**STATE OF VERMONT**
**BOARD OF MEDICAL PRACTICE**

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| In re: Patty A. Thornton, PA-C | ) | Docket Nos. MPN 022-0219 & MPN 057-0519 |

**STIPULATION AND CONSENT ORDER**

NOW COME Patty A. Thornton, PA-C and the Vermont Board of Medical Practice and stipulate and agree as follows:

1. Patty A. Thornton, PA-C ("Respondent") holds Vermont medical license number 055.0030838 and was first licensed by the Vermont Board of Medical Practice ("Board") on October 5, 1996. Respondent is a physician assistant.

2. Jurisdiction in this matter vests with the Vermont Board of Medical Practice pursuant to 26 V.S.A. §§ 1353-1354, 1370-74, 1731-1739 and 3 V.S.A. §§ 809-814, and other authority.

**Findings of Fact**

3. Respondent has been a physician assistant for 25 years. She currently practices at All Dimensions Primary Care in Rutland, Vermont.

4. The Board opened docket number MPN 022-0219 in February 2019 after it received information that Respondent may be prescribing controlled substances inappropriately.

5. The Board opened docket number MPN 057-0519 in May 2019 after it received a complaint that Respondent had been terminated from employment because her medical records were untimely and inaccurate. The complaint alleged that Respondent's patient records did not document basic information such as the condition for which the patient was being treated and prescribed medication. The Board assigned the investigation of both matters to the North Investigative Committee ("Committee").

6. The Committee's investigation included, but was not limited to, the review of medical records and prescribing histories of four patients (hereinafter referred to as Patients 1-4) to whom Respondent prescribed controlled substances, Vermont Prescription Monitoring System records, and other information. All four patients were treated by Respondent for chronic pain, among other chronic conditions.

7. The Committee's investigation identified practice concerns and deficiencies related to Respondent's prescribing of controlled substances and medical recordkeeping.

8. Respondent produced 460 pages of records related to her care of Patient 1. The records document care Respondent provided between August 7, 2014 and March 27, 2019. 178 pages of the records were incomplete, lacked documentation of the care provided by Respondent, or were not signed by Respondent. Those records are dated between October 7, 2014 and January 11, 2019.

9. Respondent began treating Patient 1 on August 7, 2014. The note of Patient 1's initial visit with Respondent noted diagnoses of depression, anxiety disorder, chronic interstitial cystitis, chronic pain, and chronic headaches, among others.

10. Patient 1's current medications at that visit included duloxetine ("Cymbalta"), clonazepam (Klonopin), methylphenidate (Ritalin), and methadone. Patient 1's methadone prescription directed Patient 1 to take 10 mg, nine times per day as needed. The daily morphine milligram equivalent ("MME") of the prescription was 270 MME.

11. On August 26, 2014, Respondent increased Patient 1's methadone prescription to 30 mg four times per day for 360 MME and maintained the dosages of other medications she prescribed. Patient 1's medical records do not document the reason Respondent increased her

methadone prescription. Respondent continued to prescribed Patient 1 methadone with a daily MMD of 360 until her employment was terminated on April 12, 2019.

12. On May 16, 2017, Patient 1's drug screen was positive for a codeine, a medication not prescribed to her. In addition, Patient 1 reported that her dog ate her Ritalin prescription. Respondent warned Patient 1 that her methadone prescription would be discontinued if she had another positive drug screen. Respondent further stated that she would conduct random drug screens and routine pill counts at every appointment. However, Patient 1's medical records do not contain any documentation of Respondent doing either.

13. On June 1, 2017, Patient 1's drug screen was positive for cocaine. Respondent did not begin to taper Patient 1's methadone as she warned she would on May 16. Instead, Respondent again warned Patient 1 that her methadone prescription would be discontinued if she had another positive random drug screen.

14. Respondent did not review Patient 1's controlled substance treatment agreement with her every 365 days and document the review in her medical records in the years 2015, 2016, 2017, 2018, and 2019.

15. Although Respondent prescribed Patient 1 a benzodiazepine (clonazepam) and methadone with a daily MME of 360 concurrently for over four years, she did not prescribe her naloxone or document in her medical record that she had a prescription for naloxone in 2017, 2018, or 2019.

16. Respondent produced 487 pages of records of her care of Patient 2. The records document the care Respondent provided between September 9, 2014 and January 1, 2019. 272 pages of the records were incomplete, lacked documentation of the care provided by Respondent,

or were not signed by Respondent. These records are dated between September 9, 2014 and March 27, 2019.

17. Respondent began treating Patient 2 on September 9, 2014. The note of Patient 2's initial visit with Respondent noted diagnoses of hypothyroidism, lumbar stenosis, chronic wrist pain, chronic pain disorder, hypothyroidism, and chronic obstructive pulmonary disorder.

18. Patient 2's current medications at that visit included MS Contin 30 mg three times per day, morphine 15 mg once per day, Lyrica, and other medications. The daily MME of Patient 2's MS Contin and morphine prescriptions was 135.

19. On January 14, 2015, Respondent added a prescription for 4 mg hydromorphone six times per day. The daily MME of that prescription was 96. Combined with Patient 2's MS Contin and morphine prescriptions, the total MME of her prescriptions was 231.

20. Respondent did not receive a signed informed consent for the hydromorphone prescription from Patient 2 prior to writing the prescription.

21. Respondent did not review Patient 2's controlled substance treatment agreement with her every 365 days and document the review in her medical records in the years 2015, 2016, 2017, 2018, and 2019.

22. Although Respondent prescribed Patient 2 MS Contin, morphine and hydromorphone with a daily MME exceeding 90 for over four years, she did not prescribe her naloxone or document in her medical record that she had a prescription for naloxone in 2017, 2018, or 2019.

23. Respondent produced 412 pages of records of her care of Patient 3. The records document care Respondent provided between August 26, 2014 and March 25, 2019. 82 pages of the records were incomplete, lacked documentation of the care provided by Respondent, or were

not signed by Respondent. Those records are dated between October 29, 2014 and March 6, 2019.

24. Respondent began treating Patient 3 on or about August 26, 2014 and prescribed her nambumetone, MS Contin ER 60 mg twice per day, and morphine IR 15 mg six times per day for a daily MME of 210. However, there is no record of Patient 3's visit with Respondent or the diagnoses for which she prescribed the medication. Subsequent records indicate that Respondent was treating Patient 3 for chronic obstructive pulmonary disorder, depression, chronic pain syndrome, and other conditions.

25. The earliest record of Patient 3 visiting Respondent is dated October 29, 2014 when she presented for a medication refill and Respondent prescribed her acetaminophen-hydrocodone (Vicodin) 325/7.5 two tabs every four hours, MS Contin ER 60 mg twice per day, and Morphine IR 15 mg six times per day for a daily MME of 270. The record does not document a diagnosis, the care Respondent provided at that visit, or the reason she prescribed additional opioid medication to Patient 3.

26. A note in Patient 3's record indicates that she transferred to a different provider and Respondent prescribed a narcotic taper on March 3, 2015. However, on November 2, 2015, Respondent prescribed Patient 3 morphine ER 30 mg three times per day, morphine IR 15 mg three time per day, Cymbalta, and other medications. Patient 3's medical records do not document that she conducted a medical evaluation and physical examination before prescribing the opioid medication, the diagnosis for which she was prescribing, and a risk assessment of Patient 3's potential for misuse, abuse, diversion, addiction, or overdose.

27. Respondent did not document in Patient 3's chart that she received a signed informed consent for the opioid prescriptions from Patient 3 prior to writing the prescriptions.

28. On November 30, 2015, Respondent prescribed Patient 3 alprazolam (Xanax) 1 mg four times per day.

29. Respondent continued to prescribe opioid medication and Xanax to Patient 3 until March 25, 2019. Respondent's final prescriptions to Patient 3 were for morphine ER 30 mg three times per day, morphine 15 mg three times per day, MS Contin ER 15 mg at bedtime, and Xanax 1 mg four times per day. The daily MME of the opioid prescriptions was 150.

30. Respondent did not review Patient 3's controlled substance treatment agreement with her every 365 days and document the review in her medical records in the years 2015, 2016, 2017, 2018, and 2019.

31. Although Respondent prescribed Patient 3 morphine with a daily MME exceeding 90 concurrently with a Xanax for over three years, she did not prescribe her naloxone or document in her medical record that she had a prescription for naloxone in 2017, 2018, or 2019.

32. Respondent produced 593 pages of records of her care of Patient 4. The records document care Respondent provided between August 26, 2014 and March 18, 2019. 245 pages of the records were incomplete, lacked documentation of the care provided by Respondent, or were not signed by Respondent. These records are dated between March 19, 2015 and March 18, 2019.

33. Respondent began treating Patient 4 on or about March 18, 2015 and prescribed her Xanax 1 mg three times per day, oxycodone 30 mg four times per day, and morphine ER 60 mg twice per day. The opioid prescriptions had a daily MME of 240. However, the record of that visit is incomplete, unsigned by Respondent, and does not include information such as the diagnoses for which she prescribed the medication. Subsequent records, though also incomplete, indicate that Respondent was treating Patient 4 for PTSD, anxiety, chronic pain, migraine, and other conditions.

34. Respondent also prescribed hydromorphone to Patient 4 in addition to her other opioid medications on two occasions. She prescribed Patient 4 hydromorphone 2 mg every six hours on September 1, 2015, and hydromorphone 4 mg every four to six hours on November 12, 2015. Respondent did not receive a signed informed consent for the hydromorphone prescription from Patient 4 prior to writing the prescription and document it in her medical records.

35. Respondent continued prescribing Patient 4 Xanax, oxycodone, and morphine at the same dosages and frequency until she stopped treating her in March 2019.

36. Respondent did not review Patient 4's controlled substance treatment agreement with her every 365 days and document the review in her medical records in the years 2016, 2017, 2018, and 2019.

37. Although Respondent prescribed Patient 4 oxycodone and morphine with a daily MME exceeding 90 concurrently with Xanax for over three years, she did not prescribe her naloxone or document in her medical record that she had a prescription for naloxone in 2017, 2018, or 2019.

38. On March 25, 2021, the Committee requested that Respondent take a continuing medical education course "PROBE: Ethics & Boundaries" conducted by the Center for Personalized Education for Physicians ("CPEP") and submit a written report to the Committee after completing the course describing what she learned and how she will apply that knowledge to her practice.

39. Respondent agreed, completed the course, and submitted a written report as requested by the Committee. However, on July 24, 2021, CPEP advised that Respondent had earned the grade of "Fail" for the PROBE Program.

**Conclusions of Law**

40. The Board may find that "failure to comply with provisions of … State statutes or rules governing the practice of medicine or surgery" constitutes unprofessional conduct. 26 V.S.A. § 1354(a)(27).

41. A prescriber shall "conduct and document a thorough medical evaluation and physical examination as part of the patient's medical record when prescribing opioids for chronic pain." See Vermont Department of Health's Rule Governing the Prescribing of Opioids for Pain § 6.1.1.[1]

42. When prescribing opioids for chronic pain, prescribers are also required to review the patients' controlled substance treatment agreements "no less frequently than once every 365 days to reevaluate the patient. These reviews shall be documented in the patient's medical record." See Vermont Department of Health ("VDH") Rules Governing the Prescribing of Opioids for Pain § 6.4.1 (2017); see also VDH Opioid Prescribing Rule § 7.1 (2015).

43. Prior to prescribing a dose of opioids or combination of opioids, the prescriber must document in the patient's medical records a reevaluation of the effectiveness and safety of the patient's pain management plan, the potential for the use of non-opioid and non-pharmacological alternatives for treating pain, a functional examination of the patient, and a

[1] Unless otherwise noted, references to the Vermont Department of Health Rules Governing the Prescribing of Opioids for Pain refer to the rules effective July 1, 2017. Provisions such as this one, which were also present in the prior version of the Rule effective August 1, 2015, will be so noted. See Section 4.1 of the Rule Governing the Prescribing of Opioids for Chronic Pain effective August 1, 2015.

review of the patient's controlled substance treatment agreement and informed consent. See VDH Opioid Prescribing Rule § 6.4.2 (2017); VDH Opioid Prescribing Rule § 7.2 (2015)[2]

44. When a patient receives a daily opioid prescription that exceeds 90 MME, the prescriber must co-prescribe naloxone (Narcan). A prescriber must also prescribe naloxone for a patient prescribed opioids and a concurrent benzodiazepine prescription. See VDH Opioid Prescribing Rule §§ 7.1-7.2 (2017).

45. Respondent acknowledges that if this matter were to proceed to a contested hearing, the State could prove that she did not follow all the applicable VDH Opioid Prescribing Rules, constituting non-compliance with Vermont state statutes and rules of practice by:

a. failing to document a thorough medical evaluation and physical examination of Patients 1-4 as part of their medical records when prescribing opioids for chronic pain;

b. failing to document her review of the controlled substance treatment agreements for Patients 1-4 at least once every 365 days;

c. failing to document in the medical records of Patients 1-4 a reevaluation of the effectiveness and safety of the patient's pain management plan, the potential for the use of non-opioid and non-pharmacological alternatives for treating pain, a functional examination of the patient, and a review of the patient's controlled substance treatment agreement and informed consent before she prescribed them opioids; and

d. failing to prescribe Patients 1-4 naloxone in 2017, 2018, and 2019.

[2] The 2017 VDH Rule Governing the Prescribing of Opioids for Pain applied to prescriptions with a daily MME greater than 90. The 2015 Rule applied to prescriptions with a daily MME greater than 120. Respondent's opioid prescriptions for Patients 1-4 all exceeded 120 MME.

46. Consistent with Respondent's cooperation with the Board, she acknowledges that if the State were to file charges it could satisfy its burden at a hearing and a finding adverse to her could be entered by the Board, pursuant to 26 V.S.A. § 1354(a)(27).

47. Respondent agrees that the Board may enter as its facts and/or conclusions in this matter any one or more of Paragraphs 1 through 46 above, and further agrees that this is an adequate basis for the Board actions set forth herein. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

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

49. Respondent agrees and understands that by executing this document she 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 her own to contest any allegations by the State.

50. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matters shall be closed 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.

51. This Stipulation and Consent Order is conditioned upon its acceptance by the Board. 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, she

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.

52. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in her 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.

53. 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, it is hereby ORDERED that:

Respondent's medical license shall be CONDITIONED as follows:

1. No later than one year from the date of approval of this Stipulation and Consent Order, Respondent shall successfully complete comprehensive continuing medical education ("CME") courses that address: (a) ethics and professionalism; and (b) medical record keeping.

Respondent shall seek prior approval, in writing, from the Committee for the CME courses. The courses must be live, in-person courses or live, interactive courses offered remotely. Upon successful completion of the CME courses, Respondent shall provide the Committee with proof of attendance. Respondent shall also provide the Committee with brief written narratives of the CME courses that document what she learned from the courses and how she will apply that knowledge to her practice. Respondent shall provide proof of attendance and the written narratives to the Committee within 30 days of completion of each course. Respondent shall be solely responsible for all costs associated with the CME courses.

2. Respondent shall retain the services of a "practice monitor" for a minimum of three years, subject to the terms and conditions set forth in the attached "Practice Monitoring Agreement," which is incorporated by reference and attached hereto as Exhibit A. The three-year practice monitoring requirement will not begin until the official "start date" as defined in the attached Practice Monitoring Agreement. Respondent shall comply with the terms and obligations of the Practice Monitoring Agreement. Respondent shall provide a copy of this Stipulation to the practice monitor. Respondent shall be responsible for ensuring that the practice monitor complies with the terms and obligations of the Practice Monitoring Agreement. The practice monitoring requirement shall not cease until the Committee has approved, in writing, Respondent's written request to end the monitoring. Respondent shall be solely responsible for all costs associated with the practice monitor. Respondent shall be responsible for ensuring that the practice monitor's reports are timely submitted to the Committee.

## SIGNATURES

Dated at Burlington, Vermont, this 9 day of December, 2022.

Leo LeCours
Chair, North Investigative Committee
Vermont Board of Medical Practice

Dated at Rutland, Vermont, this 5th day of December, 2022.

Patty A. Thornton, PA-C

**APPROVED AS TO LEGAL FORM:**

Dated at Rutland, Vermont, this 5th day of December, 2022.

John J. Welch, Jr., Esq.
8 East Center Street
Rutland, VT 05701
Counsel for Respondent

Dated at Montpelier, Vermont this 5th day of December, 2022.

Kurt A. Kuehl Digitally signed by Kurt A. Kuehl Date: 2022.12.05 17:37:44 -05'00'

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**AS TO PATTY A. THORNTON, PA-C**
**APPROVED AND ORDERED**
**VERMONT BOARD OF MEDICAL PRACTICE:**

Signed on Behalf of the Vermont Board of Medical Practice:

By: 

Rick Hildebrant, M.D.
Chair, Vermont Board of Medical Practice

Vote documented in the Vermont Board of Medical Practice meeting minutes, dated January 4, 2023.

Dated: January 4, 2023.