COMMONWEALTH of VIRGINIA

Sandra Whitley Ryals
Director

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

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April 7, 2009

Peter L. Campbell, M.D.
8103 Carleigh Parkway
Springfield, Virginia 22152

CERTIFIED MAIL
7160 3901 9845 3430 8362

RE: License No. 0101-029943

Dear Dr. Campbell:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Thursday May 21, 2009, at 11:30 a.m., at the office of 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:

1. You may have violated Sections 54.1-2915.A(3)*, (8), (13), (16), and (17), 54.1-3303.A, 54.1-3408.A of the Code, in that, from approximately 1998 to 2008, you failed to properly manage the care and treatment of Patients A-K, in that:

a. You failed to consistently obtain a complete patient history prior to prescribing controlled substances, including prior psychiatric and substance abuse history, as well as past intervention and treatment for chronic pain conditions for Patients D, F, I, and J.

b. You prescribed narcotics and benzodiazepines to patients without performing any physical examination, evaluation or assessment of the patient. Further, you

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

regularly prescribed narcotics to patients on dates when the patients did not present to your office for an examination, often in response to telephonic requests from patients for additional medications.

c. You prescribed narcotics and benzodiazepines to patients without diagnosing a medical condition justifying such prescriptions, ordering diagnostic tests to determine the etiology of the patient's pain, or documenting your reasons for selecting the types of medications prescribed.

d. You failed to develop a comprehensive treatment plan and/or to periodically review and monitor the efficacy of treatment for patients, including monitoring and managing patients' usage of narcotic and/or benzodiazepine medications. Specifically:

i. You did not employ pain rating scales or other appropriate measures to determine the effect of prescribed medications on patients' activities of daily living.

ii. With one exception, you did not have a pain management or similar contract in place with patients for whom you regularly prescribed narcotic and/or benzodiazepine medications. Although you did have a pain management contract signed by Patient D, you did not enforce the terms of that agreement.

iii. You failed to order any drug urine/serum screens, conduct pill counts, or take other appropriate measures to determine whether your patients were taking their medications as prescribed and were otherwise compliant with their medication regimen.

e. You prescribed controlled substances to patients who exhibited drug-seeking behavior or who you knew or should have known were abusing or had become addicted to or dependent upon their medications. Further, you failed to address or document that you had addressed signs and symptoms of escalation or abuse of narcotic therapies, nor did you appropriately treat or refer patients for treatment of substance abuse. For example:

i. You repeatedly authorized early refills of medications, without any medical indication other than information provided to you by the patients themselves. For example, you routinely replaced medications reported as lost, stolen, misappropriated, disappeared, necessitated by vacation, short-changed by the pharmacist, left in Hawaii, vomitted up, spilled in the sink, spilled in

vomitus, destroyed in fire, by flood, in an automobile accident, etc., and other non-verified explanations provided by patients for early medication refills.

ii. You routinely prescribed narcotics and/or benzodiazepines to patients after they admitted failing to take their medications as prescribed, thereby allowing patients to unilaterally increase their dosage of medications without first consulting you. After such misuse, you continued to prescribe narcotic and/or benzodiazepine medications to patients, often at the increased dosage implemented by your patients.

iv. You prescribed narcotic and benzodiazepine medications to patients who exhibited symptoms of slurred speech and oversedation; whose family members, physicians, insurance companies, or pharmacists informed you that they were misusing their medications or receiving medications from multiple providers; who you were aware had been refused or dismissed from other physicians' practices or pain management centers due to noncompliance or medication misuse; who you were aware had entered detoxification for drug abuse; and who you were aware were sharing their medications with others, were taking the medications of others, or had obtained illicit drugs. Further, in the case of Patient G, you continued to prescribe narcotics after you became aware that he had fraudulently obtained medications by stealing prescription pads from and forging the name of another physician.

f. You failed to appropriately recommend or prescribe to your chronic pain patients treatment modalities other than the prescription of controlled substances.

g. You failed to make appropriate patient referrals to, and/or to consult and coordinate treatment with, other physicians, nor did you consistently obtain medical records from other physicians involved in the care of your patients.

2. You may have violated Sections 54.1-2915.A(3), (13), and (16) of the Code in your care and treatment of Patients G, H, and J, in that:

a. Without performing adequate physical examinations or assessments, performing necessary blood or laboratory work, or consulting with or referring to other appropriate healthcare providers, you treated Patient G for a thyroid condition, including prescribing Synthyroid, from approximately 2005 to 2007.

b. From approximately October 2005 to February 2006, you prescribed Cialis to Patient H without performing any physical examination or assessment or obtaining a relevant medical history.

c. From approximately April to November 2004, and then again from September to December 2007, you prescribed Viagra to Patient J without performing any physical examination or assessment or obtaining a relevant medical history.

3. You may have violated Sections 54.1-2915.A(3), (13), (16), and (17) and 54.1-3408.01 of the Code, in that, on numerous occasions, you wrote multiple, post-dated narcotic prescriptions for Patients B, C, E, F, J, and K at a single visit.

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. 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. These materials have been provided this date to your counsel, Kevin Byrnes, 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, Richmond, Virginia 23233-1463, by **April 30, 2009**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Julia K. Bennett wish to submit any documents for the Committee's consideration after **April 30, 2009**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

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 **April 21, 2009**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **April 21, 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 Julia K. Bennett, Adjudication Specialist, at (804) 367-4427.

Sincerely,

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

Enclosures:
Informal Conference Package
Attachment I
Map

cc: Stephen E. Heretick, J.D., President Virginia Board of Medicine
Sandra Whitley Ryals, Director, Department of Health Professions
Reneé S. Dixson, Discipline Case Manager, Board of Medicine
Julia K. Bennett, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Naima Fellers, Senior Investigator [119400]
Kevin Byrnes, Esquire

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: PETER L. CAMPBELL, M.D.
License No.: 0101-029943

CONSENT ORDER

On May 21, 2009, a Special Conference Committee ("Committee") of the Virginia Board of Medicine met with Peter L. Campbell, M.D., to inquire into allegations that he may have violated certain laws and regulations governing the practice of medicine and surgery as set forth in a Notice of Informal Conference dated April 7, 2009.

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 convened with Dr. Campbell on May 21, 2009, in Richmond, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: Jane Piness, M.D., chair; Stuart Mackler, M.D.; and General Clara Adams-Ender, R.N. Dr. Campbell appeared personally and was represented by legal counsel, Kevin Byrnes, Esquire. Julia K. Bennett, Adjudication Specialist, of the Administrative Proceedings Division of the Department of Health Professions, was also present.

After commencing the informal conference, the Board offered Dr. Campbell a consent order to resolve the matters before it. Dr. Campbell, after consultation with counsel, hereby agrees to settle this matter by way of a consent order, and, in lieu of proceeding with the informal conference, the Board and Dr. Campbell, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Campbell to practice

practice medicine and surgery in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

1. Peter L. Campbell, M.D., was issued license number 0101-029943 by the Board to practice medicine and surgery in the Commonwealth of Virginia on December 4, 1978. Said license is currently active and will expire on January 31, 2010, unless renewed or otherwise acted upon.

2. Dr. Campbell violated Sections 54.1-2915.A(13) and (17), 54.1-3303.A, and 54.1-3408.A of the Code, in that, from approximately 1998 to 2008, he failed to properly manage the care and treatment of Patients A-K, in that:

a. Dr. Campbell failed to consistently obtain a complete patient history prior to prescribing controlled substances, including prior psychiatric and substance abuse history, as well as past intervention and treatment for chronic pain conditions for Patients D, F, I, and J.

b. Dr. Campbell prescribed narcotics and benzodiazepines to patients without performing any physical examination, evaluation or assessment of the patient. Further, Dr. Campbell regularly prescribed narcotics to patients on dates when the patients did not present to his office for an examination, often in response to telephonic requests from patients for additional medications.

c. Dr. Campbell prescribed narcotics and benzodiazepines to patients without

diagnosing a medical condition justifying such prescriptions, ordering diagnostic tests to determine the etiology of the patient's pain, or documenting his reasons for selecting the types of medications prescribed.

d. Dr. Campbell failed to develop a comprehensive treatment plan and/or to periodically review and monitor the efficacy of treatment for patients, including monitoring and managing patients' usage of narcotic and/or benzodiazepine medications. Specifically:

i. Dr. Campbell did not employ pain rating scales or other appropriate measures to determine the effect of prescribed medications on patients' activities of daily living.

ii. With one exception, Dr. Campbell did not have a pain management or similar contract in place with patients for whom he regularly prescribed narcotic and/or benzodiazepine medications. Although Dr. Campbell did have a pain management contract signed by Patient D, he did not enforce the terms of that agreement.

iii. Dr. Campbell failed to order any drug urine/serum screens, conduct pill counts, or take other appropriate measures to determine whether his patients were taking their medications as prescribed and were otherwise compliant with their medication regimen.

e. Dr. Campbell prescribed controlled substances to patients who exhibited drug-seeking behavior or who he knew or should have known were abusing or had

become addicted to or dependent upon their medications. Further, Dr. Campbell failed to address or document that he had addressed signs and symptoms of escalation or abuse of narcotic therapies, nor did he appropriately treat or refer patients for treatment of substance abuse. For example:

i. Dr. Campbell repeatedly authorized early refills of medications, without any medical indication other than information provided to him by the patients themselves. For example, Dr. Campbell routinely replaced medications reported as lost, stolen, misappropriated, disappeared, necessitated by vacation, short-changed by the pharmacist, left in Hawaii, vomitted up, spilled in the sink, spilled in vomitus, destroyed in fire, by flood, in an automobile accident, etc., and other non-verified explanations provided by patients for early medication refills.

ii. Dr. Campbell routinely prescribed narcotics and/or benzodiazepines to patients after they admitted failing to take their medications as prescribed, thereby allowing patients to unilaterally increase their dosage of medications without first consulting him. After such misuse, Dr. Campbell continued to prescribe narcotic and/or benzodiazepine medications to patients, often at the increased dosage implemented by his patients.

iv. Dr. Campbell prescribed narcotic and benzodiazepine medications to patients who exhibited symptoms of slurred speech and oversedation; whose family members, physicians, insurance companies, or pharmacists informed

him that they were misusing their medications or receiving medications from multiple providers; who Dr. Campbell was aware had been refused or dismissed from other physicians' practices or pain management centers due to noncompliance or medication misuse; who Dr. Campbell was aware had entered detoxification for drug abuse; and who Dr. Campbell aware were sharing their medications with others, were taking the medications of others, or had obtained illicit drugs. Further, in the case of Patient G, Dr. Campbell continued to prescribe narcotics after he became aware that Patient G had fraudulently obtained medications by stealing prescriptions pads from and forging the name of another physician.

f. Dr. Campbell failed to appropriately recommend or prescribe to his chronic pain patients treatment modalities other than the prescription of controlled substances.

g. Dr. Campbell failed to make appropriate patient referrals to, and/or to consult and coordinate treatment with, other physicians, nor did he consistently obtain medical records from other physicians involved in the care of his patients.

3. Dr. Campbell violated Sections 54.1-2915.A(3) and (13) of the Code in his care and treatment of Patients G, H, and J, in that:

a. Without performing adequate physical examinations or assessments, performing necessary blood or laboratory work, or consulting with or referring to other appropriate healthcare providers, Dr. Campbell treated Patient G for a

thyroid condition, including prescribing Synthyroid, from approximately 2005 to 2007.

b. From approximately October 2005 to February 2006, Dr. Campbell prescribed Cialis to Patient H without performing any physical examination or assessment or obtaining a relevant medical history.

c. From approximately April to November 2004, and then again from September to December 2007, Dr. Campbell prescribed Viagra to Patient J without performing any physical examination or assessment or obtaining a relevant medical history.

4. Dr. Campbell violated Sections 54.1-2915.A(13) and (17) and 54.1-3408.01 of the Code, in that, on numerous occasions, he wrote multiple, post-dated narcotic prescriptions for Patients B, C, E, F, J, and K at a single visit.

CONSENT

I, Peter L. Campbell, 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;

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

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 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 ORDERED that Peter L. Campbell, M.D., be, and hereby is, issued a REPRIMAND, and it is FURTHER ORDERED that the license of Dr. Campbell be, and hereby is, permanently restricted from prescribing Schedule II, III, and IV controlled substances.

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

Violation of this Consent Order may constitute grounds for the suspension or revocation of Dr. Campbell's license. In the event Dr. Campbell violates any of the terms and conditions of 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 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 William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 5/22/2009

SEEN AND AGREED TO:

Peter L. Campbell, 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 State of Virginia, at large, this 21st day of May, 2009, by Peter L. Campbell, M.D.

Notary Public

My commission expires: June 30th, 2010

Registration No.: 7057255

JENNIE F. WOOD NOTARY PUBLIC COMMONWEALTH OF VIRGINIA

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: PETER L. CAMPBELL, M.D.
License No.: 0101-029943

CONSENT ORDER

The Virginia Board of Medicine and Peter L. Campbell, M.D., as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Campbell to practice medicine and surgery in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

1. Dr. Campbell was issued license number 0101-029943 by the Board to practice medicine and surgery in the Commonwealth of Virginia on August 8, 1980. Said license is currently active and will expire on January 31, 2012, unless renewed or otherwise restricted.

2. Dr. Campbell violated Section 54.1-2915.A(13), and (16) of the Code of Virginia (1950), as amended ("Code"), in that, on February 2, 2010, while waiting to see patients incarcerated at a prison facility via live tele-med computer/video communication connecting Dr. Campbell's home office to the clinic tele-med examining room at the prison, Dr. Campbell was observed by staff exposing his unclothed lower body on camera.

3. As a result of the foregoing incident, Dr. Campbell's employment was terminated.

4. Dr. Campbell has indicated his intention to retire from the practice of medicine, and his desire to voluntarily surrender his medical license.

CONSENT

I, Peter L. Campbell, 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 Kevin Byrnes, 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 and Conclusions of Law;

6. I waive the right to contest any sanction imposed herein in any future judicial or administrative proceedings where the Board is a party; and

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

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, and with the consent of the licensee, it is hereby ORDERED that the Board accepts the VOLUNTARY PERMANENT SURRENDER of the license of Peter L. Campbell, M.D., to

practice medicine and surgery in the Commonwealth of Virginia, in lieu of further administrative proceedings in this matter.

Upon entry of this Consent Order, the license of Peter L. Campbell, M.D., will be recorded as SURRENDERED and no longer current. Dr. Campbell 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:

Jennifer L. Deedens

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

ENTERED: 8/2/2010

SEEN AND AGREED TO:

Peter L. Campbell, M.D.

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

Subscribed and sworn to before me, the undersigned Notary Public, in and for the Commonwealth of Virginia, at large, this 22nd day of July, 2010, by Peter L. Campbell, M.D.

Amy Tang

Notary Public

My commission expires: 07-31-20

Registration No.: 7016577

AMY TANG
COMMONWEALTH OF VIRGINIA
Registry No. 7016577
NOTARY PUBLIC

* I, Notaried Peter L Campbell only