IN THE MATTER OF	*	**BEFORE THE**
GHISLAINE FOUGY, M.D.	*	**MARYLAND STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
LICENSE NO.: D18251	*	**CASE NO.: 2010-0847**

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CONSENT ORDER

On March 23, 2012, the Maryland State Board of Physicians (the "Board") charged Ghislaine Fougy, M.D. (the "Respondent") (D.O.B. 3/15/38), License Number D18251, with violating the Maryland Medical Practice Act (the "Act"), codified at Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2009 Repl. Vol. and 2011 Supp.).

The pertinent provisions of the Act under § 14-404 provide:

> (a) *In general.* --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:
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> (3) Is guilty of: ...
> (ii) Unprofessional conduct in the practice of medicine
>
> (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; [or]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

Further, the American Medical Association ("AMA") Code of Medical Ethics provides in pertinent part:

> **Opinion 8.19 – Self-treatment or Treatment of Immediate Family Members**
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> Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered....When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
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> Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preferences for another physician or decline a recommendation for fear of offending the physician...
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> ...Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

On May 2, 2012, a Case Resolution Conference was held before a panel of the Board. As a result of negotiations, the Respondent agreed to enter into this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background of Licensee

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in Maryland. The Respondent was originally licensed to practice medicine in Maryland on August 4, 1975, under license number D18251.

2. The Respondent's license will expire on September 30, 2012.

3. The Respondent was originally licensed to practice medicine in the District of Columbia on January 1, 1977, which license expired on June 25, 2003

4. Since April 30, 1981, the Respondent has been board-certified in Psychiatry and Neurology.

5. At all times relevant hereto, the Respondent has maintained a private practice located at in Silver Spring, Maryland and holds privileges at a hospital in Silver Spring, Maryland.

II. The Complaint

6. On or about May 7, 2010, the Board received a complaint from someone close to the Respondent, Complainant, alleging, *inter alia*, that the Respondent was routinely prescribing and dispensing medications for at least four (4) members of the Respondent's family over a period of at least twelve (12) years without maintaining medical records of the treatment.

7. Complainant was a former employee of the Respondent on an off for a period of approximately eleven (11) years and had also resided with the Respondent

and Family Member A, Family Member B, Family Member C and Family Member D for approximately three (3) years during the same eleven (11) year time period.[1]

8. Throughout her complaint and during a telephonic interview with Board staff, Complainant reported the following:

a. The Respondent prescribed various medications, including controlled substances ("CDS"), to Family Members A, B, C and D, during which time the Respondent and her Family Members shared the same residence;

b. The Respondent prescribed and dispensed prescriptions for Family Member A for at least twelve (12) years, primarily for the treatment of severe bipolar disorder;

c. The Respondent prescribed various medications to minor Family Members B and C for conditions that included ADHD, ADD and asthma and failed to obtain the informed consent of their parents;

d. The Respondent kept a variety of drug samples at her home, unsecured, and would sometimes dispense these samples to Family Members and Complainant;

e. The Respondent did not consult medical records from Family Members' or Complainant's other treating physicians, and she did not keep medical records reflecting her treatment of Family Members and Complainant; and

f. The Respondent failed to properly address Family Member A's repeated threats of violence and suicide.

9. The Board initiated an investigation based upon the complaint.

III. Investigative Findings

10. During a sworn interview with the Board's compliance analyst, the Respondent admitted to having dispensed and prescribed medications to Complainant and Family Members A, B, C and D for at least (10) years between January 2000 and

[1] In order to protect their privacy, the complainant's name and the patients' names will not be used in this document but are known to the Respondent.

December 2010.

11. The Respondent maintained that she did not consider Family Members and Complainant to be her patients and described her dispensing and prescribing habits to these individuals as "bridging gaps" during periods when they had no health insurance.

12. Further, the Respondent indicated that she did not regularly authorize refills of the prescriptions she wrote for Family Members and Complainant.

13. The Respondent stated that she did not maintain any medical records for Family Members and Complainant. The Respondent also stated she did not keep any documentation regarding her prescribing or dispensing of prescriptions to Family Members and Complainant because she could rely on the dispensing pharmacy's records if necessary.

14. The Board, in the course of its investigation, obtained computerized pharmacy prescription records from the pharmacies where Family Members most often filled their prescriptions.

15. The Board referred the case to the Maryland Psychiatric Society for peer review by two board certified psychiatrists ("peer reviewers").

16. In May, 2011, the Respondent was interviewed by the two peer reviewers.

17. The Respondent told the peer reviewers that she kept no medical records, did not keep a log of the prescriptions that she wrote, and did not conduct a psychiatric or physical examination of Family Members or Complainant.

18. The Respondent also told the peer reviewers that she had not contacted any of Family Members' or Complainant's other prescribing physicians during the period

when she was prescribing and dispensing them medication.

19. Based on the reports of the two peer reviewers, the Board voted to charge the Respondent.

IV. Patient Specific Findings

A. Family Member A

20. According to Complainant and the Respondent, Family Member A suffered from bipolar disorder, diabetes and gout.

21. Family Member A resided with the Respondent on and off for many years, including between 2003 and 2009.

22. Based on computerized pharmacy records obtained by the Board, between January 1, 2000 and October 21, 2010, the Respondent wrote, and Family Member A had filled, at least seventy-eight (78) prescriptions (including refills) for Family Member A.

23. These prescriptions were often for drugs used in the treatment of bipolar disorder and included Depakote/divalproex [2], benztropine[3], indomethacin[4], Wellbutrin[5], and lorazepam[6]. Most of the prescriptions were written for at least a 30-day supply per medication and often included several authorized refills.

24. For example, the pharmacy records indicate that between August 11, 2009 and August 24, 2010, Family Member A relied solely on monthly refills of

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[2] Depakote is the brand name for divalproex, an anti-convulsant medication used to treat bipolar disorder. It can sometimes cause serious liver problems.
[3] Benztropine is used to treat involuntary movements due to the side effects of certain psychiatric drugs.
[4] Indomethacin is a non-steroidal anti-inflammatory used to relieve pain, swelling, and joint stiffness caused by arthritis, gout, bursitis, and tendonitis.
[5] Wellbutrin is the brand name for bupropion and is an anti-depressant.
[6] Lorazepam is a benzodiazepine used for the treatment of anxiety and is a Schedule IV controlled dangerous substance.

divalproex authorized under the Respondent's August 2009 prescription for treatment of his bipolar disorder.

25. In addition, the Respondent stated during her interview with the Board's compliance analyst that she sometimes took drug samples, such as Depakote, from her office to her residence for Family Member A when he could not afford to buy his medication.

26. Further, although the Respondent described her household as having a "tendency to be dysfunctional," in part because of Family Member A's threats to kill her and others, she continued to act as his primary prescriber during the time Family Member A lived with her.

27. The Respondent did not record or document her treatment or prescribing for Family Member A.

28. The Respondent failed to consult Family Member A's other prescribing physicians prior to issuing prescriptions for Family Member A.

29. The Respondent admitted to the peer reviewers that although she routinely orders valproate levels and liver function tests for her documented patients to whom she prescribes divalproex, due to the effects it can have on liver function, she did not order such blood tests for Family Member A and has no knowledge of his prior laboratory studies.

30. The peer reviewers opined that the standard of quality care requires:

a. Performing a diagnostic work-up on a patient (including laboratory testing when indicated and review of previous records);

b. Ongoing assessment, to include ensure the prescribed treatment is appropriate for the patient with regard to reasonable standards of safety and efficacy;

c. Consideration of treatment options (including risk-benefit analyses);

d. Referral to consultants and other providers when appropriate; and

e. Documenting the care provided, including, as appropriate, the progress in treating target symptoms; the patient's overall clinical status; pertinent psychosocial issues; emerging developments in treatment such as side effects; rationale for medication and medication changes; and details of dispensed medications, including informed consent.

31. The peer reviewers opined that the Respondent's treatment of Family Member A failed to meet the standard of quality care because the Respondent failed to:

a. Record her prescriptions and reasons for prescribing;

b. Monitor Family Member A's clinical progress or concerns;

c. Monitor Family Member A for medication side effects, including failing to obtain appropriate laboratory studies;
d. Document an assessment of suicidal or homicidal ideation in Family Member A, an unstable patient;

e. Communicate with Family Member A's other treating physicians; and

f. Document that she had obtained informed consent for the medications prescribed.

32. In addition, the peer reviewers concurred that the Respondent's conduct of 1) regularly prescribing medications to Family Member A; and 2) failing to maintain adequate documentation of her treatment of Family Member A constituted unprofessional conduct in the practice of medicine.

B. Family Member B

33. At all times relevant hereto, Family Member B was a minor (between the ages of 6 and 12) who resided with the Respondent between 2003 and 2009.

34. According to the Respondent and Complainant, Family Member B had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) by another physician at some point prior to 2003. Family Member B also suffered from asthma.

35. Based on computerized pharmacy records, between May 5, 2003 and October 21, 2010, the Respondent wrote at least sixty-two (62) prescriptions (including refills) for Family Member B, including prescriptions for Advair[7], Albuterol[8], dextroamphetamine[9], Vyvanse[10], Ritalin-LA[11] and Focalin.[12]

36. The Respondent usually wrote these prescriptions for a thirty (30) day supply for both psychiatric and non-psychiatric medications.

37. The Respondent admitted during her interview with the Board that she did not record or document her treatment or prescribing for Family Member B.

38. The Respondent reported to the peer reviewers that she was able to assess the effectiveness of these medications based on observing Family Member B's behavior in her home but admitted that she never sought or received input from Family Member B's school nor communicated with Family Member B's other treating physicians. The peer reviewers opined that proper diagnosis and treatment of ADHD in

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[7] Advair is used to control and prevent symptoms caused by asthma or ongoing lung disease.
[8] Albuterol as an asthma rescue inhaler.
[9] Dextroamphetamine is a stimulant used to treat ADHD and is Schedule II controlled dangerous substance.
[10] Vyvanse is a stimulant used to treat ADHD and is an amphetamine-like medication.
[11] Ritalin is a methylphenidate stimulant used to treat ADHD and is a Schedule II controlled dangerous substance.
[12] Focalin is the brand name for dexmethylphenidate, a mild stimulant used to treat ADHD. It is a Schedule II controlled dangerous substance.

a child must involve input from the child's school in order to properly assess the symptoms and efficacy of treatment.

39. The peer reviewers opined that the standard of quality care requires:

a. Performing a diagnostic work-up on a patient (including laboratory testing when indicated and review of previous records);

b. Ongoing assessment, including periodic input from Family Member B's school regarding his ADHD, to ensure the prescribed treatment is appropriate for the patient with regard to reasonable standards of safety and efficacy;

c. Consideration of treatment options (including risk-benefit analyses);

d. Referral to consultants and other providers when appropriate; and

e. Documenting the care provided, including, as appropriate, the progress in treating target symptoms; the patient's overall clinical status; pertinent psychosocial issues; emerging developments in treatment such as side effects; rationale for medication and medication changes; and details of dispensed medications, including informed consent.

40. The peer reviewers determined that the Respondent had not met the standard of quality care in her treatment of Family Member B because the Respondent had failed to:

a. Record her prescriptions, which included CDS prescriptions, and reasons for prescribing;

b. Monitor Family Member B's clinical progress or concerns, including failing to seek periodic input from Family Member B's school regarding his ADHD;

c. Monitor Family Member B for medication side effects, including failing to monitor the child's growth trajectory;

d. Communicate with Family Member B's other prescribers; and

e. Document that she obtained informed consent from either or both of Family Member B's parents for the medications prescribed.

41. In addition, the peer reviewers concurred that the Respondent's conduct of 1) regularly prescribing and dispensing medications, including CDS, to Family Member B for both psychiatric and other serious conditions; and 2) failing to maintain adequate documentation of her treatment of Family Member B constituted unprofessional conduct in the practice of medicine.

C. Family Member C

42. At all times relevant hereto, Family Member C was a minor who resided with the Respondent between 2003 and 2009.

43. According to the Respondent, Family Member C had been diagnosed by another physician with ADHD.

44. Based on computerized pharmacy records, between January 12, 2004 and December 30, 2008, the Respondent wrote at least six (6) prescriptions for Family Member C.

45. The Respondent usually wrote these prescriptions for a thirty (30) day supply of Daytrana patches[13] for treatment of Family Member C's ADHD.

46. The Respondent stated during her interview with the Board's compliance analyst that she would bring drug samples, such as risperdal and Depakote, to her home if Family Member C's parents could not afford to buy his medication.

47. The Respondent admitted to Board staff and the peer reviewers that she did not maintain a record for her treatment of Family Member C. The peer reviewers opined that proper diagnosis and treatment of ADHD in a child must involve input from

[13] A Daytrana patch is a patch applied to the skin for the administration of a Ritalin-like drug to the patient for the purpose of treating ADHD. It is a Schedule II controlled dangerous substance.

the child's school in order to properly assess the symptoms and efficacy of treatment, but the Respondent made no effort to seek such information before prescribing or dispensing to Family Member C.

48. The peer reviewers again opined that the standard of quality care requires:

a. Performing a diagnostic work-up on a patient (including laboratory testing when indicated and review of previous records);

b. Ongoing assessment, including periodic input from Family Member C's school regarding his ADHD, to ensure the prescribed treatment is appropriate for the patient with regard to reasonable standards of safety and efficacy;

c. Consideration of treatment options (including risk-benefit analyses);

d. Referral to consultants and other providers when appropriate; and

e. Documenting the care provided, including, as appropriate, the progress in treating target symptoms; the patient's overall clinical status; pertinent psychosocial issues; emerging developments in treatment such as side effects; rationale for medication and medication changes; and details of dispensed medications, including informed consent.

49. The peer reviewers determined that the Respondent had not met the standard of quality care in her treatment of Family Member C because the Respondent had failed to:

a. Record her prescriptions, which included CDS prescriptions, and reasons for prescribing;

b. Monitor Family Member C's clinical progress or concerns, including failing to seek periodic input from Family Member C's school regarding his ADHD;

c. Monitor for medication side effects, including a failure to monitor the child's growth trajectory;

d. Communicate with Family Member C's other prescribers; and

e. Document that she obtained informed consent from either or both of Family Member C's parents for the medications prescribed.

50. In addition, the peer reviewers concurred that the Respondent's conduct of 1) regularly prescribing and dispensing medications, including CDS, to Family Member C; and 2) failing to maintain adequate documentation of her treatment of Family Member C constituted unprofessional conduct in the practice of medicine.

D. Family Member D

51. According to the Respondent and Complainant, Family Member D suffers from sickle cell anemia and bipolar disorder. Also, Family Member D has had approximately ten (10) strokes.

52. Family Member D is disabled and resides with the Respondent, relying on the continuous care of aides when the Respondent is unavailable.

53. Based on computerized pharmacy records, between January 1, 2000 and October 21, 2010, the Respondent wrote at least 246 prescriptions (including refills) for Family Member D. These prescriptions represent approximately 80% of the prescriptions Family Member D received from all of her treating prescribers during that time period.

54. The prescriptions written by the Respondent included, but were not limited to, Trileptal[14], Depakote, risperidone[15], Coumadin[16], hydroxyurea[17], Trihexyphenidyl/artane[18], Zantac[19], dipyridamole[20], and buproprion.

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[14] Trileptal is the brand name for oxcarbazepine and is used to treat seizure disorders and bipolar disorder.

[15] Risperidone is used to treat certain mental disorders (such as schizophrenia, manic phase of bipolar disorder.)

55. These prescriptions indicate the Respondent was treating Family Member D for both psychiatric and non-psychiatric conditions, including Family Member D's sickle cell anemia.

56. Further, the Respondent stated during her interview with the Board's compliance analyst that she sometimes took drug samples, such as Depakote, from her office to her residence in order to dispense the tablets to Family Member D.

57. The Respondent admitted to the peer reviewers that although she routinely orders valproate levels and liver function tests for her documented patients to whom she prescribes Depakote, due to the damaging effects it can have on the liver, she did not order such blood tests for Family Member D and has no knowledge of Family Member D's prior laboratory studies.

58. The peer reviewers opined that the standard of quality care requires:

a. Performing a diagnostic work-up on a patient (including laboratory testing when indicated and review of previous records);

b. Ongoing assessment, to include ensuring the prescribed treatment is appropriate for the patient with regard to reasonable standards of safety and efficacy;

c. Consideration of treatment options (including risk-benefit analyses);

d. Referral to consultants and other providers when appropriate; and

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[16] Coumadin is the brand name for warfarin and is used to treat blood clots and/or to prevent new clots from forming.
[17] Hydroxyurea is used in people with sickle cell anemia to reduce the number of painful crises caused by the disease and to reduce the need for blood transfusions.
[18] Trihexyphenidyl is used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs.
[19] Zantac is the brand name for ranitidine, a medication used to treat ulcers of the stomach and intestines and prevent them from returning after treatment. It is also used to treat and prevent certain stomach and throat (esophagus) problems caused by too much stomach acid.
[20] Dipyridamole is used in combination with "blood thinners" such as Coumadin to keep clots from forming after heart valve replacements.

e. Documenting the care provided, including, as appropriate, the progress in treating target symptoms; the patient's overall clinical status; pertinent psychosocial issues; emerging developments in treatment such as side effects; rationale for medication and medication changes; and details of dispensed medications, including informed consent.

59. The peer reviewers opined that the Respondent's treatment of Family Member D failed to meet this standard of quality care because the Respondent failed to:

a. Record her prescriptions and reasons for prescribing;

b. Monitor Family Member D's clinical progress or concerns;

c. Monitor for medication side effects, including a failure to obtain appropriate laboratory studies, particularly in light of Family Member D's serious medical history;

d. Document an assessment of suicidal or homicidal ideation in Family Member D, an unstable patient;

e. Communicate with Family Member D's other prescribers; and

f. Document that she obtained informed consent for the medications prescribed.

60. In addition, the peer reviewers concurred that the Respondent's conduct of 1) regularly prescribing and dispensing medications to Family Member D for both psychiatric and other serious conditions; and 2) failing to maintain adequate documentation of her treatment of Family Member D constituted unprofessional conduct in the practice of medicine.

CONCLUSIONS OF LAW

The Respondent's conduct as described herein constitutes violations of §§ 14-404(a)(3)(ii) (is guilty of unprofessional conduct in the practice of medicine); 14-404(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); and 14-404(40) (fails to keep adequate medical records as determined by appropriate peer review), as stated in the Board's Charges.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 27th day of JUNE, 2012, by a majority of the quorum of the Board considering this case:

ORDERED that the Respondent is hereby **REPRIMANDED**; and be it further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **TWO (2) YEARS** and until she fully and satisfactorily complies with the following terms and conditions:

1. The Respondent shall successfully complete a Board-approved one-to-one ethics tutorial focusing on prescribing practices and professional boundaries, particularly with respect to prescribing and dispensing for family members;

2. The Respondent shall successfully complete a Board-approved ethics course regarding prescription writing and dispensing of medications to family members;

3. Within ninety (90) calendar days of the effective date of this Consent Order, the Respondent shall enroll in both the one-to-one ethics tutorial and the ethics course described in Conditions 1 and 2 above;

4. The Respondent shall not prescribe any medications to her family members, including CDS;

5. The Respondent shall provide a copy of this Consent Order to all hospitals where she maintains privileges and to any medical facility or office where she may be employed; and

6. The Respondent shall not dispense from her office any prescription medications, including samples, to her family members. And be it further

ORDERED that after two (2) years from the date the Consent Order goes into effect, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions, and there are no pending complaints related to the charges; and be it further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining thereto; and be it further

ORDERED that if the Respondent violates any term or condition of probation or of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before the Office of Administrative Hearings if there is a genuine dispute as to the underlying facts, or an opportunity for a show cause hearing before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and be it further

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

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2009 Repl. Vol.).

6-27-12
Date

Carole J. Catalfo
Executive Director
Maryland State Board of Physicians

CONSENT

I, Ghislaine Fougy, M.D., acknowledge that 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 the 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 might have followed after any such hearing.

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

June 1st 2012
Date

Ghislaine Fougy, M.D.

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 1st day of June, 2012, before me, a Notary Public of the foregoing State and City/County personally appear **GHISLAINE FOUGY, M.D.**, License Number D18251, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notary seal.

CHARLES A. MATTHEWS
Notary Public, State of Maryland
City of Baltimore
My Commission Expires October 28, 2014

Notary Public

My commission expires: October 28, 2014