BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA COMPOSITE MEDICAL BOARD, **Petitioner,** **v.** **WILLIAM BURNETT,** **Respondent.**	**Docket No.: 2109138** **2109138-OSAH-GCMB-PHY-67-Malihi** **Agency Reference No.: 20121324, 20140319, 20150747**

INITIAL DECISION

The Georgia Composite Medical Board ("Petitioner" or "Board") initiated this matter for the purpose of sanctioning Respondent's medical license. Specifically, Petitioner seeks the revocation of Respondent's medical license. The hearing was conducted on February 22-25, 2021, at the Office of State Administrative Hearings. The Board was represented by Senior Assistant Attorney General David Stubins, and the Respondent appeared *pro se*. The record closed on April 5, 2021, following completion of the transcript by the court reporter.[1] After careful consideration of the evidence presented, and for the reasons stated below, the undersigned **RECOMMENDS** that Respondent's license be **REVOKED**.

I. Preliminary Matters

Prior to the hearing, on February 19, 2021,[2] Respondent filed a document entitled Motion for Dismissal/Summary Determination, which the Court construes as a motion for summary determination. As Respondent acknowledges in his motion, under Ga. Comp. R. & Regs. 616-1-2-.15(1)(b), a motion for summary determination must be filed and served "no later than thirty

[1] The final volume of the transcript was submitted by the court reporter after office hours on Friday, April 2, 2021, a state holiday, and is considered to have been filed on April 5, 2021.

[2] February 19 was the Friday before the hearing began on Monday, February 22, 2021.

(30) calendar days before the date set for hearing," although "[f]or good cause shown, a motion may be filed at any time before the close of the hearing." Respondent presumes that he has shown good cause, but that is properly the determination of the Court, which does not find good cause for the late motion. Even assuming Respondent had shown good cause for an untimely submission, however, the submission in both its substance and form fails to conform to the requirements of a motion for summary determination as set forth in Ga. Comp. R. & Regs. 616-1-2-.15(1)(a). The Court hereby **DENIES** Respondent's motion.

Next, on February 28, 2021, after the conclusion of the hearing, Respondent filed a document entitled "Notice to Produce." Having reviewed the submission and Petitioner's response, the Court concludes that Petitioner has satisfied its obligation to Respondent.

Finally, on March 19, 2021, which, again, was after the conclusion of the hearing, Respondent filed a Motion to Dismiss. Petitioner was granted an extension of time within which to file a response. Having reviewed these filings, the Court hereby **DENIES** Respondent's motion as untimely and without merit. See Ga. Comp. R. & Regs. 616-1-2-.16(1)(c).

II. Findings of Fact

A. Background

1.

Respondent holds a license to practice as a Physician in the State of Georgia, and he held such license at all times relevant to the issues presented for hearing. His license was issued on April 11, 1979, and its current status is Active. The expiration date is December 31, 2021. His designation is DO, Doctor of Osteopathy. His specialty is listed as Family Medicine. Since 2009, Respondent's practice, Your Family Doctor, has been located at 2720 Mall of Georgia Boulevard, Suite 207, Buford, Georgia. (Transcript [hereinafter T.] 38, 44-45; Exhibit P-1).

2.

In 1989, Respondent entered into a consent order with the Board, Docket No. 89-3 ("1989 Consent Order"). As set forth in the 1989 Consent Order, Respondent did not contest that he had engaged in unprofessional conduct in violation of Rule 360-2-.09 "by prescribing medication without proper precautions to avoid adverse physical reaction, habituation or addiction." As a result, his license was suspended for one year, with all but forty-five days of the suspension stayed and served on probation. At the conclusion of the forty-five days of suspension, Respondent's license was placed on probation for a period of five years. (T. 55-56, Matters Asserted ¶ 2, and Exhibit 2 attached to Matters Asserted; Exhibit P-3.)

3.

By the terms of the 1989 Consent Order, during the probation period, Respondent was not allowed to prescribe, administer, or dispense any Schedule II or III controlled substances;[3] he was required to complete an 87-hour "mini residency" in the Proper Prescribing of Controlled Dangerous Substances; and he was required to complete a total of 200 hours of continuing education, including pharmacology, drug abuse, and related areas. In 1998, several years after the conclusion of the five-year probation period, Respondent completed the terms of probation and petitioned to have the probation lifted. Over the years, as recently as 2019, Respondent completed a number of courses related to the appropriate prescribing of opioids and recordkeeping. (T. 49-56, Matters Asserted ¶ 2, and Exhibit 2 attached to Matters Asserted; Exhibit P-2, P-3.)

[3] See O.C.G.A. § 16-13-21(26.1); 21 U.S.C. § 812 (defining controlled substances).

B. Concerns Arising in 2011 Regarding Respondent's Practice

4.

In 2011, Respondent's medical practice and prescribing attracted the attention of a pharmacist, the Georgia Drugs and Narcotics Agency ("GDNA"), the Drug Enforcement Administration ("DEA"), the Gwinnett County Police Department, and the Board. (T. 136, 175, 200-03, 235, 263.)

i. Pharmacist Apollon Constantinides

5.

Pharmacist Apollon Constantinides is the owner of Lakeside Pharmacy and Compounding Lab. In 2011, he noticed prescriptions written by Respondent that raised red flags for him. For example, Mr. Constantinides was concerned about the strength of medication he saw prescribed by Respondent—most commonly, oxycodone 30 milligrams and 15 milligrams. According to Mr. Constantinides, he typically would see pain medication of this strength prescribed by a dentist doing root canals or an oncologist treating cancer patients, as opposed to a doctor specializing in family medicine like Respondent. He also noticed that Respondent's patients were coming to his pharmacy daily seeking to have their prescriptions filled, even though in his opinion his pharmacy was not conveniently located for them. Sometimes Mr. Constantinides or other pharmacists at Lakeside would learn from the customers seeking to fill these prescriptions that they also had visited other pharmacies. In such a situation, the pharmacist would contact the other pharmacies

to determine whether the customers might be "doctor shopping," or obtaining similar prescriptions from multiple doctors.[4] (T. 168-69, 171-73.)

6.

Mr. Constantinides or others working in his pharmacy contacted Respondent three or four times in 2011 to report their concerns that Respondent's patients could be doctor shopping. Mr. Constantinides would have expected Respondent to take action after receiving this information, such as cancelling the prescriptions; Respondent took no such action, however. (T. 175-76.)

7.

Mr. Constantinides next contacted GDNA, and he spoke with Agent Margaret Brosh approximately two or three times regarding Respondent's practice. He also spoke with an agent at the DEA, Scott Nesbit. (T. 177-79, 191.)

ii. GDNA Agent Margaret Brosh

8.

[4] Today, rather than calling around to other pharmacies, pharmacists and certain others would be able to access the Prescription Drug Monitoring Program ("PDMP") Database, which includes the following information regarding each prescription dispensed for a Schedule II, III, IV, or V controlled substance:

(1) DEA permit number or approved dispenser facility controlled substance identification number;
(2) Date the prescription was dispensed;
(3) Prescription serial number;
(4) If the prescription is new or a refill;
(5) National Drug Code (NDC) for drug dispensed;
(6) Quantity and strength dispensed;
(7) Number of days supply of the drug;
(8) Patient's name;
(9) Patient's address;
(10) Patient's date of birth;
(11) Patient gender;
(12) Method of payment;
(13) Approved prescriber identification number or prescriber's DEA permit number;
(14) Date the prescription was issued by the prescriber; and
(15) Other data elements consistent with standards established by the American Society for Automation in Pharmacy, if designated by regulations of the department.

See O.C.G.A. § 16-13-57, et seq. See also T. 173, 395. The PDMP is a "relatively new tool." (T. 397-98.) Prescribers have been required to enroll as PDMP users since 2018. See Ga. Comp. R. & Regs. 360-38-.02(1).

Agent Margaret Brosh, who retired in 2018, worked at GDNA for thirty-nine years. She is a pharmacist and was POST-certified[5] until 2019. (T. 136-38.)

9.

Agent Brosh became aware of Respondent in 2011 when she received reports from approximately twenty pharmacists in her assigned territory, Gwinnett County. The pharmacists contacted Agent Brosh because they were concerned about the prescriptions they saw written by Respondent. She began an investigation in March of 2011. (T. 143-46.)

10.

Agent Brosh reviewed records of prescriptions that she obtained from the pharmacies that contacted her. She in turn contacted Respondent on ten to twenty occasions to let him know that patients of his were "double doctoring," or, in other words, that they were "seeing multiple doctors getting overlapping scripts." According to Agent Brosh, Respondent informed her that he intended to stop writing oxycodone prescriptions for new patients and that he was only going to continue writing them for current patients for the next two months, in order to allow those patients time to find a pain clinic. (T. 147-49, 151.)

11.

Agent Brosh contacted the DEA's Tactical Diversion Squad to report her concerns about Respondent's prescribing. She also, to the best of her recollection, informed the Board about the red flags she observed regarding Respondent's practice, including weekly prescriptions for oxycodone and the use of cash payments for the office visits. As she gathered further information regarding Respondent, she would pass it along to the DEA and the Board. (T. 150-52.)

[5] "POST" refers to Peace Officer Standards and Training. Agent Brosh attended the police academy. (T. 136.)

iii. DEA Agent Scott Nesbit

12.

Scott Nesbit has been an agent with the DEA since 2004. He worked with the Tactical Diversion Squad from approximately 2011 until 2017. The Tactical Diversion Squad focuses on the illegal diversion of legal prescription drugs. Typically, the drugs involved are opioids. (T. 191-93.)

13.

Agent Nesbit first became aware of Respondent in 2012. He was asked to investigate Respondent's practice, in part because of the information that the DEA had received from GDNA and Agent Brosh. He began conducting surveillance at Respondent's medical practice and observed certain things that were suspicious, in his opinion. For example, many cars had out-of-county tags, suggesting that they had traveled out of their way for this particular practice, and disheveled people were hanging out and smoking in the parking lot. People also arrived in groups for their appointments. The team sometimes saw Respondent go outside and talk to patients in their cars, which they considered unusual for a doctor to do. On one occasion, Agent Nesbit encountered two patients, husband and wife, leaving the area and discovered that the wife was extremely impaired, to the point of slurring her speech. (T. 201-05, 213, 217.)

14.

Agent Nesbit and his team conducted this surveillance from approximately 2012 through 2014 or 2015, off and on. They worked in conjunction with local police in Gwinnett County. Ultimately, the team shifted their focus to investigate larger operations, and Respondent's clinic became less of a priority in comparison to other clinics they were investigating. (T. 202-03, 214-15.)

15.

Agent Nesbit's team obtained subpoenas to gather information from the Prescription Drug Monitoring Program. In his review of these records, he found that the number of patients being prescribed opioids by Respondent was higher than he would have expected with a family practice clinic. (T. 211-12.)

iv. Gwinnett County Police Lieutenant Jason Ayres

16.

Lieutenant Jason Ayres works for the Gwinnett County Police Department. His precinct is located across the street from Respondent's practice. Lieutenant Ayres became aware of Respondent in 2011. He observed people hanging out in Respondent's parking lot and noticed out-of-area license plates. (T. 232, 235-36.)

17.

On March 16, 2012, Lieutenant Ayres was returning to the precinct around 7:00 AM, when he noticed a vehicle parked backwards in front of Respondent's practice. This was unusual because the practice and the other businesses nearby were not open yet. Lieutenant Ayres called for backup and walked outside while he waited. He noticed that the front door was not secured, and it opened when he pulled the handle. When backup arrived, the two of them entered the facility and saw that it was in disarray. For example, behind the counter, Lieutenant Ayres could see files scattered all over the floor. Down the hallway was a room with a makeshift bed, and in the women's restroom they found a baby's playpen. He also found a room with a puppy in it, with urine and feces all over the floor. Finally, in another room, they saw an air mattress, and a man who eventually identified himself as Respondent's son was there, asleep. Respondent's son explained to the officers that it

was his vehicle parked in front of the building. He stated that he had not realized that the front door was unlocked. (T. 242-46, 250-51.)

18.

Lieutenant Ayres prepared a report that he sent to the narcotics unit of the Gwinnett County Police Department, though he does not know what may have become of it. Based on his observations of activity outside the clinic and the condition of the inside, he was concerned that the practice was a pill mill. (T. 248-51.)

v. Board Investigator Emmalie Kirkland

19.

Board Investigator Emmalie Kirkland, who is now retired, worked for the Board from 2003 until 2014. She is POST-certified. She became familiar with Respondent in 2012 or 2013, when she was assigned to investigate him after the Board received a complaint from a Kroger pharmacy and information from the DEA. (T. 258, 260-61, 263, 272.)

20.

Investigator Kirkland reviewed prescriptions logs that she received from the DEA. She was concerned because she saw similar recurring prescriptions for people with the same address, which is unusual. There were also prescriptions on a short cycle, such as a 30-day supply written in a 21-day timeframe. She noticed a troubling and popular combination of drugs, known as the "trinity," which is a hydrocodone product along with muscle relaxant and a benzodiazepine; these were prescribed together on an ongoing monthly basis to certain patients. She wanted to know whether

there was a legitimate medical reason for this prescribing, so she obtained a subpoena in order to review Respondent's medical files. (T. 272-74.)

21.

On September 10, 2013, and October 29, 2013, Investigator Kirkland and a colleague went to retrieve the subpoenaed files from Respondent's office. While there, Investigator Kirkland spoke with Respondent about the two allegations she was investigating: possible prescribing without legitimate medical purpose and possible prescribing for a habitual drug user. Respondent indicated that he was not accepting new chronic pain[6] patients, and Investigator Kirkland explained to him how to sign up to use the PDMP, which he had not yet done. After she reviewed the records, Investigator Kirkland arranged to have them peer reviewed by a doctor. (T. 274-80, 282.)

C. Review of Patient Records by Dr. Steven Lobel

22.

Steven Lobel, M.D., is an interventional spine physician. He has been licensed to practice in Georgia since 2004, and he is Board-certified in physical medicine and rehabilitation and pain medicine. He currently practices at Medical Associates of North Georgia and is Medical Director of the Spine Center. (T. 303-05.)

23.

Dr. Lobel reviewed the medical records of fourteen of Respondent's patients, spanning the years 2011 through 2019. Dr. Lobel testified that over the years, the guidelines generally accepted by the medical profession relating to prescription of opioids, including guidelines promulgated by the Centers for Disease Control and Prevention, have changed. In the past, opioids were

[6] See, e.g., Ga. Comp. R. & Regs. 360-3-.06(c) (defining "chronic pain" as "pain requiring treatment which has persisted for a period of ninety days or greater in a year, but shall not include perioperative pain, i.e., pain immediately preceding and immediately following a surgical procedure, when such perioperative pain is being treated by a physician in connection with a surgical procedure.").

aggressively prescribed. Then around 2004, the guidelines moved toward less aggressive prescribing of opioids and encouragement of more multi-modal care. Around 2018, the tide began to turn somewhat, and anti-opioid rhetoric became less extreme. Regardless of these types of shifts, it is Dr. Lobel's opinion that, for the patient records he reviewed, Respondent was never within the standard of care. (T. 368-70, 394-98, 471, 517, 519; Exhibit 7-001 through 7-014.)

24.

Four of the patients whose records Dr. Lobel reviewed were members of the same family: Rog. H., L.H., Rob. H., and J.H. These four patients typically came into the office together for their appointments, and they have very similar charts, with similar exams, diagnoses, and treatments. They were all treated for chronic pain. Three of the four family members were prescribed oxycodone 30 milligrams, or sometimes 15 milligrams, in a quantity of 50 pills, also known as Roxicodone; the fourth was 10 milligrams oxycodone in a quantity of 50, also known as Percocet, as well as Roxicodone. Respondent testified that the family traveled together and made appointments on the same days because they had transportation issues. Dr. Lobel opined that the similarities of the medical records for the family members was "more than suspicious." (T. 445-48, 487; Exhibit 7-001, 7-002, 7-003, 7-004.)

i. Patient Rog. H.

25.

Respondent began treating Rog. H. in May of 2011. Rog. H. was born in 1965. The records for Rog. H. show that the examination during his initial visit on May 2, 2011, was limited, and the medical history was incomplete, although there is a note that he had multiple back surgeries and vascular surgeries. At the hearing, Respondent supplemented the record with an imaging report from another facility verifying prior surgery. Regardless, the collection of records during this

initial visit was insufficient. For new patients, the standard of care requires that the physician obtain, review and document the review of the patient's outside medical records, including prior testing, prior treating physician's notes, and prior imaging, nerve studies, biopsies, or blood work. Those prior medical records must be summarized in the physician's history. The physician must also document the history of the present illness, including the location, quality, radiation, severity, timing, duration, aggravating and relieving factors. In addition, the physician should obtain family history and demographic information, such as the patient's employment. The physician should also perform certain basic tests, such as observing the patient's gait or putting the patient's back through a range of motion, depending on the complaint, to help determine the veracity and nature of the complaint. Based on the limited information gathered during the initial visit, the treatment plan for Rog. H. consisted only of medication in the form of Roxicodone 30 milligrams, the highest dose available, every four hours as needed, in a quantity of 50 pills. The record does not provide a medical justification for this prescription. Typically, prescription of opioids would not be "first-line" treatment for chronic pain. Before resorting to opioids, a physician would evaluate the patient's risk for abuse or addiction, a drug screen would be sought, and the physician would determine whether less risky or aggressive treatment options have already been attempted and failed. (T. 371-74, 377, 384-84, 390, 400, 423, 426-27, 432-33, 471-72; Exhibit 7-004, 8.)

26.

Rog. H.'s next appointment was May 12, 2011, only ten days later. The record of this visit contains no additional records that may have been gathered in the interim to support the continuation of the treatment plan. At this second visit, Rog. H. received another prescription for Roxicodone 30 in a quantity of 50 pills. There is no medical justification in the records for this prescription. (T. 435-36; Exhibit 7-004.)

27.

The next appointment was May 20, 2011, eight days after the second appointment. Again, Rog. H. received a prescription for Roxicodone 30 in a quantity of 50 pills. There is no medical justification in the records for seeing this patient so frequently. Moreover, there is nothing in the records to suggest that Rog. H. was being assessed for diversion of the medication. This ongoing prescription could be detrimental to the patient. (T. 437-39, 442; Exhibit 7-004.)

28.

Rog. H. remained under the care of Respondent over the years through July of 2019. There are no substantive changes in the records from note to note. For years, with substantially the same documentation, Rog. H. received the same prescription, same drug, and same quantity, time and again. At the final documented visit, on May 28, 2019, Rog. H. was prescribed oxycodone, 15 milligrams, with a quantity of 96 pills. There is no documentation to explain the change in dosage. Overall, from 2011 through 2019, Respondent's prescribing for Rog. H. was excessive and was not justified. Certain records contain notes regarding in-house drug tests, and certain of those which appear to be failed drug tests do not seem to have been sent to outside labs for follow up. In Dr. Lobel's opinion, the treatment of Rog. H. from 2011 through 2019 did not comport with the expected standard of care. (T. 400, 409-10, 443-45, 449, 458-59, 472, 507-08, 517; Exhibit 7-004.)

ii. Patients L.H., Rob. H., and J.H.

29.

As noted, in addition to Rog. H., three of his family members were also treated by Respondent for chronic pain. Records for Patient L.H., born in 1966, indicate that she was treated

from 2014 through 2018. She was regularly prescribed Roxicodone. Respondent stated that, based on his concerns, he dismissed L.H. as a patient and sent her elsewhere for pain management. Records for Rob H., born in 1988, indicate that he was treated from 2014 to 2019. He was prescribed Percocet and Roxicodone. Records for J.H., born in 1970, indicate that he was regularly prescribed Roxicodone. He was treated from 2014-2019. The records for these three patients show similar deficiencies in documentation as outlined for the records of Rog. H., including excessive and unjustified prescriptions for opioids. (T. 445-47, 472, 474, 577; Exhibit 7-001, 7-002, 7-003.)

30.

According to Dr. Lobel, most chronic pain patients are older people. For example, in his own practice and experience, the average chronic pain patient is 75 years old. Younger people typically have not yet developed chronic pain. It is unusual for people younger than 40 to have developed chronic pain, and in his own patient population, Dr. Lobel estimates that about 10% are between the ages of 40 and 60. Based on the records submitted to this Court, when Rog. H. began treating with Respondent in 2011, he was approximately 46 years old. Respectively, when they began their own treatment with Respondent, L.H. was approximately 48 years old, Rob. H. was approximately 26, and J.H. was approximately 44. (T. 311-12; Exhibit 7-001, 7-002, 7-003, 7-004.)

iii. Additional Patient Records

31.

In addition to the patients above, Dr. Lobel also reviewed records for patients A.B., A.E., B.G., C.B., C.P., J.D., L.C., M.M., P.B., and S.H. These records span the years of 2012 through 2019. As noted, it is Dr. Lobel's opinion that, according to the records reviewed, Respondent's prescribing of opioids was outside of the standard of care. In records for patients who were treated

during the time when prescribers were mandated to check the PDMP,[7] Dr. Lobel also raised a concern with utility of the checks performed, and he noted that there was minimal documentation regarding the checks. The records typically contained a note that the PDMP had been checked, but the printout of the PDMP report was not included, nor were there any physician's comments about the contents of the report. In Dr. Lobel's opinion, that is below the standard of care. Moreover, Dr. Lobel was concerned by the narrow window and ineffective timing of certain PDMP checks. (T. 369-70, 396, 474-77, 517; Exhibits 7-005 through 7-014.)

D. Respondent's Testimony

32.

According to Respondent, his prescribing practices have changed over the years since 2011, and his pain management treatment has improved. He stated that he currently provides access to naxolone nasal spray to his patients in case of overdose. He further stated that he has decreased his prescription of opioids. He currently is not co-prescribing benzodiazepines and

[7] In relevant part, O.C.G.S. § 16-13-63 provides as follows:

> (2) (A) On and after July 1, 2018, when a prescriber is prescribing a controlled substance listed in paragraph (1) or (2) of Code Section 16-13-26 or benzodiazepines, he or she shall seek and review information from the PDMP the first time he or she issues such prescription to a patient and thereafter at least once every 90 days, unless the:
>
> > (i) Prescription is for no more than a three-day supply of such substance and no more than 26 pills;
> >
> > (ii) Patient is in a hospital or health care facility, including, but not limited to, a nursing home, an intermediate care home, a personal care home, or a hospice program, which provides patient care and prescriptions to be administered and used by a patient on the premises of the facility;
> >
> > (iii) Patient has had outpatient surgery at a hospital or ambulatory surgical center and the prescription is for no more than a ten-day supply of such substance and no more than 40 pills;
> >
> > (iv) Patient is terminally ill or under the supervised care of an outpatient hospice program; or
> >
> > (v) Patient is receiving treatment for cancer.

opioids; after 2019, he began to taper the dosage of benzodiazepines for those patients who were taking both. He stated that during the time in 2011 when his office was in disarray, his late wife was in poor health, causing him to be absent from the office frequently. The office has since been renovated. He also stated that he intends to improve his utilization of the PDMP by conducting more checks immediately before seeing a patient. (T. 566, 570-74.)

III. Conclusions of Law

1.

The Board bears the burden of proof in this matter. Ga. Comp. R. & Regs. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 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 in unprofessional conduct that fails to conform to the minimal reasonable standards of acceptable and prevailing practice. O.C.G.A. § 43-1-19(a)(6).

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:

> (1) Failed to demonstrate the qualifications or standards for a license, certificate, or permit contained in this chapter or in the rules and regulations of the board. It shall be incumbent upon the applicant to demonstrate to the satisfaction of the board that he or she meets all requirements for the issuance of a license; and, if the board is not satisfied as to the applicant's qualifications, it shall not issue a license, certificate, or permit;
>
> [. . . .]
>
> (7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which 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;
>
> [. . . .]
>
> (19) Failed to maintain appropriate medical or other records as required by board rule;
>
> [. . . .]

4.

The Board's Rule regarding unprofessional conduct, Ga. Comp. R. & Regs. 360-3-.02, was amended in 2012, 2014, 2016, and 2019. The previous and current versions of the rule include the following definitions:

> (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.
> >
> > [. . . .]
>
> (14) Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem.
>
> (15) Failing to use medications and other modalities based on generally accepted or approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction in the treatment of patients. However, nothing herein shall be interpreted to prohibit investigations conducted under protocols approved by a state medical institution permitted by DHS and with human subject

review under the guidelines of the United States Department of Health and Human Services.

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

(a) A physician shall be required to maintain a patient's complete medical record, which may include, but is not limited to, the following: history and physical, progress notes, X-ray reports, photographs, laboratory reports, and other reports as may be required by provision of the law. A physician shall be required to maintain a patient's complete treatment records for a period of no less than 10 years from the patient's last office visit.

[. . . .]

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

Ga. Comp. R. & Regs. 360-3-.02.

5.

The 2012 amendment to the above rule, in relevant part, added the following definition for "unprofessional conduct": "Failing to comply with Rule 360-3-.06," regarding pain management. Ga. Comp. R. & Regs. 360-3-.02(22).

6.

Similarly, the Board's Rule regarding Pain Management, Ga. Comp. R. & Regs. 360-3-.06, was adopted in 2012 and amended in 2013. In relevant part, the previous and current versions of the rule include the following:

(1) Definitions. As used in this rule, the following terms shall mean:

(a) "Annual patient population" shall mean those patients seen by a clinic or practice in a twelve month calendar year, but shall not include patients that are in-patient in hospital, nursing home or hospice facilities licensed pursuant to O.C.G.A. T. 31, Ch. 7.

[. . . .]

(c) “Chronic pain” shall mean pain requiring treatment which has persisted for a period of ninety days or greater in a year, but shall not include perioperative pain, i.e., pain immediately preceding and immediately following a surgical procedure, when such perioperative pain is being treated by a physician in connection with a surgical procedure.

(d) “Monitoring” means any method to assure treatment compliance including but not limited to the use of pill counts, pharmacy or prescription program verification. Monitoring must include a urine, saliva, sweat, or serum test performed on a random basis.

(e) “Terminal condition” means an incurable or irreversible condition, which would result in death in a relatively short period of time.

7.

Further, Ga. Comp. R. & Regs. 360-3-.06(2) as amended in 2013, provides as follows:

(2) O.C.G.A. § 43-34-8. authorizes the Board to take disciplinary action against licensees for unprofessional conduct, which includes conduct below the minimum standards of practice. With respect to the prescribing of controlled substances for the treatment of pain and chronic pain, the Board has determined that the minimum standards of practice include, but are not limited to the following:

(a) Physicians cannot delegate the dispensing of controlled substances to an unlicensed person.

(b) When prescribing controlled substances, a physician shall use a prescription pad that complies with state law.

(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. In the event of a documented emergency, a physician may prescribe an amount of medication to cover a period of not more than 72 hours without a physical examination.

(d) When a physician is treating a patient with controlled substances for pain or chronic pain for a condition that is not terminal, the physician shall obtain or make a diligent effort to obtain any prior diagnostic records relative to the condition for which the controlled substances are being prescribed and shall obtain or make a diligent effort to obtain any prior pain treatment records. The records obtained from prior treating physicians shall be maintained by the prescribing physician with the physician's medical records for a period of at least ten (10) years. If the physician has made a

diligent effort and is unable to obtain prior diagnostic records, then the physician must order appropriate tests to document the condition requiring treatment for pain or chronic pain. If the physician has made a diligent effort and the prior pain treatment records are not available, then the physician must document the efforts made to obtain the records and shall maintain the documentation of the efforts in his/her patient record.

(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) consecutive 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 regimen and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances. The requirement of a visit at a minimum of once every three months can be waived and the clinical visit be at least once per year if the doctor determines there is a substantial hardship and documents such hardship in the patient's record or if the morphine equivalent daily dose ("MEDD") is 30 mg. or less.

(g) When prescribing a Schedule II or III controlled substance for 90 (ninety) consecutive days or greater for the treatment of chronic pain arising from conditions that are not terminal or patients in a nursing home or hospice, a physician must monitor compliance with the therapeutic regimen. Patients should be randomly monitored at least annually via bodily fluid analysis. However, body fluid analysis may be performed more frequently than once a year, if the provider considers it to be necessary in his/her patient population, in order to assess and assure compliance with the prescribed treatment regimen. A clinical examination should occur once every three (3) months, except for hardship in certain cases, which must be well documented in the patient record.

(h) The physician shall respond to any abnormal result of any monitoring and such response shall be recorded in the patient's 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.

> (j) Any physician who prescribes Schedule II or III substances for chronic pain for greater than 50% of that physician's annual patient population must document competence to the Board through certification or eligibility for certification in pain management or palliative medicine as approved by the Georgia Composite Medical Board ("Board"). The Board recognizes certifications in pain medicine or palliative medicine by the American Board of Medical Specialties or the American Osteopathic Association, the American Board of Pain Medicine and the American Board of Interventional Pain Physicians. If the physician does not hold this certification or eligibility he/she must demonstrate competence by biennially obtaining 20 (twenty) hours of continuing medical education ("CME") pertaining to pain management or palliative medicine. Such CME must be an AMA/AOA PRA Category I CME, a board approved CME program, or any federally approved CME. The CME obtained pursuant to this rule may count towards the CME required for license renewal.

8.

Prior to the 2013 amendment to the above rule, Ga. Comp. R. & Regs. 360-3-.06(2), in relevant part, the previous version of subsections (f) and (g) were as follows (and subsections (h), (i), and (j) were added in 2013):

> (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, 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 to evaluate the patient's response to treatment, compliance with the therapeutic regimen and any new condition that may have developed and be masked by the use of Schedule II or III controlled substances. The physician shall respond to any abnormal result of any monitoring and such response shall be recorded in the patient's record. Exceptions to the requirement of a clinical visit once every three (3) months may be made for hardship in certain cases and such hardship must be well documented in the patient record. When a physician determined that a new medical condition exists that is beyond their scope of training, he/she shall make a referral to the appropriate practitioner.
>
> (g) Any physician who prescribes Schedule II or III controlled substances chronic pain for greater than 50% of the physician's annual patient population must document competence to the Board [. . . .]

9.

The Board is also authorized to take disciplinary action pursuant to Ga. Comp. R. & Regs. 360-3-.03 for violations of laws, rules, and regulations which relate to or in part regulate the practice of medicine. These laws, rules, and regulations include, but are not limited to, the Georgia Medical Practice Act, O.C.G.A. §§ 43-34-20 to -45; and the Rules of the Georgia Composite Medical Board, Ga. Comp. R. & Regs. 360-3-.01 et seq. Disciplinary action may include revocation of a professional license. O.C.G.A. § 43-34-8(b)(1)(F).

10.

Pursuant to Ga. Comp. R. & Regs. 360-3-.01,

> The Georgia Composite Medical Board ("Board") is authorized to deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician or physician assistant for all the grounds set forth in O.C.G.A. § 43-34-8 and to deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician pursuant to O.C.G.A. § 43-34-8. In addition, the Board is authorized to terminate the approval of a physician's assistant and to revoke the license of a physician's assistant pursuant to O.C.G.A. § 43-34-107.

11.

In relevant part, O.C.G.A. § 16-13-57 provides as follows:

> (a) As used in this part, the term:
>
> (1) "Department" means the Department of Public Health.
> (2) "PDMP" means the prescription drug monitoring program data base.
>
> (b) Subject to funds as may be appropriated by the General Assembly or otherwise available for such purpose, the department shall, in consultation with members of the Georgia Composite Medical Board, the State Board of Pharmacy, and the agency, establish and maintain a program to electronically record into an electronic PDMP prescription information resulting from the dispensing of Schedule II, III, IV, or V controlled substances and to electronically review such prescription information that has been entered into such data base. The purpose of such PDMP shall be to assist in the reduction of the abuse of controlled substances; to improve, enhance, and encourage a better quality of health care by promoting the proper use of medications to treat pain and terminal illness; to reduce duplicative prescribing and overprescribing of controlled substance

practices for health oversight purposes; and to gather data for epidemiological research. The PDMP shall be administered by the department.

(c)(1) Each prescriber who has a DEA registration number shall enroll to become a user of the PDMP as soon as possible, and no later than January 1, 2018; provided, however, that prescribers who attain a DEA registration number after such date shall enroll within 30 days of attaining such credentials. A prescriber who violates this subsection shall be held administratively accountable to the state regulatory board governing such prescriber for such violation.

12.

Further, as set forth in O.C.G.A. § 16-13-57, in relevant part:

(2) (A) On and after July 1, 2018, when a prescriber is prescribing a controlled substance listed in paragraph (1) or (2) of Code Section 16-13-26 or benzodiazepines, he or she shall seek and review information from the PDMP the first time he or she issues such prescription to a patient and thereafter at least once every 90 days, unless the:

(i) Prescription is for no more than a three-day supply of such substance and no more than 26 pills;

(ii) Patient is in a hospital or health care facility, including, but not limited to, a nursing home, an intermediate care home, a personal care home, or a hospice program, which provides patient care and prescriptions to be administered and used by a patient on the premises of the facility;

(iii) Patient has had outpatient surgery at a hospital or ambulatory surgical center and the prescription is for no more than a ten-day supply of such substance and no more than 40 pills;

(iv) Patient is terminally ill or under the supervised care of an outpatient hospice program; or

(v) Patient is receiving treatment for cancer.

(B) This paragraph shall not become effective unless the department's certification required by subsection (d) of Code Section 16-13-57 has been issued.

(C) A prescriber who violates this paragraph shall be held administratively accountable to the state regulatory board governing such prescriber but shall not be held civilly liable for damages to any person in any civil or administrative action or criminally responsible for injury, death, or loss to person or property on the basis that such prescriber did or did not seek or obtain information from such data base when prescribing such substance.

> (3) A prescriber who has reviewed information from the PDMP shall make or cause to be made a notation in the patient's medical record stating the date and time upon which such inquiry was made and identifying the individual's name who made such search and review. If the PDMP does not allow access to such individual, a notation to that effect shall also be made containing the same information of date, time, and individual's name.
>
> (4) Nothing in this part shall require a prescriber to obtain information from the PDMP when he or she is prescribing a controlled substance that is classified as a Schedule II, III, IV, or V controlled substance for a patient other than those controlled substances listed in paragraph (1) or (2) of Code Section 16-13-26 and benzodiazepines. Such prescriber shall not have a duty and shall not be held civilly liable for damages to any person in any civil or administrative action or criminally responsible for injury, death, or loss to person or property on the basis that the prescriber did or did not seek or obtain information from such data base when prescribing such a substance.

13.

The Board proved, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct in violation of O.C.G.A. §§ 43-1-19(a)(6), 43-34-8(a), and Ga. Comp. R. & Regs. 360-3-.02. These practices departed from, or failed to conform to, the minimum standards of acceptable and prevailing medical practice.

14.

Based on the evidence presented at the hearing, Respondent's treatment of patients Rog. H., L.H., Rob. H., J.H., A.B., A.E., B.G., C.B., C.P., J.D., L.C., M.M., P.B., and S.H. fell below the minimum standards of acceptable and prevailing medical practice. The undersigned finds credible Dr. Lobel's statements that Respondent prescribed controlled substances in excessive amounts given the patients' conditions. This practice falls below the minimum standard of care, and thus constitutes unprofessional conduct under Ga. Comp. R. & Regs. 360-3-.02 and .06.

15.

The undersigned also finds credible Dr. Lobel's statements that Respondent failed to maintain appropriate medical records. Respondent's documentation of the care of his patients was woefully inadequate and did not support the numerous prescriptions for controlled substances. Respondent's record-keeping thus failed to conform to the minimum standards of acceptable and prevailing medical practice. O.C.G.A. § 43-34-8(a)(7); O.C.G.A. § 16-13-57; Ga. Comp. R. & Regs. 360-3-.02; Ga. Comp. R. & Regs. 360-3-.06.

16.

The aforementioned violations provide sufficient justification to revoke Respondent's license. Moreover, Respondent was previously sanctioned by the Board for very similar conduct. It is clear that he has no intention of changing his behavior. The conduct at issue in this case reaches back to 2011 and has continued through 2019. For these reasons, the undersigned concludes that Respondent's license should be revoked.

IV. Decision

For the reasons stated, the undersigned recommends that Respondent's license be **REVOKED**. Pursuant to O.C.G.A. § 43-1-19(d)(8), the Board has the authority to collect fees or charges in an amount necessary to reimburse it for the administrative and legal costs incurred in conducting an investigative or disciplinary proceeding. The Board has represented that the costs of this proceeding include $3,808.97 for witness fees and peer review of records,[8] and it is authorized to seek reimbursement of this amount from Respondent. In addition, the Board is authorized to seek reimbursement of the cost of the court reporter's take down, which the court

[8] Specifically, on March 26, 2021, as ordered by this Court, Petitioner filed an expense report identifying costs for Margaret Brosh (witness fee, mileage, and parking), Emmalie Kirkland (witness fee, mileage and parking) and Steven Lobel, MD (first peer review, second peer review, and hearing testimony). Respondent did not file an objection. (See Court File.)

reporting service has billed to the Board. Finally, the Board is authorized to seek reimbursement of the Court's fees related conducting the hearing and preparing this Initial Decision, the bill for which will be provided to the Board.

SO ORDERED, this the 5th day of May, 2021.

Michael Malihi

Michael Malihi
Administrative Law Judge

NOTICE OF INITIAL DECISION

Attached is the Initial Decision of the administrative law judge. A party who disagrees with the Initial Decision may file a motion with the administrative law judge and/or an application for agency review.

Filing a Motion with the Administrative Law Judge

A party who wishes to file a motion to vacate a default, a motion for reconsideration, or a motion for rehearing must do so within 10 days of the entry of the Initial Decision. Ga. Comp. R. & Regs. 616-1-2-.28, -.30(4). All motions must be made in writing and filed with the judge's assistant, with copies served simultaneously upon all parties of record. Ga. Comp. R. & Regs. 616-1-2-.04, -.11, -.16. The judge's assistant is Kevin Westray - 404-656-3508; Email: kwestray@osah.ga.gov; Fax: 404-656-3508; 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303.

Filing an Application for Agency Review

A party who seeks review by the referring agency must file an application for agency review within 30 days after service of the Initial Decision. O.C.G.A. §§ 50-13-17(a), -41. **In nearly all cases, agency review is a prerequisite for judicial review.** O.C.G.A. § 50-13-19(a).

The application for agency review must be filed with: GEORGIA COMPOSITE MEDICAL BOARD, 2 PEACHTREE ST NE, 6TH FLOOR, ATLANTA, GA 30303. Copies of the application for agency review must be served upon all parties of record and filed simultaneously with the OSAH Chief Clerk at 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303. If a timely application for agency review is not filed and the referring agency does not review the Initial Decision on its own motion, the Initial Decision will become the Final Decision of the referring agency by operation of law. O.C.G.A. §§ 50-13-17(a), -41.