COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

John W. Hasty
Director of the Department

Warren W. Koontz, M.D.
Executive Director of the Board

6606 West Broad Street
4th Floor
Richmond, Virginia 23230-1717
(804) 662-9908
FAX (804) 662-9517

August 14, 1998

John F. Heath, M.D.
6451 Jefferson Place
McLean, VA 22101

CERTIFIED MAIL
Z 356 168 086

RE: License No.: 0101-014152

Dear Dr. Heath:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on Wednesday, September 16, 1998, at 1:30 p.m., at the Sheraton Inn, 2801 Plank Road, Fredericksburg, Virginia. The conference will be conducted pursuant to Sections 54.1-2919 and 9-6.14:11 of the Code of Virginia (1950), as amended ("Code").

An Informal Conference Committee ("Committee"), composed of three members of the Board, will inquire into allegations that you may have violated certain laws governing the practice of medicine in Virginia. Specifically, you may have violated Section 54.1-2915.A(4) and (3), as further defined in Section 54.1-2914.A(3), (9), (10), (13) and (14), and Section 54.1-3303.A of the Code, and Section 54.1-3408.A of the Drug Control Act, in that:

1. From about April 26, 1994, through October 4, 1996, you provided treatment to Patient A for recurrent major depression and post traumatic stress syndrome. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to adequately document a comprehensive history; symptoms of Patient A's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan.

b) You indiscriminately and excessively prescribed various controlled substances of abuse potential to Patient A, a person you knew, or should have known was receiving concurrent prescriptions from a least one other physician for controlled substances to include, Percocet (oxycodone and acetaminophen, Schedule II); Fiorinal (butalbital, Schedule VI); and Vicodin (hydrocodone bitartrate, Schedule III). Specifically, from about January 10, 1996 through October 4, 1996, you prescribed the following medications, to include approximately:

i) 1,500 dosage units of Valium 10mg (diazepam, Schedule IV);

ii) 1,110 dosage units of Xanax (lorazepam, Schedule IV); and

iii) 230 dosage units of Dalmane (flurzaepam hydrochloride, Schedule IV).

c) Regarding the controlled substances you prescribed: On more than one occasion, you failed to adequately document in the patient's medical record one or more of the following: the strength, dosage, quantity, number of refills authorized; and the reason for the prescription.

2. From about September 16, 1996, through October 11, 1996, you provided treatment to Patient B. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to adequately document a comprehensive history; symptoms of Patient B's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan.

b) You indiscriminately and excessively prescribed Xanax (alprazolam, Schedule IV), a controlled substance of abuse potential, to Patient B, a person you knew, or should have known was receiving concurrent prescriptions from a least one other physician for hydrocodone bitartrate and acetaminophen (Schedule III). Specifically, from about September 23, 1996, through October 11, 1996, you prescribed approximately 270 dosage units of Xanax to Patient B; however, you failed to document in the patient's medical record the reason for the prescription.

c) You failed to respond to Patient B's and her sister's repeated attempts to contact you.

3. From about July 1, 1996, through October 18, 1996, you provided treatment to Patient C for panic disorder. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to adequately document a comprehensive history; symptoms of Patient C's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan. Also, on more than one occasion, you failed to adequately document in the patient medical record one or more of the following: a prescription's strength, dosage, quantity, number of refills; and the reason for the prescription.

b) You indiscriminately prescribed various controlled substances of abuse potential to Patient C, a person you knew, or should have known, was drug dependent, and had expressed suicidal ideation. Specifically:

i) From about July 17, 1996, through August 22, 1996, you prescribed approximately 260 dosage units of lorazepam (Schedule IV); and 2 dosage units of temazepam (Schedule IV).

ii) On or about July 17, August 5, and August 7, 1996, you prescribed lorazepam for Patient C; ;however, you failed to document these prescriptions in the patient's medical record.

iii) On or about August 5, 1996, you prescribed temazepam for Patient C: however, you failed to document the prescription in the patient's medical record.

iv) On or about August 20, September 12, and October 1, 1996, by your own admission, you authorized prescriptions for lorazepam and temazepam without seeing the patient or assessing her condition.

4. From about March 1994 through October 15, 1996, you provided treatment to Patient D for her complaint of narcolepsy. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to document a comprehensive history; symptoms of Patient D's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b) You indiscriminately prescribed controlled substances of abuse and high abuse potential to Patient D, a person you knew, or should have known, was drug dependent, and who had exhibited suicidal ideation. Specifically:

i) From about July 11, 1995, through June 20, 1996, you prescribed approximately 2,160 dosage units of Dexedrine (dextroamphetamine, Schedule II).

ii) On or about July 5, 1994; September 22, 1994; October 11, 1994; November 10, 1994; March 28, 1995; April 25, 1995; January 30, 1996; and June 20, 1996, you prescribed various combinations of Dexedrine; Ritalin (methylphenidate, Schedule II); Desyrel (trazodone, Schedule VI); Bumex (bumetanide, Schedule VI); and Prozac (fluoxetine, Schedule VI) without documenting the strength, quantity and dosage units prescribed. In addition, you failed to document the reason for the prescriptions, and on more than one occasion, you renewed the prescriptions without examining the patient to assess her condition.

5. From about December 9, 1993, through July 16, 1996, you provided treatment to Patient E. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to adequately document a comprehensive history; symptoms of Patient E's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan;

b) You indiscriminately prescribed a controlled substance of abuse potential to Patient E. Specifically:

i) From about October 25, 1994, through July 16, 1996, you prescribed approximately 350 dosage units of diazepam (Schedule IV).

ii) On or about July 23, 1996, you renewed the patient's prescription for diazepam, with two refills, without assessing the patient's condition.

c) On more than one occasion, you failed to adequately document in the patient's medical record one or more of the following: a prescription's strength, dosage, quantity, number of refills; and the reason for the prescription.

6. From about January 26, 1996, through October 15, 1996, you provided treatment to Patient F for her complaint of Attention Deficient Hyperactivity Disorder ("ADHD"). A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to document a comprehensive history; symptoms of Patient F's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b) From about January 30, 1996, through October 15, 1996, you prescribed 830 dosage units of Ritalin (methylphenidate, Schedule II); however, you failed to document in the patient's medical record the reason for the prescriptions, as well as the strength, number of dosage units prescribed and number of authorized refills.

c) From April 26, 1996, through June 3, 1996, you prescribed 60 dosage units of Temazepam (Schedule IV); however, you failed to document these prescriptions in the patient's medical record.

d) On or about September 19, 1996, you prescribed 47 dosage units of Temazepam; however, you failed to document the strength or the reason for the prescription in the patient's medical record.

7. From about May 8, 1991, through October 8, 1996, you provided treatment to Patient G. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to document a comprehensive history; symptoms of Patient G's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b) You indiscriminately prescribed Valium (diazepam, Schedule IV), to Patient G, a person you knew or should have known was drug dependent. In addition, you failed to adequately document the reason for the prescriptions, the strength, dosage, quantity and number of refills.

c) You inappropriately documented prescriptions for Individual A in the medical record of Patient G.

8. On or about March 14, 1994, April 9, 1994, and February 8, 1996, you provided treatment to Patient H. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to document a comprehensive history; symptoms of Patient H's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b) On or about April 9, 1994, you indiscriminately prescribed Valium (diazepam, Schedule IV), a controlled substance of abuse potential, to the patient, a person you knew or should have known was drug dependent. You failed to document the reason for the prescription, or the number of refills authorized.

c) You prescribed Paxil (paroxetine, Schedule VI) without documenting the reason for the prescription, the quantity, dosage and number of authorized refills.

d) On or about February 1, 1996, Patient H filled a prescription for 90 dosage units of Valium 10mg.; however, you failed to document any assessment or treatment of the patient for that date, nor is the prescription documented in the medical record.

9. From about August 17, 1995, through October 22, 1996, you provided treatment to Patient I. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to document a comprehensive history; symptoms of Patient I's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b) On or about August 17, 1995, you prescribed Ritalin (Schedule II) without documenting the reason for the prescription or the number of refills authorized.

10. In July 1996, you indiscriminately prescribed Valium (diazepam, Schedule IV), to Patient J, a person you knew or should have known was drug dependent, and who you had not examined since approximately December 1993.

11. From about September 1992 through May 4, 1996, you provided treatment to Patient K. A review of pharmacy records and the medical records presented demonstrated the following:

a) You failed to document a comprehensive history; symptoms of Patient K's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b) On or about May 4, 1996, you prescribed 100 dosage units of Imipramine 50mg. (Schedule VI) with two refills; however, you failed to document the prescription in the patient's medical record.

c) You combined the medical record of Patient K with that of Patient L. On or about October 29, 1996, during an interview with an Investigator with the Virginia Department of Health Professions ("DHP") you discussed Patients K and L as if they were one person.

12. From about August 11, 1994, through July 23, 1996, you indiscriminately prescribed Valium (diazepam, Schedule IV), a controlled substance of abuse potential to Individual A without establishing a bona fide practitioner-patient relationship. In addition, you inappropriately documented prescriptions and refills for diazepam for Individual A in the medical record of Patient G, a relative of Individual A. Moreover, you failed to adequately document the reason for the prescriptions, the strength, dosage, quantity and number of refills.

13. You inappropriately prescribed medications for family members with who you did not have a bona fide practitioner-patient relationship, and for who you failed to maintain appropriate written patient records. Specifically:

a) On more than one occasion from about April 6, 1995, through October 13, 1996, you prescribed various antibiotics for Individual B, a minor.

b) On more than one occasion from about March 27, 1994, you prescribed Schedule VI controlled substances for Individual C, to include Proventil inhaler, Ventolin inhaler, and Synthroid.

c) On more than one occasion from about July 17, 1993, through September 15, 1996, you prescribed various controlled substances for Individual D, to include Retin-A, Seldane, Trimax, Ovcon-35, Claritin, and various antibiotics.

14. On or about October 15, 1996:

a) Law enforcement officers found four prescriptions in unsealed envelopes taped to the front door of your office in Manassas, Virginia. In your October 29, 1996, interview with a DHP Investigator, you admitted it was your usual practice to leave prescriptions taped to your office door for your patients to pick-up. You stated that, in the future, you would mail patients' prescriptions.

b) Law enforcement officers found your office front door unlocked with no one present in the office; the file cabinets containing patient records were unlocked and readily accessible, and blank prescription pads were in full view and readily accessible.

In order to protect the privacy of your patients, they have been referred to by letter only. Please see Attachment I for the identity of these individuals. The following actions may be taken by this Committee:

The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing;

2. The Committee may notify you in writing that you are fully exonerated of any charge that might affect your right to practice medicine in Virginia;

3. The Committee may reprimand or censure you, or;

4. The Committee may place you on probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of medicine in Virginia.

You have the right to information which will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents which will be distributed to the members of the Committee, and will be considered by the Committee when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. If you have additional documents for review which are not contained in this package, please bring at least six copies with you to the meeting. I also enclose relevant sections of the Administrative Process Act, which governs proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia.

A request to continue this proceeding must be made in writing and directed to me at the address listed on this letter. Such request must be received by 5:00 p.m. on August 28, 1998. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after August 28, 1998, will not be considered.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, as a motion for a continuance due to the unavailability of counsel will not be considered unless received by August 28, 1998. Further, it is your responsibility to provide the enclosed materials to your attorney.

Further, to facilitate this proceeding, the Committee requests that you provide to Patricia L. Larimer, Senior Legal Assistant, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717, five (5) copies of any documents you intend to submit for its consideration by August 28, 1998.

Please advise the Board of your intention to be present. Should you fail to appear at the informal conference the Board may proceed to a formal administrative hearing in order to impose sanctions. Should you have any questions regarding this notice, please contact Patricia L. Larimer, Senior Legal Assistant, at (804) 662-7444.

Sincerely,

Warren W. Koontz, M.D.
Executive Director
Virginia Board of Medicine

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cc: Clarke Russ, M.D., President, Virginia Board of Medicine
John W. Hasty, Director, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Patricia L. Larimer, Senior Legal Assistant
Sue S. Zich, Senior Investigator (97-00103) 68158
Judy Smith, Senior Administrative Assistant

Enclosures:

Virginia Code Sections:

54.1-2914
54.1-2915
54.1-2919
54.1-3303
54.1-3408
9-6.14:11

Informal Conference Package
Map
Attachment I

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOHN F. HEATH, M.D.
License No.: 0101-014152

ORDER

In accordance with Sections 54.1-2919 and 9-6.14:11 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with John F. Heath, M.D., on September 16, 1998, in Fredericksburg, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the informal conference committee ("Committee") were Paul M. Spector, D.O., Chairman; Brian R. Wright, D.P.M.; and Harry C. Beaver, M.D. Dr. Heath appeared personally and was not represented by legal counsel. The purpose of the informal conference was to inquire into allegations that Dr. Heath may have violated certain laws governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated August 14, 1998 ("Notice").

FINDINGS OF FACT

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

1. From about April 26, 1994, through October 4, 1996, Dr. Heath provided treatment to Patient A for recurrent major depression and post traumatic stress syndrome. A review of pharmacy records and the medical records presented demonstrated the following:

   a. Dr. Heath failed to adequately document a comprehensive history; symptoms of Patient A's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan.

   b. Dr. Heath indiscriminately and excessively prescribed various controlled substances of abuse potential to Patient A, a person he knew, or should have known, was receiving concurrent prescriptions from at least one other physician for controlled substances to

   c. include Percocet (oxycodone and acetaminophen, Schedule II); Fiorinal (butalbital, Schedule VI); and Vicodin (hydrocodone bitartrate, Schedule III). Specifically, from about January 10, 1996, through October 4, 1996, Dr. Heath prescribed the following medications, to include approximately:

1,500 dosage units of Valium, 10 mg (diazepam, Schedule IV);

i. 1,110 dosage units of Xanax (alprazolam, Schedule IV);

ii. 230 dosage units of Dalmane (flurazepam, Schedule IV); and

iii. an undetermined amount of lorazepam (Schedule IV).

c. On more than one occasion, Dr. Heath failed to adequately document in the patient's medical record the prescription strength, dosage, quantity, number of refills authorized and the reason for the prescription.

2. From about September 16, 1996, through October 11, 1996, Dr. Heath provided treatment to Patient B. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to adequately document a comprehensive history; symptoms of Patient B's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan.

b. Dr. Heath indiscriminately and excessively prescribed Xanax (alprazolam, Schedule IV), a controlled substance of abuse potential, to Patient B, a person he knew, or should have known, was receiving concurrent prescriptions from at least one other physician for hydrocodone bitartrate and acetaminophen (Schedule III). Specifically, from about September 23, 1996, through October 11, 1996, Dr. Heath prescribed approximately 270 dosage units of Xanax to Patient B; however, he failed to document in the patient's medical record the reason for the prescription.

3. From about July 1, 1996, through October 18, 1996, Dr. Heath provided treatment to Patient C for panic disorder. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to adequately document a comprehensive history; symptoms of Patient C's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan. Also, on more than one occasion, Dr. Heath failed to adequately document in the patient's medical record one or more of the following prescription strength, dosage, quantity, number of refills authorized, and the reason for the prescription.

b. Dr. Heath indiscriminately prescribed various controlled substances of abuse potential to Patient C, a person he knew, or should have known, was drug dependent and had expressed suicidal ideation. Specifically:

i. From about July 17, 1996, through August 22, 1996, Dr. Heath prescribed approximately 260 dosage units of lorazepam (Schedule IV); and 2 dosage units of temazepam (Schedule IV).

ii. On or about July 17, August 5, and August 7, 1996, Dr. Heath prescribed lorazepam for Patient C; however, he failed to document these prescriptions in the patient's medical record.

iii. On or about August 5, 1996, Dr. Heath prescribed temazepam for Patient C; however, he failed to document the prescription in the patient's medical record.

iv. On or about August 20, September 12, and October 1, 1996, Dr. Heath, by his admission, authorized prescriptions for lorazepam and temazepam without seeing the patient or assessing her condition.

4. From about March 1994 through October 15, 1996, Dr. Heath provided treatment to Patient D for her complaint of narcolepsy. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to document a comprehensive history; symptoms of Patient D's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b. Dr. Heath indiscriminately prescribed controlled substances of abuse and high abuse potential to Patient D, a person he knew, or should have known, was drug dependent, and who had exhibited suicidal ideation. Specifically:

i. From about July 11, 1995, through June 20, 1996, Dr. Heath prescribed approximately 2,160 dosage units of Dexedrine (dextroamphetamine, Schedule II).

ii. On or about July 5, 1994; September 22, 1994; October 11, 1994; November 10, 1994; March 28, 1995; April 25, 1995; January 30, 1996; and June 20, 1996, Dr. Heath prescribed

iii. various combinations of Dexedrine; Ritalin (methylphenidate, Schedule II); Desyrel (trazodone, Schedule VI); Bumex (bumetanide, Schedule VI); and Prozac (fluoxetine, Schedule VI) without documenting the strength, quantity and dosage units prescribed. In addition, Dr. Heath failed to document the reason for the prescriptions, and on more than one occasion he renewed the prescriptions without examining the patient to assess her condition.

5. From about December 9, 1993, through July 16, 1996, Dr. Heath provided treatment to Patient E. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to adequately document a comprehensive history; symptoms of Patient E's complaints and present illness; results of a clinical examination; working diagnosis based on examination and history; and treatment plan.

b. On more than one occasion, Dr. Heath failed to adequately document in the patient's

c. medical record one or more of the following: prescription strength, dosage, quantity, number of refills authorized, and the reason for the prescription.

6. From about January 26, 1996, through October 15, 1996, Dr. Heath provided treatment to Patient F for her complaint of Attention Deficit Hyperactivity Disorder (ADHD). A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to document a comprehensive history; symptoms of Patient F's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b. From about January 30, 1996, through October 15, 1996, Dr. Heath prescribed 830 dosage units of Ritalin (methylphenidate, Schedule II); however, he failed to document in the patient's medical record the reason for the prescription, or the strength and number of dosage units prescribed.

c. From about April 26, 1996, through June 3, 1996, Dr. Heath prescribed 60 dosage units of

d. temazepam (Schedule IV); however, he failed to document these prescriptions in the patient's medical record.

e. On or about September 19, 1996, Dr. Heath prescribed 47 dosage units of temazepam; however, he failed to document the strength or the reason for the prescription in the patient's medical record.

7. From about May 8, 1991, through October 8, 1996, Dr. Heath provided treatment to Patient G. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to document a comprehensive history; symptoms of Patient G's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b. Dr. Heath indiscriminately prescribed Valium (diazepam, Schedule IV) to Patient G, a person he knew, or should have known, was drug dependent. In addition, Dr. Heath failed to adequately document the reason for the prescriptions, the strength, dosage, quantity and number of refills authorized.

8. On or about March 14, 1994; April 9, 1994; and February 8, 1996, Dr. Heath provided treatment to Patient H. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to document a comprehensive history; symptoms of Patient H's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b. On or about April 9, 1994, Dr. Heath indiscriminately prescribed Valium (diazepam, Schedule IV), a controlled substance of abuse potential, to the patient, a person he knew, or should have known, was drug dependent. Dr. Heath failed to document the reason for the prescription or the number of refills authorized.

c. Dr. Heath prescribed Paxil (paroxetine, Schedule VI) without documenting the reason for the prescription, the quantity, dosage and number of refills authorized.

d. On or about February 1, 1996, Patient H filled a prescription for 90 dosage units of Valium, 10 mg;

e. however, Dr. Heath failed to document any assessment or treatment of the patient for that date, and failed to document the prescription in the patient's medical record.

9. From about August 17, 1995, through October 22, 1996, Dr. Heath provided treatment to Patient I. A review of pharmacy records and the medical record presented demonstrated the following:

a. Dr. Heath failed to document a comprehensive history; symptoms of Patient I's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b. On or about August 17, 1995, Dr. Heath prescribed Ritalin (Schedule II) without documenting the reason for the prescription.

10. From about September 1992 through May 4, 1996, Dr. Heath provided treatment to Patient K. A review of pharmacy records and the medical records presented demonstrated the following:

a. Dr. Heath failed to document a comprehensive history; symptoms of Patient K's complaints and present illness; results of a clinical examination; working diagnosis based on examination; and treatment plan.

b. Dr. Heath combined the medical record of Patient K with that of Patient L. On or about October 29, 1996, during an interview with a Department of Health Professions ("Department") investigator, Dr. Heath discussed Patients K and L as if they were one patient.

11. From about August 11, 1994, through July 23, 1996, Dr. Heath indiscriminately prescribed Valium (diazepam, Schedule IV), a controlled substance of abuse potential, to Individual A. In addition, Dr. Heath inappropriately documented prescriptions and refills for diazepam for Individual A in the medical record of Patient G, a relative of Individual A. Moreover, Dr. Heath failed to adequately document the reason for the prescriptions, the strength, dosage, quantity and number of refills authorized.

12. On or about October 15, 1996:

a. Law enforcement officers found four prescriptions in unsealed envelopes taped to the front door of Dr. Heath's office in Manassas, Virginia. In an October 29, 1996, interview with a Department

b. investigator, Dr. Heath admitted that it was his usual practice to leave prescriptions taped to his office door for his patients to pick up. He stated that in the future he would mail patients' prescriptions.

c. Law enforcement officers found Dr. Heath's office front door unlocked with no one present in the office; the file cabinets containing patient records were unlocked and readily accessible, and blank prescription pads were in full view and readily accessible.

13. The Committee dismisses allegations #10 and #13 of the Notice.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Committee concludes that Dr. Heath is in violation of Section 54.1-2915.A(3), as further defined in Section 54.1-2914.A(10) of the Code.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that the matter of John F. Heath, M.D., be, and hereby is, CONTINUED GENERALLY on the following terms and conditions:

1. Within one (1) year of entry of this Order, Dr. Heath shall successfully complete the mini-residency program sponsored by Forensic and Educational Consultants entitled "The Proper Prescribing of Controlled Dangerous Substances" or an equivalent course approved in advance of registration by the Executive Director of the Board.

2. Within six (6) months of entry of this Order, Dr. Heath shall successfully complete a course in medical record keeping which shall be approved in advance of registration by the Executive Director of the Board.

3. Pursuant to Section 54.1-2922 of the Code, a Medical Complaint Investigation Committee ("MCIC") shall be impaneled within approximately nine (9) months of entry of this Order, to conduct an inquiry into the medical practice of Dr. Heath, including the utilization of controlled substances and medical record keeping. The report of the MCIC shall be presented to the informal conference committee to make a final determination regarding any issues which may arise during the MCIC inquiry.

4. In approximately one (1) year, Dr. Heath shall be noticed to appear before an informal conference committee of the Board. Said committee shall provide the ongoing monitoring of Dr. Heath's Order, determine the frequency of

further appearance by Dr. Heath before it, and shall serve as the instrument of the Board responsible for reviewing and approving all information relative to the terms and conditions of this Order, except as noted above.

5. Dr. Heath shall cooperate with the Board and the Department in the investigation or inspectionof his practice to verify that he is in compliance with this Order.

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

7. Violation of this Order constitutes grounds for the revocation of the license of Dr. Heath. In the event Dr. Heath violates the terms of this Order, an administrative proceeding will be convened to determine whether the license of Dr. Heath should be revoked.

Pursuant to Section 9-6.14:14 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.

Dr. Heath may, not later than 5:00 p.m., on October 26, 1998, notify Warren W. Koontz, M.D., Executive Director, Board of Medicine, 6606 West Broad Street, Richmond, Virginia 23230, in writing that he desires a 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 26, 1998, unless a request for a hearing is received as described above.

FOR THE BOARD

/s/ Warren W. Koontz

Warren W. Koontz, M.D.
Executive Director
Virginia Board of Medicine

Entered: Sept 23, 1998

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COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

John W. Hasty
Director of the Department

William L. Harp, M.D.
Executive Director of the Board

6606 West Broad Stree
4th Floo
Richmond, Virginia 23230-171
(804) 662-990
FAX (804) 662-951

February 6, 2001

John F. Heath, M.D.
6451 Jefferson Place
McLean, Virginia 22101

RE: **License No.: 0101-014152**

Dear Dr. Heath:

The Board of Medicine ("Board") has received a copy of a letter dated January 17, 2001, from your attorney, Steven A. Merril, regarding the status of your compliance with the Board's Order entered September 23, 1998. The Board regrets the delay in bring this matter to conclusion. The Board has made diligent efforts to convene a Medical Complaint Investigation Committee ("MCIC"). However, we have been unsuccessful in our efforts. Therefore, in order to bring this matter to a conclusion, the Board has approved modification of Terms 3 and 4 of your Order as follows.

> ***Term 3. Within 90 days from the date of this letter, an investigator from the Department of Health Professions shall conduct a survey of schedule II through VI controlled substances prescribed by Dr. Heath since January 1, 1999. Further, the investigator shall obtain copies of ten (10) complete patient records for review by the Board.***
>
> ***Term 4. Upon submission of the documentation as required by Term 3, the material will be reviewed by the Executive Director of the Board, who is authorized to make a recommendation to the informal conference committee regarding whether Dr. Heath should be noticed to reappear before an informal conference committee or if the matter should be closed.***

Due to the Board's decision to incorporate the above modifications with the Order entered September 23, 1998, this document will be made a permanent part of your Board Order. Therefore, you should maintain a copy of this letter with the Order.

If you have any questions regarding this matter, please contact the Board office at (804) 662-7009.

Sincerely,

William L. Harp, M.D.
Executive Director

cc: Steven A. Merril, Esquire
Katherine Wax, Probation Review Analyst [68158]

Enclosure:
Board Order. 9/23/98

COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

John W. Hasty
Director of the Department

William L. Harp, M.D.
Executive Director of the Board

6606 West Broad Street
4th Floor
Richmond, Virginia 23230-1717
(804) 662-9908
FAX (804) 662-9517

November 9, 2001

John F. Heath, M.D.
6451 Jefferson Place
McLean, Virginia 22101

CERTIFIED MAIL
7106 4575 1294 3561 9485

RE: License No.: 0101-014152

Dear Dr. Heath:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Thursday, December 13, 2001, at 1:00 p.m., at the Holiday Inn Select, 2801 Plank Road, Fredericksburg, Virginia**. The conference will be conducted pursuant to Sections 54.1-2919, 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

An Informal Conference Committee ("Committee"), composed of three members of the Board, will review your compliance with the terms and conditions imposed upon your license to practice medicine in Virginia, as set forth in an Order of the Board entered September 23, 1998, and amended February 6, 2001, and inquire into allegations that you may have violated certain laws governing the practice of medicine in Virginia. Specifically, you may have violated Section 54.1-2915.A(3), as further defined in Section 54.1-2914.A(7), (8) and (12) [formerly Sections 54.1-2914.A(9) (10) and (14)], and Section 54.1-3303(A) of the Code. Specifically, in accordance with Terms 3 and 4 of the Order, as amended on February 6, 2001, a Department of Health Professions Inspector obtained a survey of Schedule II through Schedule VI controlled substances prescribed by you, as well as the records of ten (10) patients. A review of these documents demonstrate certain deficiencies in your practice, to include, but not limited to, the following:

1. Your progress notes are primarily composed of the patient's reporting in the session and a list of medications to be written. Your notes seldom contain a mental status examination, analytical assessment of the patient's progress, and rationale for medication changes. Further, the patient's diagnosis is inconsistently charted.

2. On or about October 5, 2000, you prescribed ten (10) dosages units Ultram 50mg, a Schedule VI controlled substance, for Individual A, with whom you had no bona fide physician/patient relationship.

3. Records from CVS Pharmacy #1404, Woodbridge, Virginia, indicate that on or about July 11, 1999, you telephoned in a prescription for six (6) dosage units hydrocodone/APAP, a Schedule III controlled substance, for Patient B; however, you failed to note said prescription in the patient's record. Further, between on or about July 16, 1999, and October 13, 2000, on at least four (4) different occasions, you prescribed for Patient B, who was hospitalized for an overdose in 1995, Vicodin ES (hydrocodone), a Schedule III controlled substance, either on an "emergency" basis, or "in case of migraine."

4. Between on or about August 3, 1999, and March 19, 2001, you self-prescribed and/or self-administered ten (10) dosage units Depo-testosterone (Schedule III controlled substance) 100mg VL 10ml, as well as the following Schedule VI controlled substances:

408 dosage units Albuterol Inhaler
900 dosage units Allegra 60mg
690 dosage units Accolate 20mg tab
30 dosage units Tetracycline 250mg cap
90 dosage units Sumycin 500mg cap
400 dosage units Calan SR 240mg tab
285 dosage units Vasotec 10mg tab
300 dosage units Vaseretic 10/25 tab
91 dosage units Flovent
405 dosage units Celebrex 200mg
210 dosage units Singulair 10mg

In order to protect the privacy of your patients, they have been referred to by letter only. Please see Attachment I for the identity of these individuals.

The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing;

2. In the event the Committee finds that you have violated the terms of the Board's Order entered September 23, 1998, as amended February 6, 2001, the Committee may reprimand or censure you;

3. The Committee may impose a monetary penalty pursuant to Section 54.1-2401 of the Code, or;

4. The Committee may modify the previous Board Order to include placing you on probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing your profession in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of medicine and other healing arts in Virginia.

You have the right to information, which will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents, which will be distributed to the members of the Committee and will be considered by the Committee when discussing the allegations with you and when deliberating upon your case. Since you have been noticed of an alleged violation of Section 54.1-2914.A(7) [formerly 54.1-2914.A(9)] of the Code, enclosed in these documents is Opinion 8.19 of the American Medical Association's Code of Medical Ethics. The Committee may consider this opinion when determining whether you have conducted your practice in a manner contrary to the standards of ethics of the practice of medicine. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. I also enclose relevant sections of the Administrative Process Act, which governs proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia.

Absent good cause shown to support a request for a continuance, the informal conference will be held on December 13, 2001. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made in writing to me at the address listed on this letter and must be received by 5:00 p.m. on **November 16, 2001**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **November 16, 2001**, will not be considered.

You may be represented by an attorney at the informal conference. Further, it is your responsibility to provide the enclosed materials to your attorney.

To facilitate this proceeding, you must submit eight (8) copies of any documents you intend for the Committee's consideration to Reneé Dixson, Case Manager, Board of Medicine, Department of Health Professions,

6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717, by **November 16, 2001**. Should you or Senior Adjudication Analyst Patricia L. Larimer, wish to submit any documents for the Committee's consideration after **November 16, 2001**, such documents shall be considered only upon a ruling by the Chair that good cause has been shown for late submission.

I enclose for your reference copies of the relevant statutes and the Board's September 23, 1998 Order, and the February 6, 2001 amendment. Please advise the Board of your intention to be present. Should you fail to appear at the informal conference the Board may proceed to a formal administrative hearing in order to impose sanctions. Should you have any questions regarding this notice, please contact Patricia L. Larimer, Senior Adjudication Analyst, at (804) 662-7444.

Sincerely,

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

WLH:fd1109N1.ifcnot.heath.01
PLL\Heath08NIF.doc

cc: Harry C. Beaver, M.D., President, Virginia Board of Medicine
John W. Hasty, Director, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Informal Conference Committee
Steven A. Merrill, Esquire
Patricia L. Larimer, Senior Adjudication Analyst
Marta Ishmael, Inspector (Case # 80308)
Katherine Wax, Probation Analyst (Case # 80308)
Reneé Dixson, Discipline Case Manager, Board of Medicine
Carolyn McCracken, Senior Administrative Assistant, Board of Medicine

Enclosures:
Virginia Code Sections:
2.2-4019
2.2-4021
54.1-2914
54.1-2915
54.1-2919
54.1-3303
Order dated September 23, 1998
Amendment to Order dated February 6, 2001
Attachment I
Informal Conference Package
Map

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOHN R. HEATH, M.D.
License No.: 0101-014152

ORDER

In accordance with Sections 2.2-4019, 2.2-4021 and 54.1-2919 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with John R. Heath, M.D., on December 13, 2001, in Fredericksburg, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Informal Conference Committee ("Committee") were: Robert Nirschl, M.D., Chairman; Robert J. Bettini, M.D.; and Cedric Rucker. Dr. Heath appeared personally and was not represented by legal counsel. The purpose of the informal conference was to review Dr. Heath's compliance with the terms and conditions imposed upon his license to practice medicine in Virginia by Order of the Board entered September 23, 1998, and modified by letter from the Board dated February 6, 2001, and to inquire into allegations that he may have violated certain laws governing the practice of medicine in Virginia, as set forth in a Notice of Informal Conference dated November 9, 2001.

FINDINGS OF FACT

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

1. Dr. Heath was issued License No. 0101-014152 to practice medicine and surgery in the Commonwealth of Virginia on December 1, 1959. His license will expire on October 31, 2002, unless renewed.

2. By Order of the Board entered September 23, 1998, and modified by letter dated February 6, 2001 ("Order"), Dr. Heath became subject to certain terms and conditions, due to findings of poor documentation and indiscriminately and excessively prescribing controlled substances of abuse potential.

3. Dr. Heath is compliant with the terms and conditions of the Order.

4. A prescription survey and review of the records of ten (10) patients revealed that Dr. Heath's progress notes are primarily composed of the patient's reporting in the session and a list of medications to be written. His notes seldom contain a mental status examination, analytical assessment of the patient's progress, and rationale for medication changes. Further, the patient's diagnosis is inconsistently charted. However, Dr. Heath reported to the

Committee that he now employs a "SOAP" format in his documentation, to include documenting the patient's diagnosis on each visit.

5. On or about October 5, 2000, Dr. Heath prescribed ten (10) dosages units Ultram 50mg, a Schedule VI controlled substance, for Individual A, a colleague, with whom he had no bona fide physician/patient relationship. Following his interview, on or about March 28, 2001, with a Department of Health Professions Senior Investigator, Dr. Heath generated a patient record for Individual A to document the Ultram prescription.

6. Records from CVS Pharmacy #1404, Woodbridge, Virginia, indicate that on or about July 11, 1999, Dr. Heath telephoned in a prescription for six (6) dosage units hydrocodone/APAP, a Schedule III controlled substance, for Patient B; however, he failed to note said prescription in the patient's record. Further, between on or about July 16, 1999, and October 13, 2000, on at least four (4) different occasions, Dr. Heath prescribed for Patient B, who was hospitalized for an overdose in 1995, Vicodin ES (hydrocodone), a Schedule III controlled substance, either on an "emergency" basis, or "in case of migraine." Dr. Heath reported to the Committee that Patient B has been terminated as his patient.

7. Between on or about August 3, 1999, and March 19, 2001, Dr. Heath self-prescribed and/or self-administered ten (10) dosage units Depo-testosterone (Schedule III controlled substance) 100mg VL 10ml, as well as the following Schedule VI controlled substances:

408 dosage units Albuterol Inhaler
900 dosage units Allegra 60mg
690 dosage units Accolate 20mg tab
30 dosage units Tetracycline 250mg cap
90 dosage units Sumycin 500mg cap
400 dosage units Calan SR 240mg tab
285 dosage units Vasotec 10mg tab
300 dosage units Vaseretic 10/25 tab
91 dosage units Flovent
405 dosage units Celebrex 200mg
210 dosage units Singulair 10mg

Dr. Heath stated that he now has a prescription from his treating physicians for each of his present medications.

8. Dr. Heath stated to the Committee that, without exceptions, he no longer prescribes any type of medication, other than psychiatric medication, for his patients.

9. Dr. Heath described to the Committee his method of tracking and documenting medication prescriptions for his patients. Dr. Heath stated that while his system may not be perfect, it works "pretty well."

CONCLUSIONS OF LAW

The Committee concludes that Dr. Heath is properly before it, and it is responsible for reviewing and approving all information relative to the terms of the Board's Order entered September 23, 1998, as modified by letter from the Board dated February 6, 2001.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that the terms and conditions imposed upon the license of John F. Heath., M.D., are TERMINATED, and that his license is REINSTATED to a full and unrestricted status.

Pursuant to Section 9-6.14:14 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.

FOR THE BOARD

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

Entered: 12/28/01

PLL\Heath08Ord.doc

COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
TEL (804) 367- 4400
FAX (804) 527- 4475

December 15, 2009

John F. Heath, M.D.
9300 Forest Point Circle
Manassas, Virginia 20110

CERTIFIED MAIL
7160 3901 9848 0162 6465

RE: License No.: 0101-014152

Dear Dr. Heath:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Wednesday, January 20, 2010, at 2:15 p.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia**. The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws and regulations governing the practice of medicine and surgery in Virginia. Specifically, you may have violated Sections 54.1-2915.A(3), (12), (13), (16), and (18) of the Code and 18 VAC 85-20-26.C of the Board of Medicine General Regulations in that between April, 2007, and April, 2009, while treating Patients A – C:

1. You failed to obtain and document a complete patient history, including prior psychiatric and substance abuse history, prior to prescribing stimulant and anxiolyitic medication.

2. You prescribed medication for Patients A - C without sufficient data to determine the patients' diagnoses. For example, you began prescribing Adderall (Schedule II) and Xanax (Schedule IV) to Patient B in November, 2007, based solely on his self-report that a prior physician had diagnosed him with Attention Deficit Disorder ("ADD") and his report that his mother was taking these medications. You failed to document any symptoms to support the use of these medications, and failed to request prior treatment records. Further, you failed to diagnose Patient B with the disorders that warranted these medications until June, 2008.

3. You failed to develop a treatment plan and to review and monitor the efficacy of medication prescribed for patients. For example, you prescribed Adderall to Patient C between April, 2007, and July, 2007, without documenting any response to the medication.

4. You regularly prescribed stimulants and anxiolyitics to Patients A-C on dates when the patients did not present to your office for an examination, and you created no physician notes to explain why you prescribed these medications.

5. You routinely authorized refills or replacements of stimulant and anxiolytic medications based on information from patients that their medications or prescriptions had been "thrown away," "lost," or "stolen."

6. You prescribed stimulant and anxiolytic medication to Patient A, whose husband reported to you in late December, 2008, or early January, 2009, that she was addicted to controlled substances and was abusing the medications you prescribed for her. Further, you continued to prescribe these medications for Patient A after being told by her husband in approximately March or April, 2009, that she was being treated concurrently by an addictionologist, and was giving away some of the prescriptions that you wrote for her.

Please see Attachment I for the name of the patients referenced above.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Continue/Place you on probation with such terms it deems appropriate;
3. Reprimand you;
4. Modify a previous Board Order; and
5. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. Further, if you retain counsel, it is your responsibility to provide the enclosed materials to your attorney.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, Virginia, 23233, by **January 6,**

2010. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Emily Field wish to submit any documents for the Committee's consideration after **January 6, 2010,** such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

You may be represented by an attorney at the informal conference. If you obtain counsel, you should do so as soon as possible, because absent good cause to support a request for a continuance, the informal conference will be held on January 20, 2010. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by **December 28, 2009**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **December 28, 2009**, will not be considered.

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at **http://leg1.state.va.us.** To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at **http://www.dhp.virginia.gov/medicine**. You may request a paper copy from the Board office by calling (804) 367-4513.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Emily Field, Adjudication Specialist, at (804) 367-4678.

Sincerely,

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

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EF/Heath80NIC.DOC

Enclosures:

Attachment I
Informal Conference Package (w/CD)
Map

cc: Jane E. Piness, M.D., President, Virginia Board of Medicine
Reneé S. Dixson, Discipline Case Manager, Board of Medicine
Emily Field, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Pamela Kincheloe, Senior Investigator [125480]

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOHN F. HEATH, M.D.
License No.: 0101-014152

CONSENT ORDER

By letter dated December 15, 2009, the Virginia Board of Medicine ("Board") noticed John F. Heath, M.D., for an informal conference to inquire into allegations that he may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia.

In lieu of proceeding to this informal conference, the Board and Dr. Heath, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Heath to practice medicine and surgery in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

1. John F. Heath, M.D., was issued license number 0101-014152 by the Board to practice medicine and surgery in the Commonwealth of Virginia on December 1, 1959. Said license is currently active and will expire on October 31, 2010, unless renewed or otherwise restricted.

2. Dr. Heath violated Section 54.1-2915.A(3), (12), (13), (16), and (18) of the Code of Virginia (1950), as amended, ("Code") and 18 VAC 85-20-26.C of the Board of Medicine General Regulations in that between April, 2007, and April, 2009, while treating Patients A – C:

a. He failed to obtain and document a complete patient history, including prior psychiatric and substance abuse history, prior to prescribing amphetamines and benzodiazepines.

b. He prescribed medication for Patients A-C without sufficient evidence or diagnostic studies to determine the patients' diagnoses. For example, Dr. Heath began prescribing Adderall (Schedule II) and Xanax (Schedule IV) to Patient B in November, 2007, based on his self-report that a prior physician had diagnosed him with Attention Deficit Disorder ("ADD"), and his report that his mother was taking these medications. Dr. Heath failed to perform any tests or document any symptoms to support Patient B's diagnosis of ADD, which he failed to document in the patient record until June, 2008.

c. Dr. Heath failed to develop a treatment plan and to review and monitor the efficacy of medication prescribed for patients. For example, he prescribed Adderall to Patient C between April, 2007, and July, 2007, without documenting any response to the medication.

d. Dr. Heath regularly prescribed amphetamines and benzodiazepines to Patients A-C on dates when the patients did not present to his office for an examination, and he created no physician notes to explain why he prescribed these medications.

e. Dr. Heath routinely authorized refills or replacements of amphetamine and benzodiazepine medications based on information from patients that their medications or prescriptions had been "thrown away," "lost," or "stolen."

f. Dr. Heath prescribed amphetamines and benzodiazepines to Patient A, whose husband reported to him in late December, 2008, or early January, 2009, that the Patient was addicted to controlled substances and was abusing the medications that Dr. Heath prescribed for her. Further, Dr. Heath continued to prescribe these medications for Patient A after being told by her husband in approximately March or April, 2009, that she was being treated concurrently by an addictionologist, and was giving away some of the prescriptions that Dr. Heath wrote for her.

3. Dr. Heath reported that he had decided to retire from the practice of medicine, and that he has begun the process of transferring his patients to other physicians for care and treatment.

CONSENT

I, John F. Heath, 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;

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 an informal conference before the Board; and

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

4. I waive all rights to an informal conference;

5. I admit the truth of the above Findings of Fact and Conclusions of Law; and

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

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, and with the consent of the licensee, it is hereby ORDERED that the Board accepts the VOLUNTARY SURRENDER of the license of John F. Heath, M.D. to practice medicine and surgery in the Commonwealth of Virginia, effective April 1, 2010.

Dr. Heath shall immediately begin the process of notifying his patients of his decision to retire from practice, and aiding those patients in the transfer of their care to other physicians.

The license of John F. Heath, M.D., will be recorded as SURRENDERED and no longer current as of April 1, 2010. Dr. Heath will not be eligible for reinstatement of his license at any future date.

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

1/20/2010
ENTERED

SEEN AND AGREED TO:

John F. Heath M.D.
JOHN F. HEATH, M.D.

COMMONWEALTH OF VIRGINIA
COUNTY/CITY OF Henrico, TO WIT:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this 20th day of January, 2010, by John F. Heath, John F. Heath, M.D.

Jennie F. Wood
Notary Public

Registration Number: 7057255
My commission expires: June 30th, 2010

JENNIE F. WOOD NOTARY PUBLIC COMMONWEALTH OF VIRGINIA

EF/Heath80PHCO.DOC