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| **IN THE MATTER OF** | * | **BEFORE THE MARYLAND** |
| **SPYROS J. MONOPOLIS, M.D.** | * | **BOARD OF** |
| **Respondent** | * | **PHYSICIANS** |
| **License Number: D31365** | * | **Case No.: 2007-0514** |

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## CONSENT ORDER

On April 20, 2009, the Maryland State Board of Physicians (the "Board"), charged Spyros J. Monopolis, M.D. (the "Respondent") (D.O.B. 05/03/1947), License Number D31365, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 14-404(a) (2005 Repl. vol. & 2008 Supp.). Specifically, the Board charged the Respondent with the following provisions of the Act under Health Occ. § 14-404:

> The pertinent provisions of the Act provide the following:
>
> (a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

On September 2, 2009, a Case Resolution Conference was convened in this matter. Based on negotiations occurring as a result of this Case Resolution

Conference, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order.

## FINDINGS OF FACT

### I. BACKGROUND

The Board finds the following:

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on September 6, 1984.

2. The Respondent, who is board-eligible, specializes in child and adolescent psychiatry, and at the time of the incidents described herein, worked approximately one day per week at Upper Bay Counseling and Support Services (hereinafter "Upper Bay") from 2003 through July 3, 2007.[1] The Respondent saw the patients described herein at Upper Bay. Additionally, the Respondent maintained an office at Psych Associates of Maryland, LLC, 120 Sister Pierre Drive, Suite #403, Towson, Maryland, 21204, held privileges at the University of Maryland Medical System, Key Point Health Services and worked for the Baltimore city public schools.

3. On or about January 25, 2007, the Board received an anonymous complaint[2] from an employee at Upper Bay Counseling and Support Services ("Upper Bay") with regard to 2 children, alleging that a child[3] was accidentally prescribed a lethal dose of Wellbutrin-XL and that the

[1] Every 3 months, the Respondent worked an additional Thursday.
[2] The anonymous complainant was later identified during the Board's investigation as a physician and former employee of Upper Bay.
[3] Labeled as Patient 1 in the charging document.

Respondent raised the second child's[4] dose of Depakote without a Depakote level in the chart, and she was taken to the emergency room for "Depakote toxicity." The complaint further alleged that the second child collapsed in the middle of a cross-walk on the way to school. Shortly thereafter, the Board opened an investigation.

4. On or about July 20, 2007, the Board notified the Respondent of its investigation with regard to Patients 1 and 2 and provided him with an opportunity to respond to the allegations in the complaint.

5. On or about August 27, 2007, the Board received a response from the Respondent's attorney regarding the allegations cited in the complaint concerning Patient 1. The Respondent denied there was any intent to increase Patient 1's Wellbutrin dosage beyond 450 mg. per day. The Respondent contends that an unintentional transcription error resulted in the erroneous prescription that went undetected by the Respondent, Upper Bay, the pharmacy and Patient 1's mother.

6. Also, on August 27, 2007, the Board received a separate response from the Respondent's attorney regarding the allegations cited in the complaint concerning Patient 2. At the time the complaint was issued, the Respondent did not have access to Patient 2's records and was unable to specifically respond to the allegations. According to the Respondent's attorney however, the Respondent's recollection was that his care and treatment of Patient 2 met the applicable standards of care.

[4] Labeled as Patient 2 in the charging document.

7. On November 2, 2007, the Board's Compliance Staff conducted an interview of the Respondent with regard to the two patients cited in the complaint.

8. The Board subpoenaed records for the two patients cited in the complaint as well as randomly selected patient records and in June 2008 transmitted 14 patient records and other investigative documents to an independent peer review organization, Permedion, to conduct a peer review. Permedion assigned the review to two physicians who are board-certified in psychiatry; one of the reviewers specializes in child and adolescent psychiatry (hereinafter the "reviewers").

9. Based on its investigation, the Board voted to charge the Respondent with violating Health Occ. § 14-404(a) (22) and (40).

## II. PSYCHOTROPIC MEDICATIONS

The Respondent treated the pediatric patients cited in the charging document with several different psychotropic medications. Psychotropic medications are defined as any medication capable of affecting the mind, emotions, and behavior. The standard of quality care used in prescribing psychotropic medications for children includes: psychiatric evaluation, treatment and a safety/efficacy monitoring plan, psychoeducation and consent of the family (patient), monitoring for therapeutic effects of the medication and possible side effects. When prescribing multiple psychotropic medications to a child, such use should be kept to "clearly justifiable circumstances," pursuant to the 2001

American Academy of Child and Adolescent Psychiatrist's policy statement regarding prescribing psychoactive medications for children and adolescents.

The following identifies some of the psychotropic medications prescribed by the Respondent including common indications for use, complications and certain treatment guidelines:

**Wellbutrin XL and SR**

Wellbutrin is used in the treatment of major depression. It is associated with a dose-dependent increased risk of seizures. In order to to minimize the risk of seizures, dose increases should be done gradually, and the total daily dose of Wellbutrin should not exceed 450 mg. per day, under routine clinical conditions.

**Concerta**

Concerta, a long acting methylphenidate product, is a Schedule II Controlled Dangerous Substance ("CDS") used in the treatment of Attention Deficit Hyperactivity Disorder ("ADHD"). Standards of quality medical care include monitoring of height, weight and blood pressure. Cardiac problems and other side effects have been identified as a complication related to this medication. In certain clinical situations, an EKG is indicated. For children aged 6-12 currently on Concerta, the recommended dosage should not exceed 54 mg daily. In patients aged 13-65, dosages may be adjusted to a maximum of 72 mg/day, under routine clinical conditions.

**Depakote**

Depakote is used to control bipolar disorder and related conditions. The medication can cause liver problems and other side effects including abdominal

pain, bruising, constipation, dizziness, emotional changeability, hair loss, headache, incoordination, indigestion, nausea, nervousness, sedation, vomiting, weakness and weight gain.

The standard of quality care requires that laboratory studies be obtained including a baseline complete blood count ("CBC") and liver function tests ("LFT's") and periodic monitoring of the CBC and LFT's, more frequently at the beginning of treatment. Additionally, Depakote levels should be drawn approximately 10-14 days after initiating the Depakote, as well as with each increase of medication and every three months or as clinically indicated.

**Risperdal**

Risperdal is an atypical antipsychotic used in the treatment of bipolar disorder and related conditions. Side effects of Risperdal include Metabolic Syndrome including weight gain, hyperglycemia and hyperlipidemia and neurologic side effects. When prescribing this psychotropic medication, the standard of quality medical care includes obtaining a baseline BMI ("body mass index"), blood pressure and laboratory studies to include fasting glucose and lipid profiles. It is necessary for the practitioner to monitor the baseline laboratory values, ongoing weights, any side effects and the efficacy of treatment.

**Geodon**

Geodon is used in the treatment of schizophrenia and bipolar disorder. It can be associated with several side effects including hyperglycemia. Serious side effects that can occur from taking Geodon include cardiac abnormalities or a

rare condition called neuroleptic malignant syndrome. Under certain conditions it is advisable when initiating Geodon to obtain a baseline EKG.

**Adderall XR**

Adderall XR, a once daily extended-release amphetamine, is a Schedule II CDS used in the treatment of ADHD. The AACAP recommends that an EKG and cardiac evaluation be considered and conducted when there is a history of certain cardiac conditions. The maximum recommended dose for children is 30 mg/day as doses greater than 30 mg/day of Adderall XR® have not been studied in children, under routine clinical conditions.

## III. PATIENT-RELATED FINDINGS

### PATIENT 1

1. Patient 1 was an 8 year-old male when he began seeing the Respondent for psychiatric care at Upper Bay in October 2003. Prior to seeing the Respondent for psychiatric care, Patient 1 had seen other providers at Upper Bay since late in 2001. He had a history of attention difficulties, temper dyscontrol, oppositional behavior, learning difficulties, problems sleeping and encopresis (the repeated involuntary passage of feces into places not appropriate for that purpose). Patient 1 had been treated with a failed trial of Prozac[5] in 2003, and subsequently Concerta was initiated for a short period of time. Additionally, one month before Patient 1's initial visit with the Respondent, another provider had started him on Abilify.[6]

[5] An antidepressant.
[6] An antipsychotic medication sometimes prescribed to treat schizophrenia and psychotic features of bipolar and schizoaffective disorders as well as mood swings.

2. On October 17, 2003, the Respondent's diagnostic impression was that Patient 1 had ADHD with symptoms noticeable at home and school; and Oppositional Defiant Disorder ("ODD"), with symptoms noticeable only at home. The Respondent also diagnosed Patient 1 with Anxiety Disorder, Depressive Disorder and Mood Disorder. The Respondent continued Patient 1 on Abilify. Additionally, he prescribed Wellbutrin XL for him. The Respondent ordered laboratory studies for Patient 1, and they were within normal limits.

3. The Respondent saw Patient 1 on approximately a monthly basis, primarily for medication management, until Patient 1 died in June 2006.

4. Patient 1's records reflected that he saw a therapist[7] on approximately a weekly basis between July 2002 and May 2006.

5. On April 26, 2005, the Respondent started Patient 1 on Concerta in conjunction with Wellbutrin XL and Abilify, and by May 24, 2005, he was on 54 mg. of Concerta daily.

6. On September 6, 2005, Patient 1 was generally doing well, but had increased stress with a new middle school. The Respondent increased Patient 1's dosage of Abilify to 30 mg. at bedtime in conjunction with Wellbutrin XL 150 mg., 3 tablets in the a.m. and Concerta 54 mg.

7. On November 1, 2005, the Respondent documented that Patient 1 had anger/mood changes and his oppositional defiant disorder symptoms were noticeable. He ordered baseline laboratory studies, and they were within

[7] Patient 1 saw 3 different providers for therapy over the course of approximately 4 years.

normal limits. The Respondent began prescribing Risperdal,[8] and by November 29, 2005, Patient 1 was on .5 mg. daily at bedtime. Abilify was gradually tapered and discontinued.

8. On January 24, 2006, a "prescription and pharmacy error" resulted in Patient 1 taking a lower than prescribed dose for 12 days. The Respondent noted a significant increase in his symptoms.

9. On February 21, 2006, the Respondent documented that Patient 1's symptoms had improved. He gradually increased Patient 1's dosage of Risperdal to 2 mg. daily at bedtime.

10. On May 16, 2006, the Respondent noted that Patient 1 had increased anger, noticeable mood swings and a family history of bipolar disorder. The Respondent initiated Depakote. The Respondent failed to document informed consent from Patient 1's parents prior to prescribing on a consent form.[9] Additionally, he increased Patient 1's dosage of Concerta to 72 mg (2 tablets of 36 mg.). This was in addition to his prescriptions for Risperdal, 3 mg. at bedtime (also increased) and Wellbutrin XL, 150 mg., 3 tablets daily.

11. On May 29, 2006, the Respondent documented that Patient 1 had a reduction in symptoms and that his weight was 108 pounds.

12. On June 5, 2006, Patient 1's mother was seeing a therapist (Ms. M) at Upper Bay and raised the concern with Ms. M that her son's last dosage of Wellbutrin was "too high." Ms. M obtained a copy of the prescription

[8] According to the Respondent, this was intended to replace the Abilify.
[9] The Respondent documented on the medication record that the benefits and side effects of Depakote had been discussed.

from the pharmacy that had been issued by the Respondent on May 16, 2006. The prescription reflected that it was written for 3 tablets daily of 300 mg. of Wellbutrin XL (for a total of 900 mg.). Patient 1's correct dosage as confirmed by his medical chart,[10] was 150 mg. of Wellbutrin XL, three tablets daily (for a total of 450 mg). The maximum recommended dosage of Wellbutrin XL is 450 mg. daily. There was no evidence in the Respondent's progress note of May 16, 2006 that he intended to increase the Wellbutrin XL dosage.

13. Ms. B, a C.M.A.,[11] documented on June 5, 2006, that she "advised" Patient 1's mother not to give Patient 1 this dose as it was too high, and that she would speak to the Respondent about it on June 6, 2006. Ms. B however, was not in the office on June 6, and instead, left a note in the Respondent's box with a copy of the original prescription.[12] The Respondent was not notified of these events until June 6, 2006.

14. On June 6, 2006, the Respondent documented in Patient 1's chart that he received a note in his box regarding the erroneous Wellbutrin dosage for Patient 1, and wrote a new prescription with the correct dosage.[13] The Respondent then called Patient 1's mother, and found out Patient 1 had been hospitalized at Hershey Medical Center in Pennsylvania, having

[10] The Respondent documented the dosage of Wellbutrin in Patient 1's Medication Orders in his chart as Wellbutrin 150 mg., 3 tablets daily, which would total 450 mg.
[11] Certified Medical Assistant.
[12] Ms. B was aware she would not be in the office and spoke with the Administrator, who advised her to put a note in the Respondent's box.
[13] This prescription was never issued to Patient 1, as by the time it was written, he had already been hospitalized.

collapsed at the theme park during a school trip, with cardiac arrest and a grand mal seizure.

15. On June 6, 2006, Patient 1's hospital records reflect he had taken the 900 mg. of Wellbutrin XL through his morning dose. Patient 1 reported feeling a little ill the morning of June 6. After collapsing at the park, he was transported to the Medical Center, and never regained consciousness. His life support was terminated on June 12, after brain death was confirmed. Patient 1's autopsy report confirmed that his cause of death was due to complications of Wellbutrin toxicity.

16. The Respondent prescribed multiple psychotropic medications to Patient 1 without adequate documentation of "clearly justified circumstances."[14]

17. The Respondent failed to meet the standard of quality medical care and/or failed to maintain adequate records with regard to Patient 1 as outlined in pertinent part above for reasons including but not limited to:

    a. prescribing of multiple psychotropic medications without adequate documentation of clearly justified circumstances;

    b. failure to document informed consent prior to prescribing Depakote; and/or

    c. writing a prescription for twice the recommended dose of Wellbutrin XL to an 11 year-old child.

**PATIENT 2**

18. On or about February 14, 2006, Patient 2 was a 14 year-old female when she began seeing the Respondent at Upper Bay for a psychiatric evaluation. Patient 2 saw the Respondent on approximately a monthly

[14] Pursuant to the 2001 AACAP policy statement regarding prescribing psychoactive medications for children and adolescents.

basis between February 14, 2006 and June 2007. She had a history of depression, ADHD and ODD. Patient 2 had attempted suicide twice; once, she put a belt around her neck in an argument with her mother; and, on a second occasion, tried to jump out of a 2 story building.

19. Patient 2's initial evaluation by the Respondent revealed behavioral problems at home including aggression, angry outbursts and arguing with her parents. Her diagnoses included a depressive disorder, mood disorder and an impulse control disorder. Patient 2 had been prescribed Concerta by another provider before she began seeing the Respondent.

20. The Respondent's plan included obtaining labs and parent/teacher reports. Additionally, the Respondent encouraged the weekly individual therapy to be consistent, with family and group modalities. Patient 2 saw 2 different therapists at Upper Bay on approximately a weekly basis from approximately September 2005 through June 2007.

21. On February 14, 2006, the Respondent prescribed Wellbutrin SR for depression, and over the course of several months increased the dosage to 150 mg., 2 times daily.

22. On or about April 25, 2006, the Respondent began prescribing the additional prescription of Risperdal for mood disorder, anger, aggression and oppositional and defiant behaviors, gradually increasing the prescription to 1.5 mg. The Respondent failed to record baseline laboratory results of fasting glucose or a lipid panel.

23. Patient 2 showed some improvement, but sustained a weight gain. On August 29, 2006, the Respondent started to gradually taper off the dose of Risperdal, and added Geodon, gradually increasing the dosage to 80 mg. daily. This was in addition to continuing Patient 2's prescription of Wellbutrin SR, 150 mg. twice daily.

24. On September 26, 2006, the Respondent prescribed hydroxyzine[15] to Patient 2 for her complaints of insomnia in conjunction with her Geodon (which he noted he was increasing due to her ODD, anger and aggression) and her Wellbutrin SR.

25. On October 17, 2006, the Respondent documented that Patient 2 had increased ODD and explosive anger at home, but not at school. He noted police intervention and that she had difficulty sleeping. He noted a partial hospitalization might be necessary. The Respondent prescribed Wellbutrin SR, Geodon and hydroxyzine.

26. On November 21, 2006, Patient 2 was seen by the therapist for an unscheduled appointment due to ongoing conflicts at home necessitating recent police involvement and an emergency room visit the day before. The therapist arranged for her and her mother to sign a contract addressing what action to take in the event Patient 2 threatened to harm herself or others. Patient 2 also saw the Respondent on this date who documented an increase in symptoms including difficulty with organization and focusing. The Respondent recommended the possibility of a day hospital or a partial hospitalization if necessary and was considering

[15] An antihistamine that may be used as a sedative.

treatment of ADHD symptoms. He issued her prescriptions for Wellbutrin SR and Geodon. He discontinued Patient 2's hydroxyzine. Additionally, he began prescribing Depakote 250 mg., twice daily for "out of control behaviors." There was no consent form for Depakote in the record.[16]

27. Potential side effects of Depakote include sedation, dizziness, nausea/vomiting and confusion and should be monitored and documented. The standard of quality care requires that when significant side effects occur, stat blood levels should be drawn, and dosages should be immediately lowered or the drug discontinued as appropriate.

28. Patient 2 had laboratory studies drawn in the Emergency Room the day before her visit with the Respondent.

29. On December 12, 2006, Patient 2 complained of gastrointestinal distress when taking her medications without food; the Respondent recommended she take her medications with food, and that she should follow up with her primary care provider if there was no improvement. The Respondent increased Patient 2's dosage of Depakote to 750 mg. / per day (250 mg. every morning and 500 mg. at bedtime) for her significant mood changes. He documented that he planned to check Patient 2's Depakote level and LFT's in 2 weeks. There were no laboratory results however, in the chart reflecting that he obtained these tests.

[16] The Respondent documented on the medication record that the benefits and side effects of Depakote had been discussed.

30. On December 21, 2006, Patient 2 told her therapist that the medication was making her forgetful. The therapist documented she would alert the CMA.

31. On January 7, 2007, Patient 2's mother contacted the office for assistance as Patient 2 was agitated. She took Patient 2 to the Emergency Room at Harford Memorial Hospital for a worsening of symptoms. Patient 2's Depakote level (as ordered by the Emergency Room physician) was 108 (normal levels are 50-100).

32. On January 8, 2007, Patient 2's therapist documented that she had spoken with the CMA regarding her potential side effects, and that the CMA would address it with the physician. The Respondent was on administrative leave from January 9, 2007 to January 30, 2007 and was not notified about this.

33. On January 10, 2007, Patient 2 was again taken to the Emergency Room (at Harford Memorial Hospital) for confusion and a "glazed appearance." She was disoriented and had fallen on her way to school. Her Depakote level as ordered by the Emergency room physician was 129. Patient 2's symptoms were evaluated as being due to Depakote toxicity. The Emergency Room physician documented on the discharge form that he recommended a decrease of Patient 2's Depakote dosage to 1 Depakote, twice daily.

34. On January 17, 2007, Patient 2's mother contacted the Respondent's office for a new Depakote prescription, and the Respondent was out of the

office on administrative leave. Dr. M (an adult psychiatrist who worked at Upper Bay and was providing coverage) provided samples to Patient 2's mother and recommended that Patient 2 have another Depakote level drawn.

35. On January 24, 2007, Dr. M, the Medical Director at the Havre de Grace clinic, noted that Patient 2 had not taken her Depakote dosage 2 days before her blood test (Depakote level), evidencing inconsistent compliance with her prescription. Now, however, she documented that Patient 2 was taking her Depakote as ordered and was experiencing side effects once again.

36. On February 20, 2007, the Respondent prescribed Depakote 250 mg. twice daily in conjunction with Wellbutrin SR 150 mg., twice daily. Additionally, the Respondent re-started Patient 2 on Geodon, 60 mg. (gradually tapering her to a dose of two tablets daily) and started her on Clonidine,[17] 1 mg., ½ to 1 tablet at bedtime.

37. On March 19, 2007, Patient 2 returned to the Emergency Room at Harford Memorial Hospital with complaints of difficulty ambulating from weakness, cramps in her legs and complaints of dizziness and fatigue. The Emergency Room again drew a Depakote level; the result was 54.

38. On March 20, 2007, the Respondent tapered Patient 2 off Depakote and started her on Trileptal[18] as her mood and oppositional behavior continued. The Respondent continued to see Patient 2 until June, 2007.

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[17] Can be used to treat side effects of stimulant induced insomnia.
[18] May be used as a mood stabilizer in bipolar disorder.

39. The Respondent failed to meet the standard of quality medical care for Patient 2 and/or failed to maintain adequate records for Patient 2 for reasons outlined in pertinent part above including but not limited to:

a. his failure to document that he obtained Consent prior to starting Patient 2 on Depakote;

b. his failure to obtain Patient 2's laboratory results while she remained on Depakote;

c. his failure to adequately evaluate and/or document Patient 2's symptom course and development while on Depakote; and/or

d. his failure to obtain baseline laboratory studies when initiating Patient 2 on Risperdal.

**PATIENT 3**

40. Patient 3 was an 8 (almost 9) year-old female on March 29, 2005, when she first saw the Respondent for a psychiatric evaluation. She had a history of suicidal threats, mood changes, ODD, ADHD, sadness and anxiety. She had been prescribed Adderall XR and Clonidine by her pediatrician when she initially saw the Respondent. Patient 3 continued to see the Respondent for management of her medications through June 2007.

41. In addition to the Respondent, Patient 3 saw a therapist in the practice, but often missed her sessions.

42. On March 29, 2005, the Respondent prescribed Adderall XR 45 mg every morning, Clonidine .1 mg. at bedtime and Lexapro[19] 5 mg. a day (that was gradually increased over 3 weeks to 10 mg.).

[19] Used in the treatment of depression and generalized anxiety disorders.

43. Patient 3's dosage of 45 mg. of Adderall XR was higher than the recommended dosage for children up to age 12. The Respondent failed to document that he considered a lower dosage or any alternatives prior to prescribing 45 mg. for her.

44. He noted on his progress note that he "ordered" labs but did not specify what laboratory studies were ordered, and there were no results in Patient 3's chart.

45. On October 17, 2006, the Respondent noted that Patient 3 had an increase in symptoms (anger and mood changes) and started her on Risperdal in addition to her other medications (Adderall XR and Clonidine). The Respondent circled that he had ordered laboratory studies, but did not specify what studies. There is no laboratory report in Patient 3's chart, nor are the results documented.

46. On November 21, 2006, the Respondent documented that Patient 3 had a decrease in her symptoms including mood swings, anger and ODD, but then on the second page of the note, indicated that "at times" she was angry and irritable and "at times" was angry and defiant. He increased her Risperdal for "further mood and behavior improvement."

47. It appears from Patient 3's records that she missed visits for several months. The next documented visit with the Respondent was on February 13, 2007. He noted an improvement and a schedule to decrease and then discontinue her Clonidine.

48. On May 1, 2007, Patient 3's mother requested that the Respondent decrease Patient 3's Adderall XR, and the Respondent decreased the dosage to 40 mg. on a "trial basis." He also ordered laboratory studies, Glucose, Cholesterol and Triglycerides, but there were no documented results in Patient 3's chart.

49. On May 29, 2007, Patient 3's mother cancelled her appointment with the Respondent. On June 5, 2007, however, the Respondent provided prescriptions for Patient 3 for Lexapro, Adderall XR and Risperdal.

50. On June 19, 2007, Patient 3 complained of a recent onset of intermittent left shoulder movements. The Respondent held her Adderall and documented that a decrease or discontinuation of her Risperdal may be needed to rule out involuntary movements due to Risperdal. The Respondent provided Patient 3 however, with a prescription for her usual dosage of Risperdal.

51. Patient 3 failed to appear for her next appointment with the Respondent.

52. The Respondent failed to meet the standard of quality medical care for Patient 3 and/or failed to maintain adequate records for Patient 3 for reasons outlined in pertinent part above including but not limited to:

    a. his dosage of Adderall (45 mg.) exceeded the recommended dosage for an 8 year-old child, without documentation of adequate clinical justification; and/or

    b. he failed to obtain the results of laboratory studies for Patient 3 prior to prescribing Risperdal and continued to prescribe the medication.

**PATIENT 4**

53. Patient 4 was an 8 year-old male on March 1, 2005, when he initially saw the Respondent for psychiatric care. He was a twin and had been born prematurely with multiple medical problems. Patient 4 had symptoms of ADHD and had been on Concerta since 2002. Additionally, he had encopresis and separation anxiety disorder. Patient 4 was taking Carbitol for a seizure disorder that was not managed by the Respondent.

54. Patient 4 saw the Respondent on approximately a monthly basis through July 2007, and also saw a therapist approximately twice monthly.

55. During Patient 4's initial visit, the Respondent continued the Concerta at 27 mg. daily and added Ritalin[20] 5 mg for ADHD.

56. During the next visit, on March 31, 2005, the Respondent began prescribing Risperdal for anger, mood changes, aggression and defiance. Additionally, he increased Patient 4's Ritalin by 5-10 mg. as needed.

57. On April 12, 2005, the Respondent noted that Patient 4's parents would talk with Patient 4's primary care provider regarding [taking] Risperdal with his antiseizure medication (Carbitol). Additionally, he increased Patient 4's Concerta to 36 mg. daily for continuous ADHD symptoms.

58. On January 24, 2006, the Respondent noted there was stress at Patient 4's home and increased his dosage of Risperdal to .75 mg to address his mood problems and oppositional behavior.

[20] Ritalin (AKA methylphenidate), a Schedule II CDS, is used to treat ADD.

59. On September 5, 2006, the Respondent noted symptoms of "oppositional defiant disorder" and anger and increased his dosage of Risperdal to 1 mg. at bedtime.

60. On October 31, 2006, based on family issues/illness at home, the Respondent increased Patient 4's dosage of Concerta to 54 mg for ADHD symptoms.

61. The next month, on November 28, 2006, the Respondent again increased Patient 4's dosage of Concerta to 63 mg. daily "to address ADHD sx."

62. The maximum studied dosage of Concerta for a child between the ages of 6 and 12 is 54 mg.

63. The Respondent failed to meet the standard of quality medical care for Patient 4 and/or failed to maintain adequate records for Patient 4 for reasons outlined in pertinent part above including but not limited to:

    a. his failure to document adequate clinical justification of prescribing methylphenidate (Concerta and Ritalin) and Risperdal simultaneously; and/or

    b. his dosage of Concerta for Patient 4 exceeded the recommended dosage without documentation of adequate clinical justification.

**PATIENT 5**

64. Patient 5 was a 6 (almost 7) year-old male when he began seeing the Respondent for psychiatric care on February 20, 2004. He had a history of disruptive behavior, violent episodes and aggression and mood swings. He experienced symptoms at home and at school. His diagnoses

included mood disorder, ADHD, ODD, Impulse Control Disorder, and r/o (rule out) Anxiety and r/o Depressive Disorder.

65. Patient 5 saw the Respondent on approximately a monthly basis through June 2007, and also saw a therapist in the practice for individual and family therapy. Over the course of treatment with the Respondent, Patient 5 received multiple medication trials at different times including Strattera,[21] Risperdal, Wellbutrin SR, Abilify, Lexapro and Trileptal.

66. On February 20, 2004, the Respondent began prescribing Abilify 5 mg. daily to the Respondent and increased the dosage in March 2004 to 10 mg. to address anger and mood changes.

67. On March 12, 2004, the Respondent added Wellbutrin XL, 150 mg. daily to Patient 5's medication regime, as Patient 5 was noted to be aggressive and angry and to address underlying sadness (one of his underlying diagnoses was r/o depressive disorder).

68. On May 7, 2004, the Respondent added Strattera to Patient 5's medications based on ADD symptoms "noted by parent and teacher."

69. On December 14, 2004, Patient 5 experienced suicidal ideation and the Respondent recommended day treatment as well as a neurological consultation and an EEG. He increased his dosage of Abilify to 25 mg., and his Wellbutrin to 300 mg.

70. The next month, on January 4, 2005, the Respondent increased Patient 5's Strattera from 25 mg. per day to 40 mg. daily.

[21] A nonstimulant medication approved for the treatment of ADHD.

71. On May 3, 2005, the Respondent prescribed an additional medication, Adderall XR for continuous ADHD symptoms, but the family did not have the prescriptions filled. Additionally, the Respondent increased Patient 5's Abilify again to 30 mg. daily for anger and mood changes. Patient 5 admitted to his mother (who contacted his therapist) that he had not been taking his Abilify for approximately 3 weeks.

72. On June 30, 2005, the Respondent increased Patient 5's Strattera to 50 mg. daily due to ongoing ADHD symptoms. This exceeded the recommended dosage of Strattera in children (1.4 mg. /kg daily).

73. On February 7, 2006, the Respondent again increased Patient 5's dosage of Strattera, to 60 mg daily, as he was more "fidgety" at home (he was "OK" at school).

74. On March 7, 2006, the Respondent documented increased symptoms and a plan to wean Patient 5 off of Abilify and initiate Risperdal. He initially prescribed .25 mg. of Risperdal for Patient 5, and increased the dosage every 3 days to 1 mg. daily. There was no baseline weight noted in Patient 5's chart.

75. On May 30, 2006, Patient 5's weight was noted for the first time (61 ¾ lbs.), and the Respondent noted he had some decrease in his symptoms.

76. On October 17, 2006, the Respondent increased Patient 5's dosage of Risperdal.

77. On November 14, 2006, the Respondent added Lexapro to Patient 5's medications for symptoms of depression.

78. On February 13, 2007, the Respondent added Trileptal to Patient 5's medications for mood changes.

79. During Patient 5's May 8, 2007 visit with the Respondent, he noted Patient 5 had recently been hospitalized with suicidal ideation (on April 26). His Lexapro was discontinued and his Trileptal increased to 300 mg. twice daily for "mood change and anger."

80. The Respondent failed to meet the standard of quality medical care for Patient 5 and/or failed to maintain adequate records for Patient 5 for reasons outlined in pertinent part above including but not limited to:

a. his dosage of Strattera exceeded recommended guidelines without documentation of adequate clinical justification for exceeding the recommended dosage of Strattera; and/or

b. his failure to document baseline weights prior to prescribing medications and/or consistently document Patient 5's weights during office visits.

**PATIENT 6**

81. Patient 6 was a 10 year-old male when he began seeing the Respondent on September 27, 2005 for a prior diagnosis of ADHD (diagnosed at age 5). When Patient 6 initially saw the Respondent, his pediatrician was prescribing Adderall 30 mg., twice daily, which is in excess of the maximum recommended dosage. Additionally, Patient 6 presented with symptoms of Obsessive Compulsive Disorder, ODD and difficulty sleeping (had a history of sleepwalking).

82. Patient 6 saw the Respondent for psychiatric care (primarily medication management) through June 2007. He also received individual therapy through other providers in the practice.

83. The Respondent initiated Patient 6 on Trazodone (an antidepressant with sedative properties) to address his sleep disturbance. Patient 6's pediatrician continued prescribing Adderall for him.

84. On January 28, 2006, Patient 6 had a sleep study done at St. Joseph Medical Center.

85. On January 31, 2006, the Respondent increased Patient 6's dosage of Trazodone based on increased sleep "disturbance" and order that it be taken earlier in the evening.

86. On May 23, 2006, Patient 6's weight was recorded at 64 ¼ pounds. His weight was not recorded again until approximately one year later. On March 6, 2007, his weight increased to 71 ½ pounds.

87. On August 29, 2006, the Respondent added Geodon, and gradually increased to 80 mg. /day, to Patient 6's medications, based on anger and mood issues.

88. There is a notation on Patient 6's chart that an EKG was ordered several months after the drug was started (on December 12, 2006).

89. On September 26, 2006, the Respondent increased Patient 6's dosage of Geodon to 120 mg. daily (maximum recommended dosage for a child is 80 mg. daily) for anger issues. Additionally, based on a note from Patient 6's 5th grade teacher that he had developed a hand tremor, Patient 6's

pediatrician discontinued Adderall and initiated Concerta. Patient 6's pediatrician was also reportedly evaluating him for possible "diabetes, thyroid disturbance anemia, hyperglycemia" based on symptoms of polyuria, polydipsia, body shaking and dizziness relieved by eating.

90. On November 14, 2006, the Respondent noted Patient 6 was taking Concerta 54 mg., as prescribed by his pediatrician.

91. On December 12, 2006, the Respondent documented that the pediatrician would not increase Patient 6's Concerta beyond 54 mg. daily and the Respondent told Patient 6's mother that he would manage Patient 6's Concerta prescriptions. The Respondent increased Patient 6's dosage of Concerta to 63 mg. to address Patient 6's ADHD symptoms after lunch and additionally was still prescribing Geodon (120 mg.) and Trazodone (50-100 mg. at bedtime).

92. The Respondent's dosage of Concerta at 63 mg. exceeded the recommended dosage.

93. On or about December 22, 2006, Patient 6 was seen in the emergency room at Harford Memorial Hospital with a possible seizure. Patient 6's mother called Upper Bay's emergency number to report the incident, but did not receive a telephone call until 4 hours later. The on-call therapist, after contacting the on-call psychiatrist, told Patient 6's mother to decrease Patient 6's Geodon to 60 mg.[22] and to discontinue the

[22] The on-call psychiatrist's note reflects that she advised the mother to discontinue the Trazodone and decrease the Geodon to 40 mg. only (as the patient was on the medication twice daily). This however, is likely a clerical error as the therapist and the Respondent both documented 60 mg. and Patient 6 was on 120 mg. daily.

Trazodone. The Respondent documented this information in a note when Patient 6's mother reported this to him on December 26, 2006.

94. On January 23, 2007, another psychiatrist in the practice saw Patient 6 and his mother. She noted that Patient 6's mother had discontinued the Geodon, but continued the Trazodone.

95. On January 26, 2007, Patient 6's mother called the office to report her son was experiencing "shakiness" on his medications.

96. Patient 6 saw a pediatric neurologist on or about February 6, 2007. At the time, Patient 6 was taking Trazodone 50 mg at bedtime and Focalin 20 mg and 10 mg.[23] According to her report, the neurologist opined that Patient 6's seizure might be related to the Geodon since "Geodon causes seizure in rare cases." She ordered an EEG.

97. The Respondent failed to meet the standard of quality medical care and/or failed to maintain adequate medical records for Patient 6 for reasons outlined in pertinent part above including but not limited to:

a. his failure to document baseline weights and/or vital signs prior to prescribing medications and/or document Patient 6's weights and/or vital signs during office visits; and/or

b. his dosages of Concerta and Geodon exceeded recommended guidelines without documentation of adequate clinical justification.

**PATIENT 7**

98. Patient 7 was a 10 year-old male when he first saw the Respondent on September 12, 2003. He continued seeing the Respondent through June

[23] It's unclear from the progress notes when the Respondent discontinued Patient 6's Concerta and initiated the Focalin. Focalin contains a lower dose of methylphenidate and is used in the treatment of ADHD.

12, 2007, shortly before the Respondent left the practice. Prior to seeing the Respondent, Patient 7 had been seen at Upper Bay by other providers for anger management issues and ADHD. He had been hospitalized twice for anger issues.

99. On September 12, 2003, the Respondent diagnosed Patient 7 with depression, ADHD, suicidal and homicidal ideation, r/o ("rule out") intermittent explosive disorder and a history of trichotillomania (an impulse control disorder characterized by pulling out body hair). The Respondent ordered laboratory studies, a neurological evaluation and an EEG and a Children's Depression Inventory ("CDI"). At the time the Respondent saw Patient 7, he was taking Risperdal .25 mg., 1 tablet every morning and 2 tablets in the evening and Adderall XR, 20 mg. every morning.

100. From August 2002 through June 5, 2007, Patient 7 also saw a therapist at Upper Bay on approximately a weekly basis.

101. The Respondent continued Patient 7 on Adderall XR, eventually gradually increasing the dosage over 3 ½ years. On January 2, 2007, he increased the dosage to 60 mg. daily for treatment of ADHD.

102. In January 2007, the Respondent was prescribing 1 mg. /kg. for Patient 7 (he was 13 and weighed approximately 132 pounds or 59.87 kg.).

103. On February 14, 2006, the Respondent noted that he discussed the FDA recommendation for an EKG and cardiac evaluation for patients on stimulants.

104. On December 5, 2006, the Respondent documented that the EKG and cardiac evaluation were not done.

105. On January 30, 2007, the Respondent documented he attempted to reach Dr. K, the Medical Director at Upper Bay, for "peer consultation" due to the high Adderall XR dosage and following the Upper Bay policy, but he could not reach her. His plan was to change the Adderall XR to Focalin.

106. There is an undated note in Patient 7's medical record by the Respondent entitled "Peer Consultation." The Respondent documented that he discussed Patient 7's case with Dr. K, and she agreed it was appropriate to continue the Adderall XR 60 mg. daily while waiting for an EKG. The Respondent did not prescribe Focalin, but continued Patient 7 on the 60 mg. of Adderall XR.

107. The Respondent documented that he ordered an EKG and cardiovascular examination while continuing Patient 7 on the large dose of Adderall XR, but Patient 7 did not have the EKG until February 6, 2007. Although the results did not reveal any arrhythmia, the results did show Patient 7 had an abnormality: biventricular hypertrophy.

108. On February 27, 2007, the Respondent provided a copy of the abnormal EKG to Patient 7's father and recommended that Patient 7 follow up with his primary care provider and a pediatric cardiologist. The Respondent continued to prescribe the 60 mg. of Adderall XR to Patient 7.

109. On April 24, 2007, the Respondent documented that Patient 7 saw his primary care provider, who did not express any concerns about the EKG

findings and treatment with Adderall XR and did not recommend any treatment changes, but again recommended that he follow up with a pediatric cardiologist. There is no documentation in Patient 7's chart that he saw a cardiologist following his abnormal EKG. The Respondent continued to prescribe the 60 mg. of Adderall XR to Patient 7.

110. Although Patient 7 did not complain of side effects from the Adderall XR, he continued to have difficulties at school with academics. The Respondent did not recommend any academic or cognitive testing for Patient 7, instead just continued to increase the dosage of the stimulant.

111. The Respondent continued Patient 7 on the Risperdal, decreasing his initial dosage on April 12, 2005[24] to .25 mg. twice daily, and continuing this dosage through June 12, 2007.

112. The standard of quality care requires monitoring laboratory studies (including triglycerides, cholesterol, lipids and glucose) and weights when a patient is on Risperdal.

113. The only laboratory results for triglycerides, cholesterol, lipids or glucose in Patient 7's record were drawn on February 6, 2007 (ordered on December 5, 2006). After the Respondent assumed the psychiatric care of Patient 7, the first recorded weight was June 20, 2006. There were no weights recorded for Patient 7 for more than 3 years (from January 14, 2003 until June 20, 2006).

[24] According to a June 18, 2004 note, Patient 7's parents decreased his dosage to .25 mg., 1 tablet twice daily.

114. The Respondent failed to meet the standard of quality medical care and/or failed to maintain adequate records for Patient 7 for reasons outlined in pertinent part above including but not limited to:

a. he failed to order or recommend any cognitive or academic testing be done despite Patient 7's continued problems with schoolwork;

b he failed to obtain the appropriate laboratory testing for Patient 7 for several years while on Risperdal and/or to include the results in his medical record; and/or

c. he failed to document that Patient 7's weight was taken and recorded for over 3 years (from January 2003 until June 2006), while he continued him on Risperdal.

**PATIENT 8**

115. Patient 8 was an 8 year-old male when he began seeing the Respondent for psychiatric care on September 12, 2006. Patient 8 had a learning disorder, was repeating first grade for the second time, a history of physical abuse by his mother's boyfriend (having sustained a head injury at age 5), ADHD and post-traumatic stress disorder. Patient 8 was on Strattera 40 mg. daily and Adderall XR, 15 mg. daily. The Respondent diagnosed him with anxiety and depression and a history of ADHD.

116. Patient 8 saw the Respondent for psychiatric care for 3 months, through December 19, 2006. Additionally, he saw therapists on approximately a weekly basis at Upper Bay from September 12 - December 19, 2006.

117. During the first visit, the Respondent continued Patient 8 on his Strattera dosage, increased his Adderall XR to 20 mg. daily for ADHD symptoms and initiated Lexapro, gradually increasing the dosage to 5 mg. daily.

118. During the second visit, on October 31, 2006, the Respondent gradually increased Patient 8's dosage of Lexapro to 10 mg. daily to address his "sadness and anxiety" and added Trazodone (for insomnia) to Patient 8's medications.

119. On November 21, 2006, the Respondent decreased Patient 8's Lexapro to 1 ½ tablets (7.5 mg.) daily.

120. On December 19, 2006, the Respondent increased Patient 8's Adderall XR to 25 mg. daily for increased ADHD symptoms in school and at home. Additionally, he increased Patient 8's Lexapro to 10 mg. daily.

121. The Respondent failed to record vital signs and weight for Patient 8 (aside from a weight from several months before his initial visit).

122. The Respondent failed to meet the standard of quality medical care for Patient 8 and/or failed to maintain adequate records for Patient 8 for reasons outlined in pertinent part above including but not limited to:

a. his failure to document adequate clinical justification for his simultaneous increase in Lexapro and initiation of Trazodone; and/or

b. his failure to adequately record weight and/or vital signs.

**PATIENT 9**

123. Patient 9 was a 4 year-old female when she was referred to Upper Bay for consideration of a diagnosis of ADHD. The Respondent saw Patient 9 for an initial evaluation on October 17, 2003, and continued to see her monthly for medication management, through June 19, 2007. The Respondent's initial impression was that Patient 9 had ODD mostly at

home, ADHD-like symptoms, impulse control disorder and r/o depressive disorder. His plan was to consider a trial of "mood stabilizer, neuroleptic or stimulant."

124. Patient 9 also saw different therapists at Upper Bay on a weekly basis from September 3, 2003 through June 4, 2007.

125. On November 14, 2003, the Respondent started Patient 9 on Strattera for ADHD symptoms, gradually increasing the dosage to 10 mg. twice daily.

126. The next month, on December 12, 2003, the Respondent noted that Patient 9 had no symptom improvement, discontinued her Strattera, and started her on Metadate (a Schedule II CDS stimulant used in the treatment of ADHD), gradually increasing the dosage to 10 mg. twice daily, and Ritalin 5 mg. daily.

127. On February 6, 2004, the Respondent started Patient 9 on Prozac for "r/o anxiety and depressive disorder." Her dosage was gradually increased to 20 mg. daily on June 25, 2004.

128. On March 2, 2004, Patient 9's therapist wrote a Memorandum to the Respondent indicating that Patient 9's mother was requesting a change to her medications as she had an increase in her lack of focus and concentration after school.

129. On March 5, 2004 the Respondent made the following changes to Patient 9's medications: he increased her Metadate to 20 mg. daily, discontinued her afternoon dose of Ritalin and initiated Trazodone 50 mg. (½-1 as needed for sleep).

130. On May 28, 2004, the Respondent increased the dosages of both Metadate to 30 mg. daily and Prozac for an increase in ODD symptoms and "mood [change], 'very grumpy,' sad, anxious."

131. In June 2004, the Respondent initiated Risperdal (increasing the dosage over a 2 week period to .25 mg. twice daily) for increased anger and mood changes and ODD symptoms. In September, Patient 9 had gained 7 pounds, and the Respondent appropriately discontinued the medication.

132. On September 21, 2004, the Respondent gradually discontinued Patient 9's Prozac due to lack of effectiveness.

133. On October 26, 2004, the Respondent noted an increase in symptoms. He continued to prescribe Trazodone. Additionally, he initiated Concerta 18 mg. daily (based on Mother's request) for ADHD symptoms and Abilify 2.5 mg for anger, mood swings, irritability and ODD.

134. On December 6, 2005, the Respondent documented that Patient 9 had anger and increased ADHD, ODD symptoms. He gradually increased her dosage of Abilify to 10 mg.

135. On January 31, 2006, based on Patient 9's continued difficulty to fall asleep, the Respondent increased her dosage of Trazodone 50 mg. to 2 ½-3 tablets at bedtime.

136. On June 20, 2006, over a 2 week period, the Respondent increased Patient 9's Abilify from 15 mg. to 20 mg. daily for increased mood changes, anger and irritability at home and school. She was also taking

Trazodone 50 mg. (2 ½-3 at bedtime) and Concerta 63 mg. daily and Ritalin 5 mg. daily.

137. On August 15, 2006, the Respondent again increased Patient 9's dosage of Abilify to 25 mg. daily for increased anger and mood changes and continued the other medications noted in ¶ 136. For the first time, the Respondent recommended psychoeducational testing be conducted. There were no results noted in Patient 9's record.

138. On September 12, 2006, the Respondent increased Patient 9's Abilify to 30 mg. for increased anger and Concerta to 72 mg. for ADHD symptoms in addition to her Trazodone and Ritalin. She began receiving individual therapy at school.

139. The Respondent exceeded the recommended dosage for Concerta in children.[25]

140. On October 10, 2006, the Respondent documented that Patient 9's mother had not increased her Abilify as she wanted to see what would happen with the increase in Concerta. He prescribed 25 mg. of Abilify at bedtime along with 150 mg. of Trazodone and 5 mg. of Ritalin.

141. On November 28, 2006, the Respondent weaned her off and discontinued Patient 9's Abilify and started her on Seroquel,[26] gradually increasing the dosage to 100 mg. at bedtime, based on his evaluation she was emotional

[25] Higher doses can be justified for good effect and symptom control, but based on the rapid increase in dosage and multiple medication changes for Patient 9, this dosage was not adequately justified.
[26] A mood stabilizing medication used in the treatment of bipolar disorder.

with tantrums. The other medication dosages remained the same (Trazodone, Ritalin and Concerta).

142. The next month, on December 26, 2006, the Respondent began weaning Patient 9 off of the Seroquel as she was "moody, hyperactive and fidgety." He noted also that Patient 9 was having motor movements in the office. The other dosages remained the same (Trazodone, Concerta and Ritalin). His plan was to consider a trial of Depakote or Lithium for Patient 9's mood disorder.

143. On December 27, 2006, Patient 9 was taken to the Emergency Room with symptoms of a dystonic reaction. She was being prescribed Seroquel 25 mg., 4 times daily, Concerta, 72 mg. daily and Trazodone. The Emergency Room physician contacted Upper Bay to speak with the Respondent or the on-call psychiatrist. Dr. K, the Medical Director, spoke with the Emergency Room physician. She documented that Patient 9 was experiencing a "severe dystonic reaction" and recommended stopping her medications, giving Patient 9 half her dose of Concerta and using Benadryl for sleep.

144. On December 28, 2006, Dr. M spoke with Patient 9's mother who called to ask whether Patient 9's Concerta should be held. Dr. M told her to hold the Concerta until she saw the Respondent. Additionally, she notified the Respondent as well as Dr. K who also called Patient 9's mother.

145. The Respondent documented that on January 2, 2007 he discontinued Patient 9's Ritalin, Concerta, and Trazodone per "ER and Dr. [M]." He

noted that she had significant insomnia, significant anger, violence, thoughts of self harm, was very hyper and very labile. The Respondent recommended that Patient 9 be hospitalized at Rockford Center (an inpatient mental health and treatment center) for stabilization and therapy.

146. On January 5, 2007, Patient 9's therapist documented that she spoke with Patient 9's mother who reported Patient 9 seemed to have a reaction to the medication change and was "extremely jittery, constantly moving" and had not slept in 2 days. Rockford Center discharged Patient 9 on January 8, 2007.

147. On February 13, 2007, Patient 9 returned to see the Respondent for an outpatient visit. While at Rockford Center, the physicians had changed Patient 9's medications to Focalin XR, 15 mg. daily and Trazodone 50 mg. for sleep. During this visit, the Respondent increased the Focalin XR to 20 mg. daily for increased ADHD symptoms, and the Trazodone to 75-100 mg. at bedtime for insomnia.

148. Two weeks later, on February 27, 2007, due to continued ADHD symptoms, the Respondent changed Patient 9's Focalin to Adderall XR and gradually increased the dosage to 10 mg. He also initiated Trileptal, 150 mg. for mood swings. He prescribed 100 mg. of Trazodone at bedtime.

149. On March 13, 2007, the Respondent increased Patient 9's Adderall XR to 15 mg. noting ADHD symptoms. Additionally, he increased her dosage of Trileptal to 150 mg., twice daily for anger and mood disturbance. He

continued the prior dosage of Trazodone. The Respondent noted "awaiting psychoeducational testing."

150. On April 3, 2007, the Respondent again increased the dosages of Patient 9's Trileptal for "mood swings" to 150 mg, 1 ½ twice daily and her Trazodone for "insomnia" to 125 mg. at bedtime.

151. On May 1, 2007, the Respondent increased Patient 9's Adderall XR to 20 mg. as well as her Trazodone (to 150 mg.) for increased sleep and ADHD symptoms.

152. The Respondent failed to meet the standard of quality medical care for Patient 9 and/or failed to maintain adequate records for Patient 9 for reasons outlined in pertinent part above including but not limited to:

a. his dosage of Concerta exceeded recommended guidelines without adequate documented clinical justification; and/or

b. his failure to adequately document specific rationale for prescribing each psychoactive medication.

**PATIENT 10**

153. Patient 10 was an 8 year-old male when he was first seen by the Respondent for a psychiatric evaluation on November 21, 2003. The Respondent saw him on a monthly basis through June 12, 2007, primarily for medication management. The Respondent noted that Patient 10 had a history of ODD, was "overanxious", had ADHD symptoms, anger and learning problems. Patient 10 was being treated with Adderall, Risperdal, Zoloft[27] and Trazodone. The Respondent continued these medications

[27] Used in the treatment of depression and anxiety.

and also added Trileptal that was gradually increased to 150 mg. twice daily for anger and mood changes.

154. Patient 10 also saw various therapists at Upper Bay on approximately a weekly basis from November 2003 through May 2007.

155. On January 2, 2004, the Respondent increased Patient 10's Trileptal to 300 mg. twice daily for increased aggression and anger.

156. On March 1, 2004, the Respondent noted Patient 10 had increased anger, aggression and mood change; he increased Patient 10's Trileptal to 450 mg. twice daily. Patient 10's dose of Zoloft was at 150 mg. daily, but it is unclear when the dosage changed.

157. On April 23, 2004, the Respondent noted that Patient 10 had been taken to the Emergency Room by the school's staff because he fell asleep in class and could not be awakened. The Respondent documented that Patient 10 had taken his Trazodone at 1:00 a.m. the night before the Emergency Room visit. Additionally, the Respondent noted that Patient 10's Risperdal had been decreased; the prescribed dosage on this date was 1 mg. in the morning and 1.5 mg. at bedtime. The medication sheet is illegible with regard to the prior Risperdal dosage.

158. On June 18, 2004, the Respondent increased Patient 10's Risperdal dosage to 1 mg. in the morning, .5 mg. in the afternoon and 1.5 mg. at bedtime due to anger and mood changes. He noted he was overall "fairly ok" but had a mood change in the late afternoon.

159. In November 2004, the Respondent increased Patient 10's Adderall XR to 35 mg. in the morning (in addition to Adderall 10 mg. in the afternoon) as his ADHD symptoms at school had increased.

160. On June 30, 2005, the Respondent increased Patient 10's Trileptal dosage to 300 mg., 1 ½ in the morning and 2 in the afternoon for increased mood changes and ODD symptoms.

161. Beginning on October 4, 2005, the Respondent increased Patient 10's Trileptal dosage to 300 mg., 2 twice daily (1200 mg.) for increased anger and mood changes. The maximum adult dosage of Trileptal is 1200 mg. daily. At age 11, Patient 10 weighed only 82 pounds[28] and was receiving the maximum adult dosage.

162. In October 2005, the Respondent also increased Patient 10's Risperdal for an increase in symptoms (anger, mood changes, defiance).

163. On November 29, 2005, the Respondent increased Patient 10's Risperdal 1 mg. to 1 ½ in the morning and 2 ½ at bedtime, as he had been angry and aggressive.

164. On June 6, 2006, the Respondent noted that Patient 10 had been assaulted by a 24 year old male who was arrested; he noted that he was taking less Risperdal by "mother's decision." He noted "f/u with lab work and EKG." Patient 10 eventually had an EKG done in February 2007, and this was included in the chart. There were no laboratory results noted in Patient 10's chart.

[28] This is approximately 37 kg.

165. On October 31, 2006, the Respondent changed Patient 10's timing of his Risperdal at the mother's request. In November, the Respondent decreased Patient 10's Risperdal in the morning and increased the dosage at bedtime, due to his sleepiness.

166. On December 26, 2006, the Respondent changed the time Patient 10 took his Risperdal to .1 mg, ½ at noon, to address Patient 10's "anger and irritability in school."

167. On February 20, 2007, the Respondent increased Patient 10's dosage of Adderall XR in the morning to 35 mg., to address his increased ADHD symptoms and decreased performance in school. He documented that he "discussed new Upper Bay policy re: [increased] meds dosages (beyond PDR recommendations)."

168. On March 20, 2007, the Respondent noted an increase in Patient 10's ADHD symptoms and that the recent EKG was within normal limits; he added a prn afternoon dose of Adderall 5 mg. (in addition to the 35 mg. of Adderall XR in the morning). He documented "we'll try a small [increase] in Adderall in the PM (total dosage lower than that of a few months ago)."

169. The maximum recommended dose of Adderall XR for a child is 30 mg/day. Patient 10 was a child of 82 pounds (37 kg) and he was receiving up to 35 mg/day, which exceeded the recommended dose for children.

170. On April 17, 2007, the Respondent again ordered laboratory studies be drawn for glucose levels, triglycerides and cholesterol, as required when prescribing Risperdal. The next month, on May 15, 2007, he noted the

blood tests were pending. There were no results documented in Patient 10's records

171. The Respondent failed to meet the standard of quality medical care for Patient 10 and/or failed to maintain adequate records for Patient 10 for reasons outlined in pertinent part above including but not limited to:

a. his prescribing of Adderall XR and Trileptal exceeded recommended guidelines without documentation of adequate clinical justification; and/or

b. his failure to obtain the appropriate laboratory studies while Patient 10 remained on Risperdal.

**PATIENT 11**

172. Patient 11 was an 11 year-old male on September 29, 2005 when he was initially seen by the Respondent for a psychiatric evaluation. He had a history including ADHD, ODD, a mood disorder, aggression and violence and had been prescribed Risperdal 1 mg. at bedtime and Adderall XR, 25 mg. The Respondent documented the past therapy had not been helpful; he maintained Patient 11 on the Adderall XR, but weaned him off Risperdal and started Abilify and Trazodone.

173. Patient 11 continued to see the Respondent on approximately a monthly basis through July 3, 2007, when the Respondent left the practice.

174. From approximately August 2005 until July 2007, in addition to seeing the Respondent for medication management, Patient 11 received individual and family therapy at Upper Bay with different therapists.

175. Over Patient 11's course of treatment with the Respondent, he prescribed multiple psychotropic medications to Patient 11 at different times, including Focalin XR (for ADHD), Clonidine (for insomnia), Adderall XR (for ADHD), Zyprexa,[29] Abilify, Depakote and Risperdal (all for mood disorder, ODD, aggression and violent behavior).

176. The Respondent noted that on April 4 and May 23, 2006, Patient 11 was suspended from taking the school bus for threatening peers.

177. On May 9, 2006, the Respondent started Patient 11 on Depakote for mood changes, gradually increasing his dosage to 250 mg. twice daily.

178. On June 13, 2006, Patient 11's mother discontinued his Depakote due to side effects. The Respondent did not obtain a Depakote level while Patient 11 was on the medication. Also during the June 13 visit, the Respondent added Zyprexa to Patient 11's medications.

179. On October 3, 2006, Patient 11 was noted to be aggressive at home and at school. He also noted that Patient 11 had difficulty with homework and had decreased patience and attention. He was suspended from school for 3 days. The Respondent increased the dosages of Patient 11's Zyprexa, for anger and mood changes, and Adderall XR, for ADHD symptoms, simultaneously.

180. On December 12, 2006, Patient 11 was suspended from school again, and was noted to have been sleeping in school. The Respondent increased his dosage of Zyprexa for anger and mood disorder symptoms and ordered he take it at bedtime.

[29] Used in the treatment of bipolar disorder and schizophrenia.

181. The next month, in January 2007, Patient 11 was suspended again from school and had additional temper problems. The Respondent noted ADHD symptoms in school. On January 2, 2007, the Respondent increased 2 medications simultaneously: he increased his dosage of Zyprexa and Adderall XR.

182. On March 13, 2007, the Respondent documented that Patient 11 had been hospitalized at Shepard and Enoch Pratt Hospital ("SEPH") for out of control behavior in school, including aggression, anger, mood changes, ADHD symptoms and increased disruptive behavior, and had been started on Clonidine, ½ in the morning and 1 at bedtime. Additionally, he had been prescribed 40 mg. of Adderall XR at SEPH (a dosage which exceeded recommended guidelines). The Respondent documented in his plan: recommended a partial hospitalization or residential treatment center ("RTC") for Patient 11. The Respondent continued Patient 11 on the Clonidine. Additionally, he increased his dosages of Zyprexa and Adderall XR for ADHD simultaneously.

183. The Respondent ultimately prescribed 50 mg. of Adderall XR daily to Patient 11, The Respondent failed to document his rationale for exceeding the recommended guidelines.

184. On March 27, 2007, Patient 11's therapist documented he was suspended from school. Patient 11's mother had called to inquire how to "get him back into Sheppard Pratt."

185. On April 18, 2007, the CMA documented that Patient 11's mother called to speak with the Respondent or with her therapist as Patient 11 was kicking her car and un-manageable. Patient 11's mother was requesting that the C.M.A. come to her home and take her son to Shepard Pratt.

186. On May 15, 2007, the Respondent made the following alterations in Patient 11's medications simultaneously: he increased his dosage of Clonidine, changed his Adderall XR to Focalin XR, and increased his dosage of Zyprexa. Additionally, he "considered" a therapy trial with Lithium.

187. On June 29, 2007, the Respondent ordered laboratory studies (because he was considering a trial of Lithium) that revealed Patient 11 had a mild elevation of his LDH, glucose and T3, and a moderate elevation of his Alkaline Phosphatase. The previous laboratory report included in Patient 11's record was from June 2005.

188. On July 3, 2007, the Respondent recommended that Patient 11 follow up with his primary care provider based on his elevated liver function tests.

189. As outlined above, during several visits, the Respondent made simultaneous medication changes for Patient 11. Making more than one medication change at a time for Patient 11 limited the Respondent's ability to determine the effectiveness of the respective modifications.

190. The Respondent failed to meet the standard of quality medical care and/or failed to maintain adequate records for Patient 11 for reasons outlined in pertinent part above including but not limited to:

a. his prescribing of Adderall XR exceeded recommended guidelines without adequate documented clinical justification;

b. making more than 1 medication change at a time without adequate documented clinical justification; and/or

c. his failure to obtain a Depakote level while Patient 11 was being prescribed the medication.

**PATIENT 12**

191. Patient 12 was an 8 year-old female when she initially saw the Respondent for a psychiatric evaluation on August 22, 2006. She had a history of ADHD, ODD and a mood disorder. Her symptoms included insomnia, anger, hyperactivity, impulsiveness, defiance and decreased frustration tolerance. She had a family history of bipolar disorder and depression. The Respondent documented that Ritalin and Focalin XR had caused side effects, Strattera had not been beneficial and Adderall XR had made the patient worse. At the time Patient 12 saw the Respondent, she was taking Concerta at 72 mg. daily prescribed by another provider. The Respondent diagnosed Patient 12 with an anxiety disorder, ODD, ADHD and a depressive disorder.

192. Patient 12 continued seeing the Respondent primarily for medication management until July 3, 2007, when he left the practice. Additionally, she saw various therapists in the practice from March 2004 through July 2007, usually at least once weekly.

193. Over the course of treating Patient 12, the Respondent prescribed various psychotropic medications at different times including Abilify, Trazodone, Concerta, Risperdal and Ritalin.

194. During the August 22, 2006 visit, the Respondent continued Patient 12 on her Concerta dosage of 72 mg. daily, which exceed recommended prescribing guidelines.

195. On August 22, the Respondent also started Patient 12 on Risperdal for mood swings and ODD behavior. The Respondent circled that he ordered laboratory studies, but no results were included in Patient 12's medical record.

196. By December 5, 2006, Patient 12's symptoms had improved, but she had a weight gain. The Respondent noted that he increased her Risperdal and recommended diet and exercise.

197. On January 2, 2007, the Respondent documented that he increased Patient 12's Risperdal to address her anger and ODD symptoms.

198. On March 27, 2007, the Respondent decreased Patient 12's Risperdal based on her weight gain. The Respondent documented "lab tests pending" but there are no results noted in Patient 12's record.

199. On April 24, 2007, Patient 12 had increased symptoms and her weight continued to increase. The Respondent tapered off her Risperdal and replaced it gradually with Abilify for mood changes and ODD symptoms. The Respondent circled that he had "ordered" laboratory studies, but no results were included in Patient 12's records.

200. On July 3, 2007, Patient 12's final visit with the Respondent, he documented that he ordered laboratory studies and noted a 7 pound increase in her weight.

201. The Respondent failed to meet the standard of quality medical care and/or his documentation was inadequate for Patient 12 for reasons outlined in pertinent part above including but not limited to:

a. his prescribing of Concerta exceeded recommended guidelines without adequate documented clinical justification;

b. his failure to obtain baseline laboratory studies when prescribing Risperdal; and/or

c. his failure to adequately document his rationale for making treatment changes.

## CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions and inactions as outlined above constitute violations of Health Occ. § 14-404(a)(22) and (40).

## ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of October, 2009, by a majority of a quorum of the Board considering this case:

**ORDERED** that the Respondent's medical license shall be **SUSPENDED** for a period of **TWO (2) YEARS**; and be it further

**ORDERED** that the **SUSPENSION** shall be immediately **STAYED**; and that the Respondent be placed on **PROBATION** for a minimum **PERIOD OF TWO (2) YEARS** from the effective date of this Consent Order, that date being the date the Board executes this Consent Order; subject to the following terms and conditions:

1. The Respondent shall meet with and undergo review by a Board-approved child/adolescent psychiatrist ("reviewer") through review of his psychiatric patient records for a minimum period of one (1) year, based on a monthly review of a minimum of five (5) randomly reviewed records of his child and adolescent patients from his various practice locations. The review shall apply to care provided by the Respondent after the effective date of this Consent Order. The Respondent shall meet with the reviewer and ensure that records are made available to the reviewer so that the reviewer is able to submit to the Board reports addressing the review on a quarterly basis. The Respondent shall have the opportunity to communicate with the reviewer on a monthly basis prior to each of the reviewer's quarterly reports to the Board to discuss any issues/questions/concerns in regard to the review and provide clarification, if necessary. An unsatisfactory report may constitute a violation of the Consent Order. The Respondent has the ability at the end of one (1) year and three (3) satisfactory reports, to petition the Board (through the Investigative Review Panel) for termination of this condition;

2. Within six (6) months of the execution of the Consent Order, the Respondent shall successfully complete a Board-approved comprehensive course in psychotropic medication administration for children/adolescents. This course is not to be counted towards the Respondent's Continuing Medical Education ("CME") requirements for licensure;

3. Within 6 months of the execution of the Consent Order, the Respondent shall successfully complete a Board-approved comprehensive course in

documentation pertaining to psychiatry. This course is not to be counted towards the Respondent's CME requirements for licensure;

4. Within one (1) year of the execution of the Consent Order and thereafter at the Board's discretion until the probationary period has ended, the Board shall conduct a chart and/or peer review of the Respondent's child and adolescent patients from his various practice locations. The review shall apply to the care provided by the Respondent after the effective date of this Consent Order. An unsatisfactory finding may be considered a violation of the Consent Order. The final chart/peer review shall be completed by the end of the probationary period; and it is further

**ORDERED** that the Respondent shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

**ORDERED** that the Respondent may submit a written petition to the Board requesting termination of probation no earlier than two (2) years from the date of the commencement of his probationary period but only if he has fully and satisfactorily complied with all the requirements of the Consent Order and if there are no pending complaints against the Respondent; and it is further

**ORDERED** that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

**ORDERED** that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, after notice and an opportunity for a show cause hearing before the Board, may impose any sanction which the Board may

have imposed in this case under §§ 14-404(a) and 14-405.1 of the Health Occupations Article, including, revocation or suspension, probation with terms and conditions, reprimand, and monetary fine; and it is further

**ORDERED** that the Board Order regarding a violation of this Consent Order may not be stayed pending review; and it is further

**ORDERED** that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2004 Repl. vol. & 2008 Supp.).

10/28/09
Date

John Papavasiliou, Deputy Director
Maryland Board of Physicians

**CONSENT ORDER**

I, Spyros J. Monopolis, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to

issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

9-25-2009
Date

Spyros J. Monopolis, M.D.

Reviewed and Approved by:

Anthony J. Breschi, Esquire

**STATE OF** Maryland

**CITY/COUNTY OF** Harford

**I HEREBY CERTIFY** that on this 25th day of September, 2009, before me, a Notary Public of the foregoing State and City/County personally appeared Spyros J. Monopolis, M.D., License Number D31365, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Notary Public
My Commission Expires 12/1/09