

**STATE OF VERMONT  
BOARD OF MEDICAL PRACTICE**

In re: Mitchell R. Miller, M.D.

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Docket No. MPC 76-1100

**DECISION AND ORDER  
ON RESPONDENT'S MOTION TO RECONSIDER SUMMARY SUSPENSION AND TO  
IMMEDIATELY REINSTATE DR. MITCHELL R. MILLER'S LICENSE**

**Procedural History**

On April 1, 2009, after an emergency *ex parte* hearing at its regularly scheduled monthly meeting, the Board of Medical Practice (the Board) issued a Summary Decision and Order summarily suspending Respondent Dr. Miller's license to practice medicine.

On April 20, 2009, the Respondent filed a Motion to Enlarge Time to File Response to Specification of Charges requesting that the deadline for filing his answer be extended to June 5, 2009. The Motion was granted by Board order dated April 28, 2009.

On April 30, 2009, the Respondent filed the Motion to Reconsider Summary Suspension and to Immediately Reinstate Dr. Mitchell R. Miller's License (the Motion), and the State of Vermont responded on May 5. A hearing was held at the Board's regularly scheduled monthly meeting on May 6, 2009, after which the Board issued a procedural order on the Motion, effective May 8, scheduling a limited evidentiary hearing, which was held on May 20, 2009.

Appearances and Participation:

Marjorie Power, Esq., served as Presiding Officer. Assistant Attorney General James Arisman appeared for the State of Vermont, and Debra Bouffard, Esq. of Sheehey Furlong & Behm appeared for the Respondent.

The Board members participating in the hearing are identified in the transcript. The members of the Board's Central Investigative Committee were not present during the hearing or deliberations, and did not participate in this decision.

The Board has based this Decision and Order on the factual allegations as set out in its Summary Decision and Order effective April 1, 2009, and on the testimony and evidence adduced at the hearing.

## Findings of Fact

1. Before his license to practice was summarily suspended on April 1, 2009, Dr. Mitchell R. Miller was employed as the full-time Regional Medical Director for Prison Health Services, a private corporation which provides medical care at Vermont's correctional facilities. He also served as the Medical Director for the Gill Odd Fellows Home, a skilled nursing facility in Ludlow. Dr. Mitchell R. Miller's Prefiled Testimony (Miller) at 1.

2. Dr. Miller planned to close his private practice in Ludlow by January, 2009. Miller at 1, Supplemental Affidavit of Philip J. Ciotti (Ciotti Supplemental) at 2.

3. During the months immediately before Dr. Miller's license was summarily suspended on April 1, 2009, he was still treating at least seven patients in his private practice: [REDACTED] and [REDACTED]. Ciotti Supplemental at 2, 8, transcript from hearing of May 20, 2009 (tr.) at 85 et seq.

4. Of the remaining patients, only two had written drug contracts. Both of the written contracts were old and did not reference the medications actually being prescribed. Ciotti Supplemental at 1-2, 6.

5. In order to see Dr. Miller, the remaining patients call or page him and he meets them at his Ludlow office. They come in through the back door of the office. Transcript from hearing on April 1, 2009 (Ciotti tr.) at 1.

6. When Investigator Ciotti visited the office on March 12, 2009, it was not possible to get in through the front door, because it was not maintained; it was all filled with snow. Ciotti tr. at 1.

7. There is no longer a sign showing that it is a medical office, and there is a For-Sale sign outside. It gives the appearance of an empty building. The furnishings are very sparse, with boxes scattered here and there in disarray. Ciotti tr. at 1-2.

8. There are no nursing or administrative assistants helping Dr. Miller at this office. Ciotti tr. at 6.

9. [REDACTED] a mother of two children, is employed as a full-time, year-round housekeeper. She suffers from a painful condition of her right elbow/shoulder. She is enrolled in the Medicaid program. Affidavit of [REDACTED], Respondent's Exhibit (Exh.) 1 at 1-2, 11.

10. [REDACTED] signed a "Contract for Use of Controlled Medications" dated August 10, 2005, stating that she would only obtain Oxycodone 15mg and Oxycontin 40mg. The contract did not contain any indication that she would receive prescriptions for Duragesic/Fentanyl. Ciotti Supplemental at 5.

11. On March 9, 2009, Dr. Miller provided [REDACTED] with two prescriptions as follows:

- a. seven Duragesic 100 mcg patches to be applied every 48 hours;
- b. seven Duragesic 100 mcg patches to be applied every 48 hours, to be filled after

March 23<sup>rd</sup>.

Tr. at 21, 67-73.

12. At the prescribed dosing schedule, these two prescriptions would be sufficient to last the patient for 28 days, or until April 6, if filled on the same day they were written.

13. Three days later, on March 12, Dr. Miller provided [REDACTED] with two more prescriptions as follows:

- a. 30 Oxycodone 15 mg tablets;
- b. 15 Duragesic 100 mcg patches to be applied every 48 hours.

Ciotti Supplemental at 3.

14. At the prescribed dosing schedule, this would have been an additional 30 days' supply, which, if taken as directed, in conjunction with her previous prescriptions would have lasted into the first week of May. Tr. at 75-76.

15. Dr. Miller did not actually see [REDACTED] on March 12, but she had arranged for her boss to pick up the prescription for her because she was unable to leave work. Dr. Miller had arranged to leave the narcotic prescriptions stuck in the door if he had to leave the office, but, in fact, he was there to present the prescriptions to [REDACTED] boss. Ciotti Supplemental at 4.

16. The two prescriptions for seven Duragesic tablets and the prescription for Oxycodone were filled at the [REDACTED] pharmacy and paid for by Medicaid. The prescription for 15 Duragesic was filled at the [REDACTED] pharmacy in [REDACTED]. Payment was denied by Medicaid and [REDACTED] had to pay approximately \$831 out of her own pocket. Ciotti Supplemental at 3.

17. Dr. Miller met with [REDACTED] again before the end of March, 2009. Tr. at 83.

18. On March 30, 2009, Dr. Miller gave [REDACTED] two prescriptions for Fentanyl patches, one of them read do not fill before April 17. Ciotti Supplemental at 5.

19. Sometime during the first week of April, [REDACTED] tried to get one of the March 30 prescriptions filled, but was refused because Dr. Miller's license had been suspended. She went to the emergency room where she was given a prescription for three Duragesic patches, one to be used every 48 hours which she filled on April 7. Ciotti Supplemental at 5. The emergency room visit suggests that she had already used up the previous prescriptions which should have lasted into May if used as prescribed.

20. Dr. Miller prescribed drugs for [REDACTED] but did not routinely examine her. Her visits to Dr. Miller's office were quick, just to pick up her prescriptions. [REDACTED] did not really find it strange that Dr. Miller did not examine her "cause [sic] he never really did check me." Exh. 1 at 3, Ciotti Supplemental at 4.

21. When [REDACTED] takes less medication or runs out, she gets “really sick, puking, just really sick and at times I feel like I am going to die!” In these situations she is unable to work or function. Exh. 1 at 6, Ciotti Supplemental at 4.

22. [REDACTED] recognized that she was drug dependent and so stated in her affidavit, adding, “I wish Dr. Miller at the beginning would of [sic] told me you can get bad withdrawls [sic] from this medicine and the side effects because I would of [sic] thought twice about taking it.” She claims that Dr. Miller never told her that she might become addicted. Exh. 1 at 5; Ciotti Supplemental at 4.

23. [REDACTED] reported that two pharmacists had commented to her that she was taking a lot of pain medication for a person of her age and weight. Exh. 1 at 5.

24. [REDACTED] twice requested that her medical records be transferred to her new doctor. Dr. Miller told her he had to get them together as some were at his home and some were in the office. Ciotti Supplemental at 6.

25. [REDACTED] is a painter. He is self-employed and is sometimes required to climb up and down 40 foot ladders. He sometimes does work for Dr. Miller Tr. at 87, 93.

26. Dr. Miller was treating [REDACTED] for moderate to severe bilateral knee pain. Tr. at 93.

27. On March 2, 2009, Dr. Miller wrote a prescription for [REDACTED] for 120 Oxycodone 15 mg to be taken 1-2 pills four times per day for moderate breakthrough or incident pain. If he took the maximum of eight per day, on March 5 he would have taken 32 pills and would have had 88 pills (11 days’ supply) remaining when Dr. Miller wrote another prescription on March 6. Ciotti Supplemental at 6; tr. at 85-86.

28. On March 6, 2009, Dr. Miller wrote several prescriptions for [REDACTED] as follows:

- a. 60 Oxycodone 30 mg to be taken 1-2 tablets to be taken three times per day as needed for moderate to severe breakthrough pain
- b. 90 Oxycontin 40 mg one tablet to be taken three times per day, to be filled on March 15<sup>th</sup>;
- c. 60 Oxycodone 30 mg 1-2 tablets to be taken three times per day, to be filled March 20<sup>th</sup>;
- d. 90 Oxycontin 40 mg one tablet to be taken three times per day, to be filled April 10<sup>th</sup>;
- e. 120 Oxycodone 15 mg to take 1-2 tablets four times per day as needed for mild to moderate breakthrough pain.

Ciotti Supplemental at 6-7; tr. at 86, 89-91.

29. Because he understood that he could not write a prescription for more than one month’s supply of Oxycodone, Dr. Miller instead wrote [REDACTED] two 30 day prescriptions at a single visit, despite the fact that he would have been available to examine [REDACTED] at the time when he would

normally need a renewal if he were taking the prescribed dosage. Tr. at 96-97.

30. Dr. Miller said specifically that he did not feel the need to examine [REDACTED] every month. “[I]t was someone that I felt comfortable with not seeing every month.” Tr. at 96.

31. On March 31, 2009, Dr. Miller wrote more prescriptions for [REDACTED] as follows:

- a. 60 Oxycodone 30 mg to take 1-2 three times per day as needed for moderate to severe breakthrough pain
- b. 60 Oxycodone 30 mg to take 1-2 three times per day as needed for moderate to severe breakthrough pain to be filled on or after April 7.

Ciotti Supplemental at 7; tr. at 90.

32. None of these prescriptions would be flagged as "early refills" because of the changes in dosages. Ciotti Supplemental at 6.

33. The dispensing pharmacist, when asked by Investigator Ciotti whether this was typical prescribing practice for physicians treating pain, opined that Dr. Miller was the only one that would prescribe like this, and the pharmacist did not understand the rationale behind it. Ciotti Supplemental at 7.

34. [REDACTED] was one of Dr. Miller's chronic pain patients. On December 8, 2008, Dr. Miller had faxed to the Board a list updating the status of his chronic pain patients which listed [REDACTED] as "transferred 12/08". Ciotti Supplement at 8.

35. Prescription records from The Pharmacy in [REDACTED] show that Dr. Miller continued to prescribe for [REDACTED] as follows:

1/03/09 - 15 Lorazepam .5 mg  
1/07/09 - 15 Lorazepam .5mg  
1/08/09 - 90 Tramadol 50 mg  
1/09/09 - 30 Lisinopril 10 mg  
1/13/09 - Fluticasone 50 mcg spray  
1/14/09 - Albuterol .083% nebulizer  
1/15/09 - 30 Trazodone 100mg  
1/17/09 - 15 Benzonatate 200mg  
1/17/09 - 15 Butilbital/APAP/CAF  
1/25/09 - 15 Lorazepam .5 mg  
2/19/09 - 56 Tramadol 50 mg  
2/25/09 - 56 Tramadol 50 mg  
3/03/09 - 56 Tramadol 50 mg  
3/08/09 - 15 Prednisone 10 mg  
3/08/09 - 30 Cephalexin 500 mg  
3/10/09 - 60 Tramadol 50 mg

3/13/09 - 6 Temazepam 15 mg

Ciotti Supplemental at 8-9.

36. On March 24, 2009, Dr. Miller wrote a prescription for Suboxone with 5 refills for [REDACTED].  
Ciotti Supplemental at 6.

37. On March 24, 2009, Dr. Miller wrote two prescriptions for [REDACTED] as follows:

- a. 120 Percocet
- b. 30 Dilaudid 2 mg

Ciotti Supplemental at 6.

38. At the time of his suspension, Dr. Miller had taken back and was treating [REDACTED], a patient who had previously left his practice. Ciotti Supplemental at 2, Notice of Appeal Under Part 18.1 (filed by [REDACTED] in this Docket).

39. [REDACTED], a former patient of Dr. Miller's, went through drug withdrawal under the supervision of another doctor after she left his practice because her house had been broken into and "I found out from the police that my drugs had a lot of street value and I didn't want that stuff in my house anymore [sic]." Ciotti Supplemental at 7.

40. Since leaving Dr. Miller's care, two of his patients, [REDACTED] and [REDACTED], have been weaned from the use of narcotics after going through difficult withdrawals, and a third, [REDACTED], has been tapered down on his use of narcotics. Ciotti Supplemental at 5, 7.

41. Through the month of March 2009, until his license was suspended, the Respondent operated his private medical practice in breach of the Board's *Policy for the Use of Controlled Substances for the Treatment of Pain* and of the numerous undertakings he made in his letter of assurance, dated April 26, 2004, to the Central Investigative Committee of the Board, which had opened an investigation of his prescribing practices in November, 2000 (Exhibit 1 to the Specification of Charges [the Charges]).

42. In summary, the facts as found, in conjunction with the allegations, if proven, show the Respondent as a physician who, up to the date that his license was suspended, abused his professional privileges as follows:

- a. The respondent prescribed narcotics (DEA Schedule II and III opioids) over long periods for a number of patients without adequate medical evaluation, subsequent supervision, and/or documentation that meet ordinary standards of care.
- b. The respondent prescribed these narcotics without consideration of the effect on the patients of possible dependency, adverse side effects, and/or interactions of the numbers of different drugs, the frequency, and/or the quantities he was prescribing.
- c. The respondent has prescribed these narcotics in such numbers, quantities, and

frequency that suggest that he has ignored or failed to recognize possible drug seeking behavior and drug abuse by these patients. On the contrary, he has prescribed in a manner that would facilitate such behavior.

d. The respondent has prescribed these narcotics in such numbers, quantities, and frequency that suggest that he has ignored or failed to recognize possible drug diversion for use and/or abuse by individuals who are not his patients and for whom such drugs may not be medically indicated. On the contrary, he has prescribed in a manner that would facilitate such use.

e. The respondent continued to see patients under substandard conditions at an office that he had said was closed.

## Conclusions of Law and Decision

### Introduction

In response to the State's Specification of Charges against the Respondent and Motion for Summary Suspension, on April 1, 2009, the Board issued a Summary Decision and Order summarily suspending Respondent's license to practice medicine. On April 30, 2009, the Respondent filed the Motion to Reconsider Summary Suspension and to Immediately Reinstate Dr. Mitchell R. Miller's License, which is the subject of this decision. This decision on Respondent's Motion should be read in conjunction with the Board's Summary Decision and Order.

The Board's summary suspension authority rests on 3 V.S.A. §314(c), which reads:

No revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the institution of agency proceedings, the agency gave notice by mail to the licensee of facts or conduct which warrant the intended action, and the licensee was given an opportunity to show compliance with all lawful requirements for the retention of the license. *If the agency finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined. (Emphasis added.)*

The italicized portions of this provision set out the exception to the requirement for notice and hearing before disciplinary action can be imposed on a licensee. According to the statute, a license can be summarily suspended when the required finding for emergency action is made by the licensing authority. There is no procedural prerequisite of any kind for a summary suspension, and the provision clearly contemplates that the next phase of the case will be proceedings on the merits of the charges.

### Constitutional and Due Process Claims

Respondent argues at length that the summary procedure authorized in 3 V.S.A. §314(c) breaches the due process requirements of the United States Constitution. Respondent's Memorandum in Support of the Motion (Motion Memo) at 2-6. The State contends that it does not.

However, irrespective of the merits of the parties' arguments, the Board is precluded from ruling on this claim. It is well established Vermont case law that administrative tribunals do not have the power to declare statutory provisions unconstitutional. This power is reserved solely to the courts. *Chase v. State*, 2008 VT 107 ¶14, *Westover v. Village of Barton Electric Department*, 149 Vt. 356 (1988).

Respondent further claims that he is entitled to a prompt post-suspension hearing for review of the summary suspension decision itself. The plain language of 3 V.S.A. §314(c) demonstrates no statutory entitlement for such a hearing and a ruling on a constitutional challenge to an alleged statutory infirmity is not within the authority of the Board. *Id.*

Respondent cites with approval the statutory requirements of other states for prompt post-suspension hearings to be held within 7-10 days of the suspension order. However, it is incongruous for Respondent to complain about procedural delays. Respondent's first filing, over two weeks after the Charges and summary suspension order were served, was a request for an extension of time of another month to file his answer to the Charges. It was nearly a full month before he filed the Motion for relief under consideration in this order.

Although not obliged by law to hold a hearing on the propriety of its summary suspension decision, the Board did, at the Respondent's request, convene two hearings on the subject as quickly as possible. Even so, the Respondent failed to make the filings required for the evidentiary hearing in a timely fashion as required by the Board's Procedural Order effective May 8, 2009. Any further delay must be ascribed to the parties, who both claim that they need time to conduct extensive discovery, and who, despite the request of the Presiding Officer by letter dated May 8, 2009, have failed to file an agreed discovery schedule.

The Board's process has fully conformed with and, indeed, has exceeded the procedural requirements of the applicable statutory provision, 3 V.S.A. §314(c).

#### Prerequisite for Summary Suspension

For a summary license suspension, pursuant to 3 V.S.A. §314(c), the Board must make a specific finding that the "public health, safety, or welfare imperatively requires emergency action." At the request of the Respondent, and for further assurance that the unprofessional conduct alleged by the State was not simply rooted in the past, but continued to the date of the suspension, and was likely to continue into the future if no action were taken, the Board scheduled an expedited evidentiary hearing. The subject matter was limited to the Respondent's professional conduct in the month before his license was suspended, March 2009, and matters raised in Investigator Ciotti's Supplemental Affidavit.

The Board treated as prefiled testimony the two affidavits of Investigator Ciotti and the transcript of his testimony at the April 1<sup>st</sup> hearing. Respondent was given the opportunity to present prefiled testimony, and both parties were permitted to prefile additional exhibits relevant to the Respondent's care of his private practice patients during this time frame. (See Procedural Order on Respondent's Motion to Reconsider Summary Suspension and to Immediately Reinstate Dr. Mitchell R. Miller's License, effective May 8, 2009.)

In the Respondent's Memorandum in support of the Motion, he claims that by March of 2009, he continued to treat only three patients in his private practice and that only one of them was still receiving pain medications. Motion Memo at 13. However, the evidence shows that he was actually continuing to treat at least seven patients. Findings of Fact (Finding(s)) ¶3. Moreover, there is evidence showing that, during that same month, he was prescribing pain medication to at least five of these patients: narcotics to three patients, a scheduled opiate substitute to another patient, and a non-scheduled pain medication to still another. Findings ¶¶11, 13, 18, 27, 28, 31, 34, 35, 36, 37.

Respondent further claims that the allegations in this case are not sufficiently egregious to support a summary suspension. Respondent's Memo at 15-16. Most of the circumstances cited in the Respondent's memorandum involve sexual transgressions of one kind or another or substance abuse by the practitioner. However, in the Superior Court case relied on by the Respondent, the court acknowledges that "[t]here is no case law addressing the difference between the standards for summary suspensions and those for 'regular' suspensions." *In re Glen Myer*, Docket No. 140-2-07, Decision on Merits of Appeal (January 31, 2008) at 9, Attachment A to the Motion.

There is no requirement for extreme or bizarre behavior to support a summary suspension. Based on 3 V.S.A. §814(c), a simple two step analysis is used to establish whether summary suspension is appropriate.

(1) The Board determines whether the licensee's conduct would be sufficient to support, after "regular" proceedings, a finding of unprofessional conduct under 26 V.S.A. §1354 for which an appropriate penalty could be revocation, suspension, annulment, or withdrawal of the Respondent's license. 3 V.S.A. §314.

(2) Once that finding is made, the Board determines whether emergency action is required to protect the public.

#### (1) Unprofessional Conduct

The Respondent claims that, in assessing charges based on allegations relating to the prescribing of controlled substances, the Board must analyze the Respondent's practices in the light of the Board's *Policy for the Use of Controlled Substances for the Treatment of Pain* (the Policy). The Board agrees.

In reviewing a physician's prescribing practices, the Board does not rely only on the evidence of the prescriptions, but the entire context in which the prescribing takes place. "The Board will judge the validity of the physician's treatment of the patient based on *available documentation*, rather than solely on the quantity and duration of medication administration." (Emphasis added.) Policy at 2. The importance of complete and thorough documentation is repeatedly stressed throughout the Policy. Policy at 1-4.

The practice guidelines are very emphatic that a physician's record keeping must be absolutely scrupulous:

**Evaluation of the Patient** - A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity

of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

## Policy at 2.

**Medical Records**-The physician should keep accurate and complete records to include:

1. medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed, documented in a clear manner in a readily accessible section of the medical record. Some physicians keep copies of all scheduled drug prescriptions in one section of the medical record; others use a flow chart for this purpose, such as the sample in Appendix C),
9. instructions and agreements, and
10. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

## Policy at 3.

The Specification of Charges allege that Respondent repeatedly failed in the documenting the care of patients for whom he was prescribing controlled substances: "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." Charges ¶20. This general failure of documentation is specifically alleged with regard to ten individual patients.

At the hearing on May 20, 2009, neither party offered as evidence copies of any of the patient charts or other documentary records of treatment. Dr. Miller was asked a number of questions about the patients referenced in his prefiled testimony and that of Investigator Ciotti. He claimed that he was unable to answer without referring to their charts, but he had not brought the charts to the hearing. Tr. at 65, 83. There is evidence that Dr. Miller's record keeping may be less careful than the strict requirements of the Policy. When [REDACTED] had to ask for the second time that her records be sent to her new doctor, Dr. Miller told her that some were at his office, but some were at home. Finding ¶24. This was clearly a breach of the Policy that records "be maintained in an accessible manner and readily available for review."

A lack of adequate documentation, if proven, could of itself be considered unprofessional conduct in this context, but the absence of documentation gives rise to further questions about whether the patient actually received those medical services required by the Policy. The Policy requires that an initial physical examination be conducted and that there be regular and detailed evaluation and review based on objective medical evidence. Policy at 2, 3.

The evidence at the hearing suggests that Dr. Miller's initial examination and his continuing oversight of his patients was superficial at best and not up to the strict professional standards required under by the Policy for physicians prescribing narcotics. In [REDACTED]'s affidavit, which was submitted as evidence by the Respondent, she says that Dr. Miller never examined her when she saw him, but just gave her prescriptions. Her comments further suggest that she may never have received a complete physical examination from Dr. Miller. Finding ¶20. Dr. Miller also testified that he saw no need to examine [REDACTED] before prescribing a two month's supply of Oxycodone along with several other prescriptions for narcotics. Finding at ¶30.

The Policy further requires that the physician fully discuss the risks and benefits of the use of controlled substances with the patient. [REDACTED]'s affidavit suggests that this step in her treatment may have been passed over superficially or missed altogether, "I wish Dr. Miller at the beginning would of [sic] told me you can get bad withdrawals [sic] from this medicine and the side effects because I would of [sic] thought twice about taking it." She claims that he never told her about the addictive properties of the medications he was prescribing for her. Finding ¶22. Although [REDACTED] did have a "Contract for Use of Controlled Medications", signed in 2005, it did not cover the bulk of the medications she was actually being prescribed in March of 2009. Finding ¶10.

The Policy also requires that physicians should carefully and objectively evaluate behaviors that may indicate prescription medication abuse or diversion while taking care to avoid misinterpreting attempts to achieve adequate pain relief as drug-seeking behaviors. The evidence suggests that Dr. Miller's care was also deficient in this area. On March 9, 2009, in two prescriptions, Dr. Miller prescribed enough 100 mcg Duragesic patches to cover [REDACTED] for 30 days at the prescribed dosing schedule. This would have been ample to cover the period when Dr. Miller was expected to be away on vacation and when [REDACTED] herself might have been away. Finding ¶11, Exh. 7 at 1. [REDACTED] claimed that the pharmacy was able to supply only five of the seven patches in the first prescription, which would have left her four days short. The evidence is not clear on whether this was the actually the case, but on March 12, just before he left on vacation, Dr. Miller prescribed not just enough to cover the possible shortfall, but another entire 30 days' supply, essentially leaving [REDACTED] with twice the amount of medication needed for the prescribed dosing schedule. The evidence shows that she filled all the prescriptions.

Dr. Miller's prescribing practices were so egregious as to excite negative comments from pharmacists one of whom found his prescribing excessive and without an obvious rationale. Findings ¶¶23, 33. Dr. Miller's testimony at the post-suspension evidentiary hearing on May 20, 2009, failed to provide the missing rationale or adequate explanation of his treatment and prescribing practices or the lack of documentation required by both the Policy and the commitments made by Dr. Miller in his letter of assurance to the Board's Central Investigating Committee, dated April 26, 2004. Finding¶ 41. Accordingly, the Board finds that Dr. Miller's treatment of the patients in his private practice during the last month before the suspension of his license did not meet the standards of care required by the Policy.

Accordingly, the Board finds that the evidence of record, in conjunction with the allegations in the State's Specification of Charges, if proven, demonstrates behavior that constitutes unprofessional conduct under a number of provisions of 26 V.S.A. §1354, which may include, but

may not be limited to: selling, prescribing, giving away or administering drugs for other than legal and legitimate therapeutic purposes; conduct which evidences unfitness to practice medicine; willfully making and filing false reports or records in his or her practice as a physician; in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions, that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred; failure to comply with provisions of federal or state statutes or rules governing the practice of medicine; performance of unsafe or unacceptable patient care; failure to conform to the essential standards of acceptable and prevailing practice. The Board finds that Dr. Miller's conduct is sufficiently egregious to support a suspension of the Respondent's license, pursuant to 26 V.S.A. §1361(b).

## (2) Need for Emergency Action

Having determined that Dr. Miller's substandard care for his private practice patients did constitute unprofessional conduct, the second phase of the analysis must determine whether emergency action is necessary to protect the public health, safety, or welfare. In its Summary Decision and Order dated April 1, 2009, the Board found that the Respondent's practices, if proven as alleged in the Charges, could be a threat to the public. The Board found that allegations of substandard medical care and inadequate supervision of the patients whom he treated at his office could threaten their health, safety and welfare and that his alleged excessive prescribing in terms of numbers of drugs, amount, and frequency, could increase the risk that potent narcotics could be diverted and used by members of the public without medical supervision and without knowledge of or regard to side effects, interactions, or overdoses, with the consequent threat to the users' health, safety, and welfare.

At the hearing on May 20, 2009, the Board wished to hear evidence as to whether the practices alleged in the Charges, which referenced Respondent's practices during the last five years, were based on stale information relating to activities which had long since ceased or whether they had continued up to the date of the hearing and were likely to continue into the future unless immediate action was taken by the Board. The evidence adduced at the hearing by both parties confirmed the Board's finding as to the imperative need for emergency action.

The history of the Respondent's treatment of █████ during the month of March 2009 is illustrative of the potential for harm. On March 9<sup>th</sup>, Dr. Miller gave her two prescriptions for narcotic Duragesic patches which would last a total of 28 days (in addition to a prescription for Oxycodone). Finding ¶11. On March 12<sup>th</sup>, he gave her another prescription for Duragesic patches which would last for an additional 30 days. Finding ¶13. If taken as prescribed, these prescriptions should have provided enough patches to last into the first week of May. Finding ¶16. Nevertheless, on March 30<sup>th</sup>, he gave █████ another prescription for Fentanyl (Duragesic) patches. Finding ¶18.

The record shows that █████ paid more than \$800 for the March 30<sup>th</sup> prescription. Finding ¶16. The record includes disputed evidence as to whether █████ was doubling up on her medication by wearing two patches at once, but a finding on this point is not necessary. Clearly, if she were taking a double dose of this powerful medication contrary to instructions, her health, safety and welfare and that of her family were at risk. If she were not herself using these drugs, it is unlikely

that, given their high cost, they would simply be thrown away. They were items with a significant “street value” which could have been diverted to others for whom they had not been prescribed. Finding ¶39. In either event, there was a high likelihood of harm.

The record contains multiple references to the harm [REDACTED] had already suffered from Dr. Miller’s promiscuous prescribing of narcotics and his failure to give her more care than just prescriptions for more narcotics. Findings ¶¶21, 22. The record shows that at least two pharmacists had commented to her on the inappropriate quantity of medication she was being prescribed for a person of her weight. Finding ¶23. The record suggests that Dr. Miller himself thought that she was taking too much medication and that she should taper down, but his prescribing practices continued to enable her overconsumption. Ciotti Supplemental at 4. Although she had prescription coverage through the Medicaid program, her excessive consumption of narcotics caused her to pay a large sum to have an extra prescription filled privately. She was unable to reduce her use of narcotics without becoming so sick that she was unable to work. Finding ¶21. She herself recognized that she had become drug dependent. Finding ¶22.

[REDACTED] continued to receive narcotic prescriptions from Dr. Miller right up to the day before his license suspension, March 30, 2009. The Board finds that without the license suspension, it is likely that she would have continued as Dr. Miller’s patient and would have continued to receive the same dangerously substandard care that she had before his license was suspended to the detriment of her health and welfare.

After she ceased to be cared for by Dr. Miller, she suffered from withdrawal symptoms, but under her new doctor’s care, she is being treated with Suboxone, an opiates substitute, and is now able to work, feels better, and is happy to be off narcotics. Ciotti Supplemental at 5. Two other individuals have also received help from other practitioners in withdrawing from or reducing their use of narcotics since they ceased to be Dr. Miller’s patients. Finding ¶40.

Dr. Miller had at least seven patients in his private practice at the time his license was suspended. Finding ¶1. Despite his claims that he was closing his private practice, he continued to see patients at his old office building under substandard conditions. Findings ¶¶2, 5-8. He had taken back as a patient an individual who had previously left his practice, and was continuing to prescribe for another whom he claimed had transferred from his practice months before. Finding ¶34, 38.

Respondent claims that these patients “relate to only one small aspect” of his medical practice. All patients are at all times entitled to treatment that meets professional standards. His unprofessional conduct puts them at risk, and the harm from his prescribing may extend beyond these individuals to the community at large. Finding ¶39. His grossly unprofessional and irresponsible treatment of this group of patients raises justifiable questions about his suitability to care for any patients at all. Accordingly, the Board finds that public health, safety, and welfare imperatively required emergency action to suspend Dr. Miller’s license to practice medicine and that that suspension should remain in effect.

#### Prompt institution of Proceedings

Mindful of the effect of the continuing license suspension on Dr. Miller’s earning

capacity and of its statutory obligation under 3 V.S.A. §814(c) requiring the prompt institutions of proceedings, the Board is anxious to proceed expeditiously to a hearing on the merits.

The parties both indicated at the hearing on May 6<sup>th</sup> that they intended to do extensive discovery, and since they failed to file an agreed discovery schedule on May 20<sup>th</sup> as requested by the Presiding Officer, the Board will order the filing of a Stipulated Discovery Schedule by June 12, 2009. If the parties are unable to agree to a schedule, they shall each file, by the same date, a proposed discovery schedule supported by a rationale for their schedule and a full explanation for their inability to reach agreement.

**ORDER**

In accordance with the Findings of Fact and Conclusions of Law set out above:

1. The Respondent's Motion to Reconsider Summary Suspension and to Immediately Reinstate Dr. Mitchell R. Miller's License is **DENIED** based on the Board's finding that public health, safety, or welfare imperatively required emergency action

2. The suspension of the Respondent's license shall remain in force pending further order of the Board.

3. The parties shall file a Stipulated Discovery Schedule on or before June 12, 2009. If the parties are unable to agree to a schedule, they shall each file, by the same date, a proposed discovery schedule supported by a rationale for their schedule and a full explanation for their inability to reach agreement.

**FOR THE BOARD:**

**DATE:**

Patricia A. King M.D. Ph.D.  
PATRICIA A. KING, M.D., Ph.D.,

6/5/09

Vice Chair, Vermont Board of Medical Practice

EFFECTIVE DATE: 6/5/09

DATE OF ENTRY: 6/5/09