**VIRGINIA:**

**BEFORE THE BOARD OF MEDICINE**

**IN RE: SHAMA SAIYED, M.D.**
**License No.: 0101-242372**

## CONSENT ORDER

On May 4, 2016, a Special Conference Committee ("Committee") of the Virginia Board of Medicine ("Board") convened to inquire into allegations that Shama Saiyed, M.D., may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia. After thorough review of the matters before it, the Committee determined that it could not resolve the matter within the limits of its authority, as set forth in Section 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), and referred the matter to a formal administrative hearing.

In lieu of proceeding to a formal administrative hearing, the Board and Dr. Saiyed, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting Dr. Saiyed's license to practice medicine in Virginia.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Board adopts the following findings of fact and conclusions of law in this matter:

1. Shama Saiyed, M.D., was issued license number 0101-242372 by the Board to practice medicine and surgery in the Commonwealth of Virginia on August 13, 2007. Said license is currently active and will expire on March 31, 2018, unless renewed or restricted.

2. Dr. Saiyed violated Section 54.1-2915.A(3), (12), (13), (16), and (18) of the Code and 18 VAC 85-20-26.C of the Board's Regulations in that her handwritten progress notes for Patients A, B, C, D, G, J, N, Q, R, S, T, U, V, and W are inadequate, incomplete, and so illegible as to render them virtually impossible to be read by any other practitioner.

3. Dr. Saiyed violated Section 54.1-2915.A(3) and (18) of the Code and 18 VAC 85-20-26.C of the Board's Regulations with respect to her psychiatric treatment (from approximately July 2013 to June 2014) of

Patient A, a 22-year-old female whom Dr. Saiyed diagnosed with attention deficit disorder ("ADD"), major depressive disorder, and anxiety and prescribed Adderall (C-II), Ambien (C-IV), Trazadone (C-VI), and Vistaril (C-VI), subsequently replaced with Xanax (C-IV). Specifically, based on the original handwritten medical record for Patient A that Dr. Saiyed provided to the Department of Health Professions' ("DHP") Investigator ("Investigator") on or about June 18, 2014:

a. Dr. Saiyed failed to obtain or document attempting to obtain prior treatment or pharmacy records for Patient A at or subsequent to her initial visit on or about July 17, 2013. Had Dr. Saiyed obtained such treatment records, she would have learned that Patient A had a history of substance abuse, including inpatient treatment for abuse of Xanax during 2010. Moreover, had Dr. Saiyed accessed Patient A's Virginia Prescription Monitoring Program ("PMP") report at her first visit, Dr. Saiyed would have learned that the patient had just been prescribed a 30-day supply of methylphenidate hydrochloride (C-II) from another physician only seven days earlier, thereby negating the need for Dr. Saiyed to authorize another 30-day script for amphetamines (Adderall) at her July 17, 2013 visit.

b. Although Dr. Saiyed diagnosed Patient A with ADD and began prescribing her Adderall, a C-II controlled substance with high abuse potential, at her first office visit (and thereafter quickly increased the dosage thereof), Dr. Saiyed failed to perform or document an adequate work up to diagnosis that condition, including accessing (or documenting attempts to access) historical or collateral information with respect thereto, e.g., from the patient's family or Patient A's school records.

c. Starting on or about October 10, 2013 and continuing at office visits thereafter, Dr. Saiyed documented significant new symptoms for Patient A that she had not previously noted, such as poorly controlled behavior and impulses, needing assistance for self-care, a disheveled appearance, pressured

speech, mania, grandiosity, delusions, withdrawal and social isolation, flight of ideas, racing thoughts, psychosis, combativeness, incoherent thought process, disorientation, labile mood, restricted effect, and paranoia. However, there is no documentation that Dr. Saiyed assessed or evaluated these new symptoms or formulated or modified her treatment plan to address them.

d. Although Dr. Saiyed referred Patient A for psychotherapy/counseling and/or psychological testing at almost every office visit during the treatment period, she took no appropriate responsive action when the patient failed to follow through on any of these recommendations. Similarly, although Dr. Saiyed repeatedly documented that Patient A's daily dose of Adderall and Xanax should be decreased and recommended that she start taking an SSRI for her depression, the patient refused to follow this advice.

e. Although Dr. Saiyed regularly prescribed abuseable controlled substances to a patient with a substance abuse history, she failed to adequately monitor and manage Patient A's usage of such medications, e.g., Dr. Saiyed failed to execute a controlled substance contract with Patient A or to appropriately utilize monitoring tools, such as urine drug screens, pill counts, or the PMP. Although Dr. Saiyed informed a DHP Investigator that she "regularly" reviewed Patient A's PMP, information from the Deputy Director of the PMP indicates that Dr. Saiyed accessed the PMP for Patient A only one time, on June 13, 2014, after she had been contacted by the Investigator regarding this patient and the same day on which Dr. Saiyed purportedly dismissed the patient from her practice.

4. Dr. Saiyed violated Section 54.1-2915.A(1), (12), and (18) of the Code and 18 VAC 85-20-26.C and 18 VAC 85-20-105 of the Board's Regulations in that she provided the Board's Investigator with deceptive, false, misleading and/or fraudulent information with respect to her medical records for Patient A. Specifically:

a. Due to the illegibility of Dr. Saiyed's handwritten records for Patient A, the Investigator asked her (on or about June 18, 2014) to provide a verbatim typed version of these notes. However, Dr. Saiyed subsequently provided the Investigator with extensive typed notes that she created after-the-fact using the template from her new electronic medical record ("EMR"). This typed version of Dr. Saiyed's notes for Patient A does not correspond to her original handwritten notes in that it includes a tremendous amount of additional information that was not present in the original notes, includes information that expressly contradicts the information documented in Dr. Saiyed's original notes, adds new diagnoses (e.g., bipolar II disorder) that were not documented in the original record, uses a completely different template with different subject headings from Dr. Saiyed's original notes, and fails to include information that was documented in Dr. Saiyed's original handwritten notes. In sum, these later typed notes are completely different from and bear little or no resemblance to Dr. Saiyed's original handwritten notes.

b. When the Investigator subsequently asked Dr. Saiyed to explain why the typed medical records she provided for Patient A were significantly different from the original handwritten notes Dr. Saiyed had initially given her, Dr. Saiyed reported that she "had no other way of transcribing the [original] record" except to use the template provided in her new EMR. Further, Dr. Saiyed admitted to the Investigator that, based on her memory and use of symbols. she provided altered and augmented information in the typed transcription that had not been included in her original handwritten notes.

c. When the Investigator Dr. Saiyed a second time (on or about July 27. 2015) to provide a typed verbatim transcription containing only the exact information documented in her original handwritten record for Patient A, with no modifications. additions. or interpretations. Dr. Saiyed

again provided records that were not the same as and were markedly different from not only her original handwritten records, but also from the first purported records transcription she had provided the Investigator. Further, although the Investigator had asked Dr. Saiyed not to use an EMR template/format to provide this typed transcription (since Dr. Saiyed had not used that format in documenting her original notes), Dr. Saiyed yet again provided the Investigator with a transcription using this inconsistent EMR template. While acknowledging to the Investigator that this latest transcription (faxed on or about August 28, 2015) appeared similar to the initial transcription in which Dr. Saiyed had used an EMR template, she asserted that the current transcription constituted "a typed version of exactly what appeared in the handwritten record, with no additional material information" and "reflected only exactly what was written" in the handwritten record. However, these statements are patently false.Dr. Saiyed falsely informed the Investigator (in an interview on or about June 18, 2014) and the Board (in a letter dated June 17, 2014), and falsely documented in the two sets of transcribed notes she provided the Investigator, that she regularly accessed and reviewed Patient A's PMP throughout the treatment period; however, the Deputy Director of the PMP reports that Dr. Saiyed only accessed Patient A's PMP once, on June 13, 2014, the date on which Dr. Saiyed discharged the patient from her practice.

5. Dr. Saiyed violated Section 54.1-2915.A(3) and (18) of the Code and 18 VAC 85-20-26.C of the Board's Regulations with respect to her care of Patient B. a 22-year-old female whom she treated for depression, anxiety, and attention deficit hyperactivity disorder ("ADHD") on or about September 13, 2013, October 11, 2013, and November 11, 2013. Specifically, although Dr. Saiyed diagnosed Patient B with ADHD on or about September 13, 2013 at her first office visit and prescribed her Adderall at that and her two

subsequent office visits, Dr. Saiyed failed to perform an adequate work up to establish that condition, including accessing (or documenting attempts to access) historical or collateral information with respect thereto, e.g., from the patient's family or Patient B's school records. Moreover, Dr. Saiyed failed to obtain or document attempting to obtain prior treatment records for Patient B at or subsequent to her initial visit nor did Dr. Saiyed document an adequate medical history at the patient's initial visit.

6. Dr. Saiyed violated Section 54.1-2915.A(1), (12) and (18) of the Code and 18 VAC 85-20-26.C and 18 VAC 85-20-105 of the Board's Regulations in that she willfully and deliberately gave the Investigator deceptive, false, misleading and/or fraudulent information with respect to Patients C-M, Patients O-Q, and Patient S during the course of her investigation. Specifically:

a. Dr. Saiyed informed the Investigator in an interview on or about June 18, 2014 that she did "not prescribe narcotics to any patients, unless they are suffering from acute withdrawal symptoms; and only enough pills to last until their next appointment with the prescribing physician." However, that statement was false as evidenced by the fact that, after the Investigator confronted Dr. Saiyed with her prescriber PMP for Patient C, Dr. Saiyed admitted regularly prescribing narcotic pain medications to the patient for over a year, as shown in the PMP. Specifically, the PMP report indicated that, from March 11, 2013 to March 27, 2014, Dr. Saiyed authorized 23 Percocet prescriptions for Patient C, for a total of #660 dosage units of that medication.

b. After conceding that she had prescribed narcotics to Patient C in her June 18, 2014 interview with the Investigator, Dr. Saiyed asserted that she ran PMP reports on Patient C several times to ensure that she was not getting medications from any other providers; however, the Director of the PMP stated

that a review of PMP records indicates Dr. Saiyed never accessed a PMP report for Patient C during the January 1, 2012 to September 22, 2014 period.

c. After reviewing her PMP for Patient C, Dr. Saiyed falsely informed the Investigator in her June 18, 2014 interview that "[Patient C] was the only patient for whom she had prescribed narcotic medication" and reiterated that she did "not prescribe pain medications to [her] patients." However, after again being confronted by the Investigator with her prescriber PMP, Dr. Saiyed admitted in a subsequent interview on or about November 7, 2014 that she had in fact prescribed narcotic pain medications to Patients D –M, O, P, and S on multiple occasions.

d. In an interview on or about November 7, 2014, Dr. Saiyed falsely informed the DHP Investigator that, before prescribing pain medications, in all cases she first reviewed a patient's PMP, including with respect to Patients A, C, G, J, Q, and S; however, information obtained from the Director of the PMP indicates that Dr. Saiyed failed to access the PMP for Patients A, C, G, J, Q, and S at any time during the treatment periods at issue (or accessed the PMP only after she had been contacted by the Investigator regarding said patient or had discharged said patient).

e. Although Dr. Saiyed informed the Investigator that, for her Suboxone/Subutex therapy patients she accessed the PMP at their first visit and on a monthly basis thereafter, Dr. Saiyed failed to access (or document accessing) the PMP for Patient R, a Suboxone/Subutex patient, at her first visit on or about February 1, 2012, nor did Dr. Saiyed access (or document accessing) her PMP on a monthly basis thereafter.

7. Dr. Saiyed violated Sections 54.1-2915.A(3) and (18) of the Code and 18 VAC 85-20-26.C of the Board's Regulations with respect to her care of psychiatric Patient C, a 47-year-old female whom she treated from approximately January 2013 to November 2014, as set forth below:

a. Dr. Saiyed prescribed Percocet, a C-II narcotic, to Patient C on a monthly basis without having or documenting an adequate medical indication for doing so. Specifically, when Dr. Saiyed started prescribing Patient C Percocet on or about March 11, 2013 and thereafter throughout the treatment period, she failed to document any condition warranting this medication and failed to document authorizing these prescriptions. In addition, prior to initiating narcotic therapy for Patient C, Dr. Saiyed failed to obtain or document a history of a chronic pain condition nor did she obtain (or document attempting to obtain) prior medical records relating to such a condition.

b. Despite the fact that Dr. Saiyed regularly prescribed Patient C Percocet throughout the treatment period, she failed to perform or document any physical examinations of Patient C nor did she order or obtain diagnostic testing to provide objective information regarding, or to establish the etiology of, Patient C's pain. Moreover, Dr. Saiyed failed to adequately document pain complaints and symptoms reported by Patient C throughout the treatment period.

c. Though Dr. Saiyed noted Patient C had suffered a stroke five years before her first visit, Dr. Saiyed failed to obtain or document attempting to obtain any prior or current treatment records relating to said stroke or her alleged multiple sclerosis diagnosis.

d. Dr. Saiyed also informed the Investigator that she prescribed Percocet to Patient C "only until she could find a pain management physician," and she was unable to find such a physician; however, there is no such documentation of this information in Dr. Saiyed's medical record. Moreover, contrary

to Dr. Saiyed's assertions to the Investigator (as discussed above), she failed to access the PMP for Patient C from January 2013 to September 22, 2014 in order to determine whether any other providers were prescribing pain medications to Patient C at the same time she was doing so (or had done so prior thereto).

e. Although Dr. Saiyed began prescribing Ritalin (C-II) to Patient C at her first office visit on or about January 14, 2013 (and continued to do so thereafter), Dr. Saiyed failed to document diagnosis of a condition, such as ADD or ADHD, warranting that prescription; Dr. Saiyed failed to perform or document an adequate workup to establish an ADD or ADHD diagnosis; and Dr. Saiyed failed to elicit a prior medical history or symptoms from the patient, or to obtain (or document attempting to obtain) prior medical records, with respect to the prescription of amphetamines or any prior diagnosis of ADD or ADHD.

f. Although Dr. Saiyed regularly prescribed Patient C Percocet and Ritalin for over a year, she failed to appropriately monitor and manage the patient's usage of such medication. Specifically, Dr. Saiyed failed to obtain a substance abuse history from Patient C prior to prescribing her narcotics; failed to enter into a controlled substance agreement with Patient C until eleven months after she had commenced prescribing her controlled substances (including narcotics); failed to utilize monitoring tools, such as pill counts or the PMP, to ensure compliance with Dr. Saiyed's treatment plan; and failed to take any appropriate responsive action (including substance abuse treatment or evaluation for same) when UDS results were inconsistent with Dr. Saiyed's medication regimen, as set forth below:

i. An in-house UDS performed on or about January 28, 2014 was negative for oxycodone, even though Dr. Saiyed had been prescribing Patient C Percocet on a monthly basis for quite some time. Moreover, that UDS was positive for the illicit substance methamphetamine.

ii. An in-house UDS performed on or about May 12, 2014 was positive for the illicit substance methamphetamine.

8. Dr. Saiyed violated Sections 54.1-2915.A(3), and (18), of the Code and 18 VAC 85-20-26.C of the Board's Regulations with respect to her care and treatment of psychiatric Patient D, a 45-year-old female, from approximately September 2012 to October 2014. Specifically:

a. At Patient D's initial visit on or about September 18, 2012, Dr. Saiyed diagnosed the patient with ADD and prescribed her Adderall (which Dr. Saiyed continued throughout the treatment period); however, Dr. Saiyed failed to perform an adequate work-up to establish that condition, including obtaining (or attempting to obtain) historical or collateral information with respect thereto. Moreover, Dr. Saiyed failed to obtain (or document attempting to obtain) prior treatment records for Patient D, which might have indicated a prior ADD workup by another physician, nor did Dr. Saiyed access the PMP to determine whether Patient D had previously been prescribed amphetamines.

b. Dr. Saiyed reported to the Investigator that, on or about January 22, 2013, February 15, 2013, and May 3, 2013, she prescribed Patient D Percocet for back pain and pain following shoulder surgery, at a time when the patient purportedly was in crisis and awaiting an appointment with her regular prescribing physician. However, none of this information is documented in Dr. Saiyed's record for Patient D, and, in fact, Dr. Saiyed's office note from January 22, 2013 mentions that the patient had recently undergone knee (not shoulder) surgery. There is no other notation in Dr. Saiyed's progress

notes explaining why she prescribed Percocet to Patient D on these occasions or what condition she was allegedly treating, nor did Dr. Saiyed perform or document any physical examinations of Patient D indicating a painful condition. Moreover, Dr. Saiyed failed to consult or confer with Patient D's surgeon or other regularly prescribing physician (or to access the PMP) to ensure that she was not duplicating their narcotic prescribing or to otherwise coordinate her narcotics prescribing with their treatment plan.

c. Although Dr. Saiyed documented (at her initial September 18, 2012 visit) that Patient D had been hospitalized twice for drug overdoses, with the most recent suicide attempt occurring two years previously, and that she had a remote history of cocaine abuse, Dr. Saiyed failed to closely monitor and appropriately manage the patient's usage of the controlled substances that she prescribed the patient, including Xanax, Adderall, Percocet (as described above), and other psychotropic medications. Specifically, during the September 18, 2012 to October 27, 2014 treatment period at issue, Dr. Saiyed failed to execute a controlled substance agreement with the patient until July 8, 2014; failed to perform any pill counts; failed to timely respond to inconsistent UDS testing until the third such test reporting aberrant results (on or about October 20, 2014); and failed to note or respond to PMP information indicating Patient D was doctor-shopping. Moreover, Dr. Saiyed failed to adequately address the following noncompliant behaviors:

d. Patient D consistently returned negative results for alprazolam and amphetamines on UDS testing performed on or about July 8, 2014, September 19, 2014, and October 20, 2014, despite the fact that Dr. Saiyed regularly prescribed those medications to Patient D.

e. Information from the PMP indicates that, during the treatment period at issue, Dr. Saiyed accessed PMP reports for Patient D on or about June 26, 2013 and June 7, 2014. However, Dr. Saiyed failed to take any appropriate action in response to information in these PMP's showing Patient D was receiving and filling prescriptions for controlled substances from other practitioners, including the same medications Dr. Saiyed was prescribing the patient (i.e., Xanax and Percocet).

9. Dr. Saiyed prescribed or authorized refills or renewals of amphetamine and benzodiazepine medications for Patient D prior to the time that she should have run out of such medication if she was taking it as prescribed, Dr. Saiyed violated Section 54.1-2915.A(3) and (18) of the Code and 18 VAC 85-20-26.C of the Board's Regulations with respect to her care and treatment of psychiatric Patients G, J, N, Q, S, T, and U. Specifically:

a. With respect to Patient G, a 32-year-old female whom Dr. Saiyed treated from approximately July 1, 2013 to October 19, 2014:

i. Starting at Patient G's initial visit on or about July 1, 2013 and at each of the patient's next three office visits (on or about July 29, 2013, August 26, 2013, and September 23, 2013), Dr. Saiyed prescribed Patient G a 30-day supply of Percocet without documenting or having a medical indication for doing so; without performing or documenting physical examinations; without diagnosing or documenting the diagnosis of a pain condition; without documenting reported symptoms regarding the patient's pain or a history with respect thereto; and without obtaining prior treatment records relating to the patient's pain.

ii. Dr. Saiyed failed to appropriately monitor and manage Patient G's usage of the controlled substances she regularly prescribed the patient (including Xanax). nor did Dr. Saiyed

take timely responsive action (including substance abuse evaluation and treatment or referral for same) when Patient G exhibited signs of misusing or abusing her prescribed medications or other noncompliance with Dr. Saiyed's medication regimen, as evidenced by the following:

- Dr. Saiyed's failure to enter into a controlled substance agreement with Patient G until July 3, 2014, over a year and a half after Dr. Saiyed had commenced regularly prescribing the patient Xanax.
- All but one of the seven UDS' Dr. Saiyed performed on Patient G were inconsistent with her medication regimen, as set forth in the table below:

| Date Urine Collected | Inconsistent UDS Results |
|---|---|
| 12/16/13 | Positive for marijuana. |
| 1/13/14 | Positive for marijuana and also for morphine, a medication Dr. Saiyed was not prescribing Patient G. |
| 2/12/14 | Positive for hydrocodone, a medication Dr. Saiyed was not prescribing Patient G, and negative for benzodiazepines, although Dr. Saiyed regularly prescribed Patient G Xanax. |
| 4/10/14 | Positive for oxycodone and tramadol, medications Dr. Saiyed was not prescribing Patient G, and also positive for marijuana and cocaine. |
| 8/4/14 | Negative for benzodiazepines, even though Dr. Saiyed regularly prescribing Xanax to Patient G. |
| 9/2/14 | Positive for marijuana. |

Despite these inconsistent results, Dr. Saiyed failed to address (or document addressing) any of the foregoing with Patient G.

- On October 21, 2013 and November 18, 2013, Dr. Saiyed noted that Patient G had demonstrated irregular compliance with her medications. Yet, Dr. Saiyed failed to discuss (or document discussing) this issue with the patient, nor did she take any responsive action

when Patient G informed her that she had lost all of her medications on or about February 27, 2104.

- Dr. Saiyed failed to access the PMP for Patient G until on or about November 6, 2014, after Dr. Saiyed allegedly had discharged her from her practice. Had Dr. Saiyed regularly accessed the PMP during the treatment period, she would have learned the Patient G was regularly receiving and filling prescriptions for controlled substances, including Xanax, from multiple different providers while under Dr. Saiyed's care.

iii. In an interview with the Investigator on or about November 7, 2014, Dr. Saiyed stated that she had discharged Patient G due to her failure to comply with office policy regarding medications; however, no such notation of termination or a discharge/dismissal letter are present in Patient G's file.

b. With respect to Patient J, a 44-year-old female whom Dr. Saiyed treated from approximately December 2012 to October 2014:

i. Starting at Patient J's second office visit on or about January 12, 2013 and continuing on a monthly basis through April 5, 2013, Dr. Saiyed prescribed Patient J Percocet (totaling #120 dosage units over the course of four prescriptions), and, on or about October 21, 2014, Dr. Saiyed prescribed Patient J #45 APAP/hydrocodone. However, Dr. Saiyed failed to establish or document a condition for which these medications were indicated or prescribed; failed to perform or document any physical examinations; failed to document reported symptoms regarding the patient's pain or a history with respect thereto; failed to obtain prior treatment records relating to the patient's pain; and failed to document these prescriptions in her progress

notes. Moreover, Dr. Saiyed failed to access the PMP to determine whether any other providers were already prescribing Patient J pain medication before she began doing so.

ii. Dr. Saiyed informed the Investigator that she initially prescribed Percocet to Patient J when she showed Dr. Saiyed a bottle with a month's supply of oxycodone 30mg written by another provider and was crying, allegedly because Dr. Saiyed did not want her to suffer withdrawal symptoms. However, none of this information is documented in Patent J's record nor would it constitute an adequate rationale for Dr. Saiyed's initiation and continuation of Percocet prescriptions to the patient.

iii. Although Dr. Saiyed provided Patient J with five prescriptions for narcotics, she failed to consult or coordinate such prescribing with the multitude of other physicians who were concurrently prescribing the patient such pain medications (a fact that Dr. Saiyed would have known had she timely accessed the patient's PMP).

c. Dr. Saiyed treated Patient N, a 29-year-old female diagnosed with anxiety, depression, and bipolar disorder, from approximately February 2013 to July 2014. Although Dr. Saiyed documented at Patient N's first visit that she was being prescribed methadone to treat her Percocet abuse and that the patient previously had made two suicide attempts by drug overdose, Dr. Saiyed failed to adequately monitor and manage Patient N's usage of the benzodiazepines (first clonazepam and then Xanax) that she regularly prescribed her. Specifically, Dr. Saiyed failed to execute a controlled substance agreement with Patient N until almost 1 ½ years after she began prescribing her benzodiazepines; failed to perform or document any pill counts; performed only one UDS after approximately 1 ½ years of treatment (which was inconsistent with her medication regimen, showing a negative result for Xanax); and failed

to access the PMP during the treatment period (had Dr. Saiyed done so, she would have observed that many other physicians were prescribing controlled substances to Patient N, including two practitioners who prescribed the patient benzodiazepines).

d. With respect to Patient Q, a 15-year-old male whom Dr. Saiyed treated from approximately November 9, 2012 to April 16, 2014:

i. At Patient Q's first visit on or about November 9, 2012, Dr. Saiyed noted that the patient had previously been diagnosed with ADHD and prescribed Vyvanse (C-II). Without obtaining (or documenting attempts to obtain) prior medical records establishing that diagnosis or medication regimen (including the PMP), and without performing her own work-up or documenting any symptoms consistent with ADHD, Dr. Saiyed diagnosed Patient Q with that condition and prescribed him Vyvanse. Without documenting any reason or medical rationale therefor, at Patient Q's next visit on or about December 11, 2012, Dr. Saiyed discontinued prescribing Vyvanse and did not resume prescribing Patient Q any medication for ADHD until on or about September 10, 2013, at which time Dr. Saiyed prescribed the patient Adderall (again without documenting any reason for starting that medication or continuing it thereafter).

ii. At Patient Q's second office visit on or about December 11, 2012, Dr. Saiyed prescribed him #20 clonazepam (C-IV), a medication that is not recommended for and has not been approved for use in children under 18 (except to treat seizures, a condition from which Patient Q did not suffer). Moreover, Dr. Saiyed failed to document her reasons for prescribing this medication to Patient Q on this one occasion during the treatment period.

iii. Based on the PMP and a copy of Dr. Saiyed's original script, she prescribed Patient Q Lortab on or about February 14, 2013; however, Dr. Saiyed failed to document this prescription or the reason therefor in her progress notes (or to include a copy of this script in the patient record).

e. With respect to Patient S, a 36-year-old female whom Dr. Saiyed treated from approximately June 2013 to May 2014:

i. At Patient S' first visit on or about June 28, 2013, Dr. Saiyed diagnosed her with ADHD and began prescribing her Adderall therefor without performing an adequate work-up to diagnose that condition, including accessing (or documenting attempts to access) historical or collateral information with respect thereto or prior treatment records or the patient's PMP.

ii. Dr. Saiyed failed to appropriately monitor and manage Patient S' usage of the Adderall she regularly prescribed her in that Dr. Saiyed failed to have the patient execute a controlled substance contract, failed to access the patient's PMP (until after Patient S was no longer her patient), and failed to perform any pill counts or UDS testing during the treatment period.

iii. Dr. Saiyed failed to take timely or adequate responsive action (including substance abuse evaluation and treatment or referral for same) when Patient S exhibited signs of misusing or abusing her Adderall or other noncompliance with her medication regimen, as evidenced by the fact that (among other things) Dr. Saiyed repeatedly filled or authorized refills or renewals of Adderall prescriptions for Patient S prior to the time that she should have run out of such medication if she was taking it as prescribed, i.e., on or about July 17 and 30, 2013; August 16, 2013; October 4, 2013; January 17 and 30, 2014; February 21, 2014; and March 18, 2014.

iv. On or about April 17, 2014 and May 1, 2014, Dr. Saiyed prescribed Percocet to Patient S; however, Dr. Saiyed failed to establish or document a condition for which this medication was indicated or prescribed; failed to perform or document any physical examinations; failed to document reported symptoms regarding the patient's pain or a history with respect thereto; failed to obtain prior treatment records relating to the patient's pain; and failed to access the PMP to determine whether any other providers were already prescribing Patient S pain medication.

f. Dr. Saiyed failed to address or take any appropriate responsive action (or document dosing so) when Patient T, a 13-year-old male whom she treated for ADHD and continuously prescribed Adderall from approximately February 2012 to October 2014, produced two UDS results (on or about February 10, 2014 and July 23, 2014) that were negative for Adderall.

g. Dr. Saiyed failed to address or take appropriate responsive action (or document dosing so) when Patient U, a 51-year-old male whom she treated for anxiety, bipolar disorder, and depression and to whom she continuously prescribed Xanax (and other controlled substances) from approximately August 2012 to December 2014, had positive UDS results for cocaine and marijuana on March 19, 2014 and subsequently had another positive UDS for marijuana on or about June 16, 2104. Although Dr. Saiyed noted a counseling referral after the latter result, there is no documentation that she discussed these results with Patient U or performed or referred him for substance abuse evaluation and/or treatment; instead. Dr. Saiyed continued to regularly prescribe Patient U Xanax, an abuseable controlled substance.

10. Dr. Saiyed violated Section 54.1-2915.A(3) and (18) of the Code and 18 VAC 85-20-26.C of the Board`s Regulations with respect to her care and treatment of Patient R, a 27-year-old female, from approximately February 2012 to October 2014, in that:

a. At Patient R's first visit (on or about February 1, 2012), Dr. Saiyed diagnosed her with opiate dependency and began prescribing her Subutex for that condition. Although Patient R reported she had been taking Suboxone or Subutex (C-III) since 2007, Dr. Saiyed failed to obtain a comprehensive medical history regarding her past opiate abuse or Suboxone/Subutex therapy nor did she obtain or attempt to obtain (or document attempting to obtain) prior treatment records with respect thereto.

b. Notwithstanding her awareness of Patient R's substance use/abuse history and prescription of Suboxone/Subutex therapy therefor, Dr. Saiyed diagnosed Patient R with ADD and began prescribing her Adderall at her first office visit (and continued to do so regularly thereafter), even though Adderall is a schedule II controlled substance with high abuse potential. Moreover, Dr. Saiyed established the patient's ADD diagnosis at her initial visit without performing or documenting an adequate work-up with respect thereto.

c. Although Dr. Saiyed documented that Patient R was taking 120mg of Adderall per day at the time of her initial visit, Dr. Saiyed failed to access Patient R's PMP report to confirm this dosage or her reported Suboxone/Subutex history.

d. From February 2012 to October 2014, Dr. Saiyed regularly prescribed Patient R 120mg per day of Adderall, an amount greatly exceeding the maximum recommended safe dose of 40mg per day for that medication.

e. Despite Dr. Saiyed's awareness of Patient R's prior substance use/abuse history, Dr. Saiyed failed to appropriately monitor and manage Patient R's use of the Adderall and Subutex that she prescribed her. Specifically, Dr. Saiyed took no responsive action when she became aware of the

following information indicating medication abuse or misuse or other noncompliance by Patient R with her treatment plan:

f. Dr. Saiyed constantly filled or authorized refills or renewals of Adderall and/or Subutex prescriptions for Patient R prior to the time that she should have run out of such medications if she was taking them as prescribed. Based on Patient R's report that she had lost her Adderall and Subutex medications on or about July 2, 2013, Dr. Saiyed provided her with early renewals of those prescriptions, even though such action contravened her controlled substance agreement with the patient.

g. Results from two of the UDS that Patient R submitted to on or about February 8, 2013 and January 9, 2014 were inconsistent with Dr. Saiyed's medication regimen in that both of these tests were negative for Adderall, a medication Dr. Saiyed had been prescribing in extremely large doses to Patient R for some time.

11. Dr. Saiyed provided the Board with documentation that she had completed 91.75 hours of in-person continuing medical education, including a 53.75 hour course "Comprehensive Review of Psychiatry" from July 29 to August 2, 2015; a 17 hour course from April 21- 22, 2016, in the subject area of medical record keeping; and a 21 hour course from April 9-10, 2016, in the subject area of prescribing. Dr. Saiyed also provided information regarding the electronic medical record now utilized in her practice, including recent examples of her electronic medical record documentation.

## CONSENT

I. Shama Saiyed, M.D., by affixing my signature hereto, acknowledge that:

1. I have been advised specifically to seek the advice of counsel prior to signing this document and am represented by Michael Goodman, Esq., and Eileen Talamante, Esq.;

2. I am fully aware that without my consent, no legal action can be taken against me, except pursuant to the Virginia Administrative Process Act, § 2.2-4000.A et seq. of the Code of Virginia;

3. I have the following rights, among others:

a. the right to a formal hearing before the Board;

b. the right to appear in person or by counsel, or other qualified representative before the agency; and

c. the right to cross-examine witnesses against me;

4. I waive all rights to a formal hearing;

5. I neither admit nor deny the truth of the above Findings of Fact and Conclusions of Law and agree not to contest the Findings of Fact, Conclusions of Law or any sanction imposed hereunder in any future judicial or administrative proceedings where the Board is a party; and

6. I consent to the following Order affecting my license to practice medicine in the Commonwealth of Virginia.

## ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law and in lieu of a formal hearing, Dr. Saiyed's license to practice medicine shall be INDEFINITELY SUSPENDED for a period of not less than nine (9) months commencing as of July 31, 2016 ("Effective Date").

Should Dr. Saiyed seek reinstatement of her license, she shall be noticed to appear before the Board, in accordance with the Administrative Process Act. As petitioner, Dr. Saiyed will have the burden of proving her competency and fitness to practice medicine and surgery in the Commonwealth of Virginia in a safe manner.

On the Effective Date of this Consent Order, the license of Saiyed Shama, M.D., will be recorded as SUSPENDED and no longer current.

Pursuant to Section 54.1-2400.2 of the Code, the signed original of this Consent 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.

FOR THE BOARD:

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

6/23/16
ENTERED

SEEN AND AGREED TO:

Shama Saiyed
Shama Saiyed, M.D.

STATE OF Virginia
COUNTY/~~CITY~~ OF Henrico, TO WIT:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the state of Virginia, at large, this 22nd day of June, 2016, by Shama Saiyed, M.D.

Erika Edrys Almstead
Notary Public

ERIKA EDRYS ALMSTEAD
NOTARY PUBLIC
REG. #7668408
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES DEC. 31, 2020

Registration Number: 7668408

My commission expires: 12/31/2020