BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

FILED

OCT 1 9 2015

Kevin Westray, Legal Assistant

GEORGIA COMPOSITE MEDICAL BOARD,	:	
Petitioner,	:	
	:	**Docket No:**
v.	:	**OSAH-CSBME-PHY-1602303-44-Walker**
	:	
HARVEY B. LESLIE, M.D.,	:	
Respondent.	:	

INITIAL DECISION

I. Procedural History

On July 7, 2015, the Georgia Composite Medical Board (hereinafter "Petitioner" or "Board") issued a Statement of Matters Asserted seeking final disciplinary action against Respondent's license to practice medicine. An administrative hearing was held on September 2, 2015. Petitioner was represented by Graham Barron, Esq.[1] Respondent failed to appear.[2] After considering the evidence presented at the final disciplinary hearing, the undersigned recommends that Respondent's license be **REVOKED.**

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[1] The record in this case reflects that multiple attorneys have represented Respondent during the course of the Board's investigation and disciplinary proceedings. On September 3, 2015, attorney Frances E. Cullen filed an entry of appearance on behalf of Respondent. On October 5, 2015, Ms. Cullen moved to withdraw as counsel for Respondent, stating that "[Respondent] failed to cooperate, *failed to be truthful* and failed to provide needed information in defense of his case." (Request to Withdraw as Attorney of Record for Respondent Harvey B. Leslie, MD at p.1, emphasis in original). Having received no opposition to the Motion to Withdraw, the motion is **GRANTED.**

[2] One day after the hearing concluded, on September 3, 2015, Respondent filed a pleading styled "Motion to Vacate Default Judgement, Motion to Reopen Record and Motion for Rehearing." Respondent filed an Amendment to this pleading on September 4, 2015, and Petitioner responded on September 11, 2015. On September 17, 2015, the undersigned issued an Order denying the motions, finding that "Respondent's patently unreasonable behavior in failing to appear at the hearing or seek a continuance does not merit relief on any of the grounds stated in the pleadings." (Order at p. 5)

II. Findings of Fact

1.

Respondent holds a license to practice as a physician in the State of Georgia, and has held such certificate at all times relevant to the issues presented for hearing. (Transcript of Hearing (hereinafter "T1-") at p.8; Exhibit P-1). Respondent's license to practice indicates that he "is **Not** a holder of a Pain Management Clinic license." (emphasis in original).[3]

2.

On August 23, 2010, the Board sanctioned Respondent's license based on his use of unlicensed individuals to provide physical therapy services to his patients. The Board issued a Public Reprimand to include a $5000.00 fine and administrative costs. (Exhibits P-1; P-2).

3.

Following the Public Reprimand, the Board commenced another investigation regarding Respondent's medical practice. The Board contacted Respondent and requested that he provide patient records in two cases. (T-28-29). Respondent provided the records requested to the Board. (Exhibits P-4, P-5).

4.

Barry Neil Straus has been a physician for approximately thirty five years. He holds a B.A. from Rensselaer Polytechnic Institute, an M.D. from Albany Medical College and a J.D. from Georgia State University. After extensive training in the field of anesthesiology, he served as the Medical Director of the North Georgia Pain Clinic from 1991-2013. Dr. Straus has published articles,

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[3] Respondent holds himself out as a Diplomate of the American Academy of Pain Medicine; however, this is not a specialty recognized by the American Board of Medical Specialties. (T-29-30).

lectured and provided expert testimony in the field of pain management. He has served as a peer reviewer for the Board since 2003. (T-10-13; Exhibit P-3).

5.

The Board contacted Dr. Straus and requested that he review records for two of Respondent's patients and determine whether or not Respondent's treatment conformed to the minimal standards of acceptable and prevailing medical practice. (T-25).

6.

Dr. Straus reviewed records for patients C.T. and D.P. (T-26; Exhibits R-4, R-5). Based on his review, Dr. Straus concluded that Respondent's diagnosis, treatment and recordkeeping constituted a departure from or a failure to conform to the minimum standards of acceptable and prevailing practice of medicine in the State of Georgia. (T-28).

7.

On July 7, 2015, the Medical Board issued a Statement of Matters Asserted charging that Respondent's treatment of two patients departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice. (Statement of Matters Asserted ¶ 3.)

A. Patient C.T.

8.

From 2009 to 2011, Respondent treated patient C.T. for pain management. (Exhibit P-4). Respondent's records reflect that C.T. was a forty five year old female with a history of low back pain. (T-30).

9.

Controlled substances are substances which have a risk of abuse and addiction. (T-16, 59). The federal Drug Enforcement Agency ranks these substances from one through five, with schedule one controlled substances having the highest risk of abuse. (T-16). In order to prescribe controlled substances, a physician must obtain a license from the Drug Enforcement Administration. (T-16).

10.

Prior to prescribing a controlled substance, a competent physician needs to take a patient's medical history, perform a physical and make a diagnosis. (T-17). According to Dr. Straus, C.T.'s medical records do not reflect that Respondent performed physical exams or diagnostic testing to support the medications prescribed by Respondent. (T-32, T-40).[4]

11.

Lortab is a schedule two controlled substance. (T-32). In early December of 2009, Respondent prescribed Lortab, 10 mg, four times a day for C.T.'s pain. (T-32). On December 23, 2009, Respondent also prescribed Soma for C.T. Soma is a muscle relaxant that is typically prescribed a maximum of three times a day; however, Respondent prescribed it to be taken four times a day. (T-33). A few weeks later, on January 7, 2010, Respondent added Oxycontin to C.T.'s regimen, essentially tripling the amount of narcotics being prescribed. (T-33).

12.

A physician prescribing controlled substances should begin by prescribing small amounts, "because these medications have side effects." (T-18-19). According to Dr. Straus, the record

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[4] Although the results of a later [Magnetic Resonance Imaging] performed would support the need for pain medication, this testing "post-date[d] giving the medications." (T-41).

did not "[justify] why [C.T.] needed this amount of medication." (T-40). Respondent's actions in this regard "fell below minimum standards." (T-39).

13.

The minimum standards of acceptable and prevailing practice mandate that doctors should seek alternative treatments or medications for patients who are being prescribed controlled substances; "if there's a condition which can be cured and fixed, you'd like to find that." (T-41). There was no documentation in the record that Respondent evaluated C.T.'s response to the medications prescribed, or that he considered alternative treatments or medications for C.T. (T-42-43). Additionally, the failure to document C.T.'s response to the prescribed medications did not meet minimum standards for recordkeeping in a case involving pain management. (T-45).

14.

A competent physician must do periodic follow-ups to ensure that the medications are working and document any side effects. (T-19). Further, a physician should monitor a patient for possible abuse or addiction by mandating that the patient undergo drug testing. (T-20). Approximately a year after her initial appointment, Respondent administered drug screening to C.T. (T-35).

15.

On December 10, 2010, C.T.'s drug screen was negative, reflecting that she had taken none of the prescribed medication for the past three to seven days. (T-35). On January 15, 2011, C.T.'s drug screening indicated she was negative for Oxycontin, one of the prescribed medications. (T-36). The minimum standards of acceptable and prevailing practice of medicine mandate that Respondent should have discussed the negative drug screening with C.T. to make sure the patient

was not consuming more medication than prescribed and then running out of medication. (T-38).

16.

On April 15, 2011, the drug screening demonstrated that the prescribed medications were being taken appropriately. (T-36).

17.

On May 13, 2011, the drug screening demonstrated that C.T. had cocaine in her system. (T-36). According to Dr. Straus, the screening indicating cocaine use was a "sentinel event[] . . . if you see that, red flags go up, rockets go up, we've got a problem here." (T-43-44). The positive cocaine screening "pretty much means they were taking it up 'till the night before they came to the office" and is "strong evidence of addiction." (T-44).

18.

At a minimum, Dr. Straus opined that the drug use should have been "addressed in the record" and you would "need very substantial justifications in the record for why you would continue to prescribe in the face of that." (T-39). C.T.'s medical records do not reflect that Respondent discussed C.T.'s consumption of cocaine with her or that he cautioned her about the results of the screening. (T-38). Respondent continued to prescribe the controlled substances to C.T. without substantial justification. (Exhibit P-4).

19.

The next four drug screens, through January 2012, indicated that C.T. had intermittently ingested numerous illegal controlled substances including cocaine, amphetamines, and ecstasy. C.T. also tested positive for methadone. (T-36-37). In February 2012, the drug screen reflected C.T. was positive for cocaine, amphetamines, and methadone. (T-37). The drug screens indicating that

C.T. had both cocaine and methadone in her system suggest that she was selling the prescribed drugs for cocaine. (T-39).

20.

According to Dr. Straus, there was "no justification in the record for why [Respondent] continued to prescribe narcotics in the face of urine drug screens which were positive for illegal drugs." (T-39-40). In essence, Respondent became a "drug dealer in a white coat." (T-57).

B. Patient D.P.

21.

On November 21, 2011, Respondent provided the Board with Medical records for patient D.P. (Exhibit R-5). Respondent provided patient D.P. with medical treatment for pain management related to cervical and lumbar disc degeneration, anxiety, depression and insomnia. (Exhibit P-5).

22.

Respondent's diagnosis, documentation and treatment of D.P. all fell below the standard of care. (T-51). Respondent did not perform an adequate physical examination or obtain a sufficient medical history from D.P. prior to prescribing controlled substances for her pain. (T-50).

23.

During the course of the treatment, Respondent prescribed the following medications: Ambien, Percocet 10mg four times daily, Soma 350mg four times daily, Tramadol 50mg four times daily, and Tizanidine, a muscle relaxer. (T-46). A review of the record does not reflect a basis for prescribing the medication and Respondent's treatment of D.P. fell below the minimum standard of care. (T-51).

24.

Although Respondent met with D.P. on a monthly basis, D.P.'s records do not reflect her response to the prescribed medications or any exploration into the use of alternative treatments. (T-51; Exhibit P-5). The failure to document D.P.'s treatment response to the medications fell below the minimum standard of care. (T-51).

25.

D.P.'s family members contacted Respondent to express concern that he was over-prescribing controlled substances to D.P. (T-47). The family reported that "she's always crying, started wetting her clothes and acts out." (Exhibit P-5). If a third party contacts a physician about a patient's potential abuse of medication, the standard of care requires a physician to evaluate whether or not the patient has an addiction issue. (T-48-49).

26.

Medical records provided by Respondent do not indicate that he took steps that could be characterized as a "normal course of action." (T-49). Respondent did not discuss the family's concerns with the patient, require drug screening, ask D.P. to bring her medications to him so that he could make sure she was taking them appropriately or send D.P. to another expert for evaluation. (T-49).

27.

Dr. Straus concluded that Respondent's diagnosis, treatment and documentation in this case fell below the minimum standard of care. (T-51).

III. Conclusions of Law

1.

The Board bears the burden of proof in this matter. Ga. Comp. R. & Regs. r. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21(4).

2.

Professional licensing boards may discipline a licensee upon a finding by a majority of the entire board that the licensee has engaged either in unprofessional conduct that fails to conform to the minimal reasonable standards of acceptable and prevailing practice or engaged in conduct that violates a rule or regulation of this state. O.C.G.A. § 43-1-19(a)(6), (8).

3.

In turn, under O.C.G.A. § 43-34-8(a) the Board has the authority to discipline a physician upon a finding that the licensee has:

...

> (7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or failure to conform to, the minimum standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimum standards of acceptable and prevailing medical practice or by rule of the board;

...

> (10) Violated or attempted to violate a law, rule, or regulation of this state, any other state, the board, the United States, or any other lawful authority without regard to whether the violation is criminally punishable, which law, rule, or regulation relates to or in part regulates the practice of medicine, when the licensee or applicant knows or should know that such action is violative of such law, rule, or regulation;

...

(19) Failed to maintain appropriate medical or other records as required by board rule;

. . . .

4.

Pursuant to O.C.G.A. § 43-34-8(b)(1), if the Board finds cause for discipline it may, under Ga. Comp. R. & Regs. r. 360-3-.01, deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician. *See also* O.C.G.A. §§ 43-1-19(d), 43-34-8(b)(1).

5.

Pursuant to Ga. Comp. R. & Regs. r. 360-3-.02 unprofessional conduct includes:

(1) Prescribing controlled substances for a known or suspected habitual drug abuser or other substance abuser in the absence of substantial justification.

. . .

(7) Failing to maintain appropriate patient records whenever Schedule II, III, IV or V controlled substances are prescribed. Appropriate records, at a minimum, shall contain the following:

(a) The patient's name and address;

(b) The date, drug name, drug quantity, and patient's diagnosis necessitating the Schedule II, III, IV, or V controlled substances prescription; and

(c) Records concerning the patient's history.

. . .

(16) Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment and response.

. . .

(18) Any other practice determined to be below the minimum standards of acceptable and prevailing practice.

6.

As specifically regards pain management, Ga. Comp. R. & Regs. r. 360-3-.06(2) provides that the minimum standards of practice include, but are not limited to:

> (c) When initially prescribing a controlled substance for the treatment of pain or chronic pain, a physician shall have a medical history of the patient, a physical examination of the patient shall have been conducted, and informed consent shall have been obtained.
>
> . . .
>
> (e) When a physician determines that a patient for whom he is prescribing controlled scheduled substances is abusing the medication, then the physician shall make an appropriate referral for treatment for substance abuse.
>
> (f) When prescribing a Schedule II or III controlled substance for 90 (ninety) days or greater for the treatment of chronic pain arising from conditions that are not terminal or patients who are not in a nursing home or hospice, a physician must have a written treatment agreement with the patient and shall require the patient to have a clinical visit at least once every three (3) months, while treating for pain, to evaluate the patient's response to treatment, compliance with the therapeutic regiment and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances.
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> . . .
>
> (g) When prescribing a Schedule II or III controlled substance for 90 (ninety) days or greater for the treatment of chronic pain arising from conditions that are not terminal or patients who are not in a nursing home or hospice a physician must monitor compliance with the therapeutic regimen.
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> . . .
>
> (h) The physician shall respond to any abnormal result of any monitoring and such response shall be recorded in the patient record.
>
> (i) When a physician determines that a new medical condition exists that is beyond their scope of training, he/she shall make a referral to the appropriate practitioner.
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> . . . .

7.

The Board proved, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct or practice harmful to the public in violation of O.C.G.A. §§ 43-1-19, 43-34-8, and Ga. Comp. R. & Regs. r. 360-3-.02. These practices departed from, or failed to conform to, the minimum standards of acceptable and prevailing medical practice. As an initial matter, Respondent failed to adequately take C.T.'s or D.P.'s medical history, perform necessary physical examinations and make a diagnosis before prescribing controlled substances. There was no documentation in the record reflecting that, in conjunction with prescribing controlled substances, Respondent sought alternative treatments or medications, or that he evaluated the patients' response to the medications prescribed. Even when D.P.'s family voiced specific concerns about her reaction to the prescribed medications, Respondent took no action to evaluate or address this matter.

8.

C.T.'s drug screens reflected that not only had she failed to take her medications as prescribed, clearly she was abusing illegal drugs on a regular basis. Prescribing controlled substances for a known or suspected habitual drug abuser or other substance abuser in the absence of substantial justification, and failing to refer the abuser for treatment, clearly violates the directives of Ga. Comp. R. & Regs. rr. 360-3-.02 and 360-3-.06. The regulations mandate that a physician stop prescribing controlled substances and refer a patient for treatment.

9.

Respondent's records detail no effort to address this issue. Although the evidence of addiction was unambiguous, Respondent continued to prescribe the controlled substances over and over again without question. Instead of treating his patient, his actions proved detrimental to her health because he enabled her continuing addiction. This conduct was not merely negligent or careless; Respondent was a "drug dealer in a white coat." Such egregious conduct merits revocation of his medical license.

IV. Decision

Based on the aforementioned Findings of Fact, the Board has proven by a preponderance of the evidence its allegations that Respondent engaged in unprofessional conduct that failed to conform to the minimal reasonable standards of acceptable and prevailing practice and engaged in conduct that violated O.C.G.A. §§ 43-1-19, 43-34-8, and Ga. Comp. R. & Regs. r. 360-3-.02. The undersigned also notes that the Board has disciplined this physician on one prior occasion. For the reasons stated, the undersigned recommends Respondent's license be **REVOKED.**

SO ORDERED, this 19 day of October 2015.

RONIT WALKER
Administrative Law Judge