COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, SS.

BOARD OF REGISTRATION
IN MEDICINE

ADJUDICATORY NO. 2009-011

In the Matter of

Claude Curran, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Claude Curran, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice, as set forth herein. The investigative docket numbers associated with this order to show cause are 03-095, 03-464, 03-634, and 04-086.

BACKGROUND INFORMATION

1. The Respondent was born on September 15, 1953.

2. The Respondent graduated from the University of Rome Medical School in Italy in 1991.

3. The Respondent's specialty is psychiatry.

4. The Respondent is not certified by any member Board of the American Board of Medical Specialties.

5. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 157979 since October 7, 1998.

6. The Respondent is also licensed to practice medicine in Rhode Island and Florida.

7. The Respondent has privileges at the Dr. John C. Corrigan Mental Health Center in Fall River, Massachusetts; the Pocasset Mental Health Center; and Taunton State Hospital.

8. The Respondent has not received any specialized training in addiction medicine.

9. The Respondent has a private practice in Fall River, Massachusetts.

10. The Respondent's patient population is comprised mostly of people with substance abuse problems.

FACTUAL ALLEGATIONS

11. In 2003, the Respondent received a waiver from the Substance Abuse and Mental Health Services Administration to practice opioid addiction therapy with approved Schedule III, IV, or V narcotics pursuant to the Drug Addiction Treatment Act of 2000 (DATA 2000).

12. The approved narcotics for treatment of opiate addiction under DATA 2000 are Subutex and Suboxone.

13. Subutex contains only buprenorphine and is intended for use at the beginning of treatment for drug abuse.

14. Subutex has no opiate antagonistic properties.

15. Suboxone contains both buprenorphine and the opiate antagonist naloxone and is intended to be the formulation used in maintenance treatment of opiate addiction.

16. If mixed with opiates, Suboxone will induce opiate withdrawal.

17. Symptoms of withdrawal can include restlessness, muscle and bone pain, insomnia, diarrhea, nausea, vomiting, cold flashes with goose bumps ("cold turkey"), and involuntary leg movements.

18. Prior to December 2006, a physician providing medication-assisted opioid treatment under DATA 2000 could treat up to 30 patients on such addiction treatment at any one time.

19. In 2004, the Respondent admitted in a letter to the Substance Abuse and Mental Health Services Administration of the U.S. Public Health Service that he was treating patients in excess of the then 30-patient limit under DATA 2000.

20. In December 2006, DATA 2000 was amended to allow physicians providing medication-assisted opioid treatment for one year or longer to seek permission to treat up to 100 patients at any one time.

21. In January 2007, the Respondent sought and was granted permission to treat up to 100 patients at any one time.

22. On or about May 25, 2005, the U.S. Drug Enforcement Agency (DEA) sent a Letter of Admonition to the Respondent for his failure to maintain the thirty patient limit under DATA 2000, in violation of Title 21 of the United States Code § 823(g)(2)(E)(i).

23. The Respondent was treating approximately 120 patients with buprenorphine during the month of August 2005.

24. The Respondent was treating approximately 70 patients with buprenorphine as of September 30, 2005.

25. In January 2006, the Respondent was treating approximately 55 patients with buprenorphine.

26. The Respondent exceeded the maximum patient load under DATA 2000 during the period of January 2007 through March 2007.

27. The Respondent exceeded the maximum patient load under DATA 2000 during the period of April 2007 through June 2007.

28. The Respondent exceeded the maximum patient load under DATA 2000 during the period of July 2007 through September 2007.

29. The Respondent exceeded the maximum patient load under DATA 2000 during the period of October 2007 through December 2007.

30. The Respondent exceeded the maximum patient load under DATA 2000 during the period of January 2008 through March 2008.

31. The Respondent exceeded the maximum patient load under DATA 2000 during the period of April 2008 through June 2008.

32. On or about December 11, 2003, the Board received a letter from the Chief Executive Officer of Habit Management, Inc.

33. Habit Management, Inc. (HMI) is a narcotic treatment program.

34. The Chief Executive Officer of Habit Management, Inc. reported that, on two separate cases, the Respondent knowingly administered Suboxone to patients who were in Methadone treatment.

35. Methadone is a synthetic opioid that blocks the effects of heroin and other prescription drugs containing opiates.

36. On or about January 29, 2004, the Board received a copy of a letter that had been written directly to the Respondent by the Medical Director of SSTAR in Fall River.

37. SSTAR provides mental health and substance abuse treatment services.

38. The Medical Director of SSTAR was concerned that SSTAR was seeing increasing numbers of addicted patients receiving benzodiazepines from the Respondent.

39. The Medical Director of SSTAR noted that five of the nine patients receiving treatment at SSTAR were receiving benzodiazepines from the Respondent.

40. Benzodiazepines are central nervous system (CNS) depressants.

41. CNS depressants slow normal brain function. In higher doses, some CNS depressants can be used as general anesthetics or pre-anesthetics.

42. Benzodiazepines are prescribed to treat anxiety, acute stress reactions, panic attacks, convulsions, and sleep disorders.

43. For sleep disorders, benzodiazepines are usually prescribed only for short-term relief of sleep problems because of the development of tolerance and risk of addiction.

44. Some benzodiazepines have a synergistic effect when mixed with opiates, including Methadone.

45. CNS depressants should not be combined with any medication or substance that causes drowsiness, including prescription pain medicines, certain over-the-counter cold and allergy medications, or alcohol. If combined, they can slow both the heart and respiration, which can be fatal.

46. Long-term use of opioids or CNS depressants can lead to physical dependence and addiction.

47. On or about October 20, 2006, the Board received a letter from the Medical Director of HMI in Fall River.

48. The Medical Director of HMI met with patients treated at HMI for opiate dependence.

49. Many of the patients that the Medical Director of HMI met with were patients of the Respondent.

50. The Medical Director of HMI reported that it was not unusual for patients who were actively abusing benzodiazepines to suddenly produce new prescriptions for benzodiazepines from the Respondent.

51. If it appeared that a patient of the Respondent was abusing benzodiazepines, the Medical Director of HMI generally would have called the Respondent or had a counselor call the Respondent to relay that information.

52. Over the years, the Medical Director of HMI made numerous phone calls to the Respondent's office and found him to be increasingly inaccessible.

53. The Respondent tried to convince the Medical Director of HMI that Xanax was no different than a glass of wine when administered to a patient receiving addiction treatment.

54. Xanax is a benzodiazepine.

55. On or about November 16, 2006, the Medical Director of HMI requested from the Respondent a written response addressing the Respondent's treatment plan for several patients who were receiving Methadone treatment from HMI and benzodiazepines from the Respondent.

56. On or about October 5, 2006, the Medical Director of HMI noted that he met with HMI Patient #1 "to discuss ongoing illicit benzo[diazepine] use."

57. HMI Patient #1 was taking Xanax in addition to the Klonopin that the Respondent was prescribing.

58. Klonopin is a benzodiazepine.

59. On or about October 19, 2006, the Respondent changed HMI Patient #1's prescription for Klonopin to Xanax.

60. HMI Patient #1 was also receiving Percocet from his primary care physician.

61. Percocet, or oxycodone, is a Schedule II controlled substance and is also a legitimately prescribed drug indicated for the management of extreme pain.

62. Percocet was not present on HMI Patient # 1's toxicology screens.

63. The Medical Director of HMI suspected diversion of Percocet by HMI Patient #1.

64. HMI Patient #1 had agreed to address his benzodiazepine abuse with the Respondent.

65. On or about November 16, 2006, toxicology screens for HMI Patient #2 were positive for benzodiazepines other than Klonopin.

66. At least one toxicology screen for HMI Patient #2 detected lorazepam (Ativan).

67. Ativan is a benzodiazepine.

68. HMI Patient #2 was receiving prescriptions for Klonopin from the Respondent.

69. HMI Patient #2 denied using benzodiazepines other than Klonopin.

70. The Medical Director of HMI notified the Respondent about HMI Patient #2's toxicology screens.

71. On or about November 16, 2006, toxicology screens for HMI Patient #3 were positive for benzodiazepines other than Klonopin.

72. HMI Patient #3 was receiving prescriptions for Klonopin from the Respondent.

73. HMI Patient #3 admitted to taking extra Klonopin on some days and then running out early, forcing him to find additional Klonopin or Valium on the street.

74. HMI Patient #3 admitted to the Medical Director of HMI that he was supplementing or substituting his Klonopin with Valium.

75. Valium is a benzodiazepine.

76. HMI Patient #3 had a poor understanding of the risk of overdose while abusing benzodiazepines and on opiate agonists.

77. The Medical Director of HMI notified the Respondent about HMI Patient #3's toxicology screens.

78. On or about November 30, 2006, the Medical Director of HMI resent the request referenced in paragraph 55 to the Respondent because he had not yet responded in writing.

79. Board staff met with the Respondent on several occasions between 2005 and 2008.

80. In 2005, the Respondent admitted to Board staff that he did not keep an inventory log for the samples he dispensed.

81. Board staff asked the Respondent to bring his inventory logs to the meeting scheduled on or about August 1, 2006.

82. The Respondent did not bring his inventory logs to the meeting scheduled on or about August 1, 2006 because he did not keep inventory logs.

83. On or about October 26, 2006, the Respondent admitted to Board staff that he had about 180 patients on Suboxone.

84. On or about October 26, 2006, the Respondent admitted to Board staff that he told his patients he was reducing his prescriptions for benzodiazepines because he was under investigation.

85. The protocol taught at the training that the Respondent took for his certification in opioid addiction treatment under DATA 2000 included performing a physical examination, obtaining informed consent and profiling patients in order to determine who was a good candidate for treatment.

86. The Respondent does not conduct physical examinations on the patients he treats for opioid dependence.

Board Guidelines and Policies:

87. On August 1, 1989, the Board adopted Policy 89-01, *Prescribing Practices Policy and Guidelines*.

88. Policy 89-01 was amended on December 12, 2001.

89. The Respondent did not follow Policy 89-01.