

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

))
In re: William A. O'Rourke, Jr., M.D.) Docket No. MPN 101-0707
))

SPECIFICATION OF CHARGES

NOW COMES, the State of Vermont, by and through Attorney General William H. Sorrell and the undersigned Assistant Attorney General, Jacob A. Humbert, and alleges as follows.

1. William A. O'Rourke, Jr., M.D. ("Respondent") of Rutland, Vermont holds Medical License Number 042-0002399 issued by the Vermont Board of Medical Practice on September 10, 1958. Respondent is an internist and has a private practice medical office in Rutland, Vermont.

2. Jurisdiction in these matters vests with the Vermont Board of Medical Practice ("Board") pursuant to 26 V.S.A. §§ 1354-1357, 1361, 1398, 3 V.S.A. §§ 809-814 and other authority.

I. Background

3. The Board opened a complaint against Respondent on June 4, 2002 following review of Respondent's prescribing for a patient. The Board's investigation established that Respondent on two occasions prescribed Vicoden ES tablets, a controlled substance, for the family member of another physician without first examining her or taking a medical history from her.

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4. By stipulation and consent order with the Board, dated November 5, 2003, Respondent settled the matter, agreeing to the following:

- a. his medical license to be conditioned for a minimum of 24 months;
- b. full compliance by him with all terms of the stipulation and consent order;
- c. all prescribing of controlled substances by him to be based upon a current diagnostic assessment and treatment plan with specific entries for the patient's diagnosis or condition and rationale for prescribing, with all such records to be produced for review by the Board upon request;
- d. all prescribing of controlled substances by him to be clearly noted in writing in the patient's office record with the date of prescribing indicated, with all such records to be produced for review by the Board upon request;
- e. all prescribing of DEA schedule II, III, and IV drugs to be copied and retained in duplicate, with one copy placed in a chronologically-ordered file for review by the Board at any time and the other copy placed in the patient's chart; and
- f. remedial education in controlled substance management, including appropriate medical record keeping related to such prescribing, subject to review and approval of the Board and to be completed within one year of approval of the stipulation and consent order.

5. With no reasonable or proper basis, Respondent failed to complete, within one year of the effective date of the November 5, 2003 stipulation and consent order, educational coursework "address[ing] the legal and professional requirements related to the judicious prescribing of controlled substances, including related medical record keeping," as required by Paragraphs 26-28 of the stipulation and consent order. Respondent even sought to avoid compliance with this

requirement by petitioning the Board's North Investigatory Committee for relief from such requirement.

6. On or about January 24, 2005, the State of Vermont, by and through the Attorney General, filed a specification of charges against Respondent alleging a failure to attend the required coursework in a timely fashion in violation of the November 5, 2003 stipulation and consent order. The State also alleged an attempt to engage in inappropriate ex parte communications with the Committee chair; failure to maintain and timely produce required records; and deficient care of, and record keeping concerning, a patient.

7. On or about December 20, 2006, a Hearing Committee for the Board determined that Respondent failed to timely comply with the Board order to successfully complete a remedial education course and, therefore, engaged in unprofessional conduct for which discipline was warranted. The Hearing Committee recommended that Respondent's license be suspended for 10 days.

8. On or about March 20, 2007, the Board found no legitimate or acceptable excuse for Respondent's failure to timely complete the education course required under the November 5, 2003 stipulation and consent order. The Board ordered that Respondent be reprimanded and that his license be suspended for 20 consecutive days.

9. As of the undersigned date, the Board has not released Respondent from the conditions of the November 5, 2003 stipulation and consent order.

10. On or about July 16, 2007, the Board opened the current complaint against Respondent because of a continuing failure to conform to various applicable conditions of the November 5, 2003 stipulation and consent order.

II. Current Unprofessional Conduct of Respondent

11. On or about July 7, 2009, Board Investigators Philip Ciotti and Paula Nenninger went to Respondent's office to examine lists of prescriptions in order to evaluate Respondent's compliance with the November 5, 2003 stipulation and consent order. Investigators Ciotti and Nenninger were given access to the records and provided an exam room to conduct their inspection. They counted 175 prescriptions for controlled substances involving 74 patients over the period of January 2008 to July 2009. At the end of the inspection, they requested copies of the 175 prescriptions that had been reviewed. In addition, Respondent was provided a written request for production of 13 patients' charts, concerning persons who investigators determined had been prescribed controlled substances based on previous review of pharmacy records, but for whom Respondent's staff could not then locate patient charts. Respondent was given 20 days to produce both sets of records.

12. By letter of July 30, 2009, Respondent's office provided eight of the 13 requested charts, but could not locate the other five. Three missing charts related to then-deceased former patients. One missing chart related to a current patient. And one missing chart related to a former patient who was under the care of another doctor, but for whom Respondent maintained a "skeleton" chart.

13. Investigator Ciotti subsequently performed another review of pharmacy records in order to determine whether all the prescriptions for controlled substances issued by Respondent from January 2008 to July 2009 had been documented in Respondent's files. It was determined that of 63 patients who had been reported in the pharmacies, 12 patients had filled prescriptions for controlled substances (totaling 34 prescriptions) for which no records were provided by Respondent during the July 7, 2009 inspection. As a result, in August 2009, Investigator Ciotti requested that Respondent provide the charts of these patients. (This request was originally for 13 charts; but one person was later determined to not be a patient of Respondent, meaning this request was ultimately for only 12 charts.)

14. Investigator Ciotti returned to Respondent's office on September 1, 2009 to review the 12 patients' charts. During this review, Respondent entered the exam room where Investigator Ciotti was located and confronted him about a letter dated August 26, 2009 in which Investigator Ciotti requested that all future correspondence to him and the Board be signed by Respondent personally. The stated purpose was to ensure that Respondent is fully aware of all correspondence. Respondent asked: "What's this all about? You mean to tell me you can't make appointments with staff, it has to be me?" Investigator Ciotti responded that he had no problem coordinating with staff, as that was not the issue; and pointed out that he had made this September 1, 2009 appointment with staff. Respondent then asked "Who told you to write this letter?" Investigator Ciotti responded that it was

the general policy of the Board to communicate directly with their licensees. While attempting to show Respondent a letter written from Suzanne O'Rourke (Respondent's spouse and office nurse) indicating that certain patients' charts could not be found for the September 1, 2009 inspection, Investigator Ciotti explained that an inability to locate charts was a problem and that he wanted to make sure Respondent was aware of the situation. Respondent then turned his back to Investigator Ciotti and walked out of the exam room, saying it was nothing but more harassment and that Investigator Ciotti had nothing better to do.

15. Of the 12 requested charts, Respondent could not locate three charts, which related to former patients who were then-deceased. Of the nine charts produced to Investigator Ciotti, four were sparse in content; two lacked indications of prescriptions issued; and one lacked a proper medication flow sheet. All nine charts produced were disorganized and difficult to understand.

III. State's Allegations of Unprofessional Conduct

Count 1

16. Paragraphs 3 through 15, above, are restated and incorporated by reference.

17. Paragraph 22 of the November 5, 2003 stipulation and consent order requires Respondent to ensure that all prescribing of controlled substances by him are based upon a current diagnostic assessment and treatment plan with specific entries for the patient's diagnosis or condition and rationale for prescribing, and produce all such records for review by the Board upon request.

18. Respondent failed to produce, upon the Board's August 2009 request, current diagnostic assessment and treatment plans (with specific entries for the patient's diagnosis or condition and rationale for prescribing) related to three patients (individually "Patient A", "Patient B", and "Patient C") to whom he prescribed controlled substances. Respondent prescribed Phenobarbital to Patient A 11 times between February 4, 2008 and November 28, 2008, without producing that patient's chart to a Board investigator on September 1, 2009. Respondent prescribed Propo N/APAP to Patient B three times between December 17, 2008 and February 12, 2009, without producing that patient's chart to a Board investigator on September 1, 2009. Respondent prescribed Phenobarbital to Patient C five times between January 28, 2008 and May 30, 2008, without producing that patient's chart to a Board investigator on September 1, 2009. Moreover, Respondent similarly failed to produce, upon the Board's July 7, 2009 request, current diagnostic assessment and treatment plans (with specific entries for the patient's diagnosis or condition and rationale for prescribing) related to five additional patients to whom he prescribed controlled substances. Respondent's conduct described above, on multiple occasions, violated Paragraph 22 of the November 5, 2003 stipulation and consent order. His conduct thereby constitutes multiple violations of 26 V.S.A. § 1354(a)(25) ("failure to comply with an order of the board or violation of any term or condition of a license which is restricted or conditioned by the board"). Such conduct by Respondent is unprofessional.

Count 2

19. Paragraphs 3 through 18, above, are restated and incorporated by reference.

20. Paragraph 23 of the November 5, 2003 stipulation and consent order requires Respondent to ensure that each controlled substance he prescribes is clearly noted in writing in the patient's office record with the date of prescribing indicated, and produce such records for review by the Board upon request.

21. Respondent failed to produce, upon the Board's August 2009 request, office records providing clear written notations, including dates, related to two prescriptions of controlled substances made to two patients. These patients' charts lacked any notations of the prescriptions issued. Respondent's conduct described above violated Paragraph 23 of the November 5, 2003 stipulation and consent order. His conduct thereby constitutes two violations of 26 V.S.A. § 1354(a)(25) ("failure to comply with an order of the board or violation of any term or condition of a license which is restricted or conditioned by the board"). Such conduct by Respondent is unprofessional.

Count 3

22. Paragraphs 3 through 21, above, are restated and incorporated by reference.

23. Paragraph 24 of the November 5, 2003 stipulation and consent order requires Respondent to ensure that each prescription by him for patients seen (other than those in hospital and nursing home settings) for DEA schedule II, III,

and IV drugs is copied and retained in duplicate by him, with one copy of each prescription placed in a chronologically-ordered file available for review by the Board upon request and the other copy placed in the patient's file.

24. Respondent failed to produce, upon the Board's July 7, 2009 request, copies of 34 prescriptions by him for DEA schedule II, III, and IV drugs to 12 patients from January 2008 to July 2009. His conduct thereby constitutes multiple violations of 26 V.S.A. § 1354(a)(25) ("failure to comply with an order of the board or violation of any term or condition of a license which is restricted or conditioned by the board"). Such conduct by Respondent is unprofessional.

Count 4

25. Paragraphs 3 through 24, above, are restated and incorporated by reference.

26. Respondent's conduct of knowingly and willfully disregarding various conditions on his license imposed by the November 5, 2003 stipulation and consent order constitutes evidence of an unfitness to practice within the general field of medicine. Such conduct by Respondent violates 26 V.S.A. § 1354(a)(7) and is unprofessional.

Count 5

27. Paragraphs 3 through 26, above, are restated and incorporated by reference.

28. Respondent's failure to fully cooperate with a Board investigator's lawful efforts to confirm Respondent's compliance with the conditions of the

November 5, 2003 stipulation and consent order, and/or Respondent's continuing failure to comply with various conditions of such order, constitute dishonorable and/or unprofessional conduct that is in violation of 26 V.S.A. § 1398. Such conduct is thereby subject to Board discipline.

Count 6

29. Paragraphs 3 through 28, above, are restated and incorporated by reference.

30. Respondent's failure to fully cooperate with a Board investigator's lawful efforts to confirm Respondent's compliance with the conditions of the November 5, 2003 stipulation and consent order, and/or Respondent's continuing failure to comply with various conditions of such order, constitute a violation of 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice). Such conduct by Respondent is unprofessional.

Count 7

31. Paragraphs 3 through 30, above, are restated and incorporated by reference.

32. Respondent's deficient record keeping, as described above, constitutes a gross failure, on repeated occasions, to use and exercise that degree of care, skill and proficiency that is commonly exercised by the ordinarily 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. Such conduct by Respondent

thereby constitutes multiple violations of 26 V.S.A. § 1354(a)(22) and is unprofessional.

Count 8

33. Paragraphs 3 through 32, above, are restated and incorporated by reference.

34. Respondent's deficient record keeping, on numerous occasions, constitutes multiple violations of 26 V.S.A. § 1354(b)(2) (failure to conform to the essential standards of acceptable and prevailing practice). Such conduct by Respondent is unprofessional.

WHEREFORE, petitioner, State of Vermont, moves the Board of Medical Practice, pursuant to 26 V.S.A. §§ 1354-1361 and/or 1398, to revoke, or take any other action it deems appropriate as to, the medical license of Respondent William A. O'Rourke, Jr., M.D.

DATED at Montpelier, Vermont this 15TH day of July 2010

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By: _____


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Foregoing Charges, In re: William A. O'Rourke, Jr. M.D., Docket No. MPN 101-0707, are hereby issued:

By: Margaret Funk Martin
Margaret Funk Martin
Secretary, Vermont Board of Medical Practice

Signed and Dated at Middlebury, Vermont this 2nd day of August 2010.

State of Vermont
County of Addison
Subscribed and sworn to (or affirmed) before me this <u>2nd</u>
day of <u>August</u> , 2010
By <u>Margaret Funk Martin</u>
Notary Public <u>Ann F. Webster</u>
My Commission Expires February 10, 2011

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