State of New Hampshire
Board of Medicine
Concord, New Hampshire 03301

In the Matter of:
Greg Thompson, M.D.
License No.: 6720
(Misconduct Allegations)

CONSENT ORDER

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine ("Board") and Greg Thompson, M.D. ("Dr. Thompson" or "Respondent"), a physician licensed by the Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a; and Medical Administrative Rule ("Med") 206 and 210, the Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.

2. The Board first granted Respondent a license to practice medicine in the State of New Hampshire on June 3, 1983. Respondent holds license number 6720. Respondent practices psychiatry in Hampstead, New Hampshire.

3. On or about October 31, 2013, the Board received information alleging that Respondent may be prescribing controlled substances without a valid medical reason.

4. In response to this, the Board conducted an investigation and obtained information from various sources pertaining to Respondent's alleged misconduct. Based on the opinion rendered by the outside expert, the Board issued a Notice of Hearing on April 13, 2016. *See Attachment A.* The disciplinary hearing in this matter began on December 13, 2016.

5. Respondent stipulates that if a disciplinary hearing were to take place before this Board, Hearing Counsel would introduce evidence in an attempt to prove that Respondent engaged in professional misconduct, in violation of RSA 329:17, VI (c), (d), (k), and Med 501.02 (b), (d), (e), and (h).

6. The Board finds that Respondent committed the acts as described in the attached Notice of Hearing and concludes that, by engaging in such conduct, Respondent violated RSA 329:17, VI (c), (d), (k), and Med 501.02 (b), (d), (e), and (h).

7. Respondent acknowledges that this conduct constitutes grounds for the Board to impose disciplinary sanctions against Respondent's license to practice as a physician in the State of New Hampshire.

8. Respondent consents to the Board imposing the following discipline, pursuant to RSA 329:17, VII:

   A. Respondent is reprimanded.

   B. Respondent's license to practice medicine is suspended for the period of one (1) year. This suspension shall begin sixty (60) days after the effective date of this *Consent Order.* During these sixty (60) days, Respondent shall make every effort to assist all his patients in finding alternative treatment.

Respondent may petition the Board to extend this period if he is unable to appropriately transfer all patients. If it becomes necessary to file such a petition, ~~Responded~~ Respondent shall provide a detailed explanation as to why an extension is necessary and shall include what steps he has taken to assist patients.

C. Prior to returning to practice, Respondent must file a petition with the Board demonstrating that he has complied with the following provisions:

1) Respondent shall meaningfully participate and complete an assessment of his medical skills through a consultant that will include, but not be limited to, Respondent's practice of general psychiatry and addiction treatment as well as his recordkeeping and billing practices. Respondent shall choose the consultant, but the consultant must be approved by the Board.

   a. Respondent shall provide the consultant with copies of this *Consent Order,* as well as the *Notice of Hearing,* and the Report of Investigation, along with any other documents requested by the reviewer.

   b. The clinical assessment shall include evaluation of Respondent's clinical knowledge, clinical reasoning, patient care decision-making skills, and should address the issues identified in the Report of Investigation and the *Notice of Hearing.* The clinical assessment shall also include a record review, chart-based discussions, case presentations, and topic based discussions.

c. Following the completion of the clinical assessment, the consultant shall write a detailed report outlining the findings of the assessment and including any recommendations for improving Respondent's practice, including any suggested education.

d. Respondent shall follow all recommendations included in the clinical assessment report. Any additional education recommendations shall be complete prior to Respondent returning to practice.

2) Respondent shall enter into a monitoring agreement with the consultant. The Monitor shall meet with Respondent monthly to review patient records and discuss clinical treatment. The Monitor shall review Respondent's treatment of patients to determine Respondent's compliance with accepted medical practices and all applicable states and federal laws, regulations, and administrative rules, as well as the American Medical Association's Code of Medical Ethics. The Monitor shall provide written reports to the Board and to Respondent every ninety (90) days.

a. The written reports submitted to the Board every ninety (90) days shall:

i. Evaluate Respondent's clinical care in the areas identified as needing further education in ~~AMI's~~ Consultant's Report;

ii. Identify any deficiencies in Respondent's care which reasonably warrant corrective action; and

iii. Provide an assessment of Respondent's progress in implementing recommendations for his clinical care.

b. Respondent shall take any and all corrective actions that are reasonably necessary to correct any and all deficiencies identified in any review by the Monitor. Not later than thirty (30) days after Respondent's receipt of the monitor's report, Respondent shall submit to the Board a detailed written report identifying the steps that have been taken, or are being taken, to correct the deficiencies cited in the Monitor's report, and the dates by which such corrective actions will be completed.

c. The Board, in its discretion, may request at any time during the period of monitoring that a different monitor be selected. If the monitor becomes unable to serve or fulfill his/her obligations, Respondent may nominate a different monitor who is acceptable to the Board. In the event that the monitor is unable to complete his/her review or report in a timely fashion due to the monitor's own personal and/or professional commitments, Respondent shall notify the Board in writing of the reasons the monitor is unable to complete his/her review or the report by that date, and the Board, for good cause shown, may extend the deadline for completion of the review and report.

d. The terms and provisions of Respondent's monitoring agreement shall be incorporated into this *Consent Order* by reference. Respondent's failure to comply with any monitoring agreement terms shall constitute a violation of the terms of the *Consent Order*. It is the responsibility of Respondent to provide information to the monitor in a timely and complete manner and to assure that all written reports setting forth findings of the monitor are timely transmitted to the Board every ninety (90) days.

3) Respondent shall work with the consultant to implement an appropriate medical record and billing system that complies with *AMA Principle of Medical Ethics* Opinion 3.3.2 (adopted June 2016).

D. Upon returning to practice, Respondent's license shall be restricted to the practice of general psychiatry and addiction treatment utilizing medication assisted treatment. Respondent's prescribing practices shall be restricted in that he may only prescribe controlled substances or other medications recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services for the purpose of medication assisted treatment of addiction.

E. Respondent is required to meaningfully participate in a program of 15 hours of continuing medical education in the area of medical ethics and 15 hours continuing medical education in the area of recordkeeping. These hours shall be in addition to the hours required by the Board for renewal of licensure and

shall be completed within one (1) year from the effective date of this *Consent Order*. Within fifteen (15) days of completing these hours, Respondent shall notify the Board and provide written proof of completion.

F. Respondent is assessed an ADMINISTRATIVE FINE in the amount of $10,000. Respondent shall pay this fine in full within thirty (30) days of the effective date of this *Consent Order*, as defined further below, by delivering a money order or bank check, made payable to "Treasurer, State of New Hampshire," to the Board's office at 121 South Fruit Street, Concord, New Hampshire.

G. Respondent shall bear all costs of evaluation, and reporting required by this *Consent Order*, but he shall be permitted to share such costs with third parties.

H. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the *Consent Order* to any current employer for whom Respondent performs services as a physician or work which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority which licenses, certifies or credentials physicians, with which Respondent is presently affiliated.

I. For a continuing period of four (4) years from the effective date of this agreement, Respondent shall furnish a copy of this *Consent Order* to any employer to which Respondent may apply for work as a physician or for work in any capacity which requires a medical degree and/or medical license or

directly or indirectly involves patient care, and to any agency or authority that licenses, certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

9. Respondent's breach of any terms or conditions of this *Consent Order* shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the Board.

10. Except as provided herein, this *Consent Order* shall bar the commencement of further disciplinary action by the Board based upon the misconduct described above. However, the Board may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.

11. This *Consent Order* shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.

12. Respondent voluntarily enters into and signs this *Consent Order* and states that no promises or representations have been made to him other than those terms and conditions expressly stated herein.

13. The Board agrees that in return for Respondent executing this *Consent Order*, the Board will not proceed further with the formal adjudicatory process based upon the facts described herein.

14. Respondent understands that his action in entering into this *Consent Order* is a final act and not subject to reconsideration or judicial review or appeal.

15. Respondent has had the opportunity to seek and obtain the advice of an attorney of his choosing in connection with his decision to enter into this agreement.

16. Respondent understands that the Board must review and accept the terms of this *Consent Order*. If the Board rejects any portion, the entire *Consent Order* shall be null and void. Respondent specifically waives any claims that any disclosures made to the Board during its review of this *Consent Order* have prejudiced his right to a fair and impartial hearing in the future if this *Consent Order* is not accepted by the Board.

17. Respondent is not under the influence of any drugs or alcohol at the time he signs this *Consent Order*.

18. Respondent certifies that he has read this document titled *Consent Order*. Respondent understands that he has the right to a formal adjudicatory hearing concerning this matter and that at said hearing he would possess the rights to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on his own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Consent Order*, he waives these rights as they pertain to the misconduct described herein.

19. This *Consent Order* shall take effect as an Order of the Board on the date it is signed by an authorized representative of the Board.

FOR RESPONDENT

Date: 12/14/16

Greg Thompson M.D.
Greg Thompson, M.D.
Respondent

Date: 12/14/16

Michael J. Iacopino, Esquire
Counsel for Respondent

Date: 12/14/16

Jaye Rancourt, Esquire
Counsel for Respondent

FOR THE BOARD/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: 12/14/2016

Penny Taylor
(Signature)

PENNY TAYLOR
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

/* Board members, recused/did not participate:
Emily Baker
Louis Rosenthall, M.D.
John Wheeler, D.O.
Frank Dibble, Jr., M.D.
Mark Sullivan, P.A.
Gail Barba
Daniel Morrissey, O.P.

Attachment A

State of New Hampshire
Board of Medicine
Concord, New Hampshire

In the Matter of:
Greg Thompson, M.D. Docket No. 16-03
License No.: 6720
(Adjudicatory/Disciplinary Proceeding)

NOTICE OF HEARING

1. The New Hampshire Board of Medicine ("Board") first granted a license to practice medicine in the State of New Hampshire to Greg Thompson, M.D. ("Dr. Thompson" or "Respondent") on June 3, 1983. Respondent holds license number 6720. Respondent practices psychiatry in Hampstead, New Hampshire.

2. On or about October 31, 2013, the Board received information alleging that Respondent may be prescribing controlled substances without a valid medical reason.

3. The Board commenced an investigation to determine whether Respondent committed professional misconduct pursuant to RSA 329:17, VI and RSA 329:18.

4. Based upon the information gathered during the investigation as outlined herein, the Board finds that there is a reasonable basis for commencing an adjudicatory/disciplinary proceeding against Respondent pursuant to RSA 329:17, I, RSA 329:18-a, and Medical Administrative Rule ("Med") 206.

5. In support of this *Notice of Hearing*, the Board alleges the following facts:

   A. On February 1, 2012, Respondent began treating Patient 1. At his initial appointment, Patient 1 disclosed that he had a history of substance abuse and that he was using Ritalin that he had been buying off the street. Patient 1 stated that the Ritalin gave him energy and that if he could he

would use it every day. He also stated that sometimes the Ritalin would interfere with his sleep so he would use Nyquil to help him fall asleep. Patient 1 also told Respondent that he had not been to the doctor since he was a child.

B. Respondent documented in Patient 1's record that Patient 1 was seeking treatment for ADHD with the stimulant Ritalin which has previously helped him improve focus and function. Respondent also documented that Patient 1 had been treated for ADD with Ritalin by his primary care provider and had also been prescribed alprazolam and trazadone for sleep issues. Respondent's assessment of Patient 1 was that he was a probable functional alcoholic and polysubstance abuser seeking the stimulant Ritalin for soft ADD history and signs. Respondent documented that he prescribed Patient 1 methylphenidate 20 mg bid and alprazolam 1-2 mg po qhs, and that the patient understood that alprazolam was contraindicated with alcohol and could cause blackouts. Patient 1 was actually provided with a prescription for Trazadone 50 mg #30 and not alprazolam.

C. At his second appointment on February 20, 2012, Patient 1 disclosed to Respondent that taking the Ritalin had made him move and that he took it more for the high. Patient 1 also stated that he had tried the Trazadone but did not like it, so Respondent recommended trying Clonidine. Patient 1 asked if Respondent could prescribe Xanax as he had taken that off the street before and liked it. Respondent asked Patient 1 how many he would

need for three weeks and provided Patient 1 with prescriptions for Alprazolam 2 mg #21 and Methylphenidate 20 mg #42.

D. In the records for Patient 1's second appointment, Respondent documented that Patient 1 was pleased that he had more focus, organization and energy with the methylphenidate.

E. At his third appointment, Patient 1 disclosed to Respondent that while partying on a cruise, he crushed and snorted his methylphenidate prescription in order to get a quick rush and stay up late. Respondent provided Patient 1 with prescriptions for Alprazolam 2 mg #21 and Methylphenidate 20 mg #42. In the records for this date, Respondent documented that Patient 1 reported ongoing benefit with the medications, the alprazolam for sleep and methylphenidate for concentration, improved mood, and energy.

F. At his next appointment on April 2, 2012, Patient 1 told Respondent that he had again crushed and snorted methylphenidate and that he allowed a friend to also snort one of his pills. He also stated that he gave the same friend a couple of his pills. Patient 1 also asked Respondent to add ten pills to his prescription and suggested that Respondent leave him a blank prescription in exchange for $100. Respondent refused, but did provide Patient 1 with prescriptions for Alprazolam 2 mg #21 and Methylphenidate 20 mg #42. In the records for this appointment,

Respondent documented that Patient 1 was experiencing ongoing relief with the medications and denied any side effects.

G. At his fifth appointment on May 12, 2012, Patient 1 disclosed to Respondent that he continued to use his prescriptions recreationally and that he sold part of his prescriptions for money. Respondent told Patient 1 that he could no longer prescribe to him after this appointment. Patient 1 offered to split the money with Respondent if he kept prescribing, but Respondent refused. Respondent warned Patient 1 that he could get in trouble with the law, but added that if Patient 1 did get in trouble he could help him by providing letters for being clean. Respondent provided Patient 1 with prescriptions for Alprazolam 2 mg #21 and Methylphenidate 20 mg #42. The records for this appointment document that Patient 1's treatment was terminated after he indicated that he had experimented and liked the use of methylphenidate intranasally and that Patient 1 communicated an unethical business idea. The records do not document any prescriptions being provided to Patient 1.

H. Respondent made no formal assessment of endangerment in any of his notes for Patient 1 and there was no indication in the records that he performed any kind of diagnostic assessment of ADD for Patient 1.

I. After terminating care with Patient 1, Respondent did not document discussing with Patient 1 the potentially serious consequences for abrupt cessation of alprazolam.

J. In his response to the Board, Respondent stated that Patient 1 had been previously treated for ADD with methylphenidate 20 mg po bid by his PCP who was no longer available, which left Patient 1 without his medication "for a number of months." Respondent further stated that Patient 1 did not show any signs of being under the influence of alcohol or other substances and was cooperative in his treatment with "dramatic improvement in his target symptoms and functioning."

K. Patient 2 began treatment with Respondent on June 20, 2013. Patient 2 told Respondent she wanted a prescription for Adderall in order to have more energy and possibly help her lose a few pounds. Patient 2 disclosed to Respondent that she had tried her friend's son's ADHD medication and liked the additional energy it had given her. Respondent told Patient 2 that she had to meet the criteria of attention deficit disorder in order for him to be able to prescribe Adderall to her and suggested she start a trial of phentermine. Respondent provided Patient 2 with prescriptions for phentermine 37.5 mg qAM #30 and Clonidine 0.1 mg #20 in case Patient 2 had trouble falling asleep.

L. Respondent's records for Patient 2 state that Patient 2 had an unofficial trial of a close friend's prescription for Adderall and reportedly was able to function so much better at work that she was able to handle details of orders better at work, communicate with multiple people without confusion and multitask with streamlined efficiency. Respondent also

documented that Patient 2 exhibited "Soft signs of ADD; no real substantiating hx of ADD…" The record only documents the prescription for phentermine and not the prescription for clonidine.

M. At her next appointment on July 10, 2013, Patient 2 told Respondent that she found that the phentermine did not do much for her even after she doubled the dosage. Respondent asked Patient 2 what she was aiming to get and explained that he can only prescribe Adderall for attention deficit disorder, concentration, short term memory loss and sometimes depression. Respondent told Patient 2 that he could not prescribe it simply for weight loss. Respondent then asked Patient 2 about how things were going since her last appointment and provided her with a prescription for Adderall 20 mg #30.

N. Patient 2's record for her second visit documents attention deficit disorder and states that Patient 2 did not find benefit for her concentration, energy, or mood from the phentermine. It further stated that "As she previously had a positive experience with Adderall, she would like to resume it."

O. At her next appointment on July 24, 2013, Patient 2 told Respondent that she was taking one dose in the morning and one in the afternoon, but that by night time she felt like she needed another pick me up. She asked Respondent if she could increase her dose in order to feel even better. Respondent suggested she try a 30 mg dose instead of 20 mg. Patient 2 also asked if she could get more than 30 and Respondent agreed to give

her a three week supply (42). Patient 2 disclosed during this appointment that she had given her friend some of the pills because she owed her. She explained that she wanted additional pills because she still owed that friend more pills. Patient 2 also stated that she had given a different friend a couple of pills as well. Respondent told her not to do that and not to tell him that. At the end of the appointment, Respondent provided Patient 2 with a prescription for Adderall 30 mg #42.

P. In his notes for this appointment, Respondent documented that Patient 2 benefited with trial of Adderall for ADD and experienced better concentration and focus for at least four hours. It was also documented that she requested an increased dose and that her sleep, mood, appetite and weight were stable.

Q. Patient 2 did not return for additional treatment with Respondent after her July 24, 2013 appointment.

R. Respondent made no formal assessment of endangerment in any of his notes for Patient 2 and there was no indication from the records that he performed any kind of diagnostic assessment of ADD for Patient 2.

S. In his response to the Board, Respondent stated that Patient 2 demonstrated multiple symptoms of Attention-Deficit/Hyperactivity disorder which he treated conservatively by prescribing generic Adderall. Respondent stated that by Patient 2's third session, she had "dramatically

improved functioning and decreased ADD target symptoms" with minimal adverse effects.

T. Patient 3 treated with Respondent from March 2007 until March 2014. When Patient 3 first presented, Respondent documented a history of intermittent psychiatric treatment with two hospitalizations for post-traumatic stress disorder, panic disorder, depression, and significant past heroin and cocaine abuse.

U. At her initial appointment, Patient 3 was prescribed olanzapine 2.5 mg tid prn for "anxiety, agitation, sleep." Her next note does not mention olanzapine or why it was discontinued.

V. In Patient 3's initial evaluation, it is reported that she had a past problem of misusing clonazepam prescriptions by taking up to 10-12 mg per day. On September 2, 2007, Respondent documented that he would change Patient 3 back to increased clonazepam 1 mg TID #21. No explanation was documented for this change. At her next appointment on September 11, 2007, it is documented that her medication was changed back to alprazolam 1 mg QID #50 after Patient 3's husband reported ill side effects of the clonazepam.

W. For a significant portion of Patient 3's treatment, Respondent prescribed clonidine 0.2 mg po qhs, alprazolam 2 mg po tid to qid, risperidone 0.5 mg po qd, and topiramate 50-100 mg po qd. Alprazolam was prescribed, reportedly, because nothing else worked. Risperidone was prescribed for

OCD and anxiety. There were no clear statements regarding indications for topiramate.

X. ADHD was not mentioned in Patient 3's records until September 1, 2009, when the patient reported that her outpatient therapist reportedly thought the she looked "like ADD." There was no indication from the records that Respondent performed any kind of diagnostic assessment of ADD for Patient 3. On March 2, 2010, Respondent started prescribing Adderall to Patient 3 for the treatment of ADHD. Over time, her dose of Adderall was increased so that by the end of her treatment she was taking 90 mg of Adderall daily.

Y. On March 3, 2009, Respondent prescribed Patient 3 Aripiprazole 5 mg po qam with no explanation. Other than this one prescription, there is no reference to Aripiprazole in Patient 3's record.

Z. Respondent stated that Patient 3 had been "prescribed a mood stabilizer, initially topiramate and later lamotrigine," but the records do not document their use as "a mood stabilizer," the indications for the change to lamotrigine, or the disorder lamotrigine was meant to treat. There is no documentation in the records that Respondent discussed with Patient 3 the risks of lamotrigine or possible interactions it might have with the alprazolam she was also taking at that time or possible interactions when gabapentin was later added to the regime. This medication was continued for approximately one year. The records do not document when

lamotrigine was discontinued, the reason it was discontinued, or the effect the discontinuation had on Patient 3's mental status.

AA. On May 12, 2011, Respondent prescribed Keflex 500 mg, BID #20 to Patient 3 after she reported she had cystitis. According to the records, Respondent did not order any tests and did not recommend any follow-up for continued symptoms.

BB. On September 13, 2012, Respondent prescribed "Zyprex 10 mg qhs ½ to one qhs prn," but there was no explanation for why it was prescribed or continued until the end of Patient 3's treatment.

CC. On April 24, 2013, Respondent prescribed Patient 3 Gabapentin 200 mg TID after documenting that the patient had previously been prescribed a high dose in the past for bladder pain and requests it now for anxiety. Patient 3's medical record does not document an established diagnosis, an evaluation for its indications, or discussion of possible adverse effects and drug interactions with her current medications. Gabapentin was not continued after this appointment.

DD. Respondent did not adequately document a formal assessment of endangerment in any of his notes for Patient 3. In her initial assessment, Respondent documented only "She contracts for safety, and denies suicidality," without any further explanation. In 2009, Respondent also documents for a brief period of time "Verbal contracts for safety in place," with no other explanation. On April 24, 2012, Respondent documented

that Patient 3 was continuing to have mood swings, was housebound and suicidal, yet there is no indication he assessed this safety risk or responded to it in his treatment plan for this visit in any way.

EE. There is no documentation in the records that Respondent ever assessed Patient 3 for ADHD.

FF. Although Respondent documented Patient 3 had a history of very serious abuse and exposure to violence during her childhood, there is no documentation that this led to a comprehensive assessment of the active symptoms of PTSD impacting Patient 3. There is no documentation that any of the diagnostic criteria for PTSD were initially evaluated or subsequently tracked as "target symptoms."

GG. Depression and Obsessive Compulsive Disorder ("OCD") were listed as diagnoses for Patient 3, but there is no documentation to suggest Respondent ever conducted a diagnostic review for either disorder.

HH. There is no documentation to indicate that Respondent coordinated care of Patient 3 with any of her other therapists or providers.

II. There is no documentation to indicate that Respondent considered or ruled out bipolar disorder or an eating disorder for Patient 3 although she exhibited signs of both.

JJ. Respondent's notes abruptly stop of March 3, 2014, without any documentation as to why treatment was terminated.

KK. Respondent's records for all three patients do not adequately document the patients' clinical presentation or Respondent's clinical decision-making or changes to the treatment plan.

LL. Respondent failed to adequately document informed consent with all three patients.

MM. Respondent did not keep any billing records for Patients 1, 2, and 3.

NN. Respondent keeps his records in an electronic format on his computer. His medical records are not time or date stamped.

6. The specific issues to be determined at the adjudicatory/disciplinary proceeding include, but are not limited to the following:

A. Whether Respondent engaged in professional misconduct by negligently prescribing prescription drugs to Patient 1, in violation of RSA 329:17, VI (c) and/or (d); and/or

B. Whether Respondent engaged in professional misconduct by negligently prescribing prescription drugs to Patient 2, in violation of RSA 329:17, VI (c) and/or (d); and/or

C. Whether Respondent engaged in professional misconduct by negligently prescribing prescription drugs to Patient 3, in violation of RSA 329:17, VI (c) and/or (d); and/or

D. Whether Respondent engaged in professional misconduct by negligently managing Patient 3's medications, in violation of RSA 329:17, VI (c) and/or (d); and/or

E. Whether Respondent engaged in professional misconduct by failing to properly assess endangerment, in violation of RSA 329:17, VI (c) and/or (d); and/or

F. Whether Respondent engaged in professional misconduct by failing to perform appropriate diagnostic assessments when diagnosing and treating multiple conditions, in violation of RSA 329:17, VI (c) and/or (d); and/or

G. Whether Respondent engaged in professional misconduct by failing to properly diagnose and treat Patients 1, 2, and 3, in violation of RSA 329:17, VI (c) and/or (d); and/or

H. Whether Respondent engaged in professional misconduct by improperly terminating patient care, in violation of RSA 329:17, VI (c) and/or (d); and/or

I. Whether Respondent engaged in professional misconduct by failing to maintain adequate, accurate, and/or complete medical records in violation of RSA 329:17, VI (d), (k), Med 501.02 (d) and/or (e); and/or

J. Whether Respondent engaged in professional misconduct by engaging in dishonest conduct, in violation of RSA 329:17, VI (d) and/or Med 501.02(b); and/or

K. Whether Respondent engaged in professional misconduct by failing to maintain appropriate electronic records, in violation of RSA 329:17, VI (d), Med 501.02(h), and AMA Code of Ethics Opinion 5.07; and/or

L. Whether Respondent engaged in professional misconduct by failing to obtain appropriate informed consent, in violation of RSA 329:17, VI (d), Med 501.02(h), and AMA Code of Ethics Opinion 8.08; and/or

M. Whether Respondent engaged in professional misconduct by failing to act in the best interests of his patients, in violation of RSA 329:17, VI (d), Med 501.02(h), and AMA Code of Ethics Opinion 10.015; and/or

N. If any of the above allegations are proven, whether and to what extent Respondent should be subjected to one or more of the disciplinary sanctions authorized by RSA 329:17, VII.

THEREFORE, IT IS ORDERED that an adjudicatory/disciplinary proceeding be commenced for the purpose of resolving the issues articulated above pursuant to RSA 329:18-a, Med 206. To the extent that the Board's rules do not address an issue of policy or procedures, the Board shall apply the N.H. Department of Justice Rules, Part 800; and,

IT IS FURTHER ORDERED that information gathered during the investigation and information set forth in the Report of Investigation shall remain confidential and exempt from public disclosure, unless specifically referred to in this Notice of Hearing, unless and until such time as an adjudicatory hearing commences, at which time such information may become evidence in or the subject of the adjudicatory hearing.

IT IS FURTHER ORDERED that the identities of the patients shall remain confidential and the patients shall be referred to by initials or numbers during the proceedings. All identifying information for the patients shall be redacted from all documents and the patients' medical records shall remain confidential and be exempt from the provisions of RSA 91-A; and,

IT IS FURTHER ORDERED that Respondent shall appear before the Board on October 5, 2016 at 1:00 P.M., at the Board's office located at 121 South Fruit Street, Concord, N.H., to participate in this adjudicatory/disciplinary proceeding and, if deemed appropriate, be subject to sanctions pursuant to RSA 329:17, VII, and

IT IS FURTHER ORDERED that if Respondent elects to be represented by counsel, at Respondent's own expense, counsel shall file a notice of appearance at the earliest date possible; and,

IT IS FURTHER ORDERED that Respondent's failure to appear at the time and place specified above may result in the hearing being held *in absentia* and disciplinary sanctions may be imposed without further notice or an opportunity to be heard; and,

IT IS FURTHER ORDERED that Assistant Attorney General Michelle Heaton, 33 Capitol Street, Concord, N.H., 03301 is appointed to act as Hearing Counsel in this matter with all the authority within the scope of RSA Chapter 329 to represent the public interest. Hearing Counsel shall have the status of a party to this proceeding; and,

IT IS FURTHER ORDERED that Michael Barr, M.D., or any other person whom the Board may designate, shall act as presiding officer in this proceeding; and,

IT IS FURTHER ORDERED that any proposed exhibits, motions or other documents the parties intend to become part of the record in this proceeding, be filed by the proponent with the Board, in the form of an original and eleven (11) copies, and with an additional copy mailed to any party to the proceeding, and to Lynmarie Cusack, Esq., Counsel to the Board, N.H. Department of Justice, 33 Capitol Street, Concord, New Hampshire 03301. All responses or

objections to such motions or other documents are to be filed in similar fashion within ten (10) days of receipt of such motion or other document unless otherwise ordered by the Board; and,

IT IS FURTHER ORDERED that a witness list and any proposed exhibits shall be pre-marked for identification only and filed with the Board no later than fourteen (14) days before the date of the hearing. Respondent shall pre-mark his exhibits with capital letters, and Hearing Counsel shall pre-mark her exhibits with Arabic numerals; and,

IT IS FURTHER ORDERED that unless good cause exists, all motions shall be filed at least ten (10) days before the date of any hearing, conference, event or deadline which would be affected by the requested relief, except any motion seeking to postpone a hearing or conference, which shall be filed at least fourteen (14) days before the hearing or conference in question; and,

IT IS FURTHER ORDERED that the entirety of all oral proceedings be recorded verbatim by the Board. Upon the request of any party made at least ten (10) days prior to the proceeding or conference or upon the Board's own initiative, a shorthand court reporter shall be provided at the hearing or conference and such record shall be transcribed by the Board if the requesting party or agency shall pay all reasonable costs for such transcription; and,

IT IS FURTHER ORDERED that all documents shall be filed with the Board by mailing or delivering them to Penny Taylor, Administrator, N.H. Board of Medicine, 121 South Fruit Street, Concord, New Hampshire 03301; and,

IT IS FURTHER ORDERED that routine procedural inquiries may be made by contacting Penny Taylor, Administrator, N.H. Board of Medicine, 121 South Fruit Street, Concord, New Hampshire 03301, (603) 271-1203, but that all other communications with the

Board shall be in writing and filed as provided above. *Ex parte* communications are forbidden by statute and the Board's regulations; and,

IT IS FURTHER ORDERED that a copy of this hearing notice shall be served upon Respondent by certified mail addressed to the address he supplied to the Board in his latest renewal application. *See*, RSA 329:18, VI, Med. 501.02 (a) and RSA 329:16-f. A copy shall also be delivered to Hearing Counsel.

BY ORDER OF THE BOARD/*

Dated: April 13, 2016

Penny Taylor

Penny Taylor, Administrator
Authorized Representative of the
N.H. Board of Medicine

/* Louis Rosenthall, M.D., Board member(s), did not participate