IN THE MATTER OF	*	BEFORE THE MARYLAND
DAVID W. BASSETT, M.D.,	*	STATE BOARD OF
Respondent.	*	PHYSICIANS
License No. D32444	*	Case No. 2001-0013

* *

FINAL DECISION AND ORDER

I. PROCEDURAL HISTORY

The Board charged David W. Bassett, M.D. ("Dr. Bassett"), a psychiatrist, on January 31, 2005, with failing to meet appropriate standards for the delivery of quality medical care in violation of Md. Health Occ. Code Ann. § 14-404(a) (22), and with failing to keep adequate medical records in violation of Md. Health Occ. Code Ann. § 14-404(a)(40). The Board's charges were based on the results of its investigation, which included a peer review of Dr. Bassett's treatment of a 34-year-old female patient, who had a history of substance abuse and complained of chronic pain and depression ("Patient 1").[1] Two Board-certified psychiatrists who reviewed Dr. Bassett's care of Patient 1 both concluded that Dr. Basset had little knowledge of the treatment of chronic pain and addictions and that he failed to meet appropriate standards for the delivery of quality medical care with respect to both clinical care and medical record keeping.

[1] For purposes of confidentiality, the name of Dr. Bassett's patient whose care was the subject of the Board's charges will not be used in this Final Decision and Order, but she will be referred to as "Patient 1."

The Board's charges ultimately proceeded to an evidentiary hearing before an Administrative Law Judge ("ALJ") at the Office of Administrative Hearings. Dr. Bassett was represented by counsel at the pre-hearing conference before the ALJ. In August 2005, Dr. Bassett's counsel withdrew her appearance from the case. An evidentiary hearing was held before the ALJ on September 13, 2005.[2] The Administrative Prosecutor was present on behalf of the State. Neither Dr. Bassett nor an attorney on his behalf appeared at the hearing. At the hearing, the Administrative Prosecutor informed the ALJ that she had received a letter from Dr. Bassett, dated August 15, 2005, in which he informed her that he had retired from his job under ordinary disability and that "he did not see myself ever practicing medicine again." (State's Exhibits -Attachment A) Also in that letter, Dr. Bassett acknowledged that "in this legal process there are procedures that must be followed and time constraints that must be met"; however, he did not say he needed a postponement of the hearing date. (State's Exhibits –Attachment A) About three days after receiving Dr. Bassett's letter, the Administrative Prosecutor spoke with Dr. Bassett by telephone. During that conversation, Dr. Bassett told the Administrative Prosecutor that "he intended to appear at the hearing." (ALJ Hearing Transcript, p. 4)

At the hearing, the ALJ found that Dr. Bassett had been duly notified of the hearing date and the hearing could proceed in his absence and that "[i]f he showed up after the hearing starts he'll be able to participate for the remainder of the hearing."

[2] An evidentiary hearing was originally scheduled for June 9 and 10, 2005, but was postponed at Dr. Bassett's request.

(ALJ Hearing Transcript, p. 5.) Forty-nine documentary exhibits were admitted into evidence, including the medical records and pharmacy records for Patient 1. In addition, three witnesses testified on behalf of the State – Dr. Michael Glasser, M.D., admitted as an expert in the area of Psychiatry, a Board investigator, and Patient 1.

On December 6, 2005, ALJ James W. Power issued a Proposed Decision in which he proposed findings of fact, conclusions of law, and a disposition, or sanction. One of the ALJ's proposed findings of fact was that Dr. Bassett was:

> properly notified of the hearing date, both personally and through counsel, who represented him at the time the hearing date was chosen by the parties.

(ALJ's Proposed Decision, page 3 (finding of fact # 2)). The ALJ proposed that the Board's charges be affirmed, and also proposed conclusions of law that Dr. Bassett violated sections 14-404 (a) (22) and (a) (40) of the Medical Practice Act. As a sanction, the ALJ proposed that Dr. Bassett's medical license be revoked. In the Proposed Decision, the ALJ gave written notice to Dr. Bassett of his right to file exceptions with the Board within 15 days of the receipt of the Proposed Decision. The ALJ's Proposed Decision was sent to Dr. Bassett at his address of record. At no time since the issuance of the ALJ's Proposed Decision on December 6, 2005, has Dr. Bassett filed exceptions (or any other type of written document) with the Board regarding the ALJ's Proposed Decision or any other aspect of his case before the Board.

II. FINDINGS OF FACT

The Board adopts the ALJ's findings of fact numbers 1 –17 in their entirety as set forth in the ALJ's Proposed Decision. (The ALJ's December 6, 2005 Proposed Decision is incorporated into this Final Decision and Order and is appended as Attachment A.) A summary of those findings of fact follows.

Dr. Bassett treated Patient 1 from June 1994 through November 1997, and again from August 1999 through February 2000. Patient 1 was a 34-year-old female, who had a history of substance abuse. Patient 1 was seeing Dr. Bassett for complaints of chronic pain, including complaints of back and jaw pain and depression. Even though Patient 1 had specific complaints of back and jaw pain, Dr. Bassett never performed a physical examination or had another physician perform a physical exam to determine the cause of Patient 1's complaints of back and jaw pain.

Dr. Bassett knew that Patient 1 was addicted to prescription drugs, that she had pled guilty to prescription drug fraud and had been treated in an inpatient facility for addiction. However instead of providing appropriate care and management for Patient 1's prescription drug addiction, Dr. Bassett provided care that actually furthered, instead of treated, her addiction. For example, Patient 1 resided in an inpatient treatment facility for three weeks and at the time of her admission was taking over 500 hundred pills per month. Despite being warned by the inpatient treatment facility not to give Patient 1 any narcotics after discharge, Dr. Bassett

began prescribing Tylenol # 4[3] (a Schedule III Controlled Dangerous Substance), and Butalbital (a barbiturate) for Patient 1 a few days after discharge. At times, Dr. Bassett prescribed doses of Tylenol and Codeine above what is generally considered the lethal limit. For instance, he prescribed 5200 milligrams a day of Tylenol to Patient 1, while the toxicity level is generally considered to be 4000 milligrams. Dr. Bassett continued to prescribe increasing dosages of Tylenol #3 and #4 with Codeine, with little or no apparent regard for the side effects. The standard of care required that Dr. Bassett adequately monitor Patient 1 for harmful side effects of the drugs he was prescribing by performing liver function tests on an ongoing basis, but Dr. Bassett did not do so.

Dr. Bassett's treatment of Patient 1 enabled her drug addiction in other ways. He gave Patient 1 refills for narcotics without questioning what happened to the prior supply or determining the need for the requested refill. On one occasion, when a pharmacist refused to refill a prescription for narcotics that Dr. Bassett had written, Dr. Bassett advised Patient 1 to go to another pharmacy in another county to try to have the prescription filled.

Dr. Bassett also violated the standard of care by failing to keep adequate medical records for Patient 1. Even though Dr. Bassett was treating Patient 1 during 1999 and 2000, he did not maintain any medical records for the period of time from August 1999 through February 2000. The State's expert testified that Dr. Bassett's

[3] The number following "Tylenol" indicates the amount of codeine, *e.g.*" #3"= 30 milligrams of codeine; "#4" =60 milligrams of Codeine. An increase by one number indicates double the amount of codeine.

failure to document any progress notes for almost a two-year period was a violation of the standard of care, especially when prescribing narcotics. (ALJ Hearing Transcript, p. 25). Bassett's failure to keep medical records for Patient 1 during 1999-2000 also shows a complete lack of understanding of the continuity-of-care function that medical records serve for patients and other health care providers.

III. CONCLUSIONS OF LAW

The ALJ found that Dr. Bassett was properly notified of the hearing date. (ALJ's Proposed Decision, page 3 (Finding of Fact # 2)). The Board concludes that Dr. Bassett's case before the Board may proceed to final disposition and imposition of a sanction pursuant to section 14-405 (d) of the Medical Practice Act which provides:

> If after due notice the individual against whom the action is contemplated fails or refuses to appear, nevertheless the hearing officer [the ALJ] may hear and refer the matter to the Board for disposition.

Md. Health Occ. Code Ann. § 14-405 (d). Accordingly, based on the foregoing findings of fact, the Board concludes that Dr. Bassett has failed to meet appropriate standards for the delivery of quality medical or surgical care in violation of the Medical Practice Act at Md. Health Occ. Code Ann., § 14-404 (a)(22) and that Dr. Bassett has failed to keep adequate medical records as determined by appropriate peer review in violation of Md. Health Occ. Code Ann., § 14-404 (a)(40).

IV. SANCTION

At the hearing, the Administrative Prosecutor recommended to the ALJ that Dr. Bassett's medical license be revoked. The ALJ proposed to the Board that Dr.

Bassett's license be revoked. Neither of the parties filed exceptions to the ALJ's proposed sanction of revocation. The Board will adopt the ALJ's proposed sanction and revoke Dr. Bassett's license to practice medicine in the State of Maryland.

V. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the charges filed against Dr. Bassett for violating sections 14-404(a) (22) and (40) of the Medical Practice Act be **UPHELD**; and it is further

ORDERED that Dr. Bassett's license to practice medicine in the State of Maryland is hereby **REVOKED**; and it is further

ORDERED that this is a Final Decision and Order of the Maryland State Board of Physicians and, as such, is a **PUBLIC DOCUMENT** pursuant to the Maryland State Gov't Code Ann., §§ 10-611 *et seq.*

3/29/06
Date

C. Irving Pinder, Jr., Executive Director,
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occ. Code Ann. § 14-408 (b), Dr. Bassett has the right to take a direct judicial appeal. Any appeal shall be filed within thirty (30) days from the receipt of this Final Decision and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Procedure Act, State Gov't Article § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Bassett files an appeal, the Board is a party and should be served with the court's process. In addition, Dr. Bassett should send a copy to the Board's counsel, Thomas W. Keech, Esq. at the Office of the Attorney General, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201.

The Administrative Prosecutor is no longer a party to the case and need not be served or notified.

STATE BOARD OF PHYSICIANS	* **BEFORE JAMES W. POWER,**
v.	* **AN ADMINISTRATIVE LAW JUDGE**
DAVID W. BASSETT, M.D.,	* **OF THE MARYLAND OFFICE**
RESPONDENT	* **OF ADMINISTRATIVE HEARINGS**
License No. D32444	* **OAH NO.: DHMH-SBP-71-05-17043**
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PROPOSED DECISION

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ISSUE
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STATEMENT OF THE CASE

On January 31, 2005, the State Board of Physicians ("Board") issued charges against David Bassett, M.D. ("Respondent") for alleged violation of the Medical Practice Act. Md. Code Ann., Health Occ. § 14-404(a)(22), (40) (2005).

An evidentiary hearing was originally scheduled for June 9 and 10, 2005, but was postponed at the Respondent's request, because he was recovering from back injuries sustained at work. The hearing was then held on September 16, 2005 at the Office of Administrative Hearings, before James W. Power, Administrative Law Judge ("ALJ"). Md. Code Ann., Health Occ. § 14-405(a) (2005). The Respondent failed to appear for the hearing.[1] Dawn Rubin, Assistant Attorney General, represented the Board.

[1] The Respondent was represented at the prehearing conference. However, Counsel withdrew her appearance from the case in August 2005.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure of the State Board of Physicians, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2004 & Supp. 2005); Code of Maryland Regulations ("COMAR") 10.32.02; COMAR 28.02.01.

ISSUES

1. Whether the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medial and surgical care performed in an out patient surgical facility, office, hospital, or any other location in this State in violation of § 14-307(a) (22).
2. Whether the Respondent failed to keep adequate medical records as determined by appropriate peer review in violation of § 14-404(a)(40).

SUMMARY OF THE EVIDENCE

Exhibits

See attached Exhibit list.

Testimony

The following testified on behalf of the Board:

Dr. Michael Glasser M.D., expert in the area of Psychiatry

Ruth Ann Arty, Compliance Analyst with the Board

Patient 1

FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by a preponderance of the evidence.

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland. He was initially licensed to practice medicine on or about June 27, 1985. His license is presently active.

2. The Respondent was properly notified of the hearing date, both personally and through counsel, who represented him at the time the hearing date was chosen by the parties.

3. The Respondent is licensed to practice in the area of psychiatry. In 1987 he closed his private practice in LaPlata, Maryland and continued to see some of his private patients using another physician's office space in Waldorf.

4. In 1994, the Respondent was treating Patient 1, a 34 year old female, who had a history of substance abuse. She had complaints of chronic back pain and depression, as well as pain in her jaw. The Respondent treated Patient 1 from June 1994 through November 1997. He again treated her in August 1999 through February 2000.

5. The Respondent never performed a physical exam or had another physician perform a physical exam to determine the cause of the jaw and back pain.

6. In 1996 and 1997, the Board issued newsletters explaining proper record keeping, guidelines for prescribing drugs and the Board's policy on prescribing controlled dangerous substances.

7. Despite Patient 1's addiction, the Respondent continued to prescribe increasing doses of Tylenol with Codeinea narcotic drug, in conjunction with Floricet.

8. In 1999 Patient 1 was arrested for prescription fraud. She pled guilty on or about September 9, 1999.

9. Patient 1's family attempted a family intervention by getting the Patient into a treatment facility in 1999. Patient 1 contacted the Respondent about what to do. The Respondent told Patient 1 that she had a right not to be confined and she should call the police to be released from the treatment facility.

10. Patient 1 was then admitted to Fr. Martin Ashley, a treatment center, where she resided for three weeks. At the time of her admission, she was taking over 500 hundred pills per month.

11. Despite being warned by the treatment facility not to give the Patient any narcotics after her discharge, the Respondent began prescribing Tylenol and Butababtil for Patient 1 a few days after her discharge. The Respondent indicated to the Patient that he understood better than the treatment center what the Patient's problems were.

12. At one time, the Respondent was prescribing 5200 milligrams a day of Tylenol. The maximum standard beyond which toxicity appears is 4000 milligrams.

13. On one occasion, Patent 1 attempted to refill a prescription for narcotics prescribed by the Respondent. The pharmacist had concerns about the refill and refused to refill the prescription. The Respondent then told Patient 1 that she should go to a pharmacy in another county to fill the prescription.

14. The Respondent had no medical records for Patient 1 for the period of 1999 -2000, even though he was treating her at that time.

15. Patient 1 was very manipulative and dishonest in dealing with the Respondent. She would often fabricate stories about the need for refills of her prescriptions. The

Respondent never confronted or challenged Patient 1 and always gave her refills for addictive narcotics.

16. The Respondent failed to adaquately monitor for the side effects of the drugs he was prescribing. Specifically, he did not perform ongoing liver tests on Patient 1.

17. On August 1, 2005, the Respondent retired from his current job with the Anne Arundel County Health Department under ordinary disability, due to an injury sustained at work. Because of severe pain, the Respondent takes sedating narcotic medications twenty-four hours a day.

DISCUSSION

The Board has charged the Respondent with failing to provide appropriate medical care and not maintaining proper medical records. It seeks to revoke his medical license. Based on the testimony of the Board's witnesses, as well as a review of the documents and the Respondent's own statements, I agree with the Board and recommend the Respondent's license be revoked.

The Board's actions are based on the following law:

Section 14-404(a) provides, in pertinent part:

> (a) In general.--Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

Md. Code Ann., Health Occ. § 14-404(a)(22) (2005).

> 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.

Md. Code Ann., Health Occ. § 14-404(a)(40).

Fails to keep adequate medical records as determined by the appropriate peer review.

The Board's action in this case centers on the treatment of Patient 1, who in 1994 was 34 years old and seeing the Respondent for chronic pain. Patient 1 testified before me and candidly admitted that at the time she had a drug abuse problem. She was addicted to prescription drugs and would often lie or mislead the Respondent in order to get refills of narcotics. She testified that the Respondent made no effort at all to question her as to the need for the medications. She also pled guilty to prescription drug fraud.

The actions of Patient 1 are to be expected, given her drug abuse problem. One would expect an individual who is addicted to drugs to engage is deceitful behavior in order to maintain her addiction. However, a psychiatrist, above all other professionals, is expected to be on guard against such manipulative behavior and deal with the Patient in an appropriate manner.

The Respondent in this case not only failed to act appropriately, but actually furthered Patient 1's drug abuse. He gave her refills for narcotics without questioning what happened to the prior supply. When a pharmacist questioned a prescription on one occasion, he told the Patient to simply go to another pharmacy to have the prescription filled.

The Respondent was also aware that Patient 1 had pled guilty to prescription drug fraud and had been treated in an inpatient facility. Instead of encouraging treatment, he advised the Patient to call the police and seek release. He also continued to prescribe narcotics to Patient 1, after being on notice she was addicted to these drugs.

The Board also called Dr. Michael Glasser to testify as an expert in psychiatry. Dr. Glasser explained that the Respondent was prescribing increasing doses of pain killers with little or no regard for the side effects. In some cases, such as Tylenol and Codeine, the Respondent was actually prescribing doses above the lethal limit. Certain testing, such as liver function, which should have

been done on an ongoing basis, was sporadic and not done in accordance with the appropriate medical standards.

With respect to medical records, the Respondent failed to maintain any records at all for Patient 1 in 1999-2000, even though he was treating her. The Respondent's response to the Board also shows a compete lack of understanding for the need for such record keeping. The Respondent indicated that he was aware of the issues in Patient 1's care and did not see the need for any records.

Dr. Glasser also spoke with the Respondent in person. According to Dr. Glasser, the Respondent was disheveled, sometimes confused and showed little or no understanding of the entire area of narcotic drugs. The Respondent simply indicated that the job of the physician was to "alleviate pain", thereby justifying whatever actions he took, whether they met the appropriate medical standard or not.

The Board has mailed numerous guidelines to physicians, concerning proper record keeping and prescribing of narcotics. The publications clearly outline what is expected of physicians in these areas. However, the Respondent also disregarded these guidelines from the Board.

Dr. Glasser also indicated that the Respondent was certified in the American Society of Addictive Medicine, yet had little knowledge about the addiction process for someone who had been certified by this organization.

Although the Respondent did not appear for the hearing, he did respond to the Board in writing. The Respondent agrees that he should not practice medicine, but not for the same reasons cited by the Board. As a result of a fall at work, the Respondent has retired on disability. He is currently undergoing pain management, and according to his own physician can no longer work.

The Respondent is himself taking pain killing narcotics and is often confined to bed. His physician explained his condition as follows, in a letter from May, 2005:

> Dr. David W. Bassett is a psychiatrist with a medical condition that precludes functioning as a physician. Specifically, the patient has a degenerative spondyolosthesis at L4-5 with instability noted on flexion, the extension views.....The patient is not improving, requires narcotic pain medication in order to deal with his symptoms; and is currently weighing his options of an attempt of treating this condition with a lengthy and involved posterior lumbar decompression and instrumental fusion. As the patient is limited with his pain, functional status, and is taking around the clock narcotics in order to help control symptoms, I feel this precludes him engaging in activities demanded of those of a psychiatrist or for that matter any physician who needs to be alert and with a clear mind in order to properly care for his patients.
>
> Attachment 2

Based on the Respondent's professional behavior with respect to Patient 1, however, I conclude that he is subject to discipline and should not practice medicine, based not only in his physical limitations but his professional conduct.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact and Discussion, I conclude, as a matter of law, that the Respondent violated sections 14-404(a)(22) and (4). I further conclude that, as a result, the Board may Revoke the Respondent's license. Md. Code Ann., Health Occ. § 14-404(a)(2005)

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board on against the Respondent be **AFFIRMED** and the Respondent's license be **REVOKED**.

December 6, 2005
Date

James W. Power
Administrative Law Judge

JWP/gar
#77370

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NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions, in writing, to this Proposed Decision with the State Board of Physicians within fifteen (15) days of receipt of the decision. The Office of Administrative Hearings is not a party to any review process. Md. Code Ann., State Gov't § 10-216 (2004 & Supp. 2005) and COMAR 10.32.02.03F.