STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Edward Peter Durling, PA-C	)	Docket No. MPC 145-1019

STIPULATION AND CONSENT ORDER

NOW COME Edward Peter Durling PA-C, and the State of Vermont, by and through Vermont Attorney General Thomas J. Donovan, Jr. and the undersigned Assistant Attorney General Megan Campbell, and agree and stipulate as follows:

1. Edward Peter Durling, PA-C ("Respondent") of Queensbury, New York held Vermont medical license number 055.0030945 first issued by the Vermont Board of Medical Practice ("the Board") on January 7, 2009. Respondent's medical license lapsed on January 31, 2020 and is no longer active.[1] Respondent is a physician assistant.

2. Jurisdiction in this matter vests with the Board pursuant to 26 V.S.A. §§ 1353-1354, 1370-1374, 1731-1739 and 3 V.S.A. §§ 809-814, and other authority.

FINDINGS OF FACT

I. Prior Board History and Stipulations

3. On October 2, 2013, Respondent entered into a stipulation and consent order with the Board. This stipulation included findings that he used an account with a medical supply company to purchase controlled substances for an immediate family member and also

[1] The Board retains jurisdiction to resolve unprofessional conduct that arose while Respondent had an active license to practice medicine notwithstanding the subsequent lapse of that license pursuant to 3 V.S.A. § 814(d).

medication for his own use in violation of the law and the Vermont Department of Health's Rules. The Board reprimanded Respondent and required that he complete continuing medical education courses on the topics of medical ethics, prescribing best practices, and medical recordkeeping. Respondent also has a Board action from New Hampshire dated November 19, 2013 for the same conduct.

4. In April of 2020, Respondent surrendered his medical license in New York in a stipulated agreement that was based upon the conduct identified in the 2013 New Hampshire stipulation. In that New York State Board of Professional Medical Conduct Order, Respondent agreed that he had prescribed controlled substances to multiple patients without adequate medical indication from 2006-2013 as outlined in the New Hampshire stipulation.

II. Present Board Action

5. In September of 2019, the Vermont Board of Medical Practice received notification that Respondent was engaging in concerning prescribing practices. On or about that time, the Board also received information that Respondent had forged a colleague's name on a prescription for controlled substances he wrote for his housemate. The Board opened this matter and assigned it to the Central Investigative Committee of the Board ("the Committee) for further investigation.

6. While this matter was under investigation, Respondent entered into a Cessation of Practice Agreement with the Board on November 6, 2019. Pursuant to that agreement, he agreed to cease and desist immediately from the practice of medicine in Vermont and not to seek to renew his DEA license to prescribe controlled substances, which he surrendered on October 15, 2019.

7. The Committee conducted an extensive investigation of Respondent's prescription practice for patients receiving controlled substances. This investigation included, but was not limited to, the review of medical records and prescribing histories for nine patients prescribed controlled substances by Respondent, hereafter Patients 1-9. The Committee also reviewed evidence that Respondent falsified a prescription for Patient 1. The Committee's findings regarding these patients include the practice concerns which follow.

8. Respondent treated Patient 1 for chronic pain, seizure disorder, Attention Deficit Disorder, and substance abuse. Respondent prescribed Patient 1 numerous medications during this course of treatment including opioids, benzodiazepines, and the medications methylphenidate and zolpidem at high dosages. In addition, Patient 1 lived at Respondent's home for a three-month period in the fall of 2019.

9. Respondent began prescribing opiates to Patient 1 in July 2018 at a daily morphine milligram equivalent ("MME") of 25-30. Three months later, Respondent increased that dose to 120 MME with no note or documentation in Patient 1's medical record. Respondent also failed to prescribe naloxone to Patient 1 when he increased the opioid dosage. The Vermont Department of Health Rule Governing the Prescribing of Opioids for Pain effective July 1, 2017 includes a requirement that providers prescribe naloxone for patients receiving an MME that exceeds 90, or opioids with a concurrent prescription for a benzodiazepine.[2] Naloxone (also known as Narcan) is required for these patients due to the increased risk of patient aspiration or overdose at higher MMEs or when the patient is prescribed concurrent opioid and benzodiazepine medications.

[2] The Vermont Department of Health Rule Governing the Prescribing of Opioids for Pain was amended on March 1, 2019, but this requirement is still included in section 7.1 in the current version of the Rule.

10. In May of 2019 Respondent increased Patient 1's daily MME to 300 without any monitoring procedures in place for this prescription such as urine drug screens or pill counts. Thereafter, Respondent began to taper Patient 1 down to an MME of 90.

11. In September of 2019 Respondent prescribed the benzodiazepine clonazepam for Patient 1 over the phone. This prescription was initiated without documentation of patient counseling or an office note. Respondent also failed to initiate a naloxone prescription for Patient 1 at this time as required by Vermont Department of Health Rule Governing the Prescribing of Opioids for Pain.

12. On September 9, 2019 Respondent was confronted by the managing practitioner at Convenient Medical Care regarding his concerning prescribing practices for multiple patients. Respondent chose to resign in lieu of termination.

13. Shortly thereafter, on September 17, 2019, Patient 1 was discharged from Convenient Medical Care due to belligerent behavior during a medical appointment.

13. On September 19, 2019, a woman dropped off a Ritalin prescription for Patient 1 at a local pharmacy. The prescription purportedly bore the signature of the managing practitioner at Convenient Medical Center who had confronted Respondent about his prescribing issues ten days prior. The pharmacy noted irregularities with this signature and contacted investigators about a potential fraudulent prescription. Thereafter, investigators showed the prescription to the practitioner who had purportedly signed it and she confirmed the signature was not hers. She identified the writing on the prescription as similar to Respondent's.

14. Investigators questioned Respondent about whether he wrote the fraudulent prescription. Respondent denied writing it and ascribed the false prescription to Patient 1. He

reported that Patient 1 was a friend that sometimes stayed with him at his residence. According to Respondent, Patient 1 found prescription pads from his former employer Convenient Medical Center while at Respondent's residence and used one of those prescribing pads to forge the prescription.

15. Investigators compared the handwriting on the prescription at issue with the handwriting of both Patient 1 and Respondent. They observed that it had a greater resemblance to Respondent's handwriting and decided to question Respondent again on October 15, 2019. During this interview, Respondent provided more information about his relationship with Patient 1. He disclosed that Patient 1 had been a "bad influence" on him, Patient 1 resided at his residence for the last three months, and he had loaned Patient 1 $7,000. Respondent also later claimed that as his relationship with Patient 1 progressed, Patient 1 began to intimidate Respondent into prescribing him increasingly stronger medication.

16. Respondent further admitted to investigators that he wrote three prescriptions on Patient 1's behalf for Ritalin, Percocet, and gabapentin, and forged his former colleague's signature on them. These prescriptions were part of a plan devised by Patient 1 and another of Respondent's former patients to fill the prescriptions and sell the drugs for money. Respondent admitted to participating in this enterprise with his former patients but expressed that he had done so with ambivalence - claiming he argued with Patient 1 about the plan and later purposely left the diagnosis code portion of the prescriptions blank to signal to the pharmacy that they were fake.

17. In addition to the prescribing issues above, there were concerning prescribing practices noted for the other patients whose care was reviewed by the Committee. One of these patients was Patient 2, a clinician with whom Respondent had a professional relationship and

who had previously prescribed controlled substances to Respondent from November 2017 until April 2018. Patient 2's diagnoses included Attention Deficit Disorder and hypertension. From December 2018 until August 2019, Respondent prescribed Patient 2 the stimulant medications Vyvanse and Dextro-Amphetamine.

18. Patient 2's prescriptions sometimes lasted longer than the prescribed duration which raises the concern that Patient 2 was not taking the medications every day and a lesser dosage may have been appropriate.

19. Respondent created no medical records regarding his medical treatment for Patient 2. He had no controlled substance agreement with Patient 2, nor is there evidence he engaged in clinical monitoring of these prescriptions.

20. Another instance of concerning patient care occurred during Respondent's treatment of Patient 3, a thirteen-year-old high school student whose initial appointment on March 28, 2019, was for a high school sports physical. Respondent's documentation for this appointment is sparse. He notes no patient history regarding routine questions for adolescents such as menstruation, depression, body image, diet, or alcohol and nicotine use, nor does he document any parental concerns. Respondent cleared Patient 3 to play sports with no restrictions and stated she should have a follow up appointment in six months.

21. Five days later on April 2, 2019, Respondent began to prescribe Patient 3 methylphenidate. Respondent's medical records from the March 28th visit include no corresponding diagnosis justifying this prescription or mention of this medication, nor is there any mention of any counseling about the medication's potential side effects or risk and benefits

with either Patient 3 or her parents. There is no documentation of an office visit on April 2, 2019.[3]

22. Respondent prescribed refills of Patient 3's methylphenidate in May, June, July and August of 2019 without any documented medical appointments. On July 19, 2019, Respondent doubled Patient 3's methylphenidate dose to 10 mg twice a day without any medical record documenting the reason for this dosage increase.

23. There were multiple commonalities in Respondent's prescribing issues for the remaining patients, Patients 4-9. Those issues are documented below by theme with specific examples included as follows:

a. **Poor prescribing decisions**; Examples of this issue include Respondent's decision to prescribe Percocet to Patient 6, a patient with a pre-existing opioid use disorder. This concerning prescribing was compounded by Respondent's lack of clinical monitoring to ensure Patient 6 was taking the Percocet as prescribed. Respondent also showed poor clinical judgment when prescribing high dosages of multiple sedating medications to Patient 9 who had liver disease and sleep apnea. In addition, Respondent engaged in unsafe prescribing practices when he prescribed lorazepam at high dosages for Patient 5 who was also consuming alcohol in significant quantities and taking Suboxone. This polypharmacy put Patient 5 at risk of side effects such as aspiration, falls, and trauma.

b. **Failure to engage in appropriate screening or clinical evaluation prior to prescribing an initial opioid dosage**; Per Vermont Department of Health Rule Governing the

[3] Patient 3 has an Individualized Education Plan dated January 31, 2019 that does not mention an issue with Attention deficit hyperactivity disorder (ADHD), or concerns about distractibility or inattention. It also states that Patient 3's behavior does not impede her learning.

Prescribing of Opioids for Pain, section 6.1, Respondent should have engaged in a medical evaluation and a risk assessment prior to writing his initial prescription for an opioid for Patient 8, a patient with chronic pain from multiple sources.

c. **Failure to follow up on aberrant test results**; Respondent failed to perform proper clinical follow up for Patient 4, a patient with chronic pain and opioid dependence, after a urine drug screen showed the presence of non-prescribed amphetamines in Patient 4's urine.

d. **A lack of medical documentation to support clinical decision-making as well as missing or absent documentation for medical encounters**; There are multiple examples of serious documentation omissions in Respondent's recordkeeping that include:

- Respondent's medical documentation for Patient 4 contains a complete lack of documentation to justify the prescription of controlled substances for this patient including opioids and benzodiazepines as well as an absence of records for any of Respondent's appointments with this patient in the first half of 2018.
- Respondent prescribed lorazepam at high dosages to Patient 5, a patient taking Suboxone who also had significant alcohol consumption, without sufficient documentation to explain his clinical decision-making given the risks to the Patient's safety from this polysubstance use.
- Respondent increased Patient 6's Percocet dosage in August and September 2019 but failed to include documentation to support this medication increase.
- Respondent prescribed opioids to Patient 7 starting at 30 MME in escalating dosages up to 135 MME over a seven-month period with no notes of documentation in the medical record and no clinical monitoring.

- Respondent's recordkeeping for Patients 8 and 9 suffers from deficiencies including a lack of documentation for visits at which dosage increases occurred, inadequate decision-making explaining his rationale for prescribing opioids, and inadequate clinical monitoring.

e. **Failure to prescribe naloxone when required**; Respondent failed to prescribe naloxone when required by the Vermont Department of Health Rule Governing the Prescribing of Opioids for Pain for both Patient 4, for whom he prescribed an opioid and a benzodiazepine, and for Patient 7, for whom he prescribed opioids at an MME of 135.

CONCLUSIONS OF LAW

24. The Board may find "that failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct." 26 V.S.A. § 1354(b). "Failure to practice competently includes, as determined by the board... (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standards of acceptable and prevailing practice." 26 V.S.A. § 1354(b)(1) and (2).

25. Respondent failed to conform to the essential standards of acceptable and prevailing practice in his care of Patients 1 – 9. As detailed above, the problematic aspects of his practice included prescribing decisions that were not sufficiently supported by his medical documentation - and in some instances were not in accordance with the Vermont Department of Health Opioid Rule - and inadequate or absent clinical monitoring to ensure where warranted that his prescriptions were taken as prescribed. This is additionally concerning because

Respondent also demonstrated a significant lack of professional boundaries in his relationships with patients as was the case with Patients 1 and 2.

26. The Board may also find unprofessional conduct when there is "gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions, that degree of care, skill, and proficiency that is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred." 26 V.S.A. § 1354(a)(22).

27. Respondent committed a gross failure to exercise that degree of care, skill, and proficiency when he prescribed stimulants to Patient 3, a thirteen-year-old, without documentation of any decision-making justifying that prescription. At a minimum Respondent should have documented consultation and decision-making with this patient's parents and teachers, and ideally would have consulted with behavioral health/mental health counselors as well. After issuing Patient 3's stimulant prescription, Respondent was also responsible for scheduling and documenting regular office visits to evaluate the effect of the medication, review feedback from educators, and assess whether the patient was experiencing side effects; those visits, if they occurred, are absent from Patient 3's records.

28. The Board may also find that conduct that "evidences unfitness to practice medicine" is unprofessional conduct. 26 V.S.A. § 1354(a)(7).

29. Respondent engaged in conduct that constitutes unfitness to practice medicine when he forged a colleague's signature on Patient 1's prescription for a controlled substance, and in his initial conversations with investigators attributed that forgery to Patient 1.

30. Consistent with Respondent's cooperation with the Board, he agrees that if the State were to file charges against him it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. § 1354(a)(7), (a)(22) and § 1354(b)(1) and (2).

31. Respondent agrees that the Board will enter as its facts and conclusions in this matter Paragraphs 1 through 37 herein, and further agrees that this is an adequate basis for the Board's Order. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

32. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into this instant agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; he has concluded that this agreement is acceptable and in the best interest of the parties.

33. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of his own to contest any allegations by the State.

34. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be resolved by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

35. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this agreement, none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall be kept in strict confidence. And it shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

36. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to the Federation of State Medical Boards Board Action Databank and the National Practitioner Data Bank. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

37. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

ORDER

WHEREFORE, based on the foregoing and the consent of Respondent, the Board enters as its facts and conclusions in this matter Paragraphs 1 through 37 above, it is hereby ORDERED that:

1. Respondent shall be REPRIMANDED for the conduct above.

2. Upon Board approval of this Stipulation, Respondent is hereby relieved from the Cessation of Practice Agreement that went into effect on November 6, 2019, but upon approval of the stipulation, by agreement of the parties Respondent's license will thereupon be revoked on a permanent basis.

SIGNATURES

Dated at Chelsea, Vermont, this 19th day of July, 2021.

STATE OF VERMONT
THOMAS J. DONOVAN, JR.
ATTORNEY GENERAL

by: E-SIGNED by Megan Campbell on 2021-07-19 08:56:00 EDT

Megan Campbell, Esquire
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, VT 05609-1001

Dated at Queensbury, New York, this ____ day of July, 2021.

E-SIGNED by Edward Durling on 2021-07-19 09:39:00 EDT

Edward Peter Durling, PA-C
Respondent

AS TO EDWARD PETER DURLING, PA-C
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Signed on Behalf of the Vermont Board of Medical Practice

By: _____
Richard Bernstein MD
Chair
Vermont Board of Medical Practice

Vote documented in the Vermont Board of Medical Practice meeting minutes, dated **August 4, 2021.**

Dated: **August 4, 2021**