COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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

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TEL (804) 367- 4400
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October 4, 2011

Leonard M. Dileo, M.D.
Atlantic Psychiatric Services
800 Viking Drive, Ste 200
Virginia Beach, Virginia 23452-7477

UPS OVERNIGHT

RE: License No.: 0101-031222

Dear Dr. Dileo:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Wednesday, November 9, 2011, at 11:30 a.m., at the Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia**. A map is enclosed for your convenience. 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 the Commonwealth of Virginia. Specifically:

1. You may have violated Sections 54.1-2915A.(3)[1], (13), and (16) of the Code in your care and treatment of Patients A - F between 2003 and 2010 in that, while providing psychiatric treatment to said patients, you treated their pain-related complaints with various Schedule II - IV narcotics, and did so without employing appropriate or acceptable pain management practices. Specifically:

   a. You failed to conduct or document physical examinations of Patients B - F before initiating treatment with narcotics.

[1] Prior to July 1, 2003, Section 54.1-2915.A(3) was codified as Section 54.1-2915.A(4) as written to include gross ignorance or carelessness in the practice, or gross malpractice. After July 1, 2003, it was rewritten to include intentional negligent conduct in the practice that causes or is likely to cause injury to the patients.

b. You prescribed narcotics to Patients A - F without diagnosing a medical condition warranting such prescriptions or having an adequate medical indication for such prescribing.

c. You prescribed narcotics to Patients B, E, and F based upon their unconfirmed representations regarding which medications they were currently prescribed, and without performing your own independent examination and evaluation to establish a diagnosis.

d. You diagnosed medical conditions without sufficient objective evidence of diagnostic testing or studies to support your diagnoses, and you failed to determine the etiology of patients' pain or other symptoms prior to prescribing medications.

e. Without explanation or file documentation as to your rationale for doing so, you changed Patient A's medication from hydrocodone to hydromorphone on March 18, 2009, then back to hydrocodone on September 18, 2009, and then to oxycodone/acetaminophen on November 10, 2009.

f. You prescribed OxyContin for Patient C on her first visit with you on January 4, 2005, without medical indication. You continued to prescribe OxyContin on a regular basis for a period of at least five (5) years without recording anything more descriptive than "chronic pain."

g. You noted on April 24, 2008 that Patient C might need treatment at a psychiatric hospital for depression and "detox from oxycont." Nevertheless, you continued to prescribe OxyContin for Patient C for the next two years.

h. Without explanation or file documentation of your rationale for doing so, you modified the dosage of Patient C's OxyContin prescription from 40 mg to 80 mg on September 29, 2008, and you modified the dosage of Patient C's oxycodone prescription from 40 mg to 80 mg on December 2, 2008.

i. Without explanation or file documentation of your rationale for doing so, you switched Patient D back and forth between hydrocodone/ibuprofen and hydrocodone/acetaminophen on September 5, 2008, September 8, 2008, September 26, 2008, and January 6, 2009.

j. You failed to obtain or include in Patient E's file a current and past medical surgical and pain history, including any past interventions and treatments for the particular pain condition being treated. In fact, although you began treating Patient E in 2005, the "Initial Diagnostic Evaluation" in Patient E's file is dated

August 17, 2006, and leaves blank the sections for the patient's medical history, past psychiatric history, occupational history, alcohol and drug history.

k. On two occasions, August 22, 2008 and January 27, 2009, you were notified by Patient E's health insurer that Patient E was receiving more than the recommended daily dose of acetaminophen.

l. You were notified by Patient E's health insurer on August 22, 2008 that Patient E was getting simultaneous prescriptions for oxycodone and hydrocodone from you and from another prescriber, and you failed to take responsive action.

m. You began treating Patient F in 2002, but failed to take a patient history or make a request to Patient F's PCP for her records until January of 2004. When the requested records were not provided, you made no further effort to obtain them. Your own records fail to note or otherwise document Patient F's two 2005 hospitalizations for drug overdoses while under your care.

n. Without explanation or file documentation of your rationale for doing so, between April 16, 2008 and November 3, 2008, and again between January 28, 2009 and September 30, 2009, you switched Patient F's prescriptions for morphine between and among morphine CR 30 mg, morphine ER 100 mg, morphine ER 60 mg, and morphine ER 15 mg.

o. Despite documentation in your file of Patient F's overdose on Dilaudid in July of 2005, you prescribed Dilaudid for Patient F for a period of 5 years (June 2005 - May 2010) without conducting or ordering appropriate tests to determine the possibility of abuse.

p. When Patient F called three (3) times in a single day asking for prescriptions for narcotics, you failed to address this behavior at that time or at Patient F's next office visit.

2. You may have violated Sections 54.1-2915A.(3), (13), and (16) of the Code in your care and treatment of Patients B and E by prescribing medications for conditions unrelated to psychiatric care or pain management without related examinations, consultations, or rationale. Specifically, from 2005 - 2010, you regularly prescribed Megace, a hormone, to Patient E.

3. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code, and 18 VAC 85-20-26.C of the Board of Medicine General Regulations (effective October 19, 2005), in that your records for Patients A - F are so illegible as to render it virtually impossible for another treatment provider to ascertain the care and treatment you provided these patients.

The records included in the patient files demonstrate only sporadic notations, rendering it impracticable to determine if, in fact, all office visits are included. Where a record of an office visit does exist, patient notes are illegible and/or insufficient. For example, your records for prescriptions written for Patients A - F are incomplete in that you failed to adequately or fully record the types of medications prescribed, the reason why each medication was selected, the selected dose, the selected schedule for administration of the medication, the date prescribed, or the quantity prescribed; you failed to record all therapeutic and diagnostic procedures performed; and you failed to record all laboratory results.

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

After consideration of all information, the Committee may:

1. Exonerate you;
2. 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 UPS overnight mail. Copies of this documentation have been provided to your attorney, Anisa P. Kelley, Esquire.

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, Henrico, Virginia, 23233, by **October 20, 2011**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Gerald A. Milsky wish to submit any documents for the Committee's consideration after **October 20, 2011**, 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 November 9, 2011. 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 **October 14, 2011**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **October 14, 2011**, 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 Gerald A. Milsky, Adjudication Specialist, at (804) 367- 4601

Sincerely,

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

Enclosures:
Attachment I
Informal Conference Package (6 volumes)
Map

cc: Gerald A. Milsky, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Anisa P. Kelley, Esquire [*w/enclosures by UPS*]
Charlotte Hudson, Senior Investigator (130966)

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

RE: LEONARD M. DILEO, M.D.
License No.: 0101-031222

CONSENT ORDER

The Virginia Board of Medicine ("Board") and Leonard M. Dileo, M.D., as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Dileo 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. Leonard M. Dileo, M.D., was issued license number 0101-031222 by the Board to practice medicine and surgery in the Commonwealth of Virginia on September 18, 1979. Said license is currently active and will expire on January 31, 2012, unless renewed or otherwise restricted.

2. Dr. Dileo violated Sections 54.1-2915A.(3), (13), and (16) of the Code in his care and treatment of Patients A - F between 2003 and 2010 in that, while providing psychiatric treatment to said patients, he treated their pain-related complaints with various Schedule II - IV narcotics, and did so without employing appropriate or acceptable pain management practices. Specifically:

   a. Dr. Dileo failed to conduct or document physical examinations of Patients B - F before initiating treatment with narcotics.

b. Dr. Dileo prescribed narcotics to Patients A - F without diagnosing a medical condition warranting such prescriptions or having an adequate medical indication for such prescribing.

c. Dr. Dileo prescribed narcotics to Patients B, E, and F based upon their unconfirmed representations regarding which medications they were currently prescribed, and without performing his own independent examination and evaluation to establish a diagnosis.

d. Dr. Dileo diagnosed medical conditions without sufficient objective evidence of diagnostic testing or studies to support his diagnoses, and failed to determine the etiology of patients' pain or other symptoms prior to prescribing medications.

e. Without explanation or file documentation as to his rationale for doing so, Dr. Dileo changed Patient A's medication from hydrocodone to hydromorphone on March 18, 2009, then back to hydrocodone on September 18, 2009, and then to oxycodone/acetaminophen on November 10, 2009.

f. Dr. Dileo prescribed OxyContin for Patient C on her first visit on January 4, 2005, without medical indication. Dr. Dileo continued to prescribe OxyContin on a regular basis for a period of at least five (5) years without recording anything more descriptive than "chronic pain."

g. Dr. Dileo noted on April 24, 2008 that Patient C might need treatment at a psychiatric hospital for depression and "detox from oxycont." Nevertheless, Dr. Dileo continued to prescribe OxyContin for Patient C for the next two years.

h. Without explanation or file documentation of his rationale for doing so, Dr. Dileo modified the dosage of Patient C's OxyContin prescription from 40 mg to 80 mg on September 29, 2008, and modified the dosage of Patient C's oxycodone prescription from 40 mg to 80 mg on December 2, 2008.

i. Without explanation or file documentation of his rationale for doing so, Dr. Dileo switched Patient D back and forth between hydrocodone/ibuprofen and hydrocodone/acetaminophen on September 5, 2008, September 8, 2008, September 26, 2008, and January 6, 2009.

j. Dr. Dileo failed to obtain or include in Patient E's file a current and past medical surgical and pain history, including any past interventions and treatments for the particular pain condition being treated. In fact, although Dr. Dileo began treating Patient E in 2005, the "Initial Diagnostic Evaluation" in Patient E's file is dated August 17, 2006, and leaves blank the sections for the patient's medical history, past psychiatric history, occupational history, alcohol and drug history.

k. On two occasions, August 22, 2008 and January 27, 2009, Dr. Dileo was notified by Patient E's health insurer that Patient E was receiving more than the recommended daily dose of acetaminophen.

l. Dr. Dileo was notified by Patient E's health insurer on August 22, 2008 that Patient E was getting simultaneous prescriptions for oxycodone and hydrocodone from Dr. Dileo and from another prescriber, and failed to take responsive action.

m. Dr. Dileo began treating Patient F in 2002, but failed to take a patient history or make a request to Patient F's PCP for her records until January of 2004. When the requested records were not provided, Dr. Dileo made no further effort to obtain them. Dr. Dileo's own records fail to note or otherwise document Patient F's two 2005 hospitalizations for drug overdoses while under his care.

n. Without explanation or file documentation of his rationale for doing so, between April 16, 2008 and November 3, 2008, and again between January 28, 2009 and September 30, 2009, Dr. Dileo switched Patient F's prescriptions for morphine between and among morphine CR 30 mg, morphine ER 100 mg, morphine ER 60 mg, and morphine ER 15 mg.

o. Despite documentation in his file of Patient F's overdose on Dilaudid in July of 2005, Dr. Dileo prescribed Dilaudid for Patient F for a period of 5 years (June 2005 – May 2010) without conducting or ordering appropriate tests to determine the possibility of abuse.

p. When Patient F called three (3) times in a single day asking for prescriptions for narcotics, Dr. Dileo failed to address this behavior at that time or at Patient F's next office visit.

2. Dr. Dileo violated Sections 54.1-2915A.(3), (13), and (16) of the Code in his care and treatment of Patients B and E by prescribing medications for conditions unrelated to psychiatric care or pain management without related examinations, consultations, or rationale. Specifically, from 2005 – 2010 Dr. Dileo regularly prescribed Megace, a hormone, to Patient E.

3. Dr. Dileo violated Sections 54.1-2915.A(3), (13), and (16) of the Code, and 18 VAC 85-20-26.C of the Board of Medicine General Regulations (effective October 19, 2005), in that his records for Patients A – F are so illegible as to render it virtually impossible for another treatment provider to ascertain the care and treatment provided these patients. The records included in the patient files demonstrate only sporadic notations, rendering it impracticable to determine if, in fact, all office visits are included. Where a record of an office visit does exist, patient notes are illegible and/or insufficient. For example, Dr. Dileo's records for prescriptions written for Patients A - F are incomplete in that he failed to adequately or fully record the types of medications prescribed, the reason why each medication was selected, the selected dose, the selected schedule for administration of the medication, the date prescribed, or the quantity prescribed; he failed to record all therapeutic and diagnostic procedures performed; and he failed to record all laboratory results.

CONSENT

I, Leonard M. Dileo, 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 Anisa P. Kelley, Esquire;

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 contained herein and agree not to contest the Findings of Fact or Conclusions of Law 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 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 license of Leonard M. Dileo, M.D., be placed on INDEFINITE PROBATION subject to the following terms and conditions:

1. Dr. Dileo shall be permanently restricted from prescribing Schedule II – V opioids (natural or synthetic) and other analgesics;

2. Within six (6) months from the entry of this Order, Dr. Dileo shall submit evidence satisfactory to the Board verifying that he has completed twelve (12) hours of Board-

approved continuing medical education ("CME") in the subject of medical recordkeeping and record management. 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. Within twelve (12) months following the submission of satisfactory evidence certifying completion of Term #2 above, Dr. Dileo shall make his records available to an investigator for the Department of Health Professions, who shall randomly select ten (10) current patient medical records for review.

4. The Board authorizes the Executive Director of the Board to review the records obtained pursuant to Term #3 and to close this matter, or refer it to a Special Conference Committee for review and final determination. Any closure of this matter shall have no effect upon the permanent restriction imposed on Dr. Dileo's license with respect to prescribing as set forth in Term #1.

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

Dr. Dileo 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.

Pursuant to Section 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.

FOR THE BOARD:

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

ENTERED: 12/6/11

SEEN AND AGREED TO:

Leonard M. Dileo, M.D.

COMMONWEALTH OF VIRGINIA
COUNTY/CITY OF Virginia Beach TO WIT:

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this 1 day of December, 2011, by Leonard M. Dileo, M.D.

KATHERINE ANN ROSE
Notary Public
Commonwealth of Virginia
Reg. #7312193
My Commission Exps. March 31, 2014

Katherine Ann Rose
Notary Public
Registration No: 7312193
My Commission expires: 3/31/2014

COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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April 10, 2012

Leonard M. Dileo, M.D.
Atlantic Psychiatric Services
500 Viking Drive, Suite #200
Virginia Beach, Virginia 23452-7477

CERTIFIED MAIL
7196 9008 9111 0155 5712

RE: **License No.: 0101-031222**
Modification of Consent Order

Dear Dr. Dileo:

The Virginia Board of Medicine ("Board") is in receipt of a letter from your counsel dated April 2, 2012, whereby you request that the Board modify the terms and conditions of the Consent Order entered December 6, 2011. Specifically, you have requested that the Board delete the requirement for an unannounced inspection as required by Term #3.

A Special Conference Committee ("Committee") met on April 5, 2012, and considered your request for modification. Members of the Board serving on the Committee were Karen Ransone, M.D., Chair; Sandra Bell, M.D.; and Robert Hickman, M.D.

After careful consideration of the information presented, the Committee determined that your request should be granted. Therefore, the Consent Order entered December 6, 2011, has been modified by eliminating Term #3. You should maintain a copy of this letter since it is considered as an amendment to the Consent Order.

Pursuant to Va. Code §54.1-2400.2, this decision 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.

Should you have any questions regarding this matter, please contact the Board office at (804) 367-4513.

Sincerely,

Jennifer L. Deschenes
Deputy Executive Director, Discipline
Virginia Board of Medicine

cc: Susan Brooks, Office Manager, APD [130966]
Anisa P. Kelley, Esquire

COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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Perimeter Center
9960 Mayland Drive, Suite 300
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FAX (804) 527- 4475

June 14, 2012

Leonard M. Dileo, M.D.
Atlantic Psychiatric Services
500 Viking Drive, Suite #200
Virginia Beach, Virginia 23452-7477

CORRECTED

RE: License No.: 0101-031222

Dear Dr. Dileo:

The Virginia Board of Medicine ("Board") has received verification of your compliance with the terms and conditions imposed pursuant to entry of the Board Order entered December 6, 2011, and subsequently modified by letter dated April 10, 2012. Therefore, pursuant to the authority granted to me by Term #4, I have determined that the probation and terms imposed on your license should be TERMINATED effective **May 3, 2012.**

Please note that this decision does not remove the permanent restriction as referenced in Term #1, regarding your ability to prescribe Schedule II - V opioids (natural or synthetic) and other analgesics.

Pursuant to §54.1-2400.2 of the *Code of Virginia,* a signed copy of this letter 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.

The Board wishes you well in your future endeavors.

Sincerely,

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

cc: Anisa P. Kelley, Esquire
Susan Brooks, Office Manager, APD [130988]