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.

90. On December 15, 2004, the Board adopted the *Model Policy for the Use of Controlled Substances for the Treatment of Pain* issued by the Federation of State Medical Boards of the United States, Inc.

91. The Respondent did not follow the *Model Policy for the Use of Controlled Substances for the Treatment of Pain.*

Patient 1:

92. Patient 1 was an adult female who saw the Respondent from approximately April 1999 through approximately March 2007.

93. The Respondent diagnosed Patient 1 with Anxiety.

94. The Respondent did not diagnose Patient 1 with Opioid Dependence.

95. In 1999, the Respondent noted that Patient 1 had been on Valium for 5 years.

96. The Respondent prescribed Valium to Patient 1 between 1999 and 2007.

97. In 2004 and 2005, the Respondent prescribed Vicodin and Percocet to Patient 1 for complaints of pain.

98. Vicodin, or hydrocodone, is a Schedule III controlled substance and is also a legitimately prescribed drug indicated for the management of moderate to severe pain.

99. In 2004 and 2005, the Respondent continued to prescribe Valium to Patient 1.

100. On or about June 24, 2004, the Respondent noted that Patient 1 had undergone right-shoulder surgery.

101. The Respondent began prescribing Vicodin to Patient 1 on or about June 28, 2004.

102. Sometime between February 2006 and March 2006, the Respondent gave Patient 1 a trial of Suboxone for a reason other than opioid addiction treatment.

103. On or about March 6, 2006, Patient 1 complained of nausea with Suboxone.

104. On or about March 6, 2006, the Respondent changed Patient 1's Suboxone to Subutex for a reason other than opioid addiction treatment.

105. Patient 1 was using Fentanyl patches at the time the Respondent prescribed Suboxone and Subutex for complaints of pain.

106. Fentanyl is an opiate (narcotic) analgesic used to relieve moderate to severe pain that is expected to last for some time, that does not go away, and that cannot be treated with other pain medications.

107. The Respondent knew that Patient 1 was receiving pain medication from other treatment providers.

108. The Respondent never spoke to Patient 1's surgeon or other treatment providers.

109. The Respondent did not perform a physical examination on Patient 1 prior to prescribing controlled substances for complaints of pain.

110. The Respondent did not perform any tests to determine Patient 1's need for Percocet or Vicodin.

111. The Respondent did not complete an adequate medical history addressing the nature of Patient 1's complaints of pain.

112. The Respondent did not assess Patient 1's risk of addiction to Vicodin and Percocet.

113. The Respondent did not coordinate Patient 1's treatment with her other healthcare providers.

114. The Respondent did not explore appropriate alternatives to drug therapy for Patient 1.

115. The Respondent did not refer Patient 1 to a pain clinic.

116. The Respondent did not obtain or monitor objective evidence of Patient 1's improved or diminished function.

117. The Respondent failed to monitor adequately his treatment of Patient 1 with Suboxone and Subutex.

118. The Respondent inappropriately prescribed Vicodin and Percocet to Patient 1.

119. The Respondent inappropriately prescribed Suboxone to Patient 1.

120. The Respondent inappropriately prescribed Subutex to Patient 1.

121. The Respondent's medical records for Patient 1 are inadequate.

122. The Respondent's care of Patient 1 was substandard.

Patient 2:

123. Patient 2 was an adult female who saw the Respondent from approximately January 2002 through approximately October 2006.

124. The Respondent diagnosed Patient 2 with Post Traumatic Stress Disorder.

125. The Respondent first saw Patient 2 on or about January 17, 2002.

126. On or about January 17, 2002, Patient 2 reported to the Respondent that she was taking Prozac 80 mg and had poor effect from Xanax.

127. Prozac is selective serotonin reuptake inhibitor.

128. On or about January 17, 2002, the Respondent prescribed Klonopin and Seroquel to Patient 2 and continued her on Prozac.

129. Seqroquel is an atypical antipsychotic.

130. In February 2002, a representative from the Department of Social Services notified the Respondent that Patient 2 was abusing benzodiazepines and opiates.

131. On or about May 13, 2002, the Respondent prescribed Vicodin to Patient 2.

132. At various times in 2005, Patient 2 complained of back and abdominal pain, arthritis, and headaches.

133. At various times in 2005, the Respondent prescribed Vicodin to Patient 2 for complaints of pain.

134. On or about May 23, 2005, the Respondent learned that Patient 2 was receiving Percocet from another provider.

135. On or about August 29, 2005, the Respondent increased Patient 2's dose of Vicodin.

136. Patient 2 filled a prescription for Vicodin issued by the Respondent on or about October 14, 2005.

137. On or about October 19, 2005, Patient 2 admitted to the Respondent recent use of cocaine.

138. The Respondent was aware of Patient 2's admission to recent use of cocaine.

139. Patient 2 filled a prescription for Vicodin issued by the Respondent on or about October 26, 2005.

140. Patient 2 filled a prescription for Vicodin issued by the Respondent on or about November 10, 2005.

141. The Respondent continued to regularly prescribe Vicodin to Patient 2 in 2006.

142. The Respondent did not perform a physical examination on Patient 2 prior to prescribing controlled substances for complaints of pain.

143. The Respondent did not perform any tests to determine Patient 2's need for Vicodin.

144. The Respondent did not complete an adequate medical history addressing the nature of Patient 2's complaints of pain.

145. The Respondent did not assess Patient 2's risk of addiction to Vicodin.

146. The Respondent did not explore appropriate alternatives to drug therapy for Patient 2.

147. The Respondent did not refer Patient 2 to a pain clinic.

148. The Respondent did not obtain or monitor objective evidence of Patient 2's improved or diminished function.

149. The Respondent failed to monitor adequately his treatment of Patient 2.

150. The Respondent inappropriately prescribed Vicodin to Patient 2.

151. The Respondent's medical records for Patient 2 are inadequate.

152. The Respondent's care of Patient 2 was substandard.

Patient 3:

153. Patient 3 was an adult male who saw the Respondent from approximately March 2002 through approximately April 2007.

154. The Respondent diagnosed Patient 3 with Post Traumatic Stress Disorder and Panic Disorder with Agoraphobia.

155. The Respondent did not diagnose Patient 3 with Opioid Dependence.

156. On or about February 5, 2003, the Respondent prescribed Lamictal to Patient 3.

157. Lamictal is an anticonvulsant used for abnormal moods.

158. Lamictal may cause serious allergic reactions, including rashes.

159. The Respondent did not warn Patient 3 about the allergy risks associated with Lamictal.

160. On or about February 12, 2003, the Respondent noted that Patient 3 was worried about risks of rash with use of Lamictal and that Patient 3 may stop using Lamictal.

161. On or about February 10, 2005, the Respondent prescribed Suboxone to Patient 3 for a reason other than opioid addiction treatment.

162. On or about June 7, 2005, the Respondent changed Patient 3's Suboxone to Subutex for a reason other than opioid addiction treatment.

163. The Respondent failed to monitor adequately his treatment of Patient 3 with Suboxone and Subutex.

164. The Respondent inappropriately prescribed Suboxone to Patient 3.

165. The Respondent inappropriately prescribed Subutex to Patient 3.

166. The Respondent's medical records for Patient 3 are inadequate.

167. The Respondent's care of Patient 3 was substandard.

Patient 4:

168. Patient 4 was an adult male who saw the Respondent from approximately May 2005 through approximately June 2006.

169. The Respondent diagnosed Patient 4 with Post Traumatic Stress Disorder and Opioid Dependence.

170. Patient 4 initially saw the Respondent on or about May 12, 2005.

171. Patient 4 was twenty-four years old on or about May 12, 2005.

172. On or about May 12, 2005, the Respondent noted that Patient 4 had a history of abusing Oxycontin and Percocet since age 13.

173. Oxycontin is an opiate.

174. On or about May 12, 2005, the Respondent prescribed to Patient 4 Suboxone 8 mg with one refill, Xanax 1 mg with one refill, Clonidine, and Bentyl.

175. Clonidine is an antihypertensive that is used in the management of the symptoms of opiate withdrawal.

176. Bentyl is an anti-spasmodic agent that is used in the management of abdominal cramps and diarrhea associated with opiate withdrawal.

177. The Respondent did not document Patient 4's last use of opiates.

178. The Respondent did not document whether Patient 4 was experiencing symptoms of opiate withdrawal.

179. The Respondent did not document Patient 4's pattern of opiate use.

180. On or about August 30, 2005, the Respondent noted possible abuse of Xanax by Patient 4.

181. On or about April 5, 2006 the Respondent discontinued Suboxone for Patient 4.

182. On or about April 12, 2006, the Respondent started Patient 4 on Methadone.

183. The Respondent prescribed Methadone to Patient 4 for treatment of opioid dependence.

184. Pursuant to 42 C.F.R. Part 8, Methadone products, when used for the treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed only by opioid treatment programs (and agencies, practitioners or institutions by formal agreement with the program sponsor) certified by the Substance Abuse and Mental Health Services Administration and approved by the designated state authority.

185. The Respondent is not an accredited and certified Opioid Treatment Program authorized to treat opioid dependence with Methadone.

186. On or about May 12, 2006, the Respondent noted that Patient 4 sold his Methadone.

187. The Respondent's medical records for Patient 4 are inadequate.

188. The Respondent failed to monitor adequately his treatment of Patient 4 with Suboxone.

189. The Respondent inappropriately prescribed Suboxone to Patient 4.

190. The Respondent inappropriately prescribed Suboxone and Xanax at the same time to Patient 4.

191. The Respondent inappropriately prescribed Clonidine to Patient 4.

192. The Respondent inappropriately prescribed Bentyl to Patient 4.

193. The Respondent inappropriately prescribed Methadone to Patient 4.

194. The Respondent illegally prescribed Methadone to Patient 4, in violation of 42 C.F.R. Part 8.

195. The Respondent's care of Patient 4 was substandard.

Patient 6:

196. Patient 6 was an adult female who saw the Respondent from approximately June 2003 through approximately August 2003.

197. The Respondent diagnosed Patient 6 with Post Traumatic Stress Disorder, Alcohol Dependence, Unspecified Mental Disorder (non-psychotic), and Major Depressive Disorder Single Episode, Severe without Psychotic Features.

198. The Respondent prescribed Klonopin to Patient 6.

199. The Respondent knew that Patient 6 had a history of "detoxes."

200. The Respondent knew that Patient 6 was arrested trying to sell Klonopin.

201. The Respondent knew that Patient 6 was actively using alcohol.

202. The Respondent inappropriately prescribed Klonopin to Patient 6.

203. The Respondent's medical records for Patient 6 are inadequate.

204. The Respondent's care of Patient 6 was substandard.

Patient 7:

205. Patient 7 was an adult female who saw the Respondent from approximately February 2000 through approximately January 2007.

206. The Respondent diagnosed Patient 7 with Obsessive-Compulsive Disorder.

207. The Respondent did not diagnose Patient 7 with Opioid Dependence.

208. The Respondent prescribed Suboxone to Patient 7 for a reason other than opioid addiction treatment.

209. The Respondent prescribed Vicodin to Patient 7 from September 2005 to May 2006 for complaints of pain.

210. The Respondent prescribed Vicodin to Patient 7 from July 2006 through November 2006 for complaints of pain.

211. The Respondent did not perform a physical examination on Patient 7 prior to prescribing controlled substances for complaints of pain.

212. The Respondent did not perform any tests to determine Patient 7's need for Vicodin or Suboxone.

213. The Respondent did not complete an adequate medical history addressing the nature of Patient 7's complaints of pain.

214. The Respondent did not assess Patient 7's risk of addiction to Vicodin.

215. The Respondent did not explore appropriate alternatives to drug therapy for Patient 7.

216. The Respondent did not refer Patient 7 to a pain clinic.

217. The Respondent did not obtain or monitor objective evidence of Patient 7's improved or diminished function.

218. The Respondent inappropriately prescribed Vicodin to Patient 7.

219. The Respondent inappropriately prescribed Suboxone to Patient 7.

220. The Respondent's medical records for Patient 7 are inadequate.

221. The Respondent's care of Patient 7 was substandard.

Patient 9:

222. Patient 9 was an adult male who saw the Respondent from approximately February 2005 through approximately March 2007.

223. The Respondent diagnosed Patient 9 with Opiate Dependence, Bipolar II Disorder, and Panic Disorder with Agoraphobia.

224. The Respondent first saw Patient 9 on or about February 24, 2005.

225. On or about February 24, 2005, Patient 9 reported to the Respondent that he had been on Subutex for 90 days with one pill left.

226. The Respondent did not corroborate Patient 9's report about his Subutex treatment.

227. On or about February 24, 2005, the Respondent prescribed Subutex 8 mg to Patient 9 with five refills.

228. On or about February 24, 2005, the Respondent ordered urine screens for Patient 9 to be done once a month for one year.

229. On or about March 23, 2005, the Respondent started Patient 9 on Xanax.

230. Lab work ordered by the Respondent for Patient 9 on or about April 25, 2005, showed that Patient 9 tested negative for benzodiazepines and positive for cannabinoids.

231. The Respondent continued prescribing Xanax to Patient 9 between 2005 and 2007.

232. The Respondent inappropriately prescribed Suboxone to Patient 9.

233. The Respondent inappropriately prescribed Xanax to Patient 9.

234. The Respondent prescribed Suboxone to Patient 9 without adequate monitoring.

235. The Respondent's medical records for Patient 9 are inadequate.

236. The Respondent's care of Patient 9 was substandard.

Patient 10:

237. Patient 10 was an adult male who saw the Respondent from approximately August 2002 through approximately January 2004.

238. The Respondent diagnosed Patient 10 with Bipolar Disorder not otherwise specified and Opioid Dependence.

239. On or about December 4, 2003, the Respondent noted that Patient 10 was taking 40 mg of Methadone through a Methadone clinic.

240. On or about December 4, 2003, the Respondent prescribed Suboxone to Patient 10.

241. Suboxone should not be prescribed to a patient who is on more than 30 mg of Methadone.

242. The Respondent did not communicate with the Methadone clinic where Patient 10 was receiving treatment.

243. On or about December 4, 2003, Patient 10 suffered withdrawal symptoms.

244. The Respondent did not refer Patient 10 to an Emergency Room when he was suffering withdrawal symptoms.

245. The Respondent sent Patient 10 home with instructions to call the Respondent.

246. Patient 10 did "odd jobs" for the Respondent.

247. Opinion 10.015, *The Patient-Physician Relationship*, of the American Medical Association (AMA) Code of Medical Ethics states that: "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients'

welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."

248. The Respondent did not follow Opinion 10.015, *The Patient-Physician Relationship*, of the AMA Code of Medical Ethics.

249. Section 2, Part 2 of the American Psychiatric Association (APA) Principles of Medical Ethics states that: "The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals."

250. The Respondent did not follow Section 2, Part 2 of the APA Principles of Medical Ethics.

251. The Respondent inappropriately prescribed Suboxone to Patient 10.

252. The Respondent did not provide adequate medical support to Patient 10 when Patient 10 was suffering withdrawal symptoms.

253. The Respondent inappropriately had Patient 10 perform "odd jobs" for him.

254. The Respondent's medical records for Patient 10 are inadequate.

255. The Respondent's care of Patient 10 was substandard.

Patient 11:

256. Patient 11 was an adult female who saw the Respondent from approximately January 2005 through approximately October 2007.

257. The Respondent diagnosed Patient 11 with Opioid Dependence and Panic Disorder with Agoraphobia.

258. The Respondent prescribed Klonopin to Patient 11 without trials of non-addictive alternatives.

259. On or about January 20, 2005, the Respondent was aware of Patient 11's Methadone detox treatment for Oxycontin.

260. The Respondent did not communicate with the Methadone clinic where Patient 11 was receiving treatment.

261. On or about March 14, 2005, the Respondent prescribed Vicodin to Patient 11 for complaints of pain.

262. On or about June 13, 2005, Patient 11's Methadone treatment was discontinued because she was on Vicodin.

263. The Respondent started Patient 11 on Suboxone on or about June 13, 2005.

264. Prior to starting Suboxone, the Respondent did not obtain Patient 11's last Methadone dose.

265. Prior to starting Suboxone, the Respondent did not obtain the date when Patient 11 was last dosed with Methadone.

266. The Respondent changed Patient 11 from Suboxone to Subutex for no apparent reason.

267. On or about March 21, 2006, the Respondent noted that Patient 11 was still using Percocet for complaints of pain.

268. On or about March 21, 2006, the Respondent prescribed Vicodin to Patient 11 with 5 refills.

269. The Respondent did not prescribe Percocet to Patient 11 and did not note on the medical record that he was prescribing Percocet to Patient 11..

270. The Respondent did not perform a physical examination on Patient 11 prior to prescribing controlled substances for complaints of pain.

271. The Respondent did not perform any tests to determine Patient 11's need for Vicodin.

272. The Respondent did not complete an adequate medical history addressing the nature of Patient 11's complaints of pain.

273. The Respondent did not assess Patient 11's risk of addiction to Vicodin.

274. The Respondent did not explore appropriate alternatives to drug therapy for Patient 11.

275. The Respondent did not refer Patient 11 to a pain clinic.

276. The Respondent did not obtain or monitor objective evidence of Patient 11's improved or diminished function.

277. The Respondent did not monitor adequately Patient 11's Subutex treatment.

278. The Respondent inappropriately prescribed Klonopin to Patient 11.

279. The Respondent inappropriately prescribed Vicodin to Patient 11.

280. The Respondent inappropriately prescribed Suboxone to Patient 11.

281. The Respondent inappropriately prescribed Subutex to Patient 11.

282. The Respondent's medical records for Patient 11 are inadequate.

283. The Respondent's care of Patient 11 was substandard.

Patient 12:

284. Patient 12 was an adult male who saw the Respondent from approximately August 2001 through approximately April 2006.

285. The Respondent diagnosed Patient 12 with Acute Stress Disorder.

286. Patient 12 had a lung transplant one year prior to August 2001.

287. On or about September 28, 2001, the Respondent noted in Patient 12's medical record that Patient 12 had been hospitalized at Brigham and Women's Hospital due to blood clots in lungs. The Respondent also noted that Patient 12's respiration was "still not good."

288. In November 2001, the Respondent prescribed Vicodin to Patient 12 for complaints of pain that Patient 12 had as a result of a car accident.

289. Vicodin can decrease respiration.

290. On or about November 12, 2001, the Respondent noted in Patient 12's medical record that Patient 12 was wearing a mask "due to respiratory history."

291. On or about November 12, 2001, the Respondent prescribed Vicodin to Patient 12.

292. On or about April 12, 2002, the Respondent noted in Patient 12's medical record that Patient 12 was wearing a breathing mask.

293. On or about April 12, 2002, the Respondent prescribed Vicodin to Patient 12.

294. The Respondent continued to prescribe Vicodin to Patient 12 between May 2003 and April 2005.

295. The Respondent did not document any visits for Patient 12 between May 2003 and April 2005.

296. The Respondent did not consult with Patient 12's healthcare providers prior to prescribing Vicodin.

297. The Respondent did not perform a physical examination on Patient 12 prior to prescribing controlled substances for complaints of pain.

298. The Respondent did not perform any tests to determine Patient 12's need for Vicodin.

299. The Respondent did not complete an adequate medical history addressing the nature of Patient 12's complaints of pain.

300. The Respondent did not assess Patient 12's risk of addiction to Vicodin.

301. The Respondent did not explore appropriate alternatives to drug therapy for Patient 12.

302. The Respondent did not refer Patient 12 to a pain clinic.

303. The Respondent did not obtain or monitor objective evidence of Patient 12's improved or diminished function.

304. The Respondent inappropriately prescribed Vicodin to Patient 12.

305. The Respondent's medical records for Patient 12 are inadequate.

306. The Respondent's care of Patient 12 was substandard.

Patient 13:

307. Patient 13 was an adult male who saw the Respondent from approximately April 1999 through approximately April 2007.

308. The Respondent diagnosed Patient 13 with Post Traumatic Stress Disorder and Panic Disorder with Agoraphobia.

309. The Respondent prescribed Vicodin to Patient 13 for complaints of back pain related to a disk injury.

310. The Respondent did not perform a physical examination on Patient 13 prior to prescribing controlled substances for complaints of pain.

311. The Respondent did not perform any tests to determine Patient 13's need for Vicodin.

312. The Respondent did not complete an adequate medical history addressing the nature of Patient 13's complaints of pain.

313. The Respondent did not assess Patient 13's risk of addiction to Vicodin.

314. The Respondent did not explore appropriate alternatives to drug therapy for Patient 13.

315. The Respondent did not refer Patient 13 to a pain clinic.

316. The Respondent did not obtain or monitor objective evidence of Patient 13's improved or diminished function.

317. The Respondent inappropriately prescribed Vicodin to Patient 13.

318. The Respondent's medical records for Patient 13 are inadequate.

319. The Respondent's care of Patient 13 was substandard.

Patient 14:

320. Patient 14 was an adult female who saw the Respondent from approximately June 2001 through approximately May 2007.

321. The Respondent diagnosed Patient 14 with Post Traumatic Stress Disorder, Obsessive-Compulsive Disorder, and Intermittent Explosive Disorder.

322. The Respondent first saw Patient 14 on or about June 21, 2001.

323. The Respondent prescribed Klonopin to Patient 14 at that first visit.

324. The Respondent did not obtain an adequate substance abuse history from Patient 14.

325. On or about July 9, 2001, the Respondent noted that Patient 14 was abusing Klonopin.

326. On or about July 9, 2001, Patient 14 discussed her past history of drug use with the Respondent.

327. The Respondent continued to prescribe Klonopin to Patient 14 in increasing amounts between 2001 and 2007.

328. On or about July 2, 2001, the Respondent noted that Patient 14 had been on Vicodin for four years.

329. On or about July 2, 2001, the Respondent noted that Patient 14's primary care physician would no longer give her Vicodin.

330. On or about May 9, 2002, the Respondent noted that Patient 14 was getting urges to use cocaine.

331. On or about March 15, 2004, Patient 14 reported to the Respondent that a friend stole 12 tablets of Klonopin from her.

332. The Respondent prescribed Vicodin to Patient 14 since at least June 22, 2004.

333. The Respondent continued to prescribe Vicodin to Patient 14 in 2004 and between 2005 and 2007.

334. The Respondent did not perform a physical examination on Patient 14 prior to prescribing controlled substances for complaints of pain.

335. The Respondent did not perform any tests to determine Patient 14's need for Vicodin.

336. The Respondent did not complete an adequate medical history addressing the nature of Patient 14's complaints of pain.

337. The Respondent did not assess Patient 14's risk of addiction to Vicodin.

338. The Respondent did not explore appropriate alternatives to drug therapy for Patient 14.

339. The Respondent did not refer Patient 14 to a pain clinic.

340. The Respondent did not obtain or monitor objective evidence of Patient 14's improved or diminished function.

341. The Respondent inappropriately prescribed Vicodin to Patient 14.

342. The Respondent inappropriately prescribed Klonopin to Patient 14.

343. The Respondent's medical records for Patient 14 are inadequate.

344. The Respondent's care of Patient 14 was substandard.

Patient 15:

345. Patient 15 was an adult female who saw the Respondent from approximately September 2001 through approximately April 2007.

346. The Respondent diagnosed Patient 15 with Mood Disorder Due to General Medical Condition.

347. The Respondent did not diagnose Patient 15 with Opioid Dependence.

348. The Respondent prescribed Vicodin to Patient 15 for treatment of Fibromyalgia.

349. In March 2006, the Respondent increased the dosage of Vicodin that he prescribed to Patient 15 due to complaints of pain following a motor vehicle accident.

350. On or about May 16, 2006, the Respondent noted that Patient 15 was developing tolerance to Vicodin.

351. On or about May 16, 2006, the Respondent prescribed Suboxone to Patient 15 for a reason other than opioid addiction treatment.

352. On or about May 17, 2006, the Respondent changed Patient 15 from Suboxone to Subutex.

353. On or about May 30, 2006, the Respondent increased Patient 15's dose of Vicodin.

354. Patient 15 was receiving treatment from pain clinics at the same time that the Respondent was prescribing Vicodin to her.

355. The Respondent continued to prescribe Vicodin to Patient 15 throughout 2006 and 2007.

356. The Respondent did not perform a physical examination on Patient 15 prior to prescribing controlled substances for complaints of pain.

357. The Respondent did not perform any tests to determine Patient 15's need for Vicodin.

358. The Respondent did not complete an adequate medical history addressing the nature of Patient 15's complaints of pain.

359. The Respondent did not assess Patient 15's risk of addiction to Vicodin.

360. The Respondent did not explore appropriate alternatives to drug therapy for Patient 15.

361. The Respondent did not refer Patient 15 to the pain clinic where she was receiving treatment.

362. The Respondent did not obtain or monitor objective evidence of Patient 15's improved or diminished function.

363. The Respondent inappropriately prescribed Vicodin to Patient 15.

364. The Respondent inappropriately prescribed Suboxone to Patient 15.

365. The Respondent inappropriately prescribed Subutex to Patient 15.

366. The Respondent's medical records for Patient 15 are inadequate.

367. The Respondent's care of Patient 15 was substandard.

Patient 16:

368. Patient 16 was an adult male who saw the Respondent from approximately November 2001 through approximately February 2007.

369. The Respondent diagnosed Patient 16 with Bipolar Disorder not otherwise specified and Opioid Dependence.

370. The Respondent first saw Patient 16 on or about November 13, 2001.

371. On or about November 13, 2001, the Respondent noted that Patient 16 had a history of intravenous drug abuse.

372. On or about November 13, 2001, the Respondent noted that Patient 16 had been clean for three years.

373. On or about November 13, 2001, the Respondent noted that Patient 16 was on Methadone.

374. The Respondent prescribed Klonopin to Patient 16 at the first visit.

375. The Respondent prescribed Klonopin to Patient 16 without trials of non-addictive alternatives.

376. The Respondent did not communicate with the Methadone clinic where Patient 16 was receiving treatment.

377. On or about September 26, 2002, the Respondent noted that Patient 16 was on rapid Methadone detox.

378. On or about March 17, 2004, the Respondent noted that Patient 16 was detoxed at Adcare.

379. On or about April 26, 2004, the Respondent noted that Patient 16 was detoxed off heroin at SSTAR.

380. On or about April 26, 2004, the Respondent noted that Patient 16 had difficulty going through detox from Klonopin.

381. On or about April 26, 2004, the Respondent discontinued Klonopin.

382. On or about November 12, 2004, the Respondent began prescribing Vicodin to Patient 16 for complaints of pain.

383. The Respondent continued prescribing Vicodin to Patient 16 until approximately April 22, 2007.

384. On or about December 5, 2006, the Respondent noted that another physician was evaluating Patient 16 for a knee replacement.

385. The Respondent did not perform a physical examination on Patient 16 prior to prescribing controlled substances for complaints of pain.

386. The Respondent did not perform any tests to determine Patient 16's need for Vicodin.

387. The Respondent did not complete an adequate medical history addressing the nature of Patient 16's complaints of pain.

388. The Respondent did not assess Patient 16's risk of addiction to Vicodin.

389. The Respondent did not explore appropriate alternatives to drug therapy for Patient 16.

390. The Respondent did not refer Patient 16 to a pain clinic.

391. The Respondent did not obtain or monitor objective evidence of Patient 16's improved or diminished function.

392. The Respondent did not defer Patient 16's pain treatment to the physician who was evaluating him for a knee replacement.

393. The Respondent inappropriately prescribed Klonopin while Patient 16 was on Methadone.

394. The Respondent inappropriately prescribed Vicodin to Patient 16.

395. The Respondent's medical records for Patient 16 are inadequate.

396. The Respondent's care of Patient 16 was substandard.

Patient 18:

397. Patient 18 was an adult male who saw the Respondent from approximately April 2000 through approximately April 2007.

398. The Respondent diagnosed Patient 18 with Post Traumatic Stress Disorder and Major Depressive Disorder Recurrent Severe with Psychotic Features.

399. On or about November 11, 2002, Patient 18 requested from the Respondent small amounts of Vicodin or Tylenol #3 for complaints of pain near an incision from a recent esophageal surgery.

400. On or about November 11, 2002, the Respondent prescribed Vicodin to Patient 18 without refills.

401. On or about January 30, 2003, the Respondent noted that Patient 18 was going to have follow-up in Boston that day for the esophageal surgery.

402. On or about January 30, 2003, the Respondent prescribed Vicodin to Patient 18.

403. The Respondent continued to prescribe Vicodin to Patient 18 in 2003, 2004 and 2005.

404. On or about July 29, 2005, the Respondent prescribed 270 tablets of Vicodin to Patient 18, which represented a three-month supply.

405. On or about August 23, 2005, the Respondent prescribed a one-month supply of Vicodin to Patient 18.

406. On or about September 22, 2005, the Respondent noted that Patient 18 lost the Vicodin prescription of August 23, 2005.

407. The Respondent continued to prescribe Vicodin to Patient 18 throughout 2005 and 2006.

408. The Respondent did not perform a physical examination on Patient 18 prior to prescribing controlled substances for complaints of pain.

409. The Respondent did not perform any tests to determine Patient 18's need for Vicodin.

410. The Respondent did not complete an adequate medical history addressing the nature of Patient 18's complaints of pain.

411. The Respondent did not assess Patient 18's risk of addiction to Vicodin.

412. The Respondent did not explore appropriate alternatives to drug therapy for Patient 18.

413. The Respondent did not refer Patient 18 to a pain clinic.

414. The Respondent did not refer Patient 18 to the physician who performed the esophageal surgery.

415. The Respondent did not obtain or monitor objective evidence of Patient 18's improved or diminished function.

416. The Respondent did not adequately document his rationale for discontinuing Vicodin on or about June 19, 2006.

417. The Respondent did not monitor adequately his treatment of Patient 18 with Vicodin.

418. The Respondent inappropriately prescribed Vicodin to Patient 18.

419. The Respondent's medical records for Patient 18 are inadequate.

420. The Respondent's care of Patient 18 was substandard.

Patient 19:

421. Patient 19 was an adult female who saw the Respondent from approximately April 1999 through approximately October 2007.

422. The Respondent diagnosed Patient 19 with Major Depressive Disorder Recurrent Moderate and Intermittent Explosive Disorder.

423. Patient 19 had a history of migraine headaches.

424. On or about August 19, 1999, the Respondent noted that Patient 19 was having an MRI that date because of her headaches.

425. The Respondent did not order the MRI referenced to in paragraph 456.

426. On or about July 16, 1999, the Respondent started Patient 19 on Fioricet for headaches.

427. Fioricet contains butalbital, a barbiturate, which can be habit forming.

428. The Respondent continued treating Patient 19 with Fiorcet through 2000 and 2001.

429. On or about May 8, 2001, Patient 19 told the Respondent that she wanted to resume using Vicodin.

430. On or about May 8, 2001, the Respondent noted that Patient 19 was going to see her primary care physician for the headaches.

431. On or about May 8, 2001, the Respondent prescribed Vicodin, with one refill, to Patient 19.

432. On or about June 28, 2001, the Respondent noted that Patient 19 needed to increase Vicodin.

433. On or about June 28, 2001, the Respondent increased Patient 19's prescription for Vicodin and noted on Patient 19's record that the Vocodin was "with one refill for two months."

434. The Respondent continued to prescribe Vicodin to Patient 19 through 2007.

435. The Respondent did not perform a physical examination on Patient 19 prior to prescribing controlled substances for complaints of pain.

436. The Respondent did not perform any tests to determine Patient 19's need for Vicodin.

437. The Respondent did not complete an adequate medical history addressing the nature of Patient 19's complaints of pain.

438. The Respondent did not assess Patient 19's risk of addiction to Vicodin.

439. The Respondent did not explore appropriate alternatives to drug therapy for Patient 19.

440. The Respondent did not refer Patient 19 to a pain clinic.

441. The Respondent did not refer Patient 19 to her primary care physician.

442. The Respondent did not obtain or monitor objective evidence of Patient 19's improved or diminished function.

443. The Respondent inappropriately prescribed Vicodin to Patient 19.

444. The Respondent's medical records for Patient 19 are inadequate.

445. The Respondent's care of Patient 19 was substandard.

Patient 20:

446. Patient 20 was an adult female who saw the Respondent from approximately March 2002 through approximately October 2007.

447. The Respondent diagnosed Patient 20 with Post Traumatic Stress Disorder.

448. On or about April 10, 2002, the Respondent began prescribing Klonopin to Patient 20.

449. On or about October 1, 2002, the Respondent noted that Patient 20 was seen by her primary care physician.

450. On or about December 10, 2002, the Respondent noted that Patient 20 had pain secondary to axillary lumpectomy.

451. On or about March 3, 2003, the Respondent noted that Patient 20 was complaining of arthritic pain and was diagnosed and treated by another physician, Dr. St. Martin.

452. On or about March 3, 2003, Patient 20 wanted to increase Klonopin but the Respondent refused.

453. On or about April 18, 2003, the Respondent noted that Patient 20 had poor tolerance to medications other than Klonopin.

454. On or about April 18, 2003 the Respondent noted that Patient 20 had pain and was to have a pain injection.

455. On or about April 18, 2003 the Respondent prescribed Vicodin to Patient 20 with one refill.

456. On or about June 25 2003, the Respondent began prescribing Vicodin to Patient 20.

457. On or about August 27, 2003, the Respondent noted that Patient 20 had chronic pain.

458. On or about August 27, 2003, the Respondent told Patient 20 to go to St. Anne's Pain Clinic.

459. On or about November 26, 2003, Patient 20 complained of severe left chest and arm pain secondary to surgery.

460. On or about November 26, 2003, the Respondent prescribed Vicodin to Patient 20 with five refills.

461. The Respondent continued to prescribe Vicodin to Patient 20 between 2004 and 2007.

462. On or about July 19, 2004, the Respondent noted that Patient 20 had run into traffic to hurt herself.

463. On a note dated September 9, 2004, the Respondent wrote that Patient 20 reported a recent suicidal attempt and was seen in the emergency room.

464. On the September 9, 2004 note, the Respondent recorded the treatment plan as being "Increase Klonopin to 1 mg QID (28) with one refill in order to get supply after overdose."

465. On or about October 24, 2006, the Respondent noted that Patient 20 admitted to crack use.

466. On or about October 24, 2006, the Respondent noted that Patient 20 was five months pregnant.

467. On or about October 24, 2006, the Respondent noted that another physician, Dr. August, was Patient 20's Suboxone provider.

468. On or about October 24, 2006, the Respondent prescribed Klonopin to Patient 20 with five refills.

469. On or about March 18, 2007, the Respondent noted that Patient 20 was stressed due to involvement with the Department of Social Services.

470. On or about March 18, 2007, the Respondent noted that Patient 20 was required to attend the SSTAR program.

471. On or about March 18, 2007, the Respondent noted that Patient 20 was taking Suboxone 8 mg for complaints of pain.

472. On or about March 18, 2007, Patient 20 reported to the Respondent that she was getting an upset stomach with Vicodin.

473. On or about March 18, 2007, the Respondent noted that Vicodin bothered Patient 20, "but anyway, we continued her on Vicodin BID (21) with one refill."

474. The Respondent did not perform a physical examination on Patient 20 prior to prescribing controlled substances for complaints of pain.

475. The Respondent did not perform any tests to determine Patient 20's need for Vicodin.

476. The Respondent did not complete an adequate medical history addressing the nature of Patient 20's complaints of pain.

477. The Respondent did not assess Patient 20's risk of addiction to Vicodin.

478. The Respondent inappropriately prescribed Klonopin to Patient 20.

479. The Respondent did not explore appropriate alternatives to drug therapy for Patient 20.

480. The Respondent did not obtain or monitor objective evidence of Patient 20's improved or diminished function.

481. The Respondent failed to monitor adequately his treatment of Patient 20.

482. The Respondent's assessments of Patient 20's suicide risks were inadequate.

483. The Respondent inappropriately prescribed Vicodin to Patient 20.

484. The Respondent's medical records for Patient 20 are inadequate.

485. The Respondent's care of Patient 20 was substandard.

Patient 22:

486. Patient 22 was an adult female who saw the Respondent from approximately November 2003 through approximately July 2007.

487. The Respondent diagnosed Patient 22 with Tourette's Disorder and Depressive Disorder not otherwise specified.

488. The Respondent did not diagnose Patient 22 with Opioid Dependence.

489. The Respondent first saw Patient 22 on or about November 14, 2003.

490. On or about November 14, 2003, the Respondent noted that Patient 22 reported having osteoarthritis of the back, renal problems and fibromyalgia.

491. On or about November 14, 2003, the Respondent prescribed Vicodin to Patient 22.

492. The Respondent continued to prescribe Vicodin to Patient 22 in 2004 and 2005.

493. On or about November 14, 2005, the Respondent told Patient 22 to see a physician for sciatic pain.

494. On or about November 14, 2005, the Respondent prescribed Vicodin to Patient 22.

495. On or about December 12, 2005, the Respondent prescribed Vicodin with one refill to Patient 22.

496. The Respondent continued to prescribe Vicodin to Patient 22 in 2006.

497. On or about March 10, 2006, the Respondent noted that Patient 22 still had kidney problems and was going to be seen in Boston.

498. On or about March 10, 2006, the Respondent prescribed Vicodin to Patient 22.

499. On or about June 8, 2006, the Respondent noted that Patient 22 was seeing an internist.

500. Patient 22 filled Vicodin prescriptions issued by the Respondent on or about June 1, 2006 and on or about June 30, 2006.

501. On a note dated November 20, 2006, the Respondent wrote that Patient 22 "had Vicodin scrip [discontinued] because of trial with Methadone."

502. On or about November 20, 2006, the Respondent also prescribed Suboxone 8 mg to Patient 22 for a reason other than opioid addiction treatment.

503. The Respondent did not document Patient 22's last use of opiates prior to prescribing Suboxone to Patient 22 on or about November 20, 2006.

504. The Respondent never performed a physical examination on Patient 22 prior to prescribing controlled substances for complaints of pain.

505. The Respondent did not perform any tests to determine Patient 22's need for Vicodin.

506. The Respondent did not complete an adequate medical history addressing the nature of Patient 22's complaints of pain.

507. The Respondent did not assess Patient 22's risk of addiction to Vicodin.

508. The Respondent did not explore appropriate alternatives to drug therapy for Patient 22.

509. The Respondent did not refer Patient 22 to a pain clinic.

510. The Respondent did not obtain or monitor objective evidence of Patient 22's improved or diminished function.

511. The Respondent inappropriately prescribed Vicodin to Patient 22.

512. The Respondent inappropriately prescribed Suboxone to Patient 22.

513. The Respondent's medical records for Patient 22 are inadequate.

514. The Respondent's care of Patient 22 was substandard.

Patient 23:

515. Patient 23 was an adult female who saw the Respondent from approximately April 1999 through approximately October 2003.

516. The Respondent diagnosed Patient 23 with Post Traumatic Stress Disorder and Panic Disorder with Agoraphobia.

517. The Respondent prescribed Klonopin to Patient 23.

518. On or about March 3, 2003, the Respondent noted that Patient 23 admitted to using cocaine.

519. On or about March 18, 2003, the Respondent noted that Patient 23 denied using cocaine.

520. The Respondent did not test Patient 23 for cocaine use after her denial about using cocaine.

521. On or about March 18, 2003, the Respondent prescribed Valium to Patient 23.

522. The Respondent prescribed benzodiazepines to Patient 23 without taking an adequate substance abuse history.

523. The Respondent inappropriately prescribed Klonopin to Patient 23.

524. The Respondent inappropriately prescribed Valium to Patient 23.

525. The Respondent's medical records for Patient 23 are inadequate.

526. The Respondent's care of Patient 23 was substandard.

Patient 24:

527. Patient 24 was an adult male who saw the Respondent from approximately May 2002 through approximately January 2003.

528. The Respondent diagnosed Patient 24 with Bipolar Disorder not otherwise specified.

529. The Respondent prescribed Xanax to Patient 24.

530. On or about June 28, 2002, the Respondent received a report from Patient 24's girlfriend.

531. Patient 24's girlfriend reported that Patient 24 was abusing Xanax.

532. On or about June 28, 2002, the Respondent confronted Patient 24 about his girlfriend's report.

533. Patient 24 did not return for follow up until on or about October 10, 2002.

534. On or about October 10, 2002, Patient 24 denied medication or alcohol abuse.

535. The Respondent did not corroborate Patient 24's denial about medication or alcohol abuse.

536. The Respondent prescribed Valium, Halcion and Xanax to Patient 24.

537. Halcion is a benzodiazepine.

538. The Respondent inappropriately prescribed Valium to Patient 24.

539. The Respondent inappropriately prescribed Xanax to Patient 24.

540. The Respondent inappropriately prescribed Halcion to Patient 24.

541. The Respondent did not adequately address reports that Patient 24 was abusing his medication and mixing it with alcohol.

542. The Respondent failed to monitor adequately his treatment of Patient 24.

543. The Respondent's medical records for Patient 24 are inadequate.

544. The Respondent's care of Patient 24 was substandard.

Patient 25:

545. Patient 25 was an adult female who saw the Respondent from approximately March 2002 through approximately May 2002.

546. The Respondent diagnosed Patient 25 with Post Traumatic Stress Disorder.

547. On or about March 7, 2002, the Respondent noted that Patient 25 had a history of poly-substance abuse that included alcohol.

548. In 2005, the Respondent told Board staff that Patient 25 had a history of abusing cocaine, crack, alcohol, ecstasy and Klonopin.

549. The Respondent prescribed Klonopin to Patient 25.

550. On or about March 11, 2002, Patient 25's family reported to the Respondent that she was abusing Klonopin.

551. The Respondent continued prescribing Klonopin to Patient 25.

552. The Respondent inappropriately prescribed Klonopin to Patient 25.

553. The Respondent's medical records for Patient 25 are inadequate.

554. The Respondent's care of Patient 25 was substandard.

Patient 26:

555. Patient 26 was an adult female who saw the Respondent from approximately November 2004 through approximately March 2007.

556. The Respondent diagnosed Patient 26 with Mood Disorder due to General Medical Condition.

557. The Respondent first saw Patient 26 on or about November 9, 2004.

558. On or about November 9, 2004, the Respondent noted that Patient 26 had severe pain due to degenerative joint disease of the spine and knees.

559. On or about November 9, 2004, the Respondent noted that Patient 26 had been treated in the past by Dr. Chadfield-Taylor with Percocet for complaints of pain.

560. On or about November 9, 2004, Patient 26 told the Respondent that Dr. Chadfield-Taylor had died.

561. The Respondent did not corroborate Patient 26's prior treatment.

562. On about November 9, 2004, the Respondent prescribed Percocet to Patient 26.

563. The Respondent continued to prescribe Percocet to Patient 26 from 2005 through 2007.

564. On or about March 12, 2007, the Respondent noted a report from a CVS pharmacy.

565. CVS pharmacy reported that Patient 26 received 240 tablets of Percocet from another physician and paid in cash.

566. CVS pharmacy also reported that Patient 26 was going to a pain clinic.

567. The Respondent did not perform a physical examination on Patient 26 prior to prescribing controlled substances for complaints of pain.

568. The Respondent did not perform any tests to determine Patient 26's need for Vicodin.

569. The Respondent did not complete an adequate medical history addressing the nature of Patient 26's complaints of pain.

570. The Respondent did not assess Patient 26's risk of addiction to Vicodin.

571. The Respondent did not explore appropriate alternatives to drug therapy for Patient 26.

572. The Respondent did not refer Patient 26 to a pain clinic.

573. The Respondent did not obtain or monitor objective evidence of Patient 26's improved or diminished function.

574. The Respondent failed to monitor adequately his treatment of Patient 26.

575. The Respondent inappropriately prescribed Percocet to Patient 26.

576. The Respondent's medical records for Patient 26 are inadequate.

577. The Respondent's care of Patient 26 was substandard.

Patient 27:

578. Patient 27 was an adult female who saw the Respondent from approximately May 2001 through approximately March 2007.

579. The Respondent diagnosed Patient 27 with Major Depressive Disorder Recurrent Moderate.

580. On or about January 15, 2003, Patient 27 complained of neck pain and temporal mandibular joint pain.

581. On or about January 15, 2003, the Respondent prescribed Vicodin to Patient 27.

582. On or about November 6, 2003, the Respondent increased Patient 27's Vicodin dose.

583. The Respondent continued prescribing Vicodin to Patient 27 between 2004 and 2006.

584. The Respondent did not perform a physical examination on Patient 27 prior to prescribing controlled substances for complaints of pain.

585. The Respondent did not perform any tests to determine Patient 27's need for Vicodin.

586. The Respondent did not complete an adequate medical history addressing the nature of Patient 2's complaints of pain.

587. The Respondent did not assess Patient 27's risk of addiction to Vicodin.

588. The Respondent did not explore appropriate alternatives to drug therapy for Patient 27.

589. The Respondent did not refer Patient 27 to a pain clinic.

590. The Respondent did not obtain or monitor objective evidence of Patient 27's improved or diminished function.

591. The Respondent failed to monitor adequately his treatment of Patient 27.

592. The Respondent inappropriately prescribed Vicodin to Patient 27.

593. The Respondent's medical records for Patient 27 are inadequate.

594. The Respondent's care of Patient 27 was substandard.

Patient 28:

595. Patient 28 was an adult female who saw the Respondent from approximately July 2001 through approximately February 2007.

596. The Respondent diagnosed Patient 28 with Post Traumatic Stress Disorder.

597. On or about August 10, 2001, the Respondent prescribed Depakote to Patient 28 for complaints of migraine pain.

598. On or about December 6, 2002, the Respondent noted that Patient 28 had frequent pounding headaches.

599. On or about December 6, 2002, the Respondent noted that Patient 28 was taking Tylenol #4 with good effect from a friend.

600. On or about December 6, 2002, the Respondent prescribed Depakote to Patient 28.

601. Depakote is used to prevent migraine headaches, but not to relieve headaches that have already begun.

602. The Respondent continued prescribing Depakote to Patient 28 between 2003 and 2006.

603. On or about December 6, 2002, the Respondent prescribed Vicodin with one refill to Patient 28.

604. The Respondent continued prescribing Vicodin to Patient 28 in 2003, 2004, 2005 and 2006.

605. The Respondent did not perform a physical examination on Patient 28 prior to prescribing controlled substances for complaints of pain.

606. The Respondent did not perform any tests to determine Patient 28's need for Vicodin.

607. The Respondent did not complete an adequate medical history addressing the nature of Patient 28's complaints of pain.

608. The Respondent did not assess Patient 28's risk of addiction to Vicodin.

609. The Respondent did not explore appropriate alternatives to drug therapy for Patient 28.

610. The Respondent did not refer Patient 28 to a pain clinic.

611. The Respondent did not obtain or monitor objective evidence of Patient 28's improved or diminished function.

612. The Respondent failed to monitor adequately his treatment of Patient 28.

613. The Respondent inappropriately prescribed Vicodin to Patient 28.

614. The Respondent's medical records for Patient 28 are inadequate.

615. The Respondent's care of Patient 28 was substandard.

Patient 29:

616. Patient 29 was an adult female who saw the Respondent from approximately November 2001 through approximately March 2007.

617. The Respondent diagnosed Patient 29 with Major Depressive Disorder Recurrent Severe with Psychotic Features, Panic Disorder without Agoraphobia, and R/O Bipolar Disorder not otherwise specified.

618. On or about November 1, 2003, Patient 29 complained of pain related to recent radiation treatment of right breast.

619. On or about November 1, 2003, Patient 29 asked the Respondent for a brief course of Vicodin.

620. On or about November 1, 2003, the Respondent prescribed Vicodin to Patient 29.

621. On or about November 1, 2003, the Respondent noted that Patient 29 was to receive Vicodin for two months only.

622. The Respondent continued prescribing Vicodin to Patient 29 in 2004, 2005 and 2006.

623. The Respondent did not perform a physical examination on Patient 29 prior to prescribing controlled substances for complaints of pain.

624. The Respondent did not perform any tests to determine Patient 29's need for Vicodin.

625. The Respondent did not complete an adequate medical history addressing the nature of Patient 29's complaints of pain.

626. The Respondent did not assess Patient 29's risk of addiction to Vicodin.

627. The Respondent did not explore appropriate alternatives to drug therapy for Patient 29.

628. The Respondent did not refer Patient 29 to a pain clinic.

629. The Respondent did not obtain or monitor objective evidence of Patient 29's improved or diminished function.

630. The Respondent failed to monitor adequately his treatment of Patient 29.

631. The Respondent inappropriately prescribed Vicodin to Patient 29.

632. The Respondent's medical records for Patient 29 are inadequate.

633. The Respondent's care of Patient 29 was substandard.

LEGAL BASIS FOR PROPOSED RELIEF

A. Pursuant to G.L. c. 112, § 5, ninth par. (b) and 243 C.M.R. 1.03(5)(a)2, the Board may discipline a physician upon proof satisfactory to a majority of the Board that the physician has committed an offense against the provisions of the laws of the Commonwealth relating to the practice of medicine or rule or regulation promulgated thereunder. General Laws c. 94C relates to the practice of medicine, including:

1. G.L. c. 94C, § 19(a), issuing prescriptions for other than legitimate medical purposes and outside the usual course of the physician's professional practice.

B. Pursuant to G.L. c. 112, §5, ninth par. (c) and 243 C.M.R. 1.03(5)(a) 3, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician engaged in conduct which calls into question her competence to practice medicine, including but not limited to practicing medicine with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

C. Pursuant to G.L. c. 112, §5, ninth par. (h) and 243 C.M.R. 1.03(5)(a) 11, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician violated a rule or regulation of the Board.

1. Pursuant to 243 C.M.R. 2.07(5), a licensee who violates G.L. c. 94C also violates a rule or regulation of the Board.

2. Pursuant to 243 C.M.R. 2.07(13), a physician shall maintain a medical record for each patient that is adequate to enable the physician to provide proper diagnosis and treatment.

D. Pursuant to 243 C.M.R. 1.03(5)(a) 10, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician practiced medicine deceitfully, or engaging in conduct that has the capacity to deceive or defraud.

E. Pursuant to 243 C.M.R. 1.03(5)(a) 17, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician is guilty of malpractice within the meaning of G.L. c. 112, § 61.

F. Pursuant to 243 C.M.R. 1.03(5)(a) 18, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has committed misconduct in the practice of medicine.

The Board has jurisdiction of this matter pursuant to G.L c. 112, §§ 5, 61 and 62. This proceeding will be conducted according to the provisions of G.L. c. 30A and 801 C.M.R. 1.01 et seq.

NATURE OF RELIEF SOUGHT

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may, in addition to or instead of revocation or suspension, order one or more of the following: admonishment, reprimand, censure, fine, the performance of uncompensated public

service, a course of education or training, or other limitation on the Respondent's practice of medicine.

ORDER

Wherefore, it is hereby ORDERED that the Respondent show cause why he should not be disciplined for the conduct described herein.

By the
Board of Registration in Medicine,

Date: May 6, 2009

John B Herman MD

John B. Herman, M.D.
Chairman

SENT CERTIFIED MAIL
5/6/09

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

MIDDLESEX, SS.

Adjudicatory Case No. 2009-011

In the Matter of Claude Curran, M.D.	FINAL DECISION AND ORDER

This matter came before the Board for final disposition on the basis of the First Administrative Magistrate's Recommended Decision, dated October 27, 2011. After full consideration of the Recommended Decision, the Board hereby ADOPTS the Recommended Decision, attached hereto and incorporated by reference, with the exception of the final two words, "as moot."

The Statement of Allegations is hereby dismissed without prejudice.

DATE: January 18, 2012

Peter Paige, M.D.
Chairman

SENT CERTIFIED MAIL
1-18-12 KSR

THE COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss.

Board of Registration in Medicine,
Petitioner

v.

Claude Curran, M.D.,
Respondent

Division of Administrative Law Appeals
98 North Washington Street, 4th Floor
Boston, MA 02114
(617) 727-7060
www.state.ma.us/dala

Docket No. RM-09-280

Appearance for Petitioner:

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Wakefield, MA 01880

Appearance for Respondent:

Paul R. Cirel, Esq.
Dwyer & Collora, LLP
600 Atlantic Avenue
Boston, MA 02110

Administrative Magistrate

James P. Rooney

Summary of Decision

Motion to dismiss Statement of Allegations issued to psychiatrist should be allowed when based on Complaint Counsel's representation that insufficient evidence exists to proceed.

RECOMMENDED DECISION

On May 6, 2009, the Board of Registration in Medicine issued a Statement of Allegations ordering psychiatrist Claude Curran, M.D. to show cause why he should not be

disciplined for the manner in which he handled his drug addiction treatment practice. On the same date, the Board referred the matter to the Division of Administrative Law Appeals (DALA).

On December 2, 2011, by mutual agreement among the parties, Complaint Counsel filed a Stipulation of Facts and Conclusions of Law. I adopted the facts as stipulated and issued a recommended decision on January 13, 2011.

The Board of Registration in Medicine, after considering the stipulation, proposed adding a conclusion of law that Dr. Curran had violated M.G.L. c. 112, ¶ 9(b) and 243 C.M.R 1.03(5)(a)(2). Dr. Curran declined to accept this change. The Board remanded the matter to DALA on May 4, 2011 for further proceedings.

I held a prehearing conference with the parties on June 24, 2011. I established a schedule with a deadline for Dr. Curran to file a motion to dismiss. Thereafter, on September 16, 2011, Dr. Curran filed a motion to dismiss or to exclude testimony covered by the psychotherapist-patient privilege.

On September 29, 2011, Complaint Counsel moved to dismiss the Statement of Allegations it issued in this case, stating that it did not intend to pursue prosecution further due to insufficient evidence. No opposition was filed.

Accordingly, I recommend that the motion to dismiss be allowed and that this matter be dismissed as moot. 801 C.M.R. 1.01(7)(g)3.

DIVISION OF ADMINISTRATIVE LAW APPEALS

James P. Rooney
First Administrative Magistrate

Dated: