VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: STEPHEN J. MCNAMARA, M.D.
License No.: 0101-048938

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Stephen J. McNamara, M.D., on March 26, 2014, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Siobhan S. Dunnavant, Chair; Wayne Reynolds, D.O; and Fraizer W. Frantz, M.D. Dr. McNamara appeared personally and was represented by Thomas E. Albro, Esquire. Melanie Pagano, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions. The purpose of the informal conference was to inquire into allegations that Dr. McNamara may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated February 11, 2014.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law:

1. Stephen J. McNamara, M.D., was issued license number 0101-048938 to practice medicine and surgery in Virginia on December 30, 1992. Said license is currently active and will expire on November 30, 2014 unless renewed or otherwise acted upon.

2. Dr. McNamara violated Sections 54.1-2915.A(3), (17) and (18) and 54.1-3408.A of the

Code in that, despite the fact that he prescribed Patient A, a 29-year-old female psychiatric patient, Adderall (Schedule II) in high dosages and large quantities on a continuous basis from approximately September, 2010 through August, 2012, and benzodiazepines (Schedule IV) from approximately September, 2010 through March, 2011, he failed to properly assess/evaluate the patient's underlying medical condition(s) prior to prescribing these medications and/or to properly manage the patient's Adderall and/or benzodiazepine medication regimen(s). Specifically:

a. Patient A was referred to Dr. McNamara on or about September 24, 2010 (by the director of a physician wellness program) regarding concerns about the patient's ability/capacity to perform her employment functions/requirements due to physical and emotional stress. At or shortly after this initial visit, during which the patient reported that her main source of stress was her increasingly volatile marital situation, Dr. McNamara diagnosed the patient with Attention Deficit Hyperactivity Disorder (ADHD). Dr. McNamara prescribed Adderall, based on the patient's representation that she was currently being prescribed Adderall for ADHD, without obtaining and/or reviewing her prior medical records and without sufficient objective evidence to support this diagnosis. Further, Dr. McNamara continued to prescribe the patient Adderall through in or about August, 2012, without appropriate medical support.

b. Dr. McNamara stated to the Committee that only when he is confused by a patient's presentation and history, or hears discrepancies in the patient's story or memory lapses does he obtain prior records from other treating practitioners. Dr. McNamara stated that he diagnosed Patient A with ADHD from a review of her history and her report of signs

and symptoms, and that he was confident with this diagnosis. Dr. McNamara admitted that he depended only on the patient's history and description of her symptoms to establish his diagnosis.

c. Dr. McNamara stated that he saw Patient A weekly from October to December 2010; approximately monthly from January to December 2011; then approximately every three to four months from January through August 2012. Dr. McNamara stated that this fits his treatment plan for a patient with this "garden variety" diagnosis of ADHD, and given what he knew at that time, he felt he provided the patient with adequate medical treatment/support.

d. Despite the fact that Patient A's July 7, 2011 assessment report issued by Pine Grove Behavioral Health & Addiction Services (Pine Grove), discussed in detail in Paragraph 2(f)(v) suggested the exploration of non-addictive or less-addictive treatment alternatives to Adderall, Dr. McNamara failed to order such alternative care/treatment for Patient A. Dr. McNamara stated that he felt he optimized Patient A's Adderall dosage and he believed that Patient A did not have a history of addiction, which obviated the Pine Grove recommendation for "alternative, non-addicting treatment." Dr. McNamara stated that he relied on Patient A's reports of her symptoms, anxiety, marital conflict and family dynamics and that he took the patient's statements at "face value."

e. From approximately October, 2010 to August, 2012, Dr. McNamara prescribed Patient A Adderall on approximately 45 occasions, and lorazepam and/or alprazolam on approximately 4 occasions without requiring an office visit and/or performing a physical examination/assessment in order to determine the medical necessity of these medications.

Further, Dr. McNamara's medical record indicates that, in or about April/May, 2011, Patient A moved to a location approximately two and one half (2-1/2) to three (3) hours' driving distance from his practice location and was thereafter seen for a total of approximately seven office visits during this 15-month period, during which Dr. McNamara prescribed the patient high dosages and/or large quantities of Adderall. Further, despite the fact that Dr. McNamara's January and May, 2012 medical records indicate that he planned/discussed with Patient A the transfer of her medication management to a "more convenient" physician in her area, he continued to prescribe the patient Adderall through in or about August, 2012.

f. Throughout the relevant treatment period, Dr. McNamara failed to adequately address or document that he had addressed signs and symptoms of Patient A's escalation or abuse of Adderall and benzodiazepines (which he prescribed for the patient from approximately September, 2010 through March, 2011), and/or drug-seeking or other aberrant behavior, and he failed to appropriately treat or refer Patient A for treatment of substance abuse. Examples of Patient A's drug abuse, drug-seeking and/or other aberrant behavior include:

i. From approximately October 4, 2010 to August 21, 2012, Patient A failed to attend approximately 16 scheduled office visits and was late for approximately six (6) office visits. Further, on or about February 11, 2011 and August 15, 2011, after failing to attend scheduled office visits, Patient A came to Dr. McNamara's office to pick up Adderall prescriptions.

ii. Dr. McNamara stated that his record-keeping and accounts of medications prescribed for Patient A became very complicated, and he admits that he missed some signs that he had provided Adderall prescriptions to Patient A in an atypical fashion rather than in the way he provided patient prescriptions according to his "average standard of practice." Dr. McNamara stated that this atypical prescribing arose out of unique circumstances (the geographic distance) between Patient A's home and his office and legitimate nationwide supply shortages causing him to write separate, more frequent prescriptions for the full amount of dosage units, creating complications for his record keeping such that he did not keep pill counts.

iii. On or about October 27, 2010 at approximately 8:00 p.m., Patient A left Dr. McNamara a voice message indicating that she was staying awake until 3:00 a.m., "crash[ing]" until approximately 3:00 - 4:00 p.m., and requesting medication to "help reset her circadian rhythm." In response to Patient A's telephone call, Dr. McNamara prescribed the patient zolpidem tartrate. Patient A's record indicates that from approximately October 5 - October 18, 2010, she had obtained approximately 330 dosage units of Adderall 30 mg and 120 dosage units of Adderall XR 30 mg, prescribed by Dr. McNamara.

iv. Despite the fact that Patient A informed Dr. McNamara, in or about January, 2011, that alprazolam was too sedative and when, in the alternative, Dr. McNamara prescribed her lorazepam, that it too was "too sedative," the patient's records indicate that, in February, 2011, she concurrently obtained lorazepam and

alprazolam from prescriptions written by Dr. McNamara. Further, Patient A's records indicate that she became dependent on and/or was abusing alprazolam, despite denouncing its sedative effects. Specifically, on or about the evenings of February 20, 2011 and March 15, 2011, Patient A called Dr. McNamara at home to request an alprazolam prescription, stating that she had run out of this medication, despite the fact that her records indicate, on both occasions, that she had recently obtained alprazolam from prescriptions written by Dr. McNamara, and should have had sufficient amounts of this medication remaining had she taken this medication as prescribed. Moreover, on or about March 29, 2011, Patient A again called Dr. McNamara to request alprazolam, despite having been informed by him two weeks prior that he would no longer prescribe this medication for her.

v. Following Patient A's suspension from her fellowship program in or about March, 2011, she entered the Vanderbilt University Comprehensive Assessment Program (VCAP), in or about April 2011, upon referral by the director of the physician wellness program at the hospital where she was pursuing her fellowship. Patient A's May 12, 2011 VCAP report (updated on May 24, 2011) indicated diagnoses of substance abuse, to include Adderall dependence, alprazolam abuse, provisional, and alcohol abuse, rule out dependence; recommended psychotherapy, to include behavioral techniques to help manage the patient's attention problems; and that the patient seek formal support from the Virginia Health Practitioners' Monitoring Program (HPMP) and enter an extended residential inpatient assessment; and determined that, with a reasonable degree of medical certainty, the

patient was unfit to practice medicine at that time. On or about June 26, 2011, Patient A entered the Pine Grove program for a comprehensive evaluation, as referred by the physician wellness program director. The July 7, 2011 Pine Grove evaluation report indicated a diagnosis of alcohol abuse, rule out dependence and further indicated "concerns about the high doses of Adderall" Patient A was taking, recommending an intensive, residential-level treatment program of eight to twelve weeks' duration at a Virginia HPMP-approved facility, as well as exploration of non-addictive or less-addictive alternatives (to Adderall) and the incorporation of cognitive-behavioral approaches to the patient's ADHD. On or about July 26, 2011, Patient A entered the Williamsburg Place/William J. Farley Center for residential treatment, but checked out the next day, July 27, 2011, due to the patient's disagreement as to "what they were requiring of" her and/or an insurance coverage issue.

vi. From approximately May 10, 2011 to August 21, 2012, after Patient A had moved to a location approximately two-and-one-half (2-1/2) to three (3) hours' driving distance from Dr. McNamara's office, immediately after and/or inclusive of the time during which Patient A underwent evaluations at VCAP and Pine Grove and subsequently entered the Williamsburg Place/William J. Farley Center for residential treatment (detailed in Paragraph 2(f)(v)), the patient sent Dr. McNamara approximately 28 facsimile communications and contacted him twice via telephone to request Adderall prescriptions, stating in these communications that she: required additional Adderall medication because she had lost medication and/or scripts and

on one occasion because a family member had thrown out some of her medication, because she was leaving town on vacation, and because she needed "replacement script[s]"(on two occasions), as she had been prescribed generic forms of Adderall that had "side effects" and didn't "work" the same as usual; required alternate strengths and dosages of Adderall due to pharmacy supply and/or insurance issues; was shorted dosage units by the dispensing pharmacy; and/or was due to run out of this medication. In response to these written and/or oral medication requests, Dr. McNamara mailed Adderall prescriptions to her home. This pattern of prescribing resulted in Patient A receiving excessive dosages of Adderall.

3. Dr. McNamara violated Section 54.1-2915.A(3) of the Code in his care and treatment of Patient A, in that:

a. Although he identified Patient A as an ultra rapid metabolizer, and in or about December, 2010, titrated her Adderall dosage to 240 mg per day, which dosage exceeds the recommended maximum daily dosage of 60 mg per day, Dr. McNamara failed to order diagnostic laboratory testing to substantiate his diagnosis. Further, throughout the relevant treatment period, Dr. McNamara failed to perform and/or document physical assessments and examinations of Patient A, to include Patient A's blood pressure, weight, heart rate, pulse and/or other such vital signs in order to assess/evaluate the physical effects of this Adderall dosage on the patient. Moreover, Dr. McNamara's failure to appropriately monitor the amount of medication obtained by the patient, due to his poor prescribing practices detailed in Paragraph 2(f)(vi) above, resulted in Patient A obtaining Adderall in dosages and quantities that far exceeded her prescribed dosage of 240 mg per

day. Dr. McNamara stated that he does not typically take patient vital signs for the type of medications prescribed to Patient A. Dr. McNamara further stated that vital signs are not indicated for evaluation or follow-up care for adult patients with ADHD.

b. During the relevant treatment period, Dr. McNamara noted and/or expressed concerns about the need for Patient A to obtain additional and/or alternate psychiatric care and treatment, yet he failed to appropriately refer the patient for such care. Specifically, at or about her initial visit (September 24, 2010), Dr. McNamara ordered couples therapy for Patient A and her husband. Shortly thereafter, on or about October 23, 2010, Dr. McNamara's medical record indicates that the therapist noted the patient's "abysmal compliance" with sessions (having attended approximately two to three of eight scheduled appointments) as well as the patient's intractable verbosity, and opined that the situation was irreparable – "maybe the worst he has ever seen," yet he failed to order any alternate/additional therapy for the patient, despite the fact that his medical record also indicates the patient's marital strife escalated/intensified throughout the remainder of the relevant treatment period.

c. In Dr. McNamara's care and treatment of Patient A, he failed to adequately consider and/or evaluate collateral information about the patient's abuse of alcohol, Adderall and/or alprazolam from the patient's relatives, friends and/or other medical assessors/treatment providers. Specifically:

i. As stated in Paragraph 2(a) above, Dr. McNamara failed to obtain Patient A's treatment records from her prior treating physicians. Due to his failure to request/obtain these prior treatment records, Dr. McNamara failed to learn of the

patient's history, from approximately September 2008 to September, 2010, of self-increasing her Adderall dosage in excess of the prescribed dosages and of reporting "lost" Adderall medication, resulting in the issuance of a replacement prescription.

ii. As documented in the May, 2011 VCAP report and the July, 2011 Pine Grove report, two of Patient A's friends reported to evaluators the patient's frequent excessive use of alcohol, including in combination with alprazolam and in the context of suicidal ideation.

iii. On or about September 14, 2011, Patient A's mother telephoned Dr. McNamara's office (during the time that Patient A was living with her parents) with concerns about the patient's Adderall usage and requested that he taper the patient's dosage. Dr. McNamara dismissed the mother's concerns pursuant to a discussion of the call with the patient, wherein she stated that her mother "never wanted [her] to be on psychiatric medication."

iv. Patient A's brother sent Dr. McNamara a letter dated April 21, 2012 (contained in his medical record), stating that the patient had duped a physician into prescribing her Adderall during her third year of medical school citing "made-up events" in her past about concentration difficulties; that the patient used Adderall in part for weight loss, having a past history of "body issues," and was addicted to its euphoric effect; that the patient abused alcohol nightly to deal with the anxiety caused by her Adderall use; that the patient stayed awake for days at a time on Adderall and "crash[ed]"when she ran out of this medication; that the patient physically, verbally and mentally abused her mother while taking Adderall; and

that the patient had threatened suicide on at least three occasions while taking Adderall, as witnessed by her brother.

d. Dr. McNamara stated that, in discussing communications from family and friends which conflicted with Patient A's reports about these issues, Patient A's demeanor and response were convincing and appropriate and did not raise any "red flags" for him.

e. Despite the fact that Dr. McNamara's February 3, 2011 medical record acknowledged that treatment with a behavioral-cognitive therapist might be more beneficial for Patient A, he failed to refer the patient to such a therapist, instead allowing the patient to "decline" this treatment recommendation. Further, although Patient A indicated that she eventually began cognitive processing therapy (CPT) in or about August, 2011 with a psychologist closer to her place of residence, Dr. McNamara failed to consult and/or coordinate Patient A's psychiatric care and treatment with and/or to obtain the patient's treatment records from this treating psychologist. Due to Dr. McNamara's failure to consult/coordinate Patient A's care and treatment with this psychologist, he failed to learn that the patient was continuing her pattern of missing or cancelling "more appointments than she attend[ed],"which directly contradicted the patient's assertion, recorded in Dr. McNamara's August 21, 2012 medical record, that her "[w]eekly sessions with [this psychologist] continue."

4. Dr. McNamara admitted that he is "quite shaken" to have been so naïve regarding Patient A. He stated that he trusted Patient A, her story and the clinical history she recounted and admits that he could have been more vigilant and implemented procedures in his practice to minimize these limitations. Dr. McNamara stated that, to ensure safe prescription practice, he

now requires all patients who are prescribed benzodiazepines for treatment to sign a records release, that these patients initially will receive no more than one 30-day prescription to allow sufficient time for medical record transfer/review, and that no subsequent prescriptions will be written until that process is completed. Dr. McNamara further stated that he has implemented a medication log to ensure more accurate review of a patient's prescription record, and that he enrolled in the Virginia Prescription Monitoring Program (PMP) effective March 1, 2014.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that Stephen J. McNamara, M.D., is hereby issued a REPRIMAND.

It is further ORDERED that Dr. McNamara's license be subject to the following TERMS and CONDITIONS:

1. Within six months from entry of this Order, Dr. McNamara shall submit evidence satisfactory to the Board verifying that he has completed 15 hours of Board-approved continuing medical education ("CME") in the subject of proper prescribing and 15 hours of Board-approved CME in the subject of substance abuse. Such CMEs shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal, or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

2. Upon receipt of evidence that Dr. McNamara has complied with the requirements of Term 1 of this Order, the Committee authorizes the Executive Director to close this matter, or refer it to a special conference committee for review.

Dr. McNamara shall maintain a course of conduct in his practice of medicine and surgery commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Violation of this Order may constitute grounds for suspension or revocation of Dr. McNamara's license. In the event that Dr. McNamara violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Pursuant to Section 54.1-2400(10) of the Code, Dr. McNamara may, not later than 5:00 p.m., on May 3, 2014, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on May 3, 2014, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

Wm L Harp MD

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Entered: 3/31/14