VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: CHARLES E. PARKER, D.O.
License No.: 0102-026059

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 Charles E. Parker, D.O., on September 10, 2014, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Barbara Allison-Bryan, M.D., Chair; Kevin O'Connor, M.D.; and Stuart Mackler, M.D. Dr. Parker appeared personally and was represented by John Franklin, Esquire, and David Littel, Esquire. Julia Bennett, 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. Parker may have violated certain laws and regulations governing the practice of osteopathic medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated July 16, 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. Charles E. Parker, D.O., was issued license number 0102-026059 by the Board to practice medicine and surgery in the Commonwealth of Virginia on June 2, 1975. Said license is currently active and will expire on February 29, 2016, unless renewed or restricted.

2. Dr. Parker violated Sections 54.1-2915.A(3) and (18) of the Code, and 18 VAC 85-20-26.C of the Board's General Regulations, in his (and/or his nurse practitioner's) care and treatment of

Patient A, a 25-year-old male who was treated in Dr. Parker's office from approximately June 3, 2011 to September 13, 2011, in that:

a. Dr. Parker initially saw Patient A on June 4, 2011 after he had been referred to Dr. Parker's practice for counseling and medication management upon discharge from the emergency room on June 1, 2011 pursuant to the Rapid Response arrangement Dr. Parker had in place with this hospital to provide quick follow-up care to psychiatric patients. Although Dr. Parker was (or should have been) aware of this referral of Patient A to his practice from the emergency room, Dr. Parker failed to obtain a copy of these emergency room records (nor are any such records present in his medical chart for Patient A).

b. Having failed to obtain or review these critical ER records, Dr. Parker was unaware (and/or failed to document) that Patient A had gone to the emergency room on June 1, 2011 due to auditory and visual hallucinations that he experienced over the course of several days, that he reported having "lost his thoughts, no longer having thoughts anymore," and his parents' reports of manic behavior and that the patient had previously been diagnosed with schizotype personality disorder. Instead, Dr. Parker documented that Patient A had gone to the ER because he was not getting along with his mother and his mother asked him to go to the ER.

c. In assessing and diagnosing Patient A with ADD, dysthymic disorder, and sleep disorder (persistent) at his initial office visit, Dr. Parker ignored and failed to address (or failed to document any consideration of) a neuropsychological assessment performed on Patient A on January 18 and 24, 2011 (and located in his record for Patient A) that reached a

provisional diagnosis of schizotypal personality disorder and rule-out diagnosis of prodromal schizophrenia.

d. Although Dr. Parker was aware that Patient A had recently been diagnosed with ADD and treated with Adderall by another physician, he failed to access the Prescription Monitoring Program ("PMP") or to obtain (or attempt to obtain) the treatment records from this prior practitioner to determine whether said physician was still prescribing Adderall to Patient A and/or procure other important information concerning the patient's psychiatric history. Had Dr. Parker obtained these prior treatment records, he would have learned of the other physician's concerns about Patient A's use of Adderall.

e. At his initial visit, Dr. Parker prescribed Patient A Adderall XR 30 mg to be taken bid, a dose that was excessive in light of the fact that the recommended starting dose of Adderall XR is 10 mg daily, to be increased weekly by 5-10 mg, with 30 mg being the maximum recommended safe daily dose for Adderall XR. At Patient A's next visit on June 27, 2011, Dr. Parker increased his daily Adderall dosage to 80 mg (60 mg Adderall XR and 20 mg Adderall IR), an amount well in excess of the safe recommended daily dosage. Such extreme dosages were especially contraindicated in light of Patient A's self-reported marijuana abuse and other indications of medication abuse/misuse described below.

f. Dr. Parker prescribed Adderall XR to Patient A at his initial visit on June 4, 2011 and his next visit on June 27, 2011, notwithstanding numerous indications that Patient A was abusing, misusing, or had become addicted to Adderall or that such medication was otherwise contraindicated, to include the following:

i. A licensed clinical social worker in Dr. Parker's practice who saw Patient A and his mother on June 3, 2011 reported to Dr. Parker immediately after that visit (and prior to Patient A's first visit with Dr. Parker on June 4, 2011) that Patient A's mother informed her the patient was abusing and addicted to Adderall.

ii. A neuropsychological assessment performed on January 18 and 24, 2011 (and located in Dr. Parker's patient record) made a provisional diagnosis of schizotypal personality disorder and rule-out diagnosis of prodromal schizophrenia for Patient A and recommended that Patient A's Adderall be decreased or that medication for sleep and thinking, such as Seroquel, be added.

iii. On June 17, 2011, Patient A's mother provided Dr. Parker with a typed outline/timeline describing Patient A's use and abuse of Adderall (which is located in Dr. Parker's patient file), including the fact that, within two days of filling the Adderall XR prescription Dr. Parker had provided him on June 4, 2011, Patient A had consumed 9 pills, an amount well in excess of Dr. Parker's bid dosing instruction.

iv. A handwritten note (undated) from the licensed clinical social worker in Dr. Parker's office who was seeing Patient A, which stated "I think [Patient A] is having a problem taking the Adderall (taking too much of it & becoming addicted). Is there any way you could switch him to something else?"

v. In Dr. Parker's March 15, 2013 letter to the Board, he acknowledged that "sometime prior to my June 27, 2011 visit with [Patient A], I was advised by [the LCSW in his office who was treating Patient A] that [Patient A's] mother had reported concerns about his taking Adderall." However, based on Patient A's "adamant" denial

of any misuse or abuse of Adderall at that visit, Dr. Parker provided Patient A with another Adderall prescription, increasing the dosage and quantity thereof.

vi. Despite the foregoing signs of medication abuse or misuse, Dr. Parker failed to employ adequate tools, such as a controlled substance contract, urine drug screens, random pill counts, or the PMP, to monitor and manage Patient A's usage of Adderall, a Schedule II controlled substance with high potential for abuse and addiction.

g. Although Dr. Parker stopped prescribing Patient A Adderall after he became aware (on or about July 19, 2011) of the patient's involuntary hospitalization from July 9-15, 2011 for Adderall and marijuana abuse and dependence (among other things), Dr. Parker took no appropriate follow-up action when, at Patient A's September 13, 2011 office visit with his nurse practitioner (whose note he signed), Dr. Parker became aware that Patient A was back on Adderall, reporting that he had obtained prescriptions from his prior treating physician. Specifically, neither Dr. Parker nor his nurse practitioner attempted to contact or confer with said physician to inform him of Patient A's Adderall abuse or recent psychiatric hospitalization for same (nor is there any documentation of such an attempt being made).

h. Dr. Parker failed to maintain an accurate, legible, and complete medical record for Patient A in that his notes were minimal, largely unreadable, and contained scant information. For example, Dr. Parker's documentation of Patient A's second office visit on June 27, 2011 consisted of only a few cryptic entries: "Add 30 XR BID, VEN 75 A, Clonid 0.1 H, Kelsey 7, TAH 8/10, Add 30 XR 2 AM/6 PM 126 mg = tox./=80". This note failed to document significant information, including Patient A's response to the medications that

Dr. Parker had prescribed him at his initial visit three weeks earlier (Adderall, Clonidine, and venlafaxine); the status of Patient A's depression or whether he was having recurring suicidal ideation (which, at his previous visit, Dr. Parker noted he had experienced in the past); whether Patient A's focus, concentration, and mood were improved, etc.

3. Dr. Parker violated Sections 54.1-2915.A(3) and (18) of the Code, and 18 VAC 85-20-26.C of the Board's General Regulations, in his (or his physician assistant's) care and treatment of Patient B, a 45-year-old male who was treated in Dr. Parker's office from approximately January 2010 to February 2011, in that:

a. Even though Patient B reported a history of bipolar disorder (depression) and disclosed that he had been hospitalized for manic episodes on at least three occasions in the past (most recently 2004), that he had been convicted of misdemeanor indecent exposure during a manic episode lasting from August to October 2004, and had taken Lamictal and Klonopin for his bipolar condition successfully without symptomology for the past six years, Dr. Parker nevertheless discontinued Patient B's bipolar diagnosis and changed his diagnoses to dysthemic disorder, ADD, and sleep disorder (persistent) at his first office visit on January 4, 2010. However, the discontinuation of Patient B's bipolar diagnosis after only one visit, especially in light of the reported history, was unwarranted and contrary to sound medical judgment.

b. In support of his diagnoses, Dr. Parker provided the DHP Investigator with a written statement that contained significant additional detail concerning Patient B's first office visit with him on January 4, 2010, to include the following: "[Patient B] not happy with current meds, wanted a second opinion, felt life going nowhere....exceeding stress and sleep

deprivation were the causes of the regressive [manic] experience....[Patient B] denied that the experience [2004 hospitalization] was related to bipolar disorder and felt that the doctor who treated him did not understand or listen to him but simply gave him a diagnosis of convenience without any diagnostic effort." Dr. Parker also informed the DHP Investigator that Patient B reported at his first visit that he did not like the way the Lamictal made him feel. However, there is no documentation of any of the foregoing information in Dr. Parker's office visit note for Patient B.

c. Dr. Parker failed to obtain (at any time during the treatment period) Patient B's prior psychiatric records or records from his currently treating primary care physician nor did Dr. Parker consult with them in order to confirm the account Patient B gave of his prior psychiatric history. Had Dr. Parker done so, he would have learned that there had been an additional psychiatric hospitalization for Patient B in 2005 for depression (which he had not previously reported to Dr. Parker) and that, as recently as February 2008, Patient B had presented to another psychiatrist and been treated with Lamictal for bipolar depression.

d. One factor that Dr. Parker reported affected his determination of an ADD diagnosis for Patient B at his first visit was the patient's statement to Dr. Parker that he had tried Adderall before and it "worked great" for him. However, Adderall had never previously been prescribed to Patient B, indicating that he had illegally obtained such Adderall from someone else. Dr. Parker failed to consider or document the implications of or any concerns regarding such unauthorized Adderall use by Patient B, nor did Dr. Parker fully explore (or document) how that medication made the patient feel "great."

e. At Patient B's next visit on January 28, 2010, Dr. Parker discontinued the patient's Lamictal prescription, noting his report that he was "[s]o much better you have no idea." Dr. Parker informed the DHP Investigator that "[t]his response confirmed your diagnosis of ADHD for [Patient B]," since "if a patient with bipolar is prescribed a stimulant medication, the patient will rapidly deteriorate." However, the latter proposition is erroneous in that any such decompensation or deterioration could be delayed, especially in a case such as this where the stimulant prescribed at the patient's first visit was added to the prescription for a mood stabilizer (Lamictal). Moreover, Patient B's report of feeling so much better at his second visit, e.g., going from crying at his first office visit to self-rating a "10" on affect (depression in serious full remission) less than four weeks later, should have, but did not, raise any clinical concerns on Dr. Parker's part that such rapid, significant mood improvement may have indicated a regressive manic episode was already under way (or Dr. Parker failed to document any such concerns/considerations).

f. On or about February 9, 2010, Patient B complained of chest pain, which he reported was resolved when he decreased his dosage of Adderall 10 mg to bid. Dr. Parker's physician assistant documented that the patient should see his primary care doctor if the chest pain continued or come back and decreased his Adderall dosage. Notwithstanding this documentation, and without performing or sending Patient B for a work-up or evaluation regarding his chest pain or consulting/conferring with his PCP regarding such pain, Dr. Parker increased Patient B's Adderall (a medication known to produce cardiac side effects) to its former dosage at his next visit with Dr. Parker only two days later. Further, Dr. Parker's

February 11, 2010 progress note failed to address or make any notation concerning Patient B's recent chest pain.

g. At Patient B's first office visit on January 4, 2010, Dr. Parker concluded that the patient's depression was secondary to unipolar depression and seasonal affective disorder, rather than bipolar depression. Dr. Parker added Celexa to Patient B's medication regimen at this first visit, notwithstanding the known risk that such antidepressants can precipitate mood cycling and mania in patients with bipolar depression, the much more likely differential diagnosis for Patient B in light of his history. In fact, Patient B, subsequently reported to another mental healthcare provider (on or about August 23, 2011) that he experienced severe mania while under Dr. Parker's care.

h. Dr. Parker failed to maintain an accurate, legible, and complete medical record for Patient B in that his notes were minimal, largely unreadable, and left out significant objective and subjective findings and other important information, as demonstrated by (among other things) the substantial additional detail Dr. Parker provided regarding his encounters with Patient B in written and oral statements he provided to the DHP Investigator.

4. Dr. Parker acknowledged that had he had more complete prior medical records and histories for both of these patients, he likely would have followed a different medical treatment course for each of them.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Dr. Parker is issued a REPRIMAND.

It is further ORDERED that Dr. Parker's license shall be subject to the following Terms and Conditions:

1. Within six (6) months from entry of this Order, Dr. Parker 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 medical recordkeeping. Such CME 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. Within six (6) months from entry of this Order, Dr. Parker shall submit evidence satisfactory to the Board verifying that he has completed 15 hours of Board-approved CME in the subject of proper prescribing. Such CME 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.

3. Upon receipt of evidence that Dr. Parker has complied with Terms 1 and 2 above, the Committee authorizes the Executive Director to close this matter or refer it to a special conference committee for review.

Dr. Parker shall maintain a course of conduct in his practice of osteopathic medicine 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. Parker's license. In the event that Dr. Parker 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. Parker may, not later than 5:00 p.m., on October 15, 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 October 15, 2014, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

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

Entered: 9/12/14