IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA, *ex rel.* THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 14-01-4902**
MARIA M. KANE, M.D., LICENSE NO. 11134	)	
Defendant.	)	

COMPLAINT

The State of Oklahoma, *ex rel.* the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), alleges and states as follows for its Complaint against the Defendant Maria Kane, M.D.:

I. JURISDICTION

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 O.S. § 480, *et seq*.

2. The Defendant holds Oklahoma medical license no. 11134.

3. The acts and omissions complained of herein occurred while the Defendant was acting as a physician pursuant to the Defendant's medical license conferred upon her by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. ALLEGATIONS OF UNPROFESSIONAL CONDUCT

BACKGROUND

4. This action arises out of a complaint made to the Board against the Defendant on January 21, 2014. The complainant alleged the Defendant was prescribing alprazolam to numerous family members of the complainant without medical need.

5. The Defendant was personally served by Investigator RR on February 10, 2014, with a formal records request for 6 patients. At that time, the Defendant admitted to Investigator RR that she did not keep adequate records for her patients. The Defendant admitted that she did not routinely keep progress notes, and most patient charts were electronic medical records containing only dates of appointments and medication logs. The documents faxed by the Defendant to Investigator RR pursuant to the records request later that date were merely medication lists for patients.

6. The Defendant was personally served with another formal records request by Investigator RR on February 12, 2104. The Defendant stated the requested records were unavailable. A third formal records request was served by Investigator RR personally upon the Defendant on February 14, 2014. Only on this third attempt did Investigator RR receive any semblance of medical records from the Defendant. Investigator RR received 16 patient files from the Defendant, which were submitted to a qualified expert for review.

7. During the investigation, the Defendant's prescribing record was reviewed. It revealed that, for a 30-day period alone, the Defendant wrote 890 prescriptions for CDS, with 678 of them being for alprazolam. Review of another 30-day period showed similar prescribing activity. Of the 16 patient charts obtained from the Defendant, all 16 patients universally received alprazolam.

EXPERT REVIEW

8. A qualified physician was retained as an expert to examine 16 files of patients that saw the Defendant. The expert's general findings included the following:

   a. Prescribing CDS with no examination or evidence of an examination being performed.

   b. Failing to take or record sufficient symptom histories necessary for utilizing DSM-4 or 5 diagnoses of psychiatric illness (in 12 of the 16 patient files, no diagnoses were ever made).

   c. Failing to make or record complete DSM-4 or 5 diagnoses lists on initial or follow-up visits.

   d. Failing to establish legitimate patient need for CDS prescribed to patients.

   e. Writing prescriptions for CDS before a patient is seen for an initial examination.

   f. Failing to provide proper informed consent regarding diagnoses and treatments.

   g. Failing to advise or document advising patients of the known risks of high-dosage alprazolam usage or risks of combining opioids with alprazolam.

h. Failing to render treatment for psychiatric disorders within the appropriate standard of care.

i. Ignoring or not recognizing red flags for substance abuse or diversion.

9. Although problems with the files of each of the 16 patient files reviewed were found, certain egregious problems were uncovered. The qualified expert's patient-specific findings include the following:

a. **Patient No. 1:** Failing to recognize or advise patient of SNRI withdrawal risk after abruptly stopping duloxetine; failing to explore the patient's reaction regarding atypical acute stress disorder symptoms; failing to make or record any initial evaluation.

b. **Patient No. 6:** Failing to check ECG or TCA levels at any time despite prescribing therapeutic doses of amitriptyline, which could reveal life-threatening TCA toxicity; combining quetiapine, citalopram, alprazolam, and amitriptyline despite the high risk of severe side effects of such a drug combination.

c. **Patient No. 7:** Prescribing alprazolam to a pregnant patient.

d. **Patient No. 8:** Failing to provide or document any risk assessment or treatment plan for an acutely homicidal and suicidal patient; failing to render appropriate treatment for this patient or conduct adequate follow up visits.

e. **Patient No. 12:** Failing to check ECG or TCA levels at any time despite prescribing therapeutic doses of amitriptyline, which could reveal life-threatening TCA toxicity.

III. VIOLATIONS

10. Based on the foregoing, the Defendant is guilty of professional misconduct as follows:

a. Prescribing or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship, in violation of 59 O.S. 2011, § 509(12).

b. Engaging in dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public, in violation of 59 O.S. 2011, § 509(8) and Okla. Admin. Code § 435:10-7-4(11).

c. Prescribing, dispensing or administering of controlled substances or narcotic drugs in excess of the amount considered good medical practice, or prescribing, dispensing or administering controlled substances or

narcotic drugs without medical need in accordance with published standards, in violation of 59 O.S. 2011, § 509(16) and Okla. Admin. Code §§ 435:10-7-4(2), (6), (24).

d. Failing to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient, in violation of 59 O.S. 2011, § 509(18) and Okla. Admin. Code § 435:10-7-4(36).

e. Failing to provide necessary ongoing medical treatment when a doctor-patient relationship has been established, in violation of 59 O.S. 2011, § 509(19).

f. Failing to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act and maintaining adequate medical records to support diagnosis, procedure, treatment or prescribed medications, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41).

g. Engaging in the indiscriminate or excessive prescribing, dispensing or administering of Controlled or Narcotic drugs, in violation of Okla. Admin. Code § 435:10-7-4(1).

h. Engaging in gross or repeated negligence in the practice of medicine and surgery, in violation of Okla. Admin. Code § 435:10-7-4(15).

i. Failing to establish a physician-patient relationship prior to providing patient-specific medical services, care or treatment, in violation of Okla. Admin. Code § 435:10-7-4(49).

IV. CONCLUSION

Given the foregoing, the undersigned requests the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to the Defendant's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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