KP the Rocephin injection;
- she remembered being present in the room during KP's pelvic examination and PAP smear, but did not recall the procedures being painful for KP or KP vocalizing any pain;
- Respondent did not say anything to KP that caused her any concern;
- Respondent's office does not have a policy on chaperones being present for breast exams. Respondent sometimes asks her to be present for a breast exam if he is uncomfortable being alone with the patient for some reason. She provided the specific example of a breast examination for an adolescent patient.

(Testimony of Sara Hook, R.N.)

19. By the time she was interviewed on November 29, 2011, KP's mother had learned of KP's sexual relationship with SK. KP's mother told James Machamer that SK had his own appointment with Respondent and that Respondent "bragged this man up and down; lucky to have scored a 17 year old girl." (Testimony of James Machamer; State Exhibit 8)

James Machamer interviewed SK, and SK also testified at hearing. In his interview, SK told Machamer that he went to see Respondent for other medical issues and his relationship with KP was divulged. SK told Machamer that Respondent in effect told him how lucky he was to be dating a younger girl. This surprised SK because everyone else who knew about his relationship with KP disapproved of it. SK thought Respondent's comments were out of place but "no big deal." (Testimony of James Machamer; SK; State Exhibit 18)

At hearing, SK denied that KP ever told him that Respondent had treated her for a sexually transmitted disease. SK testified that he went to see Respondent because KP told him that she would "like to know that he didn't have anything." SK testified that Respondent commented to him on his age and asked him how someone who looked like him could get someone who looks that good? This was the only time that SK went to Respondent for medical treatment. (SK testimony)

Respondent's treatment records indicate that Respondent treated SK on August 31, 2011, which was approximately 20 days after KP's final appointment with Respondent.[5] SK was 44 years old at the time of this appointment. Respondent's clinical note for the appointment states, in pertinent part, that SK reports "he has recently become sexually active with a 17 year old girlfriend. Her previous partner exposed her to STDs, and she developed pelvic inflammatory disease. He wants to be 'tested' for STDs." Respondent's assessment states: "I am going to treat him with a gram of Rocephin and 7 days of 500 mg Azithromycin. This should take care of any exposure similar to what his girlfriend was treated with just recently." Respondent denies making any inappropriate comment to SK concerning his relationship with KP. (Respondent testimony; State Exhibit 20; Respondent Exhibit 4 (section 3b))

20. KP continued to have pain in the right side of her abdomen after Respondent treated her for a sexually transmitted disease. KP had her gall bladder removed in June 2012. KP was advised that she had gallstones and that her gall bladder had only been functioning at 6%, thereby causing an infection of her liver. (KP testimony)

CONCLUSIONS OF LAW

Count I: Professional Incompetency

Iowa Code section 147.55(2) provides that a license to practice a profession shall be revoked or suspended when the licensee is guilty of professional incompetency. Iowa Code section 272C.10(2) provides that a licensing board shall by rule include provisions for the revocation or suspension of a license for professional incompetency.

Iowa Code section 148.6 provides in relevant part:

> **148.6 Revocation.**
>
> 2. Pursuant to this section, the board of medical examiners may discipline a licensee who is guilty of any of the following acts or offenses:
> ...

[5] SK has consistently reported that his appointment with Respondent occurred after KP's trip to the emergency room but before KP's gynecological examination. This is clearly incorrect. (Testimony of SK; State Exhibit 18)

g. Being guilty of a willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery, osteopathic medicine and surgery, or osteopathy in which proceeding actual injury to a patient need not be established;...

...

i. Willful or repeated violation of lawful rule or regulation adopted by the board...

653 IAC 23.1(2) provides in relevant part:

653-12.4(272C) Grounds for discipline. ...The board may impose any of the disciplinary sanctions set forth in 653-subrule 25.25(1), including civil penalties in an amount not to exceed $10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

...

12.4(2) Professional incompetency. Professional incompetency includes but is not limited to:

a. Willful or repeated gross malpractice;

b. Willful or gross negligence;

c. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;

d. A substantial deviation by the physician from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;

e. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances.

f. A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine

and surgery, osteopathic medicine and surgery, or osteopathy in the state of Iowa.

The preponderance of the evidence established that Respondent violated Iowa Code sections 147.55(2), 148.6(2)(g) and (i), 272C.10(2) and 653 IAC 23.1(2)"c" –"f" when he repeatedly prescribed methadone at relatively high doses for multiple patients, ostensibly for the treatment of their chronic pain, without properly establishing the diagnoses and etiologies of the pain, either through current evaluations and examinations or by reviewing prior assessments and medical records. Respondent's records for the patients are wholly inadequate to establish that the patients in fact suffered chronic pain and that it was appropriate to treat the pain with the dosages of methadone that he routinely prescribed. Respondent contends that most of these patients were unable to afford expensive diagnostic procedures or pain clinic evaluations. Even if that was true, this does not excuse Respondent's failure to obtain the patient's prior medical records to verify their medical history and past use of medications. Moreover, Respondent never documented that he advised the patients of the importance of diagnostic evaluations but that the patients refused them because they could not afford them.

As more fully discussed under Count III, Respondent failed to properly evaluate the patients that he was purportedly treating for chronic pain and failed to develop and document proper treatment plans for the patients. The patients' admitted histories of prior drug abuse and/or drug treatment put them at increased risk for overdose and for drug diversion. Respondent failed to take appropriate steps to objectively verify what other medications or drugs, prescribed or otherwise, these patients were taking. Although he knew that several of these patients had recently left an OTP, he made no effort to verify the levels of methadone that they had in fact been receiving.

Count II: Inappropriate Prescribing

653 IAC 23.1(7) authorizes the Board to discipline licensee for indiscriminately or promiscuously prescribing, administering, or dispensing any drug for other than lawful purpose. For all of the reasons stated in connection with Count I and Count III, the preponderance of the evidence established that Respondent violated 653 IAC 23.1(7) when he indiscriminately prescribed methadone to patients without establishing a lawful purpose (e.g. chronic pain) for the prescriptions.

Count III: Improper Pain Management

At all times relevant to this Decision and Order, 653 IAC 13.2 included the following relevant provisions:

> **653-13.2(148,272C) Standards of practice-appropriate pain management.** This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of adjunct therapies such as acupuncture, physical therapy, and massage in the treatment of acute and chronic pain. This rule focuses on prescribing and administering controlled substances to provide relief and eliminate suffering for patients with acute and chronic pain.
>
> 1. This rule is intended to encourage appropriate pain management, including the use of controlled substances for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.
>
> ...
>
> 4. Physicians should not fear board action for treating pain with controlled substances as long as the physician's prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally the board is concerned about a pattern of improper pain management or single occurrence of willful or gross overtreatment or undertreatment of pain.
>
> ...
>
> 6. Inappropriate pain management may include nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.
>
> **13.2(1)** *Definitions.* For purposes of this rule, the following terms are defined as follows:

"Chronic pain" means persistent or episodic pain of a duration and intensity that adversely affects the functioning or well-being of a patient when (1) nor relief or cure for the pain is possible; (2) no relief or cure for the pain has been found; (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient. If pain persists beyond the anticipated healing period of a few weeks, patients should be thoroughly evaluated for the presence of chronic pain.

...

13.2(5) *Effective management of chronic pain.* Prescribing controlled substances for the treatment of chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain. To ensure that chronic pain is properly assessed and treated, a physician who prescribes or administers controlled substances to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history, and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

b. Treatment plan. The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objections of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs

utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible.

c. Informed consent. The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

d. Periodic review. The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. ..Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

...

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Physician-patient agreements. A physician treating patients with controlled substances or opiates shall consider establishing physician-patient agreements that specify the rules for medication use and the consequences for misuse. In preparing an agreement, a physician shall evaluate the case of each patient on its own merits, taking into account the nature of the risks to the patient and the potential benefits of treatment.

h. Substance abuse history or comorbid psychiatric disorder. A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient,

> monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.
>
> ...

The preponderance of the evidence established that Respondent violated Iowa Code section 148.6(2)(i) and 653 IAC 13.2 when he repeatedly prescribed controlled substances, particularly methadone without:

- clearly diagnosing and documenting that the patient has unrelieved pain;
- exercising sound clinical judgment and establishing an effective pain management plan;
- conducting a sufficient physical examination and taking a comprehensive medical history prior to initiating treatment. If the patient was uninsured or underinsured and unwilling to pay for diagnostic tests or further treatment of the underlying condition, Respondent still should have obtained the patient's prior medical records and should have documented what tests or procedures were declined by the patient;
- establishing a comprehensive treatment plan that tailored drug therapy to the individual needs of the patient;
- properly considering the limitations and potential complications of long-term opioid treatment;
- maintaining adequate documentation to show compliance with subrule 13.2, including documentation of patient evaluation, diagnostic studies, treatment modalities, a treatment plan, informed consent, and appropriate consultation;
- establishing physician-patient agreements in appropriate cases where the patient has an admitted history of opioid abuse; and
- exercising extra care and communication with patients requesting opiates for chronic pain when the patient has a prior history of substance abuse or a comorbid psychiatric disorder.

In many of the cases documented in the record, Respondent failed to take any reasonable steps to objectively verify the existence, location, and severity of pain reported by the patients. Respondent also failed to verify what medications, including narcotics, the patients were taking before coming to him for treatment. Respondent's clinical notes are largely subjective and based on what the patient reported to him,

without including any objective verification of that information. Based on his own statements, testimony, and clinical notes, it is clear that Respondent became so personally and emotionally affected by some of his patients and their financial problems that his ability to objectively assess the patient and maintain appropriate professional boundaries and judgment was compromised. Respondent went so far as to allow patients to put their prescription medications on his own account at the local pharmacy, which very raises serious concerns about Respondent's observance of professional boundaries in his practice.

Count IV: Violating the Laws and Rules Governing the Practice of Medicine

Iowa Code section 148.6(2)(c) and 653 IAC 23.1(10) authorize the Board to discipline a licensee for violating a statute, law, or rules of this state, another state, or the United States, which statute or law relates to the practice of medicine. Iowa Code section 125.13(1)(a) provides:

> **125.13 Programs licensed-exceptions.**
> *1.a.* Except as provided in subsection 2, a person shall not maintain or conduct any chemical substitutes or antagonists program, ...the primary purpose of which is the treatment and rehabilitation of persons with substance-related disorders without having first obtained a written license for the program from the department. [6]
> ...
> 2. The licensing requirements of this chapter do not apply to any of the following:
> ...
> *b.* Any practitioner of medicine and surgery or osteopathic medicine and surgery, in the practitioner's private practice. However, a program shall not be exempted from licensing by the board by virtue of its utilization of the services of a medical practitioner in its operation.

See also, Iowa Code section 125.21(1)(The board[7] has exclusive power in this state to approve and license chemical substitutes antagonist programs,...The chemical substitutes and antagonists programs conducted by persons exempt from the licensing requirements of this chapter pursuant to section 125.13, subsection 2, are subject to

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[6] "Department' means the Iowa Department of Public Health. Iowa Code section 125.2.

[7] "Board" means the state board of health, created pursuant to chapter 136.

approval and licensure under this section.) In addition, the Department of Public Health has adopted administrative rules that require licensure or approval of all opioid treatment programs. See 641 IAC 155.35.

The Department of Public Health cited these statutes and rules when it issued Respondent the Notification to Cease and Desist providing substance abuse treatment services. Respondent was also criminally charged under these statutes, but the criminal charges have now been dismissed. Due to the different burden of proof in this administrative proceeding, the outcome of the criminal proceeding is not binding on the Board. Nevertheless, the Board was not persuaded that Respondent was conducting a "chemical substitutes or antagonists program" or an "opioid treatment program," in violation of Iowa Code sections 125.13(1)(a), 125.21(1) or 641 IAC 155.35. As discussed in connection with Counts I-III, it is clear that Respondent was inappropriately and improperly prescribing methadone to patients in violation of the applicable standard of care and in violation of this Board's statutes and rules. It is unclear to the Board, however, whether Respondent's prescribing practices constituted a "chemical substitutes or antagonists program" or "opioid treatment program" under Iowa Code chapter 125 and/or 641 IAC 155.35. The Board was unable to find a violation under this count.

Count V: Unethical or Unprofessional Conduct

Iowa Code sections 147.55(3) and 272C.10(3) authorize the Board to discipline licensees for engaging in unethical conduct. Iowa Code section 148.6(2)(g) authorizes the Board to discipline licensees for committing an act contrary to honesty, justice or good morals, whether the same is committed in the course of the physician's practice or otherwise.

653 IAC 23.1(4) also authorizes the Board to discipline a licensee for unprofessional conduct. The rule provides that engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by the licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within this state or elsewhere; or a violation of the principles of medical ethics or 653 IAC 13.7 or 653 IAC 13.20, as interpreted by the Board. 657 IAC 13.7(4) prohibits physicians from engaging in contact, touching or comments of a sexual nature with a patient in the course of providing medical care.

This count is based on the allegation that Respondent performed an inappropriate and/or medically unnecessary physical examination of a 17 year old female patient (KP) on August 10, 2011. Respondent performed both a pelvic examination and a breast examination on this patient. It does appear to the Board that Respondent had sufficient medical justification for performing a pelvic examination on KP, even though the appointment was scheduled for suture removal. KP had asked Respondent about her "right hip pain" when he stitched her foot eleven days earlier. Six days later, KP's abdominal pain was evaluated at the emergency room with blood and urine screens and a CT scan of the pelvis and abdomen. The results of those tests were all normal, but KP did not have a pelvic examination at that time. A pelvic examination was medically warranted given KP's ongoing complaints of abdominal pain and her medical history that included an abnormal PAP smear.

Upon review of the conflicting testimony and evidence in the record, the Board was unable to conclude, by a preponderance of the evidence, that Respondent performed KP's pelvic examination without a chaperone being present in the room. Respondent's nurse testified that a nurse is always present for pelvic examinations, and she specifically recalled being in the room during KP's pelvic examination. KP admitted that Respondent's nurse handed her the gown that she changed into for the pelvic examination and that the nurse was "in and out" of the room throughout her appointment. At hearing, KP conceded that there might have been a nurse present during the pelvic examination although she did not recall seeing a nurse.

The Board was also unable to conclude, by a preponderance of the evidence, that Respondent commented to KP that she had a "nice-looking Pandora." Although the Board believes that this is what KP thought she heard, it is possible that KP misheard or misunderstood Respondent's comment to her during her pelvic examination.

The Board has not concluded, however, that Respondent's evaluation of KP for a sexually transmitted disease (STD) was performed in an appropriate manner. Respondent's evaluation was inappropriate, not because it was unethical, but because it was performed incompetently. The only diagnostic test used by Respondent was a PAP smear, which would not assist him in diagnosing an STD. Respondent failed to perform appropriate blood tests or cultures to properly establish an STD diagnosis. Respondent placed a lot of weight on his clinical finding that KP "winced and cried out in pain" when he performed the bimanual examination. However, neither KP nor the nurse recalled that KP experienced pain during the pelvic examination. In addition,

there is no indication in the record that Respondent reported his STD diagnosis to the public health authorities and no documentation that Respondent told KP that her sexual partner(s) needed to be treated.

Based on the circumstances of this case, Respondent did not have sufficient medical justification for his decision to perform a breast examination on KP. Respondent testified that he decided to do a full well woman examination, including a breast examination, based on his suspicion that KP had a pelvic infection and based on her medical history. The Board was not persuaded that a breast exam was medically appropriate or necessary. In addition, Respondent's record does not support his claim that he performed a full well woman exam, which was his justification for the breast exam, because his records do not even document that KP's vital signs were taken.

The Board was unable to conclude, by a preponderance of the evidence, that KP's breast examination was unnecessarily long or that Respondent performed it using improper or inappropriate technique. KP initially reported that the breast exam was "intense" and went on for 5 or 6 minutes. At hearing, however, KP was less certain how long the exam lasted and testified that it could have been from 1-5 minutes while Respondent testified that the breast exam was one minute or less on both sides.

It is abundantly clear to the Board, however, that KP was very uncomfortable with both the breast examination and with Respondent. It is very likely that a number of circumstances contributed to her discomfort, including that she was a 17 year old female alone in an examination room with a physician she barely knew. The medical reason for the breast exam was likely as unclear to KP as it was to the Board. Respondent's earlier lecture about male ejaculate and sperm no doubt added to her sense of discomfort with Respondent and her doubts about his intentions and motives.

Respondent testified that he does not use a chaperone for breast exams because that was how he was trained in residency. Respondent's nurse testified that he did not typically have a chaperone for breast examinations but that he would ask her to be present if he was uncomfortable being alone with a patient, such as the case of an adolescent. In reviewing whether KP's breast examination complied with professional and ethical standards, the Board cannot ignore Respondent's prior disciplinary history. Respondent has an acknowledged sexual addiction for which he has received inpatient treatment. Respondent has previously been subject to a five year probation with Board imposed restrictions relating to his treatment of female patients and patients under the

age of 18. On cross examination, Respondent testified that he is not now a practicing sex addict and that he has been "in sobriety" since 1997. Nevertheless, Respondent acknowledged that he has "thoughts... everyday" and he "polices" them. Although Respondent testified that he works his 12-step program every day, he admits he is no longer in therapy or counseling and he no longer attends structured support group meetings like SAA.

Although Respondent has been released from probation, he is still required to act professionally and ethically while treating patients. It is essential for Respondent to be vigilant in maintaining appropriate professional boundaries with his patients. Given his history, Respondent's decision to perform a breast examination on this 17 year old female without a chaperone in the room was both unprofessional and unethical, in violation of Iowa Code sections 147.55(3, 148.2(g), 272C.10(3) and 653 IAC 23.1(4). Respondent's nurse was readily available when Respondent chose to perform KP's breast examination without a chaperone. KP was in Respondent's office without a parent and Respondent had not notified her parent that he intended to convert her appointment for suture removal to a full "well woman" examination, including a breast and pelvic examination. Under all of these circumstances, it was clearly inappropriate, unethical, and unprofessional for Respondent to perform KP's breast examination without a chaperone in the room. Based on its review of this record, the Board believes that Respondent has failed to maintain appropriate professional boundaries in his medical practice.

DECISION AND ORDER

A. CITATION AND WARNING: Respondent is hereby **CITED** for engaging in professional incompetency and/or violating the laws and rules governing the practice of medicine when he inappropriately prescribed controlled substances, particularly methadone, to patients with known substance abuse histories between 2009 and 2011 in Grundy Center, Iowa, and for performing an inappropriate and/or medically unnecessary physical examination on a young female patient in his clinic in Grundy Center, Iowa, on or about August 10, 2011. Respondent is hereby **WARNED** that engaging in such conduct in the future may result in further formal disciplinary action, including suspension or revocation of his Iowa medical license.

B. CIVIL PENALTY: Respondent shall pay a **$2,500** civil penalty within twenty (20) days of the date of this Order. The civil penalty shall be paid by delivery of a check or money order, payable to the Treasurer of Iowa, to the executive director of the Board. The civil penalty shall be deposited in the State General Fund.

C. PROHIBITION - CONTROLLED SUBSTANCES: Respondent is prohibited from purchasing, procuring, possessing, administering or dispensing controlled substances under his Iowa medical license.

D. PROHIBITION - CHRONIC PAIN MANAGEMENT: Respondent is prohibited from prescribing, administering or dispensing controlled substances for the treatment of chronic pain under his Iowa medical license. Pursuant to 653 IAC 13.2(1), "*Chronic pain* means persistent or episodic pain of a duration or intensity that adversely affects the functioning or well-being of a patient when (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found; or (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient. If pain persists beyond the anticipated healing period of a few weeks, patients should be thoroughly evaluated for the presence of chronic pain."

E. BOARD-APPROVED CLINICAL COMPETENCY EVALUATION: Respondent shall successfully complete a comprehensive clinical competency evaluation at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado, Ph.#303-577-3232, within ninety (90) days of the date of this order. Respondent shall fully comply with the recommendations of CPEP. Respondent shall ensure that upon completion of the evaluation, CPEP provides the Board a written report which identifies any areas of concern or deficiency. Respondent is responsible for all costs associated with the evaluation. If Respondent fails to complete the evaluation within ninety (90) days of the date of this Order, the Board will issue a notice to Respondent that his license will be suspended within thirty (30) days of the date the notice is served on Respondent. The suspension shall occur automatically and without further Board action, unless Respondent files with the Board a request for hearing on the notice within ten (10) days of the date the notice is served.

F. BOARD-APPROVED PROFESSIONAL BOUNDARIES EVALUATION: Respondent shall successfully complete a comprehensive professional boundaries evaluation under the direction of Gene G. Abel, M.D. at the Behavioral Medicine Institute of Atlanta, in Atlanta, Georgia, #404-872-7929, within ninety (90) days of the

date of this order. Respondent shall fully comply with the recommendations of BMI. Respondent shall ensure that upon completion of the evaluation, BMI provides a written report directly to the Board. Respondent is responsible for all costs associated with the evaluation. If Respondent fails to complete the Board-approved professional boundaries evaluation within ninety (90) days of the date of this Order, the Board will issue a notice to Respondent that the license will be suspended within thirty (30) days of the date the notice is served on Respondent. The suspension shall occur automatically and without further Board action, unless Respondent files with the Board a request for hearing on the notice within ten (10) days of the date the notice is served.

G. **CHAPERONE REQUIREMENT**: Respondent shall have a Board-approved female healthcare professional chaperone continually present at all times while treating all patients under the age of 18 years old. Respondent shall also have a Board-approved female healthcare professional chaperone continually present at all times while providing breast and/or pelvic examinations for any female patient. The Board-approved chaperone shall be continually present when Respondent is providing healthcare services, including but not limited to, patient evaluation, treatment and post-evaluation treatment directions. The chaperone shall clearly document her continued presence in each patient's chart. Respondent shall provide the Board with the names of all persons providing chaperone services for him at all facilities where Respondent practices medicine under his Iowa medical license. The Board will provide all chaperones with a copy of this Order. All chaperones shall provide a written statement to the Board indicating that they have read this Order and agree to inform the Board immediately if there is any evidence of professional misconduct, sexual misconduct or a violation of the terms of this Order.

H. **INDEFINITE PROBATION**: Respondent shall be placed on **indefinite probation** subject to the following terms and conditions:

1. **Board Monitoring Program**: Within thirty days of the date of this Order, Respondent shall establish a Board monitoring program with Mary Knapp, Compliance Monitor, Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686, Ph.#515-281-5525. Respondent shall fully comply with all requirements of the monitoring program. If Respondent fails to establish a Board monitoring program within thirty days of the date of this Order or fails to fully comply with the Board monitoring plan, the Board will issue a notice to Respondent that the license will be suspended within thirty (30) days of the date

the notice is served on Respondent. The suspension shall occur automatically and without further Board action, unless Respondent files with the Board a request for hearing within ten (10) days of the date the notice is served.

2. **CPEP Recommendations:** Respondent shall fully comply with the recommendations of CPEP following the evaluation, including a supervised educational program, if recommended.

3. **BMI Recommendations:** Respondent shall fully comply with the recommendations of BMI following the professional boundaries evaluation, including any recommendations made for ongoing professional boundaries counseling and/or therapy. All counselors/therapists shall be pre-approved by the Board and shall submit written quarterly reports to the Board concerning Respondent's progress. The reports shall be filed with the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of Respondent's probation. Respondent shall continue with counseling/therapy until discharged by the Board-approved counselor/therapist and until Respondent's discharge is approved by the Board. Respondent shall meet with his Board-approved counselor/therapist as frequently as recommended by the counselor and approved by the Board. All costs of the counseling/therapy shall be the responsibility of Respondent.

4. **Practice Monitoring Plan:** Respondent shall fully comply with the Board-approved practice monitoring plan approved by the Board.

a) Respondent shall submit the name and CV of an Iowa-licensed, board-certified, family practice physician to serve as practice monitor.

b) The Board shall provide the practice monitor a copy of this order, the practice monitoring plan, all CPEP reports and all other relevant Board material in this matter.

c) The practice monitor shall provide a written statement indicating that the practice monitor has read and understands all Board material provided by the Board and agrees to serve as the practice monitor under the terms of the practice monitoring plan. The practice monitor shall meet with Respondent regularly, review selected patients records, ensure that Respondent provides appropriate care and treatment to patients and engage in a quality improvement process that addresses any areas of need identified by CPEP.

d) The practice monitor shall contact the Board immediately if there is evidence that Respondent has provided substandard care to patients.

e) The practice monitor shall agree to submit written quarterly reports to the Board not later than 1/20, 4/20, 7/20 and 10/20 of each year of this order.

f) The practice monitor may be asked to appear before the Board in-person, or by telephone or video conferencing. Such appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

5. **Quarterly Reports**: Respondent shall file sworn quarterly reports attesting to his compliance with all the terms of this Order no later than 1/10, 4/10, 7/10 and 10/10 of each year for the duration of the period of this Order.

6. **Board Appearances**: Respondent shall appear before the Board annually or upon request of the Board during the period of this order. Respondent shall be given notice of the date, time and location of the appearances. The appearances shall be subject to the waiver provisions of 653 IAC 24.2(5)(e)(3).

7. **Monitoring Fee:** Respondent shall make a payment of $100 to the Board each quarter for the duration of his probation to cover the Board's monitoring expenses in this matter. The monitoring fee shall be received by the Board with all quarterly reports required during his probation. The monitoring fee shall be sent to: Mary Knapp, Compliance Monitor, Iowa Board of Medicine, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686. The check shall be made payable to the Iowa Board of Medicine. The monitoring fee shall be considered repayment receipts as defined in Iowa Code section 8.2.

8. **Termination of Probation:** In determining whether to release Respondent from Probation, the Board will consider both the circumstances leading to this disciplinary action and Respondent's previous disciplinary history.

I. NOTIFICATIONS:

1. **Licensing Boards:** Respondent shall submit a written statement to the Board which demonstrates that Respondent has shared a copy of this order with all medical licensing boards where Respondent holds a license, whether active or not, within thirty (30) days of the date of this order.

2. **Hospitals and Clinics:** Respondent shall submit a written statement to the Board which demonstrates that he has shared a copy of this order with each hospital and clinic where Respondent practices medicine, within thirty (30) days of the date of this order.

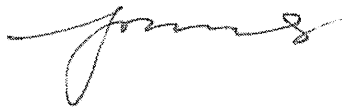
3. **Physician Assistants:** Pursuant to 653 IAC 21.6, if applicable, Respondent shall notify all physician assistant supervisees within one workday upon receiving disciplinary action from the Board or any other change in status that affects the physician's eligibility to supervise a physician assistant.

J. **FEDERAL, STATE AND LOCAL LAWS:** Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Iowa.

K. **FAILURE TO COMPLY WITH THIS ORDER:** In the event Respondent fails to comply with any of the terms of this Order, the Board may initiate action to suspend or revoke Respondent's license or to impose other license discipline as authorized in Iowa Code chapters 148 and 272 and 653 IAC 25.

IT IS FURTHER ORDERED, in accordance with 653 IAC 25.33, that Respondent shall pay a disciplinary hearing fee of $75.00. In addition, Respondent shall pay any costs certified by the executive director and reimbursable pursuant to subrule 25.33. All fees and costs shall be paid in the form of a check or money order payable to the state of Iowa and delivered to the department of public health, within thirty days of the issuance of a final decision.

Dated this 18th day of April, 2013.



Joyce Vista-Wayne, M.D.
Iowa Board of Medicine

cc: Kevin D. Engels, Respondent's Attorney
Theresa O'Connell Weeg, Assistant Attorney General

Judicial review of the board's action may be sought in accordance with the terms of the Iowa administrative procedure act.

BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

FRANK L. LAMP, M.D., RESPONDENT

FILE Nos. 02-10-557 & 02-11-664

****

STATEMENT OF CHARGES

****

COMES NOW the Iowa Board of Medicine on November 15, 2012, and files this Statement of Charges pursuant to Iowa Code section 17A.12(2). Respondent was issued Iowa medical license number 27191 on July 1, 1989. Respondent's Iowa medical license is active and will next expire on November 1, 2013.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on February 14, 2013, before the Board. The hearing shall begin at 8:30 a.m. and shall be located in the conference room at the Board office at 400 SW 8th Street, Suite C, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Statement of Charges you are required by 653 IAC 24.2(5)(d) to file an Answer. In that Answer, you should state whether you will require a continuance of the date and time of the hearing.

3. Presiding Officer. The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge make initial rulings on pre-hearing matters, and be present to assist and advise the board at hearing.

4. Prehearing Conference. A prehearing conference will be held by telephone on December 5, 2012, at 9:30 a.m., before an Administrative Law Judge from the Iowa Department of Inspections and Appeals (ALJ). Please contact Kent M. Nebel, J.D., Legal Director, Iowa Board of Medicine, at 515-281-7088 with the telephone number at which you or your legal counsel can be reached. Board rules on prehearing conferences may be found at 653 Iowa Administrative Code 25.15.

5. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 653 IAC 25. At hearing, you will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf, cross-examine witnesses, and examine any documents introduced at hearing. You may appear personally or be represented by counsel at your own expense. If you need to request an alternative time or date for hearing, you must review the requirements in 653 IAC 25.16. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

6. Prosecution. The office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address: Julie Bussanmas, Assistant Attorney General, Iowa Attorney General's Office, 2nd Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7. Communications. You may not contact board members by phone, letter, facsimile, e-mail, or in person about this Notice of Hearing. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the case. You should direct any questions to Kent M. Nebel, J.D., the Board's Legal Director at 515-281-7088 or to Assistant Attorney General Julie Bussanmas 515-281-5637.

B. LEGAL AUTHORITY AND JURISDICTION

8. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 17A, 147, 148, and 272C.

9. Legal Authority. If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code chapters 17A, 147, 148, and 272C and 653 IAC 25.

10. Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code section 17A.12(3) and 653 IAC 25.20.

C. SECTIONS OF STATUTES AND RULES INVOLVED

COUNT I

11. **Professional Incompetency:** Respondent is charged with professional incompetency pursuant to Iowa Code sections 147.55(2), 148.6(2)(g) and (i), and 272C.10(2) and 653 IAC 23.1(2)(a),(b),(c), (d), (e), and (f), by demonstrating one or more of the following:

a. Willful or repeated gross malpractice;

b. Willful or gross negligence;

c. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;

d. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;

e. A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances; or

f. A willful or repeated departure from, or the failure to conform to, the minimal standard of acceptable and prevailing practice of medicine and surgery in Iowa.

COUNT II

12. **Inappropriate Prescribing:** Respondent is charged pursuant to Iowa Code sections 148.6(2)(i) and 653 IAC 23.1(7) for willfully or repeatedly violating a lawful rule or regulation adopted by the Board when he indiscriminately or promiscuously prescribed, administered or dispensed drugs for other than a lawful purpose.

COUNT III

13. **Improper Pain Management:** Respondent is charged pursuant to Iowa Code sections 148.6(2)(i) and 653 IAC 13.2 for willfully or repeatedly violating a lawful rule or regulation adopted by the Board when he violated the standards of practice for appropriate pain management.

COUNT IV

14. **Violating the Laws and Rules Governing the Practice of Medicine:** Respondent is charged pursuant to Iowa Code section 148.6(2)(c) and 653 IAC 23.1(10) for violating a statute or law of this state, another state or the United States without regard to its designation as a felony or misdemeanor, which statute or law relates to the practice of medicine.

COUNT V

15. **Unethical or Unprofessional Conduct:** Respondent is charged pursuant to Iowa Code sections 147.55(3) 148.2(g) and 272C.10(3) and 653 IAC 23.1(4) with engaging in unethical or unprofessional conduct. Engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee's practice or otherwise, and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics or 653 IAC 13.7 or 13.20 as interpreted by the board.

STATEMENT OF THE MATTERS ASSERTED

16. Respondent is an Iowa-licensed physician who practices family medicine in Grundy Center, Iowa.

17. **Previous Disciplinary Action:** On March 19, 1997, the Board suspended Respondent's Iowa medical license indefinitely due to substance abuse. On August 23, 2000, the Board reinstated Respondent's Iowa medical license and placed him on probation for a period of five years subject to Board monitoring for substance abuse and other restrictions. On August 25, 2005, the Board terminated the terms of Respondent's probation.

18. **Criminal Charges:** On April 23, 2012, Respondent was charged with nine (9) Counts of Unlawfully Operating a Substance Abuse Treatment Program Without a License, a Serious Misdemeanor, in violation of Iowa Code Sections 125.13(1)(a), 125.21(1), and 125.58(2), when he repeatedly wrote prescriptions for methadone for three patients with known substance abuse histories who left a licensed Opioid Treatment Program between June 30, 2011, and January 9, 2012. The criminal charges are pending.

19. **Inappropriate Prescribing:** The Board alleges that Respondent engaged in professional incompetency and/or violated the laws and rules governing the practice of medicine when he inappropriately prescribed controlled substances, particularly methadone, to patients with known substance abuse histories between 2009, and 2011, in Grundy Center, Iowa, including, but not limited to, the following:

A. Respondent inappropriately prescribed methadone to three patients with known substance abuse histories who left a licensed Opioid Treatment Program between June 30, 2011, and January 9, 2012, for the treatment of opiate dependency, in violation of Iowa Code Sections 125.13(1)(a), 125.21(1), and 125.58(2), even after he received a Notification to Cease and Desist from the Iowa Department of Public Health, Bureau of Substance Abuse, dated June 16, 2011.

B. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without obtaining and/or documenting appropriate patient histories, including previous medical records with the results of diagnostic testing and treatments.

C. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without performing and/or documenting appropriate patient evaluations including diagnostic testing.

D. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without obtaining and/or documenting the medications being taken by patients.

E. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without adequately documenting the diagnosis and etiology of pain through current evaluations or review of prior assessments.

F. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without obtaining and/or documenting the existence, location and severity of pain at the initial evaluation and/or subsequent visits.

G. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without establishing and/or documenting appropriate treatment plans.

H. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without considering and/or documenting appropriate consultation and/or referral to specialists.

I. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without maintaining appropriate medical records.

J. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without utilizing appropriate pain management agreements.

K. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without appropriately assessing and/or documenting the patient's substance abuse history and/or comorbid psychiatric disorders.

L. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without performing and/or documenting drug screens.

M. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without obtaining and/or documenting the records from the Iowa Prescription Monitoring Program.

N. Respondent inappropriately prescribed relatively high doses of methadone to patients without confirming and/or documenting the patient's prior methadone dose.

O. Respondent inappropriately prescribed methadone in combination with other medications without informing patients of the potential dangers of combining the medications.

P. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients for the treatment of opiate dependency. Respondent's records do not support the treatment diagnosis of chronic pain.

Q. Respondent inappropriately prescribed controlled substances, particularly methadone, to patients without adequately evaluating patients for potential drug abuse and diversion and failed to adequately address evidence of drug abuse and diversion.

20. **Inappropriate Physical Examination:** The Board alleges that Respondent performed an inappropriate and/or medically unnecessary physical examination on a young female patient in his clinic in Grundy Center, Iowa, on or about August 10, 2011.

E. SETTLEMENT

21. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 653 IAC 25. If you are interested in pursuing settlement of this matter, please contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

F. PROBABLE CAUSE FINDING

22. On November 15, 2012, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

Colleen K. Stockdale, M.D., M.S., Chairwoman
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686