BEFORE THE DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN RE: GREGORY VILLABONA, M.D.	)	**Case No.: 10-143-13**
	)	**10-97-17**
	)	
LICENSE NO.: C1-0004007	)	**FINAL BOARD ORDER**

ORDER

At its meeting on February 5, 2019, the Board of Medical Licensure and Discipline considered the recommendation of the hearing officer. A hearing began before the hearing officer on May 29, 2018 and the hearing officer recommendation was mailed out to Dr. Villabona and the State, pursuant to 29 *Del. C.* § 8735(v)(1)d, on August 6, 2018. The State submitted exceptions to the hearing officer's recommendation by letter dated August 24, 2018. After multiple extension requests by Dr. Villabona, his exceptions were submitted to the Board by letter dated January 29, 2019. This is the Board's final disciplinary order in this matter. The duly appointed hearing officer has filed the attached written report in which the hearing officer makes a number of findings of fact, which the Board is bound by pursuant to 29 *Del. C.* § 8735(v)(1)d. Some of those findings of fact are highlighted herein.

The hearing officer found as a matter of fact that Dr. Villabona is a medical doctor licensed by this Board since 1992. The hearing officer found that Dr. Villabona has been previously disciplined by the Board in September of 2003, where he was ordered not to treat minor patients without the presence or supervision of an adult person not under his direction or control. This discipline was imposed following Dr. Villabona's criminal conviction in the state of Maryland for sexually abusing two girls. The Board ordered probation was terminated in 2005, but the restrictions on his license regarding the required notice to patients of his Maryland criminal conviction and the restriction on his treatment of children remained in place. In June

2007, the Board again placed Dr. Villabona's license on probation for a period of three years, and again prohibited him from treating any patients under the age of 18 during the period of probation. In June 2008, Dr. Villabona entered a consent agreement, agreeing to have his license further disciplined, agreeing to permanent restriction on his license to practice, restricting him to treating only male patients over the age of 18, and agreeing to the extension of his probation until June 2015. The hearing officer found as a matter of fact that the notice to his patients that Dr. Villabona was previously ordered to provide was an editorialized version of events that constituted Dr. Villabona's "take" on his criminal history and had never been approved by the Delaware Department of Justice. Dr. Villabona's medical specialty was and remains psychiatry. The hearing officer made a number of findings of fact regarding Dr. Villabona's treatment of certain patients, including the prescribing of controlled substances for pain.

The hearing officer found as a matter of fact that Dr. Villabona could not locate a risk assessment in Patient U's chart. He further found that although Dr. Villabona testified that he utilized urine drug screens with Patient U, there was no indication of the same in the chart. Dr. Villabona also did not have any documentation of a conversation he testified he had with Patient U regarding a prior treating physician's concerns about Patient U's need for an evaluation and multi-disciplinary approach. Dr. Villabona also claims to have spoken to another of Patient U's treating physicians, but there was no documentation of such a discussion in Patient U's file. Dr. Villabona provided multiple Oxycodone 15 mg for Patient U.

The hearing officer found as a matter of fact that Dr. Villabona treated Patient M beginning in 2009. Dr. Villabona's initial assessment of Patient M included a plan to have Patient M evaluated by a neurosurgeon "in the near future." This never happened. Dr. Villabona did, however, prescribe Oxycodone 15 mg and Soma. In 2012, Patient M was discharged from

another provider for securing pain medication prescriptions from multiple providers. Dr. Villabona conceded this is a violation of his pain management agreement with Patient M, but Dr. Villabona continued to write Patient M prescriptions for Oxycodone after this date. In July 2013, a Drug Court Diversion Case Manager asked Dr. Villabona to stop prescribing addictive medication to Patient M because it interfered with Patient M's rehabilitation. Dr. Villabona refused. There was a gap of approximately one year where Dr. Villabona was not charting any visits with Patient M, but was still providing Patient M with prescriptions for controlled substances. During the hearing, Dr. Villabona conceded that Patient M was clearly doctor shopping during the time he was providing Patient M with prescriptions for controlled substances. There was no evidence of any urine drug screen ever performed on Patient M. Patient M ultimately died of a drug overdose.

The hearing officer found as a matter of fact that Dr. Villabona began treating Patient T in 2006 for psychiatric concerns, and in 2013 after Patient T tested positive for cocaine with his pain management physician, Dr. Villabona began prescribing controlled substances for Patient T after his pain management physician discharged him. Dr. Villabona told Patient T he would only prescribe controlled substances for him for one month while he located a new pain management physician. Dr. Villabona continued to prescribe controlled substances to Patient T for two years, every time Patient T was refused prescription medication from other physicians or discharged from their care.

The hearing officer found as a matter of fact that Dr. Villabona treated Patient D for only three months. During this time, Dr. Villabona wrote Patient D prescriptions for Oxycodone at two weeks intervals. Dr. Villabona was aware that Patient D consumed illegal drugs and medications not prescribed for him. Dr. Villabona could not get Patient D successfully

transferred to a pain management physician because Patient D tested positive for illegal drug use. Dr. Villabona stopped prescribing for Patient D.

The hearing officer found as a matter of fact that Dr. Villabona treated Patient G, a cash paying patient, for approximately 15 years. The two had a barter arrangement where Patient G would perform services for Dr. Villabona, who in turn would write prescriptions for Patient G for Percocet. There were no records of any office visits for Patient G from 2003-2009, despite Dr. Villabona's staff's testimony that Patient G was a frequent patient who would see Dr. Villabona after hours. After the initial collection of records, Dr. Villabona attempted to produce records of Patient G's care during those years that the hearing officer found he created in anticipation of the hearing. Dr. Villabona remembered that he also prescribed Patient G Ritalin, based on a childhood diagnosis.

The hearing officer found as a matter of fact that Dr. Villabona treated Patient J, his office manager, by prescribing him opioids that Dr. Villabona testified Patient J was receiving from a prior treating physician, although there is no documentation of this in Patient J's file. After two years of prescribing controlled substances to Patient J, Dr. Villabona made his first progress note in Patient J's file. The State's expert testified that Patient J's chart makes clear that Patient J was consuming more medication than Dr. Villabona was prescribing.

The hearing officer found as a matter of fact that Dr. Villabona was treating Patient J2 by prescribing him Percocet. The State's expert testified there was no medical justification for this prescription. Patient J2's prescription monitoring report was clear that Patient J2 was receiving prescriptions from multiple physicians. There was no indication Dr. Villabona ever checked the PMP or asked Patient J2 to participate in urine drug screens.

The hearing officer found that Patient D2 knew Dr. Villabona as a neighbor for close to

fifty years and through the years, received prescriptions from Dr. Villabona for pain relief and anxiety. Dr. Villabona would occasionally pay Patient D2 for his unused medication. In 2014 when officers entered Dr. Villabona's medical practice to conduct an investigation, Dr. Villabona handed a pistol and a knife to Patient D2 and asked him to leave the office with them. Patient D2 stopped seeing Dr. Villabona at the insistence of his family. Patient D2 testified that he had abused some of the drugs prescribed for him by Dr. Villabona and that his family believed he was overmedicated.

Finally, the hearing officer found as a matter of fact that Dr. Villabona's office had an unlocked cabinet with vials, bottles, and samples of medications, some of which were controlled substances, all of which were expired. The cabinet also contained multiple filled prescriptions with the names of patients of the practice. Dr. Villabona testified that he kept drugs for patients for office administration or in case the patients needed them in the future, however, a member of his staff testified that she would observe Dr. Villabona consuming these medications himself. Dr. Villabona also had a safe in his office containing two handguns with ammunition for guns of various calibers that Dr. Villabona testified were provided to him by patients.

Conclusions of Law

The hearing officer recommends that the Board find as a matter of law that Dr. Villabona violated 24 *Del. C.* § 1731(b)(3) in that he engaged in conduct that is dishonorable, unethical, or likely to deceive, defraud, or harm the public. Specifically, the hearing officer recommends that the Board find as a matter of law that Dr. Villabona violated Board Regulation 8.1.2 in that he exploited the doctor/patient privilege for personal gain by buying back prescription medication from patient D2 for his own personal consumption. The hearing officer recommends that the Board find as a matter of law that Dr. Villabona violated Board Regulation 18.1.1 in that his

charting is almost completely devoid of documentation of the performance of overall focused physical examinations and medical histories were not complete and prior treating physician records were never requested; Board Regulation 18.1.1.4 in that he failed to articulate the presence of one or more recognized indications for the use of controlled substances; Board Regulation 18.2 in that he failed to develop treatment plans for his patients; Board Regulation 18.3 in that he failed to document discussions with his patients regarding the risks and benefits of the use of controlled substances; Board Regulation 18.4 in that he possessed signed "agreements for treatment" with his patients receiving controlled substances but did nothing to ensure he or his patients actually complied with them; Board Regulation 18.5 in that his records do not reflect a periodic review of the course of pain treatment. The hearing officer next recommends that the Board conclude as a matter of law that Dr. Villabona violated Board Regulation 18.6 in that he failed to refer patients for additional evaluation and treatment in order to achieve treatment objectives.

The hearing officer recommends the Board find as a matter of law that Dr. Villabona violated Board Regulation 8.1.13 in that he engaged in the "dishonorable or unethical" failure to adequately maintain and properly document patient records.

The hearing officer finally recommends that the Board find as a matter of law that Dr. Villabona violated 24 *Del. C.* § 1731(b)(6) in that he engaged in the use, distribution, or issuance of a prescription for a dangerous or narcotic drug, other than for therapeutic or diagnostic purposes and Section 1731(b)(11) in that he engaged in a pattern of negligence in the practice of medicine. Balancing the aggravating and mitigating factors that the hearing officer finds exist in this case against the findings of fact and recommended conclusions of law, the hearing officer recommends that the Board revoke Dr. Villabona's license to practice medicine in the State of

Delaware.

Analysis

The Board is charged with ensuring that medical practice in the State of Delaware is conducted professionally and competently. 24 *Del. C.* § 1710. To ensure the carrying out of this duty, the Board is vested with the power to promulgate rules and regulations designed to carry out its duties as provided by the General Assembly. 24 *Del. C.* § 1713(a)(12). The failure to comply with the Board's rules is a failure to maintain the minimal assurance of competency and professionalism promulgated by this Board to assure the people of Delaware that a physician possessing a Delaware license will practice in a safe, competent manner. Therefore, the Board finds that it cannot allow any physician to continue to practice, without consequence, in violation of its rules and regulations, as the Board cannot assure the citizenry that the practice will be safe and competent. The Board is bound by the findings of fact made by the hearing officer; however, it may affirm or modify the hearing officer's recommended conclusions of law and penalty. 29 *Del. C.* § 8735(v)(1)d. Here, the Board carefully considered the hearing officer's recommendation.

The findings of fact detail the treatment of specific patients. The record of how these patients were treated is unsafe and unexcusable. Repeatedly, Dr. Villabona failed to request prior treating records, failed to refer patients for other providers to determine the underlying cause of their reported pain, increased dosages without documenting any medical justification, and ignored red flags of diversion or abuse. Urine drug screens were not ordered and expired, unused urine drug screening kits were found in his office. Dr. Villabona's prescribing practices demonstrate not only unprofessional, but dangerous prescribing practices.

The Board accepts the recommended conclusions of law of the hearing officer and finds

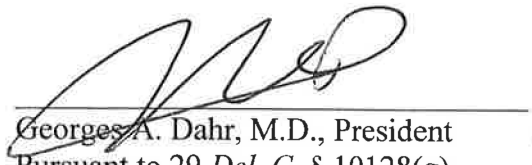
that Dr. Villabona did violate the statute and regulations as recommended by the hearing officer. In determining the appropriate discipline, the Board finds that this is not a case of technical Rule 18 errors or benign charting problems. It is clear that Dr. Villabona did not obtain or use his patients' prior treatment records or urine drug screens to inform his treatment. Dr. Villabona's practices show a gross deviation from appropriate prescribing practices at the expense of appropriate patient care.

In his exceptions, Dr. Villabona notes that the disciplinary guidelines call for at most suspension. He notes that he has already taken steps to limit his practice to psychiatry patients only. Dr. Villabona asserts that in light of the length of time his license has already been emergently suspended, the appropriate discipline would be a period of probation with terms and conditions that prohibit him from engaging in pain management practice. Dr. Villabona's "take" on this Board's prior direction that he notify his patients of the status of his license calls into question his ability to comply with such a restriction. Dr. Villabona's prescribing practices were unsafe and without medical justification. Permanent revocation is the only discipline that ensures that the public will be adequately protected. Accordingly, the Board finds that Dr. Villabona's license should be permanently revoked.

THEREFORE, the hearing officer report and recommendation is entered as an Order of this Board, and Dr. Villabona's license is hereby permanently revoked.

IT IS SO ORDERED this 5th day of March, 2019.

DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE



Georges A. Dahr, M.D., President
Pursuant to 29 *Del. C.* § 10128(g)

Date Mailed: 03/6/2019

BEFORE THE DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

In the Matter of:	)	
	)	Case Nos. 10-143-13
Gregory Villabona, M.D.	)	10-97-17
Lic. No. C1-0004007	)	

RECOMMENDATION OF CHIEF HEARING OFFICER

Nature of the Proceedings

The State of Delaware, by and through the Department of Justice, has filed two professional licensure complaints before the Delaware Board of Medical Licensure and Discipline against Gregory Villabona, M.D., a licensee of the Board with a primary specialty of psychiatry. The complaints were initially filed in September 2017. During the course of the litigation, the State has filed certain amended complaints. The final Second Amended Complaint against Dr. Villabona which governed the course of this hearing is dated May 28, 2018. A copy of the Second Amended Complaint is in a binder admitted during the hearing as State Exhibit 14 ("SX 14"). The complaint is found at SX 14 at 1.

In its Second Amended Complaint the State alleges Dr. Villabona's disciplinary history before the Board. In September 2003 the Board (then titled the Board of Medical Practice) found that Dr. Villabona had engaged in dishonorable and unprofessional conduct when he entered a plea of guilty in September 2002 in a Maryland state court to charges of third-degree and fourth-degree sex offenses in which the victim was a minor child. It is alleged that the Board therefore placed Dr. Villabona's medical license on probation for a term to run concurrently with his Maryland criminal probation. The Board ordered that Dr. Villabona not see minor patients without the presence of an adult family member, and that he disclose the Maryland convictions to all present and future patients in a writing to be approved by a Deputy Attorney General. His patients were required to execute a "notice form" which would be maintained in the patient's chart.

It is further alleged that the Board terminated Dr. Villabona's suspension in November 2005. However, the Board continued the requirement that Dr. Villabona provide patients with the criminal disclosure form concerning his sex offenses, and that he continue to treat minor patients only if an adult were present with the child.

The State alleges that in June 2007 the Board imposed discipline on Dr. Villabona's license for having violated prior orders of the Board. The Board found that Dr. Villabona had failed to require adult supervision while he treated a minor patient. Dr. Villabona's license was again placed on probation for a period of three years. The "notice" requirement concerning the Maryland criminal convictions remained in place. The Board ordered that Dr. Villabona notify his patients of his probationary status. The Board also prohibited him from treating any patients under the age of 18.

In June 2008 it is alleged that the Board accepted a consent agreement signed by Dr. Villabona in which he admitted engaging in sexual relations with a 22-year old patient. The consent resulted in a Board order that Dr. Villabona further restrict his medical practice to male adult patients only. His probation, then slated to end in June 2010, was extended to June 2015.

In conjunction with the two instant cases, certain patient files of Dr. Villabona were subpoenaed by the State. Some of the charts contained the Department of Justice-approved notice of the prior discipline and sex crimes convictions. Some files contained no required notice forms. In one chart it is alleged that investigators found an unapproved notice form in which Dr. Villabona claimed that he was falsely accused of the Maryland crimes, and that the Board had not found any evidence of his guilt. The State claims that this unapproved form was in direct contradiction of the fact that he had entered guilty pleas in the Maryland court. The State alleges that use of the unapproved form violated the Board's 2003, 2005 and 2007 orders.

The complaint then alleges certain violations of the Medical Practice Act and Board regulations with respect to Dr. Villabona's medical care for eight patients. Briefly, it is alleged that Dr. Villabona had

prescribed approximately 13 different controlled substances for patient U from 2011 and thereafter. Another physician had opined that U was engaged in drug-seeking activities and should be treated with a "multidisciplinary approach at a university pain center". Dr. Villabona did not discuss with U the "red flags" noted by the other physician.

It is further alleged that patient M was treated by Dr. Villabona with at least five controlled substances over a six-year period. The State alleges that Dr. Villabona did not investigate further after he was informed that M was receiving controlled substance scripts from multiple prescribers. It is also alleged that Dr. Villabona continued to prescribed controlled substances for M after he was requested to cease doing so by a court drug diversion program. It is further alleged that Dr. Villabona did not discuss or document the discussion with M of addiction issues, and that treatment records end in 2015 while M died from a heroin overdose in 2016.

The State alleges that Dr. Villabona prescribed controlled substances for patient T while providing him with psychiatric services and while T was receiving controlled substance scripts for pain from another physician. It is alleged that Dr. Villabona had not discussed the matter with the other physician. The State contends that Dr. Villabona's prescribing for T was without explanation or justification. The State alleges that Dr. Villabona failed to address T's mental health issues when a family member stated that T had expressed intentions of suicide. The State contends that Dr. Villabona continued prescribing for T after T had disclosed his use of LSD.

The State contends that Dr. Villabona prescribed Oxycodone 30mg for patient D on 13 dates during an approximate two-month period in 2015. The State alleges that Dr. Villabona treated patient G over a 14-year period. He prescribed controlled substances for G which are typically prescribed for Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder without having documented such conditions in G's chart. The State contends that Dr. Villabona prescribed controlled substances for G over two extensive multi-year periods while not maintaining any medical records pertaining to G.

The State alleges that Dr. Villabona prescribed four controlled substances for patient J without having maintained adequate treatment records such as recorded diagnoses. The State further alleges that Dr. Villabona prescribed controlled substances for patient J2 without recording any psychiatric diagnosis. It is further alleged that Dr. Villabona received records from another physician indicating that J2 was being prescribed controlled substances elsewhere, but did not discuss the matter with J2 and continued his prescribing for J2.

The State therefore contends that with each of the listed patients Dr. Villabona had violated Board regulations governing the prescription of controlled substances for the treatment of chronic pain. With regard to patient D2, the State alleges that Dr. Villabona prescribed methylphenidate for him. Though D2 allegedly reported that the drug interfered with his sleep, Dr. Villabona continued the prescribing. Thereafter it is alleged that D2 would return unused tablets to Dr. Villabona, who on occasion allegedly paid the patient for the medication. D2 allegedly observed Dr. Villabona self-administering the medication. It is further alleged that on one occasion D2 was in Dr. Villabona's office when certain law enforcement officers entered. The State contends that Dr. Villabona handed a handgun and knife to D2 which he had kept in a desk drawer, and that D2 took the weapons home.

After asserting allegations with regard to specific patients, the State alleges in the Second Amended complaint that when Division of Professional Regulation investigators went to Dr. Villabona's office to secure subpoenaed records in September 2017, an expired medication bottle dispensed to a patient was observed in plain view. The State further alleges that investigators found additional expired and other containers of controlled and other medications dispensed to patients in an unsecured cabinet in the office. The State alleges that Dr. Villabona would dispense medications to patients in his office even when they had been prescribed for other patients.

On the same date the State alleges that investigators observed medical devices, medications, insecticide, alcohol and other materials in the kitchen in Dr. Villabona's office space. Sharps containers

were observed overflowing with contaminated materials. Other items were also found which are listed in the complaint. Investigators found two handguns in a safe in Dr. Villabona's office. Dr. Villabona stated that they had been given to him to preclude patients from harming themselves. The State further contends that Dr. Villabona barters with his patients, accepting certain services in exchange for medical services.

Based on the allegations in the Second Amended Complaint, the State contends that Dr. Villabona has violated six provisions of the Delaware Medical Practice Act, 24 *Del. C.* Ch. 17, and multiple regulations adopted by the Board.

An open hearing on due notice was convened on May 29, 2018 at 9:05 a.m. in the offices of the Division of Professional Regulation, 861 Silver Lake Blvd., Dover DE. The State was represented by Stacey Stewart and Zoe Plerhoples, Deputy Attorneys General. Dr. Villabona was represented by Andre Beauregard, Esq. and Christopher Tease, Esq. Dr. Villabona was in attendance for the entire hearing. The hearing was conducted over a period of nine days. All witnesses testified under oath or affirmation. A registered court reporter was present on each day and made a stenographic of the proceedings.

This is the recommendation of the undersigned hearing officer to the Board of Medical Licensure and Discipline after due consideration of all relevant evidence. At the time when the State filed the initial complaint before the Board, the State simultaneously filed a complaint seeking professional discipline against Dr. Villabona's Controlled Substance Registration before the Controlled Substance Advisory Committee and the Secretary of State. That complaint has subsequently been amended on multiple occasions. The State's pending Second Amended Complaint seeking relief against Dr. Villabona's Controlled Substance Registration is found at SX 14 at 16. As the allegations in the complaints pending before this Board and the Secretary of State and Committee are similar or identical, this hearing officer directed that a single hearing would suffice to make a factual record from

which two recommendations would be generated, one to this Board and one to the Secretary, via the Controlled Substance Advisory Committee. The latter is being submitted separately to the Committee.

Pre-Hearing Proceedings

The State filed its initial licensure and Controlled Substance Registration complaints against Dr. Villabona in September 2017. The State then filed its "Amended Complaint and Motion for Temporary Suspension" against Dr. Villabona's medical license and his CSR in March 2018. In addition to amending certain claims in the two complaints, the State sought temporary emergency suspension orders against Dr. Villabona's medical license and CSR on the grounds that Dr. Villabona's conduct as alleged constituted a "clear and immediate" or "imminent" danger to the public health.

After considering the allegations in the amended medical licensure complaint (Case Nos. 10-143 and 10-97-17), and after considering the response to the amended complaint from counsel for Dr. Villabona, the Secretary of State and President of the Board of Medical Licensure and Discipline jointly issued an order on March 19, 2018 which imposed a temporary emergency suspension of his medical license pending further proceedings. SX 14 at 34. On the same date the Secretary of State issued a temporary emergency order suspending Dr. Villabona's Controlled Substance Registration in Case Nos. 38-07-17 and 38-10-17 pending further proceedings. SX 14 at 39.

As is his right under the Medical Practice Act, Dr. Villabona requested that this hearing be convened on an expedited basis, or within 15 days of the Board's receipt of a request for expedition. 24 *Del. C.* §1738(d). The hearing therefore convened on April 2, 2018, with all counsel and Dr. Villabona present.

Shortly after the hearing was convened on that date, Mr. Beauregard explained that he had received certain documents from the State only days before April 2. Though most of the documents transmitted from the Department of Justice to Dr. Villanova's attorneys were originally found in Dr. Villabona's charts of the patients identified above, Dr. Villanova argued that it was unfair surprise to

produce those materials on the last business day prior to the April 2 hearing date. His attorneys argued that they and Dr. Villabona would require extra time to review the recently produced documents and to prepare to defend against the State's allegations. Consequently, Dr. Villabona withdrew his request for an expedited hearing on the condition that this hearing reconvene within 60 days of the issuance of the emergency suspension orders as required at 24 *Del. C.* §1738(d).

The State argued against any postponement of the hearing. The State's attorneys argued that they were prepared to go forward on April 2. They also voiced concerns regarding future witness availability, that Dr. Villanova may seek to influence witnesses, and that he may seek to supplement the various patient charts with additional documents not produced to the State in response to subpoenas for their production. The State also argued other concerns.

After considering the arguments of counsel, the request for postponement was granted and Dr. Villabona was permitted to withdraw his request for an expedited hearing. Putting aside the issue of fundamental fairness and the substantial evidentiary record in this case, I determined that implicit in the right to request an expedited hearing is the right to withdraw such a request. In other words, based on the representations of the attorneys, it would be unfair to force a licensee to go through with an expedited hearing if the recent production of a substantial amount of documents placed him at a disadvantage with regard to hearing preparations.

I summarized my decision and rulings in an email to counsel later on April 2, 2018. A hearing officer in a licensure proceeding such as this one has the authority to determine "prehearing matters". Those decisions have the same legal authority as if they had been issued by the Board itself. 29 *Del. C.* Sec. 8735(v)(1)c. Based on arguments or representations made by counsel on April 2, I included a provision in the April 2 order that documents produced by Dr. Villabona after his charts on several patients had been subpoenaed and after he had certified that all requested documents had been

produced to the State should be identified as such and should be accompanied by an explanation as to why the documents were not provided to the State at an earlier date.

That ruling resulted in an objection from Dr. Villabona set forth by his attorneys in an April 10, 2018 letter. The State opposed the objection in a letter dated April 16, 2018. The State's letter resulted in additional reply arguments from Dr. Villabona in a letter dated April 17, 2018. After considering the arguments of the parties, I overruled Dr. Villabona's objection to the April 2 order in a letter dated April 18, 2018. In short, I continued to believe that the late production of documents from patient charts should be accompanied by an explanation regarding the tardy production. I was also careful to note that the April 2 email from me was not a ruling on the admissibility of any documents. For purposes of making a complete record in this case, my April 2, 2018 email, the subsequent correspondence from counsel, and my final ruling have been admitted into the record of this case as Hearing Officer Exhibit 1 ("HO X1").

At the end of my April 18 decision, I stated that it appeared to me that arguments over the admissibility of certain documents in this case may consume an inordinate amount of valuable hearing time. Therefore, I suggested that the attorneys meet and confer and stipulate to the admissibility of as many documents as possible before the hearing convened. (The vast majority of documents ultimately admitted into the record of this case originated in Dr. Villabona's charting of certain patients.) I further offered to meet with counsel to make rulings on the admissibility of as many documents as possible which remained in dispute after counsel conferred.

A teleconference with the attorneys was convened on May 8, 2018. There appeared to be a difference of opinion as to whether a pre-hearing conference such as suggested in my April 18 letter would be necessary, appropriate or likely to be productive. Ms. Stewart had requested such a conference in an email dated May 2, 2018. In a letter dated May 3, 2018, Mr. Tease argued that a pre-hearing conference would not be necessary. I found that such a conference would be appropriate and

could be productive in an May 2, 2018 email to counsel. I asked counsel to confer and select a date for such a meeting.

I met with counsel on May 21, 2018. In my view the conference was productive. It resulted in agreement between the parties on the admissibility of a large number of documents. Some patient charts as maintained by Dr. Villabona were formally admitted and marked. Some charting was simply marked for identification but not admitted. Other documents were not marked, and a decision on their admissibility was deferred until they were offered in the context of the hearing. (I note that while much pre-hearing time and energy was devoted to the timeliness of production or the admissibility of certain documents, by the time the hearing convened on May 29, 2018 many of the arguments had been resolved or waived by counsel.)

A separate but related evidentiary issue had arisen prior to the May 21 conference with counsel. At some point prior to the May 21 conference the State's attorneys had disclosed to Dr. Villabona their attention to call an expert witness (Brian Durkin, M.D.) during the hearing. Apparently Dr. Villabona had also identified an expert witness, but had ultimately determined not to retain that expert nor to call him during the hearing.

Prior to the May 21 conference with counsel, Dr. Villabona's attorneys objected to the State's intention to call Dr. Durkin in a letter dated May 17, 2018. Dr. Villabona argued that the State's late identification of Dr. Durkin was untimely and that he had little time to retain and prepare an expert to address Dr. Durkin's opinions. Ms. Stewart responded to those arguments in an email dated May 18, 2018. In that email the State argued that Dr. Durkin had been retained in part based on the fact that Dr. Villabona had identified his own expert (Dr. Gala). Ms. Stewart also argued that there is no pre-hearing legal requirement of witness or document disclosure or identification in Delaware professional licensure hearings.

The day after the May 21, 2018 pre-hearing conference, I summarized agreements, arguments and rulings which were made during the conference in a May 22, 2018 email to counsel. In that email I summarized my decision on the request to exclude the State's expert witness. In essence, I denied Dr. Villabona's request. I held that the late disclosure of the identity of a witness prior to a hearing is not a basis on which to preclude his testimony. That is specially so when disclosure is not required, but is often done as a courtesy between parties. I further determined that since many of the allegations in the State's Second Amended Complaint concern the failure to abide by professional standards, all parties were on notice that it was probable, if not likely, that one or both parties would call a witness who has the credentials to opine as to those standards. (I did not preclude Dr. Villabona from providing his own opinions.) I have combined the emails and correspondence concerning arguments regarding the necessity of a pre-hearing conference, the outcome of the conference, and the arguments regarding the request to exclude Dr. Durkin collectively as HO X2.

A final legal skirmish prior to convening the hearing surfaced when Dr. Villabona's attorneys addressed a letter to the Department of Justice dated April 26, 2018. As summarized above, certain allegations in the State's Second Amended Complaints concern Dr. Villabona's earlier license discipline stemming from his pleas in the Maryland sexual assault cases in 2002. SX 14 at 1-3. The State has offered into evidence orders of the Board and an opinion of the Delaware Superior Court which directly or tangentially refer to the Maryland criminal matter and its disciplinary sequelae in Delaware. SX 14 at 60-122, 170-176.

In their April 26 letter to the Delaware State Solicitor, counsel argued that after Dr. Villabona had successfully completed the terms of his probation after the Maryland convictions, he requested and was granted expungement of the Maryland criminal records in 2006. He now argues that the State's "decision to publicize" information regarding the Maryland convictions in this case constitutes a

violation of the Maryland state court expungement order. Dr. Villabona also asked that Ms. Stewart be removed from the prosecution of this case.

The State Solicitor (Allison Reardon, Esq.) responded to Dr. Villabona's request in a letter dated May 1, 2018. She declined to remove Ms. Stewart from this case. She noted that the Maryland expungement order did not also expunge Dr. Villabona's admission of unprofessional conduct and resulting disciplinary orders of this Board. Ms. Reardon further held that Board orders are matters of public record and are a permanent part of Dr. Villabona's licensure files.

On May 23, 2018 Dr. Villabona raised similar arguments in a letter to this hearing officer dated May 23, 2018. In his May 23 letter Mr. Tease argued that, at best, the Maryland expungement law is ambiguous. He argued further that therefore while it was the intent of the Maryland legislature to exempt judicial opinions from the scope of expungement, that exemption does not apply to the orders of administrative boards. Dr. Villabona therefore argued that the State of Delaware was required under the Maryland expungement statute to comply with the Maryland order and that neither the State nor this Board may lawfully disseminate any information publicly which concerns Dr. Villabona's arrest and prosecution in Maryland.

The State filed opposition to Dr. Villabona's expungement arguments in a letter dated May 24, 2018. The State argues that the Maryland expungement law makes no mention of collateral matters in other states. Disciplinary matters before this Board in 2003 were separate and distinct from the Maryland prosecution of Dr. Villabona. The State argues that Dr. Villabona has cited no authority which holds that a criminal court may expunge duly issued orders of a State licensing board.

In a letter dated May 25, 2018, I summarized the arguments of the parties on the expungement issue. I found that the Maryland expungement law does not have extraterritorial effect. The Maryland expungement order was directed solely to four Maryland state or local agencies or courts. Nor did this Board act in a "criminal" capacity in 2003, but, rather, its proceedings were "civil" in nature. Disciplinary

orders of this Board are not "criminal records" subject to expungement. In their written arguments both sides discussed the case of *Farr v. State of Delaware*, 1997 WL 524056 (Del. Super. Apr. 15, 1997). After reviewing the *Farr* case, I noted that the Court had considered that it may lack the authority in Delaware to expunge the records of State licensing boards. The letter arguments of Dr. Villabona's attorneys to the State Solicitor, the Solicitor's response, the letter arguments of counsel to this hearing officer, and my decision in the matter have been collectively admitted as HO X3.

Summary of the Evidence

The hearing convened at 9:05 a.m. on May 29, 2018. In her opening Ms. Plerhoples stated that it is the duty of the Board of Medical Licensure and Discipline to protect the public. In this case the State charges Dr. Villabona with multiple violations of the Medical Practice Act and Board rules. The State contends that Dr. Villabona is unable to practice medicine safely, ethically and professionally. Specifically, the State alleges Dr. Villabona's disciplinary history, disregard of prior Board orders, prescription of controlled substances in violation of Board rules, prescription for drug addicts who exhibited "red flags", bartering with patients for medical services, purchasing controlled substances from his own patients, and improper storage of medications and hazardous waste are evidence of dangers to the public health, safety and welfare. In this case the State will request that Dr. Villabona's medical license be revoked.

Mr. Beauregard stated that he has looked at the forest and the trees in this case. This "story has legs". Stories about Dr. Villabona have appeared in the United States press, including the *News Journal, Delaware State News* and *The Washington Post.* One headline featured refrence to "sex, drugs and guns". In this case the State has "cherry-picked" certain facts. Dr. Villabona had a healthy practice, with approximately 40 patients. Claims about his prescribing practices relate to events in the past.

Mr. Beauregard asked, "why are we here?" He characterized this case as a "witch hunt". The State is attempting to "gin up" people and claims. With regard to witnesses who may be called during

the hearing, Ms. Beisch is a disgruntled former employee of Dr. Villabona. She is mentally unstable and has lied to others. She "hates" Dr. Villabona. The hearing officer should assess her credibility. Former patient Davis will discuss events of the past. His treatment with Dr. Villabona ended in 2015. After Mr. Davis went through rehabilitation and divorce, he alleged bad acts in 2016.

The mother of a suicide victim (Ms. M) will blame that event on Dr. Villabona. Police will show that patient M died from a heroin overdose because his girlfriend had left him. The suicide would have occurred with or without Dr. Villabona's care. Mr. Beauregard stated that the emergency complaint initially filed by the State was intended to taint judgments. It makes reference to sex offenses in 1978 and 1981. Those events have nothing to do with the other allegations in the case. The State will also attempt to show that Dr. Villabona was dating a patient in 2008.

Much of this case concerns "sloppy record keeping". Mr. Beauregard asked why the relevant patients in this case will not be called to testify. Events regarding two of the patients occurred in 2013, three in 2016, and four in 2017. Mr. Beauregard asked, "where is the emergency?" He stated that Dr. Villabona ceased care for patient M in August 2015. The suicide occurred in January 2016, and was caused by heroin overdose, not controlled substances.

Mr. Beauregard stated that, at worst, Dr. Villabona is a poor record keeper. Of his 40 patients, the majority will stated that he is a good physician who goes "above and beyond". He stated that with these facts, "we shouldn't be here". The investigation of this case was sloppy and biased. Charges were delayed. It was a "tabloid" investigation designed to engender hate. The facts of this case will show that Dr. Villabona's medical license should be placed on probation, with a requirement that he complete additional continuing education hours and perhaps practice for a time under Board oversight.

Mr. Beauregard offered several news articles concerning Dr. Villabona. He stated that the story "went out quickly". Ms. Stewart interjected that the State is not "in cahoots" with the media. A decision on the admission of the news stories was deferred. Mr. Beauregard stated that the stories

were an effort to "taint the jury pool". After consideration of the offer and these arguments, the news stories were not admitted into the record.

Preliminarily, and on the State's request, the court reporter was instructed to redact all patient surnames inadvertently referred to in testimony should it be necessary in the future to prepare a transcript of these proceedings. Without objection, witnesses to be called during the hearing were ordered sequestered.

The State first called Ms. Tanya Beish. She has worked for Bayada since August 20917. She has been a Certified Nurse Assistant since 2016. She was an employee of Dr. Villabona from October 2012-June 2017. Her duties in his office included office manager, billing, taking patient vitals, and dealing with insurance companies. Other employees of Dr. Villabona in 2012 included David Joyner as office manager, Richard Hulz (sp?), and Kathleen Williams.

Ms. Beish was hired by Dr. Villabona to serve as a front office employee. After Mr. Joyner left the practice, she became involved in scheduling patients. Dr. Villabona was her first medical employment. Previously she had worked as a school cafeteria employee. She had no clerical experience. She was a full-time employee of Dr. Villabona. After she completed her CNA training, she took vitals. She was never a patient of Dr. Villabona, though Mr. Joyner was.

On June 23, 2017 she gave 30-days' notice to Dr. Villabona and then resigned from employment in his office. She told Dr. Villabona that she wanted more hands-on medical experience. She did not share with him her other reasons, which she entered in her DPR complaint in this matter. She believes she left his employ on good terms. She did not complain about Dr. Villabona while employed by him due to a fear of retaliation. She is aware of two prior investigations of Dr. Villabona in 2015. She was fearful that her complaint would "come out" and that Dr. Villabona would "blow up".

On occasion Dr. Villabona would come into the office and intimidate her by messing up files and then instructing her to reassemble them. She is aware that some patients perform work for Dr.

Villabona in exchange for medical services or money. Some of the patients had backgrounds which caused Ms. Beish to be fearful. She was told that some of the patients would "do anything for money".

Mr. Beauregard objected to Ms. Beish reviewing her DPR complaint (SX 14 at 215) during her testimony. The objection was overruled. Ms. Beish testified that she would observe patients "blow up" over "small things". Some of them were Dr. Villabona's friends. They would shoot pool with him and discuss matters not pertaining to their care. Some patients performed work for Dr. Villabona. She characterized the relationships as a "buddy system".

Ms. Beish filed her DPR complaint (SX 14 at 215) under a pseudonym and wrong physical address and email address because she was afraid to identify herself as the complainant. She reiterated that she was fearful of retaliation by Dr. Villabona or some of his patients.

Ms. Beish testified that Kathy Williams began her employment with Dr. Villabona in 2013 when Mr. Joyner left. Ms. Williams took over some clerical duties from Ms. Beish. The two were close. Ms. Williams was aware that Ms. Beish had filed the administrative complaint. An objection to Ms. Beish repeating statements of Ms. Williams was overruled. Hearsay evidence is not prohibited in an administrative licensure hearing. Ms. Williams spoke with investigators, and told Ms. Beish that she would join in the complaint. The two discussed their concerns daily.

Ms. Stewart asked what allegations she had entered in her administrative complaint. She listed several. They included the fact that some patients brought guns to Dr. Villabona's office and gave them to him. One patient used a gun to pay for services, according to Dr. Villabona. That patient is not on the list of patients whose care will be examined in this case. Dr. Villabona would "hold" some guns for patients, though Ms. Beish was uncertain why. Some patients would show their knives to Dr. Villabona, who cut his finger while showing a knife to one patient.

Ms. Beish and Ms. Williams would observe patients receiving pain medications which they were not to receive. Ms. Beish testified that she believes Dr. Villabona was told by the Board not to prescribe

narcotic medications during a 2013 investigation. In 2015 she opened office mail and found a complaint that alleged that Dr. Villabona had prescribed controlled substances after he was warned not to do so. Ms. Beish added that she also reported in 2017 that some patients were instructed by Dr. Villabona to take scripts to other states to be filled. Another patient with whom the pending complaint is not concerned was directed on multiple occasions to fill scripts in Maryland.

Ms. Beish was asked to describe the interior of Dr. Villabona's office. There is one door entry from the parking lot. The front door entered into a waiting area where Ms. Beish and Ms. Williams worked. The room to the right of the waiting area is Dr. Villabona's office. There is a bathroom and a kitchen as well as a back office. A door from the kitchen exits to a back yard area and a basement. Ms. Beish could see from her desk into Dr. Villabona's office through a window on the door until he installed blinds.

Ms. Williams and Ms. Beish would place documents in patient charts. Occasionally they would find misfiled documents. Files were kept in open cabinets. At times files could not be located because they were in Dr. Villabona's office. If a chart was unavailable documents were placed in a bin. The office operated with paper charting. At times Dr. Villabona typed his notes. In 2013 some charting was done electronically. Some notes were not prepared right away. Some were completed a week or two or even a month after an appointment. Ms. Beish and Ms. Williams were in the office when records were subpoenaed in 2013 and 2015.

On one occasion investigator Riddell appeared with Mr. Kemmerlin and another individual to serve a subpoena. She and Ms. Williams gathered the indicated charts. Dr. Villabona stated that some of his charting was done on a computer. After the investigators left , some charts were then completed. The investigators wanted the charts "right away". When Dr. Villabona stated that some records had to be pulled off the computer, the investigators returned the next day to pick them up. In some cases charting was completed after the investigators left. Dr. Villabona would "copy and paste"

some notes at his computer. Ms. Beish observed this with regard to patient P (who is not a patient in this case). She saw him do this for patient G, whose file was never updated. G's chart was always in Dr. Villabona's office as they never saw it.

G usually appeared late in the day after mowing the office lawn. G's appointments were usually entered in a book "after the fact". After he mowed the grass, he would come in for five minutes or so to pick up his scripts. She would see G in the office once every 30 or 60 days. He usually came in after hours. She never took G's vitals. G was a self-pay patient by cash or check. He did not pay Ms. Beish. After 2015 a "spiral card" was used to record payments. Ms. Williams received cash payments.

Dr. Villabona's office had a desk, cabinet, several chairs and a small file cabinet. There was no examination table. Ms. Beish did not observe Dr. Villabona examine any patients.

When investigators came into the office in 2013, they received the files and then saw medications in a storage cabinet. They looked in kitchen cabinets and a safe in the kitchen. They went to the basement.

A metal storage cabinet was used to store medications from pharmaceutical companies and from prior and current patients. Some medications in bags were given to Dr. Villabona by patients. Ms. Beish observed this. Dr. Villabona consumed some of those medications. He would put some of the medications in small envelopes and given them to patients. Some were given without scripts. Ms. Beish does not know why the kitchen was searched. In the kitchen were office supplies, a refrigerator, and sharps containers which were "pretty full". To her knowledge, they were never emptied in five years. After the 2013 search, the contents of the storage cabinet did not change.

Employees normally did not go into the basement. Toilet paper and other supplies were stored there. Ms. Beish does not know what files were kept there. A cabinet in the basement was used to store files of deceased, former and female patients.

Ms. Beish was asked what was kept in the kitchen. She stated that swabs, bandaids and paper goods were stored there. In a separate cabinet were stored LabCorp and Quest Diagnostic supplies, alcohol swabs and drug test kits. The kits were standard UDS kits. She never saw a patient use a kit, or leave Dr. Villabona's office to go to the bathroom to produce a urine sample. The kits remained in the cabinet. Most had expired by 2017.

At this point Ms. Beish left the hearing room due to another obligation. Before the next witness was called, certain procedural issues were addressed by the parties. Counsel discussed the admissibility of certain documents placed in a binder later admitted as SX 14. Some of the documents in the binder pertain to Dr. Villabona's prior discipline by the Board. Ms. Stewart stated that the Board is entitled to take notice of its prior orders. Mr. Beauregard argued that matters pertaining to prior discipline are "aggravating factors" in this case and therefore should be "bifurcated" from this hearing. Ms. Stewart opposed that suggestion. Mr. Beauregard argued that the documents pertaining to prior discipline of Dr. Villabona should not be submitted until after the State has entered its evidence on other claims. Ms. Stewart argued that the complaint alleges facts concerning the prior discipline and compliance with orders. Mr. Beauregard again objected. The objection was overruled and the documents starting at pages 60, 150, 164 and 169 in SX 14 were admitted.

Ms. Stewart then raised the issue of the late "supplementation" of certain patient files by Dr. Villabona. She argued that the State has had little time to review newly produced patient records. At this point the State withdrew claims concerning patient P from the Second Amended Complaint. Mr. Beauregard asked if matters pertaining to patient U are still being pursued (SX 14 at 3-4). Ms. Stewart answered in the affirmative.

After a lunch break patient D2 was called. Ms. Plerhoples noted that documents concerning D2's statement are found at SX 14 at 188-205. Mr. Beauregard objected to the PMP profiles at SX 14 at 196-200 in the D2 materials. He argued that D2 is not able to authenticate those profiles in the

absence of verification of the D2 documents by Agent R.W. Hancock of the Delaware State Police Drug Diversion Unit. Ms. Plerhoples argued that the full set of D2 records was admitted during the pre-hearing conference. Ms. Stewart added that the hearsay nature of a document does not make it inadmissible in a licensure hearing. Ms. Plerhoples added that on each page of the PMP profile D2 had verified the accuracy of the data. The objection as to the PMP data was overruled.

D2 testified that he is a patient of Dr. Villabona and is a longtime friend. They met about 50 years ago. Their farms in Maryland are adjacent. He became a patient about 30 years ago. He treated with Dr. Villabona for "severe anxiety". He was prescribed Alprazolam. He also socialized with Dr. Villabona. He was also treated for chronic back pain stemming from a 2008 motor vehicle accident. He was prescribed Percocet, Oxycodone and Oxycontin. Dr. Villabona also prescribed methylphenidate to "enhance" the pain medications.

D2 stated that he has survived two heart attacks, and presently has some memory issues. He testified that the methylphenidate did not work well. Even though he told Dr. Villabona that the drug was causing anxiety, he continued to prescribe it. It was prescribed for him several times. He saw Dr. Villabona once monthly. When he did not consume all of the methylphenidate, he returned the excess tabs to Dr. Villabona. He does not know what happened with the pills thereafter. In March 2016 he spoke with 3-4 police officers regarding Dr. Villabona. He acknowledged that his statement is found at SX 14 at 188-205.

D2's handwritten statement is at SX 14 at 202. His memory was better when he wrote the statement. He does not presently recall telling the police that he observed Dr. Villabona consuming some of the drugs stored in the office. SX 14 at 202. The statement relates that he returned medications to Dr. Villabona. He thought that is what he was supposed to do. On occasion Dr. Villabona would pay him cash for returned medications. He could not consume all of the methylphenidate. He did not need the pills. He does not recall if he had a drug addiction in 2016 when he gave the

statement. He did undergo rehab in Florida, which was good. His statement was given after he had completed rehab.

He recalls taking a pistol and switchblade from Dr. Villabona in 2014. SX 14 at 204. People entered his office wearing badges. At the time he had an office visit with Dr. Villabona. He took a gun and knife from Dr. Villabona to "help" him. At the time D2 had asked if he could help Dr. Villabona, who said, "take these". D2 concealed them on his person while leaving. He still believes he is a friend of Dr. Villabona. Prior to the April 2, 2018 aborted start of the hearing, Dr. Villabona had called him and left a message. A recording of that call was played during the hearing and entered into evidence as SX 16. In the message Dr. Villabona stated that events were "crazy". He asked that D2 return his call. He provided his phone number. Dr. Villabona stated that "we know each other's family." D2 testified that it was difficult for him to testify in this hearing.

Mr. Beauregard cross-examined. D2 has fished and hunted with Dr. Villabona. He has seen Dr. Villabona with guns at his farm. He stopped treating with Dr. Villabona in 2015 or 2016. Mr. Beauregard showed D2 a color picture of a small pistol and a knife. The photo was later admitted as Respondent Exhibit 13 ("RX 13"). D2 stated that the gun in the photo is not the one Dr. Villabona gave to him. The gun he received had a clip for ammunition.

Police interviewed D2. They asked questions about prescribed medications and the gun incident. D2 was fearful, and retained an attorney. He may have signed his statement at the office of his attorney. He does not recall if an officer was writing as he spoke. He did not read the writing to ensure accuracy. He recalls telling police that he carried the weapons out of the office. The office had been entered by men, a woman, and an African-American. Dr. Villabona informed him that they were "from the State".

D2 concealed the weapons, left the office, and made his next appointment. Dr. Villabona did not insist that he remove the weapons, but gave them to D2 when he asked if he could help. The gun

and knife had been in his desk drawer. When Mr. Beauregard asked if it were possible that Dr. Villabona was simply giving D2 the weapons as gifts, an objection that the question called for speculation by the witness was sustained. D2 does not believe the pistol was loaded. The knife resembled the one depicted in RX 13. D2 testified that it was not illegal for him to possess either weapon.

With regard to medications prescribed by Dr. Villabona, D2 did not review all of the PMP medication profiles in SX 14 at 196-200 in the presence of police. He does not know if they are accurate. Dr. Villabona informed D2 that methylphenidate would enhance the effectiveness of his pain medications. Dr. Villabona urged him to keep taking the drug. He would return unused tabs to Dr. Villabona, who would pay for them because D2 had paid $60-70 for them when scripts were filled. Over the course of a year to 18 months, Dr. Villabona took back methylphenidate tabs from him 8-10 times, or more. D2 still had the methylphenidate scripts filled because he was concerned that Dr. Villabona would stop his other prescriptions. Dr. Villabona never told D2 to fill scripts and to bring the medications to him.

When Mr. Beauregard asked D2 why he stopped treating with Dr. Villabona, D2 became tearful. His family was pressuring him to see another physician. While a patient of Dr. Villabona, his 37-year marriage ended in divorce. D2 lost a substantial amount of weight. On one occasion D2 called Dr. Villabona by mistake, and then told him they could not talk. Dr. Villabona's treatment helped D2. He admitted that he did abuse some of the drugs which Dr. Villabona prescribed for him. He admitted that his present recollections may be inaccurate.

Ms. Plerhoples conducted re-direct examination. Scott Chambers, Esq. was present on his behalf during one of his police interviews. On a form he did state that he intended to answer questions truthfully. SX 14 at 191. Dr. Villabona asked him to remove weapons from his office on only one occasion. His family thought that Dr. Villabona was "overmedicating" him. D2 never told Dr. Villabona that he was abusing prescription drugs. In response to further questioning by Mr. Beauregard, D2

stated that he did not have an attorney the first time he was questioned by police. Agent Hancock interviewed him at that time at his home. The second interview was in Mr. Chambers' office.

After a break the State called Dr. Villabona. Dr. Villabona's testimony was interrupted several times during the hearing in order to accommodate other witnesses called by both sides. Ms. Stewart asked Dr. Villabona to identify his office employees since 2008. Dawn Miller performed billing and other functions from 2008-2011. Mr. Joyner was an employee and a patient. Stacy (LNU) was office manager from 2007-2008. Kathy Williams has worked in the office from 2006-2008 and then again until the current time. Melissa Brown also performed billing functions. Ms. Beish was initially clerical and then completed her CNA training.

The State then began its questioning of Dr. Villabona in regard to specific patients, who were identified by the first letters of their surnames to preserve confidentiality. Patient M's medical records were admitted as SX 1. Dr. Villabona confirmed that he knew who patient M is. M first became his patient in 2009. He was a cash patient. M was diagnosed with severe spinal scoliosis, which was obvious on examination. Dr. Villabona did not record the results of any initial examination. Dr. Villabona acknowledged that there is little in the way of medical history on an intake form. SX 1 at 6.

M's "psychiatric evaluation" form is found at SX 1 at 192-194. Dr. Villabona's Axis III assessment was lordosis, disc herniation and chronic pain. SX 1 at 192. The form does not record an examination. Dr. Villabona stated that he did not have any MRI results on M. M's "plan" included narcotics and methylphenidate. It also included a note that M must be evaluated by a neurosurgeon "in the near future." Initial scripts written by Dr. Villabona for M in 2009 include Oxycodone 15mg and Soma. SX 1 at 145. Dr. Villabona agreed that he had written those scripts before a neurosurgical evaluation of M. He added that "anyone" would have diagnosed the lordosis condition. He admitted that he had not documented any initial physical exam. Dr. Villabona has heard of the adage, "if it's not in the chart, it didn't happen."

Dr. Villabona testified that on one occasion M could not afford the methylphenidate, while on a subsequent occasion he could. The drug was prescribed by Dr. Villabona based on his diagnosis of Attention Deficit Disorder (ADD). By prescribing it he "killed two birds with one stone" because Ritalin also enhanced his narcotic medications. Dr. Villabona stated that effect is "common knowledge".

A reference in a note for June 1, 2009 states that scripts would be "post-dated". SX 1 at 10. Dr. Villabona explained that they were dated for the next day because the renewal date had not yet arrived. Post-dating scripts would save time for M to return the next day. He did not want to bill a second visit under the circumstances. He is unaware that controlled substance regulations prohibit post-dating of scripts.

A note on August 10, 2009 states that the lack of insurance prevented a "proper work-up and referral". SX 1 at 14. Dr. Villabona stated that M needed a pain management physician and neurological work-up. However, he did not have sufficient funds for those services. Dr. Villabona conceded that at presentation he had opined that the work-up "must" be done in the near future. In August the "near future" had passed. M had a family and limited funds, with chronic pain. As of August 2009 he had not documented a physical exam of M. M's chart contained no pain ratings. Dr. Villabona recalls that M was reporting that his pain was adequately handled. As of August 2009 no current MRI had been performed. Other MRI's were "too old". Dr. Villabona stated that he does not know where in M's chart he had documented reviews of older MRI's.

Dr. Villabona stated that M's children had been severely sexually abused. The older MRI's may be in with those records. A letter from a North Carolina attorney dated November 23, 2010 is found at SX 1 at 30 and refers to the abuse matter. Dr. Villabona's letter to that attorney of the same date is found at SX 1 at 32. In a note on a script pad dated November 17, 2010, Dr. Villabona stated that M was not "cleared for travel" to North Carolina due to a diagnosis of pneumonia. SX 1 at 36.

Ms. Stewart questioned Dr. Villabona about a note in M's chart dated November 16, 2010. SX 1 at 28. The note does not document physical symptoms of pneumonia. Dr. Villabona agreed that it was written the day before the "no travel" script.

At this point Ms. Stewart asked for a determination by this hearing officer that Dr. Villabona is a "hostile" witness, though called to testify by the State. In courtroom proceedings, a finding that a witness is "hostile" provides greater latitude for the examining attorney, for instance in the "leading" form of questions. Because in this case Dr. Villabona is the State's adversary, I determined that Ms. Stewart would be provided with greater latitude in her questions and the form of the questions.

Dr. Villabona agreed that the "no travel" note (SX 1 at 36) allowed M to avoid travel to North Carolina. Augmentin is an appropriate medication for pneumonia. Dr. Villabona agreed that he did not prescribe the drug for M in November 2010. He added that he "probably called it in". He did not make a record of "call-ins" for medications. His staff probably called it in. Dr. Villabona admitted that he was therefore "remiss".

Certain medical records regarding M's hospitalization in May 2011 are found at SX 1 at 46-53. M complained of cervical and lumbar pain after a fall at work. Dr. Villabona testified that he reviewed those records.

Mr. Beauregard asked the State's attorney why questions were asked about the North Carolina matter. He argued that Dr. Villabona had not received notice that the matter would be raised during the hearing. Ms. Stewart responded that the State has alleged issues with regard to M's treatment by Dr. Villabona for the period 2009-2015. During that period the State has made allegations regarding Dr. Villabona's prescribing for M, his documentation of care, and has alleged a pattern of negligence. The State alleges that Dr. Villabona had prescribed narcotics with no assessment of pain. Ms. Stewart added that the State is not required to allege all claims with specificity in its complaint. Her examination

has been within the scope of the complaint. In fact, she argued that allegations regarding care for M contain more detail than normal, not less.

Mr. Beauregard reiterated that the State had not alleged any misconduct with respect to the pneumonia diagnosis and the North Carolina case. The State is "nit-picking". Citing to the Court's decision in the *Bilski* licensure appeal, Ms. Stewart reiterated that the law does not require allegation in the complaint of every fact supporting its claims of improper medical conduct. It was observed by this hearing officer that the Board prefers to review the entire course of treatment for patients who are at issue in cases such as this one. Mr. Beauregard reiterated that matters concerning a "false" script" were not alleged in the complaint and have no bearing on M's care. It was ruled that the State could explore issues back to 2009 as the State had alleged the entire continuum of care back to that year. SX 14 at 4.

Ms. Stewart represented that the chart reflected that when M was hospitalized at Milford Memorial Hospital after a work-related accident on May 2, 2011, his wife brought in an empty Oxycodone bottle. On discharge M was provided 20 tabs of Oxycodone-IR 5mg. SX 1 at 53. Ms. Stewart then referenced Dr. Villabona's script on the same date at SX 1 at 165. At that time Dr. Villabona prescribed 90 Oxycodone 15mg.

The State drew Dr. Villabona's attention to his note on May 24, 2011. SX 1 at 54. The note does not reflect that a physical exam was conducted. Dr. Villabona agreed that the note does not show that any increase in pain caused by the fall was discussed, nor that Dr. Villabona charted any rationale to change M's drug regimen. Dr. Villabona knew that an empty med bottle was presented to hospital staff and that he had been prescribed or given pain medications. An Oxycodone script was written on May 24 three weeks after the May 2 script. Dr. Villabona explained that M was planning to take a trip.

Dr. Villabona testified that he is aware when the FSMB "Model Policy" or Bd. Reg. 18.0 became a regulation of the Board. In late 2011 and into 2012 Dr. Villabona started to refer more of his patients

out. He still accepted new pain patients because they had no alternatives. He did not want to carry pain patients. He admitted that he is not a pain management specialist, though he had some training in that speciality in medical school. He wanted to refer patients out. One problem he faced was the fact that some pain specialists had had their licenses revoked. If a chronic pain patient lacked funds and could not be referred out, Dr. Villabona applied the oath to "first do no harm". He testified that the treatment he provided to pain patients was not less than what was required.

Ms. Stewart pointed to a lengthy, typed note of an office visit with M on January 2, 2012. Dr. Villabona agreed that the note did not refer to any physical exam, though it was "alluded to". The note does not contain pain ratings. He added that M's problems were "all acute".

Ms. Stewart drew Dr. Villabona's attention to a letter from Delaware Back Pain & Sports dated September 21, 2012. SX 1 at 102. The note states that M was securing pain medication scripts from multiple prescribers and was being discharged immediately by that practice. Dr. Villabona conceded that M's actions may have been a violation of his pain management agreement with M. A copy of that agreement is found at SX 1 at 1. The agreement states that M will not "attempt to obtain any controlled medicines, including opioid medicines...from any other doctor." *Id.* Dr. Villabona testified that it is not medically correct to punish a patient for non-compliance with such an agreement "if they can retrieve themselves." When Ms. Stewart asked him if the agreement was therefore an "empty threat", he stated that he did not enforce the agreement.

Ms. Stewart questioned Dr. Villabona on a PMP printout for M for the period September 2011-August 2012. Dr. Villabona did not discharge M based on the amount of his narcotics usage. (The printout shows that M filled approximately 28 Oxycodone 15mg scripts during that 12-month period.) Dr. Villabona stated that he had prescribed Percocet 5mg for M because of an increase in pain. Percocet 5mg is "not a preferred street drug". Dr. Villabona stated that he urine-screened M to see if he was taking only prescribed drugs. He recalls that M told him that the PMP mixed him up with his father

as the two bear the same name. Ms. Stewart pointed out that M's birthdate on the Delaware Back Pain letter and the memo by DJ are the same. Dr. Villabona "erred on the side of believing" M. He did not know that he was prescribing for a "doctor-shopper".

Ms. Stewart referenced what appears to be a file memo dated September 24, 2012 and authored by "DJ", a former employee of Dr. Villabona. The memo discusses M's use of multiple prescribers. The memo also discusses M's possible discharge, or loss of the ability to receive controlled substance scripts from Dr. Villabona. Dr. Villabona testified that M was not discharged at that point. He continued to prescribe pain medications for M. The note also discusses assistance to police if any additional information were received regarding M. Dr. Villabona did not contact Delaware Back Pain & Sports to discuss the issue of alleged name confusion.

Dr. Villabona testified that information in the memo was apparently not true because he learned that the State Police had dropped charges against M. He heard that from two sources, though his staff did not document the dismissals in the chart.

Before the hearing adjourned for the day, I raised the issue of consultation with counsel while a witness remains under oath and subject to further examination. Under Delaware ethical legal practice, an attorney is typically not permitted to discuss a case with a witness while he is still testifying. Since we had just concluded the first day of what became a nine-day hearing, I thought it unfair or unduly harsh to preclude Dr. Villabona from consulting with his attorneys for the remainder of the hearing. After listening to the arguments of counsel on the point, I directed counsel not to discuss the care of the relevant patients in this case with Dr. Villabona. Other issues would not be out of bounds.

The hearing resumed on May 30, 2018. I clarified my ruling concerning restrictions in privileged consultations between Dr. Villabona and his attorneys. Ms. Beish was then recalled for additional testimony. She identified her administrative complaint to the Division at SX 14 at 215. Mr. Beauregard objected to admission of the complaint on the basis that Ms. Beish was present to testify and the

complaint is therefore technically hearsay. Ms. Stewart noted that the complaint had earlier been admitted into evidence. The objection was overruled.

Ms. Beish was questioned about certain allegations in the complaint. Early in the complaint Ms. Beish alleges that she had seen Dr. Villabona write scripts for patients. SX 14 at 216. Those patients had the scripts filled, took out the tabs they needed, and gave the rest to Dr. Villabona. Ms. Beish testified that she had seen a patient (whose care is not a subject of this hearing) bring unused methylphenidate to Dr. Villabona. She then witnessed Dr. Villabona taking the medication "throughout the day". Other patients brought in unused medications which were placed in the office storage cabinet. The medications were then placed in small envelopes and given to patients. "From the looks of the bottles", Ms. Beish stated that some of the medications were expired. Ms. Beish sent out some of the returned medications through the mail "for years".

At the top of SX 14 at 217 Ms. Beish refers to some patients of Dr. Villabona who had tested positive for cocaine and heroin but who still received controlled substance scripts from him. Ms. Beish and Ms. Williams would request files from other physicians.

Some of the medications distributed from the cabinet to patients were expired. Ms. Beish does not know if those medications were returned by former female patients. Ms. Beish also reported that guns were "stashed around" Dr. Villabona's office. *Id.* She does not believe that was appropriate in a psychiatric practice. One of the weapons was a shotgun. She did not discuss guns with Dr. Villabona.

She also reported that Dr. Villabona was writing scripts for certain individuals who then gave them to spouses. Dr. Villabona kept an "office stock" of testosterone and other medications. Some may not have been controlled substances. Dr. Villabona also took liquid vitamins. She did not order the product when Dr. Villabona asked her to do so for his IV use.

Ms. Beish testified that she never saw an in-office urine drug screen being performed during the time she worked for Dr. Villabona. Ms. Beish filled out some applications for medical marijuana use for

two patients who had tested positive for illegal drugs. Other physicians reported to Dr. Villabona's office that certain patients had tested positive for cocaine. Some prior authorization forms, DMV license renewal forms and other forms were filled out by staff but were occasionally ignored by Dr. Villabona.

Ms. Beish has observed Dr. Villabona consume alcohol which was stored in the office kitchen. He would occasionally drink it when patient G would come into the office. In Ms. Beish's opinion, Dr. Villabona was occasionally impaired as he would sign scripts without noting dosage strengths. She knew that Mr. Beauregard was on retainer with Dr. Villabona. She knew of Dr. Villabona's prior disciplinary investigations. Ms. Beish on one occasion suggested that Ms. Williams contact DPR. The purpose was not to discuss this case. The two often talked about Ms. Williams not being paid "minimum wage".

At the end of the long paragraph at SX 14 at 217, Ms. Beish accuses Dr. Villabona of "lying" when he stated that certain notes were on his computer. On occasion he would write notes weeks or months after a particular office visit. She would put tabs on pages for him where notes had not been prepared. After investigators appeared in the office to pick up certain files, staff would type up some notes, occasionally "cutting and pasting" them.

Mr. Beauregard then cross-examined Ms. Beish. He presented her with a document containing a letter from Ms. Williams and pictures or "screen shots" of a number of texts. The document was subsequently admitted as RX 3. The first page in the exhibit is a note signed by Ms. Williams. The note relates that on February 1, 2018 she received a text from Ms. Beish's daughter Gwen reporting that Ms. Beish had been in a serious motor vehicle accident. The next day Ms. Williams asked for an update and Gwen told her there had been no change. Ms. Beish remained in critical condition with head trauma. On February 5 Gwen replied that Ms. Beish had been "lost", but had been revived. Gwen asked if Ms. Williams had informed "doc" (presumably Dr. Villanova). No report followed for the next two weeks. On March 23, 2018 Ms. Beish reported to Ms. Williams that she was "fine".

In her testimony Ms. Beish denied that she had been in an accident. She explained that after she filed her complaint with DPR (SX 14 at 215), she received phone calls from blocked phone numbers. She became frightened. The texts which she sent to Ms. Williams and which were ostensibly sent by her daughter were in fact sent by Ms. Beish. Ms. Beish "knew this was bad". She was fearful because a patient of Dr. Villabona lived near her. She did not want retaliation. She agrees it was a bad judgment call to fake the "accident". Ms. Williams was upset with her. Some of Dr. Villabona's patients will do "anything for money". That she faked the accident does not make her a bad person. It was not a plot to "fake her death". She was afraid that someone would "come after" her.

After the event, Ms. Beish went to Ms. Williams' home to see how she was feeling. She wanted to know if Ms. Williams needed a ride to this hearing. Ms. Beish was not surprised that she had hurt Ms. Williams. She apologized to Ms. Williams.

Ms. Beish stated that the testimony that she had given the day before was true and not embellished. Mr. Beauregard provided photos taken in Dr. Villabona's kitchen. One picture (subsequently admitted as RX 4) is a photo of a bottle of "Gluhwein", or German mulled wine. She brought German wine to the office for personal use. Other alcohol was stored in the kitchen. She never tasted alcohol in the office. She was not aware that "Gluhwein" is a non-alcoholic beverage. Another photo depicting the "Gluhwein" and a coffee pot was admitted as RX 5.

Ms. Beish admitted that Dr. Villabona had paid for her entire CNA training course. She does not recall the value of the training. She did not ask him to do that. She told him she needed the training, and accepted his payments. She eventually gave her 30 days notice and her last date of employement with Dr. Villabona was June 23, 2017.

Before she left that employment, she trained Melissa Brown on her duties. She was "hands on" with respect to billing, claims and charts in the office. She was referred to in Ms. Brown's statement in this matter, which was subsequently admitted as RX 6. In the statement Ms. Brown is critical of Ms.

Beish's billing practices. Some patients had not been billed by her and Dr. Villabona "lost a lot of money". *Id.*

Ms. Beish was asked why she filed her complaint with DPR two months after leaving Dr. Villabona's employment. Ms. Beish stated that she "struggled" to decide whether to complain. She feared retaliation. She wanted to ensure that Ms. Williams would be involved. She complained pseudonymously because of fear of retaliation. She discussed the matter with Ms. Williams in the office unless Dr. Villabona was near. Dr. Villabona could intimidate employees through the tone of his voice. He was "not nice" when he was undergoing chemotherapy. At times he would make Ms. Beish feel like the "size of an ant". He would leave notes on her desk. He would strew some charts "all over" and would require that she put them back together.

Ms. Beish also feared retaliation from Dr. Villabona's patients. She knew that Matt H. would "do anything for money". Dr. Villabona told her that. Matt has a violent criminal history. In addition, patient Todd M. "hangs out with the wrong crowd". Once after Dr. Villabona stitched an injury on Todd's leg, he said that it was probably from a "drug deal that went bad".

Ms. Beish admitted that she has borrowed money from Dr. Villabona. She and her husband were in a "rough patch". She borrowed from him "for a while". Dr. Villabona helped her. She does not remember amounts that were borrowed, though they were "quite a bit". She did not keep records of the loans. She admitted she did not repay them. She offered to do so, but he said "don't be concerned". She was thankful for the loans. She testified that she "should have paid them back", but took advantage of Dr. Villabona. Ms. Williams also received money from Dr. Villabona. They were not to discuss the loans with each other.

Ms. Beish denied using illegal drugs. She must limit alcohol use because of medications she was taking for fibromyalgia and a thyroid condition. She was treated in Germany by a "base physician' for

agoraphobia. She was prescribed Paxil, but stopped taking the drug. She now has "social anxiety", and has suffered previously from depression. She has not been treated in Delaware for any mental illness.

Ms. Beish discussed her DPR complaint with Ms. Williams. She did not describe all of the details in the complaint to Ms. Williams. Ms. Williams was concerned for her job. They discussed her complaint before Ms. Beish left Dr. Villabona's employment. Ms. Beish told Ms. Williams when she filed the complaint.

Ms. Beish testified that Dr. Villabona uses a bed in the basement. The building is his private dwelling as well as his office. She does not know if there are guns in the basement. "Quite a few" patients brought guns to the office to show them to Dr. Villabona. One patient (Jeff C.) paid for services with a gun in 2016, but later retrieved it. She admitted she did not put that detail in her complaint. SX 14 at 215. She knows that Dr. Villabona would show guns to patients. Dr. Villabona stated that his patients would "just bring them" but did not know why.

Dr. Villabona would also show knives to patients such as Dominic V. On one occasion as a knife was exchanged Dr. Villanova sustained a lacerated finger. That was an accident. She did not include details regarding the knives in her complaint.

Ms. Beish was questioned regarding dispensing of drugs in the office. She had seen Dr. Villabona "give them out" perhaps 5-10 times. At this point Mr. Beauregard asked why Ms. Beish looked at one of the prosecutors before or during an answer to a question. Ms. Stewart denied any communication with the witness. I did not observe any.

When dispensing drugs in the office, the storage cabinet would be opened. Dr. Villabona would take pills from the cabinet and put them in an envelope. Ms. Beish does not know what pills were being dispensed, except for Geodon (sp?) on one occasion and a blood pressure medication on another. Ms. Beish believes that at one point Dr. Villabona was barred from prescribing controlled substances. She responded that she would not be surprised if that had not been ordered in the past. Dr. Villabona at

one point stated that DPR investigator Kathleen Riddell told him that a psychiatrist could not prescribe certain pain medications. There had been a "crackdown" on physicians. Dr. Villabona was told to refer some patients to pain management physicians.

Ms. Beish did not physically observe Dr. Villabona prescribe pain medications. However, she did see his signed scripts. She was told that Dr. Villabona had had conversations with some patients about going out of state to have scripts filled. "Quite a few" of his patients did so. Patient Matt H. received a script for methylphenidate and was told to fill it outside Delaware. That was an "ongoing" instruction from Dr. Villabona. Patient Raymond M. was also told to fill scripts outside Delaware during the period 2012-2017.

Ms. Williams and Ms. Beish handled money in the office. If no one was available to do so, Dr. Villabona would handle funds. Ms. Williams handled the cash box and made payments for certain items. Ms. Williams would explain payment plans to patients. Dr. Villabona was to complete charting. If Ms. Williams was busy, Ms. Beish would assist with paperwork. Ms. Beish saw patient Michael G.'s chart on two occasions. Some unfilled scripts were in his chart. Though his chart was in the office, it was "missing for months".

Dr. Villabona had a computer in his office and would type in some charts. Ms. Beish did not have access to his computer. Dr. Villabona did not review patient charts before they were provided to DPR investigators. Staff refused or were unable to give the Division some charts because they were on Dr. Villabona's computer. Completed files were produced. Mr. Beauregard showed Ms. Beish the 2013 subpoena for records (SX 14 at 177). Investigators requested that the files be produced on the day of service of the subpoena, or the next day. Investigators returned at that time and were given files which had not been produced previously. Ms. Beish noted what was being given to the investigators, and what was being returned. She testified that some notes had not been completed when files were produced on July 29-30, 2013.

With regard to the subpoena for files in 2016, she and Ms. Williams assembled them. Some were incomplete. The investigators waited for them. Not all of the subpoenaed files were produced. Investigators returned the next day to pick up other files. Dr. Villabona had to complete some of his notes. He was "upset" because the files were subpoenaed.

Patient G never scheduled appointments. He appeared at the office after hours. However, after an office visit his name was then entered in an appointment book. G would mow the office lawn once or twice a month. Ms. Beish did not know who took G's vitals when he appeared after hours. Ms. Beish stated that office hours were 9 a.m.-4 p.m. on Monday, Tuesday and Thursday, and until 3 p.m. on Wednesdays. She testified that Dr. Villabona played pool on Wednesday afternoons.

Ms. Beish stated that the storage cabinet in the office which contained medications was "never" locked. On occasion the doors were left open. She identified a photo of the cabinet. RX 7. She acknowledged that the photo shows a key inserted in a lock in the cabinet door. She reiterated that the cabinet was never locked. She denied that the key and lanyard were always inserted in the door. Dr. Villabona used that key. At times it was lost. The keys in RX 7 belong to Dr. Villabona. Pharmaceutical company samples and old patient scripts were stored in the cabinet along with syringes, eye wash, extra swabs and other items. Ms. Beish never inventoried the drugs in the cabinet. Ms. Beish would remind Dr. Villabona when drug "take back" days were scheduled, but he would not arrange to have that done. An objection to the question by the State was overruled. At this point it was agreed that Ms. Beish would return to continue her testimony on May 31, 2018.

The State next called Kathy Williams. She has worked for Dr. Villabona since 2006, with two gaps in employment. She has been his employee continually since 2010. She has worked at the front desk, made appointments, answered the phone, and accepted payments from patients. In 2010 other employees were Mr. Joyner and Ms. Beish. Ms. Williams testified that Ms. Beish "hated me". Ms. Beish wanted "to be her boss". Later the two began to respect each other. The two are friends at

present. At age 18 Ms. Williams was a CNA, working with geriatric patients. She was then in an accident, and has done no CNA work for Dr. Villabona since that date.

Ms. Williams testified that Dr. Villabona is "great". She has not discussed this case with him or his attorneys. She has not discussed Ms. Beish's DPR complaint with her. Ms. Beish has told her that Dr. Villabona "will go down". She has spoken with Ms. Riddell in 2017 more than once. She called police on patient Matthew H. once.

Ms. Williams has never observed Dr. Villabona dispense medications to patients from the storage cabinet. She has never observed patients with alcohol. She has never seen Dr. Villabona prescribe drugs for known addicts, nor observed patients performing work for medical services. She has never seen him accept a gun from a patient except when a family member believed that a patient may use it to cause harm. She has never observed Dr. Villabona consume alcohol or drugs in the office.

Ms. Plerhoples asked Ms. Williams questions concerning patient Raymond. She never heard Dr. Villabona instruct staff not to discuss Raymond with others. She had seen Raymond do work for services. After he died, staff learned of his drug abuse. Ms. Plerhoples showed Ms. Williams a copy of an interview summary prepared by Ms. Riddell concerning Ms. Williams. Mr. Beauregard objected, arguing that a copy of the summary had not been produced by the State prior to the hearing. Ms. Plerhoples represented that it was part of Ms. Riddell's investigative report. It contains a prior inconsistent statement by Ms. Williams, which the State was not required to produce under standard rules of evidence.

Ms. Plerhoples argued that the State is not seeking to admit the interview summary. Mr. Beauregard will have an opportunity to cross-examine Ms. Williams on the document, as well as Ms. Riddell when she is called by the State. The hearing officer ruled that examination on the document would be permitted.

Ms. Williams again stated that Ms. Beish is mad at Dr. Villanova. Ms. Williams told Ms. Riddell that she "supposes" that information provided by Ms. Beish is true. Ms. Williams does not know what Ms. Beish told Ms. Riddell. Ms. Williams was upset and cried when she learned a patient had died. She never said that she saw Dr. Villanova dispensing pills. She added that Ms. Beish never called a company to come and pick up returned pills. The "DEA" arrived after Ms. Beish left. Ms. Beish told Ms. Brown, "It's all on you". The DEA wanted to see drugs kept in the office. Ms. Brown called a "company" and they came to pick up certain medications. Ms. Williams offered that she has been diagnosed with brain tumors and lung cancer.

Ms. Williams testified that Dr. Villabona was good to Ms. Beish. He paid for her nursing training and for her car repairs. Ms. Williams denied telling Ms. Riddell that Dr. Villabona was negligent, handed out expired medications, or prescribed drugs to addicts. She stated that patient Michael has performed work for services. She did not tell Ms. Riddell that Dr. Villanova took guns from patients, unless a spouse brought in a weapon for safety reasons. She denied stating that Dr.Villabona drinks while on duty. She denied that Dr. Villabona stated that he was "glad they don't know about Raymond". She denied stating that Dr. Villabona writes scripts in exchange for work by patients, or that he knew Raymond was an addict. She denied stating that Dr. Villabona's attorneys reported to him that the State had not returned certain files.

Ms. Williams testified that Ms. Beish hid patient G's chart. Ms. Brown found it in the office trash. Only Ms. Beish could have done that. Ms. Brown gave files to the investigators. Only Ms. Williams and Beish had access to the files. Dr. Villabona could ask for the files in order to complete charting. Ms. Williams told Dr. Villabona about her meeting with Ms. Riddell. Ms. Riddell had instructd her to call the police regarding Matthew H. Matthew was then arrested while at Dr. Villabona's office. When police cars arrived on that date, Dr. Villabona "joked" that they were probably there to pick him (Dr. Villabona) up.

Mr. Beauregard then cross-examined Ms. Williams. When she was told that Ms. Beish had testified that she talked with Ms. Williams about her complaint, and that Ms. Williams had agreed with her, Ms. Williams characterized her testimony as "bull hockey". She again stated that initially Ms. Beish "hated" her. Ms. Beish wanted to "own" the office and to fire Ms. Williams. When Ms. Beish took an extended vacation, Ms. Williams had no one to assist her. Eventually they learned to respect each other. Mr. Beauregard questioned Ms. Williams about Ms. Beisch's fabricated motor vehicle accident and alleged near-death injuries. Initially Ms. Williams was worried. They had become friends. Ms. Beish had lost family members and suffered from anxiety, depression and fibromyalgia. Ms. Williams stated her denials during the hearing because she did not see Dr. Villanova do certain things, other than accept guns from family members of patients. She never saw Dr. Villanova "doctor" any files.

When Ms. Williams read certain portions of Ms. Beish's complaint (SX 14 at 215-217), she said, "this is ridiculous". She then added that "a lot" in the complaint is true. However, Dr. Villanova did not break the law. He did not write "prescriptions for guns". He did not take filled prescriptions from patients and pay for them. The storage cabinet has a lock on it and was locked "the majority of the time". Only Dr. Villabona had access to it.

Ms. Williams testified that no urine drug screening was performed in the office. That was done at pain management offices if a patient were on "strong" medications. Results would be sent to Dr. Villabona's office. She again denied that Dr. Villabona bartered services for guns. If a patient were drinking, he would not write a prescription for that person. Dr. Villabona did not use medications in the office except for cancer meds. He did not take methylphenidate in the office. His physician had prescribed it for him.

Ms. Williams did observe alcohol in the office kitchen. Dr. Villabona lived on the premises. He did not "drink on the job". On occasion Ms. Beish would "have a snoot" in the office. Dr. Villabona's judgment was never impaired. Dr. Villabona treats Ms. Williams' son. Dr. Villabona is the only person

who can keep her son "stable". Ms. Williams is telling the truth, and has not been threatened by anyone. Ms. Williams has never observed Dr. Villabona making "fraudulent" notes.

Ms. Williams was given a copy of RX 3 (her cover letter and the exchange of texts regarding Ms. Beish's "motor vehicle accident".) She acknowledged her signature on the first page of the exhibit. Ms. Brown typed the cover letter, which is titled "texts from Kathy and Tanya". Ms. Williams thought at the time that she was communicating with Ms. Beish's daughter. She signed the note which is the last page of RX 3. Ms. Beish had come to her house with flowers. She said she missed Ms. Williams, and offered her a ride to this hearing in early April 2018. Ms. Williams then phoned Ms. Plerhoples.

Ms. Williams was aware of the medications in the storage cabinet. They had been returned by patients. Other than vitamin D, Dr. Villabona did not dispense them to patients. Ms. Williams handled patient cash payments and put them in the money drawer. With regard to patient G, many files were "hidden" in the office. Some bills were put in the trash. Ms. Beish would stuff files and bills in "dumb" places. Most of Dr. Villabona's charting was hand-written. Some was typed, but "never fudged".

Ms. Brown and Ms. Beish took vitals from patients. A company would pick up medications from the storage container after one of them would call. Mr. Beauregard asked why Ms. Riddell would lie about information Ms. Williams had provided. Ms. Williams stated that she (Ms. Williams) had brain tumors and cancer, and "may have said anything". She reiterated that she is upset that patient M died after a heroin overdose. At this point both parties agreed to the admission of Ms. Riddell's summary of her interview of Ms. Williams on September 1, 2017. The document was therefore admitted as Joint Exhibit 1 ("JX 1"). In concluding his cross-examination of Ms. Williams, Mr. Beauregard stated that it may be necessary to recall her to the stand later in the hearing.

Ms. Plerhoples then conducted re-direct examination of Ms. Williams. RX 3 at 3 shows an exchange of texts regarding Ms. Beish's "accident". At that point Ms. Williams was still concerned about Ms. Beish.

Ms. Williams repeated that she did not observe any urine drug screening performed by Dr. Villabona. She added that "all but one" patient being prescribed opioids had been referred to pain management. One patient (William E) had his dosing reduced by Dr. Villabona. William was referred to pain management. Ms. Williams testified that Dr. Villabona did not prescribe opioids for pain over long periods. Patients were referred to pain management physicians for opioids. One patient (Joshua T) tested positive for heroin at pain management. He killed himself. (Dr. Villanova noted the he had not prescribed for Joshua.)

Ms. Williams testified that a "company" never came to the office to pick up extra medications., Ms. Beish failed to call them. When Ms. Brown placed a call, they were picked up in 2017.

Ms. Williams testified that she intends to continue to work for Dr. Villabona. She would give notice first. Dr. Villanova is a "good person". Only he cares for his patients. Ms. Williams cares for him a great deal.

In order to accommodate Mr. Beauregard's court obligations, the hearing resumed at 11 a.m. on May 31, 2018. The State called Jason Slavoski, the Division of Professional Regulation PMP Administrator. He maintains and operates the PMP. He holds a doctorate in pharmacy and has been a pharmacy manager. He has been licensed for eight years. He also maintains a provider verification system and acts at times as a pharmacy inspector.

On September 21, 2017 Mr. Slavoski accompanied DPR investigators Tony Hernandez, Kathleen Riddell and Anthony Kemmerlin, Sr. to Dr. Villabona's office. A purpose of the visit was to inspect the office after reports had been received regarding the storage of medications and other matters. After identifying themselves, staff permitted them entry.

Investigators first observed a prescription bottle of Tizanidine on a bookshelf. A partially open storage cabinet contained various medications. A secretary called it the "medicine cabinet". It contained filled prescriptions of Tamazepan, Gabapentin, Tussinex samples and bags of medicine

bottles. Gabapentin has been labeled a "drug of concern". Though it is not a scheduled medication, it can be abused. Tussionex is a Schedule II medication prescribed for cough.

In the office during the inspection were a secretary, another employee, and two patients waiting to see Dr. Villabona. At the time he was seeing patients. During the visit Dr. Villabona came into the office area and introduced himself. He asked the purpose of the visit. He asked why the storage cabinet was being inspected. Investigators informed him that a secretary had given permission to search it. Mr. Hernandez photographed the medications in the cabinet.

Dr. Villabona stated that a bottle of Demerol was in a locked safe. The safe was atop a refrigerator. Dr. Villabona also stated that the safe contained two guns and ammunition which had been given to him by patients. He opened the safe. He asked Mr. Slavoski if guns made him nervous. He also stated that there was a shotgun in the office. The safe contained ammunition and a bottle of Demerol which had been expired for several years. The bottle was "illegal" as it had no instructions for use.

Investigators removed the contents of the storage cabinet. Almost all of the medications in the cabinet had expired. Some of them were prescribed by Dr. Villabona, and some by other physicians. Also in the cabinet was testosterone sulfionate, anti-depressant samples (Paxil, Prozac) and many other psychiatric medications. Mr. Slavoski testified that the medications were not legally stored. Dr. Villabona explained that he takes back medications from his patients. Mr. Slavoski explained that both the DEA and hazardous waste companies can remove or take back medications. Dr. Villanova did not have a contract with such a company, and stated that he was unaware of how to dispose of the meds.

Mr. Slavoski testified that the general state of the office was "very dirty". Open sharps containers were in "terrible" condition. The kitchen was "filthy". Insecticide and cleaning materials were in the kitchen contrary to OSHA rules. He added that pharmacy managers must act in compliance with those rules. Syringes were sticking out of the sharps containers. A clear baggy was observed full of

used gauze pads and other materials. Hazardous waste must be in red bags in closed containers and labeled as such. To dispose of them, a physician must contract with an authorized disposal company. Dr. Villabona stated that he "throws away" hazardous materials "as I need to".

Also in the kitchen food was located near the medical waste. Expired urine drug test kits and specimen containers were also located in the kitchen. Shelving was dirty, and rodent droppings were observed. A battery-charging station for an otolaryngoscope was covered with dust. A half-full wine bottle was in the kitchen with another bottle.

Photos taken during the inspection are found at SX 14 at 223-289. Mr. Slavoski testified that the photos accurately depict the office and items in the office at the time. SX 14 at 223 depicts the Demerol bottle. The safe over the refrigerator is at SX 14 at 224. Overfilled sharps containers are found at SX 14 at 235-237. The picture at SX 14 at 239 shows the fill line for one of the containers. SX 14 at 243 depicts the charging station and an open syringe wrapper on a kitchen counter. A plastic bag between sharps containers containing bloody gauze is found at SX 14 at 244-245. Mr. Slavoski testified that such a bag may not be left out and exposed. It should be in a red bag in a larger container. The bottle of "Gluhwein" is depicted at SX 14 at 248-249.

The medication bottle on a shelf is depicted at SX 14 at 250-251. A plastic bag in a metal cabinet with used syringes and medications is found at SX 14 at 254. An expired bottle of Depo-Medrol, a controlled substance, is depicted at SX 14 at 255-256. The script for it written by Dr. Villabona illegally states that it is for "office use". Two scripts for Temazepan (controlled drug) found in the cabinet are depicted at SX 14 at 259-260. Two scripts written by another physician for a patient Martha and dispensed in 2016 are depicted at SX 14 at 261-262. A filled Tussionex script for a patient J.D. and dated 2011 was in the cabinet. SX 14 at 263. A filled 2015 script for patient Todd M for Gabapentin was found in the cabinet. SX 14 at 269. Photos of the open cabinet are found at SX 14 at 282-285. A close view of one of the cabinet shelves is found at SX 14 at 286.

Mr. Beauregard cross-examined. Registration with the PMP for prescribers of controlled substances became mandatory in 2012. Mr. Slavoski does not know when the drugs in the cabinet were given to Dr. Villabona. Investigators inquired about them. The DEA sponsors "take back days" every six months, usually collecting medications at police departments and other agencies. Physicians are not allowed to take back medications from patients. Pharmacies have disposal bags in which medications are neutralized with water. Some contractors engage in "reverse distributions" by picking up controlled substances from physicians who are also dispensers.

The investigators who visited Dr. Villabona's office had badges. They did not want to interfere with patient care. Mr. Slavoski was told to wait until he was instructed to enter. This was his first such inspection. Mr. Slavoski was not aware that the "Gluhwein" depicted in RX 4 was non-alcoholic. He denied that investigators placed a medication bottle on a shelf because they did not have access to that area. He does not know if there was a lock on the storage cabinet. It was open when they entered.

Gabapentin has become a "drug of concern" nationally, though not yet in Delaware. The Demerol was locked in the safe. Dr. Villabona was cooperative with investigators. Mr. Slavoski was intimidated when Dr. Villabona asked him if guns made him nervous. He did not observe a shotgun in the office. Mr. Slavoski admitted that the testosterone and Paxil were not mentioned by him in his report at SX 14 at 221-222. He reiterated that Dr. Villabona stated he disposes of drugs and hazardous waste "when he needs to". The rodent droppings were not photographed nor mentioned in his report.

The plastic on the sharps container was wearing and becoming thin because it had been dumped multiple times. He did not mention that in his report. Dr. Villabona admitted re-use of the sharps containers because he had not contracted with a disposal service.

Mr. Beauregard gave Mr. Slavoski another set of photos. They did not all look familiar to him. Mr. Beauregard stated that the pictures had been taken recently. Ms. Plerhoples objected to their use unless they depict the condition of the office on the date of the inspections and are authenticated as

such. The pictures were marked for identification only and were not admitted. RX 7 is a photo of the storage cabinet with a key and lanyard in the lock on the door. Mr. Slavoski stated that, based on the picture, the cabinet is capable of being locked. However, he stated that the cabinet was open when investigators arrived.

After the conclusion of Mr. Slavoski's testimony, Ms. Beish returned and Mr. Beauregard continued his cross-examination. She stated that Dr. Villabona did empty the sharps containers. He did not use a contractor to remove medications. She would check the internet for announcement of drug "take back" days. She reiterated that she never observed Dr. Villabona performing a UDS in the office. She never saw him give a test kit to a patient. When she resigned her employment, all of the test kits had expired. The cups for the kits were on a shelf near the kitchen. None were ever removed from their boxes.

Ms. Beish stated that she is surprised if Ms. Williams now claims that her complaint was untrue. Ms. Beish did not inventory the contents of the storage cabinet. She never tried to have Ms. Williams fired. Ms. Beish never consumed alcohol at work. She organized the cabinet contents once. She put drug samples in small baskets. When billing for services, she had to refer to charts to determine what to bill for. She added that Dr. Villabona often did not circle codes for billing purposes.

Ms. Beish was asked about her faked motor vehicle accident. She was concerned because she was getting phone calls from unknown persons. She faked the accident so that she could not be reached. She reiterated that she was told that some patients would "do anything for money". She went into "panic mode". She thought Ms. Williams would relay information about the "accident" to others. She feared identifying herself on the complaint.

Ms. Beish denied hiding G's file in the building basement. It is "possible" that Mr. Joyner took it. She disagrees with Ms. Williams. Ms. Beish was not involved in the incident when Matthew was arrested at Dr. Villabona's office. She does "not recall" saying that Dr. Villabona was "going down".

She denied that Dr. Villabona paid for her car repairs. Nor did she tell Ms. Brown "it's all on you". It was intimidating to come to work on Mondays to find files separated and hard to reassemble. She denied attempting to "sabotage" Dr. Villabona.

Ms. Stewart conducted re-direct examination. Ms. Beish never observed Dr. Villabona taking patient vitals. Dr. Villabona would scatter files over the weekend with notes to reassemble them. He made the files worse. She conceded that Dr. Villabona was generous with her. She appreciated that.

After Ms. Beish concluded, Dr. Villabona resumed his testimony. The questioning by Ms. Stewart concerning patient M continued. In the chart mention is made in a note by "DJ" (Mr. Joyner) dated September 24, 2012 about Medicaid coverage for M. SX 1 at 139. Dr. Villabona stated that M would go on and off Medicaid. He had "many" children. It took 2-3 months to arrange for him to be seen by a Wilmington neurosurgeon. Ms. Stewart noted that M's chart does not reflect efforts to secure such an appointment prior to October 2016. Dr. Villabona stated that is "our fault". Staff failed to schedule the appointment. M was continued on an opioid regimen. Though it was his "common procedure" to secure medical records from other providers, they were not always received. Mr. Joyner could not get M to a neurosurgeon. Mr. Joyner's notes do not show that Dr. Villabona had instructed him to secure prior charting.

Ms. Stewart cited to Dr. Villabona's December 10, 2012 note regarding M. SX 1 at 118. M was again without Medicaid coverage. Billing records for M are found at SX 1 at 132-136. In 2009 M was paying for services with cash. Dr. Villabona admitted the records do not reflect Medicaid payments for M.

A letter dated July 16, 2013 from a Drug Court Diversion Case Manager regarding M is found at SX 1 at 108. The letter informs Dr. Villabona that M was enrolled in or ordered into the diversion program and should therefore not be prescribed addictive medications. Dr. Villabona reviewed the chart and admitted that he had not stopped such prescribing.

The State moved into evidence a new, supplemental set of medical records pertaining to M. They were admitted as SX 5. In June 2013 Dr. Villabona had prescribed for M methylphenidate and Oxycodone 15mg, 90 tabs. SX 5 at 39. In July 2013 he prescribed Clonidine and Keflex. SX 5 at 38. In July he prescribed Valtrex and Epicerin emollient. SX 5 at 37. In July he also prescribed Prednisone and Oxycodone 15mg ten days after the date of the letter from the court diversion program.

Dr. Villabona's note on M for August 21, 2013 is found at SX 1 at 171. Dr. Villabona agreed that there is no documented discussion with M about his drug charges. He added that it would have been my "100% habit" to keep that "in the forefront". He agreed that the use of illegal or unprescribed medications would have been a violation by M of his pain management agreement. He added that "during the time period" they would have discussed "doctor-shopping". He did ask M about his drug use. It was "definitely my habit" to discuss such things. He agreed that the letter from the court drug diversion program was significant. He did discuss the matter with M, but did not document the discussion. Dr. Villabona reviewed certain exhibits and stated that the first subpoena from DPR for M's records was dated July 29, 2013.

A typed note concerning M is found at SX 1 at 173-174. The note states that M was being referred to Dr. Cemerlic. He stated that was not the first time. He had referred M to pain management previously. He does not recall which physician. Nonetheless, M could not afford the referral. He had a number of problems and his circumstances were "very chaotic". When Ms. Stewart noted that she could not find other referrals, Dr. Villabona stated that he had staff make them. He believes M went to a pain management physician. He had an appointment, but may have lost his insurance coverage, in addition to his other problems.

The October 2013 note on M mentions referrals to Dr. Sugarman and Dr. Cemerlic. When M could not work, he became eligible for insurance. The chart for M contains no notes between November 2013 and April 2014. Dr. Villabona stated that M remained his patient. Other physicians

were caring for him for herpes and testicular torsion issues. If Dr. Villabona had seen him during that period, there would be a note in the chart. Scripts found at SX 5 at 20-26 reflect that Dr. Villabona continued to prescribe for M. Dr. Villabona testified that if he wrote scripts during that interim period, he did see M. He stated that he had written notes for the period, though they are not in M's chart. He would not write scripts for controlled substances without office visits.

An office note for April 16, 2014 states "usual meds". SX 1 at 177. Dr. Villabona confirmed that included controlled substances. Dr. Villabona does not know about M's visit with Dr. Cemerlic. Those notes are missing. Dr. Villabona reiterated that he thought M should see a pain management physician. An appointment with Dr. Cemerlic was made, but often that was 3-4 months into the future. Dr. Villabona testified that he "feels there are records missing". He does follow up with a patient if a referral is made. He also communicates with the physician to whom a patient is referred. He agreed there are no such notes in M's chart.

A "pain assessment chart" is found at SX 1 at 181. Dr. Villabona agreed that is the only such form in M's entire chart. He does not recall why M's charting ended in July 2015. Discharge summary documents from Dover Behavioral Health System dated August 1, 2015 are found at SX 5 at 111-115. The hospitalization occurred after M's mother reported that he had threatened suicide. Dr. Villabona believes he saw M again after August 1. An observation in the DBHS records indicates that M was engaged in drug-seeking.

At SX 5 at 114 the writer notes that Dr. Villabona stated that he was prescribing opioids for scoliosis and shingles. Dr. Villabona stated that he "probably" reported that. Dr. Villabona was also aware that DBHS was weaning M off of opioids. The records state that M was discharged to police custody on July 31, 2015. SX 5 at 114. M had reported heroin use for a month. SX 5 at 111. Dr. Villabona informed DBHS that he would stop prescribing opioids and benzodiazepines. SX 5 at 114. Dr.

Villabona admitted that two days after M's discharge he prescribed ten Xanax tabs for M. Dr. Villabona could not find an August 3, 2015 note in the chart.

PMP reports for M are found at SX 1 at 105-107. Dr. Villabona testified that he assumed he reviewed the reports. He agreed that during 2012 M filled methylphenidate scripts twice. Dr. Villabona stated that he wrote the drug every month for M. He added that Ritalin is a "drug of interest", but does not have great street use. He again referred to the potential confusion between M and his father, who each bear the same name. In 2015 M filled none of his methylphenidate scripts. SX 5 at 116-119. He did not recognize the names of prescribers of Percocet for M.

Dr. Villabona was shown a PMP report for M for a portion of 2013. SX 5 at 126. He agreed that the report provided more evidence of doctor-shopping. Nor did M fill any of the Ritalin scripts written by Dr. Villabona. He stated that he "most likely" discussed these issues with M. He approved other medications for M due to the "scope of his maladies". Though Ritalin could decrease the use by a patient of opioids, in M's case it was "fruitless". Though M was reluctant to take Ritalin, "hope springs eternal". Dr. Villabona conceded that he may have been overly optimistic for M. When he initially wrote the methylphenidate scripts for M, he was doing so to treat ADD. Dr. Villabona agreed that he did not document discussions with M over his failure to use the drug. He also conceded that M always filled his Oxycodone scripts.

The hearing resumed at 11 a.m. on June 1, 2018, with Ms. Stewart continuing her examination of Dr. Villabona. He acknowledged that the 2016 and 2017 subpoenas for documents in this matter were directed to him. Each sought records for his patients. It was his responsibility to provide complete charts on the indicated patients. His staff prepared the responses while he saw patients. He reviewed the files that were to be produced. Since Dr. Villabona's practice is a "one horse show", he could not make copies of all of the files. He acknowledged that he personally signed the attestation of completeness of the files for ten patients on September 21, 2017. SX 14 at 180.

He now understands that some produced files were not complete. For instance, the file for patient G was incomplete. He believes some of his files had been provided to Dr. Cemerlic. On the first occasion investigators were provided mostly with his scripts as that was all that there was to produce at the time. Dr. Villabona then testified that he had not reviewed all of the files that were produced to the State. His staff told him that everything had been produced. He did not ask to review the produced charts before he signed the attestation. When Ms. Riddell returned some files, he realized that G's file had been incomplete. Some of that chart had been "sequestered". In other words, some of the documents from the chart had been stuffed behind objects near the basement entrance in the office. Patient G was "cavalier" about his appointments. Dr. Villabona did his charting on the computer.

Ms. Stewart produced certain documents pertaining to patient A which had been downloaded to a flash drive. They were marked for identification as SX ID D. Dr. Villabona testified that the documents were the "sequestered" materials. They were found behind an old computer. He added that his office produced "all that we had", and that there was no intent to withhold any records.

Dr. Villabona was then questioned by Ms. Stewart about certain documents pertaining to patient G. They are found in a binder labeled "Patient G and L". Documents concerning patient L had been removed from the binder. The "G" documents in the binder were admitted during the hearing as SX 6. Another collection of documents from G's chart was initially marked for identification as SX ID D. that collection was subsequently admitted as SX 7. A Post-it note attached to the first page of SX 7 was initialed by Dr. Villabona and states, "Chris: This chart was found while cleaning and was hidden behind an old computer."

Ms. Stewart noted that some of the documents concerning G are in both SX 6 and SX 7. She asked how they could have been contained in the initial document production if they had been "hidden". Dr. Villabona stated that he does not know when the collection of G's documents was placed behind the computer. Dr. Villabona agreed that most of the office notes in SX 7 were typed by him.

They were prepared at a time when work was less "plentiful". Dr. Villabona explained that he started charting on his computer without reference to the whole file because G had been a patient for more than six years. It was not always necessary to refer to the entire file while charting. It was easier to type notes because Dr. Villabona did not always know when G would appear at the office. Dr. Villabona told one of the investigators that some notes concerning G which were typed had not been placed in G's chart.

Dr. Villabona confirmed that the chart for G was one of the files which he attested had been complete when produced. SX 14 at 180. He expedited signing the attestation because patients were present and he did not want to cause delay. He believed it was "most likely" that the investigators had complete charts. It was not easy to go back through the files. He knew that G's file was incomplete in that the typed notes were not included. Dr. Villabona denied creating notes "after the fact". He did not know if Ms. Beish had G's file. He explained further that G would arrive after hours and that Ms. Williams was unable to set up his file. Hence, Dr. Villabona typed his notes. G was a patient for 15 years, and there was little change in his condition from note to note. G would mow the lawn and that was his payment for medical services. Dr. Villabona stated that it was a "fair exchange".

Ms. Stewart noted that SX 6 at 9-11 showed no payments by G over the period 2009-2011. Dr. Villabona testified that his staff was not present after hours. The lawn mowing and his office visits were both valued at $65. Dr. Villabona was not aware that the second production of documents (SX 7) contained a pain management agreement but the first (SX 6) did not. He checked the two exhibits and confirmed that fact. Dr. Villabona stated that he typed notes using Microsoft Word. His office does not use electronic medical records. In response to Ms. Stewart, Dr. Villabona stated that he can not prove the dates on which the typed charting for G was generated.

Dr. Villabona confirmed that he did not chart any physical exam of G on January 18, 2012. SX 6 at 20. He may have taken G's blood pressure twice on the same date, thus yielding different results.

Dr. Villabona is uncertain whether G was ever imaged. He was uninsured. Dr. Villabona prescribed controlled substances for G based on patient reports.

When G was asked to provide his medical history, he only listed hepatitis B. SX 6 at 7. Dr. Villabona had treated G for years and was aware of his physical condition. Ms. Stewart asked Dr. Villabona if he had prescribed medications for G for the period 2003-2009. She also asked where were medical records for G during the pre-2009 period. Dr. Villabona stated that he did not know. He confirmed that G started treating with him in 2003. Ms. Stewart noted that the first progress note for G is dated February 5, 2009. SX 6 at 12. Dr. Villabona testified that he diagnosed bronchitis and prescribed Percocet for pain resulting from drywall installation work.

In conjunction with a formal risk assessment for G, Dr. Villabona stated that he has patients fill out a standard form. He could not locate the form in G's chart. It is not likely that he had G fill out the form more than once. He knew G for a long time going back to the period before he became a patient.

Ms. Stewart asked Dr. Villabona if he had ever referred G out for alternate pain treatments. He stated that G was on Percocet 5mg once daily. Pain management physicians would not take him as a patient with such low dosages of medication. His degenerative joint disease was amenable to surgery. G was unable to perform a desk job. Dr. Villabona suggested physical therapy to G, but such therapy is "not free". Dr. Villabona may have documented such a referral.

Ms. Stewart asked Dr. Villabona to point out in G's chart a diagnosis of degenerative joint disease prior to Dr. Villabona's prescribing opioids for him. Dr. Villabona stated that he did not list such a diagnosis early in the records, but did enter it in subsequent notes. He again noted the lack of progress notes in G's chart and his lack of knowledge of the whereabouts of such notes. He added that he has "produced what I have".

Dr. Villabona is uncertain whether he conducted a PMP check on G. He said, "mea culpa". He did not know when G would show up at his office. He added that G's pill counts and urine screens were "always good". He could access the PMP on the "back office" computer.

Ms. Stewart then questioned Dr. Villabona with regard to his care for patient U, whose chart is in a binder admitted as SX 8. Dr. Villabona started treating him in the early 2000's. In 2012 Dr. Cemerlic took over his pain care. That relationship ended in 2016 when the two had an argument. The argument was not related to U's medications. Dr. Villabona then agreed to assume U's pain care. He noted that U can be "disagreeable". He testified that he asked for a copy of Dr. Cemerlic's chart on U. He either did not receive the records, or they were not placed in U's chart. He agreed that he started U on controlled substances without the benefit of reviewing the Cemerlic chart.

Ms. Stewart referred to a note by Dr. Villabona on March 16, 2016. SX 8 at 79. Dr. Villabona read most of that note into the record. In the note Dr. Villabona observes that U was trying to "minimize his narcotic intake". He had stopped taking opioids, but that was unsuccessful. Dr. Villabona notes that he encouraged U to seek a more qualified pain management physician. He observes that U has been "irritable and impetuous", and that he had "fired" his prior physician. It was a "fit of pique". *Id.* In response to the State's attorney, Dr. Villabona testified that he could not locate a risk assessment document in U's chart in conjunction with the reassumption of his pain care. He added that he "usually" fills out a form and reviews the risks of certain treatments. He performed a UDS on U, but did not order a confirmatory lab screen. He did not commonly perform drug screening. He relies on patient-provided information.

Dr. Villabona then asked that certain testimony be given "off the record". The request was denied. He then stated that Medicare had found problems with the costs of Dr. Cemerlic's urine screening practices. Price was excessive. It was Dr. Cemerlic's practice to regularly order screens. Dr.

Villabona and Dr. Cemerlic have shared patients in the past. Dr. Villabona testified that he does not believe that he has secured Dr. Cemerlic's charting for any of the patients in this case.

With regard to the March 16, 2016 note (SX 8 at 79), Dr. Villabona acknowledged that "in most cases" pain management physicians are more "expert" than he with regard to chronic pain. He is aware that U also was seen by Dr. Howard Arian. Dr. Arian disagreed with an arachnoiditis diagnosis for U. Dr. Arian's "new patient consultation" notes for U are found at SX 8 at 142-147. Dr. Arian notes U's "misunderstanding of serious long term effects in the continuous use of narcotic analgesics." SX 8 at 143. Dr. Arian performed a complete physical exam of U. SX 8 at 143-144. He notes that U was requesting "narcotic maintenance" for chronic arachnoiditis. SX 8 at 145.

While U was requesting narcotic maintenance, Dr. Arian recommended Schedule III medications, which are appropriate for the arachnoiditis condition. *Id.* Dr. Arian opines that U would best be managed at a university pain center with a multidisciplinary approach. SX 8 at 146-147. Dr. Villabona testified that he had read Dr. Arian's report. Nonetheless, U had "other problems". Dr Villabona acknowledged that Dr. Arian was better qualified than himself with regard to the treatment of chronic pain.

The hearing resumed at 10 a.m. on June 4, 2018. The State announced its intention to call Dr. Brian Durkin as an expert witness in the case. Dr. Durkin's expert report had been provided to Dr. Villabona and his counsel earlier in the morning. Without objection, the hearing recessed and Mr. Beauregard and Mr. Tease were provided an opportunity to review the report, which Ms. Stewart had received the night before.

Brian T. Durkin, DO, was then called by the State as an expert witness. His curriculum vitae was admitted without objection as SX 9. He was awarded baccalaureate degrees in 1990 and 1995 in marketing and biology. He earned his degree in osteopathic medicine in 2001 from the Arizona College of Osteopathic Medine. He served an internship at the University of Medicine and Dentistry of New

Jersey in 2001-2002 and a fellowship at Memorial Sloan-Kettering Cancer Center in New York in 2005-2006. He completed a certificate program in pain management at UC-San Francisco in 2008-2009. He was awarded a fellowship in Leaders in Medical Education at SUNY-Stony Brook in New York for the period 2001-2013. During the period 2002-2015, he taught clinical anesthesiology, acute pain and chronic pain at SUNY-Stony Brook.

At present Dr. Durkin is the Division Director of Pain Medicine at Long Island Physician Associates in Port Jefferson NY. There he practices with and supervises four other physicians. His current practice involves seeing patients, 80-90% of whom are treating for chronic pain. He presently enjoys hospital privileges at four New York hospitals. From 2012-2015 he lectured employees of the DEA. He serves on a DEA task force on Long Island NY. He consults with insurers regarding opioid abuse and has participated in investigations. He is now President-elect of the New York Society of Interventional Pain Physicians. He has been Board-certified in anesthesiology for ten years, and in pain medicine for nine.

Dr. Durkin identified certain research in which he has been involved (SX 9 at 4), and publications which he has authored or co-authored (SX 9 at 6-9). He is licensed in New York. He has not practiced medicine in Delaware.

In conjunction with his preparations in this case, he has reviewed relevant regulations of the Board, including the Board's iteration of the FMSB "Model Policy" (Bd. Reg. 18.0 *et seq*), and the medical records of patients D, M, J and J2. His methodology in the case was to review the patient charting, incorporate his knowledge and experience, apply Bd. Reg. 18.0 in his reviews, take pertinent notes, and then prepare a report containing his opinions in the matter.

Before Dr. Durkin provided his substantive testimony, Mr. Beauregard was provided with an opportunity to conduct voir dire of Dr. Durkin. He had finished his report in this case at 11 p.m. on June 3, 2018. He was contacted by Ms. Stewart three weeks earlier. She had been given his name by a

New York prosecutor. Most of his testimony to date has been provided in criminal proceedings. This is his first testimony in a professional licensure case.

Dr. Durkin moved to New York after med school. He finished a residency in anesthesiology, and then completed work in his pain specialty. He has worked on disc decompression as treatment for pain on behalf of a product developer. He has been involved in ultrasound and nerve block courses. The heading "industry-funded" at SX 9 at 4 means that entities choose sites for clinical trials. His role as "principal investigator" with regard to a spinal "spacer" involves inserting devices in stenotic patients. Patients are then followed for two years. The principal investigator supervises sub-investigators.

Dr. Durkin remains an Associate Professor at SUNY-Stony Brook. He has not written any articles for Delaware entities, nor given lectures here. Mr. Beauregard asked Dr. Durkin if he were aware of the "ranking" of SUNY Stony Brook by *U. S. News & World Report* as a research institution. Mr. Beauregard represented that its raking is No. 57 or 59. Dr. Durkin was unaware of that fact. The school is ranked No. 77 in another category. The State objected to the questioning on the basis that the quoted rankings are irrelevant in this case. Mr. Beauregard argued that the rankings go to Dr. Durkin's knowledge and expertise. Ms. Stewart argued that Dr. Durkin has not been called to testify as to such rankings. Mr. Beauregard stated that information regarding the rankings will permit the Board to better evaluate Dr. Durkin's testimony. This hearing officer directed Mr. Beauregard to move to other areas in his voir dire.

Dr. Durkin testified that he is being paid $300 per hour for his work in this case. At the time of his testimony, he had devoted approximately ten hours of time. He is also being reimbursed for his travel and lodging costs – approximately $200. He has spent about ten hours with the patient files, which he received three weeks earlier.

Dr. Durkin did not research the date when the Board adopted the FMSB "Model Policy" as a regulation of the Board. His opinions are based on his education and experience from 2006 to present.

Dr. Durkin testified that the "Model Policy" is now "standard of care" in pain management. The "Model Policy" has been in existence since 1998. Dr. Durkin has not been asked to testify as to psychiatric standards of care.

Ms. Stewart then offered Dr. Durkin as an expert witness in this case. Mr. Beauregard testified that the State has not shown a nexus between Dr. Durkin and the State of Delaware. He questioned whether Dr. Durkin possesses the credentials to provide standard of care testimony in this state. He therefore objected to Dr. Durkin providing testimony in this case. Ms. Stewart countered with the argument that certain standards of care in pain management do not change from state to state. It was the considered judgment of this hearing officer that Dr. Durkin possesses the requisite education and experience to provide opinions in this case.

Dr. Durkin testified that his medical opinions in this case will be provided within a reasonable degree of medical certainty. Dr. Durkin identified his written opinion in the case dated June 3, 2018 and signed by him. The report was admitted as SX 10.

Dr. Durkin was asked to explain the "Model Policy". The document was drafted by the Federation of State Medical Boards in 1998. It was originally designed to "police" the prescription of opioids. It was revised in 2004 because of the "undertreatment of pain" in some cases. The profession was encouraged to treat pain seriously. In 2013 the Policy was revised again to mitigate the overprescribing of opioids in the face of an "opioid crisis".

Dr. Durkin defined a relevant "medical event". Such an event is one in which a patient reports a complaint, a medical history is taken, records are gathered, a physical exam (including vitals) is performed, imaging and lab work are ordered, a diagnosis is formed, and a treatment plan is prepared. If opioids are selected for treatment, the type of pain is determined and the patient is assessed for risks attendant with prescribing. Risk assessment tools include an Opiate Risk Tool, reviewing the records of other providers, reviewing PMP information, and testing for toxicology. All of the information gained

should be documented. Alternatives to the prescribing of opioids may include physical therapy, psychological study, yoga, non-opioid medications and other options.

Dr. Durkin testified that he "rarely" prescribes opioids, and then primarily for pain stemming from recent surgery and cancer. Treatment plans include documentation of the justification for prescribing narcotic analgesics, documenting what has and has not succeeded in the past, quantification of risk, toxicology testing (with documentation of all results), and point of care urine screening with subsequent lab testing for precise substances. There are now many types of in-office screens today. They can test for up to 30 substances. Dr. Durkin noted that testing for opiates in some instances may not show positive results for heroin.

Dr. Durkin was asked to discuss "informed consent". He stated that consent for treatment must be secured at the outset, and must be updated. The risks and benefits of the use of opioids must be explained to the patient. Dr. Durkin noted that there have not been many long term studies on the effects of opioids at this point. A "pain management agreement" is like informed consent. Use of such agreements has been standard of care for years. They should again contain an explanation of risks in the use of opioids. Consequences of non-compliance must be explained. Permission must be granted before controlled substances may be secured from other prescribers. The patient must be informed that urine drug screening will take place. Dr. Durkin testified that chronic pain patients often experience psychological problems. If they are diagnosed, it is important to refer the patients accordingly.

During re-evaluation appointments, the actions taken during the initial office visit should be repeated. The physician should consider ongoing risk mitigation. Physical exams must be performed regularly, specially if opioids have been prescribed. Urine screening should be performed to determine if the patient is compliant and if he is using illegal drugs. High risk patients should be screened at the time of every office visit.

Dr. Durkin was asked what is the significance of securing prior medical records. They should tell a story about a patient. The thought processes and choices of the prior physician should be considered. Prior medical records are intended to inform subsequent providers. They explain how a new patient came to the physician. Dr. Durkin typically requests the prior physician's last 2-3 clinical notes. He also asks to see the charts maintained by prior pain management physicians to see if there are diversion or addiction issues. Charts should be secured before the new patient's first office visit. In Dr. Durkin's practice a review of the prior charting must be performed before the new patient is seen. The PMP is also helpful in identifying other physicians with whom the new patient has treated.

Dr. Durkin discussed the "high risk" patient. Some patients are at a higher risk for addiction. Those patients are often under age 40, with a history of drug or alcohol addiction. Family histories should be taken. Some high risk patients have psychiatric histories. With high risk or even moderate risk patients, the physician should avoid the prescription of opioids "at all costs". Opioids for those patients should be the last option. Dr. Durkin opined that the four patients in this case whose charts he has reviewed are all "high risk" patients.

Dr. Durkin first testified regarding patient M. Though he was uninsured and paying cash for medical services, that should not affect his care. Standards of care are the same regardless of patient resources. At the time of M's first visit with Dr. Villabona, no physical exam was performed. Such an exam should have been "head to toe". That is specially so if Dr. Villabona was considering the prescription of opioids. If a patient complains of low back pain, there can be some common causes for the pain, while there can also be some "red flag" causes. Disc injury must be ruled out. Range of motion and strength in the lower extremities should be assessed. The physical exam should be documented in the patient chart.

It is unclear whether M was being prescribed opioids prior to 2009. There is no evidence of that in the charting. Dr. Villabona did not review any prior medical history of M. From the outset Dr.

Villabona did not prescribe other modalities for M. Nor were non-opioid medications prescribed such as Naproxyn, Gabapentin or muscle relaxants. Dr. Villabona diagnosed lordosis. Dr. Durkin stated that the condition is not normally painful. Dr. Durkin asked how Dr. Villabona diagnosed disc herniation without reference to imaging. There were no signs of herniation. M was not asked to perform straight leg raising. Dr. Villabona also diagnosed chronic pain. The diagnosis was non-specific. His diagnosis is not legitimate. It was incomplete. Dr. Durkin discussed the differences between scoliosis and lordosis.

Dr. Villabona prescribed for M Oxycodone 15mg and Soma without justification, in Dr. Durkin's opinion. He had not performed a risk assessment. There was no reason to prescribe those medications at the outset. There was no history of opioid use, no justification for opioid therapy, and going from opioid naivete to 45mg of Oxycodone daily was dangerous. Dr. Durkin would have ordered a laboratory UDS to determine what drugs M was taking.

Documentation of M's next visit on April 15, 2009 was sub-standard. The patient's somnolence was a red flag. His medication dosage may have been too great. This may have been a sign to titrate dosing. Dr. Durkin asked how Dr. Villabona could determine that M was compliant with his drug regimen after only five days, and with no UDS performed.

Dr. Durkin was asked to comment on Dr. Villabona's joint prescribing of opioids and methylphenidate. Dr. Durkin opined that the practice was dangerous. Dr. Durkin is aware that some heroin users also consume Ritalin. In combination with other drugs, the taking of methylphenidate can cause death. Dr. Durkin only prescribes methylphenidate for patients diagnosed with cancer pain. M was place on a high daily morphine equivalent dosage. Only 30% of Dr. Durkin's patients are on such daily strength, and typically they have been treating for months or years.

Dr. Durkin found a 2012 MRI in M's chart. He found some mild lumbar degeneration. Dr. Durkin testified that physical therapy is usually sufficient for 50% of such patients. However, Dr.

Villabona prescribed neither physical therapy nor home exercise. The key for such patients is to get them more mobile.

Dr. Durkin did not see any UDS results in M's chart. Dr. Villabona typically found that M was "doing well". In such case, his goal should have been to down-titrate controlled substances. Ms. Stewart asked if Dr. Durkin had noted the September 2012 report on potential doctor-shopping by M. Dr. Durkin stated that Dr. Villabona's response should have been to note that as a major red flag. It was also contrary to M's pain management agreement. Doctor-shopping exposes a patient to the risk of selling his drugs, or overdose. If medications were also being secured elsewhere, M should have been titrated down by Dr. Villabona. M should have been urine-screened at every visit. M should have been referred to an addiction specialist, or should have been discharged.

Dr. Durkin testified on the alleged confusion of M's name with that of his father. He stated that their birth dates differed. The pain management physician should have been contacted for clarification. There is no evidence in M's chart that Dr. Villabona did so.

Dr. Durkin commented on the letter informing Dr. Villabona that M had been assigned to a court drug diversion program. Dr. Villabona commented that it was hard to deal with M's problems. He continued to prescribe opioids. If M were in a drug diversion program, he was at higher risk. Standard of care pain management would have been to stop prescribing opioids for M. With regard to the period after M's hospitalization after his threat of suicide, Dr. Durkin testified that Dr. Villabona prescribed Xanax without justification. Dr. Durkin's overall opinion regarding Dr. Villabona's care for M is that it was not consistent with pain management standard of care. There were no indications for the prescribing of opioids.

Dr. Durkin was then questioned about Dr. Villabona's care for patient J2. His first visit with Dr. Villabona was in October 2008. He prescribed Percocet 10/325 four times daily. J2's chart contains no medical history or prior charting. No physical exam was documented. In Dr. Durkin's opinion, there

was no justification for the Percocet prescription. Dr. Villabona's care for J2 overlapped that of Dr. Atkins, who was also prescribing Percocet for him. Dr. Villabona does not note this "abnormality" in the chart. In Dr. Durkin's opinion, J2 was at high risk for drug diversion or addiction. He required a higher level of risk mitigation, including trials on non-opioids.

J2's chart does not contain evidence of urine screening. In Dr. Durkin's opinion, J2 should have been weaned and referred to pain management. J2 was not complying with his pain management agreement. Though the PMP shows that he was receiving short scripts, that was not noted in his chart. The PMP noted other providers, but there is no reference in the chart that Dr. Villabona was aware of that fact, or that he had tried to learn why. Though there are references by Dr. Villabona that toxicology was negative, Dr. Durkin does not know to what he was referring. A September 2014 toxicology report from LabCorp showed a positive result for opioids. No additional screening was done.

Dr. Durkin's overall opinion of Dr. Villabona's care for J2 is that the prescription of controlled substances was not consistent with standard of care. J2 was doctor-shopping, and was dishonest with Dr. Villabona. It is uncertain whether J2 was consuming his medications or was diverting. The chart contains no lab testing for this high risk patient. Physical therapy was not prescribed, and Dr. Villabona did not engage in weaning opioids. Dr. Villabona was "just refilling" medications for no valid medical purpose.

Dr. Durkin was questioned on Dr. Villabona's care for patient J, whose records are in a binder admitted as SX 3. Dr. Villabona's first progress note for J was prepared two years after J had received prescriptions for controlled substances. The chart contains no records from previous providers. The December 2008 record for J contains a blank patient information form, and no record of a physical exam, no summary of patient history, no initial complaint warranting controlled subtances, and no risk assessment of J. In Dr. Durkin's opinion, a script for Roxycodone 5mg four times daily in December 2008 was without legitimate justification. At the next visit Dr. Villabona prescribed 120 mg of

Oxycodone daily. Such a prescription could have been fatal for J were he opioid naïve at the time. A naïve patient should never be started at such levels.

Dr. Durkin noted that J's chart does not contain a pain management agreement, nor proof of the performance of urine drug screens. Dr. Durkin incorporated his earlier opinion regarding the prescribing of methylphenidate for J as given regarding M. Though Dr. Villabona prescribed a testosterone precursor for J but without documenting that he had checked present levels. Dr. Durkin was of the opinion that all of this prescribing for J was not medically justified.

Certain emails in J's chart demonstrate that J was taking more medications than prescribed. That was a red flag and breach of a pain agreement, assuming one had been signed by J. J should have been counseled by Dr. Villabona on non-compliance. He should have been examined as well. On April 27, 2009 Dr. Villabona noted that J's "MSE is WNL". If that means that his musculoskeletal exam was within normal limits, Dr. Durkin opined that that would be an "unusual" finding for a patient with a history of multiple back surgeries complaining of pain and being prescribed 130 mg daily of Oxycodone. If J was "within normal limits", Dr. Villabona should have begun to titrate the dosing downward, but did not do so.

Vital signs and physical exam were not recorded. Vitals are critical because opioid intake can affect respiration and cause pupil constriction. Lower extremity reflexes should have been assessed. Dr. Durkin also testified that constipation is a common side effect of opioid use (as in more than 50% of his patients), though none was reported or diagnosed in J's case. J's chart contained no imaging studies or completed drug screens. The prescription of narcotics for J through 2011 was not justified, In Dr. Durkin's opinion. Though they were prescribed for the period January 2012-February 2013, the chart contains no progress notes for that 13-month period.

In summary, Dr. Durkin opined that standard of care did not indicate the prescription of opioids for J during Dr. Villabona's care for him.

Dr. Durkin next testified regarding the care of D, whose medical records are in a binder admitted as RX 1. At the time of his first office visit in May 2015, D admitted the use of heroin. He was prescribed pain medications in 2012 after surgery. He purchased Oxycodone on the street, and then moved to heroin. He was not examined by Dr. Durkin. Dr. Durkin opined that the standard of care practitioner should inquire as to the heroin use. The chart documents that the matter was discussed. Dr. Villabona did not document the trial of D on non-opioids. He did try Prednisone while prescribing Oxycodone.

When Dr. Villabona prescribed Oxycodone 30mg for D at the time of his first visit, that was inappropriate. In essence, Dr. Durkin testified that Dr. Villabona was "feeding" D's addiction at a time when Dr. Villabona barely knew him. Dr. Durkin asked why Oxycodone 30mg was prescribed at a time when D was waiting to enroll in a Suboxone program. No urine screening of D is documented in the chart. No referrals to other therapies were documented. In Dr. Durkin's opinion, there was no medical justification for the prescription of opioids for D, who was in a "high risk" category.

Dr. Durkin reiterated that at the time of the first office visit with D, he should have been referred to an addiction program. Dr. Durkin queried whether D may have been selling his opioids on the street to acquire cash to purchase heroin. When heroin was found in D's urine, Dr. Villabona ended his care and referred D to pain management. Nonetheless, there are no records or notes written by Dr. Cemerlic in D's chart. In Dr. Durkin's overall opinion, prescribing narcotic drugs for D was "absolutely not" within the accepted standard of care.

Mr. Beauregard then cross-examined Dr. Durkin. Dr. Durkin stated that he was not being paid for his travel time in this case. On the day of his testimony, he was being paid for a total of eight hours. Dr. Durkin received the patient charts from the State. He also received a copy of the Second Amended Complaint, but did not read it. Dr. Durkin does not know if the charting he reviews is complete. When

incomplete charts are rendered complete, his various opinions may change. Dr. Durkin did not review charting for patients D2, U, T and P.

Dr. Durkin testified that "perhaps" it would be helpful for him to examine and interview the patients about whom he has testified. He presently practices in four offices with four other pain management physicians. His practice employs 30 individuals. He added that standard of care does not differ based on the number of employees in a practice. His office performs point-of-care urine testing, but all samples are sent to labs. Patients are referred out for imaging. Dr. Durkin devoted a month in medical school to psychiatric studies, and served a brief fellowship in the speciality.

Dr. Durkin was asked when the Delaware Board adopted the "Model Policy". Dr. Durkin did not know. He stated that new technologies and new restrictions may change pain management. As an example he noted that Hydrocodone has been moved from a Schedule III drug to Schedule II. Regulatory changes may alter practice. He added that standard of care is always based on applicable State regulations.

Mr. Beauregard handed Dr. Durkin a five-page article published in October 2014 at www.newsday.com/news/health/navigating-new-laws-on-painkillers. Dr. Durkin acknowledged that he was a source for some of the information in the article. The article was admitted as RX 8. Dr. Durkin stated that even if four files show below standard of care treatment out of 1,000, the practitioner is still practicing below standard of care. Dr. Durkin has heard the phrase "Monday morning quarterback". He testified that offering opinions on pain care in 2009 is not the same thing. His use of the phrase "best practice" in his report (SX 10 at 1) means just that. Marginal practitioners may be "below the Mendoza line", or practicing at the "bottom of the barrel".

Since 2006 Dr. Durkin has seen perhaps 15,000 patients. The files of all of those patients are consistent with the Model Policy. Physicians in his practice circulate files amongst themselves for comment and to ensure compliance. Cash and non-paying patients are due the same standard of care

practices as insured patients. Generic drugs can be prescribed to hold down costs. A physician can show a patient UTube exercises on the internet. Dr. Durkin admitted that the availability of insurance gives greater access to physicians and other treatment modalities. He reiterated that standard of care practice should be provided to all patients.

Dr. Durkin stated that, typically, physical exams are included in the costs of office visits. If imaging is necessary, a cash patient may be referred to an emergency room. Such a facility may refuse to perform an MRI. In such cases, referral can be made to another ER. There are "ways to get things paid".

Dr. Durkin defined high opioid dosing as 60mg per day or greater. That represents about 30% of Dr. Durkin's patients. He is unaware of Dr. Villabona's percentages. If a treating physician requests the charting of a predecessor with the patient and does not receive it, Dr. Durkin's practice is to contact that physician. If records are refused, the new patient is discharged to his primary care physician, or is referred to a PCP. Some patients who are prescribed 30mg per day perhaps demonstrate a greater likelihood of actual back pain. If a patient is on "500 pills a day", according to the PMP, a referral is made to addiction specialists.

Dr. Durkin's report refers to an examination of the nares as that is a common route for addicts to use to ingest drugs. Physical exams should always be documented. Though constipation is a common side effect of opioids, Dr. Durkin conceded that it is possible that the four patients in this case may all be without such effect. Dr. Durkin was asked whether some of the care in this case by Dr. Villabona was provided before the Model Policy became a Board regulation. Dr. Durkin reviewed the dates of service for the four patients, and some or all of their care was after the February 2012 adoption date. Dr. Durkin admitted that he had not spoken with any of the patients in this case.

At this point in the hearing Dr. Durkin was asked to leave the hearing room while the attorneys conferred with regard to what documents had been provided to him in conjunction with his work on this

case. Ms. Stewart described the four patient files which had been provided to him for review. A thumb drive which contains all of those documents in digital form was admitted as SX 15.

After the discussion Dr. Durkin returned to the hearing room. Ms. Stewart asked questions regarding RX 8 (the www.newsday.com article.) Dr. Durkin is quoted on page 4 of the story. He was asked to read a quote attributed to him by the author. In the quote Dr. Durkin states as follows: "The key is to properly assess the patient. If they're very high risk for addiction and it's a pain problem that can be treated with other means, they should avoid opioids." *Id.* Dr. Durkin acknowledged the quote. He added that in this case all of the patients whose care he reviewed are "high risk" individuals. Dr. Villabona failed to properly assess them, according to Dr. Durkin.

Dr. Durkin testified that other quotes attributed to him on the same page of RX 8 are accurate. Opioid prescribing is appropriate for some patients such as those suffering from acute pain caused by trauma or surgery, as well as some cancer patients. For chronic pain patients the "best alternative is to fix the problem that's causing the pain." He further states in the article that "if physical therapy or surgery doesn't work, medications like anti-inflammatory painkillers and pain drugs such as Lyrica or Cymbalta may play a role." Dr. Durkin reiterated that in this case Dr. Villabona failed to appropriately identify and treat pain.

Point-of-care urine testing involves a dipstick and a urine sample in a cup. The dipstick is used to determine whether a patient is positive for a tested substance. The same sample is then sent out for confirmatory lab testing.

The purpose of securing prior treatment records is to inform the treating physician. Emergency room or other hospital records will disclose the prescription of post-surgery medications. If a young patient is consuming PCP, abuse issues are present.

Dr. Durkin opined that Dr. Villabona's care for the four patients was not consistent with standard of care, regardless of when the Board adopted the "Model Policy" as a regulation. His opinions in this case are based on the entirety of the records reviewed by him.

This hearing officer asked Dr. Durkin if a different standard of care applies to the practice of a psychiatrist who is also treating some of his patients for chronic pain. Dr. Durkin stated that the standard of care for the treatment of chronic pain is the same for the psychiatrist engaged in such a practice as that of the pain management physician. Dr. Durkin added that a psychiatrist should have a "higher awareness" of addiction issues by virtue of his training and experience. Finally, Dr. Durkin testified that there are no studies which establish that Ritalin or methylphenidate enhances the effectiveness of pain medications.

After the conclusion of Dr. Durkin's testimony, Dr. Villabona resumed his own. He was questioned about his charting of the care for patient U, whose records are in a binder admitted as SX 8. Ms. Stewart handed Dr. Villabona a progress note for U referring to an office visit on February 8, 2016. The February note was apparently a supplemental document not contained in the produced chart for U. The February 8, 2016 note was admitted as SX 11. The note states that U had had a "disagreement over semantics" with his pain management physician, Dr. Cemerlic. On the second page of SX 11 is a list of non-prescription products which U had apparently used over time.

Dr. Villabona testified that he had decided to prescribe Oxycodone 15mg for U. He had spoken with Dr. Cemerlic and was not surprised that the two had experienced a disagreement. (Dr. Villabona's February 2016 note states that U is "easy to anger.") Dr. Villabona agreed that he had not charted his conversation with Dr. Cemerlic. He was uncertain whether U would return to Dr. Cemerlic. Dr. Villabona did not document any physical exam of U in SX 11, nor pain assessments. Dr. Villabona testified that U had recently been tox-screened.

U was a disabled patient who had undergone joint replacements and other surgeries. As of February 2016, Dr. Villabona had not prescribed opioids for U for "some time". Dr. Villabona reduced U's level of medications below that prescribed by Dr. Cemerlic. Dr. Villabona's March 16, 2016 note for U is found at SX 8 at 79. Again, he agreed that he had not documented any discussion with Dr. Cemerlic concerning U. U was reluctant to return to him. The chart does not document any efforts made by Dr. Villabona to "heal" the relationship between U and Cemerlic.

Ms. Stewart referred Dr. Villabona to a report by Howard Arian, M.D. dated June 9, 2015 which is found at SX 8 at 142. Dr. Villabona did not discuss Dr. Arian's concerns with U. He then testified that the concerns had been discussed, but the discussion was not documented. In the report Dr. Arian had recommended that U be managed at a university pain center "with a multidisciplinary approach", such as centers at Johns Hopkins or the University of Pennsylvania. SX 8 at 146-147. Dr. Villabona testified that U had not followed that recommendation.

Dr. Villabona agreed with counsel that Dr. Arian did not want to take U on as a patient. Dr. Villabona had agreed to "pick up an orphan" in U from Dr. Cemerlic, who had been prescribing opioids and other medications for him. Dr. Villabona continued prescribing for him through 2017, decreasing his medications over time. Dr. Villabona stated that he had performed a "cursory" physical exam of U in 2017. He did not document exams unless there had been a significant change in condition. He did not perform a comprehensive physical exam of U because U's PCP had done so. Dr. Villabona admitted that he, not U's PCP, had prescribed opioids.

The State next questioned Dr. Villabona about patient T, whose medical binder was admitted as SX 4. It is the most substantial of all of the patient charts in evidence. T had treated with Dr. Villabona since 2006. His medical "problem" list at SX 4 at 39 lists major depression, ADD, hypoglycemia, hypogonadism and vitamin D deficiency. T's pain management agreement is found at SX 4 at 1. It was signed in October 2012. Dr. Villabona testified that he had picked up some patients from pain

management physicians. Dr. Villabona did not know why the agreement was signed in 2012 if he was not prescribing opioids for T at the time. It may have been based on prescriptions for Adderall. Dr. Villabona is not a "big fan" of that drug.

An "informed consent form for CNS stimulants" was signed by T in January 2013. Ms. Stewart asked why such consent forms were not used prior to prescribing opioids. Dr. Villabona stated that he would discuss the matter at length with patients. He would document the fact that the patient understood. He conceded that some patients do not read documents before signing them. Dr. Villabona is aware of the requirement to use such forms in conjunction with prescribing opioids. Dr. Villabona was told by T on September 26, 2013 that he had screened positive in Dr. Cemerlic's office for cocaine. SX 4 at 201. The note states that Dr. Villabona had spoken with Dr. Cemerlic. T was likely "mad" when Dr. Cemerlic stopped prescribing opioids for him. Dr. Villabona is not aware whether T returned to Dr. Cemerlic.

Ms. Stewart brought to Dr. Villabona's attention two handwritten notes for an office visit with T on March 6, 2014. SX 4 at 211, 212. The two are not identical. Dr. Villabona testified that one of the notes is "wrong". He did not see T twice on that date, nor bill for two office visits. The second note for March 6, 2014 states that T was "distraught" when the side effects of methadone prescribed by Dr. Callahan (a pain management specialist) necessitated the prescription of morphine. Dr. Villabona prescribed Ketoralac injection and Prednisone for pain, even though T was treating with Dr. Callahan for pain. The note does not state that Dr. Callahan's agreement to the prescribing had been secured. No physical exam was documented in the March 6, 2014 notes.

A note by Dr. Villabona on April 22, 2014 states that T had left Dr. Callahan. SX 4 at 214. Dr. Villabona testified that T was mentally ill and paranoid. Dr. Villabona spoke with Dr. Callahan several times. T wanted to change medication from morphine sulfate. It would be speculation as to what Dr.

Villabona discussed with Dr. Callahan as the discussion was not charted. Dr. Villabona prescribed Oxymorphone for T for a short period until he found another pain management physician.

Dr. Villabona knew T for a long time. He did not want T to be without a physician. T had had a confrontation with Dr. Callahan, and called his prescriptions "wrong". Dr. Villabona requested Dr. Callahan's records on T twice. Dr. Villabona did not document a physical exam or risk assessment of T. He knew T well. They discussed medications. The April 22, 2014 note states that a part of the plan for T would be "medical education". Dr. Villabona stated that he "always" performed urine drug screens on patients, though he conceded that the results of those screens were not in the charts. He screened T after Dr. Cemerlic had reported a positive result for cocaine.

This hearing officer asked if Dr. Villabona charted anomalies in urine screens, i.e. the presence of unprescribed drugs, the absence of prescribed drugs, the presence of illegal drugs. Dr. Villabona stated that he was "less than habitual" in recording anomalies. He reiterated that he screened every patient receiving opioid scripts at every office visit. He stated that he "rarely" documented UDS results. During the period May-June 2014 Dr. Villabona prescribed for T Oxymorphone XR, Adderall and Clonazepam. SX 4 at 404-407. T "did better" with the Oxymorphone than with morphine.

A note by Dr. Villabona concerning a May 13, 2014 office visit with T states that Dr. Ongewu had not agreed to accept T as a patient. SX 4 at 215. A note on May 20, 2014 states that Dr. Villabona had not been informed of the reason. SX 4 at 216. T did not know the reason either. Though Dr. Villabona had earlier stated that he would prescribe opioids for T for only one additional month, he was still doing so later in 2014. Dr. Villabona stated that T could still not find a pain physician, and that he had reduced dosing for T. Dr. Villabona asked Ms. Stewart to remember that his patients were mentally ill and were therefore not normal patients.

Pain assessment charts for T are found at SX 4 at 218 and 221. Dr. Villabona testified that he would have patients fill them out unless there had been no significant change in pain. Dr. Villabona

contined to prescribe Oxymorphone through the summer months of 2014. He added Soma. Dr. Villabona stated that it would be "unprofessional" to penalize a patient for his inability to associate with a new pain management practitioner. T chose to remain with Dr. Villabona rather than return to Dr. Cemerlic.

On September 30, 2014 Dr. Villabona notes that T stated that Oxycodone 30mg is "less than adequate", but that he can tolerate 4/10 pain. Though the September 30 note does not record the change, on that date Dr. Villabona added a script for Soma (SX 4 at 390). That change was not accompanied by a documented physical exam. On December 22, 2014 Dr. Villabona informed T that he will no longer prescribe pain medications for him. SX 4 at 226. T was instructed to see a pain management physician. Dr. Villabona testified that he "may have" continued to prescribe for him. An Oxymorphone script dated February 2, 2015 is found at SX 4 at 377. Documents beginning at SX 4 at 134 indicate that T may have begun to treat with Dr. Selena Xing. A note by Dr. Xing states that Dr. Villabona made the referral to her. SX 4 at 136.

Dr. Xing conducted an extensive physical exam of T in early 2015. SX 4 at 139. Dr. Xing considered T at high risk for addiction and other aberrant behaviors. She also notes that T is "only interested in pain medication." *Id.* He refused injection therapy. Dr. Villabona testified that T did not take the Soma on a regular basis and had many tabs left over after 30 days. The medication was discontinued. SX 4 at 226. Dr. Villabona stated that he had discussed inconsistent urine screens with the pain management physician. Dr. Villabona testified that T had perhaps been to four pain practices.

When the hearing resumed in the morning of June 5, 2018, the State called Ms. Kathleen Riddell, a Division of Professional Regulation licensing investigator. Previously she had been a New Castle County police officer for 21 years and had engaged in private investigative work. As a police officer, she was a road officer, a detective and a police supervisor. Her duties with DPR include the investigation of public complaints against licensed professionals and the forwarding of completed

investigations to the Department of Justice for review. She investigated the pending complaints against Dr. Villabona.

Ms. Riddell identified the complaint she filed in Board Case No. 10-143-13 at SX 14 at 211. A case against Dr. Villabona had been reopened due to concerns that he was overprescribing pain medications. His prescribing practices had been reviewed on the PMP. Another aspect of her investigation was to determine whether female patients were treating with him contrary to a prior order of the Board. It was determined that he was compliant with that order.

While checking the PMP in conjunction with Case No. 10-143-13, a focus was placed on a group of 20-22 patients who were being prescribed testosterone and pain medications. In order to prescribe the former, a series of tests must be conducted. Investigators intended to determine whether Dr. Villabona was acting in compliance with prescribing regulations. In this case Dr. Bakst was the "Board contact" for the investigators. He assisted, answered questions and provided advice. He is either a member of the Board of Medical Licensure and Discipline or the Controlled Substance Advisory Committee. Ms. Riddell consulted with him.

Ms. Riddell identified subpoenas *duces tecum* directed in this case to Dr. Villabona at SX 14 at 177-180. Ms. Riddell served the 2013 subpoena (SX 14 at 177) while accompanied by a pharmacy investigator (Alicia Kluger) and another licensing investigator (Anthony Kemmerlin, Sr.). The pharmacy investigator joined her because it had been reported that Dr. Villabona was storing unsecured medications in his office. Mr. Kemmerlin knew Dr. Villabona, and it was assumed that the two would enjoy a certain rapport.

The 2013 subpoena was served on August 1, 2013. A report by Ms. Kluger regarding her findings on that date is found at SX 14 at 209. When they arrived a male patient was in the office waiting room. Two female employees were also present. Ms. Riddell identified herself to the receptionist, provided her with the subpoena, and asked for the indicated records. While the files were

being collected, Dr. Villabona came out of his office. The subpoena was given to him and Ms. Riddell explained the purpose of their visit.

Dr. Villabona stated that he is a physician with lawful authority to prescribe drugs. Ms. Riddell stated that State officials had grown concerned about the volume of opioids and testosterone being prescribed by him. Dr. Villabona stated that he does not like pain management, but some of his patients do not have insurance and he was helping them. Dr. Villabona was cooperative. The requested charts were voluminous and could not all be copied at that time. With Dr. Villabona's permission, all but one of the charts were taken by Ms. Riddell for copying off site. The retained chart concerned a patient to be seen on that date.

Ms. Kluger inspected the office and found "many" violations. Those violations are listed in her report. SX 14 at 209. Two employees of Dr. Villabona gathered the files while Dr. Villabona was present. Dr. Villabona did not state that there may be other files regarding the pertinent patients, or that certain files were incomplete. The files which were removed were copied and returned.

Ms. Kluger is now retired. She explained her inspection and then discussed observed violations with Dr. Villabona. Mr. Beauregard objected to Ms. Riddell's testimony regarding statements made by Ms. Kluger on the basis of hearsay. The objection was overruled. After the inspection Ms. Kluger sent her investigative report to Ms. Riddell.

Ms. Riddell then described some of the regulatory violations observed in Dr. Villabona's office. A beige metal "storage cabinet" in the office had a key in the lock on the door, but was accessible to anyone in the office. An employee opened the cabinet and medications were observed inside. A number of expired medications were found in the cabinet which are listed in Ms. Kluger's report. The majority of the drugs were expired, and had been filled for certain patients, not for Dr. Villabona. Inside the cabinet was a bottle of Depo-Medrol with a 2008 expiration date filled "for office use". Certain conversations with Dr. Villabona during the inspection are recounted at SX 14 at 210.

Dr. Villabona was informed that working video equipment for security purposes was not necessary. Ms. Kluger explained the proper means of securing the medications in the office, and of disposing them. Controlled substances must be secured at all times, with limited access. A key in the lock on the cabinet compromises security. Ms. Kluger also explained drug take-back operations and how to arrange them with the DEA. Dr. Villabona admitted that the alarm system in his office was not operational.

Ms. Riddell described conditions in the office kitchen, where medical supplies, sharps containers, food, alcohol and a safe were located. She characterized the room as a "mess". Dr. Villabona was asked to open a safe which was atop a refrigerator. Pistols were located in the safe. Ms. Riddell did not recall if drugs were stored in it. Dr. Villabona placed controlled substances in it while she was present.

The subpoenaed files were copied and returned to Dr. Villabona in about four days. Investigators asked him to sign an attestation of completeness because in other cases incomplete files were produced, only to be supplemented later. Dr. Villabona signed an attestation statement on September 21, 2017. SX 14 at 180.

A 2016 subpoena was issued by the Division in February 2016 to secure updated files since the earlier subpoena. SX 14 at 178. The 2016 subpoena was again served by Ms. Riddell, and she took the requested files and copied them. She does not recall whether Dr. Villabona was present when the 2016 subpoena was served on his office.

Ms. Riddell testified that Ms. Beish's administrative complaint dated August 29, 2017 was also assigned to her. SX 14 at 215. Initially Ms. Riddell could not contact Ms. Beish (who had filed the complaint under the pseudonym "Melissa Ann") because she had used an incorrect name and address. The complaint matched up with certain issues which had arisen in earlier investigations. Ms. Riddell determined that "Melissa Ann" had substantial knowledge and could name current office employees.

Ms. Riddell refiled the complaint under her own name because the complainant wanted to remain confidential. SX 14 at 206. Before she did so, she contacted Ms. Williams, who stepped outside and returned Ms. Riddell's call. Ms. Riddell identified herself to Ms. Williams. Ms. Williams confirmed Ms. Beish's allegations. She stated she was "sick to death" about events. She verified the claims and stated that she feared retaliation. Ms. Riddell asked Ms.Williams to contact Ms. Beish because Ms. Riddell was unable to do so. Ms. Williams gave Ms. Riddell Ms. Beish's phone number. Both Ms. Williams and Ms. Beish identified patients of Dr. Villabona who were at risk for suicide as well as those who bartered with Dr. Villabona for medical services.

Ms. Williams told Ms. Riddell that Dr. Villabona had said it was "lucky" that the Division was unaware of M's suicide. Ms. Riddell had spoken with Ms. Riddell after another patient (J.R., who is not a patient with which this case is concerned) had attempted suicide. That patient was subsequently successful. (Ms. Riddell later verified J.R.'s suicide when a subpoena was issued for that person's health records.) During one phone conversation Ms. Williams related that M had died of a heroin overdose a few months after he left Dr. Villabona's care. Dr. Villabona was instructed by an unknown person to tell investigators that G's file had not been returned. Ms. Williams stated that she would not lie for Dr. Villabona. G's file had been returned.

With regard to M's death, Ms. Riddell had conducted a search of State criminal records and found evidence of his death. Police reports regarding his death and a copy of M's death certificate are found at SX 14 at 181-187. The cause of death on the certificate is stated as "anoxic encephalopathy following cardiac arrest, drug intoxication." SX 14 at 187. Ms. Riddell contacted M's parents to inquire as to his addiction. Ms. Williams and Ms. Beish had both stated that Dr. Villabona knew of the addiction. An additional police report concerning M is found at SX 14 at 303-306. M was charged in June 2012 with "obtaining controlled substance by misrepresentation fraud forgery deception or subterfuge", a felony under the Delaware Controlled Substances Act. 16 *Del.C.* Ch. 47.

In the report it is alleged that M received a script for 60 tabs of Oxycodone 15mg from Dr. Cagampan at Delaware Back Pain on June 26, 2012, and a script for 90 tabs of the same medication the next day from Dr. Villabona. SX 14 at 304. During a three-day span in July 2012 M had allegedly obtained a script for 90 tabs of the same medication from Dr. Villabona, and then an identical script from Dr. Cagampan. Finally, during a two-day span in August 2012 M received scripts for 90 tabs of Oxycodone 15mg from Dr. Villabona and then Dr. Cagampan. SX 14 at 305.

Mr. Beauregard objected to the evidence of "doctor-shopping" by M. He accused the State's attorney of "pulling things out of the air", and argued that there was no correlation between M's activities and Dr. Villabona. The State argued that these findings were made during the investigative process, were confirmed in Dr. Villabona's records, and that "doctor-shopping" is relevant in this case. The objection was overruled. Ms. Riddell added that the police report records a statement by Dr. Villabona's office manager that M was being discharged as a patient for violations of a pain management agreement.

Ms. Riddell also met Ms. Williams at Dr. Villabona's office. She was not reluctant to talk. Ms. Williams related that her daughter had died from a drug overdose "aided" by a physician. She was "sick at heart" at what was happening in Dr. Villabona's practice. Ms. Riddell testified that Ms. Williams seemed "very honest" in her statements. She had much information, but wanted to protect Dr. Villabona's patients. Ms. Williams also informed Ms. Riddell of a scheduled appointment for another of Dr. Villabona's patients. Since there were warrants outstanding for that person's arrest, Dover police arrested patient W at Dr. Villabona's office. Ms. Riddell confirmed that JX 1 is a summary of Ms. Riddell's interview of Ms. Williams on September 1, 2017. During her last contact with Ms. Williams in 2018, Ms. Riddell was informed of Ms. Williams' treatments for a brain tumor. She stated that she would testify during this hearing, but was reluctant to do so.

Ms. Riddell testified that Ms. Williams had confirmed the following information provided initially by Ms. Beish. Dr. Villabona dispensed medications to patients from the storage cabinet. At times he dispensed medications from his pocket. He exchanged medical services for services performed by some patients. He showed guns to some patients. He had received weapons in exchange for medical services. A patient had given him a rifle for services, and the weapon was later retrieved by the patient's spouse. Dr. Villabona kept medications in a desk drawer, and kept guns in the office. Dr. Villabona consumed alcohol in his office. Patient U would call ahead for refill scripts, and would then pick them up during five-minute visits to the office.

Ms. Riddell identified the third subpoena *duces tecum* issued to Dr. Villabona (SX 14 at 179) and Dr. Villabona's attestation of chart completeness (SX 14 at 180). A September 2017 subpoena (SX 14 at 179) was issued after Ms. Riddell had received the information from Ms. Williams. That "demand" subpoena was served by Ms. Riddell in September when she was accompanied by the pharmacy inspector (the PMP administrator), and two other investigators. During the September 2017 trip to Dr. Villabona's office, investigators learned that he was still maintaining unsecured and outdated medications in the storage cabinet. The two investigators accompanied Ms. Riddell because a large number of documents were sought, and because of safety concerns stemming from information about guns in the office.

During the 2017 visit a patient was waiting to see Dr. Villabona. The subpoena was presented to his staff after investigators had identified themselves. Unsecured medications were observed on a shelf in the office. The storage cabinet was unsecured and the key was not in its lock. Mr. Slavoski inspected the premises and was shown the contents of the cabinet. Photos were taken. Three sharps containers were "overflowing". Zip-lock bags were observed containing bloody gauze and other materials. Alcohol, food and insect control containers were found in the kitchen. Ms. Williams fetched Dr. Villabona. He was provided a copy of the subpoena. Mr. Slavoski explained his authority to look in the

cabinet. Dr. Villabona stated that controlled substances and guns were in the safe. He opened it and its contents were inventoried. Ms. Riddell determined to record the registration numbers on the weapons.

When the requested charts were given to investigators, Dr. Villabona signed the attestation (SX 14 at 180). He made no statement that the produced charts were or may be incomplete. A subpoena for records issued in February 2016 sought, *inter alia,* the chart for patient D. Dr. Villabona's staff indicated that D had transferred to Dr. Cemerlic. Ms. Riddell is uncertain whether D's records were ever produced.

Mr. Beauregard then cross-examined Ms. Riddell. She again identified her statement summary in JX 1. Mr. Beauregard then requested that he be provided with all investigative reports prepared by Ms. Riddell in 2013, 2017 and 2018. Ms. Stewart objected. The reports had not been requested prior to the hearing. The reports are confidential and "work product". She noted that the confidentiality of such reports has been acknowledged in other proceedings. Mr. Beauregard argued that since Ms. Riddell reviewed one or more of her reports to prepare for the hearing, he had a right to review them. He also argued that a late request for them does not mean that such a request is improper. Ms. Stewart argued that the State's production of other materials prepared by Ms. Riddell, e.g. JX 1, was not a waiver of confidentiality.

After considering the arguments of counsel regarding the request that Ms. Riddell's investigative report(s) be produced to Dr. Villabona's counsel, I issued a ruling during the proceedings on the following day (June 6, 2018) which I have admitted into this hearing record as HO X4. In short, I found that Ms. Riddell's investigative report(s) are privileged records under D.R.E. 508 and the attorney work product doctrine. I found that Dr. Villabona had failed to show that substantial prejudice would result if the DPR investigative file is not produced to him. I denied the requests that the report(s) be ordered produced.

Ms. Riddell testified that her investigative reports were prepared in the normal course of Division business. She wrote them from her notes. In 2013 a counselor had initiated a complaint against Dr. Villabona. An additional subpoena *duces tecum* was issued to Dr. Villabona on September 20, 2017 for the records of patients J, G, R and T. Apparently the original or copies of that subpoena were not retained by the State. Mr. Beauregard located a copy of that subpoena in his records. I directed him to produce it, and it was admitted as RX 9.

Ms. Riddell continued her testimony. She recalls that in 2013 she and Ms. Kluger went into the basement in Dr. Villabona's premises. In 2013, 21 files were secured by investigators. Others were secured in 2016 and 2017. Ms. Riddell did not speak with any of the patients listed in RX 9 regarding their medical care. Nor did she speak with any of the patients whose records were secured over the four-year period.

Ms. Riddell confirmed that the storage cabinet in the office has a key lock. It contained drugs in 2013 and 2017. Ms. Riddell was asked to compare inventories of the contents of the cabinet prepared by Ms. Kluger on the earlier date and Mr. Slavoski on the latter. Ms. Riddell did not find the lists to be similar. In 2013 Ms. Kluger informed Dr. Villanova how to dispose of medications. The cabinet is in a rear area of the office not accessible to patients. In Ms. Riddell's opinion, the photos of the office depict its "messiness".

Ms. Riddell reiterated that Ms. Williams had largely confirmed information from Ms. Beish. She knew she was speaking with Ms. Williams on the phone because she had used different phone numbers, and voices differed. During the hearing Ms. Riddell had first learned about the motor vehicle accident hoax perpetrated by Ms. Beish. Ms. Riddell did not record statements by Ms. Williams and Ms. Beish.

Information regarding Dr. Villabona dispensing medications or trading guns for medical services was not received from his patients. Ms. Riddell only contacted Mr. Davis. Typically patients in similar

cases are not cooperative. They do not want to implicate themselves in "problems". Ms. Williams confirmed that they would not be cooperative.

Ms. Riddell did not substantiate any consumption of alcohol in the office. Nor could she gain access to Dr. Villabona's desk. In 2013 rifles were located in Dr. Villabona's basement. Photos were taken in 2013 of alcohol on a counter in the kitchen or in the refrigerator. Medication on a book shelf was near a cabinet. Investigators did not go into Dr. Villabona's personal office. Photos of the alcohol are found at SX 14 at 248-249. A photo of the unsecured medication bottle on a shelf is found at SX 14 at 250.

During the 2013 search guns were found in the safe in the kitchen. Dr. Villanova had opened it. Ms. Riddell did not "run" the registration numbers on the guns. Dr. Villabona stated that friends gave him the guns. Subsequently he stated that some guns were given to him to ensure the safety of others.

Ms. Stewart then conducted re-direct examination. Ms. Riddell testified that she filed complaints in this matter "automatically", or if one complaint led to another. Dr. Villabona did not ask to review patient charts before they were given to investigators. Had he asked, he would have been permitted to do so before attesting to their completeness. When Ms. Riddell spoke with Ms. Williams in this case, Ms. Beish was no longer employed by Dr. Villabona.

After the conclusion of Ms. Riddell's testimony, Dr. Villabona resumed his testimony regarding patient T. SX 4. A note in T's chart dated February 28, 2015 states that T's pain management had been assumed by Dr. Uthaman, whom he had seen for a year. SX 4 at 228. Dr. Villabona testified that he spoke with Dr. Uthaman, and would have asked for his charting. He does not now recall having reviewed Dr. Uthaman's records. An April 6, 2016 note states that T had left Dr. Uthaman after being angered by the reduction of his medication dosing. SX 4 at 246. Dr. Villabona had resumed caring for T. The chart does not document any discussion at this point between Dr. Uthaman and Dr. Villabona.

On May 18, 2016 T complained to Dr. Villabona of "severe pain". Though no examination is recorded in T's chart, Dr. Villabona stated that he would have examined T. T was in withdrawal as a result of a reduction in his medications. Dr. Villabona prescribed Diazepam. Dr. Villabona recalls telling T that he would not fill the "niche" of pain management for him. In response to a follow-up question, Dr. Villabona agreed that he had filled that "niche". His "usual" medications, including Adderall, were prescribed. On May 18, 2016 Dr. Villabona prescribed Narco 10/325 (Vicodin). SX 4 at 324. He agreed that was not recorded in his May 18, 2016 note. SX 4 at 248. Dr. Villabona added that he had a "running collection" of prescriptions for T.

He recalls receiving calls from T's sister stating or asking whether T was suicidal. A typed July 29, 2016 note in T's chart states that T's sister had reported suicidal ideation. SX 4 at 252. Dr. Villabona prescribed Dilaudid (SX 4 at 253). Though he had prescribed it ten years earlier, that was a "new drug" from Dr. Villabona.

On June 20, 2016 the Sussex Pain Relief Center addressed a letter to Dr. Villabona stating that that practice had decided not to accept T as a patient and was therefore referring him back to Dr. Villabona. SX 4 at 47. Dr. Villabona noted at this point that "mentally ill people are at high risk with opiates".

A note dated June 27, 2016 states that T was unable to produce a sufficient urine sample for a pain management physician. SX 4 at 250. Dr. Villabona testified that he believed the "reason was something else". Dr. Villabona was asked if he had contacted the Sussex Pain Relief Center. He stated that many of his patients are turned down by other physicians because they are mentally ill and at high risk.

He "vaguely" recalls Dr. Dickinson informing him that she would not take a patient referred by him because of his current medication regimen. He was referred to his chart note of September 8, 2016. SX 4 at 255. That note states that Dr. Dickinson would not take T as a patient unless Dr. Villabona

would certify that he had turned in his remaining Clonazepam and Adderall tabs. Dr. Villabona wrote back to her asking that she reconsider her position on discontinuing Adderall for T. At this point Dr. Villabona believes that T had been refused by 5-7 physicians.

On January 24, 2017 T admitted using LSD. SX 4 at 259. Dr. Villabona does not recall whether T had been screened in a hospital. Dr. Villabona agreed that he had not documented any discussion with T about illegal drug use. Nonetheless, it was his "habit" to have such discussions.

Ms. Stewart then asked Dr. Villabona a series of questions which were not patient-specific. He agreed that he had written scripts for testosterone for "office use". He may have done the same with Diazepam. He would go to the pharmacy and pick up the drugs. If the drugs were for "office use", that means that certain patients could not "get" the drugs. The drugs would be administered to patients in his office who were in "great distress". He was not aware in 2013 that he was prohibited from writing "office use" scripts.

Dr. Villabona was provided with a PMP profile concerning him. He reviewed the profile and admitted that he had written "office use" scripts for Diazepam, testosterone, Alprazolam and Lorazepam. They were filled at Moore's Pharmacy from 2011-2013. His recollection on the point is not detailed. He does recall the Depo-Medrol script which is depicted in photos taken during an inspection.

Ms. Stewart questioned Dr. Villabona about prior disciplinary proceedings concerning his medical license. He recalls that discipline imposed by the Board in 2003 required him to provide a letter to each patient stating that he could not see minor patients without the attendance of an adult. Those notice forms or letters were to be maintained in each patient's chart. The forms or letters were to make reference to his unprofessional conduct and plea in Maryland on the sex offense charges. Patients were to be informed that his practice was limited and restricted, and that his ability to treat victims of sexual abuse may be compromised.

Dr. Villabona was provided by Ms. Stewart with certain records pertaining to patient L. Those documents were admitted as SX 12. They had not been offered earlier pending the decision of this hearing officer as to whether they could be referenced in this hearing in light of the Maryland expungement order. That issue has been decided in the State's favor. H.O. X3.

Dr. Villabona testified that he recalls patient L. Ms. Stewart asked where in L's records is a copy of the required notification form or letter. Dr. Villabona testified that in some cases files were "sent out" and it was no longer necessary to retain the form. He recalls that there was a "larger" notice used previously, but "that was 15 years ago". Dr. Villabona pointed to SX 12 at 18 as the "other" notice he had used. He conceded that this "other" notice had not been approved by a member of the Department of Justice.

The document at SX 12 at 18 informs the patient that he was "falsely accused" in Maryland in 2002. He had agreed to a plea bargain in Maryland because he was weakened and fatigued from diagnosis of non-Hodgkin's lymphoma. He assumed that a Maryland judge had allowed him to enter into a probationary period without conviction because of a "strong probability of my innocence." He informs patients that as a result of his successful completion of the terms of probation, there is now "no conviction of any kind" in Maryland and that the criminal records have been expunged in that State. The "notification" letter to patients closes with the statement that the Delaware Board has "found no evidence of guilt" in the matter. *Id.*

Dr. Villabona testified that he sought to argue his innocence on the Maryland charges before this Board. He had tried to remove or change his Maryland plea without success. He agrees that the Delaware license discipline was based on his plea in the Maryland court. Dr. Villabona stated that "my take" on the proceedings before this Board is that "no evidence of guilt" was found here.

Dr. Villabona was asked to read into the record para. no. 7 at SX 14 at 66. The paragraph is contained in a final order of this Board dated September 22, 2003 in Board Case No. 10-61-02. That

paragraph, in full, states: "The Hearing Panel finds that the plea of guilty entered by Dr. Villabona in the Circuit Court for Queen Anne's County, Maryland, on September 30, 2002 was entered in accordance with his admission to that Court, among other things, that he was pleading guilty to Count 1 and Count 13 because he was in fact guilty of having committed those offenses." *Id.* Dr. Villabona testified that the Board had in fact found that Dr. Villabona had entered a plea of guilty because he was guilty.

Ms. Stewart referred to the relevant report of the Hearing Panel in the 2003 matter, which begins at SX 14 at 71. In that report the panel found that regardless of Dr. Villabona's subsequent statement that had he gone to trial in Maryland he would have been acquitted on the charges, nonetheless the Board was not required to make its own finding of guilt or innocence, and should rely on Dr. Villabona's guilty plea. SX 14 at 111. Dr. Villabona agreed that the Board relied on the report and its conclusion on the point, but noted that he was not permitted to present facts about the criminal case to this Board. Dr. Villabona stated that the "notification" letter at SX 12 at 18 had failed to inform patients that the criminal case had arisen after medical school. He added that the form letter at SX 12 at 18 was "maybe" used only a few times with other patients.

In response to a question from the State's attorney, Dr. Villabona admitted that in 2007 his period of license probation was extended by the Board. He stated that the extension had been ordered because he had seen minor patients contrary to prior orders of the Board. The Board's order of June 6, 2007 in Board Case No. 10-61-02 continued the requirement of the notification letter to patients. SX 14 at 161. His license probation continued until 2015. He was off license probation for a period of time, but probation was again imposed in 2008 until 2015. His original probation in 2003 was to run concurrently with his Maryland court probationary period. That ended in 2005.

Mr. Tease stated that Dr. Villabona would be recalled as a witness in the presentation of his own case. Ms. Stewart indicated that the State's "Additional Exhibit" binder (SX 14) would be updated so as

to contain only those documents which have been admitted into evidence. At this point the State rested.

Dr. Villabona was recalled as a witness by his counsel, Mr. Tease. During earlier questioning, a PMP profile of scripts written for Dr. Villabona's "office account" was admitted as SX 13. Dr. Villabona reiterated that he was unaware that laws or regulations prohibited such prescriptions during the period 2011-2012. He does know that some restrictions became effective in 2013. He was surprised that SX 13 lists 11 such prescriptions. Dr. Villabona noted that the Depo-Medrol script was written in March 2008.

Dr. Villabona testified that he did provide notices to patients regarding the Maryland criminal matter. Copies were placed in patient files. He retains files for seven years. If such a form is not in a patient chart, that chart may have been sent to another physician. He did create a "second notice". The form provided to patient L (SX 12 at 18) was "my rendition". He agreed that the form at SX 12 at 17 was approved by the Department of Justice.

Dr. Villabona explained the "unapproved" version (SX 12 at 18). It refers to the fact that he pled guilty to avoid stress caused by his medical condition and to avoid requiring a niece and others to testify during a trial. He agreed to the probation-before-judgment disposition as a "kindness" to family members.

Dr. Villabona opened his Dover practice in 2013. There was no interruption in his practice at another location. In 2003 when he was building his practice some patients from a prior practice remained with him. Initially he practiced three days per week. As his caseload increased, he began to work on Saturdays, and eventually worked 60 hours per week. In the mid-2000's he saw up to 50 patients or more per week. Many were afflicted with chronic mental illnesses. Their needs differed. Some were seen prn. In 2008 his patient load decreased. A Board order precluded his treating women.

His patient load eventually dropped to 35-40 patients per week, or approximately 150 per month. As of January 2018, he saw an average of 35 patients per week.

Dr. Villanova testified that the PMP became operational in 2011-2012. The instant case concerns four or five patients out of a total of 150. Dr. Villabona was asked to define an "orphan patient". Such a person is mentally ill and is receiving Schedule II medications because they do not have a pain management physician, or the lack of resources or insurance which would allow such care. He agreed that mentally ill patients being prescribed opioids are deemed at "high risk" in the medical community. Many physicians refuse to treat mentally ill persons. For some who are mentally ill, consistency of care, abiding by appointments and urine screening are difficult. These are "confounding factors" for physicians.

Patients who are 100% disabled receive Medicare. Many physicians do not accept Medicare patients. Hence, the mentally ill end up "at my doorstep" often because they do not "fit in" with the community. Dr. Villabona has never felt comfortable engaging in pain management. His practice is to follow what pain management physicians have prescribed, or "significantly less". In the last 3-4 years, he has gotten 10-15 patients completely off opioids. At times an adversarial relationship can develop with a pain patient over pill counts, urine screening, or patient excuses. Dr. Villabona does not solicit pain patients. He must act as a "guard dog". He has communicated that to patients.

Dr. Villabona testifies that he often continues the pain medications prescribed by others because there is "no alternative". Arranging for his patients to see pain management physicians has not been easy. For example, no one would see patient U. Mentally ill patients are not always welcome in other practices. The patients themselves can be the problem. Mental illness can cause homelessness. Patients can "fall through the cracks".

Dr. Villabona was asked about Dr. Durkin's report (SX 10) and his testimony. He was asked what he does with new patients. He has them fill out forms, though some choose not to. He takes vital signs

and conducts a deeper investigation into their complaints. He did not always document this stage because he did not conduct full-blown physical exams. For that he would refer to patients' primary care providers. He noted that he had to "wear two hats". Patients would be questioned about the use of alcohol or illegal drugs. Traits and "abnormalities' which could suggest danger to self or others were noted. Pain management agreements were signed. Urine screening is a risk management tool.

Some risk assessment was done because of the long-term relationships with some patients. If a patient were known over a long period (such as patients U and T), Dr. Villabona knew of their foibles and strengths. Risk assessment may differ if Dr. Villabona speaks with a patient for a full hour. A lot of that discussion is risk assessment. Dr. Villabona does not often chart patient diagnoses in notes unless a diagnosis is a new one. Dr. Villabona performs urine drug screens on patients receiving opioids, unless the patient is also being seen by a pain management physician.

Dr. Villabona listed his present and former practice employees. They include Ms. Williams, Mr. Joyner, Dawn Miller, Ms. Beish, and others whom he can not recall. Ms. Beish took patient vitals for two years. All office billing was done by a single person, such as Ms. Beish. Requests for records would be handled by Ms. Beish and Ms. Williams. They would file documents in charts. Dr. Villabona would generate a note and either put it in a file or in a box to be filed. Dr. Villabona peruses communications from other physicians and places them in the to-be-filed box.

Emptying or disposing of sharps containers in the office was not delegated to specific employees. Containers were not emptied. When they were full, a service was to pick up the contents. Ms. Beish or the office manager were to arrange that. Dr. Villabona agreed that disposal of the contents was lax. If too many medications accumulated in the office, Ms. Beish was to find out who could pick them up. He noted that flushing drugs down the toilet is now deemed irresponsible. On occasion patients will bring in drugs to be disposed. Dr. Villabona observed that mentally ill patients should not have "too many meds lying around."

Old medications were stored at the bottom of the cabinet near the secretaries. Patients had no access to it. It was accessed by Dr. Villabona, Ms. Williams and Ms. Beish. The cabinet could be locked; it "probably" was not always locked, but locked a majority of the time. Employees could access the cabinet if Dr. Villabona required a syringe, pads, or other materials.

The Meperidine depicted in the picture at SX 14 at 223 was Dr. Villabona's medication and was kept in the safe. Dr. Villabona gave the same response as to the medications depicted at SX 14 at 224-232. The drugs at SX 14 at 234 were kept in the safe. Medications at SX 14 at 247 may have been returned medications. Medications at SX 14 at 250-253 may have been brought in for disposal. The photo at SX 14 at 254 depicts an empty vial and syringe without needle. SX 14 at 266 depicts cough medicine with Hydrocodone which was kept in the cabinet. It was brought in for disposal by patients, which was not uncommon in his practice. Dr. Villabona started using a disposal service in Wilmington in 2017.

Photos at SX 14 at 267-272 depict medications prescribed for Ms. Williams' daughter. Dr. Villabona added that the daughter died when prescribed Paxil combined with cardiac medications. After the daughter had died, Ms Williams brought in her medications. Depicted at SX 14 at 275-287 is injectable testosterone which had been brought in by a patient. The inside of the storage cabinet is depicted at SX 14 at 282. Dr. Villabona testified that some UDS tests near the kitchen had expired and had been stored for too long. He did not want to mix them with others, or to throw them in the trash. When sharps containers were full, they were to be picked up and taken to a disposal facility. Ms. Beish was to arrange for the disposal, but failed to do so.

The safe was in the kitchen on top of the refrigerator. Some personal items were kept in the safe along with injectable narcotics. One of the pistols in the safe was brought in by a patient's wife who was fearful of her spouse's suicide. A second pistol was brought in by the wife of a patient who had

died. She brought in the gun for disposal. Dr. Villabona had the gun for about ten years, and had always kept it in the safe.

A schematic of the interior of the office space was admitted as RX 11. It is accurate except for a four foot wall blocking the basement steps. Patients were not allowed in the interior or kitchen area.

A series of color photos of the exterior and interior of the building was initially marked for identification but later admitted as RX 12. Dr. Villabona testified as to what each photo depicted. The photos were taken in 2018 by Mr. Tease and Dr. Villabona. The pictures accurately show where certain items were located in 2013.

RX 13 is a photo of a folding knife and "gas gun" which had been in the office "for years". Dr. Villabona recalled when investigators entered his office and D2 was present with Dr. VIllabona in his small office. When the "crowd" appeared, D2 was admiring the gun in RX 13. He wanted to show it to a family member. (In the past D2, a friend since age five, had shot and fished on Dr. Villabona's property.) D2 asked if he should take the gun. Dr. Villabona told him that was not necessary. The gun was inoperable and had been in a drawer. Dr. Villabona gave the gun and knife to D2 and he removed them from the premises. The knife in RX 13 had been discussed with D2. He took it. The gun was returned one month later.

Dr. Villabona was asked by his attorney why he had prescribed methylphenidate for some of his patients. He stated that the drug increases dopamine. As shown in a California study, Ritalin also enhances the effect of opioids. Dr. Villabona prescribed it for D for his fatigue. Since D was already being prescribed benzodiazepines, Dr. Villabona did not want to prescribe a "sleeper" drug for him. They discussed taking Ritalin in the morning prn to keep D active and to allow him to sleep more soundly at night. The California study of 300 subjects discusses Ritalin and opioids. Dr. Villabona handed three studies to his attorney. He stated that Ritalin combats somnolence in low doses.

In response to the hearing officer, Dr. Villabona testified that opioids cause somnolence and decreased cognition. Ritalin combats those conditions. If methylphenidate and opioids are taken simultaneously, studies have shown reductions in pain and opioid tolerance.

D2's Ritalin script was prn. He would bring back unused tabs to Dr. Villabona. They were placed in the storage cabinet. If D2 changed his mind, he could retrieve them from Dr. Villabona. If the pills were kept for an extended period in the cabinet, they were disposed. Dr. Villabona denied that he paid D2 for the unused drugs. He reiterated that D2 has been a lifelong friend. Dr. Villabona encouraged him to take the medication as he would nap during the day and then sleep poorly at night.

With regard to some of the claims made by Ms. Beish, Dr. Villabona stated that he never provided medical services in exchange for guns. He has accepted guns for safekeeping. He has never consumed alcohol while working. Drugs returned to him by a patient were never given to other patients. Dr. Villabona has given some drug samples (for example, antidepressants, antipsychotic meds, vitamin B12 injections, vitamin D samples and others) to patients from the cabinet.

The guns in the office were stored in the safe. One old, inoperable shotgun was displayed as decoration. It is "possible" that a knife was stored in a drawer. One patient was a collector, and gave him a "doctor's knife". Another brought in an "Arabian knife" ten years ago. Dr. Villabona stated that he shoots pool on Wednesday nights at a local bar or restaurant. Patients have seen him there. In response to his attorney, Dr. Villabona testified that he has never been restricted or barred in his ability to prescribe opioids for patients.

When Ms. Beish stated she was needy three years ago, he agreed to loan her $1,200. The loan was never repaid. They argued about it before she resigned her employment. He has had disagreements with her about vacation time. In the six-month period before her resignation, she took an excessive number of days off (18). When he mentioned that to her, she was "unfriendly" toward him. According to Dr. Villabona, she said to him, "I could say a lot of things about you." He asked her if

that was a threat. He paid for Ms. Beish's CNA and billing training. He added that while she was employed by him there were no billing problems. However, after she left the staff determined that some checks had not been deposited or cashed.

When questioned about employee Melissa Brown, Dr. Villabona stated that he is not an intimidating employer. There had been no complaints about that. If he appeared to be intimidating, there was no intent.

Dr. Villabona would work on files during weekends. He would take apart charts where documents had been misfiled and would leave notes for corrections. For example, he would find scripts and notes filed in the wrong charts.

Dr. Villabona was asked about Ms. Beish's motor vehicle accident hoax. Ms. Williams had reported the "accident" to him. Her daughter had reported that she had been taken to a hospital. He later learned that the accident was faked. There had been no story in the news about an accident involving her. He added that Ms. Beish had an absenteeism problem.

Dr. Villabona described his charting. Mentally ill patients would complain if he engaged in writing during an office visit. Therefore, he simply wrote notes and charted visits after they had occurred. He tried to spend 35-45 minutes in a visit. He wanted to pay attention to the patients. Notes would typically be written on Fridays or during evenings. Some handwritten notes were used to create typed computer notes. He added that he is a "better writer than a typer". If a patient was seeing a new physician, he would type the notes. Whether he typed or wrote depended on his "whim". His typing was better if there were few changes in a patient from visit to visit. For instance, patient G was "static" over a prolonged period. His medications were not increased.

Dr. Villabona received a subpoena from the State for G's chart. Staff produced it, and told him the whole file had been provided. Dr. Villabona therefore assumed that the produced chart was complete. Dr. Villabona never knew when G would appear for an office visit. He therefore relied on

computer records for him. Few changes occurred, and few studies were done. During G's visits, Dr. Villabona only had his computer records before him. Dr. Villabona denied that he had ever created "fraudulent" chart entries. Dr. Villabona determined that some of G's computer charting had not been placed in the chart produced to investigators.

A 43-page collection of documents captioned "M. G. Binder A" was marked for identification as RX ID A. The progress notes in the collection were all typed. Dr. Villabona identified the collection as notes on G which were taken from his computer in Spring 2018. A second 34-page collection of documents was captioned "M.G. Binder B" and was marked for identification as RX ID B. Dr. Villabona identified this second collection of documents as more notes regarding G. They had been taken off the computer or a flash drive several years before.

Mr. Tease then offered the two sets of "G" records for admission as exhibits. The State objected to the offer. The documents in the two sets had not been produced in 2013 or in 2017 in response to the State's subpoenas. Dr. Villabona was legally obligated to produce the documents at those times. There is no way to verify when they were created. Dr. Villabona's counsel argued that the documents are relevant in this case. He added that Dr. Villabona has testified that he had not reviewed files which were produced by his staff.

Ms. Stewart argued that the two sets of documents concerning G are fraudulent. Dr. Villabona's failure to produce them earlier is not an excuse. They were sought by the earlier subpoenas. G is one of the patients whose files were attested to by Dr. Villabona as complete. After considering the arguments of counsel, this hearing officer determined that the two sets of documents would not be admitted into the record. They were not produced at the time when they were subpoenaed. Dr. Villabona attested that G's files, as produced, were complete.

Counsel for Dr. Villabona stated that he intended to call a witness who will testify as to the care which he was provided by Dr. Villabona. The State's attorneys objected to such testimony if provided

by a patient whose care was not a focus of this case, or who was not present when care was provided for one of the named patients. Dr. Villabona's counsel argued that testimony regarding Dr. Villabona's ethics, professionalism and character is relevant. Further, such testimony may constitute mitigation in this case. I ruled that such testimony would be admissible because the Board has a right to be apprised of input from other patients, and because such testimony has been allowed in other cases.

Dr. Villabona then called W.E. He had treated with Dr. Villabona for 3-4 years, seeing him on a monthly basis. He experiences pain in his shoulder and pain at the L5-S1 level of the spine. He also experiences degenerative "back" disease, and arthritis. He has been prescribed pain medications since the late 1970's, and has treated with various physicians.

Dr. Villabona has prescribed for him Oxycontin, Oxycodone, Percocet, Darvocet and Methadone. Just prior to treating with Dr. Villabona, he had been prescribed 180 Methadone per month and was treated with injections. He felt like he "needed" opioids. He admitted that he had "probably abused" the drugs. Though Dr. Villabona tried to refer him to a pain management physician, Mr. E could not afford such care. Dr. Villabona helped him with his pain. He is now taking 40 Methadone monthly and is engaged in a slow weaning process. Because of his disabilities, he rarely goes out, and suffers from "panic attacks"' when he does. Dr. Villabona has prescribed Xanax for him, which has helped.

During office visits Dr. Villabona takes his time. They "relate" to each other. Dr. Villabona has "saved his lifestyle". Dr. Villabona saw his need for treatment while searching for a pain management physician to whom he could be referred. Things have been "horrible" for him since Dr. Villabona's medical license was suspended.

On cross-examination E testified that he saw Dr. Villabona for pain and for psychiatry. He asked Dr. Villabona to continue him on Methadone. It did not produce a "craving" effect for him. An objection to the question was overruled on the basis that Dr. Villabona's attorney had "opened the

door" regarding his specific treatment. Dr. Balin (his former physician) did not explain why he selected Methadone for E. He also prescribed Cymbalta.

Ms. Plerhoples asked E if Dr. Villabona had discussed with him the risks and benefits of controlled substance use. He responded that Dr. Villabona had provided him with certain literature. He did not describe the risks of certain medications. E knew that he could "research the side effects". Dr. Villabona performed physical exams but did not order imaging of his injuries or conditions because that had been done "in the past". Ms. Plerhoples asked E if Dr. Villabona had prescribed other modalities for pain treatment. E responded that Dr. Villabona had prescribed medications "that worked". E engaged in tai chi twice weekly, and therefore there was no need to engage in physical therapy.

After Mr. E's testimony had concluded, Mr. Tease resumed his examination of Dr. Villabona. He was questioned regarding patient U (SX 8). Dr. Villabona knew that U was treating with Dr. Cemerlic. He did call Dr. Cemerlic to determine his prescribed drug regimen for U. Dr. Villabona also wanted to mend the schism between U and Cemerlic.

Dr. Villabona was referred to his note on U at SX 8 at 79. The note states that Dr. Villabona had reviewed the pharmacological traits of Methadone. The note states that a urine screen was "appropriate", and that there had been no significant change in U's pain. Dr. Villabona read certain elements of his plan for U. Among them were his medications and that he would be involved in behavioral modification and insight support.

Dr. Villabona was asked to discuss differences between his chart note for U on February 8, 2016 (SX 11) and his note for March 16, 2016 (SX 8 at 79). He stated that there was greater detail in one of the notes. Dr. Villabona testified that there had been no issue for U in the past regarding abusing drugs. He added that his in-office urine drug screens had received government approval in terms of their probabilities. Dr. Villabona testified that Dr. Cemerlic had performed "too much" urine screening, in the opinions of some. If Dr. Cemerlic had seen U without performing a screen, that was an indication that

his "history would be pretty clean". U had previously been diagnosed with arachnoiditis. Dr. Villabona agreed. A second physician had disagreed with that diagnosis. U's pain treatment was based on several conditions, including degenerative joint disease, arthritis, and other conditions. Dr. Villabona's prescribing was directed at "several levels".

Dr. Villabona was referred to his note of January 30, 2017 concerning U. SX 8 at 66. Dr. Villabona testified that the note listed various risk assessment factors in U. A note written for an office visit on February 28, 2017 (SX 8 at 65) also lists risk assessment factors . It lists "positive events" for U such as a recent marriage and enjoyment of his wife's company. The note states that a pill count on that date was "appropriate". Dr. Villabona admitted that the February 28 note does not document that urine screening was performed, but it is his "habit" to order it.

A note for U dated September 14, 2016 states that observations of "posture and gait" show that U was "favoring areas" of pain. SX 8 at 71. Dr. Villabona referenced an "old joke" about medical care that a physician can diagnose certain things as soon as he observes a patient walk in the room. Dr. Villabona was asked if he had performed any risk assessment of U on October 13, 2016 (SX 8 at 70). He testified that a complete mental status exam of effect and focus was performed. That is part of his risk assessments. The form at SX 8 at 70 is called a "mental status examination". Dr. Villabona testified that if all of the boxes in the left column on that form are checked, the patient is "in a good place".

Dr. Villabona's overview of his care for U includes the fact that initially U was in an unhappy marriage. He had experienced trauma and could not work. He was diagnosed with depression and anxiety, and was at risk for suicide. Dr. Villabona tried to reduce U's narcotid dosing as such drugs can cause somnolence and poor cognition. He added that chronic pain can be debilitating. "The less narcotics the better". He tries to reduce dosing for all of his patients. He has tried patients on anti-inflammatories in the short term. He wants to give his patients the best quality of life.

Dr. Villabona's attorney then questioned him about patient T (SX 4). On March 6, 2014 a note states that Dr. Villabona did contact Dr. Callahan regarding T and requested records. T had been diagnosed with musculoskeletal and psychiatric issues. SX 4 at 212. None of the diagnoses on a "problem list" required pain medications. SX 4 at 39. Dr. Villabona testified that T has disc issues, trauma-related issues and joint inflammation.

With regard to a note at SX 4 at 246, Dr. Villabona stated that he is not certain about contacting Dr. Uthaman. He believes he did, but does not recall whether he documented a discussion. If he had spoken with that physician, he would have charted that fact. Dr. Durkin testified that on May 26, 2016 (SX 4 at 249) Dr. Villabona had prescribed Hydrocodone acetaminophen without justification. Dr. Villabona stated that T was experiencing rapid breathing and had produced a clean urine. It is "poor medicine" not to give minimally adequate care. He prescribed 15 days of Methadone for T.

On July 29, 2016 T's sister had reported T's suicidal ideation. SX 4 at 252. Dr. Villabona saw T as soon as possible. He was complaining of significant pain and discomfort. Dr. Villabona held Clonazepam and prescribed Dilaudid.

Dr. Villabona was then questioned about patient M (SX 1). Dr. Villabona listed his Axis III physical issues at SX 1 at 192. He testified that chronic pain can influence a patient's psychic health and can impact an entire family. In M's case his physical condition impacted his mental condition, and vice versa. In June 2009 Dr. Villabona wrote Oxycodone and Ritalin for M. SX 1 at 10. The reference in that note to "post-dating" scripts means that M was at the end of a prior script but still had some tabs left over. In August 2009 Dr. Villabona determined to continue medications and therapy but could not prescribe a neurosurgical evaluation due to the lack of insurance. SX 1 at 14.

M sustained a fall at work on May 2, 2011. Three weeks later Dr. Villabona had not changed his medication regimen from Oxycodone 15mg and Ritalin. SX 1 at 54. In his letter of September 21, 2012 Dr. Cagampan had reported that M was seeing multiple physicians for scripts and was being discharged.

SX 1 at 102. Dr. Villabona testified that he continued to prescribe for M and to keep him as a patient. He never produced an abnormal UDS. His pill counts were consistent. Dr. Villabona refused to penalize M based on the Cagampan letter. In addition, M had a real and existing malady. A physician is caring "for the whole family". Dr. Villabona had no conclusive proof that M had done anything wrong. He wanted to treat M until he could secure a pain management physician. Dr. Villabona conceded that a PMP report in M's chart shows that M was securing scripts from multiple physicians. SX 1 at 103. Dr. Villabona added that it is known that PMP may contain errors. Dr. Villabona was aware of drug charges against M.

Dr. Villabona testified that M and his father have the same name and address. Therefore, it is likely a pharmacy made an error. The State had informed M that charges would be dropped if he enrolled in a drug diversion program. M showed Dr. Villabona his license, which established that M and his father shared the same address. He conceded that their birth dates differed.

Dr. Villabona did refer M to a neurosurgeon in December 2012. SX 1 at 118. However, the referral did not occur due to M's limited resources. On October 18, 2013 Dr. Villabona referred M to Dr. Sugarman, a neurosurgeon. SX 1 at 173. During the gap between November 2013 and April 2014, Dr. Villabona continued to prescribe for M. Therefore, he would have seen M during that time, though notes of the visits are not in M's chart.

Dr. Villabona characterized his examination of M on January 2, 2012 as "cursory". He conceded that the exam could have been more detailed. Dr. Villabona received documentation of a new MRI report for M in 2012. The materials would not fit in an evidence binder. Dr. Villabona is certain that he reviewed the imaging. A series of photos of M's lumbar spine was admitted as RX 14. Mr. Tease stated that the exhibit had been forwarded to the Department of Justice.

At this point Mr. Beauregard offered certain studies regarding the simultaneous prescribing of opioids and Ritalin. They were offered to counter testimony by Dr. Durkin. Ms. Stewart stated that the

studies had been reviewed during the lunch break. She objected to them on the basis that they are hearsay and their authors were not present to testify as to their findings. Mr. Beauregard stated that Dr. Villabona agrees with the conclusions in the articles. Dr. Durkin may be recalled if the State intends to rebut them. The articles were subsequently admitted into the record as SX 15.

The final day of testimony on June 7, 2018 convened at 9 a.m. The State moved for an amendment to the schematic drawing of Dr. Beauregard's office because the "medicine cabinet" is referenced as "locked". Whether the cabinet was secured or not is an issue in this case. Since this hearing officer has taken extensive notes on the testimony regarding the issue, those notes will control and the schematic was not ordered amended.

Counsel engaged in other discussions regarding the admission and completeness of all documents now in the record in this case. Ms. Stewart confirmed that Dr. Durkin had not reviewed files regarding patient G which were ultimately not admitted. A current copy of the State's Second Amended Complaint was inserted in SX 14 at 1. The documents admitted as to patient J are consistent with the years of care alleged in the complaint. Mr. Beauregard again argued that the State was "cherry-picking" records. Ms. Stewart argued that the State is only alleging improper care as to J for the years. 2006-2013. The State reserves the right to file a new complaint in the future if further review of post-2013 care warrants same.

Ms. Stewart argued that it is within the discretion of the State to allege patients and dates of care as inconsistent with law and regulations. In this case the complaint has provided notice as to the years of care for J which are relevant. Dr. Villabona's argument comes too late. This hearing officer considered the arguments of counsel and ruled that post-2013 charting of care for J will not be admitted. The State had limited its allegations as to years leading up to and including 2013. Dr. Villabona had not been given notice that post-2013 years of care would be a subject of the hearing.

Dr. Villabona next called T.M., who has treated with Dr. Villabona for 12 years. He was injured in a serious accident and underwent surgeries for femoral fracture, rib fractures, fractured clavicle and other injuries. A typical office visit with Dr. Villabona would involve discussions of stress and would last approximately one hour monthly. In Mr. T.M.'s opinion, Dr. Villabona is a good psychiatrist. He has helped T.M. when there was nowhere else to turn. Dr. Villabona has referred him to other physicians.

T.M. has a personal and professional relationship with Dr. Villabona. They would meet when his wife was in care. Dr. Villabona has seen other members of his family. Dr. Villabona is honest, direct and straight-forward. He hopes to continue treating with Dr. Villabona, who is personable and "not too serious". He fills a niche in his life. His professional advice has been "beyond others". Dr. Villabona has "never steered him wrong".

In response to the State's attorney, T.M. stated that he has not read the State's complaint. He does not know the patients in this case. He has not observed Dr. Villabona's care for them.

On further re-direct examination, Dr. Villabona was asked about patient J (SX 3). Dr. Villabona testified that DHEA is a precursor drug for testosterone. Studies by the NIH and others have shown that it may be prescribed for depression. He identified an abstract which discusses the effects of DHEA (dehydroepiandrosterone) in the treatment of depression. Ms. Stewart objected to admission of the document on the basis that it is in abstract form only, was written in 2014, and that Dr. Villabona has not testified that he has relied on it. Mr. Tease argued that since it contradicts Dr. Durkin, it is relevant. Mr. Beauregard argued that it shows the main use of the medication.

In his charts Dr. Villabona stated that the acronym "MSE" means "mental status exam". Dr. Durkin wrongly interpreted it. An MSE is part of a physical exam, though not a complete exam.

With regard to patient J (SX 3), Dr. Villabona has reviewed his chart. He speculated that there are no chart notes for J for the period prior to March 2006 because they may have been sent out to another physician. J was an employee of Dr. Villabona as his office manager. He may have removed a

note or notes. J began treating with Dr. Villabona before the an initial script was written for him. Dr. Villabona stopped some treatments for J. When care began again, new-patient notes were prepared. Some of the blanks in forms at SX 3 at 13-16 may be due to the fact that Dr. Villabona already had certain information. J's "problem list" is found at SX 3 at 17.

Dr. Villabona was asked what is his practice regarding retention of old records. He stated that older records are destroyed, e.g. if a document is more than seven years old, or if a patient is no longer treating with Dr. Villabona. Forms in the file of J2 (SX 2) are also completely blank. SX 2 at 3-7. Dr. Villabona's diagnoses were disc herniation, anxiety and depression with adjustment disorder. SX 2 at 8. J2's pain management agreement is found at SX 2 at 1-2. Dr. Villabona prescribed Percocet for J2.

Dr. Atkins' evaluation of J2 is found at SX 2 at 77. In June 2008 Dr. Atkins prescribed Percocet and Mobic for J2. Two years later he was prescribing Feldene 20mg, Percocet and Vicoprofen. SX 2 at 98. Dr. Villabona asked for additional documents from Dr. Atkins in March 2011. SX 2 at 65. Dr. Villabona learned that both he and Dr. Atkins were prescribing Percocet for J2. In a letter dated November 14, 2011, Dr. Villabona informed J2 that he would be halting the prescription of pain medications for him and recommended that he see a pain management physician. SX 2 at 27. Dr. Villabona discussed that decision with J2 and his wife.

Dr. Villabona was asked about the typed notes for patient G in SX 7. Ms. Stewart stated that those notes were only offered when the State questioned Dr. Villabona about notes which had gone missing in his office. She argued further that the hearing officer had found that it is more like so than not so that the notes had been fabricated after the fact. She added that Dr. Villabona was not asked treatment questions based on the contents of SX 7. She argued that the typed form of the G notes indicates that they were created "late".

Dr. Villabona testified that ADD/ADHD was diagnosed in G when he was a child. He added that he would have been remiss if he had not noted that diagnosis. He prescribed pain medications and

Ritalin for G. He was being overmedicated so Dr. Villabona reduced his Percocet dosing. Dr. Villabona kept G as a patient and "gave him grace". Even if he showed up late for appointments, he knew that Dr. Villabona would be in the building.

G's care was "standard". He did not ask for more medications. Dr. Villabona knew his needs "for ages". Dr. Villabona candidly stated that it was his own "sloth" which caused him to turn on his computer and only enter changed conditions in G. He agreed that it was "unusual" to only prepare computer notes for a patient. Often when G arrived late, Ms. Williams had not prepped the file for a visit. He came to the office when he could. He had family obligations. Dr. Villabona conceded that he should have been more strict regarding appointments. G would mow Dr. Villabona's lawn for $65, which was also the price of his office visits, hence an exchange barter. During non-summer months G paid cash.

Patient D (RX 1) treated with Dr. Villabona for about three months. His was an unusual case. His mother stated that he was morose, depressed and in chronic pain. He had many issues, and was suicidal. He may have used illegally obtained drugs. Dr. Villabona accepted him as a patient to get him Suboxone treatment. Dr. Villabona continued him on Oxycodone with scripts at two-week intervals. He arranged for D to see Dr. Muirza (sp?). Dr. Muirza did not accept him as a patient, and Dr. Villabona then referred him to Dr. Cemerlic. D's family was concerned with his suicidal ideation. Dr. Villabona would have been remiss had he not done something.

Dr. Villabona urine-screened D on a Friday, and Dr. Cemerlic tested him on the following Monday. He tested positive for illegal drugs. Dr. Cemerlic refused to accept him as a patient without two consecutive clean urines. Dr. Villabona then refused to write more pain medications for him. Their relationship ended.

As to office staff, Ms. Williams would occasionally go out and leave her cell phone with Ms. Beish. When Ms. Beish resigned, her phone number was erased from Dr. Villabona's phone. Ms. Beish was "good at imitating people".

Dr. Villabona testified that he only took on pain patients (other than D) if they were already psychiatric patients of his. His were psychiatric patients with no access to pain relief. At times his management of pain took longer than initially anticipated. Dr. Villabona encouraged patients to remain in his care if they could find other physicians to perform pain management. He tried to decrease the dependency of his patients on opioids. He has successfully removed some patients from the drugs. He has used behavior modification, recommended publications, and prescribed exercise regimens (which assist in the weaning process.)

Dr. Villabona reiterated that he would see 35-40 patients in a 4.5 day week. He would chart care after hours. Office visits lasted one hour or more. Most of his patients are "long term". Some are "ricochets". He added that patient-physician rapport is a two-way street. He tries to show concern for his patients.

At this point Dr. Villabona called E.B., who has treated with Dr. Villabona for more than 20 years. He has been diagnosed with brain dysfunction, ADHD, depression and suicidal ideation. He would see Dr. Villabona once monthly for 15-minute med checks, but some visits lasted for an hour. Dr. Villabona was always prepared and professional. E.B. stated that Dr. Villabona had "saved his life". He is a great physician, friend and confidant. He needs to go back to Dr. Villabona. He always tells E.B. if he is wrong. Dr. Villabona prescribed Soma and Fiurnal for him.

E.B. stated that Dr. Villabona is "beyond reproach", a God-fearing and moral man, and a friend. In response to the State, E.B. admitted that he does not know the patients who are the focus of this case. Patient office visits are always private.

Dr. Villabona next called J.C., a 52-year old man who started treating with Dr. Villabona 1.5 years ago. He saw him once or twice a month. Dr. Villabona provides great care. He made J.C. feel comfortable, had a nice demeanor, and gave his "utmost care". J.C. sees other physicians for gastrointestinal issues and other conditions. A typical appointment with Dr. Villabona lasted approximately 60 minutes.

Dr. Villabona helped J.C. gain insight into himself. He stated that he has PTSD, depression and anxiety. He has helped "pull me out". He has tried different medications. Dr. Villabona is "like a friend". He never does what J.C. does not need. Dr. Villabona is his favorite physician, with a "great bedside manner".

In response to the State, J.C. stated that he does not know the patients named in the complaint. Office visits with Dr. Villabona are private, and he has not observed Dr. Villabona's care for others.

Dr. Villabona next called Ms. Melissa Brown, who has worked for Dr. Villabona for a year as his office manager. Ms. Beish trained her in her duties. She has attended medical billing training.

At the time of service of the 2017 subpoena *duces tecum,* State officials were on the premises for 30-45 minutes. They told Ms. Williams that they were there to serve a subpoena for records. Dr. Villabona was informed. Ms. Riddell gave her the subpoena. She and Ms. Williams gathered the requested files and placed them in a box. Some pictures were taken, and they asked about the office safe. They then left. Dr. Villabona did not help gather the files, or review their contents before they were removed.

Ms. Brown does billing for Dr. Villabona. When Ms. Beish left the practice, there were "tons of problems". One worker's compensation patient had not been billed for 90% of his visits, resulting in a loss of approximately $3,000. Some Medicare patients were not billed during the entire year of 2017. Some were billed too late. Some files reflected payments when bills were not sent. Some bills were not paid. Dr. Villabona's 2016 and 2017 tax returns were not filed. Some checks in envelopes were not

opened. Collections were not arranged for some patients who "owed thousands". Some documents were misfiled. Ms. Williams showed her the text messages regarding Ms. Beish's "accident". There was no accident. They believed the messages had come from Ms. Beish's daughter.

On cross-examination by the State, Ms. Brown stated that she has had no medical training. In September 2017 Dr. Villabona knew that investigators were present to secure records. Ms. Brown files Dr. Villabona's practice tax returns. Ms. Brown has not discussed her testimony with Ms. Williams. Both of them still work in the practice. The phones are answered and patients are referred out. When records are requested by other providers, the records are faxed and the originals retained.

After a lunch break, I provided to counsel my decision regarding the confidentiality of Ms. Riddell's investigative reports. HO X4. Dr. Villabona was called back to conclude his testimony. Ms. Stewart examined Dr. Villabona.

Dr. Villabona stated that he usually follows or continues the prescriptions of prior providers. J suffered from severe, debilitating trauma when he was young. He had been prescribed opioids previously. Dr. Villabona was not aware whether he was the first to prescribe opioids for M. Though he could not find reference in G's chart, he stated that G was prescribed opioids earlier. D was also prescribed opioids earlier. However, when Dr. Villabona accepted him as a patient, there had been a gap in his prescriptions.

Ms. Stewart noted that no medications were reported for patient D for the period January-May 2015 on a PMP report. RX 1 at 15. Dr. Villabona stated that he agreed there had been no Delaware prescriptions. D's parents had given him empty pill bottles. His mother feared that he had street drug access. Dr. Villabona had to "rush" to help D. He was suicidal and experienced significant pain. Dr. Villabona urine-screened D first. His office manager noted that D had been prescribed Oxycodone 15mg IR. Dr. Villabona admitted there is no reference in a May 8, 2015 note to D's mother bringing in the bottles. RX 1 at 157.

On May 21, 2015 Bayhealth sent D's records to Dr. Villabona. RX 1 at 28. That date was after Dr. Villabona had begun to prescribe Oxycodone for him. A lumbar study was also faxed to Dr. Villabona after he had begun to prescribe. RX 1 at 129. Dr. Villabona stated that he was not "overly trusting" of D. D consumed drugs not prescribed for him. Dr. Villabona admitted that he was aware that Suboxone is used to treat addiction.

On May 8, 2015 D had denied suicidal ideation. RX 1 at 157. The note does not make reference to the report form his mother. Dr. Villabona agreed that he did not document the reason for the May 2015 Oxycodone script in the chart.

With regard to the cabinet in his office, he agreed that it is not always locked. At the time when he gave the gun to D2 during the DPR visit, D2 had asked if he could remove it or take it, and Dr. Villabona gave it to him. D2 did return some unused Ritalin to Dr. Villabona, who agreed to give him money for his co-pay. The drugs were kept for D2 in case he changed his mind. His Ritalin was not prescribed for daily use.

Ms. Stewart referred to the article by Yamamotova, et al (RX 15) concerning the combination of opioids and methylphenidate. Dr. Villabona agreed that the article discussed chronic *cancer* pain. Dr. Villabona did not recall Dr. Durkin addressing cancer pain in his testimony. He agreed that the article by Tennant in RX 15 is not a study.

The article in RX 15 concerning psychotropic medications concerned palliative care and the prescribing of opioids and Ritalin. Dr. Villabona agreed that that study also concerned cancer pain. Dr. Villabona agreed that he was not prescribing for patients for post-operative care or for end-stage cancer pain. Another article in the exhibit refers to cancer fatigue. It consists of information for physicians, and does not report on studies of patients. He also agreed that the authors were inconclusive. Dr. Villabona conceded that data is "sparse" regarding the concurrent prescribing of Ritalin and opioids.

With regard to patient M (SX 1), the fact that he was arrested was not conclusive proof that M was engaged in criminal activity. He was not convicted. He did not produce abnormal drug screens. He experienced pain, and Dr. Villabona refused to penalize him. Dr. Villabona agreed that in 2012 another physician was also prescribing for him. Dr. Villabona did not speak with M's father to explore the alleged confusion in names.

Dr. Villabona did not order the MRI study placed in evidence as RX 14. Dr. Villabona was aware that patient J was being prescribed Roxycodone and that he restarted him on opioids. He did not document a physical exam of J. He did not document J's social history. Dr. Villabona stated that he was well aware of that history. He did not document tox screens for J.

In 2008 the office destroyed a number of records. If a patient had left, they may have destroyed his files. What was destroyed "depended on the patient". He does not recall destroying charts for the patients in this case. J may have taken his chart with him to a new physician.

The prescribing of pain medications can put patient and physician in an adversarial relationship. The letter from Dr. Villabona to J2 dated November 14, 2011 was an "attempt to get out of the business." SX 2 at 27. Dr. Villabona discussed with J2 the fact that two physicians were prescribing Percocet for him in the form of behavior modification and insight. Dr. Villabona agreed that after sending his letter at SX 2 at 27 he did not change his prescribing for J2.

On re-direct examination by his attorneys, Dr. Villabona stated that D's situation was "dire". He fairly described suicidal ideation. Dr. Villabona formed a short-term plan. He thought D could get into a program quickly. That did not happen. A Suboxone program rejected him until he had ceased taking opioids. Dr. Villabona kept him on opioids until Dr. Cemerlic accepted him.

Mr. Davis returned a partial Ritalin script to Dr. Villabona. Dr. Villabona continued to prescribe the drug for him. With regard to the studies and other materials in RX 15, Dr. Villabona agreed that he had chosen "low hanging fruit". He noted that it is difficult to receive funding to conduct opioid studies.

Patient G was being prescribed opioids before seeing Dr. Villabona. He knew that patient for a long time. In response to the hearing officer, Dr. Villabona estimated that approximately 3% of his patients during the period 2013-2015 were being seen for treatment of chronic non-cancer pain. He is aware of some of the requirements in the "Model Policy", but does not know when it was adopted as a regulation in Delaware.

At this point Dr. Villabona rested. The State did not offer any rebuttal evidence. The final day of the hearing (June 8, 2018) was reserved for closing arguments by counsel. Those arguments are summarized prior to the "legal conclusions" section of this recommendation.

Findings of Fact

The notice of this hearing provided Dr. Villabona and his attorneys with the date, time, place and subject matter of the hearing. The notice also contained a statement of Dr. Villabona's rights with respect to the proceedings. The notice was in fact received by counsel for Dr. Villabona, and both he and his attorneys attended the entirety of the hearing.

The following facts have been proven in this case by a preponderance of the evidence. Dr. Villabona is a medical doctor practicing in the specialty of psychiatry. He was born in 1948. SX 14 at 64. His initial Delaware medical license was issued in 1992, and remains active. Little is known about Dr. Villabona's medical education (including the completion of any formal training in chronic pain management) and experience. The State did not question him in any detail on those subjects, and Dr. Villabona did not discuss his curriculum vitae in response to questions from his own attorneys.

A Superior Court opinion in a case appealed from the Board noted that Dr. Villabona had graduated from medical school in 1989. SX 14 at 170. During a hearing in conjunction with prior discipline of Dr. Villabona by the predecessor Delaware Board of Medical Practice, an expert witness testified that Dr. Villabona had disclosed that he moved into psychiatry after a year in a family practice residency because a psychiatrist had helped him recover from depression. SX 14 at 97.

The allegations in the State's Second Amended Complaint are made in three sections which are distinguished by their subject matter. SX 14 at 1-15. The first section concerns Dr. Villabona's "Discipline History" before the Board of Medical Licensure and Discipline. The second section concerns Dr. Villabona's care for eight of his patients. The third section is labeled in the complaint as "Illegal Handling of Controlled Drugs." That section would perhaps be more accurately labeled as allegations concerning the handling of controlled drugs in Dr. Villabona's practice as well as other general practice conditions. I will set forth factual findings in the order in which these categories were alleged in the Second Amended Complaint.

Disciplinary History

This is not the first instance in which Dr. Villabona has been brought before the Board in disciplinary matters. In order to assess whether a form recently found in a patient chart constitutes a violation of a prior order or orders of the Board, it is necessary to review Dr. Villabona's disciplinary history. Since that history stretches back to 2003, it is likely that certain present members of the Board are unaware of that history. Dr. Villabona's disciplinary history is relevant in this case because (a) that history generated a condition imposed on his continuing practice by Board orders which the State alleges he violated, and (b) factors which the Board considers in determining appropriate professional discipline in a given case include "prior disciplinary record" (Bd. Reg. 17.14.2) and "failing to comply with...(Board) orders" (Bd. Reg. 17.14.9).

In January 2003 the State, by and through the Department of Justice, filed Case No. 10-61-02 against Dr. Villabona. That complaint alleged that on September 20, 2002 Dr. Villabona had entered a plea of guilty to one count of Third Degree Sexual offense (a felony) and one count of Fourth Degree Sexual offense (a misdemeanor) in the Circuit Court for Queen Anne's County in Maryland. That complaint was assigned to a three-member hearing panel of the Board. Though the State had

requested in its complaint that Dr. Villabona's medical license be suspended pending the outcome of the administrative hearing, that request was denied.

The hearing panel convened in March 2003 and concluded its work in May 2003. The panel then issued a 48-page report in June 2003. SX 14 at 71. The pertinent factual findings of the panel were summarized in the final order of the Board in Case No. 10-61-02 issued on September 22, 2003. SX 14 at 60. The panel had concluded, *inter alia,* that Dr. Villabona had in fact entered his guilty plea in the Maryland court on September 30, 2002. In that proceeding he had pled guilty to a charge of Third Degree Sex Offense in 1978 against an 11-year old minor female. He also pled guilty to a charge of Fourth Degree Sex Offense in 1983 against an 11-year old minor female. The former crime was deemed a felony under Maryland law, and the latter a misdemeanor "involving moral turpitude". SX 14 at 64-65. According to the recitation of facts in a court decision discussed below, both offenses occurred prior to Dr. Villabona's enrollment in medical school. In exchange for his plea, the State of Maryland dismissed 28 other counts in a criminal information filed against Dr. Villabona.

After accepting the guilty plea, the Maryland court ordered that Dr. Villabona be placed on "probation before judgment", that he be evaluated by the Sexual Disorder Unit of Johns Hopkins or other acceptable facility, that he have no unsupervised contact with minors, and that he seek mental health counseling. *Id.* The panel further found that Dr. Villabona had committed no sexual offenses in Delaware, and that a "significant number" of his patients "think highly of him". The panel determined that in September 2002 Dr. Villabona's contract for medical services with the Delaware Department of Health and Human Services had been terminated in September 2002. The panel found that Dr. Villabona did not suffer from either mental illness or incompetency. SX 14 at 66. The panel recommended that Dr. Villabona be barred from treating minor patients without the presence of a family member, and that he be required to disclose the sexual offense convictions to all present and future patients. SX 14 at 67. The panel determined that "in considering (Dr. Villabona's) specialty

(psychiatry) and the nature of his transgressions...his behavior has harmed the public in a general sense." The panel concluded that his convictions constituted dishonorable and unethical conduct in violation of 24 *Del. C.* §1731(b)(3) and Bd. Reg. 15.1.8.

After reviewing the panel report and considering the arguments of counsel, this Board ordered that the phrase "in a general sense" be stricken from the immediately preceding quote. Since Dr. Villabona had apparently satisfied the conditions of the Maryland probationary order, under Maryland law the guilty plea to the two offenses therefore was not considered "convictions" of the offenses charged. Nonetheless, the Board determined that Dr. Villabona's conduct in those cases was "harmful, dishonorable and unethical...even without a technical 'conviction'." SX 14 at 68.

The Board therefore agreed with the panel recommendation and ordered on September 22, 2003 that Dr. Villabona be precluded from treating minor patients without the presence or supervision of an adult person who is not under Dr. Villabona's direction or control. The Board further agreed with the disciplinary panel and ordered that a form be prepared and approved by the Department of Justice which advises Dr. Villabona's patients that his Delaware medical practice had been limited and restricted on the basis of dishonorable and unprofessional conduct reflected in the Maryland guilty pleas to charges of sexually abusing two girls. The form should also inform patients of the requirement that his minor patients be accompanied by adults, and that Dr. Villabona's "ability to treat individuals who have been sexually abusaed or who have committed such abuse may be compromised." SX 14 at 70, 118. In addition, in its June 2003 order the Board also accepted the panel's recommendation that Dr. Villabona's medical license be placed on probation for a period to run concurrent with his Maryland criminal probation. During that probation Dr. Villabona's "behavior and practice" were to be monitored by an approved Delaware physician, who was to file quarterly performance reports with the Board during the probation. SX 14 at 118.

The final September 2003 order of the Board in Case No. 10-61-02 was appealed by Dr. Villabona to the Delaware Superior Court. A copy of the Court's decision in that appeal is found at SX 14 at 170. Dr. Villabona argued to the Court, *inter alia,* that the guilty pleas in the Maryland criminal proceedings did not result in a "conviction", and that the Board's conclusion that his conduct was dishonorable and unethical was not supported by substantial evidence.

The Court affirmed the Board's 2003 disciplinary order. Evidence of Dr. Villabona's Maryland plea was properly admitted by the panel. Citing to a colloquy between Dr. Villabona and the Maryland judge, the Court found that Dr. Villabona had expressly stated that he had committed the charged acts. The pleas were "sufficient to establish unprofessional and dishonorable conduct." An expert witness had testified before the panel that Dr. Villabona's conduct was "likely to harm the public, particularly his patients." His discipline resulted from an investigation and fair proceedings which had provided him with due process. The restrictions imposed on his practice by the Board were "the minimum restrictions required to protect the public." *Villabona v. Board of Medical Practice of the State of Delaware,* 2004 WL 2827918 (Del. Super. April 28, 2004). SX 14 at 170.

In February 2005, the Maryland court granted Dr. Villabona's petition for early termination of his criminal probation. In May 2005 Dr. Villabona petitioned this Board for the corresponding early termination of his concurrent license probation. The State did not oppose Dr. Villabona's application. This Board therefore granted Dr. Villabona's request on November 1, 2005. SX 14 at 119. Nonetheless (and significantly for the purposes of the present case), the Board decided *not* to lift other restrictions on Dr. Villabona's practice. Hence, the conditions remained in place that he provide the approved "notice" forms to patients regarding disclosure of the Maryland criminal matter and that he treat patients under the age of 18 only in the presence of acceptable adult supervision. SX 14 at 121.

Certain events which occurred on September 13, 2005 caused the Board to "reopen" Board Case No. 10-61-02. A Board order dated June 6, 2007 summarizes those events. SX 14 at 150. On

September 13, 2005 the mother of a minor female psychiatric patient of Dr. Villabona reported that the child was "in crisis". Dr. Villabona agreed to see her on an emergency basis. The child's mother was unable to accompany her. Because Dr. Villabona was seeing other patients on September 13, the child was brought to his office and waited for him in the "TV/toy room".

When he was free, Dr. Villabona went into the "TV/toy room" and closed the door. Only he and the minor patient were present in the room. When the office receptionist entred to discuss a delivery, she observed Dr. Villabona seated on an ottoman pushed against a sofa where the child was lying. Apparently the receptionist testified before a hearing panel that she thought that Dr. Villabona's position proximate to the child was inappropriate. The receptionist could view the child's underwear from the doorway to the room.

The receptionist reported her observations to another employee. Subsequently police and the Division of Professional Regulation investigated the matter. The child did not report any inappropriate contact with Dr. Villabona, and the event did not result in any criminal charges. While Dr. Villanova later claimed that he was in the room for "15 seconds or 15 minutes", a hearing panel found the child more credible when she stated that the two were in the room for 20-30 minutes. There was apparently substantial, conflicting testimony as to whether a video monitoring system in Dr. Villabona's office was operational on the date in question, and whether there was a camera mounted in the "TV/toy room" on that date. No video tapes were made available to the panel concerning events in that room on September 13, 2005. The panel found that Dr. Villabona's staff had been given insufficient directions as to operation of the monitoring system.

The panel found that Dr. Villabona knew that the child was being brought to his office on the date in question. He had ample time to arrange for an employee to accompany him in the room, or to arrange for the child to be observed through a window. After considering the evidence, the hearing panel concluded that Dr. Villabona had violated 24 *Del. C.* §1731(b)(17). His actions on September 23,

2005 constituted a violation of the Board's ordered prohibition that he not treat a minor patient alone and without the supervision or attendance of another adult.

The Board rejected Dr. Villabona's argument that his staff knew that they were supposed to observe him with the child but failed to do so. Nor did the Board accept his argument that he was not "treating" the child while the two were in the "TV/toy" room. In the Board's "conclusions of law" in the matter is this pointed statement (which perhaps has application to other issues in this case): "The treatment of a psychiatric patient begins when the doctor starts talking to the patient." SX 14 at 160. The Board recited the provision in 24 *Del. C.* §1731(b)(17) that the State must prove that violation of a Board order "...more probably than not will harm or injure the public or an individual". The Board then went on to conclude that Dr. Villabona's actions with regard to the minor patient demonstrated an element of harm in that he had willingly disregarded the restrictions placed on his treatment of minor patients, which restrictions were implemented and then restated by the Board "for the protection of the public." *Id.*

The Board determined not "to allow Dr. Villabona to make a similar choice with regard to minor patients in the future." SX 14 at 161. In its order dated June 6, 2007 the Board therefore placed Dr. Villabona's medical license on probation for an additional three years. The Board further prohibited him from treating any patients under the age of 18 years during that period of probation. At the end of the probationary period, Dr. Villabona would be permitted to petition the Board to lift the probation and the prohibition against treating minors. Finally, the Board again ordered Dr. Villabona to continue to "provide the previously approved form of notice to his patients advising them that he is on probation." *Id.*

An additional professional licensure complaint which was filed against Dr. Villabona was not resolved after a hearing. Rather, the allegations in Board Case No. 10-35-06 were resolved through the consent agreement process. That agreement is found at SX 14 at 164. In Case No. 10-35-06 Dr.

Villabona agreed that in February 2002 he had engaged in consensual sexual relations with a 22-year old female patient. He further agreed that his conduct constituted a violation of 24 *Del. C.* §1731(b)(3) and Bd. Reg. 15.1.2. His actions involved exploitation of the doctor-patient privilege for personal gain or sexual gratification.

The Board accepted the professional discipline proposed in the consent agreement and imposed those terms in a Board order dated June 3, 2008. SX 14 at 168. Dr. Villabona agreed to permanently restrict his practice to the treatment of male patients over the age of 18 years. He agreed to discharge all female patients of his practice within 90 days of the date when he signed the agreement on May 27, 2008. He agreed that his license probation would be extended to June 2015. He agreed to other provisions including unannounced compliance checks of his office records by DPR investigators. In the consent Dr. Villabona agreed that the consent agreement would "extinguish and supersede the terms and provisions of all other current Orders of the Board concerning respondent." SX 14 at 166. By its terms the consent agreement did not explicitly or implicitly continue the requirement that Dr. Villabona present an approved form to current or future patients disclosing the Maryland criminal matters.

During this hearing certain medical records pertaining to patient L were admitted. SX 12. L's chart contains two documents which are pertinent. Apparently the "approved" notification form to patients regarding Dr. Villabona's Maryland guilty pleas is found at SX 12 at 17. The "approved" version references the conclusion of the Board that the Maryland guilty pleas constitute evidence of unethical and unprofessional conduct, the fact that Dr. Villabona had entered guilty pleas to two sex offenses against minor females, the fact that the pleas were accepted by the Maryland court "without entry of judgment of conviction", the fact that Dr. Villabona is restricted from treating minor patients without the presence of an adult, and the fact that patients treating with Dr. Villabona who are victims of sexual abuse or have themselves committed such acts should "be aware of Dr. Villabona's objectivity regarding such subjects may be compromised. The "approved" notification form in L's chart was signed by the

patient on October 13, 2005. *Id.* On that date the "disclosure form" requirement imposed by the Board was in full effect. SX 14 at 70.

A second document in the form of a "To Whom It May Concern" letter from Dr. Villabona is also found in L's chart on the next page after the Department of Justice-approved form. SX 12 at 18. The letter is dated September 8, 2005. In the letter Dr. Villabona states that in 2002 he was "falsely accused" in Maryland on 30-year old charges. He informs the recipient that at the time of the Maryland charges he had been diagnosed with non-Hodgkin's lymphoma and had been told that he had 2-5 years left to live. The disease cause weakness and fatigue, according to the letter. He explains to the recipient that he had agreed to a plea bargain in 2002 so that he would not "spend my remaining time in courtrooms". *Id.*

The letter goes on to say that he entered into a probationary period ordered by the Maryland court without conviction. He adds that the judge allowed that disposition of his criminal case "because of the strong probability of my innocence". *Id.* He notes that his criminal probation was terminated early, and that his record will be completely expunged by the Maryland court in November 2005. Finally, Dr. Villabona informs his patients that the Delaware Board had "found no evidence of guilt". He adds that the Board "considered my entering into this unique arrangement to clear my record as unethical and unprofessional conduct, and have instructed me to inform new patients of the scenario in writing." *Id.*

On questioning by the State's attorney regarding the "To Whom It May Concern" letter, Dr. Villabona testified that he had attempted to argue his innocence on the Maryland criminal charges to this Board. Without submitting any documents substantiating such a request, Dr. Villabona stated that he had attempted to change his Maryland plea without success. The letter at SX 12 at 18 was his "take" on the proceedings before this Board that no evidence of guilt was found in his professional licensure proceedings. On further questioning Dr. Villabona admitted that the Board found that he had entered

his guilty pleas because he was guilty. He admitted that the "To Whom It May Concern" letter was "maybe" provided to patients "a few times". Dr. Villabona conceded that the letter had not been approved by an attorney in the Department of Justice.

Patient Care

According to the record in this case, Dr. Villabona was issued his initial medical license in 1992. Before he became a "solo practitioner", Dr. Villabona was an employee of or was associated with one or more prior private medical practices in Delaware. In or about 2003, he chose to establish his own practice. Some of his former psychiatric patients elected to move with him to the new practice. During the early or mid-2000's, Dr. Villabona initially engaged in psychiatric practice three days per week. As his patient load grew, he added days to his work week and eventually established a 60-hour per week work schedule. He ultimately saw approximately 50 patients or more each week. Many or most of those patients were afflicted with chronic mental illness.

After the Board had imposed certain age and gender restrictions on Dr. Villabona's patient population, his load decreased in or about 2008. He opened his Dover practice in 2013. As of January 2018 Dr. Villabona was seeing approximately 35 patients per week. The location of his practice at 720 Woodcrest Drive in Dover appears from photos to be a residential dwelling converted for professional use. As I understand the function of the Dover ranch-style address, Dr. Villabona's medical practice is conducted on the ground floor of the building and he lives in the basement of the property. The commingling of some of his personal items or food with medical supplies in the kitchen on the ground floor will be discussed below.

While engaged in practice at the Woodcrest Drive property, and before Dr. Villabona established his practice there, his medical specialty was and remains psychiatry. According to the record, Dr. Villabona had also provided contractual psychiatric services for one or more Delaware state agencies. Over the course of years Dr. Villabona has also taken on the management of chronic, non-

cancer pain experienced by some of his psychiatric patients. According to my notes, some of those patients began to suffer from chronic pain before treating with Dr. Villabona for mental illnesses. Others sustained trauma or other causes of chronic pain while being provided psychiatric care by him. Dr. Villabona did not describe any formal training undertaken by him in the area of management of chronic pain other than perhaps some unspecified training in medical school. Nor did Dr. Villabona testify that his prior stints in private practice provided insight into or training for chronic pain management.

The bulk of the testimony and documents in this case focus on Dr. Villabona's care for a number of his patients. I will set forth factual findings regarding those patients in the order in which they are listed in the Second Amended Complaint.

Patient U (DOB: 4/9/60) treated with Dr. Villabona from 2004-2016. Dr. Cemerlic had taken over U's pain management in 2012. That relationship ended in 2016 when the two engaged in an argument not related to pain management. At that point Dr. Villabona agreed to assume U's pain care. Dr. Villabona testified that he had requested all or a portion of Dr. Cemerlic's charting for U, but no such documents are found in the file maintained by Dr. Villabona. Dr. Villabona started U on a controlled substance regimen without having reviewed Dr. Cemerlic's charting. While Dr. Villabona testified that he and Dr. Cemerlic have shared or referred patients in the past, he admitted that the charts which are in evidence in this case do not contain copies of any of Dr. Cemerlic's documentation.

In a March 2016 note Dr. Villabona observed that U was seeking to reduce his narcotic intake. He was unsuccessful in stopping consumption altogether. Dr. Villabona characterized U as a volatile or "irritable and impetuous" patient. He encouraged U to seek out another pain management practice. Dr. Villabona could not locate a "risk assessment" document in U's chart. He stated that it is "usual" practice to fill out such a form and to review the risks of opioid treatment with the patient. Though he admitted in his testimony that he does not commonly urine-screen patients, he stated that he

performed a UDS on U at some point. There does not appear to be evidence of a screen in U's chart. His typical practice is to rely on information provided by patients regarding their drug usage.

Though Dr. Villabona's chart for U does not contain documents secured from Dr. Cemerlic, the chart does contain a June 2015 consultation report prepared by Dr. Arian. Dr. Arian notes that U was "requesting narcotic maintenance for chronic arachnoiditis." Dr. Arian's recommended treatment plan includes psychiatric care for "unspecified episodic mood disorder". He adds that if in fact arachnoiditis is the correct diagnosis for U, the National Association of Rare Disorders recommends Schedule III medications, not Schedule II drugs. Dr. Arian diagnosed "mild post-laminectomy syndrome". He saw no evidence of adhesive arachnoiditis. Dr. Arian viewed U as "steering therapy toward receiving an oxycodone or long-acting oxycodone prescription." Since Dr. Arian viewed U as a "complicated case", he recommended U be managed at a "University pain center with a multidisciplinary approach." (U did not follow that recommendation.) Though Dr. Villabona claims he did so, there is no documentation of his discussion with U about Dr. Arian's concerns.

Dr. Villabona testified that he had read the Arian report, but that U had "other problems". He deferred to Dr. Arian's greater expertise in pain management. Dr. Villabona had spoken with Dr. Cemerlic about U, and decided to prescribe Oxycodone 15mg for him. The chart does not contain reference to the discussion between the physicians.

Dr. Villabona hand-wrote an extensive note in February 2016, which was apparently around the time when Dr. Cemerlic had discharged him, or U had self-discharged. SX 11. Though Dr. Villabona agreed to take U back as a patient due to their long relationship, the note contains no evidence of physical exam. Dr. Villabona stated that he had performed a cursory exam of U in 2017, the results of such an exam were not charted by him. (Dr. Villabona stated that he did not document exams as a general rule unless there had been a significant change in condition. In this case, he knew or assumed that U's PCP had done so.) Oxycodone was written for U by Dr. Villabona, though he had not prescribed

opioids for U for an extended period. Though Dr. Villabona states in SX 11 that he had "agreed" to write the script, his note does not explain his medical justification for restarting the medication.

Dr. Villabona did record U's "risk assessment factors" on January 30, 2017. SX 8 at 66. They include chronic pain, major depression/anxiety, negative life events (lumbar injury, loss of ability to work at profession, financial and divorce). In February 2017 the "positive" life events for U include recent marriage and enjoyment of his wife's company. SX 8 at 65. Though urine screening is not documented in these chart entries, Dr. Villabona again stated that it was his "habit" to do so. He made attempts to reduce U's overall opioid consumption.

The next patient addressed in the Second Amended Complaint is M (DOB: 4/3/79). M began treating with Dr. Villabona in April 2009. He suffered from lordosis, disc herniation and associated chronic pain. He had also experienced sciatica in the past. The charting does not contain documentation of a physical exam on presentation. During his testimony regarding M, Dr. Villabona volunteered that he was aware of the adage that "if it's not in the chart, it didn't happen." A psychiatric form in the chart contains an Axis I assessment of Attention Deficit Disorder (ADD). M's intake forms contain nothing further in the way of prior medical history or social history. Dr. Villabona's initial plan for M was to prescribe narcotics and methylphenidate and to have M evaluated by a neurosurgeon "in the near future".

Dr. Villabona initially prescribed Oxycodone 15mg and Soma. Those drugs were prescribed before M had been evaluated by a neurosurgeon. In Dr. Villabona's eyes, "anyone" would have diagnosed the lordotic condition. Dr. Villabona also prescribed methylphenidate (Ritalin) for the diagnosed ADD condition. By doing so he testified that he was "killing two birds with one stone", in that it is "common knowledge" that methylphenidate enhances narcotic pain medications.

M was a "cash patient". His lack of insurance prevented "proper work-up and referral." He could not afford a neurological work-up or other pain management. By August 2009 M's chart contains

no documentary evidence of a physical exam by Dr. Villabona, nor pain ratings. No current imaging of M had been performed. Though Dr. Villabona testified that "other MRI's" were too old to be of use, M's chart does not contain them, nor documentation that they had been reviewed by Dr. Villabona.

M was hospitalized after a work-related accident in May 2011 with cervical and lumbar pain. M's chart contains certain hospital records regarding the accident, which Dr. Villabona testified that he had read. On his first visit with Dr. Villabona after the accident, no physical exam was documented. Nor was any discussion regarding increased pain after the fall documented. Late in May 2011 Dr. Villabona wrote an early script for M for Oxycodone due to M's travel plans. During his testimony regarding M, Dr. Villabona candidly stated that he did not want to carry chronic pain patients. He is not a pain management specialist. He wanted to refer pain patients out. He noted that one problem in making referrals is that the licenses of some pain specialists had been revoked. He kept treating his pain patients mindful of the oath to "first, do no harm".

A letter from Delaware Back Pain & Sports in September 21, 2012 informed Dr. Villabona that M was being discharged by that practice for securing pain medication scripts from multiple prescribers. Dr. Villabona conceded that such conduct would constitute a violation of his pain management agreement with his patients. SX 1 at 1. He also conceded that he did not "enforce" his agreements because it is not "medically correct" to punish a patient for non-compliance if he can "retrieve" himself. When he was shown a PMP printout for M for a 12-month period that reflected the filling of 28 Oxycodone 15mg scripts by M, Dr. Villabona stated that he did not choose to discharge M.

Dr. Villabona was provided the excuse by M that M's father bears the same name, and that the PMP may have mixed up or confused the two. Though documents show that it was M (the patient) who was securing substantial medications, Dr. Villabona accepted his excuse or explanation. I find as a matter of fact that the claim of confusion by M was patently not credible. I further find that Dr. Villabona could have easily verified M's veracity by reviewing birthdates on documents available to him.

In other words, it is more likely so than not so that Dr. Villabona wanted to help a psychiatric patient purportedly experiencing chronic pain rather than to ascertain whether M was being untruthful so that appropriate and necessary steps could be taken.

Though Dr. Villabona wrote in 2009 that M should be neurosurgically evaluated in the "near future", he was asked during the hearing why M's chart does not reflect efforts to secure such an appointment for him until 2016. Dr. Villabona blamed the failure or delay on his staff. (During his testimony later in the hearing, he stated that such a referral was not made because of a lack of insurance.) Though Mr. Joyner in Dr. Villabona's practice was obviously involved in certain aspects of M's care, there is no chart note indicating that Mr. Joyner had been instructed to secure charting from previous providers.

In July 2013 a Drug Court Diversion Case Manager working in a program in which M had been enrolled asked that Dr. Villabona stop prescribing addictive medications as they would interfere with M's rehabilitation. Dr. Villabona refused to do so. He conceded during the hearing that such information was "significant", and that illegal drug use was a violation of M's Pain Management Agreement. There is no record in M's chart that Dr. Villabona had contacted the case manager to discuss M's situation. When confronted with evidence that drug use had resulted in criminal charges against M, Dr. Villabona did not chart any record of discussion of that subject with M. He did state that it was his "habit" to keep such information "in the forefront". He subsequently discounted the information from the courts because an arrest is not conclusive proof of engagement in criminal activity. Dr. Villabona stated that M was not "convicted".

M's chart contains at least one reference to the fact that M had been referred by Dr. Villabona to Dr. Cemerlic. Though he stated that other pain management referrals had been made for M, none were documented in M's chart. There is a gap in M's charting between November 2013 and April 2014. Dr. Villabona remained his psychiatrist (and perhaps pain management physician) during that period,

though no notes in the chart record office visits during the five months. Nonetheless, Dr. Villabona continued to prescribe controlled substances for M during the hiatus. He claimed that he had written notes during the gap period, and would not prescribe without office visits. Since there are no notes of visits with M during the gap period, I find it is more likely so than not so that refill scripts were written for M without reportable office visits.

Nor are discussions regarding M between Dr. Villabona and Dr. Cemerlic or others documented in M's chart. Dr. Villabona stated that he "feels" that certain records are missing from M's chart. He admitted that there are no notes concerning his discussions with other physicians or with M about the pain management referrals. There is a paucity of documentation by Dr. Villabona of discussions with other providers or with other patients in this case regarding pain management referrals. I find it more likely so than not so that such referrals were not made, or that Dr. Villabona was not professionally interested in learning what pain management physicians had to say about Dr. Villabona's psychiatric patients.

Certain PMP reports are found in M's chart and the charts of other patients in this case. That documentation indicates that Dr. Villabona was registered and did use the PMP. Posing queries to the PMP and filing printed drug profiles in patient charts and using that data as a valuable tool in assessing patient compliance with orders are two different things. Though Dr. Villabona monthly prescribed methylphenidate for M for an extended period, PMP profiles showed that M would often not have those scripts filled. During his testimony on the point, Dr. Villabona again referred to the potential confusion in PMP records caused by M and his father bearing the same name. I have previously found that explanation to be not credible, or easily debunked.

During the hearing Dr. Villabona agreed that a 2013 PMP report showed clear evidence of "doctor-shopping" by M. Though he claimed he "most likely" discussed that subject and M's failure to fill the Ritalin scripts with the patient, he did not document such discussions.

Dr. Durkin was asked to opine on Dr. Villabona's charting for M. He noted the lack of a "head to toe" physical exam of M at the outset of care. When a patient complains of lumbar pain, Dr. Durkin stated that certain physical tests and observations can be performed to determine whether the claim of "low back pain" is a "red flag" for the practitioner. As an example, Dr. Durkin observed that diagnosed lordosis is not normally a source of back pain. Nor did Dr. Villabona review or secure imaging of M's spine to confirm a diagnosis of disc herniation. In the absence of a thorough physical exam and review of M's medical history, Dr. Durkin opined that prescriptions for Oxycodone 15mg and Soma were without medical justification. Assuming the lack of prior use of opioids, the prescriptions for an opioid-naïve M was a "dangerous" practice. During his testimony in this case, Dr. Villabona did not provide his clinical rationale for the drugs. Based on this hearing record, Dr. Durkin's conclusion as to the propriety of the prescriptions is accepted.

With respect to several of the patients in this case, Dr. Durkin testified that the simultaneous prescribing of opioids and methylphenidate was also "dangerous". (He noted that some heroin users concurrently consume Ritalin.) When combined with other drugs, the use of Ritalin can be fatal. Dr. Durkin only prescribes Ritalin in his practice for those suffering from chronic cancer pain. In opposition to Dr. Durkin's opinions regarding the prescribing of Ritalin in conjunction with pain management, Dr. Villabona offered several exhibits to show that the benefits of the joint prescribing of methylphenidate and opioids are "common knowledge". In my view Dr. Villabona has failed to effectively contradict Dr. Durkin's opinion on the point. The articles placed in evidence on the point did not address the issue of concurrent prescribing for patients suffering from legitimately diagnosed chronic non-cancer pain.

Dr. Durkin noted the lack of documentation of referral of M by Dr. Villabona for other pain treatment modalities. He added that some mild lumbar degeneration evidence in a 2012 MRI can be effectively treated with physical therapy in 50% of such patients. Dr. Villabona did not prescribe PT nor a regimen of home exercise.

In Dr. Durkin's opinion M should have been urine-screened at every office visit. He found no documentary evidence of screening in M's chart. (During the hearing Ms. Beish testified that she was in a position to view the movements of Dr. Villabona and his patients during office visits. She does not recall a single instance in which a patient went to the office bathroom to produce a urine sample for point-of-care or lab testing. Boxes of expired and unopened urine screening kits were found in the office by investigators. Her testimony coupled with the almost complete lack of documentation of any urine screen results in the charts compels me to find that urine drug screening of "at risk" patients by Dr. Villabona did not occur, or was a rarity.) While Dr. Villabona was apparently satisfied that patients such as M were remaining compliant, he typically did not chart the specific results of any screens. During his cross-examination and during the presentation of his own case, Dr. Villabona did not point to any UDS reports of point-of-care or confirmatory laboratory screening. In Dr. Durkin's opinion, an important task in providing pain management for M should have been the down-titration of opioids and referral to an addiction specialist, or patient discharge. Dr. Villabona did not disagree with that assessment. In the alternative, he claimed that it would be contrary to his Hippocratic Oath to penalize such a patient or to discharge the "orphan" M. Dr. Villabona stated that he was caring "for the whole family" and that he would continue his care until a pain management physician would accept him.

With regard to the request by the court drug diversion program that Dr. Villabona cease prescribing addictive drugs for M, Dr. Durkin testified that M's participation in such a program clearly placed him at "high risk". Dr. Villabona agreed that the diversion program request was "significant" and did not disagree with Dr. Durkin's opinion that refusal to comply with that request was contrary to pain management standard of care.

M's official Delaware "Death Certification" is in the record at SX 14 at 187. According to the certificate M died on January 30, 2016. The official cause of death is listed as "anoxic encephalopathy

following cardiac arrest – drug intoxication". The State makes no claim in this case that Dr. Villabona's course of treatment of M played any causal role in his death. Nor do I find cause-and-effect here.

The next patient identified in the State's complaint is T (DOB: 9/22/61). T began treating with Dr. Villabona in 2006. A "problem" list in the chart includes major depression, ADD, hypoglycemia, hypogonadism and vitamin D deficiency. T signed a pain management agreement in October 2012, though he had not begun to receive opioid scripts at that point. Three months later T signed an "informed consent" for the use of CNS stimulants. Dr. Villabona explained that he did not have patients sign such a form before prescribing opioids, but would discuss the matter at length with patients at that point. He would chart the fact that patients understood and consented. Dr. Villabona is aware that such consents should be secured in conjunction with the prescription of controlled substances.

In September 2013 T disclosed to Dr. Villabona that he had tested positive for cocaine use by Dr. Cemerlic, with whom he had treated for pain management. Dr. Villabona assumed that T became mad at Dr. Cemerlic when he stopped prescribing opioids for T.

Dr. Villabona prescribed Ketoralac injections and Prednisone for pain, though T was treating with Dr. Callahan during the same period of time. Dr. Villabona did not document the performance of physical exams of T. Though Dr. Villabona stated that he had discussed T's care with Dr. Callahan, he would be speculating as to the details of that discussion as he had not charted it.

Dr. Villabona had known T for a long time and agreed to undertake his pain management after he had left Dr. Callahan. T was diagnosed by Dr. Villabona as mentally ill and paranoid and who had criticized Dr. Callahan's prescribing as "wrong". Dr. Villabona requested Dr. Callahan's chart twice, but it is not in his chart for T. Again, Dr. Villabona testified that he "always" performed drug screens on patients, though documentation of those screens and their results are not in charts. In response to a question by this hearing officer, Dr. Villabona admitted that he was "less than habitual" in charting anomalies (evidence of non-compliance) in screens. He "rarely" charted UDS results.

In May 2014 Dr. Villabona learned that Dr. Ongewu had refused to accept T as a pain patient. T claims he did not know why. Dr. Villabona did not know the reason, and apparently did not inquire. Dr. Villabona withdrew a threat or promise that he would only prescribe opioids for T for one month, and continued to prescribe for him beyond that point when he could not find a new pain management practice. He would not "penalize" a patient for not treating with a new physician.

When asked about pain assessment forms such as those found in T's chart, Dr. Villabona stated that he would have patients fill them out unless there had been no significant change in pain. In September 2014 Dr. Villabona added Soma to T's drug regimen. That change was not accompanied by a physical exam, and the clinical rationale for it was not documented in the chart.

Dr. Villabona referred T to Dr. Xing, who extensively examined him in early 2015. She considered him at high risk for addiction and other aberrant behaviors. She reported that T seemed "only interested in pain medication". He refused injections. He refused to consume all prescribed Soma. Dr. Villabona estimated that T had been to four pain practices. Dr. Villabona had discussed inconsistent urine screens with at least one of those physicians, though the discussion was not documented in T's chart.

Eventually T became a pain patient of Dr. Uthaman. Dr. Villabona discussed T with Dr. Uthaman, but the discussion was not charted. He asked for but does not recall receiving all or a portion of Dr. Uthaman's chart on T. T left Dr. Uthaman in April 2016 when he was angered at the reduction of his medication dosing. Dr. Villabona assumed T's pain management.

The reduction in medications apparently placed T in withdrawal in May 2016. Though he testified that he informed T that he would not fill a "niche" of pain management for him, Dr. Villabona continued to prescribed controlled substances for T, including Vicodin. In June 2016 the Sussex Pain Relief Center informed Dr. Villabona that it would not accept T as a patient and was referring him back. In June 2016 Dr. Villabona also learned that a pain management practice was unable to secure a

sufficient urine sample from T for testing. Dr. Villabona speculated (or knew) that "the reason was something else". Dr. Villabona conceded during his testimony on T that "mentally ill people are at high risk with opiates." In July 2016 T's sister reported suicidal ideation in T and he was prescribed Dilaudid while Clonazepam was held.

In September 2016 Dr. Dickinson refused to take on T as a patient unless T returned his unused Clonazepam and Adderall tablets. Dr. Villabona asked Dr. Dickinson to reconsider her decision to discontinue Adderall for T. At this point Dr. Villabona estimated that T had been refused by 5-7 physicians. In January 2017 T admitted use of LSD. Dr. Villabona did not document his discussion with T about the use of illegal drugs, though it was his "habit" to engage in such discussions. In response to questioning by his attorneys, Dr. Villabona testified that it is "poor medicine" to fail to give minimally adequate care.

The next patient in the complaint about whose care allegations are made is D (DOB: 12/13/90). Unlike the other patients in this case, D treated with Dr. Villabona for only a short period (three months). Dr. Villabona testified that D's mother reported that he was morose, depressed and in chronic pain, and was suicidal. Dr. Villabona took him on as a patient in order to arrange for Suboxone treatment. He would have been "remiss" not to offer some level of care. He "rushed" to provide care. D's situation was "dire". Initially Dr. Villabona wrote him scripts for Oxycodone at two-week intervals. Dr. Villanova unsuccessfully referred him to another physician.

Dr. Villabona received certain Bayhealth records on D in May 2015, after Dr. Villabona had begun to prescribe Oxycodone for him. Dr. Villabona did not document his medical rationale for the prescriptions. Dr. Villabona referred to his "distrust" of D. D consumed illegal drugs and drugs not prescribed for him. At one point Dr Villabona testified that D had denied suicidal ideation, yet he later stated that D had fairly described ideation. His plan to get D into a Suboxone program quickly was not

successful. The selected program would not accept him until and unless he ceased consuming opioids. Dr. Villabona continued him on that medication until Dr. Cemerlic assumed his care.

Dr. Villabona referred D to Dr. Cemerlic for pain management. D tested positive for illegal drug use. Dr. Cemerlic insisted on two consecutive "clean" urines before he would assume care of D. Dr. Villabona stopped prescribing for D, and their doctor-patient relationship ended.

Dr. Durkin reviewed D's chart in conjunction with his work in this case. He opined that standard of care treatment involving the prescription of addictive controlled substances should involve a detailed and charted discussion with D about his admitted heroin use. Dr. Durkin stated that the prescription of Oxycodone 30mg at the time of D's first visit with Dr. Villabona was inappropriate. He questioned the logic in prescribing that medication at a time when D was waiting to enter a Suboxone program. He noted that D's chart is devoid of documentation of urine screening and referrals to other pain treatment modalities.

Dr. Durkin stated that appropriate standard of care treatment of D should have included prompt referral to an addiction program. He would not rule out the possibility that D was securing Oxycodone scripts in order to sell the drugs on the street in order to acquire cash to purchase heroin. Dr. Villabona does not refer in D's chart to any information acquired from Dr. Cemerlic.

Dr. Durkin's fundamental conclusion was that the prescription of narcotic drugs for D was "absolutely not" within the accepted standard of pain management care. I note that Dr. Durkin reached the same conclusion with respect to most, if not all, of the patients whose charts he had reviewed in this case. Dr. Villabona failed to explain his clinical reasoning for adding new controlled substances to a patient's drug regimen, for stopping the prescription of others, or for changing the dosing of drugs he was prescribing.

Dr. Villabona sat in the hearing and appeared to listen intently to all of Dr. Durkin's testimony. Though his rationale for drug choices should have been charted as they were made, he had multiple

opportunities in questioning by the State's attorneys and by his own counsel to explain his medication decisions. For the most part, he did not take advantage of those opportunities to make a record of his rationales for subsequent review by the Board. Though he had chosen to engage in pain management for a number of his patients, it appears that he was exhibiting compassion for that cohort but was essentially leading a voyage without a compass. His efforts in having his psychiatry-pain patients treat with pain management specialists should be commended. But when those efforts failed, his patients returned to the care of a physician who was either unaware of the strictures imposed by the Board on this area of practice, or who did not believe that pain management conducted by a psychiatric specialist was constrained by those rules.

The State next makes allegations in the complaint about the care for patient G (DOB: 11/24/61). He had treated with Dr. Villabona for 15 years, and had known Dr. Villabona before that. G was a "cash" patient of Dr. Villabona. The two had what may be a unique "barter" arrangement for medical services during at least part of the year. G would mow the lawn surrounding the property at Woodcrest Drive during the Summer season. He and Dr. Villabona valued those services at $65 per mowing. His office visits with Dr. Villabona were also valued at $65. Hence, the exchange was even. Though this arrangement was perhaps evidence that Dr. Villabona was sensitive to G's limited financial means , I do not see anything in the Medical Practice Act or Board regulations which would deem such an arrangement to be unprofessional.

G rarely scheduled appointments with Dr. Villabona. He would often appear "after hours" to be seen. Dr. Villabona did not contradict Ms. Beish's testimony that at least some of his visits lasted for five minutes when he would pick up refill scripts. Nor did Ms. Beish know who took G's vitals during his after-hours visits. According to Dr. Villabona, G's condition remained relatively static over the years, and his chart reviews in conjunction with unannounced visits with G were minimal.

Prior to this hearing the State had issued subpoenas for Dr. Villabona's charting of the patients who are the subjects of this case. The chart on G which was initially produced was apparently incomplete and was supplemented later by Dr. Villabona. The initial version of the chart did not contain a copy of a pain management agreement, while the supplementation did. The produced chart contained no office notes prepared nor prescriptions written for G during the period 2003-2009. Dr. Villabona was unaware of the whereabouts of those documents. The supplemental records pertaining to G were not admitted into the record because they were produced after a time when Dr. Villabona had signed an attestation of completeness of G's chart. Their late production had precluded the State from adequately preparing to address them during the hearing. A finding was made that it was more likely so than not so that extensively typed records concerning G were prepared long after certain office visits and presumably in preparation for this hearing.

The first progress note in G's chart is dated February 2009. Bronchitis was diagnosed at that time, and Dr. Villabona prescribed Percocet for work-related pain. Though Dr. Villabona asks new patients to fill out a formal risk assessment form, none was found in G's chart. Dr. Villabona testified that pain management physicians would not take on G as a patient because of his low dosing of Percocet 5mg once daily. He may have suggested physical therapy, but G's financial means may have precluded that modality. Dr. Villabona did not record a diagnosis of degenerative joint disease prior to prescribing controlled substances for G. When asked if he had performed a PMP check on G, Dr. Villabona responded, "mea culpa". Dr. Villabona recalls that G's pill counts and urine screens were "always good", though the results of counts and screens are, for the most part, not documented in his chart.

Apparently because of their long-standing personal and professional relationship, Dr. Villabona testified that he kept G as a patient to "give him grace". Dr. Villabona had known his medical needs "for ages". He prescribed Ritalin for G as he was diagnosed with ADD/ADHD as a child. When Dr. Villabona

believed that G was being "overmedicated", his Percocet dosing was reduced. Because of his admitted "sloth", Dr. Villabona only "turned on his computer" and made chart entries for G when conditions changed. Dr. Villabona believes that G had been prescribed opioids before becoming his patient.

The State next makes allegations in the complaint about Dr. Villabona's care for patient J (DOB: 11/16/72). J was a patient of Dr. Villabona and also served for a time as his office manager. Though his care preceded March 2006, certain chart entries made prior to that date may be missing because his chart was sent to another physician, according to Dr. Villabona. Dr. Villabona also suggested that J may have removed some of the contents of his chart. During his testimony regarding J, Dr. Villabona stated that a policy followed in his office is to destroy records which are over seven years old, or records pertaining to patients no longer treating with Dr. Villabona.

A "problem list" in J's chart lists these issues as of December 2008: chronic pain secondary to trauma, depression/anxiety, lethargy, testicular insufficiency, insomnia, gait abnormality, constipation, narcotism, hyperglycemia, sciatica and hypoglycemia. Most or all of those conditions were noted as of December 2008. J suffered "severe, debilitating trauma" when he was young. Dr. Villabona followed the medication regimen of prior providers. Though the fact is not documented in J's chart, Dr. Villabona stated that J was prescribed opioids before becoming his patient.

He acknowledged that there had been a gap in prescriptions for J between Dr. Villabona and a prior prescriber. Dr. Villabona therefore started J on Roxycodone. When J became his patient, he did not document the performance of a physical exam nor J's social history. Dr. Villabona testified that he was well aware of that history. J's chart does not contain documentation of the results of any urine toxicology.

Dr. Durkin reviewed J's chart on behalf of the State in conjunction with this case. He noted that the first progress note by Dr. Villabona in J's chart was written two years after he had begun to prescribe controlled substances for J. The chart is void of documentation from the charts of previous providers.

Nor does his chart contain a record of physical exam, summary of history, initial complaint warranting the prescription of controlled substances, nor risk assessment. Dr. Durkin was of the opinion that the initial script for J for Roxycodone was without medical justification. Shortly thereafter Dr. Villabona began prescribing 120mg of Oxycodone daily. Dr. Durkin was of the opinion that such prescribing could have been fatal for J were he opioid-naïve at the time.

Dr. Durkin further opined that the absence of a pain management agreement in J's chart as well as documentation of urine toxicology results was also contrary to standard of care pain medicine. He restated his opinion regarding the interaction between methylphenidate and pain medications. He added that the prescription of a testosterone precursor was apparently not preceded by a check of then-present levels.

Dr. Durkin further testified that documentation in the chart reflected that J was consuming more medications than had been prescribed. That is a "red flag", and evidence of breach of standard pain management agreements. J should have been counseled regarding his behavior, with documentation of such a discussion. Dr. Villabona should have engaged in titration down of J's medication intake. The chart is without a record of the regular assessment of vitals. Opioid use can affect respiration in some patients. During a 13-month period in 2012-2013 prescriptions continued but no progress notes were entered in J's chart.

As with other patients, Dr. Durkin opined that the prescription of narcotic drugs for J through 2011 was not medically warranted. And as with the others, Dr. Villabona was given ample opportunity to contradict Dr. Durkin and state his reasons for the drug selections that he made. In his testimony he failed to do so. Since Dr. Villabona is a licensed physician who had elected to engage in pain management, his opinions on the subject would have been welcome and considered by this hearing officer.

An additional patient whose care was challenged by the State in its complaint was J2 (DOB: 2/26/83). A prior provider, Dr. Atkins, prepared a report concerning J2 in June 2008. Dr. Atkins had prescribed Percocet, Mobic, Feldene, Percocet and Vicoprofen for J2. Dr. Villabona requested additional documentation from Dr. Atkins. Around the time when Dr. Villabona learned that both he and Dr. Atkins were prescribing Percocet for J2, Dr. Villabona informed J2 that he would cease prescribing pain medications for J2. He discussed his recommendation that J2 treat with a pain management practice was discussed with J2 and his spouse. In his testimony Dr. Villabona characterized his decision as an "attempt to get out of the business". He admitted that J2's chart reflects that he continued to prescribe controlled substances for J2 after he conveyed his decision to J2.

Dr. Durkin also reviewed J2's chart. He again noted the absence of documentation of a physical exam of J2. Dr. Durkin opined that Dr. Villabona's Percocet prescription was without medical justification. He also noted that Dr. Villabona had not commented on the joint prescribing of Percocet in J2's chart. Dr. Durkin viewed J2 as a patient at high risk for drug diversion or addiction requiring higher levels of risk mitigation. Dr. Villabona did not disagree.

Dr. Durkin testified that standard of care practice with J2 would have been to wean him from certain medications and to refer him to a pain management practice. Though a PMP printout in J2's chart shows his simultaneous seeking of scripts from other providers, the chart contains no record that Dr. Villabona was aware of that fact, or that he had made an effort to learn the reason. When a 2014 toxicology report by LabCorp showed a positive result for opioids, no additional screening was performed, or documented.

In Dr. Durkin's opinion, J2's chart shows clear evidence of doctor-shopping and dishonesty with Dr. Villabona. Though J2 was a high-risk patient, there is no other evidence of lab testing of urine. Dr. Durkin noted that there is no evidence that Dr. Villabona had attempted to wean J2 or refer him to other treatment modalities. When provided an opportunity to do so, Dr. Villabona did not offer his own

professional opinions on the propriety or necessity of his prescriptions for J2. Nor did he attempt to counter Dr. Durkin's opinion that Dr. Villabona was "just refilling" scripts for J2 without valid medical purpose.

The final patient identified in the State's complaint is D2 (DOB: 8/13/56). D2 appeared and testified during the hearing. D2 has known Dr. Villabona for approximately 50 years. The two own adjacent farms in Maryland. He began treating with Dr. Villabona about 30 years ago for "severe anxiety" and back pain stemming from a 2008 motor vehicle accident. The pain was treated with Percocet, Oxycodone and Oxycontin. Dr. Villabona also prescribed methylphenidate for D2 to "enhance" the effectiveness of the pain medications.

D2 testified that the Ritalin caused anxiety and did not "work well". Though he explained that to Dr. Villabona, he continued to prescribe it. He saw Dr. Villabona once monthly, and would return to him Ritalin tabs which he had not consumed perhaps 8-10 times in a year. He thought he was supposed to do that. He continued to fill the methylphenidate scripts because he was concerned that if he did not do so, Dr. Villabona would stop prescribing other drugs.

D2 provided a statement for police in 2016 regarding Dr. Villabona. SX 14 at 188. His memory was better then. On occasion Dr. Villabona would pay him for the unused medication. During the hearing Dr. Villabona admitted that on occasion he would reimburse D2 for his co-payments for the drugs. Dr. Villabona stated that he would keep the Ritalin in his office in case D2 changed his mind about the drug. He does not recall whether he was addicted to controlled substances in 2016. He went through rehab in Florida, and gave the statement after completing that program.

On a date in 2014 D2 was present in Dr. Villabona's office for an office visit. Individuals "wearing badges" and "from the State" entered the office. D2 asked Dr. Villabona if he could provide assistance. Dr. Villabona handed him a pistol and a knife and said "take these". D2 stated that Dr. Villabona did not "insist" that he take the weapons. D2 concealed them on his person and left the

office with them. My assessment of this episode is that, in view of the urgency of an impending office inspection by State investigators, it is more likely so than not so that Dr. Villabona gave the weapons to D2 in order to promptly get them out of the office, and not to allow D2 to take them home to inspect or admire them. Prior to the aborted April 2, 2018 start of this hearing, Dr. Villabona had called D2 and asked him to return the call. An audio recording of that call was entered into evidence. SX 16.

When police sought to question D2 about Dr. Villabona, D2 became fearful and retained an attorney. He stopped treating with Dr. Villabona in 2015 or 2016 because his family was urging him to see another physician. They thought that he was being "overmedicated". In his testimony he stated that Dr. Villabona's treatments helped him. He also admitted that he had abused some of the drugs prescribed for him.

Drug Storage and General Office Conditions

During the investigation of Dr. Villabona over a period of four years, his office was formally inspected on two occasions. A September 16, 2013 report of an inspection by Alicia Kluger, a former Pharmacist Compliance Officer employed in the Division of Professional Regulation, is found at SX 14 at 209. That report summarizes the findings made during a visit to Dr. Villabona's office on August 1, 2013. Apparently the Division had received certain information regarding the storage of medications in his office. That was the purpose of the visit.

Ms. Kluger observed a large metal cabinet with a key inserted in a lock in the door of the cabinet. In the cabinet she observed vials, bottles or samples of eight medications, some of which were controlled substances. All of the medications had expired. The oldest medication was the opened vial of Depo-Medrol prescribed "for office use" with an expiration date of December 2008. The cabinet also contained multiple filled prescriptions bearing the names of patients of the practice. Dr. Villabona explained to Ms. Kluger that he was keeping the drugs for those patients for office administration or in case they were needed in the future. The drugs included testosterone (Inj.), Haldol Decanoate, Invega

(Inj.), and Tussionex liquid. The cabinet also contained a vial of Meperidine (Inj.) which Dr. Villabona stated that was being administered during Dr. Villabona's chemotherapy treatments.

At the time of the 2013 inspection, Dr. Villabona was instructed on the proper and required storage of controlled substances. Those precautions included their storage in a cabinet which is locked at all times and only accessible to authorized staff. He was also instructed to secure the Schedule II medication (Meperidine) in a secure safe.

Other expired medical products were found in other locations in Dr. Villabona's office. They included iodine swabs and One Touch test strips. When Ms. Kluger reminded Dr. Villabona that a large number of expired products were found in his office, he admitted that his "housekeeping practices are poor". He was instructed to remove the expired items and arrange for their destruction. Dr. Villabona was informed of an upcoming DEA "Drug Take Back" activity in October. *Id.*

A second inspection of the premises occurred on September 21, 2017. A report of that inspection by Jason Slavoski, PMP Administrator, is found at SX 14 at 221. Mr. Slavoski testified during this hearing.

On September 21 Mr. Slavoski accompanied three DPR investigators to Dr. Villabona's office. Mr. Slavoski holds a doctorate in pharmacy, and is a former pharmacy manager. The inspection was prompted by reports of improper storage of medications in the office and perhaps other matters.

After identifying themselves, the Division personnel were given entry. They observed a prescription bottle of Tizanidine on a bookshelf. The same storage cabinet as inspected in 2013 was partially open, allowing free access. (Ms. Beish, presumably in a position to know, stated under oath that the cabinet was "never" locked.) One of Dr. Villabona's staff called it the "medicine cabinet". It contained the following drugs which Mr. Slavoski inventoried in his report: expired bottle of Hydrocodone/chlorpheniramine (Tussionex) (Schedule II), two expired bottles of Temazepam (controlled) dispensed to a patient, one expired bottle of Gabapentin (a "drug of concern") dispensed to

a patient, and bottles of expired antidepressants, antipsychotics and other medications. They were "strewn" in the cabinet with controlled substances. *Id.*

Dr. Villabona opened a small safe atop a refrigerator and inside was a container of Meperidine (Demerol) (Schedule II) dispensed to Dr. Villabona. Investigators were permitted to look inside the safe. In it was another expired container of Meperidine. The medication was "illegal", as it did not include instructions on use. Also inside the safe were two handguns with ammunition for guns of various calibers. Dr. Villabona explained that the guns were given to him by patients. After Dr. Villabona asked Mr. Slavoski if guns made him nervous, he stated that he also kept a shotgun in the office.

Investigators removed the contents of the storage cabinet. Most of the medications in the cabinet had expired. Mr. Slavoski explained to Dr. Villabona that the drugs were not legally stored. When Dr. Villabona explained that he takes back unused medications from patients, Mr. Slavoski explained that the DEA and licensed hazardous waste companies can remove or take back the drugs. Dr. Villabona stated that he did not have a contract with a disposal company, and did not know how to dispose of the drugs.

Mr. Slavoski testified that the general condition of the office was "very dirty". Insecticide and cleaning materials were found in the kitchen contrary to OSHA rules. Food was located near hazardous waste. Expired urine drug test kits and specimen containers were stored in the kitchen. Rodent droppings were observed. Most, if not all, of the described conditions and stored medications were photographed by investigators. Syringes were sticking out of full sharps containers, which were in "terrible" condition. Mr. Slavoski explained how hazardous waste must be stored and labeled. Dr. Villabona stated that he "throws away" hazardous waste "as I need to".

Mr. Slavoski testified that he did not know when the drugs in the cabinet were given to Dr. Villabona. On questioning by Dr. Villabona's counsel, he reiterated that when investigators entered the premises the storage cabinet was unlocked and open, though a key lock in the door of the cabinet shows

that it was capable of being locked. Mr. Slavoski added that Dr. Villabona was cooperative with the investigators.

A comparison of the detailed findings with regard to the 2013 and 2017 inspections of his office leads to a finding by a preponderance of the evidence that Dr. Villabona clearly did not follow the guidance or instructions given to him by Ms. Kluger in 2013. My assessment of all of the evidence on the point has led me to the conclusion that it is more likely so than not so that the storage or "medicine" cabinet is not secured the majority of the time in Dr. Villabona's office. Even if it is assumed that Dr. Villabona possessed the only key which would open the cabinet door, leaving the door unlocked or ajar during the day or leaving the key inserted in the lock completely negated that security precaution. Since the 2017 inspection was his second, Dr. Villabona can not claim a lack of knowledge about basic security requirements regarding proper storage of drugs in a medical practice.

I am further left with the conclusion that Dr. Villabona forgot or ignored the instructions given to him in 2013 regarding the proper disposal of expired medications. Finally, Dr. Villabona's comment to investigators that he simply gets rid of hazardous waste accumulating in his office when he needs to and without the assistance of a certified disposal contractor presents a clear threat to the health, safety and welfare of the public.

Testimony and documentary evidence regarding the presence of weapons in Dr. Villabona's office is troubling. Dr. Villabona did not contest the gist of patient D2's testimony regarding receiving a pistol and knife from Dr. Villabona which were readily available to him and then removing them from the office while State investigators were present. Two pistols and various types of ammunition were placed in the kitchen safe for an extended period. Dr. Villabona informed investigators that he also kept a shotgun on the premises. Dr. Villabona is a hunter or shooter, and apparently often engages in displaying or sharing various weapons with his patients. Those activities caused credible fear in Ms. Beish.

In my view a medical office is not the proper place to store or keep any weapons. That is specially so in a psychiatric practice where, according to Dr. Villabona, many of his patients suffer from "severe mental illnesses". If in fact he received weapons from time to time from members of the families of his patients in order to assist in preventing suicidal or other harmful behavior, I do not question his motivation in wanting to protect patients or their friends or families. That said, in my view and as a matter of fact, all of the weapons should have been refused or stored by him off site, or the donating family members referred to law enforcement agencies.

During the hearing Ms. Beish testified at some length about the things which led her to file a professional complaint against Dr. Villabona. Some of her allegations were agreed to and then contested by another office employee, Ms. Williams. Ms. Beish testified regarding Dr. Villabona's "messing up" files which required reconstruction by staff, her fear of certain patients, the prevalence of weapons in the office, Dr. Villabona's dispensing of drugs to patients for whom they had not been prescribed, his "late" charting of certain office visits, his in-office consumption of medications and other matters which offended her or which she believed constituted unprofessional conduct. Though she had apparently agreed with some of Ms. Beish's complaints at an earlier date, during the hearing Ms. Williams recanted her concurrence.

In my view each of these two employees has certain credibility or bias problems in her respective story. Ms. Beish's resignation from employment in Dr. Villabona's practice may have been motivated by her desire for more "hands-on" medical experience. It may have also been motivated by a fear of or anger toward Dr. Villabona. The inexplicable charade which she perpetrated regarding a faked motor vehicle accident does not bode well for her credibility.

Similarly, Ms. Williams conceded that her memory of certain events in the office may have been clearer or more accurate when she seemed to agree with Ms. Beish than when she testified during this hearing. She is a present employee of Dr. Villabona, and desires to remain so. She believed that at one

point Ms. Beish "hated" Dr. Villabona. (The tone of portions of Ms. Beish's administrative complaint seem more like personal advocacy than neutral and objective reporting.) She admitted during the hearing that she is afflicted with brain tumors.

Perhaps some of the differences between the recollections of Ms. Beish and Ms. Williams may be credited to the sort of petty bickering and jealousies that plague many small and intimate organizations. I view the differences in the testimony of the two employees to essentially be a wash, and not dispositive in deciding larger issues in this case. Most of the issues raised by Ms. Beish in her administrative complaint (SX 14 at 215) have been addressed by other witnesses and in other documents, and I rely on the above factual findings on those points.

Closing Arguments of Counsel

The final day of the hearing was reserved for the closing arguments of counsel. Since those arguments constitute the advocacy of attorneys and not evidence *per se*, I have chosen to summarize them after having outlined the evidence and made factual findings.

Ms. Stewart closed for the State. She argued that in this case the State seeks revocation of Dr. Villabona's medical license. She first addressed Dr. Villabona's disciplinary history. As a result of the Maryland criminal proceedings Dr. Villabona was required to provide an approved disclosure form to all patients. In this case the file of patient L contains both an approved and unapproved form. The latter informed the patient that Dr. Villabona had been "falsely accused", and that the Board had not found guilt in the Maryland case. Ms. Stewart argued that the unapproved form was misleading and dishonest. In this case the Board did find that Dr. Villabona had pled guity in Maryland because he was in fact guilty. These facts constituted violations of 24 *Del. C.* §1731(b)(3), and 24 *Del. C.* §1731(b)(17).

Ms. Stewart then addressed the State's allegations regarding Dr. Villabona's prescribing of controlled substances. The FSMB "Model Policy" was adopted in early 2012 as a formal regulation of the Board. All patients in this case were provided care by Dr. Villabona after that date. In fact, she

argued that Dr. Durkin testified that the "Model Policy" was essentially "standard of care" for pain management prior to 2012.

With regard to particular requirements in the "Model Policy" (Bd. Reg. 18.0 *et seq*), there is little or no evidence of physical exams in the charts which are in evidence, and only sparse information regarding patient medical histories. Dr. Villabona has admitted that his exams were "cursory". That is not enough. Controlled substance prescriptions were written for patients before pain diagnoses were recorded. Bd. Reg. 18.0 contains "serious" rules and constitutes the law regarding pain management. Its purpose is to curb drug abuse and diversion.

Ms. Stewart further argued that all of the patients in this case are at "high risk". Dr. Villabona was prescribing narcotic drugs for them in the midst of an "epidemic" in society. Ms. Stewart read the portion of Bd. Reg. 18.0 which pertains to treatment plans for pain patients. Dr. Villabona's chart entries which state "meds as usual" is insufficient. Dr. Villabona rarely made referrals of patients to other pain treatment modalities. He did not explain his medical rationale for adding drugs, deleting drugs, or changing dosing.

With regard to required informed consent, only one file contained a patient consent form and that patient was treating for ADHD. There are some references in charts to a discussion of "risks and benefits" of opioid therapy, but only after years of prescribing the drugs.

Ms. Stewart argued that Dr. Villabona's testimony that he regularly performed urine drug screening is not credible. There are only brief references in some charts to UDS's. Two of Dr. Villabona's employees stated that such tests were never performed by him. Investigators found expired and unopened test kit boxes. No patients were observed going into the office bathroom to produce urines. The lack of urine screening was significant in this case because patients disclosed the use of heroine and LSD. Similarly, one or more of the patients were obviously engaged in "doctor-shopping".

Dr. Villabona never noted in any chart that any patient had produced an inconsistent UDS. Only one lab screening of one sample for a single patient is found in the charts in evidence.

Bd. Reg. 18.5 requires periodic review of the course of treatment of patients. According to the relevant charts, no such reviews were conducted by Dr. Villabona. Rather, patients were continued on controlled substances. Red flags for patients were not addressed. Bd. Reg. 18.6 requires the practitioner to consider referrals for additional evaluation and treatment. Ms. Stewart stated that Dr. Villabona failed to educate himself regarding other modalities and thereby violated this rule. If referred to other physicians, the patients in this case knew that they could return to Dr. Villabona to be continued on controlled substances.

Ms. Stewart argued that Bd. Reg. 18.9 requires that the provider ensure compliance with controlled substance laws and regulations. She noted that the State has also filed a separate complaint seeking discipline of Dr. Villabona's Controlled Substance Registration.

The State has met its burden of proof regarding care both before and after Bd. Reg. 18.0 had been adopted. This Board has previously found pre-2012 pain care to be relevant as establishing a baseline against which to review the prescription of controlled substances. In this case Dr. Durkin has opined that Dr. Villabona's choice of opioids and other controlled substances was not medically justified.

Ms. Stewart then briefly reviewed the evidence as the specific patients in this case. Patient M was not examined. Prior treatment records were not secured for review. He was not referred out to other modalities. His urine was not screened. Dr. Durkin testified that the simultaneous prescribing of opioids and Ritalin for M was dangerous. M's doctor-shopping was evident from information from other providers, from police, and from the PMP. Dr. Villabona did not independently verify whether the PMP had confused M with his father. Dr. Villabona turned a "blind eye" to M's abuse and accepted his story. Dr. Villabona did not discuss his addiction with him. Dr. Villabona informed another provider that he

would stop certain prescribing but failed to do so. He took no action regarding red flags in M's chart. M died in January 2016.

With regard to J2, Ms. Stewart argued that there is no evidence supporting Dr. Villabona's initial prescribing. He formed no diagnosis or plan for J2. His treatment of J2 was not legitimate, according to Dr. Durkin. . J2 was being written Percocet by two physicians. Yet Dr. Villabona took no action, and continued to prescribe for him.

With regard to patient J, Dr. Villabona performed no physical exam and entered no diagnosis. He collected no medical history. Though Dr. Villabona believed J had been written opioids previously, that is not supported in the chart. If in fact he was opioid-naïve at presentation to Dr. Villabona, Dr. Durking testified that Oxycodone 30mg four times daily "could have killed him". J's chart contains many missing records and blank forms.

Ms. Stewart argued that D was clearly a heroin addict. No physical exam was performed, nor diagnosis made which would support the prescribing. Dr. Durkin concluded that Dr. Villabona was "feeding" his addiction, and was thereby doing the "worst thing". D's treatment was "egregious" and evidence of gross negligence.

Patient G was prescribed for with almost no records. Dr. Villabona should not be "given a pass" for simply prescribing at low dosing levels. His care apparently often went uncharted.

Ms. Stewart argued that Ms. Beish had no motive to lie under oath in this case. She left Dr. Villabona's employment on good terms. He was generous toward her. Even if Ms. Beish made billing errors, that does not cause her testimony to be not credible. The State does not know why Ms. Williams has recanted her earlier agreement with Ms. Beish. Ms. Williams now has a "selective memory".

With regard to patient G, there is no evidence of payments for services by him. Ms. Stewart argued that Uniform Controlled Subtances Act Reg. 9.8 should apply to his care and the care for U. Bd.

Reg. 18.9. U's chart contains few records of discussions between Dr. Villabona and U's prior physicians. For example, Dr. Villabona did not request additional records from Dr. Arian, who characterized U as a "pill seeker". U had left Dr. Cemerlic to treat with Dr. Villabona. She argued that there is no exception in Bd. Reg. 18.0 when one pain manager accepts a patient from another.

Ms. Stewart argued that patient T had seen many pain management practitioners. However, none of their records are in T's chart. Still, Dr. Villabona started prescribing for him. T was not urine-screened. When T's family reported his suicidal ideation, Dr. Villabona started prescribing Dilaudid without complying with Bd. Reg. 18.0. With regard to Dr. Villabona's "barter for services" arrangements with one or more of his patients, those patients were "under his thumb". Patients should not be used to remodel basements or mow lawns. Ms. Stewart closed by arguing that the State has proven that Dr. Villabona had engaged in the "reckless" prescribing of opioids for these patients. That alone should justify license revocation.

With regard to the handling of drugs in his office, Dr. Villabona was not permitted to accept drugs from patients and to store them in his office. Nor was it proper or authorized to distribute to certain patients the drugs prescribed for others. She added that the lock on the storage cabinet in the office was irrelevant if it were not secured at all times. At the time of the 2017 inspection, controlled substances were still present in the office or the cabinet. Nor is it appropriate for Dr. Villabona to blame Ms. Beish for the conditions in the office cited by inspectors. Dr. Villabona possessed the Controlled Substance Registration for the practice and was responsible for the handling of all medications.

With regard to the presence of guns and other weapons in the office, Ms. Stewart asked whether the practice had become a "pill and weapons repository". She asked why Dr. Villabona had not turned over weapons to police. The State has proven that Dr. Villabona was accepting medications dispensed to patient D2.

With regard to the applicability of Uniform Controlled Substances Act laws and regulations, the State has proven a lack of effective controls in Dr. Villabona's office as well as his failure to act when confronted with "red flags" exhibited by patients. Dr. Villabona wrote prescriptions for non-medical purposes, and received controlled substances from his patients. Citing to controlled substance rules, Dr. Villabona had failed to secure controlled subtances, had received them from his patient, and had violated other pertinent rules. His actions were contrary to the public health, safety and welfare.

Ms. Stewart argued that a number of "aggravating" factors are present in this case under Board rules. They include prior discipline, prescription violations while on license probation, frequent acts, serious misconduct and deceptive activities, failure to comply with Board orders, intentional acts, abuse of trust, illegal conduct and bringing ill repute upon the medical profession. Ms. Stewart added that Dr. Villabona's charts in this case were a "mess". The State contends that it never received complete charts from him. Alternative explanations have been provided for missing records. Dr. Villabona has a responsibility to his patients and to the Board to maintain complete, accessible charts. Some of the charting was typed by Dr. Villabona after he had been served with two subpoenas for records.

Through his violation of Board rules, his reckless prescribing, prescribing which endangered patients, and through his accepting controlled substances back from patients, Villabona has failed to protect the public.

Mr. Beauregard then closed. He asked that the Board "look at the forest, not the trees" in this case. The bottle of "Gluhwein" found in Dr. Villabona's kitchen was non-alcoholic. Not one patient who testified stated that Dr. Villabona is a bad physician. He has been characterized as a good doctor who listens to his patients.

Ms. Beish should not be believed in this case. She is a disgruntled former employee who faked her own death after an accident which did not occur. She wanted to be the "boss" in the office. No

other witness corroborated her testimony, including Ms. Riddell. In this case the State has "cherry-picked" facts.

Patient D2 testified that Dr. Villabona helped him. The DEA officer (Hancock) did not testify in this case. Mr. Beauregard questioned why certain statements in this case were not recorded.

Though Dr. Durkin testified that it is important to review complete charts, the hearing officer has not admitted charting of J's care after 2013. The State has the burden of proof in this case. Ms. Riddell formed certain conclusions in the case without a proper investigation. She simply believed Ms. Beish. The investigation of this case was "shabby" and could have gone further.

All of the evidence in this case indicates that Dr. Villabona is a good physician. He was filling a void for high risk patients. Only a small minority of Dr. Villabona's patients were treating with him for chronic pain.

The Maryland criminal matters have nothing to do with Dr. Villabona's current care of patients. The State has introduced those matters to "poison the well". Introducing those matters has "helped to sell newspapers". Though the *New York Post* labels Dr. Villabona as a "perv doctor", he still has his medical license. The State rushed to judgment in this case, which is not of an emergency nature. This case has been a "witch hunt". Ms. Beish may be mentally unstable. D2 has been inconsistent in his recollections. The Maryland sex offenses are irrelevant.

If the patient disclosure violation occurred in 2005, why did the State not complain sooner? Mr. Beauregard reiterated that the Maryland criminal case has nothing to do with patient care by Dr. Villabona. Mr. Beauregard argued that Dr. Durkin was provided incomplete files on the patients in this case. He added that Dr. Villabona's record-keeping is not evidence of malfeasance toward his patients. This investigation has been biased against Dr. Villabona.

This case has also been a "witch hunt" because evidence has not been corroborated and has been based on no credible facts. Presumably likening this case to the "Salem witch trials", Mr. Beauregard asked if Dr. Villabona must "die" to prove he is not a "witch".

In this case Dr. Villabona contends that an appropriate disposition of this case by the Board should include an order that Dr. Villabona adopt an electronic medical records system, that he cease engaging in pain management, and continue restrictions on his practice. That will allow him to continue to provide great psychiatric services to the community. Suicide rates are climbing and Dr. Villabona is in a position to assist with mental health problems. The suspension of his license will harm the community. The "pound of flesh" sought by the State will accomplish nothing.

Mr. Beauregard asked where has been the oversight of Dr. Villabona? Dr. Durkin gave opinions on care provided years ago. Much of that care was provided before Bd. Reg. 18.0 was adopted. It is offensive that the State blames Dr. Villabona for M's death. If opioids were dangerous for D, he asked "where was the State oversight"? Dr. Villabona should not be blamed for everything.

Mr. Beauregard argued that the photos in evidence do not prove a "mess" in Dr. Villabona's office. With regard to weapons brought to the office, if Dr. Villabona had directed the donors to police, and if one of those individuals had then shot himself, would the State blame Dr. Villabona? When Dr. Villabona accepted drugs and guns from others, he was protecting patients. That was a responsible act. This case was filed because Dr. Villabona cares for his patients. If sanctions are imposed in this case by the Board, Dr. Villabona should be permitted to continue to provide care for the 97% of his patients for whom he does not provide pain management.

In rebuttal Ms. Stewart argued that Dr. Villabona's patients are unaware of pain management standards of care. They would return to him, happy to receive controlled substance scripts. She reiterated that D2 testified that he returned medications to Dr.Villabona, who paid for them and then

consumed them. She also asked, presumably rhetorically, why would a psychiatrist give a gun and a knife to a psychiatric patient.

Ms. Stewart argued that the State did not raise the issue of the unapproved disclosure form because the State only recently learned that Dr. Villabona was providing it to patients. As to Ms. Beish, Dr. Villabona has not proven that she had a motive to lie in her complaint and in her testimony.

In this case Dr. Villabona was the "star witness". He was free to offer his curriculum vitae into evidence. The case is about reckless prescribing of controlled substances and handling of drugs in Dr. Villabona's practice. This is the fourth disciplinary matter against Dr. Villabona to come before the Board. Dr. Villabona has a duty to keep accurate and complete medical records. All delays in the production of records in this case are the fault of Dr. Villabona. The hearing in this case was prompted by Dr. Villabona's actions, and because of a "travesty in medical care".

Conclusions of Law

The notice of this hearing provided Dr. Villabona and his counsel with the date, time, place and subject matter of the proceedings. Prior to issuance of the notice the date, time and place had been agreed upon by all counsel. The notice also provided the parties with a statement of the hearing rights of the parties. The notice otherwise comported with legal requirements for notices of hearings before the Board. Dr. Villabona's attorneys received a copy of the hearing notice. Dr. Villabona and his counsel attended the entire hearing.

It is a matter of public policy in Delaware that laws should be adopted which ensure that the public is properly protected from the unprofessional, improper, unauthorized or unqualified practice of medicine in this State. 24 *Del. C.* §1701. The Board of Medical Licensure and Discipline has been chartered by the legislature to serve as the State's supervisory, regulatory and disciplinary body for the practice of medicine here. 24 *Del. C.* §1710. The Board is authorized to promulgate rules which carry out its powers and duties as authorized in the Medical Practice Act. 24 *Del. C.* §1713(a)(12). The Board

is vested with the authority to hold disciplinary hearings with respect to its licensees. 24 *Del. C.* §1713(a)(11). Upon a showing of good cause, the Board may impose appropriate professional discipline upon its licensees. 24 *Del. C.* §1713(a)(9). The Board is also authorized to adopt rules which establish guidelines for the imposition of professional discipline. 24 *Del. C.* §1713(f). These are all valid means and ends rationally related to the legitimate purpose of protecting the health, safety and welfare of the public.

The allegations by the State regarding violations of provisions of the Medical Practice Act and regulations adopted by the Board are found at para. nos. 63-68 of the Second Amended Complaint. SX 14 at 14-15. The first allegation is that Dr. Villabona has violated 24 *Del. C.* §1731(b)(1). That section of the Act provides that it is "unprofessional" conduct and may be a basis for professional discipline if a licensee uses" any false, fraudulent, or forged statement or document or (uses)...any fraudulent, deceitful, dishonest, or unethical practice in connection with a certification, registration, or licensing requirement of (the Act), or in connection with the practice of medicine...." *Id.*

In her closing argument the State's attorney argued that this section of the Act has been alleged both with respect to the issue of providing an unapproved and inaccurate "disclosure" form to patients relating to the Maryland sex offense convictions, as well as the broader issue of alleged unethical practices employed by Dr. Villabona in his management of the chronic pain suffered by the patients in this case. I will address the latter legal theory after forming conclusions about Dr. Villabona's specific patient care.

The "disclosure form" claim stems from documents found in a collection of medical documents regarding patient L. Those documents are found at SX 12 at 17 and 18. As summarized above, in September 2002 Dr. Villabona entered pleas of guilty to two charges of sexual offenses against minor children. Those pleas eventually resulted in disciplinary proceedings against Dr. Villabona's Delaware medical license. After extended proceedings before a hearing panel of the Board, it was ordered in

September 2003, *inter alia,* that Dr. Villabona would be required to prepare a form advising his patients of the fact that his medical practice would be limited and restricted due to the "dishonorable and unprofessional conduct reflected in his public admission of having sexually abused two young girls in accordance with his guilty plea in the Circuit Court of the State of Maryland...." SX 14 at 69.

The Board ordered that Dr. Villabona would be required to secure the approval of the "prosecuting Deputy Attorney General" for the "disclosure" form before it could be used. In subsequent proceedings and orders of the Board the requirement of the approved disclosure form remained imposed upon Dr. Villabona's license. The requirement remained in effect in 2005.

A copy of the "approved" disclosure form is found in L's file at SX 14 at 17. That form was approved by the Department of Justice and contains the required elements ordered by the Board. However, L's file contains another "disclosure form" at SX 14 at 18. That copy of the form was not approved by a representative of the Department of Justice. More importantly, in the second form dated September 8, 2004 Dr. Villabona states that he was "falsely accused" in the Maryland criminal charges. He further states in the alternate form that he entered into a "plea bargain" because he was ill and did not want to spend time with the "incredible stress of fighting these charges." He speculates that he was permitted to enter into a "probationary period without conviction" because of the "strong probability of my innocence." Finally, Dr. Villabona's unapproved disclosure form states that this Board "found no evidence of guilt". *Id.*

Dr. Villabona testified that he had used the unapproved form with other patients, though he did not recall how many were given a copy. Based on this uncontroverted hearing record, I have concluded as a matter of law that Dr. Villabona has violated 24 *Del. C.* §1731(b)(1). The unapproved form in L's chart or file (and in the files of other patients) constitutes the use of a false or fraudulent or deceitful document in connection with Dr. Villabona's practice of medicine at a time when the disclosure requirement remained imposed on his license. The form was not approved by the

Department of Justice, and makes incorrect and fraudulent statements regarding the guilty pleas, the conclusions of this Board, and the position of the Maryland Court. More significantly, the tenor of the unapproved letter from Dr. Villabona clearly suggests that the Maryland prosecution was "much ado about nothing", that Dr. Villabona was falsely accused and blameless in the Maryland cases, and that no court or licensing authority has ever made a finding of guilt against him.

As an aside, and with respect to the State's claim that Dr. Villabona has engaged in "dishonest" conduct with regard to the practice of medicine, I determined during this hearing that it was more likely so than not so that certain of his charting in this case was not prepared contemporaneous with medical services rendered, but was prepared in preparation for this hearing.

The State next contends that Dr. Villabona has violated 24 *Del. C.* §1731(b)(2). That section of the Act deems it unprofessional conduct if a licensee engages in "(c)onduct that would constitute a crime substantially related to the practice of medicine." *Id.* The legislature has directed that the Board "promulgate regulations specifically identifying those crimes which are substantially related to the practice of medicine...." 24 *Del. C.* §1713(e). The Board has done so in adopting Bd. Reg. 15.0 *et seq.*

According to the record in this case, Dr. Villabona entered a plea of guilty to two sex offenses against minors in Maryland in September 2002. He was duly disciplined for those pleas when the Board concluded that his actions constituted unprofessional and unethical conduct in Board Case No. 10-61-02. In making that finding in September 2003 the Board noted in its final order that "Board Regulation 15.1.8 by its terms requires a 'conviction' ." SX 14 at 68. The Maryland sex offense cases are the only evidence of criminal proceedings against Dr. Villabona in this record.

As I understand the arguments of the State's attorney, other actions of Dr. Villabona which have been proven in this case also constitute "crimes substantially related to the practice of medicine." In other words, though some of his alleged or proven unprofessional conduct may never have been the subject of criminal proceedings against Dr. Villabona, nonetheless with respect to some of that conduct

all the elements of certain crimes have been proven during this hearing and a finding should be made that other "substantially related" crimes have been committed by him.

I have come to the legal conclusion that the State has not met its burden of proving such other "substantially related" crimes as a matter of law, and that a violation of24 *Del. C.* §1731(b)(2) has not been substantiated. The introductory paragraph in Bd. Reg. 15.0 states, in relevant part, as follows: "The Board finds that for purposes of...discipline, the *conviction* of any of the following crimes...is deemed to be substantially related to the practice of medicine...." *Id.* (emphasis supplied). In its 2003 discussion of the predecessor regulation to Bd. Reg. 15.0, the Board was careful to note that its regulations required a "'conviction' of the offenses." SX 14 at 68.

Since 2003 the Board has not expanded its definition of "substantially related" crimes to include incidents which may provide the factual predicate for a conviction but which have not been tried in a criminal court. In my view there is logic in the Board's restriction. The "standard of proof" in an administrative licensing hearing is proof "by a preponderance of the evidence." The standard of proof in a criminal case is proof of a crime "beyond a reasonable doubt". The two standards are different at least in terms of the convincing nature of the evidence presented by the State. In my view an administrative hearing officer is ill suited to make criminal judgments in the context of a licensure hearing which employs the less demanding proof standard.

The State next contends that Dr. Villabona has violated 24 *Del. C.* §1731(b)(3) in several respects. That section of the Act deems it unprofessional to engage in "dishonorable, unethical, or other conduct likely to deceive, defraud, or harm the public." *Id.* In Bd. Reg 8.0 *et seq* the Board has undertaken to promulgate a non-exhaustive list of those types of conduct by a licensee which constitute "dishonorable or unethical conduct likely to deceive, defraud or harm the public" as that phrase is employed in the statute. The State contends that Dr. Villabona has engaged in four forms of conduct listed in the rule.

The State first contends that Dr. Villabona has violated Bd. Reg. 8.1.2. That rule deems it "dishonorable or unethical" to engage in "(e)xploitation of the doctor/patient privilege for personal gain or sexual gratification." *Id.* (The State only alleges violation of the "personal gain" language in the regulation. Though there is evidence in this case that Dr. Villabona conceded in Board Case No. 10-35-06 that he had engaged in consensual sexual relations with a 22-year old female patient in 2002, that case has been resolved and discipline imposed through a consent agreement. SX 14 at 164.)

Patient D2 testified that Dr. Villabona prescribed methylphenidate and other medications for him. He filled the Ritalin scripts, but often did not consume all of the tabs before it was time to refill the script. He believed he was supposed to bring the unconsumed drugs to Dr. Villabona at the end of a refill period. Dr. Villabona would take the drugs back from D2 and place them in the storage cabinet. On occasion he would reimburse D2 for the copay which he made when the script was refilled. At times he would not provide such reimbursement to D2. D2 does not know what happened to the returned medications. I credit Ms. Beish's testimony that she would occasionally observe Dr. Villabona consuming some of the medications.

In my view this arrangement between D2 and Dr. Villabona constitutes a violation of Bd. Reg. 8.1.2. He apparently did not dissuade D2 of his belief that D2 was required to return the unused drugs. D2 was fearful that if he stopped receiving the Ritalin scripts from Dr. Villabona, that Dr. Villabona would stop or curtain his prescribing of other medications for D2. Taking back drugs by Dr. Villabona from a patient for his own personal use constituted, in my view, exploiting the professional relationship between the two to the advantage of Dr. Villabona.

The State also alleges that Dr. Villabona has violated Bd. Reg. 8.1.12. That rule deems it "dishonorable or unethical" to fail "to comply with the Board's regulations governing the use of controlled substances for the treatment of pain. This allegation requires a more lengthy discussion.

In para. 50 of the Second Amended Complaint the State alleges numerous violations of the Board's regulation on the "Use of Controlled Substances for the Treatment of Pain." Bd. Reg. 18.0 *et seq.* That regulation clearly applies to certain conduct by Dr. Villabona in this case. For each of the patients whose charts were placed in evidence in this case, Dr. Villanova had engaged in the treatment of chronic pain by prescribing controlled substances. Dr. Villanova did not deny that he engaged in such practice when he saw new patients, long-term patients, and patients who had either been unsuccessful in engaging a pain management practice or who had been discharged from such practices.

I credit the testimony of Dr. Durkin that Bd. Reg. 18.0, or the "Model Policy", applies to specialized pain management practices as well as to the practices of other physicians who decide to engage in the management of pain of patients who are seeing those physicians for other reasons. Similarly, the "Model Policy" is applicable to the care of insured patients as well as "cash" patients. In other words, the standard of care established in the regulation is applicable regardless of the specialty of the practitioner, the financial means of the patient, or whether a patient's pain is being managed temporarily while he seeks out pain care elsewhere.

In para. 50 of the Second Amended Complaint the State alleges ten separate violations of Bd. Reg. 18.0 with regard to Dr. Villabona's management of pain suffered (or purportedly suffered) by patients U,, M, T, D, G, J and J2. SX 14 at 10-11. I will form legal conclusions as to those violations in the order in which they are alleged.

The State first alleges that Dr. Villabona failed to obtain prior treatment records or to communicate with other providers in order to secure medical histories on the listed patients. Bd. Reg. 18.1.1. In my view this allegation has clearly been proven as a matter of law. There is an almost total absence of prior medical documentation in the patients' charts regarding prior pain treatments. Though Dr. Villabona stated on occasion that he made efforts to secure such records or to speak with prior physicians, there is little or no evidence in the charts in evidence that he did so. The charts

contain no copies of letters requesting charting from others, nor notes recording any discussions between Dr. Villabona and other physicians about medical histories. The charts are almost completely devoid of imaging of the patients. In a number of cases the charts contain blank forms where patients were apparently asked to provide their own version of their medical histories but were apparently not required to do so. That Dr. Villabona was relying almost solely on patient accounts of pain etiology was an abdication of his duty to secure medical records which presumably would have informed his care for the patients.

The State alleges that Dr. Villabona failed to adequately evaluate the patients in this case by securing medical histories, performing standard of care physical exams, regularly assessing the nature and intensity of pain, reviewing past pain treatments, assessing underlying or coexisting disease, assessing the effect of pain on physical and psychological function, reviewing history of substance abuse, and determining the presence of medical indications for the use of controlled substances. Bd. Reg. 18.1.1. In the overwhelming number of these cases, I have concluded as a matter of law that Dr. Villabona also abrogated his regulatory duties to perform these evaluations.

It has been said in other cases that standard of care pain management is "a lot of work" for the practitioner. With the possible exception of monthly assessments of psychological function, it appears that Dr. Villabona was simply satisfied to provide psychiatric care and to try a continuing regimen of controlled substances after receiving the patient's self-history and without attempting to gain a more thorough medical understanding of the patients' claims of chronic pain as required in Board rules. Of note is the fact that the patient charts do not contain documentation of "head to toe" or extensive physical exams on presentation, or focused physical exams as care continued and complaints changed. Similarly, Dr. Villabona appears to have taken little or no effective action when patients self-reported illegal drug use, or Dr. Villabona learned of such abuse from other sources. These additional violations of Bd. Reg. 18.1.1 have also been proven by a preponderance of the evidence.

The State next alleges that Dr. Villabona failed to utilize treatment plans for the patients which addressed goals of treatment, plans for further diagnostics or other treatments, or the necessity of referral to other treatment modalities. Bd. Reg. 18.2. As noted above, Dr. Villabona was provided with ample opportunity to describe his treatment plans for the patients, or, more importantly, to point out where such plans were recorded by him in the patient charting. Yet he failed to do so. In the absence of treatment plans, the management of pain often becomes an exercise in maintenance with no future blueprint for hoped-for or planned-for overall improvement in pain. Multiple violations of Bd. Reg. 18.2 have been proven in this case. In my view the anticipation of referrals to pain management specialists which often were not successful does not constitute a "treatment plan" as that term is used in Bd. Reg. 18.2.

The State alleges that Dr. Villabona failed to adjust drug therapies to meet the individual needs of the patients or to document his explanation for increases, decreases or other changes in drug therapies. This subject was testified to at length by Dr. Durkin. He noted that on many occasions in the treatment of the patients in this case Dr. Villabona would add medications or delete them from regimens without charting his clinical medical rationale for having done so. Similarly, on more than one occasion Dr. Villabona would promptly start prescribing opioids for patients without having received their medical histories or imagings, and without having discussed prior care with other providers.

Dr. Durkin opined that the medication selections Dr. Villabona made in this case were without valid medical justification. He also noted that some patients for whom opioids were initially prescribed may have been opioid-naïve and may have been endangered by the prescribing. Dr. Villabona continued to prescribe controlled substances for patients who were using illegal drugs, or for patients who were enrolled in rehab programs. Dr. Durkin further testified that he knew of no medical authority for the proposition that it is standard of care in pain management to prescribe methylphenidate and opioids concurrently to "enhance" the effectiveness of the latter. Again, after

listening to Dr. Durkin's testimony, Dr. Villabona had ample opportunity to explain his prescriptive rationale in the cases yet chose not to do so. Medical literature placed in evidence by Dr. Villabona did not address or support his theory that methylphenidate enhances the effectiveness of pain medications for those suffering with chronic, non-cancer pain.

The State alleges that there is little or no evidence in the charts that Dr. Villabona discussed the risks and benefits of the use of controlled substances in the treatment of pain. Bd. Reg. 18.3. The regulation deems such discussions (and the charting of such discussions) to be an integral part of the "informed consent" provided by patients. On more than one occasion Dr. Villabona testified in this hearing that it was his regular "habit" to engage in such discussions. If that is so, he did not chart them. Dr. Villabona acknowledged his awareness of the adage, "if it isn't in the chart, it didn't happen". Though there is reference in one chart that a "risks and benefits" discussion was had, no further detail is provided. Discussion of the "risks and benefits" of opioids and other substances is not simply another "busywork" requirement imposed by the Board. Rather, it is the necessary conveyance of important information to a patient who is embarking or continuing on a course of treatment which involves the regular consumption of addictive medications. The State has proven a violation of Bd. Reg. 18.3.

The State claims that Dr. Villabona failed to utilize or enforce treatment agreements with his patients. Bd. Reg. 18.4. Such agreements are required when patietns are at "high risk" for abuse or have demonstrated a history of abuse. *Id.* Dr. Villabona did not contest Dr. Durkin's assessment that all of the patients in this case are "high risk" individuals.

Some of the charts contain perhaps minimally adequate pain management agreements. However, implicit in those agreements is the promise by the practitioner that he will take action if it is determined that a patient is ignoring or violating such an agreement. During his testimony Dr. Villabona was confronted with evidence of multiple occasions on which patients had obviously violated their agreements. On one occasion he candidly stated that he does not believe it is his role to "punish"

patients by taking the enforcement steps outlined in the agreements, such as patient discharge. Some patients were permitted to violate their agreements on multiple occasions before they were discharged.

I have concluded as a matter of law that the State has proven violations of Bd. Reg. 18.4. I also note that a required provision in pain agreements is notification to the patients that "urine/serum medication levels screening" will be performed when requested. Bd. Reg. 18.4.1. Dr. Villabona testified that he regularly performed urine drug screens on these patients. That was his "habit". Nonetheless, the charts in evidence are almost wholly devoid of any documentatiuon of the results of any such screening. On occasion Dr. Villabona would simply note that the results of a particular screen were "appropriate". I share the State's skepticism that these high risk patients (some of whom demonstrated illegal or unauthorized drug use) regularly and consistently produced compliant drug screen results. Even if it is assumed that Dr. Villabona regularly performed point-of-care screening of the patients (an assumption which I do not accept), he admitted that he did not send out any of his POC samples for more sophisticated lab testing. He did not state that he based that decision on the means of the patients. He simply did not seek out more detailed information of the drug use of his patients. The State also contends that Dr. Villabona failed to appropriately identify or respond to "red flags" in his patients for medication abuse. This record is replete with evidence of medication or other drug abuse. PMP reports disclosed the drug-seeking behavior of some patients. Dr. Villabona was informed of illegal drug use by some of the patients. One of the patients was arrested on drug charges. Some patients were enrolled in rehab programs.

Evidence of other "red flags" is found in this case. However, more often than not Dr. Villabona's response was to largely ignore those red flags and continue patients on their established medication course. It may be that he did not want to upset the psychiatrist-patient relationship by taking affirmative action in the face of those "red flags". But Bd. Reg. 18.0 *et seq* does not provide for exceptions in the rules for those whose primary medical specialty is not pain management. In response

to a question from this hearing officer, Dr. Durkin stated that there is no difference in the standard of care between the pain management specialist and the physician who is engaged in another medical specialty when it comes to treating patients with chronic pain. Indeed, Dr. Durkin opined that a psychiatrist is in a particularly advantageous position to assess the aberrant behavior of patients who are using drugs.

The State alleges that Dr. Villabona failed to refer patients as necessary for additional evaluation and treatment in order to achieve treatment objectives. Bd. Reg. 18.6. To his credit, Dr. Villabona recognized that pain management practitioners were perhaps in a better position to treat the chronic pain of some of his psychiatric patients. (At one point he stated that he wanted to "get out of the business.") The charts and his testimony are replete with efforts to refer some of the patients out for pain management services. Those efforts were often not successful.

Nonetheless, Bd. Reg. 18.6 requires those engaged in pain management to continually consider whether additional or alternative evaluation and treatment would generate a greater likelihood of attainment of treatment objectives. If it is assumed that Dr. Villabona had established treatment objectives for the patients in this case, the files for the most part do not reflect his consideration and referral to other treatment modalities. When referrals to other pain managers were unsuccessful, the patients continued with Dr. Villabona. For more than one of the patients, Dr. Villabona appeared to concede the futility of making referrals out which would require patients of limited means to pay more for their health care. The Board has held previously that limited financial means should not be a reason to ignore the mandate of Bd. Reg. 18.6.

The State alleges that Dr. Villabona failed to conduct period reviews of the care of his pain patients pursuant to Bd. Reg. 18.5. Such reviews must include evaluation of the continuation or modification of controlled substance regimens, review of satisfactory responses to treatments, and the appropriateness of continuing a plan or referral to other modalities if progress is unsatisfactory. I have

reviewed the charting in this case. Either Dr. Villabona did not conduct periodic reviews, or did not chart them if they were performed. If he did not record such reviews in the charts, the charting is deficient both for his use and for the use of any practitioner who should assume the future care of the patients. Standard of care pain management requires that the practitioner periodically review the course of treatment and any new information gained by the practitioner in order to continually assess the best chances of pain improvement for the patient, and to assess the propriety of change in the absence of improvement. The State has proven violations of Bd. Reg. 18.5

The State alleges that Dr. Villabona has failed to maintain accurate and complete records. Bd. Reg. 18.7. That regulation lists 11 documents or types of documents which must be maintained in the chart of the chronic pain patient. Those mandatory contents include medical history, diagnostic and lab results, evaluation and consultations, documentation of pain etiology, treatment objectives, discussion of risks and benefits, informed consent documentation, treatment records, medication records, instructions and agreements, and periodic reviews.

I have discussed the absence of many of these types of records in the charts of the patients in this case. I find as a matter of law that each of the charts in evidence is deficient with respect to the great majority of the documents required by the regulation. Hence, the State has proven multiple violations of Bd. Reg. 18.7. I also note that at least one of the patients in the case continued to receive controlled substance prescriptions from Dr. Villabona while significant gaps appear in his chart. That is to say that while prescriptions continued, no care was charted. Such gaps constitute gross violations of Bd. Reg. 18.7.

In her closing the State's attorney argued that newly adopted Cont. Subst. Act Reg. 9.8 applies to the pain care provided by Dr. Villabona for patients G and U because of the more recent periods of time during which Dr. Villabona cared for them. That regulation is captioned "Safe Prescribing of Opioid Analgesics". CSA Reg. 9.8 requires, *inter alia,* that with respect to chronic pain patients, the practitioner

must query the PMP when a patient is at risk for substance abuse or misuse. Again, all of the patients in this case were characterized as at "high risk". According to the charting for G and U, in my view Dr. Villabona did not query the PMP with sufficient frequency when informed of aberrant behaviors. In addition, Dr. Villabona made little effective use of certain PMP data if In fact he had reviewed it at the times when queries were posed.

CSA Reg. 9.8.3 requires that the pain patient be administered fluid drug screens once each six months. I have found above that it is more likely so than not so that the patients in this case (including G and U) were rarely, if ever, screened by Dr. Villabona. Urine samples were admittedly not sent off for confirmatory lab testing.

CSA Reg 9.8.5 requires the utilization of approved risk assessment tools for G and U. None were found in their charts. CSA Reg. 9.8.6 requires documentation of attempts at alternative treatment options. Other than making efforts to assist patients in finding pain management practices, the charts do not contain documentation of attempts at alternative treatments, and the results of those attempts.

The State next alleges that Dr. Villabona has acted "unprofessionally" In violating Bd. Reg. 8.1.13. That regulation deems it unprofessional to fail "to adequately maintain and properly document patient records. " *Id.* Prior to and during the hearing, there was much argument as to whether and when Dr. Villabona had actually produced the complete charting of the patients in this case. During the hearing there was some question as to whether the State had yet received all subpoenaed records. I have not come to any legal conclusions regarding the "completeness" issue.

Nonetheless, Bd. Reg. 8.1.13 requires that a pain practitioner properly document the records of his patients. In the discussions above, I have found numerous instances in which the charts of each of the patients in this case are grossly incomplete. For instance, none contains even a majority of the records required by Bd. Reg. 18.7. For that reason, I find that with respect to each of the patients Dr. Villabona has violated Bd. Reg. 8.1.13.

Finally, the State alleges that Dr. Villabona has acted unprofessionally in violation of Bd. Reg. 8.1.16. That regulation deems it unprofessional if a licensee commits any "act tending to bring discredit upon the profession". As in other cases, the State did not directly try this issue during the hearing in the form of public witnesses who have views on how Dr. Villabona's conduct has "brought discredit" on the public view of medicine in Delaware. Nonetheless, in my view discredit may be inferred from the cumulation of issues which have been proven here. Those issues begin with the public guilty pleas in Maryland, continue in the fraudulent "disclosure" forms provided to his patients, in the public disciplinary action stemming from relations between Dr. Villabona and a female patient, and continue to the present with the instant proceedings which, according to Dr. Villabona's attorney, have received broad coverage in the public media.

The next legal claim in the Second Amended Complaint alleges that Dr. Villabona has violated 24 *Del. C.* §1731(b)(6). That provision of the Medical Practice Act states that it is "unprofessional" and may be a basis for discipline if a licensee uses, distributes or issues "a prescription for a dangerous or narcotic drug, other than for therapeutic or diagnostic purposes." *Id.*

During this hearing Dr. Durkin testified at length regarding Dr. Villabona's prescriptive choices for the patients in this case. Dr. Durkin's credentials and experience provided eminent qualifications to provide expert opinions on pain management as a general matter and on the patients in this case in particular. For each of the patients whose charts he reviewed, and after due consideration, he concluded that Dr. Villabona's prescribing of opioids and other controlled substance was "without legitimate medical purpose".

Dr. Villabona was certainly welcome during this hearing to serve as his own "expert" witness. That is to say that he was given ample opportunity to explain, for each of the patients, the legitimate medical purposes for which the prescriptions were written. He did not provide his clinical rationale on either a patient-by-patient or on a visit-by-visit basis. His statements that he did not want to harm

patients, that he was treating "whole families", or felt responsible for "orphan" patients were, in my view, perhaps well-intentioned but insufficient as a matter of law to establish proper medical purpose for his opioid and other scripts. Based on the fact that "legitimate medical purpose" therefore became a one-sided issue during the hearing, I have little discretion but to accept Dr. Durkin's studied opinions on the point. The State has proven violations of 24 *Del. C.* §1731(b)(6) by a preponderance of the evidence and as a matter of law.

The State next contends that Dr. Villabona has violated 24 *Del. C.* §1731(b)(11). That section of the Act holds, in relevant part, that it is unprofessional to engage in "misconduct...including...incompetence, or gross negligence or pattern of negligence in the practice of medicine...." *Id.*

The terms "incompetence", "gross negligence" and "pattern of negligence" are not defined elsewhere in the Medical Practice Act nor in Board rules. When a word or phrase in the Delaware Code is not otherwise defined, the interpreter of the law is instructed to construe words according to the common and approved usage of the English language. 1 *Del. C.* Sec. 303.

The word "incompetent" is defined as "not legally qualified...inadequate to or unsuitable for a particular purpose...lacking the qualities needed for effective action...unable to function properly." *Webster's Collegiate Dictionary* (10th ed. 1996) at 588. In this case Dr. Villabona practiced as both a psychiatrist and pain management physician. The State did not allege or offer any proof with respect to Dr. Villabona's competence as a psychiatrist. By all accounts as offered by some of his patients, he is a psychiatrist who as provided valuable medical service for his patients.

Nonetheless, I have concluded after careful consideration of this record that the State has proven that he is an "incompetent" pain management practitioner. His lack of knowledge of applicable rules and regulations, or his choice to ignore those rules, demonstrate that he lacked the qualities or knowledge to function effectively. Perhaps by his own admission, Dr. Villabona was not competent to

practice pain management. He stated on one occasion that his efforts to have a pain patient transferred to a pain management specialist offered him a chance to "get out of the business". This finding of "incompetence" is limited solely to the pain management evidence which was presented in this case. It is not a finding as to his competence as a psychiatrist.

Sec. 1731(b)(11) also deems it unprofessional and a basis for discipline if a licensee engages in a "pattern of negligence" in the practice of medicine. "Negligence" has been defined as the "failure to exercise the care that a prudent person usually exercises." *Webster's* at 777. "Negligence" has also been defined by judges for Delaware juries as "the lack of ordinary care...the absence of the kind of care a reasonably prudent and careful person would exercise in similar circumstances." *Del. P.J.I. Civ.* Sec. 5.1. Similarly, "medical negligence" has been defined for Delaware juries as the "standard of skill and care required of every healthcare provider in rendering professional services or healthcare to a patient shall be that degree of skill and care ordinarily employed, in the same or similar field of medicine as the defendant, and the use of reasonable care and diligence." *Del. P.J.I. Civ.* Sec. 7.1A.

The legal and "non-legal" definitions of "negligence" both focus on the requirement that an individual exercise the degree of care that a reasonably prudent person (or, in this case, a reasonably prudent physician engaged in chronic pain management involving the prescription of controlled substances) would exercise in similar circumstances. In this case, the question is whether Dr. Villabona exercised the degree of skill and care ordinarily employed in the field of pain management when he chose to manage the chronic pain of some of his psychiatric patients. Again, after careful consideration, I find that Dr. Villabona did not exercise the degree of care that would be exercised by reasonably prudent practitioners of pain management. Such a practitioner would comply with all rules governing the treatment of chronic pain with controlled substances. In this case I have found that Dr. Villabona fell considerably short of those standards. I further find that his shortcomings fell across all of the

patients in this case such that his negligence established a "pattern." The State has therefore proven violations of 24 *Del. C.* §1731(b)(11) as a matter of law.

The State's final legal allegation in the Second Amended Complaint is that Dr. Villabona has violated 24 *Del. C.* §1731(b)(17). That section of the Act deems it unprofessional if a licensee violates a provision of the Act or an order or regulation of the Board related to medical procedures and that such violation more probably than not will harm or injure the public or an individual.

In this recommendation I have found a substantial number of violations of the Medical Practice Act, regulations adopted by the Board and, in the case of the mandatory "disclosure" form, violations of Board orders. I have concluded as a matter of law that those violations will, more probably than not, harm or injure the public or individuals. Certain of Dr. Villabona's prescribing of opioids and other controlled substances likely harmed patients in causing or fostering drug addiction. He missed opportunities to counsel his patients on the risks of the use of controlled substances. He failed to screen patients to determine whether they were acting in compliance with Dr. Villabona's orders and agreements. He failed to note or act upon clear "red flags" that patients were engaged in aberrant drug behavior. Other shortcomings in his prescribing exposed his patients to the risk of harm.

Dr. Villabona permitted unsafe and unsanitary conditions to exist in his office. When he unilaterally chose to distribute unapproved and fraudulent "disclosure" forms to patients regarding the Maryland proceedings he hindered the ability of his patients to make fully informed choices as to whether to engage or continue to treat with Dr. Villabona. The State has proven multiple violations of 24 *Del. C.* §1731(b)(17).

The Board has adopted certain disciplinary guidelines to establish a level of uniformity in discipline depending on the nature of legal violations by licensees. Bd. Reg. 17.0 *et seq.* The range of disciplines for violation of 24 *Del. C.* §1731(b)(1) and (b)(3) runs from a fine of $1,000 to license suspension of six months. The range for violations of 24 *Del. C.* §1731(b)(6) runs from a letter of

reprimand to suspension. The range for failure to follow Bd. Reg. 18 (the "Model Policy") runs from education in pharmacology of pain management and a fine of $1,000 up to license revocation. The range for violation of 24 *Del. C.* §1731(b)(11) runs from a fine of $1,000 to six months' license suspension. A finding of incompetence may result in review by an organization and a range from one year probation to revocation. Violation of a Board order may result in a range from suspension until compliance to revocation.

The Board has also adopted lists of "aggravating" and "mitigating" factors which may assist the Board in assessing appropriate discipline, or may cause the Board to impose discipline outside the ranges established in the above guidelines. I have assessed those factors and believe the following to be present here:

Aggravators (Bd. Reg. 17.14): Prior disciplinary offenses (17.14.1); past disciplinary record (17.14.2); frequency of acts (17.14.3); nature and gravity of allegation (17.14.4); deceptive practice during disciplinary process (17.14.5); dishonest motive (17.14.6); different multiple offenses (17.14.8); failure to comply with orders (17.14.9); refusal to acknowledge wrongful nature of conduct, vulnerability of victim (17.14.10); intent (17.14.11); age capacity or vulnerability of patient or victim of licensee's misconduct (17.14. 15); potential for injury (17.14.17); pattern of misconduct (17.14.19); ill repute upon profession (17.14.11).

Mitigators (Bd. Reg. 17.15): Consent of patient (17.15.12).

On balance, I believe the aggravating factors in the Board rules and proven in this case substantially outweigh mitigating factors as the Board has articulated them.

In his closing argument, Dr. Villabona's attorney contended that an appropriate recommendation to the Board in this case would be, *inter alia,* that Dr. Villabona be ordered to discharge all patients for whom he is providing pain management within a certain period of time. From a purely logical standpoint, and all other things being equal, such an order makes some sense here. As

noted above, the State did not contend nor present proof that Dr. Villabona is not a competent psychiatrist. If the Board were satisfied that he could effectively discharge those patients and focus on psychiatry only, such a resolution would theoretically preclude further haphazard pain management.

But all things are not equal in this case. Dr. Villabona's disciplinary history suggests that the Board could not effectively trust Dr. Villabona to segregate his practice promptly and effectively. Some of the patients who have objectively established psychiatric and pain management needs lack the funds to pay for care by two physicians. Dr. Villabona has stated that he is sympathetic with "orphan" patients who have no where else to turn, and who lack the funds to leave him and treat elsewhere. The Board is certainly free to disagree with me and to adopt an order which requires Dr. Villabona's separation from all pain management, perhaps after a period of license suspension or probation during which he would be required to complete certain continuing education hours in ethics, best practice referral techniques, and the like. Given my understanding of the record in this case, however, I simply do not believe that such an order would be effective and would protect the public and his patient base. I also believe that it is more likely so than not so that after any period of license probation or suspension, Dr. Villabona would return to his current practice of serving as a multidisciplinary practitioner.

Due process has been afforded in these proceedings.

Recommendation

Based on the relevant evidence in this case and the findings of fact and conclusions of law set forth above, I recommend that the Board of Medical Licensure and Discipline revoke the medical license currently issued to Dr. Gregory Villabona.

Roger A. Akin
Chief Hearing Officer

Dated: August 6, 2018

Any party to this proceeding shall have twenty (20) days from the date on which this recommendation was signed by the hearing officer in which to submit in writing to the Board of Medical Licensure and Discipline any exceptions, comments, or arguments concerning the conclusions of law and recommended penalty stated herein. 29 *Del.C.* §8735(v)(1)d.