STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Michael E. Scovner, M.D.	)	Docket No. MPN 50-0510

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont, by and through Attorney General William H. Sorrell and alleges as follows:

1. Michael E. Scovner, M.D. ("Respondent") holds medical license number 042-0007746 issued by the Vermont Board of Medical Practice on June 21, 1988. Respondent practices internal medicine and pediatrics at his private medical office in Poultney, Vermont.

2. Jurisdiction in this matter vests with the Vermont Board of Medical Practice ("Board"), pursuant to 26 V.S.A. §§ 1353-57, 3 V.S.A. §§ 809-814, and other authority.

I. Background

3. The Board opened an investigation based upon a complaint filed on April 30, 2010, by Paul Fonteyn, President of Green Mountain College in Poultney, VT. Based on numerous conversations with his campus security personnel, students and others, Mr. Fonteyn believed that Respondent may be prescribing or dispensing medications for other than therapeutic purposes.

4. Board Investigator Philip Ciotti gathered prescription information from pharmacies and other sources to attempt to get a picture of the prescribing patterns for Respondent. Subsequently, Investigator Ciotti

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had a conversation with DEA Diversion Agent Christopher Paquette. Agent Paquette advised that he was interested in Respondent because he had received a report from Henry Schein Co. that Respondent was ordering Alprazolam (Xanax) in bulk quantities. Alprazolam is a DEA Schedule IV controlled substance, and therefor appropriate and accurate records of receipt and dispensation of this controlled substance must be maintained and readily retrievable at Respondent's office. This requirement is both a state and federal regulation. Investigator Ciotti and Agent Paquette agreed to conduct a joint investigation.

5. On May 10, 2011, Investigator Ciotti and Agent Paquette visited Respondent's office on Main Street in Poultney, Vermont. Agent Paquette asked Respondent about an order of 500 Alprazolam from Henry Schein Co. made on March 7, 2011. Respondent identified the order as being for one of his patients. The order, receipt and dispending of 500 Alprazolam, a controlled substance, was not appropriately recorded by Respondent as required by state and federal law. Respondent failed to have appropriate and accurate records of receipt and dispensation of the Alprazolam that were readily retrievable from his ordinary business records. Respondent also failed to maintain and record a biannual inventory of controlled substances in his office as required by federal law.

6. The electronic medical record for the patient dated April 19, 2011 had been amended in ballpoint pen indicating "XAM ordered" under the

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"present meds" heading. There was no indication as to the date when this amendment was made in the patient's record. Respondent advised that the amendment was made after the patient's visit on April 19, 2011, but he did not know when.

7. During the conversation with Respondent on May 10, 2011, Ciotti asked Respondent if he ever used VPMS (Vermont Prescription Monitoring System) to inquire if any his patients were getting medications from any other medical providers. Respondent stated that he had called and emailed the Department of Health in the past and could not get registered. Respondent said, "no one ever got back to me, I couldn't get in."

8. Investigator Ciotti served Respondent with two subpoenas for records of selected patients. Respondent was able to provide some complete patient charts, but some records were not available at that time.

9. On May 12, 2011, Respondent had a telephone conversation with Investigator Ciotti during which Investigator Ciotti reminded Respondent that they were still waiting for subpoenaed records.

10. On August 25, 2011, Investigator Ciotti returned to Respondent's office with another subpoena. Investigator Ciotti informed Respondent that they were still waiting for the balance of the patient charts that had been previously subpoenaed.

11. Although Respondent eventually responded to the subpoenas, it is unclear whether Respondent fully complied and produced all records requested

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in the subpoenas.

II. Respondent's Treatment of Patients A-N

Patient A

12. Respondent treated Patient A for pain in her back, neck and legs during the time period from August of 2009 until August of 2011. Respondent wrote approximately 54 prescriptions for opioid analgesics, Percocet 10/325 mg, one prescription for Oxycodone, and three prescriptions for Xanax during this time period.

13. The records from Respondent's treatment of Patient A did not contain any evidence that Respondent obtained and/or documented an adequate, comprehensive history regarding Patient A. There was also no evidence that Respondent obtained information from Patient A as to whether: she had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether she had risk factors for opioid abuse, misuse, diversion or addiction.

14. During Respondent's treatment of Patient A, Respondent never documented that Patient A suffered from Hepatitis C, nor did he document discussing this condition with her.

15. During Respondent's treatment of Patient A, Respondent increased dosages and began prescribing Patient A's opioid medications on a biweekly rather than weekly basis without any mention in the medical records of why this was necessary.

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16. Respondent's office note records were devoid of evidence that he conducted and/or documented an adequate and comprehensive physical examination of Patient A. Further, there is no documentation indicating that Respondent conducted a motor exam, sensory exam, or examination of her deep tendon reflexes.

17. The records of Respondent's treatment of Patient A were devoid of any specific diagnoses of Patient A's medical conditions.

18. During Respondent's treatment of Patient A, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance; which would include pill counts and urine toxicology specimens.

19. There was no evidence in Patient A's medical records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens.

20. There was no evidence in the medical records that Patient A benefitted from the treatment in any way as her pain scores were always documented as a 9/10 out of a 0-10 scale. There was no documentation of any objective findings to support the continued need to prescribe opioid medications.

21. There was no documentation in the medical records that Respondent discussed the risks and benefits of the use of opioids with Patient A, and there was no evidence of written informed consent with regard to the

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use of opioids.

22. During Respondent's treatment of Patient A, there was no documentation of treatment plans or objectives, and there were no periodic reviews performed.

23. There was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient A.

24. During Respondent's treatment of Patient A, Respondent did not use the Vermont Prescription Monitoring System in connection with his treatment of Patient A.

25. Respondent's sparse handwritten office notes concerning his treatment of Patient A are, for the most part, illegible.

Patient B

26. Respondent treated Patient B from approximately September 2009 until April 2011. During that time Respondent wrote approximately 25 prescriptions for Percocet 7.5/32 mg for Patient B. There was a gap in his prescribing between June 10, 2010 and December 17, 2010, which was unaccounted for in the records.

27. The records for Patient B indicated a diagnosis of "neck pain." There was no other information regarding the diagnosis or specific medical condition for Patient B's neck in Respondent's office records. There were records of cardiology consults dated February 2, 2010 and March 17, 2010 indicating that Patient B had a "fractured neck."

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28. There was no evidence in the entire medical record that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient B during the approximately 26 office visits.

29. During Respondent's treatment of Patient B, Respondent did not document that he obtained an adequate, comprehensive history regarding Patient B. There was also no evidence that Respondent obtained information from Patient B as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid abuse, misuse, diversion or addiction.

30. During Respondent's treatment of Patient B, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

31. There was no evidence in Patient B's medical records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens.

32. There was no documentation in the medical records that Respondent discussed the risks and benefits of the use of opioids with Patient B, and there was no evidence of written informed consent with regard to the use of opioids.

33. During Respondent's treatment of Patient B, there was no documentation of treatment plans or objectives, and there were no periodic reviews performed.

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34. The opioid agreement in the record signed by Patient B was undated and did not conform with what would be considered the standard of care for opioid agreements. The only requirement in this undated opioid agreement is that the patient will be subject to random pill counts. However, the agreement provides that the patient is given the option to refuse the first pill count request. There are no additional terms to Respondent's opioid agreement.

35. During Respondent's treatment of Patient B, there was no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient B.

36. Respondent's sparse handwritten office notes regarding his treatment of Patient B are, for the most part, illegible.

Patient C

37. Respondent treated Patient C from September 2009 until 2011. Patient C was a 20-year-old college student when he began to receive treatment from Respondent. During his treatment of Patient C, Respondent prescribed Vicodin, a narcotic pain medicine, and Xanax. Patient C complained variably of back pain, neck pain, abdominal pain and other pains.

38. On December 13, 2010 Respondent prescribed to Patient C 50 tablets of Vicodin 10/325 mg with no refills. On December 15, 2010 Respondent again prescribed 30 tablets of Vicodin with five refills. There was no evidence in the medical records that Respondent had an office visit with

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Patient C on December 15, 2010. Within the span of two days Respondent prescribed a total of 200 tablets of Vicodin to Patient C. On January 17, 2011 Patient C received a prescription from Respondent for 50 tablets of Vicodin with two refills.

39. During Respondent's treatment of Patient C, he did not obtain and/or document an adequate, comprehensive history regarding Patient C. There was also no evidence that Respondent obtained information from Patient C as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid abuse, misuse, diversion or addiction.

40. There was no evidence in the medical records that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient C.

41. The records of Respondent's treatment of Patient C were devoid of any specific diagnosis of Patient C's medical conditions.

42. There was no evidence in the medical record that Respondent ever evaluated Patient C for any of his pain conditions, or made a referral to a pain management specialist.

43. In April of 2009 Patient C reported to Respondent that his Xanax prescription had been taken from his room.

44. During Respondent's treatment of Patient C, there was no evidence that Respondent performed and/or documented adequate risk

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stratification or surveillance.

45. There was no evidence in Patient C's medical records that Respondent conducted and/or documented random pill counts. Respondent conducted one urine analysis of Patient C on December 13, 2010 that was positive for marijuana. Respondent did not note the results of the urine analysis in his office notes. Additionally, Respondent still prescribed 50 tablets of Vicodin on December 13, 2010, and on December 15, 2010 he gave Patient C a script for another 50 tablets of Vicodin with five refills.

46. During Respondent's treatment of Patient C, there was no documentation indicating that Respondent ever discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids.

47. During Respondent's treatment of Patient C, there was no documentation of treatment plans or objectives, and there were no periodic reviews performed.

48. There was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient C.

49. During Respondent's treatment of Patient C, there was no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient C.

50. Respondent's sparse handwritten office notes regarding his treatment of Patient C are, for the most part, illegible.

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Patient D

51. Respondent treated Patient D on approximately 10 occasions, and prescribed Vicodin 10/325 mg, 50 tablets with five refills, on those occasions. Patient D was noted to report stomach pain, back pain, shoulder pain, severe low back pain, and arthritis pain.

52. There was no evidence that Respondent ever obtained and/or documented an adequate, comprehensive history regarding Patient D. There was also no evidence that Respondent obtained information from Patient D as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid abuse, misuse, diversion or addiction.

53. Contained within Respondent's medical records of Patient D was a letter from January of 2009 from an attorney addressed to Patient D with regard to a potential claim on behalf of Patient D against an insurer regarding his Fentanyl withdrawal. Respondent did not document in Patient D's medical records that he was either taking Fentanyl, or had taken Fentanyl in the past.

54. There was no evidence in the medical records that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient D.

55. The records of Respondent's treatment of Patient D were devoid of any specific diagnoses of Patient D's medical conditions.

56. During Respondent's treatment of Patient D, there was no

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evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

57. There was no evidence in Patient D's records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens

58. During Respondent's treatment of Patient D, there was no documentation indicating that Respondent discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids.

59. During Respondent's treatment of Patient D, there was no documentation of treatment plans or objectives, and there were no periodic reviews performed.

60. There was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient D.

61. Respondent's sparse handwritten office notes regarding his treatment of Patient D are, for the most part, illegible.

Patient E

62. Respondent treated Patient E periodically from September 17, 2009 through July 6, 2012. There were nine office visits documented. During that time, Respondent prescribed Darvocet, Tramadol, and Xanax to Patient E. A July 2, 2012 office note indicates that Respondent prescribed Lunesta 2 mg, Celexa 20 mg, and Celebrex to Patient E. However, there were no

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corresponding scripts for such medications in Patient E's records.

63. On December 3, 2009, Respondent wrote Patient E a prescription for Darvocet N-100 with directions to take one tablet by mouth four times daily with a prescribed quantity of 360 tablets. In addition, Respondent wrote for five additional refills. This would have been an adequate supply of Darvocet to last for eighteen months.

64. Respondent wrote Patient E the same prescription for Darvocet on August 12, 2010, an interval of merely eight months since the December 3, 2009 prescription.

65. Respondent ordered a stock bottle of 500 Alprazolam (Xanax) from Henry Schein Co. on March 7, 2011, and then dispensed this medication to Patient E without proof that he maintained readily retrievable, appropriate records of receipt and dispensation of this controlled substance as required by federal and state law.

66. Respondent altered a note dated April 19, 2011 in Patient E's medical records without providing documentation that his addition to the note was added after the note had been created.

67. There was no evidence that Respondent ever obtained and/or documented an adequate, comprehensive history regarding Patient E. There was also no evidence that Respondent obtained information from Patient E as to whether: she had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether she had risk factors for opioid

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abuse, misuse, diversion or addiction.

68. There was no evidence in the medical records that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient E.

69. There was evidence of three office visits wherein Respondent provided the following diagnoses for Patient E: anxiety, depression, dyspnea on exertion, hiatal hernia, and abnormal pap smear. There were no legible diagnoses provided on the six remaining office visits in the record.

70. During Respondent's treatment of Patient E, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

71. There was no evidence in Patient E's medical records that Respondent conducted and/or documented any testing of urine toxicology specimens. There were notes alleging that Respondent's wife conducted at least one pill count while visiting Patient E at her home.

72. During Respondent's treatment of Patient E, there was no documentation indicating that Respondent ever discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of such medications.

73. During Respondent's treatment of Patient E, there was no documentation of treatment plans or objectives, and there were no periodic reviews performed.

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74. There was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient E.

75. The medical records did not contain any evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient E.

76. Respondent's sparse handwritten office notes regarding his treatment of Patient E are, for the most part, illegible.

Patient F

77. Between January of 2008 and May of 2011, Respondent prescribed Endocet to Patient F for migraine headaches. Respondent prescribed 100 tablets of Endocet to Patient F on a biweekly basis during the following time periods: all of 2008; 11 months in 2009; from January through April 27th in 2010; and from January through May 10th in 2011. Respondent also prescribed Flexeril and Xanax to Patient F.

78. Respondent reportedly had an informal consultation with Dr. Morris Levin at Dartmouth-Hitchcock Hospital concerning Patient F, but there was no evidence and/or documentation of such alleged consultation. Further, in a June 11, 2012 letter, Dr. Levin confirmed that he did not recall the nature of any discussions that he had with Respondent about Patient F, and did not meet Patient F or make any specific recommendations about his treatment.

79. There was no evidence that Respondent ever obtained and/or documented an adequate, comprehensive history from Patient F. Respondent

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did not document current or past medical treatment for his headaches, underlying or comorbid diseases or conditions, or the effect of headache pain on Patient F's physical or psychological functioning.

80. There was also no evidence that Respondent obtained information from Patient F as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid abuse, misuse, diversion or addiction.

81. The medical records were devoid of evidence that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient F prior to January of 2011.

82. During Respondent's treatment of Patient F, there was no evidence that Respondent performed and/or documented adequate risk stratification or surveillance.

83. In Patient F's medical records, there was evidence of a single urinalysis that was obtained on January 15, 2008. There were no other urinalysis or urine toxicology specimens documented before or after January 15, 2008. There was no evidence that Respondent conducted and/or documented any random pill counts.

84. During Respondent's treatment of Patient F, there was no documentation of treatment plans or objectives, and there were no periodic reviews performed.

85. There is an updated opioid agreement in Patient F's medical

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records that does not conform to the standard of care for opioid agreements. The only requirement in this undated opioid agreement is that the patient will be subject to random pill counts. However, the agreement provides that the patient is given the option to refuse the first pill count request. There are no additional terms to this opioid agreement.

86. There was no documentation in Patient F's medical records indicating that Respondent discussed the risks and benefits of the use of opioid therapy with him. There was no evidence of informed consent regarding the use of opioids prior to the opioid contract signed in April of 2012.

87. At no time during his treatment of Patient F did Respondent make and/or document a referral of Patient F to a specialist for the treatment of Patient F's migraine headaches.

88. During Respondent's treatment of Patient F, there was no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient F.

89. Respondent's sparse handwritten notes regarding his treatment of Patient F are, for the most part, illegible.

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Patient G

90. Respondent treated Patient G between 2009 and 2011. During this time, Respondent prescribed opioids, namely Vicodin, to Patient G on at least 14 occasions. Respondent also prescribed Xanax to Patient G.

91. Respondent prescribed 10mg Vicodin tablets with five refills at a time, and 2mg Xanax tablets with five refills at a time. The medical records did not contain an explanation for prescribing Vicodin and Xanax in this fashion.

92. The medical records indicated that Patient G variably suffered from back pain, neck pain, "whole body pain," "numerous disc herniations in the cervical and lumbar spine," neuropathy, anxiety, depression and panic attacks. Patient G's history was described by Respondent as "severe orthopedic and psychiatric problems."

93. Respondent made various notations in his office notes regarding Patient G's depression and anxiety. "Depression" was often noted as Patient G's chief complaint during office visits. On April 14, 2011, Respondent noted that Patient's G' "depression seems to be getting worse." On March 11, 2011, he noted that she is "not that interested in life," and is "having panic attacks."

94. Respondent did not document that he provided Patient G with any treatment for her mental health issues other than one prescription for Xanax on September 24, 2009. Respondent did not document that he referred Patient G to any mental health professionals. Respondent also did not document that he consulted with any mental health professionals with regard to Patient G's mental health issues.

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95. In Respondent's office note dated December 21, 2010, it was noted that Patient G suffered "severe withdrawal side effects from Xanax." However,

the medical records did not contain any treatment plan addressing Patient G's withdrawal symptoms, nor was there any other information regarding how the withdrawal may have occurred.

96. During Respondent's treatment of Patient G, he did not obtain and/or document an adequate, comprehensive history from Patient G. There was also no evidence that Respondent obtained information from Patient G as to whether: she had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether she had risk factors for opioid abuse, misuse, diversion or addiction.

97. There was no evidence in the medical records that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient G.

98. There was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient G.

99. The medical records of Respondent's treatment of Patient G were devoid of evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

100. There was no evidence in Patient G's medical records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens.

101. During Respondent's treatment of Patient G, there was no documentation indicating that Respondent ever discussed the risks and

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benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids.

102. The medical records of Respondent's treatment of Patient G did not include documentation of treatment plans or objectives, and there was no evidence of the performance of periodic reviews.

103. Respondent did not access the Vermont Prescription Monitoring System in connection with his treatment of Patient G.

104. Respondent's sparse handwritten notes regarding his treatment of Patient G are, for the most part, illegible.

Patient H

105. Respondent treated Patient H between 2009 and 2011. During that time, the medical records indicated that Respondent prescribed Vicodin 7.5/325 and 10/325 mg, 50 tablets at a time with five refills, to Patient H on multiple occasions.

106. Patient H had a variety of complaints including back pain, body pain, head pain, leg pains, chest pain, aching hands, elbow pain, arm pains, right foot pain, feet pain, wrist pain, and shoulder pain. There was no evidence that Respondent documented a definitive diagnosis, other than for osteoarthritis and hypothyroidism, in any of his office visit records. There was no clear documented basis for how these two diagnoses were made by Respondent.

107. During Respondent's treatment of Patient H, he did not obtain

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and/or document an adequate, comprehensive history from Patient H. There was also no evidence that Respondent obtained information from Patient H as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid abuse, misuse, diversion or addiction.

108. There was no evidence in the office visit notes that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient H.

109. During Respondent's treatment of Patient H, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance

110. There was no evidence in Patient H's medical records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens.

111. During Respondent's treatment of Patient H, there was no evidence in the medical records that he obtained a signed written opioid agreement.

112. Respondent's records of his treatment of Patient H were devoid of any documentation of treatment plans or objectives, and there were no periodic reviews performed.

113. Respondent did not engage and/or document a discussion of the risks and benefits of the use of opioids with Patient H, and there was no

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evidence of written informed consent with regard to the use of opioids.

114. There was no documentation that Respondent consulted with other medical providers with regard to Patient H's numerous complaints of pain.

115. Respondent did not access the Vermont Prescription Monitoring System in connection with his treatment of Patient H.

116. Respondent's sparse handwritten office notes regarding his treatment of Patient H are, for the most part, illegible.

Patient I

117. Respondent treated Patient I variably between 1997 and June 2012. During that time, Respondent prescribed Patient I Vicodin and Xanax, as well as Klonopin, on multiple occasions.

118. The medical records indicated that Patient I had a variety of pain complaints including "sore feet" and a dislocated shoulder, but there was no real indication as to what medical conditions the opioids and/or Xanax were being prescribed to treat until a June 21, 2012 office note which indicated that without the Xanax, "he gets into multiple fights and arguments." The records also noted that Patient I suffered from an anxiety disorder and severe anxiety. In the same note it was stated that Patient I, "takes opioids for severely sore feet."

119. During the 15 years of treatment of Patient I, Respondent did not obtain and/or document an adequate, comprehensive history regarding Patient

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I. There was also no evidence in the medical records that Respondent obtained information from Patient I as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid abuse, misuse, diversion or addiction.

120. There was no evidence in the numerous office visit notes that Respondent conducted and/or documented adequate, comprehensive physical examinations of Patient I.

121. During Respondent's treatment of Patient I, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

122. There was no evidence in Patient I's medical records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens.

123. During Respondent's treatment of Patient I, there was no documentation indicating that Respondent ever discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids.

124. Patient I's medical records and office visit notes kept by Respondent were devoid of documentation of treatment plans and objectives, and there were no periodic reviews performed. Additionally, Respondent failed to document any consultations with, or referrals to, mental health professionals concerning Patient I's potentially violent behavior despite

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referencing his multiple fights and arguments.

125. There was a written and signed "Drug Contract" in Patient I's medical record, but it is undated. Thus, there was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient I.

126. During Respondent's treatment of Patient I, there was no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient I.

127. Respondent's sparse handwritten office notes regarding his treatment of Patient I are, for the most part, illegible.

Patient J

128. Respondent treated Patient J variably between 2005 and 2012.

129. Patient J was diagnosed and treated for tongue cancer in 2002. She did not have surgery to treat her cancer, but rather underwent radiation therapy as her principal treatment. Patient J's oncologist, Dr. Eisemann, declared her to be cancer free in March of 2006. Yet, Respondent continued to prescribe very high doses of opioids to Patient J, including approximately 60 mg of Morphine Sulfate immediate release four times a day, 30 Duragesic Patches 125 mcg per month, Fentanyl 125 mcg 30 patches per month, and Xanax 1-2 mg through May of 2012. Respondent wrote approximately 187 prescriptions for these medications.

130. Patient J's medical records included a "Drug Contract" signed on

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April 30, 2012. There is another undated opioid agreement that is inadequate in its content, and does not conform to the standard of care for opioid agreements. The only requirement in this undated opioid agreement is that the patient will be subject to random pill counts. However, the agreement provides that the patient is given the option to refuse the first pill count request. There are no additional terms to this opioid agreement.

131. In November of 2006 Dr. Eisemann stated in an office visit note that Patient J's "use of narcotics is the central problem here." Dr. Eisemann's notes indicated that he did not have a good explanation for Patient J's ongoing pain, and that her doses of narcotics were "inappropriately high." Dr. Eisemann's office notes indicated that he offered Patient J treatment for her narcotic use, including psychiatric treatment, tapering of her medications and pain clinic referral; which were all "rejected vehemently." Dr. Eisemann expressed his concern about the long-term toxicity of the narcotics if Patient J continued to take the same high doses.

132. In December of 2008, Dr. Eisemann again noted in his office notes that Patient J was still being prescribed such high doses of narcotic medications, specifically referring to the Morphine Sulfate immediate release.

133. Despite the fact that Respondent had Dr. Eisemann's November of 2006 and December of 2008 office notes in Patient J's records, he continued to prescribe the same doses of narcotics to Patient J without any documented discussion with Patient J about such concerns. Respondent did not document

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any attempts to reduce Patient J's narcotic use, and he did not refer her for psychiatric treatment or pain clinics. Instead, Respondent continued to prescribe the narcotic medications to Patient J.

134. Patient J's medical records indicate that she had multiple medical issues including skin breakdown on her tailbone in May 2008. In November 2008, Patient J was seen by an ENT physician, and her evaluation was essentially normal except for a swallowing problem. Patient J had difficulty swallowing and had some aspiration. Additionally, Patient J was grossly underweight. During Respondent's treatment of Patient J, her weight ranged between 58 and 70 pounds. Yet, Respondent failed to document treatment plans regarding her low body weight and skin breakdown.

135. During Respondent's treatment of Patient J, he did not obtain an adequate, comprehensive history regarding Patient J. There was also no evidence that Respondent obtained information from Patient J as to whether: she had a past history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether she had risk factors for opioid abuse, misuse, diversion or addiction.

136. In Dr. Eisemann's May 1, 2006 office note, he indicated that Patient J had a history of "chronic alcoholism." Additionally, in a February 5, 2009 office consultation note with an ENT, it was noted that Patient J had a "history of severe liver disease from chronic alcoholism." There was no documentation of a discussion with Patient's J regarding her history of

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alcoholism in any of Respondent's office notes. There was also no documentation of any referrals for mental health and/or substance abuse treatment.

137. Patient J's medical records did not contain any evidence that Respondent performed and/or documented an adequate, comprehensive physical examination of Patient J.

138. During Respondent's treatment of Patient J, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

139. There was no evidence in Patient J's medical records that Respondent conducted and/or documented random pill counts or testing urine toxicology specimens.

140. During Respondent's treatment of Patient J, there was no documentation indicating that Respondent ever discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids prior to the opioid agreement signed in April of 2012.

141. Patient J's medical records and office notes kept by Respondent were devoid of documentation of treatment plans and objectives, and there were no periodic reviews performed.

142. Prior to April of 2012, Respondent did not have Patient J sign an adequate opioid agreement despite prescribing opioids to Patient J for the past

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seven years.

143. There was no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient J.

144. Respondent's sparse handwritten office notes concerning his treatment of Patient J are, for the most part, illegible.

Patient K

145. Respondent treated Patient K between 2008 and 2011. During that time, Respondent provided Patient K with approximately 18 prescriptions for Vicodin 10/325 50 tablets with five refills.

146. According to Respondent's notes, Patient K's pain complaints included "back pain," "back pain with pain into hip," "severe low back pain with pain into right leg," "severe neck and back pain with radiation into left arm," and "severe neck and back pain."

147. Patient K's chart contained an orthopedics consultation note dated June 8, 2011 which described her multiple spine surgeries. There were notes from other providers including inpatient hospitalization notes that described a history of not only chronic obstructive pulmonary disease, but coronary artery disease, hyperlipidemia, hypertension, smoking history, depression, anxiety, chronic bronchitis, GERD, asthma, chronic headaches, peptic ulcer disease and pancreatitis.

148. Despite Patient K's extensive medical history, Respondent did not obtain and/or document an adequate, comprehensive history from Patient K.

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There was also no evidence that Respondent obtained information from Patient K as to whether: she had a prior history of alcoholism or substance abuse, a family history of alcoholism or drug abuse, or whether she had risk factors for opioid abuse, misuse, diversion or addiction.

149. In Respondent's August 2, 2010 electronic medical record office note, he indicated that Patient K "feels a sense of hopelessness," and finds it "hard to get out of bed." He further noted, "she is not suicidal but I would consider treating for depression." Despite Patient K's history of anxiety and depression, and her reporting of feeling hopeless, Respondent failed to document any referrals for mental health treatment.

150. There was evidence that Respondent performed a physical examination of Patient K on one occasion, August 27, 2010. Prior and subsequent to August 27, 2010, there was no evidence in the office visit notes that Respondent conducted and/or documented adequate, comprehensive physical examinations of Patient K.

151. During Respondent's treatment of Patient K, there was no evidence that he performed and/or documented any type of risk stratification or surveillance.

152. There was no evidence in Patient K's medical records that Respondent conducted and/or documented random pill counts or testing of urine toxicology specimens.

153. Respondent's records of his treatment of Patient K were devoid of

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any documentation of treatment plans or objectives, and there were no periodic reviews performed.

154. Respondent did not engage and/or document a discussion of the risks and benefits of the use of opioids with Patient K, and there was no evidence of written informed consent with regard to the use of opioids.

155. There was no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient K.

156. Respondent did not access the Vermont Prescription Monitoring System in connection with his treatment of Patient K.

157. Respondent's sparse handwritten office notes regarding his treatment of Patient K are, for the most part, illegible.

Patient L

158. Respondent treated Patient L between January 2, 2009 and April 9, 2012. During that time, Patient L suffered from Charcot-Marie-Tooth disease, and was prescribed Percocet 7.5/325 and Duragesic Patches 100 mcg on approximately 137 occasions by Respondent. Respondent also prescribed Xanax and Flexeril to Patient L.

159. During Respondent's treatment of Patient L, he did not obtain and/or document an adequate, comprehensive history from Patient L. There was also no evidence that Respondent obtained information from Patient L as to whether: he had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether he had risk factors for opioid

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abuse, misuse, diversion or addiction.

160. There was no evidence in the office visit notes that Respondent conducted and/or documented an adequate, comprehensive physical examination of Patient L.

161. During Respondent's treatment of Patient L, there was no evidence that he performed and/or documented adequate risk stratification or surveillance.

162. There were two urine toxicology reports documented in Patient L's medical record. The first report dated January 18, 2008 was positive for Xanax and Oxycodone, which the patient was taking. The urine toxicology test done on December 17, 2010 was negative for Oxycodone, which the patient was being prescribed, and was positive for Hydrocodone, which the patient was not being prescribed. The December 17, 2010 urine toxicology results were also positive for marijuana. There was no notation in the medical records that Respondent acknowledged these inconsistent and significant findings. There was no documentation in the medical records indicating that Respondent discussed this discrepancy with Patient L.

163. There was no documentation in Patient L's medical records that Respondent conducted and/or documented any random pill counts.

164. Prior to April 2, 2012, Respondent failed to obtain a signed, written opioid agreement from Patient L. There is an undated opioid agreement in Patient L's medical records that does not conform to the

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standard of care for opioid agreements. The only requirement in this undated opioid agreement is that the patient will be subject to random pill counts. However, the agreement provides that the patient is given the option to refuse the first pill count request. There are no additional terms to this opioid agreement.

165. Respondent's records of his treatment of Patient L were devoid of any documentation of treatment plans or objectives, and there were no periodic reviews performed.

166. During Respondent's treatment of Patient L, there was no evidence that Respondent ever discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids prior to the opioid agreement signed in April of 2012.

167. Respondent did not access the Vermont Prescription Monitoring System in connection with his treatment of Patient L.

168. Respondent's sparse handwritten office notes regarding his treatment of Patient L are, for the most part, illegible.

Patient M

169. Respondent treated Patient M frequently between January 4, 2005 and March 18, 2012. There were sparse and incomplete records of treatment prior to January of 2005 dating back as far as 1995. Between July of 2008 and March of 2012 Respondent prescribed approximately 90 prescriptions for Hydromorphone 2 mg, 50 tablets to Patient M. Each 2 mg

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Hydromorphone tablet is equivalent to 15 mg of Oxycodone or three Percocet tablets. Respondent would often prescribe a large quantity of Hydromorphone tablets to Patient M in a short period of time. For example, Respondent gave Patient M a script for 50 tablets of 2 mg Hydromorphone on April 1st, April 9th, and April 16th, 2010. This equates to 150 2 mg tablets of Hydromorphone in 15 days. Additionally, on June 7, 2010 Patient M filled two prescriptions provided to her by Respondent. These two prescriptions were for 2 mg of Hydromorphone, 50 tablets each, for a total of 100 tablets There was no explanation documented in Patient's M's chart containing an explanation for these prescribing practices.

170. During his seven years of treating Patient M, Respondent also prescribed the following medications: Vicodin, Hydrocodone, Xanax, Risperidone, Wellbutrin, Celexa, Lorazepam, Naproxen, Flexeril, Effexor and Klonopin.

171. The patient chart indicated that Patient M was primarily being prescribed Hydromorphone for "foot pain". Respondent's office visit notes for Patient M did not document a specific diagnosis, or cause, of Patient M's foot pain.

172. Respondent's office note records also indicated that he was prescribing pain medications for Patient M's hip, left shoulder, back and neck pain despite normal results from the following objective diagnostic studies performed in 2005 and 2006: MRI of her cervical spine, upper extremity EMG, x-ray of bilateral hips, x-ray of left shoulder, and MRI of her lumbar spine.

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173. There was no evidence that Respondent documented specific and complete diagnoses, as well as the basis for such diagnoses, of Patient M's numerous medical conditions.

174. Respondent did not obtain and/or document an adequate, comprehensive history regarding Patient M's medical records from other medical providers which indicated that Patient M suffered from obsessive-compulsive disorder, panic disorder, depression, anxiety, anorexia, depression and bulimia. Respondent failed to document Patient M's history of such conditions.

175. There was also no evidence in the medical records that Respondent obtained information from Patient M as to whether: she had a prior history of alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether she had risk factors for opioid abuse, misuse, diversion or addiction.

176. In a Progress Note dated December 19, 2006, Respondent documented that Patient M reported, "she is at the end of rope, can't take anymore, what can she do or where can she go for help." Respondent failed to document a referral for mental health treatment.

177. During the seven years that he treated Patient M, Respondent failed to document any referrals for mental health treatment.

178. Between February of 2005 and November of 2011, Patient M also had 23 emergency department visits for both seemingly trivial problems and serious injuries. Upon discharge from all but six emergency department visits, Patient M received prescriptions for opioids and/or anti-anxiety medications.

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Despite having copies of all emergency department visits and having knowledge that Patient M received such prescription medications, Respondent continued to prescribe the same quantity and amount of prescription medications with the same frequency.

179. According to VPMS, Patient M received a prescription for Hydromorphone from Respondent on October 8, 2010, yet this prescription was not documented in Respondent's medical records concerning Patient M.

180. On December 12, 2005, Patient M called Respondent and indicated that her medications were stolen.

181. Respondent's electronic medical record office note dated August 13, 2010 indicated that Patient M, "desires to start tapering her dosage of her medication next visit." However, Respondent continued to prescribe Patient M 50 tablets of Hydromorphone 2 mg with the same frequency and quantity up until the last prescription of record in March of 2012.

182. There was no evidence in the numerous office visits that Respondent performed and/or documented an adequate, comprehensive physical examination of Patient M.

183. During Respondent's treatment of Patient M, Respondent did not perform and/or document any type of risk stratification or surveillance.

184. There was no evidence in Patient M's medical records that Respondent conducted and/or documented random pill counts or urine toxicology specimens.

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185. During Respondent's treatment of Patient M, there was no documentation indicating that Respondent ever discussed the risks and benefits of the use of opioids, and there was no evidence of written informed consent with regard to the use of opioids.

186. Patient M's medical records and office notes kept by Respondent are devoid of documentation of treatment plans and objectives, and there were no periodic reviews performed.

187. There is no evidence in the medical records that Respondent obtained a signed written opioid agreement from Patient M.

188. There is no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient M.

189. Respondent's sparse handwritten office notes regarding his treatment of Patient M are, for the most part, illegible.

Patient N

190. Respondent treated Patient N between June 17, 2008 and June 19, 2012, and prescribed opioids to her during this time. Specifically, Respondent prescribed Tylox 5/500 to Patient N on a weekly, and then biweekly, basis. Respondent also briefly prescribed Percocet 5/325, 50 tablets at a time. Respondent did not document an explanation for the change in medication from Tylox to Percocet, and then back to Tylox, in Patient N's medical records.

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191. Between January 2, 2009 and June 19, 2012, Respondent wrote a total of approximately 119 prescriptions of Tylox for Patient N.

192. Respondent also prescribed the following medications to Patient N between February 3, 2009 and June 19, 2012: Tramadol, Xanax, Citalopram, Flexeril, Clonazepam, and Wellbutrin.

193. The medical records indicated that Patient N was morbidly obese. On July 22, 2010, Patient N was 5'11" tall and weighed 419 pounds. Patient N suffered from anxiety and depression, and was a cigarette smoker.

194. Patient N reported feeling depressed at a number of office visits. Yet, Respondent did not document any referrals for mental health treatment.

195. Patient N was diagnosed with severe low back pain and treated for an extruded disc at the Spine Center at Dartmouth-Hitchcock Medical Center. The Vermont Prescription Monitoring System data showed that Patient N received prescriptions for Tylox 5/325 mg and Hydrocodone 5/500 from Dr. Ann Stein at the same time that she was receiving opioid prescriptions from Respondent.

196. There was no documentation in the medical records that Respondent performed and/or documented an adequate, comprehensive history regarding Patient N. There was also no evidence that Respondent obtained information from Patient N as to whether: she had a prior history of: alcoholism or substance abuse; a family history of alcoholism or drug abuse; or whether she had risk factors for opioid abuse, misuse, diversion or addiction.

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197. During Respondent's treatment of Patient N, there was no evidence that he conducted and/or documented an adequate, comprehensive physical examination of Patient N.

198. During Respondent's treatment of Patient N, there was no evidence that Respondent performed and/or documented any type of risk stratification or surveillance.

199. There was no evidence in Patient N's medical records that Respondent conducted and/or documented random pill counts or urine toxicology specimens.

200. During Respondent's treatment of Patient N, there was no documentation indicating that Respondent ever discussed the risks and benefits of the use of opioids.

201. Patient N's medical records and office visit notes were devoid of documentation of treatment plans and objectives, and there were no periodic reviews performed.

202. During Respondent's treatment of Patient N, he did not obtain a signed written opioid agreement, or any type of informed consent regarding the use of opioids, until April of 2012.

203. There was no evidence that Respondent accessed the Vermont Prescription Monitoring System in connection with his treatment of Patient N.

204. Respondent's sparse handwritten office notes regarding the treatment of Patient N are, for the most part, illegible.

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III. State's Allegations of Unprofessional Conduct

Count 1

205. Paragraphs 1 through 202, above, are restated and incorporated herein by reference.

206. By one or more of the acts related to the care of Patient A, as described in Paragraphs 12 through 25 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to conduct and/or document an adequate history of Patient A, including: whether or not Patient A suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient A, specifically of her back; and/or

(c) failing to conduct and/or document a motor exam, sensory exam, or examination of her deep tendon reflexes; and/or

(d) failing to conduct random pill counts and/or urine toxicology specimens during his treatment of Patient A; and/or

(e) failing to obtain a signed, written opioid agreement from

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Patient A; and/or

(f) failing to conduct and/or document risk stratification or surveillance for Patient A; and/or

(g) failing to document that Patient A suffered from Hepatitis C and discussing that condition with her; and/or

(h) failing to document the reason for the increase in dosages of Patient A's opioids; and/or

(i) failing to utilize and document a treatment plan or objectives, and/or periodic reviews; and/or

(j) failing to engage and document a discussion of the risks and benefits of the use of opioids; and/or

(k) failing to obtain written informed consent with regard to the use of opioids; and/or

(l) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient A; and/or

(m) failing to take legible notes in the Patient A's chart; and/or

(n) failing to document any objective evidence to support the continued need to prescribe opioid medications to Patient A; and/or

(o) failing to document specific diagnoses of Patient A's medical conditions.

Respondent's conduct constitutes one or more violations of 26 V.S.A.

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1354(a)(22). Such conduct is unprofessional.

207. Alternatively or cumulatively, by two or more of the acts related to the care of Patient A, as described in Paragraphs 12 through 25 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

208. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 2

209. Paragraphs 1 through 206, above, are restated and incorporated herein by reference.

210. By one or more of the acts related to the care of Patient B, as described in Paragraphs 26 through 36 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to obtain and/or document an adequate, comprehensive physical examination of Patient B; and/or

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(b) failing to conduct and/or document an adequate, comprehensive history of Patient B, including: whether or not Patient B suffered from the disease of alcoholism or substance abuse, had a family history of alcoholism or drug abuse, or had risk factors for opioid misuse, diversion or addiction; and/or

(c) failing to perform and/or document risk stratification or surveillance; and/or

(d) failing to conduct random pill counts and/or testing of urine toxicology specimens; and/or

(e) failing to obtain an adequate signed, written opioid agreement from Patient B; and/or

(f) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(g) failing to engage and document a discussion of the risks and benefits of the use of opioids; and/or

(h) failing to obtain written informed consent with regard to the use of opioids; and/or

(i) failing to document specific diagnoses of Patient B's medical conditions; and/or

(j) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient B; and/or

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(k) failing to document legible, handwritten notes in Patient B's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

211. Alternatively or cumulatively, by two or more of the acts related to the care of Patient B, as described in Paragraphs 26 through 36 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

212. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 3

213. Paragraphs 1 through 210, above, are restated and incorporated herein by reference.

214. By one or more of the acts related to the care of Patient C, as described in Paragraphs 37 through 50 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent

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physician engaged in similar practice under the same or similar conditions by:

(a) failing to obtain and/or document an adequate, comprehensive history of Patient C, including: whether or not Patient C suffered from the disease of alcoholism or substance abuse, had a family history of alcoholism or drug abuse, or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient C; and/or

(c) failing to obtain and/or document a specific diagnoses for Patient C's medical conditions; and/or

(d) failing to evaluate Patient C for any of his pain conditions; and/or

(e) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(f) failing to obtain a signed, written opioid agreement from Patient C; and/or

(g) failing to conduct random pill counts, and failing to obtain more than one urine toxicology specimen of Patient C; and/or

(h) failing to engage and document a discussion of the risks and benefits of the use of opioids; and/or

(i) failing to obtain and/or document informed consent with regard to the use of opioids; and/or

(j) failing to perform and/or document risk stratification or

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surveillance; and/or

(k) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient C; and/or

(l) failing to document legible, handwritten notes in Patient C's charts. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

215. Alternatively or cumulatively, by two or more of the acts related to the care of Patient C, as described in Paragraphs 37 through 50 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

216. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 4

217. Paragraphs 1 through 214, above, are restated and incorporated herein by reference.

218. By one or more of the acts related to the care of Patient D, as

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described in Paragraphs 51 through 61 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to conduct and/or document an adequate, comprehensive history of Patient D, including: whether or not Patient D suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient D; and/or

(c) failing to document in Patient D's medical records that he was either taking Fentanyl, or had taken Fentanyl in the past with potential withdrawal issues and symptoms; and/or

(d) failing to perform and/or document risk stratification or surveillance for Patient D;

(e) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(f) failing to document any specific diagnoses of Patient D's medical conditions; and/or

(g) failing to conduct and/or document random pill counts or testing of urine toxicology specimens; and/or

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(h) failing to engage and document a discussion of the risks and benefits of the use of opioids; and/or

(i) failing to obtain and/or document informed consent with regard to the use of opioids; and/or

(j) failing to obtain a signed, written opioid agreement from Patient D; and/or

(k) failing to document legible, handwritten notes in Patient D's charts.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

219. Alternatively or cumulatively, by two or more of the acts related to the care of Patient D, as described in Paragraphs 51 through 61 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

220. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

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Count 5

221. Paragraphs 1 through 218, above, are restated and incorporated herein by reference.

222. By one or more of the acts related to the care of Patient E, as described in Paragraphs 62 through 77 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to conduct and/or document an adequate, comprehensive history of Patient E, including: whether or not Patient E suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient E; and/or

(c) failing to utilize and/or document treatment plans, objective and/or periodic reviews for Patient E; and/or

(d) failing to engage and document a discussion of the risks and benefits of the use of opioids or benzodiazepines; and/or

(e) failing to obtain and/or document written informed consent with regard to the use of opioids; and/or

(f) failing to obtain a signed, written opioid agreement from

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Patient E; and/or

(g) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient E; and/or

(h) failing to document the amendment of a previously recorded medical record; and/or

(i) failing to conduct random urine toxicology specimens and more frequent random pill counts;

(j) failing to perform and/or document risk stratification or surveillance; and/or

(k) failing to document legible, handwritten notes in Patient E's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

223. Alternatively or cumulatively, by two or more of the acts related to the care of Patient E, as described in Paragraphs 62 through 77 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

224. Alternatively or cumulatively, Respondent's conduct failed to

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conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 6

225. Paragraphs 1 through 222, above, are restated and incorporated herein by reference.

226. By one or more of the acts related to the care of Patient E, as described in Paragraphs 62 through 77 above, Respondent failed to comply with provisions of federal and state statutes or rules governing the practice of medicine by:

(a) failing to properly maintain appropriate, accurate records of receipt and dispensation of a stock bottle of Xanax, which he received in his office and then dispensed to Patient E; and

(b) failing to maintain and record biannual inventories of all stocks of controlled substances on hand in his office.

Respondent's conduct failed to conform to state and federal law, and constitutes a violation of 26 V.S.A. 1354(a)(27).

Count 7

227. Paragraphs 1 through 224, above, are restated and incorporated herein by reference.

228. By one or more of the acts related to the care of Patient F, as described in Paragraphs 78 through 89 above, Respondent grossly failed to use

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and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to conduct and/or document an adequate, comprehensive history of Patient F, including: whether or not Patient F suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient F; and/or

(c) failing to refer Patient F to a specialist regarding the treatment of his migraine headaches; and/or

(d) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(e) failing to engage and document a discussion of the risks and benefits of the use of opioids; and/or

(f) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient F; and/or

(g) failing to obtain written informed consent with regard to the use of opioids; and/or

(h) failing to conduct and/or document random pill counts and/or

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urine toxicology specimens; and/or

(i) failing to perform and/or document risk stratification or surveillance; and/or

(j) failing to document legible, handwritten notes in Patient F's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

229. Alternatively or cumulatively, by two or more of the acts related to the care of Patient F, as described in Paragraphs 78 through 89 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

230. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 8

231. Paragraphs 1 through 228, above, are restated and incorporated herein by reference.

232. By one or more of the acts related to the care of Patient G, as

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described in Paragraphs 90 through 102 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to conduct and/or document an adequate, comprehensive history of Patient G, including: whether or not Patient G suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient G; and/or

(c) failing to make and/or document referrals to mental health professionals; and/or

(d) failing to consult, and/or document any consultations, with mental health professionals regarding Patient G's mental health issues and symptoms; and/or

(e) failing to perform and/or document risk stratification or surveillance; and/or

(f) failing to conduct random pill counts and/or testing of urine toxicology specimens for Patient G; and/or

(g) failing to obtain a signed, written opioid agreement from

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Patient G; and/or

(h) failing to engage and/or document a discussion of the risks and benefits of the use of opioids; and/or

(i) failing to obtain written informed consent with regard to the use of opioids; and/or

(j) failing to utilize and/or develop treatment plans, objectives and/or periodic reviews; and/or

(k) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient G; and/or

(l) failing to treat and/or document his treatment of Patient G for withdrawal from Xanax; and/or

(m) failing to document legible, handwritten notes in Patient G's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

233. Alternatively or cumulatively, by two or more of the acts related to the care of Patient G, as described in Paragraphs 90 through 102 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A.

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1354(a)(22). Such conduct is unprofessional.

234. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 9

235. Paragraphs 1 through 232, above, are restated and incorporated herein by reference.

236. By one or more of the acts related to the care of Patient H, as described in Paragraphs 103 through 114 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to obtain and/or document an adequate, comprehensive history of Patient H, including: whether or not Patient H suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient H; and/or

(c) failing to perform or document any risk stratification or surveillance; and/or

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(d) failing to conduct random pill counts and/or testing of urine toxicology specimens; and/or

(e) failing to obtain an adequate signed, written opioid agreement from Patient H; and/or

(f) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(g) failing to document a definitive diagnoses, and/or document a basis for how the diagnoses were made, for Patient H; and/or

(h) failing to engage and/or document a discussion of the risks and benefits of the use of opioids; and/or

(i) failing to obtain written, informed consent with regard to the use of opioids; and/or

(j) failing to document and/or engage in consults with other medical providers; and/or

(k) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient H; and/or

(l) failing to document legible handwritten notes in the Patient H's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

237. Alternatively or cumulatively, by two or more of the acts related

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to the care of Patient H, as described in Paragraphs 103 through 114 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

238. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 10

239. Paragraphs 1 through 236, above, are restated and incorporated herein by reference.

240. By one or more of the acts related to the care of Patient I, as described in Paragraphs 115 through 125 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to obtain and/or document an adequate, comprehensive history of Patient I, including: whether or not Patient I suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or

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drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient I; and/or

(c) failing to perform or document any risk stratification or surveillance; and/or

(d) failing to conduct random pill counts and/or urine toxicology specimens; and/or

(e) failing to utilize and/or document treatment plans, objective and/or periodic reviews; and/or

(f) failing to consult, and/or document consultations, with mental health professionals regarding Patient I's anxiety, panic attacks or violent behavior ; and/or

(g) failing to make and/or document referrals to mental health professionals; and/or

(h) failing to engage and/or document a discussion of the risks and benefits of the use of opioids; and/or

(i) failing to obtain written informed consent with regard to the use of opioids; and/or

(j) failing to obtain a written, signed opioid agreement from Patient I; and/or

(k) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient I;

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and/or

(l) failing to document legible, handwritten notes in Patient I's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

241. Alternatively or cumulatively, by two or more of the acts related to the care of Patient I, as described in Paragraphs 115 through 125 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

242. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 11

243. Paragraphs 1 through 240, above, are restated and incorporated herein by reference.

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244. By one or more of the acts related to the care of Patient J, as described in Paragraphs 126 through 142 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and

proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to take and/or document an adequate, comprehensive history of Patient J, including: whether or not Patient J suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient J; and/or

(c) failing to obtain and/or document Patient J's positive past history for substance abuse that was documented in the records of her treatment from other medical providers; and/or

(d) failing to address and/or document concerns from Patient J's other medical providers regarding the amount of narcotic medications that she was taking; and/or

(e) failing to perform or document any risk stratification or surveillance for Patient J; and/or

(f) failing to obtain an adequate signed, written opioid agreement from Patient J prior to April of 2012; and/or

(g) failing to engage and document a discussion of the risks and benefits of the use of opioids; and/or

(h) failing to obtain written, informed consent with regard to the

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use of opioids; and/or

(i) failing to conduct random pill counts and/or urine toxicology specimens; and/or

(j) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(k) failing to utilize, and document the use of, the Vermont Prescription Monitoring System in connection with the treatment of Patient J; and/or

(l) failing to document legible, handwritten notes in Patient J's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

245. Alternatively or cumulatively, by two or more of the acts related to the care of Patient J, as described in Paragraphs 126 through 142 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

246. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is

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unprofessional.

Count 12

247. Paragraphs 1 through 244, above, are restated and incorporated herein by reference.

248. By one or more of the acts related to the care of Patient K, as described in Paragraphs 143 through 155 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to obtain and/or document an adequate, comprehensive history of Patient K, including: whether or not Patient K suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient K; and/or

(c) failing to provide and/or document referrals to Patient K regarding her extensive mental health issues and symptoms; and/or

(d) failing to obtain and/or document any risk stratification and/or surveillance on Patient K;

(e) failing to conduct random pill counts and/or urine toxicology specimens; and/or

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(f) failing to engage and/or document a discussion of the risks and benefits of the use of opioids; and/or

(g) failing to obtain written, informed consent with regard to the use of opioids; and/or

(h) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(i) failing to obtain a signed, written opioid agreement from Patient K; and/or

(j) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient K; and/or

(k) failing to document legible, handwritten notes in Patient K's chart. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

249. Alternatively or cumulatively, by two or more of the acts related to the care of Patient K, as described in Paragraphs 143 through 155 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

250. Alternatively or cumulatively, Respondent's conduct failed to

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conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 13

251. Paragraphs 1 through 248, above, are restated and incorporated herein by reference.

252. By one or more of the acts related to the care of Patient L, as described in Paragraphs 156 through 166 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to take and/or document an adequate, comprehensive history of Patient L, including: whether or not Patient L suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient L; and/or

(c) failing to perform and/or document risk stratification or surveillance of Patient L; and/or

(d) failing to discuss and/or document a discussion concerning Patient L's negative urine toxicology test for Oxycodone, which Patient L was

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being prescribed; as well as the positive test for Hydrocodone, which he was not being prescribed; and/or

(e) failing to discuss and/or document Patient L's positive urine toxicology test which was positive for marijuana; and/or

(f) failing to conduct additional urine toxicology tests; and/or

(g) failing to engage and/or document a discussion of the risks and benefits of the use of opioids; and/or

(h) failing to conduct random pill counts of Patient L; and/or

(i) failing to obtain a written, signed opioid agreement from Patient L prior to April 2, 2012; and/or

(j) failing to obtain written, informed consent with Patient L; and/or

(k) failing to utilize and document treatment plans, objectives and/or periodic reviews; and/or

(l) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient L; and/or

(m) failing to document legible, handwritten notes in Patient L's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

253. Alternatively or cumulatively, by two or more of the acts related

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to the care of Patient L, as described in Paragraphs 156 through 166 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

254. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 14

255. Paragraphs 1 through 252, above, are restated and incorporated herein by reference.

256. By one or more of the acts related to the care of Patient M, as described in Paragraphs 167 through 187 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to take and/or document an adequate, comprehensive history of Patient M, including: whether or not Patient M suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or

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drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient M; and/or

(c) failing to document specific and complete diagnoses, as well as the basis for such diagnoses, of Patient M's numerous medical conditions; and/or

(d) failing to document Patient M's multiple and severe problems with mental illness; and/or

(e) failing to make, and/or document, referrals to Patient M for mental health treatment; and/or

(f) failing to document that Patient M received a prescription for Hydromorphone from Respondent on October 8, 2010; and/or

(g) failing to perform and/or document risk stratification or surveillance; and/or

(h) failing to revise the treatment plan for Patient M, including the dose and quantity of opioid prescriptions, despite knowledge of Patient M's receipt of opioid prescriptions from 17 emergency department visits; and/or

(i) failing to decrease the dosage of Patient M's opioid medications despite Patient M's express desire at the August 13, 2010 office visit to taper her dosage; and/or

(j) failing to conduct random pill counts and/or urine toxicology specimens; and/or

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(k) failing to obtain a signed, written opioid agreement from Patient M; and/or

(l) failing to engage and/or document a discussion of the risks and benefits of the use of opioids; and/or

(m) failing to obtain written informed consent with regard to the use of opioids from Patient M; and/or

(n) failing to utilize and/or document treatment plans, objectives and/or periodic reviews; and/or

(o) failing to obtain a written, signed opioid agreement from Patient M; and/or

(p) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient M; and/or

(q) failing to document legible, handwritten notes in Patient M's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

257. Alternatively or cumulatively, by two or more of the acts related to the care of Patient M, as described in Paragraphs 167 through 187 above, Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions.

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Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

258. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

Count 15

259. Paragraphs 1 through 256, above, are restated and incorporated herein by reference.

260. By one or more of the acts related to the care of Patient N, as described in Paragraphs 188 through 202 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

(a) failing to take and/or document an adequate, comprehensive history of Patient N, including: whether or not Patient N suffered from the disease of alcoholism or substance abuse; had a family history of alcoholism or drug abuse; or had risk factors for opioid misuse, diversion or addiction; and/or

(b) failing to conduct and/or document an adequate, comprehensive physical examination of Patient N; and/or

(c) failing to engage and/or document a discussion of the risks and

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benefits of the use of opioids; and/or

(d) failing to perform and/or document risk stratification or surveillance; and/or

(e) failing to conduct random pill counts and/or urine toxicology specimens; and/or

(f) failing to obtain a signed, written opioid agreement from Patient N prior to April of 2012; and/or

(g) failing to utilize and/or document treatment plans, objectives, and/or periodic reviews; and/or

(h) failing to make and/or document referrals to mental health professionals; and/or

(i) failing to obtain written, informed consent from Patient N; and/or

(j) failing to utilize, and/or document the use of, the Vermont Prescription Monitoring System in connection with his treatment of Patient N; and/or

(k) failing to document legible, handwritten notes in Patient N's chart.

Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

261. Alternatively or cumulatively, by two or more of the acts related to the care of Patient N, as described in Paragraphs 188 through 202 above,

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Respondent failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. 1354(a)(22). Such conduct is unprofessional.

262. Alternatively or cumulatively, Respondent's conduct failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. 1354(b)(2). Such conduct is unprofessional.

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WHEREFORE, Petitioner, State of Vermont, moves the Vermont Board of Medical Practice to take such disciplinary action against the medical license of Respondent Michael E. Scovner, M.D. permitted by 26 V.SA. §§ 1361(b) and/or 1398 as it deems proper.

Dated at Montpelier, Vermont this 29th day of August, 2014.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By: _____

William B. Reynolds
Assistant Attorney General
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The foregoing Specification of Charges, filed by the State of Vermont, as to Michael E. Scovner, M.D., Vermont Board of Medical Practice docket number MPC 50-0510, are hereby issued.

Dated at Burlington, Vermont this 22 day of Aug 2014.

VERMONT BOARD OF MEDICAL PRACTICE

By: _____

Secretary, Vermont Board of Medical Practice

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