

**STATE OF VERMONT
BOARD OF MEDICAL PRACTICE**

In re: Mitchell R. Miller, M.D.
a/k/a Mitch Miller

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Docket No.: MPC 76-1100

SPECIFICATION OF CHARGES

The State of Vermont, Petitioner, by and through Attorney General William H. Sorrell, and the undersigned Assistant Attorney General, James S. Arisman, alleges the following in the above-captioned matter involving Respondent Miller.

1. Mitchell R. Miller, M.D., Respondent, holds Vermont medical license No. 042-0009508, originally issued by the Board of Medical Practice on July 3, 1997. Respondent is a Board-certified family practice physician. Respondent has a private practice medical office located in Ludlow, Vermont.

2. Respondent also is employed or under contract to Prison Health Services, Inc., a corporation based in Tennessee.

3. The Vermont Board of Medical Practice possesses jurisdiction in this matter pursuant to 26 V.S.A. §§ 1353-1361, 1398, and other authority.

I. Background and Allegations.

4. On or about November 9, 2000, the Vermont Board of Medical Practice opened a complaint (Docket No. MPC 76-1100) against Respondent Miller, based on information provided by the Vermont Office of Professional Regulation.¹ The complaint involved a report from a Springfield pharmacist regarding Respondent Miller's alleged prescribing of large

1. A unit within the Office of the Vermont Secretary of State, regulating licensed professionals other than physicians and attorneys.

quantities of DEA Schedule II narcotics for a specific patient. A Board of Medical Practice investigator contacted both the Springfield pharmacist and two other area pharmacists in or about November 2000 regarding Respondent's prescribing of narcotics.

5. The Springfield pharmacist informed the Medical Board investigator that he had communicated with Respondent on two occasions regarding the physician's prescribing of large quantities of narcotics for the patient in question. On the first occasion, the pharmacist stated that he personally had gone to Respondent's office and expressed his concerns directly to Respondent regarding the physician's narcotic prescribing for the patient. The pharmacist warned Respondent of the possibility that the patient might be diverting the drugs to illegal sales in the community. The Springfield pharmacist met with Respondent on a second occasion and again expressed concerns regarding Respondent's narcotic prescribing for the patient.

6. The Board of Medical Practice investigator also spoke with another area pharmacist regarding Respondent's prescribing practices. This pharmacist recalled writing to Respondent in early 1999 and expressing concerns regarding the quantity of Oxycontin narcotics being prescribed by Respondent for the same patient. The pharmacist expressed concern that the patient might not be consuming all the narcotics being prescribed by Respondent and might be unlawfully diverting the drugs to other persons. The pharmacist added in his letter to Respondent, "I can't keep dispensing this quantity of narcotic without proper diagnosis, prognosis, and a specific plan of therapy." The pharmacist later began to refuse to fill Respondent's prescriptions for narcotics written for the patient in question.

7. A third area pharmacist alleged to the Medical Board investigator that Respondent's medical office had a reputation in the community as "the place to get your

drugs” and stated that because of this concern she had instructed her pharmacy staff not to fill narcotic prescriptions written for patients by Respondent Miller.

8. Respondent spoke with a Medical Board investigator in 2000 during the Board’s early investigation. Respondent later wrote to the investigator and described the clinical needs of the patient in question as “chronic low back pain” and asserted that there was no evidence of drug diversion by the patient who Respondent claimed required high doses of opioids for pain control. The Board of Medical Practice continued its investigation.

A. Respondent’s Meetings with the Central Investigative Committee.

9. The Board of Medical Practice subsequently subpoenaed on multiple occasions medical records for patients who had received narcotic prescriptions from Respondent Miller. These records were reviewed during the Board’s ongoing investigation.

10. On June 18, 2001, Respondent Miller met in person with members of the Board’s Central Investigative Committee to discuss his prescribing of narcotics for his patients. Following this meeting, the Board of Medical Practice continued to monitor Respondent’s prescribing activity.

11. On January 6, 2004, the undersigned Assistant Attorney General wrote to Respondent’s attorney and urged that Respondent provide a detailed letter of assurance to the Board of Medical Practice and that Respondent commit himself in writing “to careful, prudent prescribing and treatment of pain.”

12. On January 9, 2004, Respondent met in person with the members of the Medical Board’s Central Investigative Committee to discuss again his prescribing practices and discuss specific standards that the Committee would expect Respondent to follow in the future with regard to his narcotics prescribing and treatment of pain.

B. Respondent's April 26, 2004, Detailed Letter of Assurance.

13. Respondent later wrote to the Investigative Committee and provided detailed, written commitments regarding his prescribing practices. In a five-page letter, dated April 26, 2004, Respondent wrote to David W. Clauss, M.D., then-Chair of the Board's Central Investigative Committee and acknowledged Committee concerns regarding his narcotics prescribing. (Letter of April 26, 2004 hereinafter referred to as "Letter of Assurance".) See **Exhibit 1** (attached).

14. Respondent voluntarily committed himself in his April 26, 2004 Letter of Assurance to standards that would govern his future prescribing of narcotics for his patients and his treatment of pain. Respondent acknowledged in his letter his understanding that the Board of Medical Practice would "be relying on my adherence to the commitments included in this letter and [would] direct follow-up monitoring as to my prescribing practices and patient care." Respondent promised to take a series of steps regarding his narcotic prescribing, including preparing careful written documentation in each patient's chart of (a) Respondent's evaluation of the patient's pain; (b) his medical basis for prescribing narcotics; and (c) a current plan of treatment.

15. Respondent in his April 26, 2004 Letter of Assurance listed specific steps and standards he would follow to "improve" his medical care of patients. These included:

a. **Consultation**: Respondent assured, "I now consult regularly with Seddon R. Savage, M.D., a New Hampshire anesthesiologist, for chart reviews and discussion of my treatment of pain for individual patients." Exh. 1, p. 2, ¶ 1. Respondent also assured, "I also collaborate with Dartmouth Hitchcock Medical Center regarding certain patients." Exh. 1, p. 2, ¶ 1.

b. **Review of Medical History**: Respondent assured, "I review the patients' medical records with an eye to identifying prior diagnoses, care, and evaluations before [prescribing] opioids or other controlled substances." Exh. 1, p. 2, ¶ 2.

c. **Termination of Non-Compliant Patients**: Respondent assured, "I am unwilling to continue caring for and prescribing for non-compliant patients". Exh. 1, p. 2, ¶ 2.

c. Prudent Prescribing: Respondent assured, "I would like to make clear my commitment to careful, prudent prescribing and treatment of pain." Exh. 1, p. 2, ¶ 3.

e. Education: Respondent assured, "I will engage in . . . in continuing medical education course related to pain management, record keeping, and professionalism."² Exh. 1, p. 2, ¶ 4.

f. Restrict Number of Chronic Pain Patients: Respondent assured, "I no longer accept new [patients] who are likely to require treatment for chronic pain. Any current patient **not** now being treated . . . for chronic pain and any 'new' patients . . . will not be prescribed DEA schedule II drugs or schedule III opioids for a period longer than 14 days."³ Exh. 1, p. 3, ¶ 1.

g. Referrals of Chronic Pain Patients: Respondent assured, "Patients who newly require . . . prescriptions of such DEA schedule drugs for a period longer [than] 14 days or who recurrently require the prescribing of such drugs . . . will be promptly [referred] to another practitioner". Exh. 1, p. 3, ¶ 1. Respondent also assured, "I will maintain a complete list of all patients currently being treated with controlled substances for chronic pain." Exh. 1, p. 3, ¶ 2.

h. Board Monitoring of Respondent's Prescribing: Respondent assured, "I agree to Board monitoring of my prescribing practices, and the Board's investigators may review my patient charts at any time to examine the basis for prescribing". Exh. 1, p. 3, ¶ 2.

i. Medical Record Keeping: Respondent assured, "For each patient for whom I prescribed controlled substances I will have in the patient's chart a current diagnostic assessment and treatment plan . . . Each plan will include specific entries regarding the patient's diagnosis or condition and the rationale for prescribing. . . ." Exh. 1, p. 3, ¶ 3.

j. Retention of Copies of Prescriptions: Respondent assured, "I agree that all prescriptions written by me for DEA schedule II, III, and IV drugs will be copied and retained One copy . . . will be placed in the patient's chart. A second copy will be kept in a chronologically-ordered file in my office The third copy will be retained and every three months all such copies on hand will be promptly forwarded to the Board." Exh. 1, p. 3, ¶ 4.

k. Adherence to Professional Standards: Respondent assured, "I will review pertinent policy statements . . . with regard to the use of controlled substances in treating chronic pain. I will review the 1996 Report of the Prescribing Practices Committee of the Vermont Board of Medical Practice and the 1998 Model Guidelines [of] the Federation of State Medical Boards. I will adhere to such broad principles in caring for my patients". Exh. 1, p. 3, ¶ 5.

l. Prudent Treatment of Pain: Respondent assured, "[M]y treatment of pain will reflect careful diagnosis, detailed record keeping, and substantial efforts to control the patient's pain that will consider other important aspects of the patient's functioning, including physical, psychological, social, and vocational factors." Exh. 1, p. 3, ¶ 6.

2. Respondent completed the following coursework at Case Western Reserve University, pursuant to the terms of his letter of assurance: 1) Intensive Course in Controlled Substance Management; 2) Intensive Course in Medical Record Keeping; and 3) Intensive Course in Medical Ethics and Professionalism.

3. Under Section 812 of the Controlled Substances Act (21 U.S.C. §801 et seq.), the United States Drug Enforcement Administration (DEA) lists controlled drugs and substances according to their descending potential for abuse in Schedules I-V.

m. Evaluation of Pain: Respondent assured, "My care also will demonstrate a clear, detailed evaluation of the patient's pain (nature and intensity), current and past treatments for pain, the effect of pain on the patient's physical and psychological functioning, and any history or indication of possible substance abuse or dependency." Exh. 1, p. 4, ¶ 1.

n. Detailed, Current Treatment Plan: Respondent assured, "My care of patients with pain will include a current detailed treatment plan. The plan will set objectives to be used in determining treatment progress, such as pain relief, and improved physical and psychological functioning." Exh. 1, p. 4, ¶ 2.

o. Use of Narcotics Contracts: Respondent assured, "I also will require patients being treated for chronic pain or recurring acute pain to enter into written agreements ("prescribing contracts") governing their receipt of prescriptions for controlled substances. I also will emphasize that both the patient and I will adhere to the terms of such contracts. At each patient visit I will review the terms of the contract and the patient's compliance." Exh. 1, p. 4, ¶ 3.

p. Regular Review of Pain Care and Prescribing: Respondent assured, "I am committing myself here to regular, careful review of the course of treatment and available information as to the etiology of the patient's pain. My . . . prescribing of controlled substances will reflect careful assessment of the patient's progress toward stated treatment objectives, such as improvement in the patient's pain and better functioning. If treatment goals are not being achieved . . . I will re-evaluate the appropriateness of continued treatment and prescribing. My written records will present my reasoning in this regard." Exh. 1, p. 4, ¶ 4.

q. Referrals to Pain Specialists: Respondent assured, "I will make use of referrals to pain clinics and [specialists] for evaluation and treatment to assist my patients and me in meeting written objectives. I will direct special attention to those patients who present a risk of abusing or diverting controlled substances." Exh. 1, p. 4, ¶ 5.

r. Reputation as "Easy Mark": Respondent assured, "I am concerned regarding any possible perception in the community that I am an 'easy mark' for drug seekers or those who might seek to divert prescription drugs. The committee has my assurances that I recognize the importance of complying fully with all Federal and State laws and regulations and applicable medical standards as to the prescribing of controlled substances." Exh. 1, p. 4, ¶ 6.

II. Unprofessional Conduct of Respondent Miller.

A. Introduction.

16. Notwithstanding the promises and commitments set forth Respondent's Letter of Assurance, monitoring by the Medical Board of Respondent's prescribing of narcotics identified continuing areas of concern. Most recently, monitoring and investigation of Respondent's conduct by the Board established that Respondent had acted in bad faith and had failed to comply with the promises and standards he set forth in writing in his Letter of

Assurance. Further, Respondent made false and/or misleading statements to the Medical Board's investigator regarding his prescribing of narcotics, improperly altered patient records, and acted to conceal the true frequency and quantity of his prescribing of narcotics for patients. The charges set forth herein are based on Medical Board scrutiny of the medical records of 10 of Respondent's patients, review of pharmacy records, and Board interviews of Respondent Miller. Respondent cared for each of these 10 patients for extended periods of time and prescribed narcotics for these patients at his office in Ludlow, Vermont.

17. Respondent accepted and cared for new chronic pain patients for extended periods of time, in disregard of his promises and obligations under his April 26, 2004 Letter of Assurance. As noted, Respondent committed himself in the Letter of Assurance to a) ~~not~~ accept as his patients individuals likely to require treatment for chronic pain; b) ~~not~~ to prescribe DEA Schedule II or III opioids to newly accepted patients for longer than 14 days; and c) to refer new patients requiring opioids for more than 14 days (or recurrently) to other physicians for care and prescribing. Respondent failed to honor these commitments. Board investigation identified at least 26 new patients that Respondent treated for pain while prescribing narcotics for periods in excess of 14 days, each of whom Respondent accepted for care and treatment after he wrote and signed the April 26, 2004 Letter of Assurance.

18. Respondent's care of the 10 specific patients reviewed by the Medical Board evidences indifference and carelessness as to the patients' medical needs. Respondent's patient care and record keeping also demonstrate a disregard of possible drug seeking behaviors, abuse of controlled substances, risk of unlawful diversion, and lack of attention and concern as to the potential for dependency among his patients.

19. Respondent Miller grossly and repeatedly engaged in unprofessional conduct in his care of patients, record keeping, and in his prescribing of narcotics for them. By virtue of such conduct, Respondent's practice of medicine was incompetent. Respondent's care of his patients also was unsafe and/or professionally unacceptable. Respondent's care of patients failed to conform to the essential standards of acceptable and prevailing medical practice.

20. Respondent's medical records evidence a gross and/or repeated failure to document the taking of a proper medical history, failure to properly document the medical basis for prescribing and refilling narcotics for his patients, and/or failure to clearly document that patients were examined physically and their pain carefully evaluated.

21. Respondent's written office notes repeatedly fail to document the rationale for the continuation of narcotics prescribing and fail to document evaluation of patient compliance or non-compliance with prescribing levels. Respondent's medical records fail to document a careful consideration of possible side effects upon patients of the narcotics prescribed. Respondent failed to document preparation, maintenance, and/or updating of current treatment plans for the patients for whom he prescribed narcotics.

22. Respondent's office notes demonstrate a carelessness and indifference to sound and acceptable medical decision-making and continuity of care. Respondent's written notes frequently are sparse, vague or cryptic, and often largely identical in content from patient visit to patient visit. Respondent's medical records frequently are missing pertinent information and frequently fail to document medical assessment of the patient's current condition and care needs. The records repeatedly do not reflect meaningful inquiry by Respondent regarding the patient's pain or response to prescribed narcotics. Respondent also repeatedly failed to make

use of or personally adhere to "narcotics contracts" with his patients. Respondent failed to refer patients to pain specialists or other medical specialists for evaluation and care.

23. In sum, Respondent's care of patients and prescribing of narcotics for his patients demonstrates indifference and/or heedlessness as to proper care of his patients, possible drug-seeking behaviors, diversion, tolerance or dependency, and risk of harm to his patients or the public.

24. Respondent's conduct, as set forth above, evidences unfitness to practice medicine and is immoral, dishonorable, and/or unprofessional.

25. The Central Investigative Committee of the Vermont Board of Medical Practice, to which this matter has been assigned, has reviewed these charges and concurs with their filing by the State of Vermont against Respondent Miller.

B. Unprofessional Conduct in Care of Individual Patients.

Patient A

26. Patient A, a male, was in his early-50s, living in [REDACTED] while Respondent was cared for him. Respondent Miller cared for Patient A and prescribed large quantities of narcotics for him, beginning in or about October 2006 until at least late-February 2009. (In fact, Board investigation found that as late as March 14, 2009, Respondent was still prescribing narcotics for Patient A.) Patient A appears to have initially presented to Respondent for care on or about October 27, 2006. Respondent's typed chart entry for the initial visit was in the SOAP format. The "subjective" heading for this date included the following:

--"evaluation left shoulder, chronic pain related to improperly reduced dislocation at age 17"; and "told at dhmc inoperable";

--"use to be on percocet 2 po tid, states made a mistake and used cocaine and was discharged, hasn't used any pain medicine for a year and a half";

27. The "objective" heading for this visit included the following, "alert, pleasant, earnest" and "left shoulder unable to abduct more than 15 degrees". The "assessment" heading stated only the following, "chronic pain, left shoulder".⁴ Under the "plan" heading for October 27, 2006 Respondent wrote, "discussion of inability to take on any new chronic pain patients requiring on going opiate prescriptions, he understands and accepts this" and "referral to dhmc⁵ pain clinic".

28. During the October 27, 2006 office visit Respondent failed to take and/or document an adequate medical history or perform and/or document an adequate physical examination of Patient A. The office note also failed to document an evaluation by Respondent of the patient's pain (nature and level of intensity), past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning. The office note fails to document a detailed treatment plan.

29. Respondent's office note for October 27, 2006 also does not document with reasonable detail past treatment for pain that Patient A may have received and does not document inquiry by Respondent regarding past or present substance use and/or abuse by Patient A. Finally, the office note for this date does not document a specific entry setting forth Respondent's medical reasoning and medical basis for prescribing of opioid narcotics for the patient on this date, particularly in light of Patient A's admission of past drug abuse, prior termination of treatment by another provider, and the preceding 18-month period during which Patient A claimed to have functioned without pain medication.

4. For multiple office visits, Respondent repeated under the "objective" heading essentially the same, rote content: "alert, pleasant, earnest"; and "left shoulder: unable to abduct more than 15 degrees"; and finally, "Assessment: left shoulder pain s/p dislocation, felt to be inoperable". Such repetitive content reflects a lack of care in examining, documenting, and following up on the source of the patient's chronic pain and physical limitations.

5. Dartmouth Hitchcock Medical Center.

30. Notwithstanding the above deficiencies, Respondent Miller during the patient's initial visit on October 27, 2006 chose to prescribe: "percocet 5/325 1-2 po three times daily prn severe pain #60" for Patient A.⁶ Respondent failed to document a treatment plan addressing possible future care, diagnostic evaluations, and any treatment objectives.

31. On October 27, 2006 and thereafter, until at least late-February 2009, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for Patient A. Respondent repeatedly prescribed large quantities of narcotics for Patient A, including Percocet,⁷ MSIR,⁸ Oxycodone and Oxycontin,⁹ Methadone,¹⁰ and Dilaudid.¹¹ During this period, Respondent's care and prescribing for Patient A: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care;

6. Respondent later provided to the Board a copy of the handwritten prescription he actually wrote on this date. The prescription was written for Percocet 5/325 1-2 po quid prn pain #60. As such, Respondent's chart entry for this date is inaccurate and understates Respondent's actual, more frequent dosing for this Percocet prescription.

7. Percocet is a combination of oxycodone hydrochloride and acetaminophen. Oxycodone is a semi synthetic opioid analgesic with effects that are similar to those of morphine. Psychic dependence, physical dependence, and tolerance may develop from the repeated use of Percocet, which is a DEA Schedule II drug with a recognized potential for misuse, abuse, and criminal diversion. Physicians are warned of the possibility of "drug-seeking" behavior and "doctor shopping" as concerns related to Percocet prescribing. See Physician Desk Reference 2009 ed. at 1127- 1129.

8. MSIR (morphine sulfate immediate release tablets) is a DEA Schedule II drug. MSIR is an opioid analgesic prescribed for relief of moderate to severe pain. Psychological and physical dependence may develop with repeated administration and there is potential for abuse of the drug. See www.drugs.com/pdr/msir-oral-tablets.html.

9. Oxycodone hydrochloride (Oxycontin), is a narcotic analgesic with effects and abuse potential similar to those of morphine. It is prescribed for management of moderate to severe pain. As noted above, Oxycodone is classified as a DEA Schedule II controlled substance known to produce physical dependence and tolerance and is to be prescribed with caution. Oxycontin Tablets are not intended for use as a prn analgesic. Physicians are warned that oxycodone can be abused and is subject to criminal diversion. Physicians are warned regarding "drug seeking" behaviors and "doctor shopping" by patients seeking prescriptions. See Physician Desk Reference 2009 ed. at 2589-2593.

10. Methadone hydrochloride tablets are a narcotic pain reliever similar to morphine and are also used in drug addiction detoxification. Methadone is a DEA Schedule II drug. The Food and Drug Administration (FDA) in a 2006 public health advisory warned of the risk of death and life-threatening changes in breathing and heart beat as possible side effects, especially for patients using methadone after being treated with other narcotic pain relievers. The FDA recommends carefully counseling patients and caregivers regarding the risk of methadone overdose.

11. Dilaudid (hydromorphone hydrochloride) is a narcotic analgesic for relief of moderate to severe pain. It is a DEA Schedule II drug. Physicians are warned that mental and physical dependence may result when this drug is taken repeatedly. It is a central nervous system depressant and abusing Dilaudid or combining it with other nervous system depressants may cause serious, life-threatening side effects. See www.pdrhealth.com/drugs/rx.

and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his Letter of Assurance to the Board of Medical Practice on one or more occasions, as follows.

32. Respondent failed to document taking (or updating) a medical history for Patient A. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

33. Respondent failed to document performing (or updating) a physical examination of Patient A. Respondent did not document physical examination findings.

34. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient A's medical condition and medical needs.

35. Respondent failed to prepare and maintain current treatment plans for Patient A and/or document having done so. Respondent's "plans" repeatedly referred only to the renewal of narcotic medications, without more. Respondent failed to document proper follow-up on the medical needs of Patient A and the patient's continuing pain.

36. Respondent failed to evaluate and/or document careful evaluation of Patient A's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

37. Respondent failed to require Patient A to enter into a written "narcotics contract" addressing the physician-patient relationship and the patient's obligations as to the controlled substances being prescribed for him (or Respondent failed to document having done so).

38. Respondent repeatedly failed to document a clear, legitimate medical basis when he prescribed narcotics for Patient A. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, or making changes in dosing schedules.

39. Respondent failed to document in writing in Patient A's chart each narcotic prescription he wrote for the patient. Additionally, during some office visits by Patient A, Respondent wrote two or more prescriptions for the same narcotic drug but failed to document (or clearly document) that he had done so. Respondent also failed to document his reasoning and medical basis for double or triple prescribing of a particular narcotic during a single office visit by Patient A.

40. Respondent also wrote during a single office visit by Patient A prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

41. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient A.

42. Respondent failed to document in Patient A's chart careful consideration and evaluation of past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient. Respondent failed to follow-up on indicia of possible drug abuse or diversion by Patient A, such as claims of "lost", "stolen", or discarded narcotics.

43. Respondent failed to document careful ongoing assessment of potential side effects of his narcotics prescribing on Patient A. Respondent also failed to document assessment of whether or not the patient had progressed toward treatment objectives and improved functioning.

44. Respondent failed to document that he had addressed with Patient a medical or other concerns related to the claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing an "early" prescription for narcotics for Patient A or to consider medical or other implications.

45. Respondent also failed to document in the Patient A's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

46. Respondent also failed to document meaningful efforts by him to refer Patient A to specialists for evaluation or re-evaluation of his chronic pain and underlying medical conditions.

47. Respondent's chart entries repeatedly omitted clear identification of the specific narcotics being prescribed, strengths, and dosing schedules.

48. On April 25, 2007, by Respondent prescribed Fluoxetine 40 mg for Patient A to be renewed for 6 months, but failed to enter any documentation of a medical basis for this prescription.¹² The office note does not document any inquiry to the patient regarding symptoms, psychiatric functioning, past care, or any counseling of the patient. No assessment or treatment plan is documented in relation to Respondent's prescribing of this psychotropic drug for Patient A.

49. Respondent continued to prescribe narcotics for Patient A, even after Respondent claimed that his medical office was closing or had closed. Respondent failed to

12. Fluoxetine hydrochloride (Prozac) is a psychotropic prescribed for depressive disorders, obsessive compulsive disorder, bulimia, and panic disorder. It is not a DEA scheduled drug, but literature warns of the possibility of worsening depression, suicidal ideation, and other adverse reactions. Patient warnings regarding risks and benefits are recommended. Physicians are also advised to evaluate patients for a history of drug abuse and to monitor for signs of misuse or abuse of the drug. See Physician Desk Reference 2009 ed. at 1852-1860.

document sustained, meaningful efforts by him to timely refer Patient A to other practitioners for care in light of such planned closure of his office.

Patient B

50. Patient B first presented to Respondent on October 11 2006. Patient B, a female, was in her late-50s at this time. Respondent's medical records list the patient's address as a [REDACTED] [REDACTED] is approximately a 40-minute drive from Respondent's office in Ludlow, Vermont.

51. Respondent's typed chart entry for the initial office visit by Patient B followed the SOAP format. The "subjective" heading for this date includes the following: "here to establish, med/past medical hx/all/fam history reviewed and placed in chart". The "objective" heading includes the following: "Limited_Motion-Sine(+) flexion /extension both limited 60degrees/10degrees, also is unable to rotate normally at waist as well". The "assessment" heading states the following, "Hypertension (high blood pressure) #401.9; GERD-Esophagitis, reflux (irritated swallowing tube) #530.10; back pain, leg pain". Notwithstanding having documented hypertension in her chart, Respondent failed to take and/or document Patient B's blood pressure or weight in the patient's medical records for October 11, 2006 and for subsequent office visits by this patient.

52. The "plan" heading for Patient B's initial office visit on October 11, 2006 states, "not accepting new pain patients, suggested she find a MD in [REDACTED] area". Nonetheless, during her initial visit, Respondent Miller chose to prescribe for Patient B: "Percocet-5 (Generic- Oxycodone/Acetaminophen) (Form - Tabs (Disp - #90) (One every 4 hours as needed for pain)".

53. During this visit, Respondent failed to take and/or document a proper medical history or perform and/or document performing a proper physical examination of Patient B. Respondent's chart entries for the patient's initial office visit, on October 11, 2006, are sparse and lack detail. The office note for this date does not document evaluation by Respondent of the patient's pain (nature and level of intensity), development of differential diagnoses, or inquiry by the physician as to effect of her pain on the patient's physical and psychological functioning.

54. Nor does Respondent's office note for October 11, 2006 document any inquiry regarding past treatment for pain that Patient B may have received, document any inquiry regarding possible past substance use and abuse by Patient B, or clearly identify a medical indication for Respondent to prescribe opioid narcotics for the patient, particularly given that Patient B was a new patient for whom Respondent had not previously provided care. Further, the October 11, 2006 office note also did not document any treatment plan or recommendation to the patient by Respondent regarding possible future diagnostic procedures, treatment, or alternative modalities such as other analgesic remedies, physical therapy, exercise, or rehabilitation. Nor does the office note document that Respondent discussed with the patient the risks and benefits of the narcotic being prescribed for her.

55. Finally, Respondent recorded in the October 11, 2006 office note, "Follow Up: not planned." Nonetheless, Respondent saw Patient B again on October 23, 2006, less than two weeks later, and continued to care for her and prescribe narcotics for her until at least February 13, 2008. Between October 11, 2006 and February 13, 2008, Respondent's medical records for Patient B reflect more than 50 office visits or encounters with her. Virtually every office visit by Patient B reflected prescribing of narcotics for her by Respondent. On October 11, 2006 and

thereafter, until at least February 13, 2008, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for Patient B. Respondent Repeatedly prescribed large quantities of narcotics for Patient B, including Percocet and Oxycodone. However, during this period, Respondent's care and prescribing for Patient B: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his April 26, 2004 Letter of Assurance to the Board of Medical Practice, on one or more occasions as follows.

56. Respondent failed to document taking (or updating) a medical history for Patient B. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

57. Respondent failed to document performing (or updating) a physical examination of Patient B. Respondent did not document physical examination findings.

58. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient B's medical condition and medical needs.

59. Respondent failed to prepare and maintain current treatment plans for Patient B and/or document having done so. Respondent's "plans" repeatedly referred only to the renewal of narcotic medications, without more. Respondent failed to document proper follow-up on the medical needs of Patient B and the patient's pain.

60. Respondent failed to evaluate and/or document careful evaluation of Patient B's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or

inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

61. Respondent failed to require Patient B to enter into a written "narcotics contract" addressing the physician-patient relationship and the patient's obligations as to the controlled substances being prescribed for her (or failed to document having done so).

62. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient B during office visits. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, or changes in dosing schedules.

63. Respondent failed to document in writing in Patient B's chart each narcotic prescription he wrote for the patient. Additionally, during some office visits, Respondent wrote two or more prescriptions for the same narcotic drug but failed to document (or clearly document) that he had done so. Respondent also failed to document his reasoning and medical basis for double or triple prescribing of a specific narcotic during a single office visit by Patient B.

64. Respondent also wrote, during a single office visit by Patient B, prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

65. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient B. Respondent also failed to produce to the Board copies of an additional "paper chart" that he maintained for Patient B. Respondent claimed to have given the only copy of this "paper chart" to Patient B.

66. Respondent failed to document in Patient B's chart careful consideration and evaluation of past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient. Respondent failed to follow-up on indicia of possible drug abuse or diversion by Patient B, such as claims of "lost", "stolen", or discarded narcotics.

67. Respondent failed to document careful ongoing assessment of potential side effects of his narcotics prescribing on Patient B. Respondent also failed to document assessment of whether or not the patient had progressed toward treatment objectives and improved functioning.

68. Respondent failed to document that he had addressed with Patient B medical or other concerns related to a claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing an "early" prescription for narcotics for Patient B or consider medical or other implications.

69. Respondent also failed to document in Patient B's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

70. Respondent also failed to document sustained, meaningful efforts by him to refer Patient B to specialists for evaluation or re-evaluation of her chronic pain and underlying medical conditions and care.

71. Respondent's chart entries for Patient B repeatedly omitted clear identification of the specific narcotics being prescribed, strengths, and dosing schedules.

██████████ Criminal Charges Against Patient B

72. On or about March 12, 2008, Patient B was charged in the ██████████
██████████ with uttering a false prescription for 100 Percocet tablets in ██████████. The

prescription in question was dated February 27, 2008 and bore the printed name "Mitchell R. Miller, M.D." and Respondent's signature. A [REDACTED] pharmacist had rejected the prescription when presented due to its questionable appearance. Respondent subsequently made statements regarding this prescription to a pharmacist, the police, an attorney representing Patient B in her criminal case, and to an investigator for the Vermont Board of Medical Practice.

73. One or more of these statements by Respondent regarding the Percocet prescription was false and/or misleading. Respondent claimed on one occasion that because of errors in his records and "record keeping issues", he could not state with certainty that he had not written the February 27, 2008 narcotic prescription for Patient B. As a result, the pending criminal prescription charge against Patient B was dismissed by the [REDACTED]. Later, however, Respondent contradicted himself and directly told the Medical Board investigator that he had not written the February 27, 2008 Percocet prescription for Patient B and that the prescription, in fact, had been altered.

Patient C

74. Patient C, a female, was in her early-40s while being cared for by Respondent. Respondent Miller saw patient C for the first time on October 27, 2006. Her address is listed in Respondent's records as a post office box [REDACTED] is approximately a 40-minute drive from Respondent's office in Ludlow, Vermont.¹³

75. According to medical records, Patient C stated to Respondent during her initial visit that she had recently moved to the area from [REDACTED]. Respondent's typed chart entry for her initial office visit followed the SOAP format. The "subjective" heading for this date

13. Respondent described Patient C as being a family relation of Patient B. Respondent indicated to the Medical Board's investigator that the two patients [REDACTED] in [REDACTED]. Patient C's initial office visit with Respondent took place approximately two weeks after Patient B's first office visit with Respondent.

includes the following: "out of pain medication, has appointment but not until end of November, no one will prescribe her pain medication, back sxs-deep breaths hurt, pain constantly". The "objective" heading includes the following: "alert, mildly uncomfortable, walks slowly, dtrs normal, no paravertebral muscle spasm".

76. For the October 27, 2006 office visit, the "assessment" heading includes the following, "Herniated nucleus pulposus, uncomplicated (slipped disc) #722.2. t spine, gerd/ppi, lipids/statin". Respondent failed to clearly document in the patient's chart the medical basis or detail for his assessment of Patient C with herniated nucleus pulposus and failed to cite relevant subjective or objective signs and symptoms supporting this assessment. (Respondent also diagnosed Patient B with the same condition at a later date).

77. The "plan" heading for Patient C's initial office visit on October 27, 2006 states, "needs spine eval/has office visit scheduled at spine clinic dhmc". However, Respondent's medical records for this date and throughout her care fail to document the identity of any other physicians or specialists that Patient C was scheduled to see. Respondent's office note for this date also indicated that he planned no follow-up with Patient C. However, Patient C's medical records reflect that during her initial visit, Respondent Miller chose to prescribe for her: "percocet 5/325 #90".

78. On October 27, 2006 Respondent failed to take and/or document an adequate medical history or perform and/or document an adequate physical examination of Patient C. For example, Patient Cs medical records for October 27, 2006 (and for subsequent office visits) do not document her blood pressure, height, or weight. The office note for this date does not clearly document any assessment of the patient's pain (nature and level of intensity). Nor does it document inquiry by Respondent as to effect of her pain on the patient's physical and

psychological functioning. The office note for October 27, 2006 also does not document that Respondent ever discussed with the patient the risks and benefits of the narcotic being prescribed for her.

79. Respondent's office note for October 27, 2006 does not address or document past treatment for pain that Patient C might have received, document inquiry regarding any past substance use and abuse by Patient C, or clearly identify the medical indication and rationale for Respondent to prescribe opioid narcotics for the patient, particularly given that Patient C was a new patient for whom Respondent had not previously provided care. Nor did Respondent plan follow up care of Patient C, notwithstanding his willingness to prescribe narcotics for her on this date.

80. Respondent, in fact, subsequently cared for and prescribed for Patient C for approximately the next 16 months, beginning with her initial care on October 27, 2006 and continuing until at least February 13, 2008. Respondent's medical records reflect more than 30 office visits or patient encounters with Patient C during this period. Virtually every office visit reflected treatment for chronic pain with narcotics prescribed by Respondent. Respondent's acceptance of Patient C as a new chronic pain patient and his continuing treatment of her pain and his narcotics prescribing for her were contrary to the promise in Respondent's Letter of Assurance not to accept new patients who were likely to require treatment for chronic pain.

81. On October 27, 2006 and thereafter, until at least February 13, 2008, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for Patient C. Respondent repeatedly prescribed large quantities of narcotics for Patient C, including Percocet and Oxycodone. However, during this period, Respondent's care and prescribing for Patient C: (a) failed to meet professional standards; and/or (b) constituted

unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his Letter of Assurance to the Board of Medical Practice on one or more occasions, as follows.

82. Respondent failed to document taking (or updating) a medical history for Patient C. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

83. Respondent failed to document performing (or updating) a physical examination of Patient C. Respondent did not document physical examination findings.

84. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient C's medical condition and medical needs.

85. Respondent failed to prepare and maintain current treatment plans for Patient C and/or document having done so. Respondent's "plans" repeatedly referred only to the renewal of narcotic medications, without more. Respondent failed to document proper follow-up on the medical needs of Patient C and the patient's continuing pain.

86. Respondent failed to evaluate and/or document careful evaluation of Patient C's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

87. Respondent failed to require Patient C to enter into a written "narcotics contract" addressing the physician-patient relationship and the patient's obligations as to the controlled substances being prescribed for her (or Respondent failed to document having done so).

88. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient C during office visits. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, or making changes in dosing schedules.

89. Respondent failed to document in writing in Patient C's chart each narcotic prescription he wrote for the patient. Additionally, during some office visits, Respondent wrote two or more prescriptions for the same narcotic drug but failed to document (or clearly document) that he had done so. Respondent also failed to document his reasoning and medical basis for double or triple prescribing of a specific narcotic during a single office visit by Patient C.

90. Respondent also wrote, during single office visits by Patient C, prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

91. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written for Patient C.

92. Respondent failed to document in Patient C's chart careful consideration and evaluation of past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient.

93. Respondent failed to document careful ongoing assessment of potential side effects of his narcotics prescribing for Patient C. Respondent also failed to document assessment of whether or not the patient had progressed toward treatment objectives and improved functioning.

94. Respondent failed to document that he had addressed with Patient C medical or other concerns related to the claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing an "early" prescription for narcotics for Patient C or consider medical or other implications.

95. Respondent also failed to document in Patient C's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

96. Respondent also failed to document meaningful efforts by him to refer Patient C to specialists for evaluation or re-evaluation of her chronic pain and underlying medical conditions and for care.

Patient D

97. Patient D, a female, was in her 20s and early-30s during the period that Respondent provided care for her. Patient D's residence is listed in Respondent's records as [REDACTED] Respondent first saw Patient D as early as 2001. Between October 2004 and October 24, 2008, Respondent provided care and narcotic prescribing for Patient D, assessing "Right elbow pain, chronic s/p fracture 1992". Respondent treated Patient D until at least October 24, 2008, usually seeing her every week to 10 days.¹⁴ In fact, Patient D is still a patient of Respondent. Respondent prescribed more narcotics for Patient D as recently as March 12, 2009.

98. During the period he treated Patient D, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for Patient D. Respondent repeatedly prescribed large quantities of narcotics for Patient D, including

14. Between September 25, 2006 and October 24, 2008, Respondent documented more than 80 office visits or encounters with Patient D and prescribed narcotics for her on virtually every occasion.

Percocet, Oxycodone, and Duragesic patches¹⁵. Respondent's care and prescribing for Patient D: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his Letter of Assurance to the Board of Medical Practice on one or more occasions, as follows.

99. Respondent failed to document taking (or updating) a medical history for Patient D. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

100. Respondent failed to document performing (or updating) a physical examination by him of Patient D. Respondent did not document physical examination findings.

101. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient D's medical condition and medical needs.

102. Respondent failed to prepare and maintain current treatment plans for Patient D and/or document having done so. Respondent's "plans", when entered, repeatedly referred only to the renewal of narcotic medications, without more. Respondent failed to document proper follow-up on the medical needs of Patient D and the patient's continuing pain.

103. Respondent failed to evaluate and/or properly document careful evaluation of Patient D's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

15. Duragesic patches (fentanyl transdermal system) is indicated for moderate to severe pain requiring round-the-clock opioid administration if pain cannot be managed with non-steroidal analgesics, opioid combination products, or immediate release opioids. Duragesic contains a high concentration of the DEA Schedule II opioid, fentanyl. Opioids, such as fentanyl have a high potential for abuse and risk of fatal overdose due to respiratory depression. Fentanyl has a known potential for criminal diversion. See Physician Desk Reference 2009 ed. at 2405-2416.

104. Respondent failed to require Patient D to adhere to the terms of a written "narcotics contract" that the patient signed in 2005. Respondent failed to document responsive steps and/or imposition of consequences when the patient acted contrary to the terms of the narcotics contract.

105. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient D during office visits. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, or changes in dosing schedules.

106. Respondent failed to document in writing in Patient D's chart each narcotic prescription he wrote for the patient. Additionally, Respondent wrote multiple prescriptions for the same narcotic drug during a single office visit by Patient D. Respondent failed to document (or clearly document) that he had done so. Respondent also failed to document his reasoning and medical basis for double or triple prescribing of a specific narcotic during a single office visit by Patient D.

107. Respondent failed to document having taken precautions in the manner in which he wrote prescriptions so as to prevent Patient D from obtaining early refills when more than one prescriptions for the same narcotic was written during a single office visit.

108. Respondent also wrote, during individual office visits by Patient D, prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

109. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient D.

110. Respondent failed to document in Patient D's chart careful consideration and evaluation of possible past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient. Respondent failed to document follow-up on indicia of possible drug abuse or diversion by Patient D, such as claims of "lost" or "stolen" narcotics.

111. Respondent failed to document careful ongoing assessment of potential side effects of his narcotics prescribing for Patient D. Respondent also failed to document assessment of whether or not the patient had progressed toward treatment objectives and improved functioning.

112. Respondent failed to document that he had addressed with Patient D medical or other concerns related to the claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing an "early" prescription for narcotics for Patient D or consideration of medical or other implications.

113. Respondent also failed to document in Patient D's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

114. Respondent also failed to document sustained, meaningful efforts by him to refer Patient D to specialists for evaluation or re-evaluation of her chronic pain and underlying medical conditions and care.

115. Respondent's chart entries for Patient D repeatedly omitted clear identification of the specific narcotics being prescribed, strengths, and/or dosing schedules.

116. Respondent's treated Patient D for chronic pain until at least October 24, 2008 but his care and prescribing for her repeatedly were inconsistent with the promises and commitments that he made to the Medical Board in his April 26, 2004 Letter of Assurance.

Patient E

117. Patient E, a female, was in her 30s during the period that Respondent provided care for her. Patient E's residence is listed in Respondent's records as [REDACTED]. Respondent first saw Patient E for Patient E, assessing her with "Strain, back #847.9. chronic, work related". as early as April 2004. Until at least June 13, 2008, Respondent provided care and narcotic prescribing for Patient E.

118. During the period he treated Patient E, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for her. Respondent repeatedly prescribed large quantities of controlled substances for Patient E, including Percocet, Oxycodone, and Suboxone. Suboxone is indicated for the treatment of opioid dependence.¹⁶ Respondent's care and prescribing for Patient E: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his Letter of Assurance on one or more occasions, as follows.

16. Under the Drug Addiction Treatment Act of 2000 (DATA), 21 U.S.C. Section 823(g), Suboxone (buprenorphine HCl and naxolone HCl dehydrate sublingual tablets) and Subutex (buprenorphine HCl sublingual tablets) may be prescribed by physicians in the treatment of opioid dependence. Physicians who meet qualifying requirement and who have notified the Secretary of Health and Human Services of their intent to do so may prescribe Suboxone for the treatment of opioid dependence. Suboxone and Subutex are DEA Schedule III drugs. The literature provides a series of warning and precautions regarding the administration of Suboxone to patients, including possible short-term mental or physical impairment, opioid withdrawal effects, or overdose. See Physician Desk Reference 2009 ed. at 2601-2605. "SUBOXONE is appropriate for the treatment of people who have become physically dependent or psychologically dependent on opioids AND who are not in need of opioids for pain management. SUBOXONE is not indicated for treating pain." See www.suboxone.com/patients/opioiddependence/dependence_tolerance.aspx.

119. Respondent failed to document an updated medical history for Patient E. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

120. Respondent failed to document an updated physical examination of Patient E. Respondent did not document physical examination findings.

121. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient E's medical condition and medical needs.

122. Respondent failed to prepare and maintain current treatment plans for Patient E and/or document having done so. Respondent's "plans", when entered, repeatedly referred only to the renewal of narcotic medications or prescribing, without more.

123. Respondent failed to evaluate and/or properly document careful evaluation of Patient E's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

124. Respondent failed to require Patient E enter into a written "narcotics contract" addressing the physician-patient relationship and the patient's obligations as to the controlled substances being prescribed for him (or failed to document having done so).

125. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient E during her office visits.

126. Respondent failed to document in writing in Patient E's chart each narcotic prescription he wrote for the patient.

127. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient E.

128. Respondent failed to document in Patient E's chart careful consideration and evaluation of possible past or present substance abuse in relation to his prescribing of narcotics for the patient. Respondent failed to document follow-up on indicia of possible drug abuse or diversion by Patient D, such as claims of "stolen" narcotics.

129. Respondent failed to document careful ongoing assessment of whether or not the patient had progressed toward treatment objectives, such as ending use of pain medications, and improved functioning.

130. Respondent failed to document that he had addressed with Patient E medical or other concerns related to a claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing "early" prescriptions for narcotics for Patient D or consideration of implications.

131. Respondent also failed to document in Patient E's chart a chronological narcotic/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

132. Respondent's treated Patient E for chronic pain until at least June 13, 2008 but his care and prescribing for her repeatedly were inconsistent with the promises and commitments that he made to the Medical Board in his April 26, 2004 Letter of Assurance.

Patient E

133. Respondent prescribed large quantities of narcotics for Patient F, a female in her 40s and 50s during the period that Respondent provided care to her. Patient F's residence is listed in Respondent's records as [REDACTED] Respondent assessed Patient F with medical conditions that included chronic obstructive pulmonary disease, asthma, chest pain, chronic pain syndrome, right calcaneus fracture, depression, and chronic headaches.

Respondent first provided care to Patient F in 2002. His care of Patient F continued until at least October 14, 2008.

134. While caring for Patient F, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for her. Respondent prescribed large quantities of narcotics for Patient F, including Percocet, Oxycodone, Vicodin¹⁷, and Duragesic patches. Respondent's care and prescribing for Patient F: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his April 26, 2004 Letter of Assurance to the Board of Medical Practice on one or more occasions as follows.

135. Respondent failed to document taking (or updating) a medical history for Patient F. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

136. Respondent failed to document performing (or updating) a physical examination of Patient F. Respondent did not document physical examination findings.

137. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient F's medical condition and medical needs.

138. Respondent failed to document preparation and maintenance of current treatment plans for Patient F.

17. Vicodin (hydrocodone bitartrate and acetaminophen tablets) is an opioid analgesic and antitussive indicated for relief of moderate to moderately severe pain. Vicodin is a DEA Schedule III drug. Physicians are warned that Vicodin may be abused or diverted and warned regarding "drug seeking" and "doctor shopping" behavior of individuals who seek this narcotic for other than legitimate medical purposes. See Physician Desk Reference 2009 ed. at 529-533.

139. Respondent failed to evaluate and/or properly document careful, ongoing evaluation of Patient F's pain (nature and level of intensity), assessment of underlying causes, and/or past treatment for pain.

140. Respondent failed to execute a written "narcotics contract" with Patient F. A copy of such a contract was placed in the patient's chart on or about December 14, 2004 but never signed by either Respondent or Patient F.

141. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient F during her office visits. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, or changing dosing schedules.

142. Respondent failed to document in writing in Patient F's chart each narcotic prescription he wrote for the patient.

143. Respondent also wrote, during individual office visits by Patient F, prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

144. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient F.

145. Respondent failed to document careful, ongoing assessment of potential side effects of his narcotics prescribing on Patient F. Respondent on February 25, 2008, September 15, 2008, and October 14, 2008 made references to a "medication taper" but documented no medical reasoning or treatment plan in this regard. Respondent also failed to document assessment of progress by the patient toward treatment objectives and improved functioning.

146. Respondent also failed to document in Patient F's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

147. Respondent failed to produce to the Board of Medical Practice all medical charts he prepared for his care of Patient F.

148. Respondent also failed to document ongoing efforts by him to refer Patient F to specialists for evaluation or re-evaluation of her pain and underlying medical conditions.

149. Respondent treated Patient F for chronic pain until at least October 14, 2008 but his care and prescribing for her repeatedly were inconsistent with the promises and commitments that he made to the Medical Board in his April 26, 2004 Letter of Assurance.

Patient G

150. Patient G, a male, was in his 30s, with a listed address in [REDACTED] while Respondent was caring for him. Respondent Miller cared for Patient G and prescribed large quantities of narcotics for him, from at late-2004 until at least September 26, 2008. Respondent assessed Patient G with various medical problems, including sleep apnea, hypothyroid, depression, anxiety, fibromyalgia #729.1, and myofascial pain syndrome.

151. While caring for Patient G, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for the patient. Respondent repeatedly prescribed large quantities of narcotics for Patient G, including Percocet, Oxycontin, Oxycodone, and Hydrocodone. Respondent's care and prescribing for Patient G: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in

his April 26, 2004 Letter of Assurance to the Board of Medical Practice on one or more occasions, as follows.

152. Respondent failed to document taking (or updating) a medical history for Patient G. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

153. Respondent failed to document performing (or updating) a physical examination of Patient G. Respondent did not document physical examination findings.

154. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient G's medical condition and medical needs.

155. Respondent failed to document preparation and maintenance of current treatment plans for Patient G. Respondent's "plans" repeatedly referred only to the renewal of narcotic medications, without more.

156. Respondent failed to evaluate and/or document careful evaluation of Patient G's pain (nature and level of intensity) and document assessment of underlying causes.

157. Respondent repeatedly failed to document a clear, legitimate medical basis in each instance when he prescribed narcotics for Patient G. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, and/or changes in dosing schedules.

158. Respondent failed to document his own adherence to the terms of a narcotic contract with Patient G.

159. Respondent failed to document in writing in Patient G's chart each narcotic prescription he wrote for the patient.

160. Respondent wrote during a single office visit by Patient G prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

161. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient G.

162. Respondent failed to document in Patient G's chart careful, ongoing consideration and evaluation of past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient. Respondent failed to document follow-up on indicia of possible drug abuse or diversion by Patient G, such as claims of "lost" narcotics.

163. Respondent failed to document careful, ongoing assessment of potential side effects of his narcotics prescribing on Patient G. Respondent also failed to document assessment of whether or not the patient was progressing toward treatment objectives and improved functioning.

164. Respondent failed to document that he had addressed with Patient G medical or other concerns related to the claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in office notes when he was writing an "early" prescription for narcotics for Patient G or consideration of implications. Respondent failed to require Patient G to sign a "narcotics contract" or "prescribing contract" setting forth the terms governing the patient's receipt of narcotic prescriptions from Respondent.

165. Respondent failed to document in the Patient G's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

166. Respondent treated Patient G for chronic pain until at least September 26, 2008 but his care and prescribing for him repeatedly were inconsistent with the promises and commitments that he made to the Medical Board in his April 26, 2004 Letter of Assurance.

Patient H

167. Respondent prescribed large quantities of narcotics for Patient H, a female, who was in her 50s during the period that Respondent provided medical care to her. Patient H's residence is listed in Respondent's records [REDACTED]. Respondent Miller cared for Patient H and prescribed large quantities of narcotics for her from as early as October 2004 until at least September 25, 2008. Respondent assessed Patient H with various medical problems, including low back strain (work related) and degenerative disc disease #722.6

168. While caring for Patient H, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for the patient. Respondent repeatedly prescribed large quantities of Percocet for Patient H. Respondent's care and prescribing for Patient H: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his Letter of Assurance to the Board of Medical Practice on one or more occasions, as follows.

169. Respondent failed to document taking (or updating) a medical history for Patient H. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

170. Respondent failed to document performing (or updating) a physical examination of Patient H. Respondent did not document physical examination findings.

171. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient H's medical condition and medical needs.

172. Respondent failed to document preparation and maintenance of current treatment plans for Patient H and/or document having done so. Respondent's "plans", when entered, referred only to the renewal of narcotic medications, without more. Respondent failed to document proper follow-up on the medical needs of Patient D and the patient's continuing pain.

173. Respondent failed to evaluate and/or properly document careful, ongoing evaluation of Patient H's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

174. Respondent failed to require Patient H to adhere to the terms of a written "narcotics contract".

175. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient H during office visits.

176. Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient H.

177. Respondent failed to document in Patient H's chart careful, ongoing consideration and evaluation of possible past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient.

178. Respondent failed to document careful ongoing assessment of potential side effects of his narcotics prescribing on Patient H. Respondent also failed to document

assessment of whether or not the patient was progressing toward treatment objectives and improved functioning.

179. Respondent failed to document that he had addressed with Patient H medical or other concerns related to a claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing an "early" prescription for narcotics for Patient H or consideration of implications.

180. Respondent also failed to document in Patient H's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

181. Respondent also failed to document meaningful, sustained efforts by him to refer Patient H to specialists for evaluation or re-evaluation of her chronic pain and underlying medical conditions.

182. Respondent failed to produce to the Board of Medical Practice all medical charts he prepared for his care of Patient H.

183. Respondent's treated Patient H for chronic pain until at least September 25, 2008 but his care and prescribing for her repeatedly were inconsistent with the promises and commitments that he made to the Medical Board in his Letter of Assurance.

Patient I

184. Respondent prescribed large quantities of narcotics for Patient I, a male, who was in his late-20s while Respondent provided medical care to him. Patient I's residence is listed in Respondent's records as [REDACTED]. Respondent Miller cared for Patient I and prescribed large quantities of narcotics for him from as early as October 2004 until at least November 12, 2007. Respondent assessed Patient I with various medical problems, including

lumbosacral spine dysfunction, anxiety, depression, "alcohol a problem in the past", knee pain secondary to a fractured patella, and opiate dependence.

185. While caring for Patient I, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for the patient. Respondent repeatedly prescribed large quantities of Percocet for Patient I. Respondent's care and prescribing for Patient H: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with promises and commitments made by Respondent in his April 26, 2004 Letter of Assurance to the Board of Medical Practice on one or more occasions as follows.

186. Respondent failed to document taking (or updating) a medical history for Patient I. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

187. Respondent failed to document performing (or updating) a physical examination of Patient I. Respondent did not document physical examination findings.

188. Respondent failed to document preparation or maintenance of current diagnostic assessments of Patient I's medical condition and medical needs.

189. Respondent failed to document preparation and/or maintenance of current treatment plans for Patient I. Respondent's "plans" repeatedly referred only to the renewal of narcotic medications, without more.

190. Respondent failed to evaluate and/or document careful, ongoing evaluation of Patient I's pain (nature and level of intensity), assessment of underlying causes, past treatment

for pain, or document clear inquiry by Respondent as to effect of any pain on the patient's physical and psychological functioning.

191. Respondent repeatedly failed to document a clear, legitimate medical basis in each instance when he prescribed narcotics for Patient I. Respondent failed to document the medical basis for changing or adding different narcotics, changing dosage strengths, or making changes in dosing schedules.

192. Respondent failed to document in Patient I's chart careful, ongoing consideration and evaluation of past or present substance abuse or dependency in relation to his prescribing of narcotics for the patient.

193. Respondent failed to document careful, ongoing assessment of potential side effects of his narcotics prescribing on Patient I. Respondent also failed to document assessment of whether or not the patient was progressing toward treatment objectives and improved functioning. Respondent on November 27, 2006 and December 4, 2006 made references to an opiate "taper" for Patient I but documented no medical basis or treatment plan in this regard or any follow-up.

194. Respondent failed to document that he had addressed with Patient I medical or other concerns related to the claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in office notes when he was writing an "early" prescription for narcotics for Patient I or consideration of implications. Respondent failed to require Patient I to sign a "narcotics contract" or "prescribing contract" setting forth specific terms governing the patient's receipt of narcotic prescriptions from Respondent.

195. Respondent also failed to document in Patient I's chart a chronological narcotics/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

196. Respondent also failed to document meaningful, sustained efforts by him to refer Patient I to specialists for evaluation or re-evaluation of his chronic pain and underlying medical conditions.

197. Respondent treated Patient I for chronic pain until at least November 12, 2007, but his care and prescribing for him repeatedly were inconsistent with the promises and commitments that he had made to the Medical Board in his Letter of Assurance.

Patient J

198. Respondent prescribed large quantities of narcotics for Patient J from at least 2002 until 2008. Patient J, a female, was in her early-40s when Respondent last provided medical care to her. Patient J had multiple medical problems. From note to note, Respondent documented for Patient J an assessment, substantially verbatim, that included the following: "right arm numbness, right sided neck pain"; "Degenerative Joint Disease #715.90"; "depression/anxiety"; "Chronic pain syndrome #307.80"; and "Herniated nucleus pulposus, uncomplicated (slipped disc) #722.2". Respondent repeatedly prescribed large quantities of narcotics for Patient J, including Oxycontin, Oxycodone, and Percocet.

199. During the period he treated Patient J, Respondent repeatedly failed to provide and/or document sound medical care and prudent narcotic prescribing for her. Respondent's care and prescribing for Patient J: (a) failed to meet professional standards; and/or (b) constituted unsafe or unacceptable patient care; and/or (c) failed to conform to essential standards of acceptable and prevailing medical practice; and/or (d) was inconsistent with

promises and commitments made by Respondent in his Letter of Assurance to the Board of Medical Practice on one or more occasions, as follows.

200. Respondent failed to document taking (or updating) a current medical history for Patient J. Respondent failed to document subjective or objective data and signs adequate to support diagnoses.

201. Respondent failed to document performing (or updating) a physical examination of Patient J. Respondent did not document physical examination findings.

202. Respondent failed to document preparation of or maintenance of current diagnostic assessments of Patient J's medical condition and medical needs.

203. Respondent failed to prepare and maintain current treatment plans for Patient J and/or document having done so. Respondent's "plans", when entered, frequently referred only to the renewal of narcotic medications or prescribing.

204. Respondent failed to evaluate and/or properly document careful, ongoing evaluation of Patient J's pain (nature and level of intensity), assessment of underlying causes, past treatment for pain, or inquiry by Respondent as to effect of pain on the patient's physical and psychological functioning.

205. Respondent also failed to document meaningful, sustained efforts by him to refer Patient I to specialists for evaluation or re-evaluation of his chronic pain and underlying medical conditions and care.

206. Respondent repeatedly failed to document a clear, legitimate medical basis for prescribing narcotics for Patient J during her office visits.

207. Respondent failed to document in writing in Patient J's chart each narcotic prescription he wrote for the patient.

208 Respondent failed to produce to the Board of Medical Practice, as required, copies of all narcotics prescriptions that he had written to Patient J.

209. Respondent also wrote, during individual office visits by Patient J, prescriptions for two or more different narcotics but failed to document his reasoning and the medical basis for prescribing in this manner and for the specific drugs he chose.

210. Respondent failed to document in Patient J's chart careful, ongoing consideration and evaluation of possible past or present substance abuse in relation to his prescribing of narcotics for the patient. Respondent failed to document follow-up on indicia of possible drug abuse or diversion by Patient J, such as claims of "stolen" narcotics or medications seized as evidence by the authorities.

211. Respondent failed to document careful, ongoing assessment of whether or not the patient was progressing toward treatment objectives, such as ending use of pain medications, and improved functioning. Respondent on February 6, 2008 and March 22, 2008 made references to a "taper" of pain medication by Patient J but documented no medical basis or treatment plan in this regard.

212. Respondent failed to document that he had addressed with Patient J medical or other concerns related to a claimed need for or requests for "early" refills of narcotics. Respondent also failed to document recognition in his office notes when he was writing "early" prescriptions for narcotics for Patient J. Respondent failed to document in Patient J's chart a chronological narcotic/medication flow chart to aid him in monitoring refills, symptoms and time course, and chronicity of prescribing.

Patient J's Positive Mammogram

213. On January 21, 2008, Respondent documented in Patient J's chart, "dx: positive

screening mammogram”, but the chart entry by Respondent provides no detail such as the date or place where the mammogram was carried out, fails to refer to a report or documentation, and no provides no name of or site identification for the radiologist or other provider. For the next three office visits, on February 6, 2008, February 13, 2008, and March 13, 2008, Respondent documents no discussion or follow-up of any kind by him with Patient J regarding the “positive screening mammogram”. During each of these three visits Respondent did prescribe additional narcotics for Patient J.

214. On March 22, 2008, Respondent documented under “Plan”, “dx: f/u breast lump”. The next entry in the chart stated that Respondent planned no follow-up. In the remainder of Patient J’s chart, there is no documentation of any further discussion with the patient or follow-up action of any kind by Respondent with regard to the “positive screening mammogram” or the patient’s “breast lump”. No consultation, communication, or referral by Respondent is documented. No counseling of the patient is documented regarding risks and the need for follow-up diagnostics, care, and treatment.

215. On May 26, 2008, Respondent documented “here for med refills, doing okay otherwise” and “no acute distress”. Nonetheless, Respondent wrote on this date for Patient J two prescriptions for Oxycodone, plus an additional prescription for Oxycontin. However, Respondent made no record of these narcotic prescriptions in the patient’s chart. Instead, he merely wrote, “Medications: see Xerox copies” with no further explanation, medical basis, or other information regarding the prescriptions that had been written.

216. On June 2, 2008, Respondent documented the following regarding Patient J, “had purse stolen, medication was in it and now is gone. Police were notified and apparently a report was filed, discussed with officer responding who stated [Patient J] appeared to be

detoxing". Respondent documented no further inquiries of the patient or documented any concern on his part regarding the circumstances involved or the matter of his patient "detoxing". No other details or comment are documented in the chart. Nonetheless, Respondent on this date prescribed yet more Oxycontin for Patient J and continued to prescribe more narcotics for her until September 15, 2008 when his note documents, "moving to [REDACTED] last visit planned." At this last visit, Respondent again wrote a prescription for Oxycontin for Patient J, as well as two more prescriptions for Oxycodone. Under the heading "Follow Up", Respondent wrote "not planned".

217. Respondent failed to require Patient J to sign a "narcotics contract" or "prescribing contract" setting forth terms governing the patient's receipt of narcotic prescriptions from Respondent. Respondent's care and treatment of Patient J, including his care of her chronic pain and his narcotics prescribing for her repeatedly failed to document the content and detail he had promised to the Board of Medical Practice in his April 26, 2004 Letter of Assurance. Moreover, his care of Patient J failed to reflect scrupulous attention to care of her medical needs, professional standards, or concern regarding the consequences of his prescribing practices.

Misrepresentation by Respondent re Consultation

218. In his April 26, 2004 Letter of Assurance to the Vermont Board of Medical Practice, Respondent wrote:

During my meeting with the Central Investigative Committee on January 9, 2004, the committee's members again expressed continuing concern regarding aspects of my prescribing practices. Since that meeting with the committee in 2001, I have taken a number of steps in my practice in an effort to improve the [medical] care I provide to my patients. **I now consult regularly with Seddon R. Savage, M.D., a New Hampshire anesthesiologist, for chart reviews and discussion of my treatment of**

pain for individual patients. I also collaborate with Dartmouth Hitchcock Medical Center regarding certain patients.

See Respondent's April 26, 2004 Letter of Assurance at p. 2 (emphasis added).

219. On or about January 23, 2009, an investigator for the Vermont Board of Medical Practice questioned Respondent Miller regarding his compliance with the above statement. Respondent admitted to the investigator that he had never met Seddon Savage, M.D. He also admitted that he had never had any communication or contact with her of any kind. Dr. Savage independently corroborated that she had no record of or recollection of ever speaking with Respondent or having been contacted by Respondent regarding any matter.

220. The Medical Board investigator questioned Respondent regarding any collaboration he had pursued with other physicians regarding his chronic pain patients. Respondent answered that he consulted with other physicians only if a patient was actually being sent to a particular specialist with regard to a specific medical condition. However, the medical records reviewed by the Board of Medical Practice and discussed above fail in most cases to reflect any actual collaboration or consultation by Respondent with other physicians or with the Dartmouth Hitchcock Medical Center regarding his treatment of these patients or care of their pain. Respondent failed to identify for the Board investigator the names of any physicians with whom he claimed to have collaborated.

221. Respondent failed to correct his misleading written statement to the Board of Medical Practice regarding consultation and collaboration, until directly questioned on this point by the Board's investigator. Respondent allowed this written misrepresentation to stand in the Board's files for nearly five years and to mislead those who had relied upon it and other representations made by Respondent in his Letter of Assurance.

222. Respondent's April 26, 2004 Letter of Assurance, including his statement regarding consultation and collaboration, as set forth above in Paragraph 218, above, contained one or more knowing, material misrepresentations by Respondent, made in writing, directly to the Vermont Board of Medical Practice, regarding his care of patients, practice of medicine, and prescribing of narcotics. Respondent's conduct was duplicitous. Respondent acted in bad faith with regard to his obligations to the profession of medicine and the Vermont Board of Medical Practice.

Alteration of Patient Medical Records

223. Respondent improperly altered one or more patient medical records that were produced to the Board of Medical Practice by Respondent. Respondent improperly inserted new content and/or phrases into existing chart entries. Respondent failed to indicate clearly that he had made such alterations or insertions, date these changes, or initial or sign these. No explanation for making these changes was entered into the chart by Respondent. Respondent never disclosed to the investigator for Board of Medical Practice that he had made such alterations to the patient records while these were under review by the Board of Medical Practice.

False or Misleading Statements to Board Investigator

224. On one or more occasions, Respondent made false and/or misleading statements to a Board of Medical Practice investigator in claiming to have "closed" his medical office, as well misidentifying the number (or names) of chronic pain patients remaining in his care, for whom he was still prescribing narcotics. Respondent knew or should have known that such statements by him were false and/or misleading.

III. Statutory Violations.

Count 1

225. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

226. By one or acts in his care of or related to his care of Patient A, as described in Paragraphs 26 through 49, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 2

227. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

228. By two or more acts in his care of or related to his care of **Patient A**, as described in Paragraphs 26 through 49, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 3

229. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

230. By one or more acts in his care of or related to his care of **Patient A**, as described in Paragraphs 26 through 49, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 4

231. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

232. By one or more acts in his care of or related to his care of **Patient A**, as described in Paragraphs 26 through 49, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 5

233. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

234. By one or more acts in his care of or related to his care of **Patient A**, as described in Paragraphs 26 through 49, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 6

235. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

236. By one or acts in his care of or related to his care of **Patient B**, as described in Paragraphs 50 through 73, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 7

237. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

238. By two or more acts in his care of or related to his care of **Patient B**, as described in Paragraphs 50 through 73, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 8

239. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

240. By one or more acts in his care of or related to his care of **Patient B**, as described in Paragraphs 50 through 73, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 9

241. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

242. By one or more acts in his care of or related to his care of **Patient B**, as described in Paragraphs 50 through 73, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 10

243. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

244. By one or more acts in his care of or related to his care of **Patient B**, as described in Paragraphs 50 through 73, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice

competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 11

245. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

246. By one or acts in his care of or related to his care of **Patient C**, as described in Paragraphs 74 through 96, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 12

247. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

248. By two or more acts in his care of or related to his care of **Patient C**, as described in Paragraphs 74 through 96, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 13

249. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

250. By one or more acts in his care of or related to his care of **Patient C**, as described in Paragraphs 74 through 96, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 14

251. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

252. By one or more acts in his care of or related to his care of **Patient C**, as described in Paragraphs 74 through 96, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 15

253. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

254. By one or more acts in his care of or related to his care of **Patient C**, as described in Paragraphs 74 through 96, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 16

255. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

256. By one or acts in his care of or related to his care of **Patient D**, as described in Paragraphs 97 through 116, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 17

257. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

258. By two or more acts in his care of or related to his care of **Patient D**, as described in Paragraphs 97 through 116, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 18

259. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

260. By one or more acts in his care of or related to his care of **Patient D**, as described in Paragraphs 97 through 116, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 19

261. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

262. By one or more acts in his care of or related to his care of **Patient D**, as described in Paragraphs 97 through 116, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 20

263. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

264. By one or more acts in his care of or related to his care of **Patient D**, as described in Paragraphs 97 through 116, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice

competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 21

265. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

266. By one or acts in his care of or related to his care of **Patient E**, as described in Paragraphs 117 through 132, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 22

267. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

268. By two or more acts in his care of or related to his care of **Patient E**, as described in Paragraphs 117 through 132, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 23

269. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

270. By one or more acts in his care of or related to his care of **Patient E**, as described in Paragraphs 117 through 132, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 24

271. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

272. By one or more acts in his care of or related to his care of **Patient E**, as described in Paragraphs 117 through 132, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 25

273. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

274. By one or more acts in his care of or related to his care of **Patient E**, as described in Paragraphs 117 through 132, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 26

275. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

276. By one or acts in his care of or related to his care of **Patient F**, as described in Paragraphs 133 through 149, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 27

277. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

278. By two or more acts in his care of or related to his care of **Patient F**, as described in Paragraphs 133 through 149, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 28

279. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

280. By one or more acts in his care of or related to his care of **Patient F**, as described in Paragraphs 133 through 149, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 29

281. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

282. By one or more acts in his care of or related to his care of **Patient F**, as described in Paragraphs 133 through 149, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 30

283. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

284. By one or more acts in his care of or related to his care of **Patient F**, as described in Paragraphs 133 through 149, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice

competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 31

285. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

286. By one or acts in his care of or related to his care of **Patient G**, as described in Paragraphs 150 through 166, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 32

287. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

288. By two or more acts in his care of or related to his care of **Patient G**, as described in Paragraphs 150 through 166, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 33

289. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

290. By one or more acts in his care of or related to his care of **Patient G**, as described in Paragraphs 150 through 166, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 34

291. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

292. By one or more acts in his care of or related to his care of **Patient G**, as described in Paragraphs 150 through 166, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 35

293. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

294. By one or more acts in his care of or related to his care of **Patient G**, as described in Paragraphs 150 through 166, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 36

295. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

296. By one or acts in his care of or related to his care of **Patient H**, as described in Paragraphs 167 through 183, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 37

297. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

298. By two or more acts in his care of or related to his care of **Patient H**, as described in Paragraphs 167 through 183, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 38

299. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

300. By one or more acts in his care of or related to his care of **Patient H**, as described in Paragraphs 167 through 183, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 39

301. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

302. By one or more acts in his care of or related to his care of **Patient H**, as described in Paragraphs 167 through 183, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 40

303. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

304. By one or more acts in his care of or related to his care of **Patient H**, as described in Paragraphs 167 through 183, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice

competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 41

305. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

306. By one or acts in his care of or related to his care of **Patient I**, as described in Paragraphs 184 through 197, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 42

307. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

308. By two or more acts in his care of or related to his care of **Patient I**, as described in Paragraphs 184 through 197, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 43

309. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

310. By one or more acts in his care of or related to his care of **Patient I**, as described in Paragraphs 184 through 197, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 44

311. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

312. By one or more acts in his care of or related to his care of **Patient I**, as described in Paragraphs 184 through 197, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 45

313. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

314. By one or more acts in his care of or related to his care of **Patient I**, as described in Paragraphs 184 through 197, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 46

315. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

316. By one or acts in his care of or related to his care of **Patient J**, as described in Paragraphs 198 through 217, above, Respondent in the course of practice **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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 47

317. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

318. By two or more acts in his care of or related to his care of **Patient J**, as described in Paragraphs 198 through 217, above, Respondent in the course of practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 48

319. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

320. By one or more acts in his care of or related to his care of **Patient J**, as described in Paragraphs 198 through 217, above, Respondent's conduct evidences unfitness to practice medicine and thereby is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 49

321. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

322. By one or more acts in his care of or related to his care of **Patient J**, as described in Paragraphs 198 through 217, above, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 50

323. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

324. By one or more acts in his care of or related to his care of **Patient J**, as described in Paragraphs 198 through 217, above, Respondent failed to practice competently and/or in conformity with essential standards of acceptable and prevailing practice. Such conduct is unprofessional under the provisions of 26 V.S.A. § 1354(b)(1) (failure to practice

competently by performance of unsafe or unacceptable patient care) and/or 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice).

Count 51

325. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

326. By his conduct in making one or more written, knowing, material misrepresentations to the Vermont Board of Medical Practice regarding his consultation and/or collaboration with other physicians; by improperly altering patient records; and/or by making false and/or misleading statements to a Medical Board investigator, as described in Paragraphs 218 through 224, above, Respondent engaged in conduct which evidences unfitness to practice medicine and is unprofessional. 26 V.S.A. § 1354(a)(7).

Count 52

327. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

328. By his conduct in making one or more written, knowing, material misrepresentations to the Vermont Board of Medical Practice regarding his consultation and/or collaboration with other physicians; by improperly altering patient records; and by making false and/or misleading statements to a Medical Board investigator, as described in Paragraphs 218 through 224, above, Respondent engaged conduct which is immoral, unprofessional, and/or dishonorable. 26 V.S.A. § 1398.

Count 53

329. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

330. By two or more acts during his care of or related to his care of the patients identified above and, expressly, as to his obligations under his April 26, 2004 Letter of Assurance, as described in Paragraphs 4 through 224, above, Respondent in the course of

practice failed to use and exercise on repeated occasions, 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 and thereby engaged in unprofessional conduct. 26 V.S.A. § 1354(a)(22).

Count 54

333. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

334. By failing to act in good faith and by failing to honor his promises and commitments and by acting in disregard of his obligations under his April 26, 2004 Letter of Assurance to the Vermont Board of Medical Practice, as described in Paragraphs 4 through 224, above, Respondent engaged conduct which is immoral, unprofessional, and/or dishonorable on one or more occasions. 26 V.S.A. § 1398.

Count 55

335. Paragraphs 4 through 224, above, are repeated and incorporated by reference.

336. By one or more acts during his care of or related to his care of the patients identified above, as described in Paragraphs 4 through 224, above, specifically including the manner of his prescribing of DEA Scheduled narcotics, controlled substances, and/or regulated drugs, Respondent: (a) failed to exercise his prescriptive authority in good faith and thereby failed to comply with the lawful requirements of 26 V.S.A. § 4214(a); and/or (b) issued a prescription for other than a legitimate medical purpose and thereby failed to comply with the lawful requirements of 21 CFR 1306.04. Such conduct is unprofessional. 26 V.S.A. § 1354(a)(27).

Petitioner, the State of Vermont, for the reasons set forth above, moves the Vermont Board of Medical Practice to find **RESPONDENT MITCHELL R. MILLER**,

M.D., guilty of unprofessional conduct on one or more counts charged above, following hearing, and thereafter enter an order **REVOKING** the Vermont medical license of Respondent Miller or taking such other disciplinary action as the Board may deem proper, including entry of an order to suspend, limit, condition, or reprimand the medical license of Respondent Miller.

Dated at Montpelier, Vermont this 31st day of March 2009.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By:

James S. Arisman
JAMES S. ARISMAN
Assistant Attorney General

* * *

Charges Issued

Foregoing Charges of Unprofessional Conduct, Filed by the State of Vermont, as to Mitchell R. Miller, M.D., a/k/a Mitch Miller, Docket No. MPC 76-1100, Vermont Board of Medical Practice, Are Hereby Issued.

Margaret Funk Martin

MARGARET FUNK MARTIN
Secretary, Board of Medical Practice

4/1/09

Dated

MITCHELL R. MILLER, MD
FAMILY PRACTICE

David W. Clauss, M.D.
Chair, Central Investigative Committee
Vermont Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, Vermont 05402-0070

STATE OF VERMONT

MPB Docket No: MPC 76-1100

EXHIBIT 1

April 26, 2004

Re: Docket No. MPC 76-1100; Vermont Board of Medical Practice

Dear Dr. Clauss:

I would like to thank the members of the Central Investigative Committee of the Board of Medical Practice for meeting with me on January 9, 2004. I appreciate the committee's interest in meeting with me again to discuss aspects of my prescribing of controlled substances for patients. As you are aware, I also met with the committee on June 18, 2001 to address the same subject.

The board of Medical Practice on November 9, 2000 opened the above-referenced complaint and investigation with regard to my prescribing of Oxycontin and other controlled substances for [REDACTED], who is my patient. I am aware that the Board's investigation was opened based on the concerns of several area pharmacists regarding the quantities and dosages of Oxycontin that I had prescribed for [REDACTED]. In fact, I also was contacted directly by a local pharmacist who raised similar concerns with me.

As I previously indicated by letter dated November 20, 2000, [REDACTED] suffers from low back pain and a number of other debilitating medical conditions. He has been followed by my practice since March 1998. When I met with the Central Investigative Committee in 2001, I recall that the members expressed great concern regarding the quantities of narcotics [REDACTED] was receiving, the escalation of his dosages over time, and the apparent lack of notable progress in managing his pain. The committee was troubled that there appeared to be no clear etiology for this pain. The committee also expressed concern that diversion of controlled substances might be occurring.

As I stated to the committee during our first meeting in 2001 I too was concerned that I had not been more successful in helping [REDACTED] achieve greater control of his pain. I also was concerned by the dosages of narcotics that he was requiring for pain control. I hoped to see [REDACTED] reduce or eliminated his use of pain killers within three or four months following our meeting in June 2001. I also set the objective of making progress in identifying the source of his chronic pain.

Unfortunately, [REDACTED] pain has persisted. Since I met with the committee in June 2001, I have worked with [REDACTED] in an effort to reduce his dosages and make use of a number of different analgesics. I have now arranged for [REDACTED] to be seen at the pain clinic at Fletcher Allen Health Care on April 27, 2004 at [REDACTED] p.m. I have made clear to [REDACTED] that this assessment of his pain and medical condition is important and that I expect him to keep this appointment without fail. I have indicated that I expect him to fully cooperate in good faith with the assessment and with any recommendations for follow-up.

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assessment, care, therapeutics, and prescribing. I have advised [REDACTED] that if he fails to follow-through as expected, I will no longer provide medical care for him. I will promptly provide the committee with a copy of the results and recommendations from [REDACTED] assessment at the pain clinic.

During my meeting with the Central Investigative Committee on January 9, 2004, the committee's members again expressed continuing concern regarding aspects of my prescribing practices. Since that meeting with the committee in 2001, I have taken a number of steps in my practice in an effort to improve the medical care I provide to my patients. I now consult regularly with Seddon R. Savage, M.D., a New Hampshire anesthesiologist, for chart reviews and discussion of my treatment of pain for individual patients. I also collaborate with Dartmouth Hitchcock Medical Center regarding certain patients. I have completed CME study regarding pain management. I expect to pursue further CME credits with regards to prescribing and pain management.

In response to the committee's concerns, I also have become more skeptical regarding treating new patients with chronic pain. I review the patients' medical records with an eye to identifying prior diagnoses, care, and evaluations before prescribing opioids or other controlled substances. I am unwilling to continue caring for and prescribing for non-compliant patients, particularly those unwilling to follow through on referrals for consultations or assessment by a pain clinic.

I am appreciative of the committee's advise, and I have taken seriously the committee's concerns regarding my prescribing of controlled substances, treatment of pain, and response to possible drug seeking behaviors. I am well aware from the media reports and my interactions with colleagues that professional regulatory boards and law enforcement agencies have recently investigated the prescribing practices of many individual physicians, often in connection with abuses involving Oxycontin. Notably, the complaint opened against me in 2000 involved my prescribing for several other patients. Again, I would like to make clear my commitment to careful, prudent prescribing and treatment of pain. I also would like to identify for the committee a number of specific steps I will take in this regard.

Education

I will engage in the next year in continuing medical education courses related to pain management, record keeping, and professionalism. I understand that three courses that the committee regards as satisfactory are taught at Case Western reserve in Cleveland. These are:

- 1) Intensive course in Controlled Substance Management
- 2) Intensive course in Medical Record Keeping
- 3) Intensive Course in Medical Ethics and Professionalism

I agree to attend and satisfactorily complete either these courses or other comparable courses agreeable to the Board within the next year. I also agree to provide the Board with documentation verifying my satisfactory completion of each course taken within the one-year period. I understand that any expenses involved will be my responsibility.

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Chronic Pain Patients

I already have taken steps to minimize the number of chronic pain patients in my practice. I no longer accept new patients who are likely to require treatment for chronic pain. Any current patient not now being treated within my practice for chronic pain and any "new" patients who later require treatment for pain will not be prescribed DEA schedule II drugs or schedule III opioids for a period longer than 14 days. Patients who newly require treatment for chronic pain and who require prescriptions of such DEA schedule drugs for a period longer than 14 days or who recurrently require the prescribing of such drugs for acute pain will be promptly referred to another practitioner for care, preferably with a physician who has special expertise in pain management.

To assist the Board's investigators in monitoring my prescribing practices I will maintain a complete list of all patients currently being treated with controlled substances for chronic pain. I agree to Board monitoring of my prescribing practices, and the Board's investigators may review my patient charts at any time to examine the basis for prescribing and the adequacy of my record keeping. I also comply promptly with board subpoenas for patient records and will produce records by mail or courier in response to such subpoenas.

Record Keeping

For each patient for whom I prescribed controlled substances I will have in the patient's chart a current diagnostic assessment and treatment plan that will be available for review by the Board. Each plan will include specific entries regarding the patient's diagnosis or condition and the rationale for prescribing controlled substances for the patient. Each controlled substance prescribed for a patient will be clearly noted in writing in the patient's chart with the date of prescribing indicated.

Prescribing

I agree that all prescriptions written by me for DEA schedule II drugs and schedule III opiates will be copied and retained in triplicate. One copy of each prescription will be placed in the patient's chart. A second copy will be kept in a chronologically ordered file in my office that will be available for review by the Board or its agents at any time. The third copy will be retained, and every three months all such copies on hand will be promptly forwarded to the Board for review. I am aware that the language of 21 CFR 1306.05(a) prohibits the pre-dating of prescriptions for controlled substances. All prescriptions that I write will be accurately dated and actually signed on the date indicated on the prescription. Finally, I will prescribe only for bonafide patients seen in my office, a hospital, or other institutional setting.

I also will review pertinent policy statements and other guidance with regard to the use of controlled substances in treating chronic pain. For example, I will review the 1996 Report of the Prescribing Practices Committee of the Vermont Board of Medical Practice and the 1998 Model Guidelines on prescribing from Federation of State Medical Boards. I will adhere to such broad principles in caring for my patients with chronic or other pain.

Treatment of Pain

I wish to assure the committee that my treatment of pain will reflect careful diagnosis, detailed record keeping, and substantial efforts to control the patient's pain that will consider other important aspects of the patient's functioning, including physical, psychological, social, and vocational factors.

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My care also will demonstrate a clear, detailed evaluation of the patient's pain (nature and intensity), current and past treatments for pain, the effect of the pain on the patient's physical and psychological functioning, and any history of indication of possible substance abuse or dependency.

My care of patients with pain will include a current detailed treatment plan. The plan will set objectives to be used in determining treatment progress, such as pain relief, and improved physical and psychological functioning. The plan will indicate what further diagnostic evaluations, referrals, or other treatments are planned and when these will occur.

I also will require patients being treated for chronic pain or recurring acute pain to enter into written agreements ("prescribing contracts") governing their receipt of prescriptions for controlled substances. I also will emphasize that both the patient and I will adhere to the terms of such contracts. At each patient visit I will review the terms of the contract and the patient's compliance. I am aware that such contracts are particularly valuable in cases where there is a risk of possible substance abuse, dependency, or drug diversion.

I acknowledge here the validity of the committee's concerns regarding protracted prescribing of controlled substances or escalating dosages. I am committing myself here to regular, careful review of the course of treatment and available information as to the etiology of the patient's pain. My choice of treatment and prescribing of controlled substances will reflect careful assessment of the patient's progress toward stated treatment objectives, such as improvement in the patient's pain and better functioning. If treatment goals are not being achieved, even with adjustments in dosing and treatment strategy, I will re-evaluate the appropriateness of continued treatment and prescribing. My written records will present my reasoning in this regard.

I will make use of referrals to pain clinics and specialists for evaluation and treatment to assist my patients and me in meeting written objectives. I will direct special attention to those patients who present a risk of abusing or diverting controlled substances. I agree that the management of pain in patients with a history of substance abuse or psychiatric disorders requires extra care, monitoring, documentation, and consultation with experts in the management of such patients. As appropriate, my patients will receive timely referrals for re-evaluation of their pain by specialists. Patients who fail to cooperate fully with diagnostic procedures or referrals to pain specialists or clinics will receive heightened scrutiny or will be terminated from my practice.

I am concerned regarding any possible perception in the community that I am an "easy mark" for drug seekers or those who might seek to divert prescription drugs. The committee has my assurances that I recognize the importance of complying fully with all Federal and State laws and regulation and applicable medical standards as in the prescribing of controlled substances.

I understand that the Board will be relying on my adherence to the commitments included in this letter and will direct follow-up monitoring as to my prescribing practices and patient care. I agree that the Board may consider this letter of assurance and my compliance with it in determining whether the above-referenced Docket No. MPC 76-1100 may be administratively closed at a later date without disciplinary action by the Board.

In conclusion, it is my understanding that the Board of Medical Practice intends at this time to take no further action in this matter so long as its monitoring does not produce information or indications contrary to the above assurances or inconsistent with sound principles of prescribing and care. I also understand that the board could review or reopen this matter at any time in the future in the event of a new complaint or if questions arise regarding my prescribing practices.

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I appreciate the Board's investment of time and effort in reviewing this matter and again meeting with me. My intention is to assist the Board in its public responsibilities and to establish a basis for the Board to conclude that my care of the patients is consistent with the provision of a high quality medical care to the citizens of Vermont.

Sincerely yours,



Mitchell R. Miller, M.D.

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