COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1411

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY MELBORNE A. WILLIAMS, M.D., LICENSE NO. 17071, 106 EAST LEXINGTON AVENUE, DANVILLE, KENTUCKY 40422-1518

COMPLAINT

Comes now the Complainant C. William Briscoe, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on June 21, 2012, states for its Complaint against the licensee, MELBORNE A. WILLIAMS, M.D., as follows:

1. At all relevant times, Melborne A. Williams, M.D., ("the licensee") was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is psychiatry.
3. In or around September or October 2011, Chris Johnson, R.Ph., an investigator with the Drug Enforcement and Professional Practices branch of the Office of Inspector General of the Cabinet for Health and Family Services ("Drug Enforcement") reported to the Board that several informants in Drug Enforcement cases had identified the licensee as a reliable source for Xanax.
4. On or about October 20, 2011, at the Board's request, Drug Enforcement analyzed the licensee's prescribing patterns and referred twenty (20) patient names for further review, based upon patient ages, similar past names, polypharmacy, addictive drug combinations and distance traveled. The Board subpoenaed and obtained the patient records of these twenty (20) patients from the licensee on or about November 14, 2011.

5. The Board's Medical Investigator, Doug Wilson, interviewed Stuart W. Larson, M.D., who stated substantially as follows: in or around June 2011, he began practicing at CentEx in Danville, Kentucky, where the licensee also practiced; he noticed that car loads of patients would come from various places in the state to see the licensee, so that the parking lot, waiting areas and outside areas were full; patients complained to him that "junkies" were hanging around the practice; there were discussions among patients as to what and how much they were being prescribed and how much money could be charged on the street for Xanax pills; a child was heard asking, "Mommy, do you want me to pee in a cup again?"; when covering for the licensee and seeing the licensee's patients, Dr. Larson noticed that the licensee's patients were receiving high doses of Xanax, 3-5 per day and sometimes 6mg per day, regardless of diagnosis and that the Xanax was often prescribed as part of a "cocktail" with other controlled substances, including Trazadone; and Dr. Larson reported his concerns about the licensee's practices to Bryan Wood, M.D., an owner of CentEx.
6. The Board's Medical Investigator, Doug Wilson, interviewed CentEx owner, Bryan Wood, M.D., who stated substantially as follows: when hired, the licensee brought many of his established private practice patients with him into the CentEx practice; after several weeks, Dr. Larson approached him with concerns about how the practice was evolving due to the licensee's practices, including the prescribing of large amounts of Xanax along with a "cocktail" of Seroquel, Klonopin and Trazadone; after Dr. Larson expressed concerns regarding the licensee's practice, Dr. Wood reviewed the licensee's patient charts and found that approximately 97% of the licensee's patients were receiving high doses of Xanax and a "cocktail" of other

controlled substances; Dr. Wood met with the licensee about his practices but when it became clear that an ongoing relationship was not going to work out, the licensee was terminated from CentEx.

7. In December 2011, Billy Madden, Medical Investigator, received a call from a woman who stated that she was a nurse at Manchester Memorial Hospital but refused to give her name; according to the caller, she was seeing a trend with Xanax overdoses in the Clay County community and that several of the overdoses were patients of the licensee.

8. In January 2012, Clay County Sheriff, Kevin Johnson, contacted Billy Madden, Medical Investigator, and reported that several of the licensee's patients had died of overdose in Clay County and that several confidential informants and drug case witnesses had identified the licensee as a known source for Xanax.

9. Also in January 2012, Clay County Coroner, Danny Finley, contacted Billy Madden, Medical Investigator, and reported that he had worked several overdose deaths in Clay County and that many of the deceased were the licensee's patients. Based upon the Coroner's information, the Board subpoenaed and obtained the medical records of eleven (11) of the licensee's patients who had overdosed in Clay County.

10. In February 2012, Clay County Coroner, Danny Finley, reported to the Board that another patient of the licensee, Patient A, had overdosed in Clay County. The medical records of Patient A and her husband, Patient B, were subpoenaed and obtained from the licensee.

11. In March 2012, at the Board's request, the Drug Enforcement and Professional Practices Branch of the Office of Inspector General, analyzed the licensee's

prescribing of Alprazolam (Xanax) and found him to be the #1 prescriber of Alprazolam in the Commonwealth of Kentucky, with 1,351,745 dosage units on 12,622 prescriptions recorded from April 1, 2011 through March 12, 2012.

12. In May 2012, a Board consultant reviewed the thirty-two (32) patient charts obtained from the licensee and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices in the diagnosis and treatment of patients; that the licensee prescribed or dispensed medications in such amounts that he knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under acceptable and prevailing medical practice standards; and that the licensee committed a pattern of acts during the course of his medical practice which, under the attendant circumstances, demonstrate gross incompetence, gross ignorance, gross negligence or malpractice.

Specifically, the Board consultant noted the following:

- There was no documentation in the patient charts of informed consent regarding the potential risks of the use of controlled substances, especially in combination with other prescribed or illicit drugs;

- There was inadequate documentation of patients' past medical history or concurrent medications/therapies prescribed by other physicians, even when those might have potentially serious interactions with the licensee's prescriptions;

- There was inadequate documentation of patients' past or current substance abuse history or treatment. Even where illicit substances were present on intake drug screens, these were not noted in the chart;

- Although the licensee indicated to the Board that he performed regular KASPER checks on his patients, only one chart had a notation that a KASPER was checked after his office received calls about a patient going to multiple doctors. KASPER reports on the patients who had died of overdoses in Clay County revealed obvious patterns of aberrant behavior which should have been detected and addressed by the licensee if he had performed KASPER reviews, including patients getting opiate prescriptions from more than one

provider (in one case as far away as Atlanta), using multiple pharmacies, and being prescribed CNS depressants by other (often multiple) physicians;

- The licensee did not meet the standard of care when he prescribed benzodiazepines to patients with histories of addiction to alcohol or other substances - without first requiring the use of alternative, non-addictive medications or cognitive therapy, without closely monitoring that the patient is engaged in a recovery program, and without prescribing the lowest effective dose for the shortest possible period. As an example, the Board consultant noted one case in which the licensee restarted Xanax in an adolescent, Patient M, even after that patient was psychiatrically hospitalized and discharged with a diagnosis of Xanax abuse and had been taken off Xanax during hospitalization. In addition, Patient M was prescribed Paxil in spite of a black box warning about the use of that medication in adolescents;

- Although the licensee regularly obtained urine drug screens on his patients, there was a pattern of failure to follow-up or document intervention or modification of treatment plans as a result of those drug screens. 25 of the 32 reviewed charts demonstrated aberrant behavior, including the absence of prescribed medications or presence of non-prescribed controlled substance medications;

- The licensee prescribed in a manner which placed patients at risk of potentially serious drug interactions or other adverse health consequences. For example, two patients with documented histories of asthma were prescribed propranolol; there were multiple cases in which patients were on benzodiazepines and opiates; and several patients were prescribed doses of citalopram greater than 40mg qD, even after an FDA alert of August 2011 regarding the risk of cardiac events at such higher doses;

- A review of patient encounter records revealed that the licensee saw, on average, 41.5 patients per day at CentEx – more than double the number of patients seen by each of the other two CentEx psychiatrists, even though they worked two more hours per day than the licensee. Also, in October 2011, after he had left CentEx and was in private practice, he saw an average of 42.7 patents per day. This patient load is at least twice what the average psychiatrist would see on a typical day, even in a busy community mental health center with other physician extenders available;

- The licensee deviated from acceptable and prevailing medical practices when he began patients on and maintained patients on high doses of benzodiazepines, instead of beginning patients on lower doses and then titrating the doses up if clinically indicated or titrating doses down when anxiety symptoms stabilized.

The consultant's report is attached hereto and incorporated herewith in its entirety.

13. In 2004, the Board issued a Letter of Admonishment to the licensee based upon his prescribing to himself and/or his family. In that letter, the Board recommended that the licensee attend a Continuing Medical Education Course entitled *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center.

14. On January 19-21, 2005, the licensee attended and completed the *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center. The content of the course included components dealing with improving practice management, dealing with problem patients, exploration of personality traits that influence prescribing practices, and critical issues in pharmacological management of patient complaints.

15. On June 6-8, 2012, in anticipation of the Panel's review of the 2011-2012 investigation as described above, the licensee again attended and completed the *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center.

16. On June 21, 2012, the Board's Inquiry Panel A determined that the licensee's continued practice constitutes a danger to the health, welfare and safety of his patients or the general public. As a result, the licensee was suspended from the practice medicine in the Commonwealth of Kentucky.

17. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.

18. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) His failure to respond may be taken as an admission of the charges;

    (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

19. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for December 11 and 12, 2012, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by MELBORNE A. WILLIAMS, M.D.

This 26th day of June, 2012.

C. William Briscoe MD

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., Hearing Officer, 415 West Main Street, P.O. Box 676, Frankfort, Kentucky 40602-0676; a copy was mailed via certified mail return-receipt requested to the licensee, Melborne A. Williams, M.D., 106 E. Lexington Avenue, Danville, Kentucky 40422-1518; and a copy was sent electronically and via first-class mail to the licensee's counsel, James E. Smith and David B. Gazak, 3220 Office Pointe Place, Suite 200, Louisville, Kentucky 40220 on this 26th day of June, 2012.

Leanne K. Diakov
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

Integrative Psychiatry

RECEIVED
MAY 29 2012
K.B.M.L.

May 28, 2012

Mr. Doug Wilson
Medical Investigator
Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RE: Consultation on Melbourne Williams, M.D., Grv. #11739

Dear Mr. Wilson:
The following is my report on the grievance regarding Melbourne Williams, M.D. I have reviewed the information in your Investigation Report, as well as the 15 Exhibits and 32 patient charts you provided.

Selection of charts reviewed
I reviewed a total of 32 patient charts. This was not a random sampling of Dr. Williams' patient population. 22 charts were identified by an Investigative Report by the Cabinet for Health and Family Services, Office of the Inspector General, based on a review of KASPER. These charts were selected "based on age, similar last names, polypharmacy, addictive drug combinations, and distance traveled." Additionally, 10 patients were identified by the Clay County Coroner. These patients were all deceased within the past year, and all had multiple drugs in their system on postmortem toxicology that was considered a factor in their deaths. The coroner wrote: "My concern specifically is, at risk individuals are being treated by multiple physicians, primary care, pain management and psychiatry. Each appears to be prescribing without regard to the others recommendations. There seems to be total disregard for the addictive properties of many medications. In addition to commonly abused benzodiazepines and opiates, many other medications with CNS depressant qualities are being prescribed in combination."

Summary of opinions:
a. Diagnosis
The majority of patient charts contained relatively sparse documentation regarding diagnosis beyond "depression" or "panic anxiety." There were several patients with a diagnosis of bipolar depression, "OCD," "PTSD," or "ADD," but the basis of those diagnoses was not recorded in the medical record. Past psychiatric history was poorly documented, and no standardized scales or diagnostic instruments were used. As

EXHIBIT # 9

detailed below, there was a paucity of information in the chart regarding past or concurrent medical and substance abuse history. It is my opinion that this falls below minimum standard.

b. Treatment

As detailed below, it is my opinion that "use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction" fell below minimum standards.

c. Record-keeping

Overall, it is my opinion that Dr. Williams' medical record keeping was "within minimum standards." There appears to be a chart entry for each office visit, and photocopies of each written prescription for both controlled and non-scheduled medications. A checklist-style office note template was used, but additional notes were minimal.

d. My overall opinion is that the treatment provided in these cases clearly falls below minimum standards.

Basis of Opinions:

No documentation of informed consent regarding risks of controlled substance

There is no documentation in the chart of any written or verbal informed consent regarding the potential risks of the use of controlled substances, especially in combination with other prescribed or illicit drugs.

Inadequate documentation of past medical history

Beyond an occasional notation of "LBP" (low back pain) or other medical condition, the patient's past medical and psychiatric history was very sparse. Most importantly, there was minimal, if any, documentation of concurrent medications or therapies prescribed by other physicians, even when those might have potentially serious interactions with Dr. Williams' prescriptions.

Lack of detailed substance abuse history and evaluation

There was no documentation of past or current substance abuse history or treatment beyond an occasional notation of "suboxone clinic." No screening instruments, except for a few questions on the initial intake form, were apparently used. Even when illicit substances were present on intake drug screens, these were not noted in the chart. There was no documentation of referral for AA/NA or other substance abuse evaluation or treatment, even in patients with obvious problems.

Monitoring of patient compliance

Dr. Williams did not do phone refills or refills without an office visit. His initial prescription of Xanax was usually only for a month. Subsequent prescriptions usually included one refill.

Although in his responses to KBML Dr. Williams reported doing regular KASPER checks, only one chart had a notation that KASPER was checked after his office received calls about a patient going to multiple doctors. That patient was dismissed from his practice. The accompanying Exhibit 15 was apparently a report of 11 patients who Dr. Williams had checked KASPER. This included the 10 patients who were deceased

and identified in the grievance filed by the Clay County Coroner; they were also all dated "2/24/2012" and I cannot determine if they were checked during the course of usual treatment. According to his lawyer's letter in response to the grievance proceedings, Dr. Williams had checked the 11th patient's KASPER, but had no record of that person having been his patient. Of the 10 patients, 6/10 would be considered aberrant. This would include patients getting opiate prescriptions from more than one provider (in one case as far away as Atlanta), using multiple pharmacies, and being prescribed CNS depressants by other (often multiple) physicians that would warrant modification of treatment. There was no documentation in the medical records regarding these matters.

Use of benzodiazepines in patients with past or current substance abuse/ dependence

As mentioned above, there was minimal documentation in the patient charts of a thorough history and evaluation of substance abuse and dependence problems, risk factors, and past and current treatment. However, on the brief intake form a number of patients described themselves as "in recovery," and others were noted to be in Suboxone programs for opiate dependence.

The use of benzodiazepines in a patient with a history of addiction to alcohol or other substances is somewhat controversial. Although some conservative addiction specialists would say it is never appropriate, most psychiatrists and accepted practice guidelines suggest that it may be safe and effective in selected patients with severe anxiety disorders. However, even in these rare situations, it would require that alternative, non-addictive medications were first tried, as well as options such as cognitive therapy. It would also be critical that the patient be closely monitored and be actively engaged in a recovery program, and that benzodiazepines be prescribed in the lowest effective dose, for the shortest possible period. It is my opinion that Dr. Williams did not meet this standard of care.

As an example of this prescribing pattern, Dr. Williams restarted Xanax in adolescent (VG) even after that patient was psychiatrically hospitalized and discharged with a diagnosis of Xanax abuse and had been taken off Xanax during hospitalization. According to the discharge summary, she was reportedly snorting Xanax that had been smuggled onto the psych unit, and was sharing it with peers. Following discharge, and while prescribed benzodiazepines, this adolescent also had urine drug screens indicating the presence of opiates, as well as methadone. The patient was also prescribed Paxil in spite of black box warning about use of that medication in adolescents. This is particularly pertinent in this adolescent who was admitted to the hospital because of cutting behaviors.

Failure to follow-up on aberrant drug screens

Dr. Williams regularly obtained urine drug screens on his patients. However, there was a pattern of failure to follow-up or document intervention or modification of treatment plan as a result of those drug screens. 25 of the 32 patient charts reviewed would be classified as aberrant. These include the absence of a prescribed drug in the screen (usually benzodiazepine, but also one case of stimulant prescription), the presence of other controlled substances that were not noted on the chart (most often opiates), and

the presence of metabolites of benzodiazepines that were not prescribed by Dr. Williams (metabolites of clonazepam rather than alprazolam). 25% of the charts included drug screens that were positive for THC, and on a few occasions that was noted in the chart with "advised to d/c." Two of the 32 patients were dismissed by Dr. Williams for non-compliance with recommended treatment, based in part on the results of the drug screens. It is possible that some of the controlled substances present in the urine toxicology screens were legitimately prescribed by another physician. For example, a number of patients reportedly had histories of chronic pain syndromes. However, these problems and prescribed therapies would have important implications for drug interactions, and were not documented in the medical record. In the majority of the cases, it is most likely that these patients were not legitimately prescribed these drugs because of the combinations found, e.g., barbiturates, opiate combination such as buphenorphrine (used for opiate detoxification)+oxycodone and other opiates, amphetamines, tramadol, have no legitimate medical indication and carry significant risks of toxicity.

Incidents of potentially serious drug interactions

Two patients were prescribed propranolol who had documented histories of asthma. A number of patients showed methadone on urine drug screen, but the dose of benzodiazepine was not modified. Although not absolute contraindications, there were a number of medication combinations with potentially serious drug-drug interactions that were not noted or explained in the medical record, e.g., mirtazapine+alprazolam, tramadol+citalopram, as well as multiple cases of benzodiazepines+opiates. Several patients were prescribed doses of citalopram greater than 40mg qD, even after the FDA alert of August, 2011, regarding risk of cardiac events at higher doses.

Inadequate time to complete adequate evaluations and management of patients due to extremely high case load

A review of Dr. Williams' patient encounter records at the CenTex office (06/06/2011 to 07/08/2011) indicates that he saw an average of 41.5 patients per day. By contrast, the records of the two other psychiatrists in the clinic showed they saw 20.2 and 17.5 patients per day, even though they saw patients two more hours per day. The patient schedule was set for 15 minute appointment slots, and were typically double or triple booked, indicating that Dr. Williams' total encounter time was five to seven minutes per patient.

A review of Dr. Williams' patient encounter records at his Bluegrass Psychiatry office (10/01/2011 to 10/31/2011) indicated he was averaging 42.7 patients per day. Based on my experience, this patient load is at least twice what the average psychiatrist would see on a typical day, even in a busy community mental health center with other physician extender providers available.

While there are certainly stable, long-term patients that can be adequately managed in a 5-minute checkup appointment, it is my opinion that this is inadequate for most psychiatric patients with severe symptoms and medical and chemical dependency comorbidities. This lack of time for evaluation, treatment planning, and monitoring is likely a major factor in the deficiencies I have cited. It also accounts for a pattern in

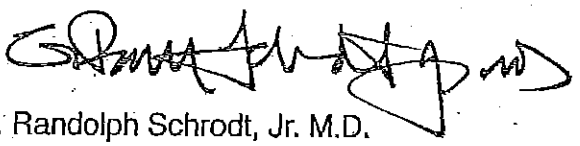
these cases for Dr. Williams to employ a standardized drug regimen of citalopram, trazodone, propranolol, and alprazolam in the majority of the cases.

Regular use of high dose benzodiazepines

In standard psychiatric practice, there is a great deal of individual variation in the dose of alprazolam (and benzodiazepines in general) that is necessary to achieve adequate therapeutic response in anxiety disorders. However, it is standard practice to begin with low doses and gradually titrate the dose as clinically indicated. Dr. Williams typically began the patients that I reviewed at a dose of 3 to 4mg per day, generally considered a high dose. In some cases, he further increased the dose to 6mg per day. Although there are patients that may require this dose, these higher doses are associated with a much greater risk of psychological and physical dependence, and abrupt discontinuation may be associated with very severe abstinence syndromes, including seizures and death, particularly when taken in combination with other CNS depressants. It is also standard practice for the dose of benzodiazepine to be reduced when the anxiety symptoms are stabilized. I did not identify any cases when the dose of benzodiazepine was reduced.

With regards to the specific questions in your letter:

1. I do not believe that Dr. Williams "prescribed or dispensed medication(s) with the intent or knowledge that the medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose."
2. It is my opinion that Dr. Williams prescribed or dispensed medication(s) in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amount(s) so prescribed or dispensed were excessive under accepted and prevailing medical practice standards."
3. It is my opinion that Dr. Williams "engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky."
4. Based on the sampling of cases I reviewed, it is my opinion that Dr. Williams demonstrated "a pattern of acts during the course of the physician's medical practice, which under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice."



G. Randolph Schrodt, Jr. M.D.
Distinguished Fellow,
American Psychiatric Association
Past President,
Kentucky Psychiatric Association
Past President,
Greater Louisville Medical Society
Associate Clinical Professor,
Dept. of Psychiatry & Behavioral Sciences,
University of Louisville School of Medicine

COMMONWEALTH OF KENTUCKY
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IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWALTH OF KENTUCKY HELD BY MELBORNE A. WILLIAMS, M.D., LICENSE NO. 17071, 106 EAST LEXINGTON AVENUE, DANVILLE, KENTUCKY 40422-1518

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, considered this matter at its June 21, 2012, meeting. At that meeting, Inquiry Panel A considered a memorandum by Doug Wilson, Medical Investigator; Investigative Reports from the Office of the Inspector General, Division of Audits and Investigations, Cabinet for Health and Family Services, dated October 20, 2011 and March 12, 2012; correspondence from Danny L. Finley, Clay County Coroner, to Kevin Johnson, Clay County Sheriff, dated February 6, 2012; correspondence from Danny L. Finley, Clay County Coroner, to Jimmy Smith, Clay County Deputy Sheriff, dated February 18, 2012, including post-mortem toxicology report regarding Patient A; correspondence from Danny L. Finley, Clay County Coroner, to Billy Madden, Medical Investigator, undated; Report of the Clay County Coroner regarding Clay County Drug Deaths in 2011, dated January 27, 2012; post-mortem toxicology reports of Patients B through L; emergency department physician notes regarding Patient D, dated December 30, 2011; certificates of Death for Patients B and E through J; correspondence from Danny L. Finley, Clay County Coroner, to Doug Wilson, Medical Investigator, dated February 23, 2012; correspondence from Danny L. Finley, Clay County Coroner, to Chief of Police, City of Manchester, dated April 13, 2011; Clay County EMS Patient Care Report regarding Patient K, dated March 29, 2011; correspondence from the

licensee's counsel, James E. Smith, to Doug Wilson, Medical Investigator, dated November 28, 2011, March 9, 2012, March 20, 2012 and May 16, 2012; Investigative Physician Profile/Background, faxed November 28, 2011; a Board Consultant report, dated May 28, 2012; a Letter of Admonishment from the Board to the licensee, dated August 31, 2004; and certifications that the licensee attended a Continuing Medical Education Course entitled *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center on January 19-21, 2005 and on June 6-8, 2012. The licensee and his counsel were present at the Panel's June 21 meeting and were heard by the Panel before the Panel chose to take action in this matter.

Having considered all of this information and being sufficiently advised, Inquiry Panel A ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Suspension:

1. At all relevant times, Melborne A. Williams, M.D., ("the licensee") was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is psychiatry.
3. In or around September or October 2011, Chris Johnson, R.Ph., an investigator with the Drug Enforcement and Professional Practices branch of the Office of Inspector General of the Cabinet for Health and Family Services ("Drug Enforcement")

reported to the Board that several informants in Drug Enforcement cases had identified the licensee as a reliable source for Xanax.

4. On or about October 20, 2011, at the Board's request, Drug Enforcement analyzed the licensee's prescribing patterns and referred twenty (20) patient names for further review, based upon patient ages, similar past names, polypharmacy, addictive drug combinations and distance traveled. The Board subpoenaed and obtained the patient records of these twenty (20) patients from the licensee on or about November 14, 2011.

5. The Board's Medical Investigator, Doug Wilson, interviewed Stuart W. Larson, M.D., who stated substantially as follows: in or around June 2011, he began practicing at CentEx in Danville, Kentucky, where the licensee also practiced; he noticed that car loads of patients would come from various places in the state to see the licensee, so that the parking lot, waiting areas and outside areas were full; patients complained to him that "junkies" were hanging around the practice; there were discussions among patients as to what and how much they were being prescribed and how much money could be charged on the street for Xanax pills; a child was heard asking, "Mommy, do you want me to pee in a cup again?"; when covering for the licensee and seeing the licensee's patients, Dr. Larson noticed that the licensee's patients were receiving high doses of Xanax, 3-5 per day and sometimes 6mg per day, regardless of diagnosis and that the Xanax was often prescribed as part of a "cocktail" with other controlled substances, including Trazadone; and Dr. Larson reported his concerns about the licensee's practices to Bryan Wood, M.D., an owner of CentEx.

6. The Board's Medical Investigator, Doug Wilson, interviewed CentEx owner, Bryan Wood, M.D., who stated substantially as follows: when hired, the licensee brought many of his established private practice patients with him into the CentEx practice; after several weeks, Dr. Larson approached him with concerns about how the practice was evolving due to the licensee's practices, including the prescribing of large amounts of Xanax along with a "cocktail" of Seroquel, Klonopin and Trazadone; after Dr. Larson expressed concerns regarding the licensee's practice, Dr. Wood reviewed the licensee's patient charts and found that approximately 97% of the licensee's patients were receiving high doses of Xanax and a "cocktail" of other controlled substances; Dr. Wood met with the licensee about his practices but when it became clear that an ongoing relationship was not going to work out, the licensee was terminated from CentEx.

7. In December 2011, Billy Madden, Medical Investigator, received a call from a woman who stated that she was a nurse at Manchester Memorial Hospital but refused to give her name; according to the caller, she was seeing a trend with Xanax overdoses in the Clay County community and that several of the overdoses were patients of the licensee.

8. In January 2012, Clay County Sheriff, Kevin Johnson, contacted Billy Madden, Medical Investigator, and reported that several of the licensee's patients had died of overdose in Clay County and that several confidential informants and drug case witnesses had identified the licensee as a known source for Xanax.

9. Also in January 2012, Clay County Coroner, Danny Finley, contacted Billy Madden, Medical Investigator, and reported that he had worked several overdose deaths in

Clay County and that many of the deceased were the licensee's patients. Based upon the Coroner's information, the Board subpoenaed and obtained the medical records of eleven (11) of the licensee's patients who had overdosed in Clay County.

10. In February 2012, Clay County Coroner, Danny Finley, reported to the Board that another patient of the licensee, Patient MH, had overdosed in Clay County. The medical records of Patient A and her husband, Patient B, were subpoenaed and obtained from the licensee.

11. In March 2012, at the Board's request, the Drug Enforcement and Professional Practices Branch of the Office of Inspector General, analyzed the licensee's prescribing of Alprazolam (Xanax) and found him to be the #1 prescriber of Alprazolam in the Commonwealth of Kentucky, with 1,351,745 dosage units on 12,622 prescriptions recorded from April 1, 2011 through March 12, 2012.

12. In May 2012, a Board consultant reviewed the thirty-two (32) patient charts obtained from the licensee and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices in the diagnosis and treatment of patients; that the licensee prescribed or dispensed medications in such amounts that he knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under acceptable and prevailing medical practice standards; and that the licensee committed a pattern of acts during the course of his medical practice which, under the attendant circumstances, demonstrate gross incompetence, gross ignorance, gross negligence or malpractice.

Specifically, the Board consultant noted the following:

- There was no documentation in the patient charts of informed consent regarding the potential risks of the use of controlled substances, especially in combination with other prescribed or illicit drugs;

- There was inadequate documentation of patients' past medical history or concurrent medications/therapies prescribed by other physicians, even when those might have potentially serious interactions with the licensee's prescriptions;

- There was inadequate documentation of patients' past or current substance abuse history or treatment. Even where illicit substances were present on intake drug screens, these were not noted in the chart;

- Although the licensee indicated to the Board that he performed regular KASPER checks on his patients, only one chart had a notation that a KASPER was checked after his office received calls about a patient going to multiple doctors. KASPER reports on the patients who had died of overdoses in Clay County revealed obvious patterns of aberrant behavior which should have been detected and addressed by the licensee if he had performed KASPER reviews, including patients getting opiate prescriptions from more than one provider (in one case as far away as Atlanta), using multiple pharmacies, and being prescribed CNS depressants by other (often multiple) physicians;

- The licensee did not meet the standard of care when he prescribed benzodiazepines to patients with histories of addiction to alcohol or other substances - without first requiring the use of alternative, non-addictive medications or cognitive therapy, without closely monitoring that the patient is engaged in a recovery program, and without prescribing the lowest effective dose for the shortest possible period. As an example, the Board consultant noted one case in which the licensee restarted Xanax in an adolescent, Patient M, even after that patient was psychiatrically hospitalized and discharged with a diagnosis of Xanax abuse and had been taken off Xanax during hospitalization. In addition, Patient M was prescribed Paxil in spite of a black box warning about the use of that medication in adolescents;

- Although the licensee regularly obtained urine drug screens on his patients, there was a pattern of failure to follow-up or document intervention or modification of treatment plans as a result of those drug screens. 25 of the 32 reviewed charts demonstrated aberrant behavior, including the absence of prescribed medications or presence of non-prescribed controlled substance medications;

- The licensee prescribed in a manner which placed patients at risk of potentially serious drug interactions or other adverse health consequences.

For example, two patients with documented histories of asthma were prescribed propranolol; there were multiple cases in which patients were on benzodiazepines and opiates; and several patients were prescribed doses of citalopram greater than 40mg qD, even after an FDA alert of August 2011 regarding the risk of cardiac events at such higher doses;

- A review of patient encounter records revealed that the licensee saw, on average, 41.5 patients per day at CentEx – more than double the number of patients seen by each of the other two CentEx psychiatrists, even though they worked two more hours per day than the licensee. Also, in October 2011, after he had left CentEx and was in private practice, he saw an average of 42.7 patents per day. This patient load is at least twice what the average psychiatrist would see on a typical day, even in a busy community mental health center with other physician extenders available;

- The licensee deviated from acceptable and prevailing medical practices when he began patients on and maintained patients on high doses of benzodiazepines, instead of beginning patients on lower doses and then titrating the doses up if clinically indicated or titrating doses down when anxiety symptoms stabilized.

The consultant's report is attached hereto and incorporated herewith in its entirety.

13. The Panel finds and concludes that controlled substances are controlled and regulated by the General Assembly because they are, by their very nature, dangerous if not managed appropriately. Controlled substances present a danger to the health, welfare and safety of patients if they are not prescribed or are not taken in an appropriate manner. Controlled substances also create a danger to the health, welfare and safety of the public if they are diverted for illegal sale and/or use. To that end, the Board has issued an opinion which reflects appropriate and safe practices by which to provide controlled substances to patients. (Opinion Regarding the Use of Controlled Substances in Pain Treatment, *published* 10/10/08). The Panel specifically finds and concludes that the prescribing of controlled substances to patients creates a danger to the public health, safety and/or welfare, if a physician prescribes such substances in a manner inconsistent with the board's opinion.

14. In 2004, the Board issued a Letter of Admonishment to the licensee based upon his prescribing to himself and/or his family. In that letter, the Board recommended that the licensee attend a Continuing Medical Education Course entitled *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center.

15. On January 19-21, 2005, the licensee attended and completed the *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center. The content of the course included components dealing with improving practice management, dealing with problem patients, exploration of personality traits that influence prescribing practices, and critical issues in pharmacological management of patient complaints.

16. On June 6-8, 2012, in anticipation of the Panel's review of the 2011-2012 investigation as described above, the licensee again attended and completed the *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center.

17. On June 21, 2012, the Panel reviewed the investigation. The licensee and his counsel appeared before the Panel and were heard.

18. When asked by the Panel, the licensee initially could not recall having completed the *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls* at Vanderbilt University Medical Center previously in 2005; he later stated that he believed that he had completed a course in 2001.

19. Simultaneous to the issuance of this Emergency Order of Suspension, the Panel ordered the licensee to submit to a neuropsychological evaluation.

20. The licensee's failure to conform to or comply with acceptable and prevailing practices in the diagnosis and treatment of patients prescribed controlled substances, as described above, and the licensee's inability to be effectively reeducated on the prescribing of controlled substances, demonstrates that the licensee is unable to practice medicine safely.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4).
4. The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
5. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a

physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general. Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.

6. The United States Supreme Court has ruled that it is not a violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and 2) the statute provides for a prompt post-deprivation hearing. *Barry v. Barchi*, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); *FDIC v. Mallen*, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and *Gilbert v. Homar*, 117 S.Ct. 1807 (1997). *Cf.* KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Melborne A. Williams, M.D., is SUSPENDED and Dr. Williams is prohibited from performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

Inquiry Panel A further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee or his counsel.

SO ORDERED this 26th day of June, 2012.

C. William Briscoe MD.

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed via certified mail return-receipt requested to the licensee, Melborne A. Williams, M.D., 106 E. Lexington Avenue, Danville, Kentucky 40422-1518; and a copy was sent electronically and via first-class mail to the licensee's counsel, James E. Smith and David B. Gazak, 3220 Office Pointe Place, Suite 200, Louisville, Kentucky 40220 on this 26th day of June, 2012.

Leanne K. Diakov

Leanne K. Diakov
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

Integrative Psychiatry

RECEIVED
MAY 29 2012
K.B.M.L.

May 28, 2012

Mr. Doug Wilson
Medical Investigator
Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RE: Consultation on Melbourne Williams, M.D., Grv. #11739

Dear Mr. Wilson:
The following is my report on the grievance regarding Melbourne Williams, M.D. I have reviewed the information in your Investigation Report, as well as the 15 Exhibits and 32 patient charts you provided.

Selection of charts reviewed
I reviewed a total of 32 patient charts. This was not a random sampling of Dr. Williams' patient population. 22 charts were identified by an Investigative Report by the Cabinet for Health and Family Services, Office of the Inspector General, based on a review of KASPER. These charts were selected "based on age, similar last names, polypharmacy, addictive drug combinations, and distance traveled." Additionally, 10 patients were identified by the Clay County Coroner. These patients were all deceased within the past year, and all had multiple drugs in their system on postmortem toxicology that was considered a factor in their deaths. The coroner wrote: "My concern specifically is, at risk individuals are being treated by multiple physicians, primary care, pain management and psychiatry. Each appears to be prescribing without regard to the others recommendations. There seems to be total disregard for the addictive properties of many medications. In addition to commonly abused benzodiazepines and opiates, many other medications with CNS depressant qualities are being prescribed in combination."

Summary of opinions:
a. Diagnosis
The majority of patient charts contained relatively sparse documentation regarding diagnosis beyond "depression" or "panic anxiety." There were several patients with a diagnosis of bipolar depression, "OCD," "PTSD," or "ADD," but the basis of those diagnoses was not recorded in the medical record. Past psychiatric history was poorly documented, and no standardized scales or diagnostic instruments were used. As

EXHIBIT # 9

detailed below, there was a paucity of information in the chart regarding past or concurrent medical and substance abuse history. It is my opinion that this falls below minimum standard.

b. Treatment

As detailed below, it is my opinion that "use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction" fell below minimum standards.

c. Record-keeping

Overall, it is my opinion that Dr. Williams' medical record keeping was "within minimum standards." There appears to be a chart entry for each office visit, and photocopies of each written prescription for both controlled and non-scheduled medications. A checklist-style office note template was used, but additional notes were minimal.

d. My overall opinion is that the treatment provided in these cases clearly falls below minimum standards.

Basis of Opinions:

No documentation of informed consent regarding risks of controlled substance

There is no documentation in the chart of any written or verbal informed consent regarding the potential risks of the use of controlled substances, especially in combination with other prescribed or illicit drugs.

Inadequate documentation of past medical history

Beyond an occasional notation of "LBP" (low back pain) or other medical condition, the patient's past medical and psychiatric history was very sparse. Most importantly, there was minimal, if any, documentation of concurrent medications or therapies prescribed by other physicians, even when those might have potentially serious interactions with Dr. Williams' prescriptions.

Lack of detailed substance abuse history and evaluation

There was no documentation of past or current substance abuse history or treatment beyond an occasional notation of "suboxone clinic." No screening instruments, except for a few questions on the initial intake form, were apparently used. Even when illicit substances were present on intake drug screens, these were not noted in the chart. There was no documentation of referral for AA/NA or other substance abuse evaluation or treatment, even in patients with obvious problems.

Monitoring of patient compliance

Dr. Williams did not do phone refills or refills without an office visit. His initial prescription of Xanax was usually only for a month. Subsequent prescriptions usually included one refill.

Although in his responses to KBML Dr. Williams reported doing regular KASPER checks, only one chart had a notation that KASPER was checked after his office received calls about a patient going to multiple doctors. That patient was dismissed from his practice. The accompanying Exhibit 15 was apparently a report of 11 patients who Dr. Williams had checked KASPER. This included the 10 patients who were deceased

and identified in the grievance filed by the Clay County Coroner; they were also all dated "2/24/2012" and I cannot determine if they were checked during the course of usual treatment. According to his lawyer's letter in response to the grievance proceedings, Dr. Williams had checked the 11th patient's KASPER, but had no record of that person having been his patient. Of the 10 patients, 6/10 would be considered aberrant. This would include patients getting opiate prescriptions from more than one provider (in one case as far away as Atlanta), using multiple pharmacies, and being prescribed CNS depressants by other (often multiple) physicians that would warrant modification of treatment. There was no documentation in the medical records regarding these matters.

Use of benzodiazepines in patients with past or current substance abuse/ dependence

As mentioned above, there was minimal documentation in the patient charts of a thorough history and evaluation of substance abuse and dependence problems, risk factors, and past and current treatment. However, on the brief intake form a number of patients described themselves as "in recovery," and others were noted to be in Suboxone programs for opiate dependence.

The use of benzodiazepines in a patient with a history of addiction to alcohol or other substances is somewhat controversial. Although some conservative addiction specialists would say it is never appropriate, most psychiatrists and accepted practice guidelines suggest that it may be safe and effective in selected patients with severe anxiety disorders. However, even in these rare situations, it would require that alternative, non-addictive medications were first tried, as well as options such as cognitive therapy. It would also be critical that the patient be closely monitored and be actively engaged in a recovery program, and that benzodiazepines be prescribed in the lowest effective dose, for the shortest possible period. It is my opinion that Dr. Williams did not meet this standard of care.

As an example of this prescribing pattern, Dr. Williams restarted Xanax in adolescent (VG) even after that patient was psychiatrically hospitalized and discharged with a diagnosis of Xanax abuse and had been taken off Xanax during hospitalization. According to the discharge summary, she was reportedly snorting Xanax that had been smuggled onto the psych unit, and was sharing it with peers. Following discharge, and while prescribed benzodiazepines, this adolescent also had urine drug screens indicating the presence of opiates, as well as methadone. The patient was also prescribed Paxil in spite of black box warning about use of that medication in adolescents. This is particularly pertinent in this adolescent who was admitted to the hospital because of cutting behaviors.

Failure to follow-up on aberrant drug screens

Dr. Williams regularly obtained urine drug screens on his patients. However, there was a pattern of failure to follow-up or document intervention or modification of treatment plan as a result of those drug screens. 25 of the 32 patient charts reviewed would be classified as aberrant. These include the absence of a prescribed drug in the screen (usually benzodiazepine, but also one case of stimulant prescription), the presence of other controlled substances that were not noted on the chart (most often opiates), and

the presence of metabolites of benzodiazepines that were not prescribed by Dr. Williams (metabolites of clonazepam rather than alprazolam). 25% of the charts included drug screens that were positive for THC, and on a few occasions that was noted in the chart with "advised to d/c." Two of the 32 patients were dismissed by Dr. Williams for non-compliance with recommended treatment, based in part on the results of the drug screens. It is possible that some of the controlled substances present in the urine toxicology screens were legitimately prescribed by another physician. For example, a number of patients reportedly had histories of chronic pain syndromes. However, these problems and prescribed therapies would have important implications for drug interactions, and were not documented in the medical record. In the majority of the cases, it is most likely that these patients were not legitimately prescribed these drugs because of the combinations found, e.g., barbiturates, opiate combination such as buphenorphrine (used for opiate detoxification)+oxycodone and other opiates, amphetamines, tramadol, have no legitimate medical indication and carry significant risks of toxicity.

Incidents of potentially serious drug interactions

Two patients were prescribed propranolol who had documented histories of asthma. A number of patients showed methadone on urine drug screen, but the dose of benzodiazepine was not modified. Although not absolute contraindications, there were a number of medication combinations with potentially serious drug-drug interactions that were not noted or explained in the medical record, e.g., mirtazapine+alprazolam, tramadol+citalopram, as well as multiple cases of benzodiazepines+opiates. Several patients were prescribed doses of citalopram greater than 40mg qD, even after the FDA alert of August, 2011, regarding risk of cardiac events at higher doses.

Inadequate time to complete adequate evaluations and management of patients due to extremely high case load

A review of Dr. Williams' patient encounter records at the CenTex office (06/06/2011 to 07/08/2011) indicates that he saw an average of 41.5 patients per day. By contrast, the records of the two other psychiatrists in the clinic showed they saw 20.2 and 17.5 patients per day, even though they saw patients two more hours per day. The patient schedule was set for 15 minute appointment slots, and were typically double or triple booked, indicating that Dr. Williams' total encounter time was five to seven minutes per patient.

A review of Dr. Williams' patient encounter records at his Bluegrass Psychiatry office (10/01/2011 to 10/31/2011) indicated he was averaging 42.7 patients per day. Based on my experience, this patient load is at least twice what the average psychiatrist would see on a typical day, even in a busy community mental health center with other physician extender providers available.

While there are certainly stable, long-term patients that can be adequately managed in a 5-minute checkup appointment, it is my opinion that this is inadequate for most psychiatric patients with severe symptoms and medical and chemical dependency comorbidities. This lack of time for evaluation, treatment planning, and monitoring is likely a major factor in the deficiencies I have cited. It also accounts for a pattern in

these cases for Dr. Williams to employ a standardized drug regimen of citalopram, trazodone, propranolol, and alprazolam in the majority of the cases.

Regular use of high dose benzodiazepines

In standard psychiatric practice, there is a great deal of individual variation in the dose of alprazolam (and benzodiazepines in general) that is necessary to achieve adequate therapeutic response in anxiety disorders. However, it is standard practice to begin with low doses and gradually titrate the dose as clinically indicated. Dr. Williams typically began the patients that I reviewed at a dose of 3 to 4mg per day, generally considered a high dose. In some cases, he further increased the dose to 6mg per day. Although there are patients that may require this dose, these higher doses are associated with a much greater risk of psychological and physical dependence, and abrupt discontinuation may be associated with very severe abstinence syndromes, including seizures and death, particularly when taken in combination with other CNS depressants. It is also standard practice for the dose of benzodiazepine to be reduced when the anxiety symptoms are stabilized. I did not identify any cases when the dose of benzodiazepine was reduced.

With regards to the specific questions in your letter:

1. I do not believe that Dr. Williams "prescribed or dispensed medication(s) with the intent or knowledge that the medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose."
2. It is my opinion that Dr. Williams prescribed or dispensed medication(s) in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amount(s) so prescribed or dispensed were excessive under accepted and prevailing medical practice standards."
3. It is my opinion that Dr. Williams "engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky."
4. Based on the sampling of cases I reviewed, it is my opinion that Dr. Williams demonstrated "a pattern of acts during the course of the physician's medical practice, which under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence or malpractice."

G. Randolph Schrodt, Jr. M.D.
Distinguished Fellow,
American Psychiatric Association
Past President,
Kentucky Psychiatric Association
Past President,
Greater Louisville Medical Society
Associate Clinical Professor,
Dept. of Psychiatry & Behavioral Sciences,
University of Louisville School of Medicine

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1411

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY MELBORNE A. WILLIAMS, M.D., LICENSE NO. 17071, 106 EAST LEXINGTON AVENUE, DANVILLE, KENTUCKY 40422-1518

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Hearing Panel B, and Melbourne A. Williams, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally resolve the pending Complaint without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Indefinite Restriction:

1. At all relevant times, Melborne A. Williams, M.D., ("the licensee") was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is psychiatry.
3. In or around September or October 2011, Chris Johnson, R.Ph., an investigator with the Drug Enforcement and Professional Practices branch of the Office of Inspector General of the Cabinet for Health and Family Services ("Drug Enforcement") reported to the Board that several informants in Drug Enforcement cases had identified the licensee as a reliable source for Xanax.
4. On or about October 20, 2011, at the Board's request, Drug Enforcement analyzed the licensee's prescribing patterns and referred twenty (20) patient names for further