

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Alban J. Coghlan, MD

Docket No. MPC 112 – 112-0806

Proposed Decision and Order

Procedural History

The State of Vermont has petitioned the Vermont Board of Medical Practice (“Board”), pursuant to 26 VSA §§ 1351-61 and §1398, to revoke the medical license of Alban J. Coghlan, M.D. It filed a ten-count Specification of Charges on February 12, 2010 alleging Dr. Coghlan (“Respondent”) had engaged in unprofessional conduct in violation of several provisions of 26 VSA § 1354 :

Hearing

On December 6 and 7, 2010, a hearing committee (“Committee”), consisting of Margaret Funk Martin, Harvey S. Reich, M.D. and William Stouch, M.D. conducted a hearing in this matter, pursuant to 3 VSA §§ 809-14 and 26 VSA § 1355, to consider whether the State could prove its allegations. Marjorie Power served as presiding officer. Respondent was represented by R. Joseph O’Rourke, Esq. Assistant Attorney Jacob A. Humber represented the State of Vermont.

The parties agreed at the conclusion of the hearing that Respondent could supplement the record by submitting copies of checks written to Henry Schein Medical Supply during a period from May 8, 2002 through January 8, 2007. (Exhibit P) The evidence was closed on December 28, 2010.

Recommended Findings of Fact and Conclusions of Law

After considering all evidence admitted at the hearing and the agreed upon supplemental information, the Committee recommends that the Board adopt the following Findings of Fact, Conclusions of Law and Order.

1. Alban J. Coghlan, M.D. (“Respondent”) of East Dorset, Vermont holds medical license number 042-0005324 issued by the Board on July 25, 1974.
2. Respondent is a psychiatrist with a private medical practice in East Dorset, Vermont. He is also Medical Director of Serenity House, a substance abuse treatment facility in Wallingford, Vermont and has been employed from time-to-time by the Rutland Regional Medical Center.

3. For periods relevant to this proceeding, Respondent maintained a private medical office in Rutland and/or East Dorset, Vermont.
4. The Board has jurisdiction under 26 VSA §§ 1351-61 and 3 VSA §§ 809-14.

Count 1

The State alleges that Respondent practiced medicine without a license in violation of 26 VSA §1314 - a criminal statute¹ calling for imprisonment for up to three months upon conviction. It contends that this, in turn, means that he engaged in unprofessional conduct under 26 VSA § 1354 (a) (27) (violation of a statute governing the practice of medicine).

Findings of Fact (“Facts”):

5. Respondent’s license to practice Medicine expired on November 30, 2004. It was not renewed until December 8, 2004. Hearing Transcript of Testimony (“T”) (12/6) pp. 26-27.
6. Respondent admits that he practiced medicine without a license on December 2, 3 and 7, 2004. Respondent’s Request to Find (“RRTF”) #5; Respondent, T. (12/6) p.215
7. During the period that he practiced without a license, Respondent saw 23 patients. State’s Exhibit #5
8. Respondent also wrote prescriptions for eight Serenity House residents during the period that he had no medical license (12/1/04 -12/7/04). Ciotti, T (12/6). p.81

Conclusions of Law(“Conclusions”):

- There is no dispute that, as a matter of fact, Respondent practiced medicine without a license.
- Respondent’s conduct is a violation of *Vermont Medical Practice Board Rule 3.2* which says that a physician may not legally practice medicine after his/her license has lapsed. “The physician must halt the practice of medicine until it is reinstated.”
- The State *has* proven that Respondent has failed to comply with a Board rule governing the practice of medicine. In doing so, it has proven that Respondent engaged in unprofessional conduct in violation of 26 VSA § 1354 (a) (27) (“failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery”).

¹ The Board does not have jurisdiction to adjudicate violations of criminal statutes.

Count II

The State has three theories of unprofessional conduct.

- (1) The State alleges that Respondent violated 13 VSA §1754 (a) by knowingly giving false information to a law enforcement officer (Investigator Ciotti). Title 13 VSA §1754 (a) is a criminal statute². A person convicted of violating this statute may be imprisoned for up to three months. The State contends that this conduct, in turn, constituted a violation of 26 VSA §1354 (a) (27) (violation of a statute governing the practice of medicine).
- (2) The State also charges that Respondent's conduct violated 26 VSA §1354 (a) (7) ("conduct which evidences unfitness to practice medicine")
- (3) Finally it charges that this conduct also violated 26 VSA §1398 (Board may refuse to issue a license to a person who engages in "immoral, dishonorable" or unprofessional conduct).

Facts

9. The Board opened an investigation of Respondent in August 2006. The investigation related, in part, to concern that Respondent had practiced medicine without a license during a period from 12/1/04 through 12/7/04. Ciotti, T(12/6) p. 36
10. On September 14, 2006, Respondent called Board Investigator Philip Ciotti and told Investigator Ciotti that he (Respondent) had "closed his practice" and not seen patients or written prescriptions during the period that his license had lapsed (12/1/04 -12/7/04). T (12/6). pp. 37-38
11. On September 18, 2006, Respondent followed up with a letter to "Mr. Ciotti and Members of the Board of Medical Practice" in which he repeated the gist of the statement he had made to Investigator Ciotti:

" . . . When I heard from Tracy Hayes, licensing specialist at your office, at her instruction I canceled the patients I had scheduled for the first week in December and wrote no prescriptions for the period of December 1st through December 7th. . ." Ciotti, T (12/6). 40; State's Exhibit #2
12. As #5-8 (above) demonstrate, these statements to Investigator Ciotti and the Board were not true. Respondent admitted that he made a "false and misleading" statement which he referred to in his testimony before the Committee as a "white lie." RRTF #7; Respondent, T(12/6) p. 220

² The Board does not have jurisdiction to adjudicate violations of criminal statutes.

Conclusions:

- There is no dispute that Respondent made false and misleading statements to Investigator Ciotti and the Board.
- The State *has* proven that Respondent knowingly gave false information to Investigator Ciotti and the Board in an effort to deflect the investigation of him. The Committee concludes that this conduct is unprofessional because it “evidences unfitness to practice medicine.” 26 VSA §1354 (a) (7)
- The State *has* proven that Respondent’s conduct in lying to Investigator Ciotti and the Board is a violation of 26 VSA §1398 (“refusal or revocation of license” when a person who engages “immoral, unprofessional or dishonorable conduct”). The Committee concludes that this constitutes unprofessional conduct.

Count III

The State has two theories of unprofessional conduct.

- (1) It alleges that during a period from 2004 through 2007, Respondent billed Medicare for services provided by other medical professionals. Respondent claimed these services were “incident to” his services. The State maintains that these services were not entitled to Medicare reimbursement because they were not “incident to” Respondent’s services as that phrase is defined in Medicare regulations. That is, under Medicare rules, a physician may not claim reimbursement for services “incident to” that physician’s services unless that physician “directly supervises” the medical professionals whose services are “incident to” that of the physician. Medicare rules provide, in turn, that a physician may not claim that he/she is directly supervising other medical professionals for purposes of Medicare reimbursement unless the physician was in his/her office while these services were being performed. The State contends that Respondent was not in his office when the “incident to” services were being provided as required by Medicare rules; and, that as a consequence, several “incident to” claims that the Respondent made during 2004 through 2007 were “false. “ The State claims this constitutes unprofessional conduct under 26 VSA §1354 (a)(16) (16) (“gross overcharging for professional services on repeated occasions, including filing of false statements for collection of fees for which services are not rendered”).
- (2) The State also contends this was unprofessional conduct under 26 VSA §1354 (a) (27) (“failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery”) because Respondent’s conducted violated Medicare Regulation 42 CFR 410.26 which defines “incident to” as under the direct supervision of

the physician and 410.32 (b)(3)(ii) which, in turn, defines “direct supervision” as services rendered while the physician is present in the office.

Facts

13. During the period from 2004 through 2007, Respondent often did not work in his office on Mondays and Wednesdays. Respondent, T (12/7) pp. 25-32
14. During that period, Respondent billed/ filed claims with Medicare for 19 “services” that were provided by other medical professionals while Respondent was not in his office. Aube, T (12/7), pp. 81-82
15. Medicare later denied these claims when it learned that Respondent was not in his office when the services were provided. Under Medicare regulations, a physician may not be paid for services that are provided “incident to” his/her services unless the medical professionals providing services “incident to” the physician’s services are “directly supervised” by the physician. Medicare rules provide further that a physician does not “directly supervise” under these circumstances unless the physician is in his/her office. Aube, T. (12/6) p. 147
16. Respondent admitted that he was not in his office on 17 of the days when he billed Medicare for services provided by others. Respondent T. (12//7) p. 38
17. Respondent testified that the person who “billed” had made the mistake. “I don’t have control over what the person puts on the billing form.” Respondent T. (12/7) p.38
18. Respondent later testified that he thought he could be paid for services provided “incident to” his services if he was “available.” He testified that he did not know that “incident to” meant he had to be in the office. Respondent, T. (12/7) p. 39

Conclusions

- The State *has* proven that Respondent’s conduct was unprofessional as defined in 26 VSA §1354 (a)(16) (16) (“gross overcharging for professional services on repeated occasions, including filing of false statements for collection of fees for which services are not rendered”).
- The State *has* proven that Respondent violated Medicare Regulation/ Rule 42 CFR 410.26 by billing Medicare for services that were provided while he was not present in his office. This, in turn, constitutes unprofessional conduct under 26 VSA §1354 (a) (27)

("failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery").

Count IV

The State has three theories of unprofessional conduct.

- (1) The State alleges that the Respondent violated 18 VSA §4210 by failing to keep a record of regulated drugs that were received, or otherwise disposed of, by him and that this, in turn, constitutes a violation of 26 VSA §1354 (a) (27) ("failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery").
- (2) The State also maintains Respondent violated 18 VSA § 4223 (obtaining a regulated drug by misrepresentation or deceit) - criminal statute³ calling for imprisonment for up to two years and a day upon conviction. It charges that this, in turn, constitutes a 26 VSA §1354 (a) (27) ("failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery")
- (3) Finally, the State asserts that the Respondent engaged in unprofessional conduct 26 VSA §1354 (b) (2) by failing to "practice competently" by failing to "conform to the essential standards of acceptable and prevailing practice."

Facts

19. During the period beginning in May 2002 and ending January 8, 2007, some 10,500 tablets of the controlled drug Lorazepam were ordered from Henry Schein Medical Supply through Respondent's office, using Respondent's DEA License number. Many of the orders were paid for through Respondent's business account. State's Exhibits 6 and 7; Respondent's Exhibit P
20. The Lorazepam was ordered by an immediate family member of Respondent. "Immediate Family Member," T (12/6) p. 172
21. Respondent told Investigator Ciotti in March 2007 that he had "taken care" of the fact that his immediate family member had been using his DEA number to order Lorazepam "a year and a half ago" (i.e. late 2005). He said that the immediate family member had "a problem with" Lorazepam. Respondent said that as of the time of Investigator Ciotti's March interview, his home had been drug and alcohol free for a "year and a half." Respondent told Investigator Ciotti in March 2007 that he had discovered three bottles of

³ The Board does not have jurisdiction to adjudicate violations of criminal statutes.

Lorazepam with 500 tablets over a period of time and that he had destroyed all of them.
T (12/6) p. 62-63

22. Respondent and his immediate family member testified at the December 2010 hearing that Respondent did not learn that his immediate family member was using his DEA number until *December 2006* when he found Lorazepam in a laundry basket while his immediate family member was in a rehabilitation facility in Bradford, Vermont. "Immediate Family Member," T (12/6) pp.177-78; Respondent, T (12/6) pp. 250-51
23. Although Respondent told Investigator Ciotti that he had "taken care of" the fact that his immediate family member was ordering Lorazepam using his DEA number by late 2005, States Exhibits 6 and 7 show that the Lorazepam was ordered using his DEA number on 6 occasions from February 2006 through January 8, 2007.
24. Respondent testified at the December 2010 hearing that when he told Investigator Ciotti in March 2007 that he had "taken care of" the Lorazepam problem "a year and half ago," he was referring to the fact that the immediate family member had been required to enter a alcohol rehabilitation program in Florida "approximately a year and a half to two years earlier" Respondent, T (12/6) p. 254
25. Respondent told Investigator Ciotti in March 2007 that on *September 3, 2003*, Respondent had ordered 100 Vicodin tablets from Henry Schein Medical Supply for his own use. However, the same order also included 500 tablets of Lorazepam (the drug that the immediate family member "had a problem with" at the time). Ciotti, T(12/6) pp. 65 - 66; State's Exhibit 6

Conclusions

- The State *has* proven that Respondent engaged in unprofessional conduct by violating 18 VSA §4210 (a) and (d) by failing to keep required records detailing the disposal of regulated drugs. Respondent's business received thousands of tablets of a regulated drug that was ordered using respondent's DEA license number. Yet there was no record of its receipt. Respondent told Investigator Ciotti that he had disposed of three bottles of Lorazepam. Yet there was no record of when or how he had disposed of them. These violations of 18 VSA §4210, in turn, constitute unprofessional conduct under 26 VSA §1354 (a) (27) ("failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery").
- The State *has not* proven conduct 26 VSA §1354 (b) (2) by failing to "practice competently" by failing to "conform to the essential standards of acceptable and

prevailing practice.” The Committee concludes that there was not enough evidence admitted at the hearing for it to conclude by a preponderance of the evidence that Respondent knew, or should have known, that his immediate family member was using Respondent’s DEA number to obtain large quantities of Lorazepam.

Count V

The State has three theories of unprofessional conduct. All are under 26 VSA §1354 (b) (2). All are based on an allegation that on multiple occasions during the period from 1999-2001, Respondent prescribed Oxycodone and/ or Lorazepam for an immediate family member.

- (1) First, the State contends that this practice, in itself, is a violation of 26 VSA §1354 (b) (2) - failing to “practice competently” which, if the Board so concludes, may include “failure to conform to the essential standards of acceptable and prevailing practice.”
- (2) Second, it charges that this conduct is unprofessional under VSA 26 §1354 (b) (2) because it violates American Medical Association Opinion No.8-19 which says, in part: “Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV)”
- (3) Finally, the State contends that Respondent’s conduct is a violation of 26 VSA §1354 (b) (2) because it violates *Vermont Medical Practice Board Rule 4.3* (“Board Rule”) which says in part: “it is unacceptable practice and unprofessional conduct for a licensee to prescribe controlled substances listed in (DEA) Schedules II, III and IV” to a member of his or her immediate family, except in a bona fide emergency “of short-term and unforeseeable character.”

Facts

26. Respondent prescribed Lorazepam (six prescriptions with refills) and Oxycodone (two prescriptions with refills) to the same immediate family member (Count IV) during the period from 1999 through 2001. State’s Exhibit 13

Conclusions

- The State *has* proven that Respondent engaged in unprofessional conduct under 26 VSA §1354 (b) (2) by failing to practice competently by failing to conform to the essential standards of acceptable and prevailing practice.
- The State *has* proven that Respondent engaged in unprofessional conduct under 26 VSA §1354 (b)(2) by violating Board Rule 4.3 which says that it is unprofessional conduct

for a physician to prescribe controlled substances listed in DEA Schedules II and IV to a
an immediate family member.

Count VI

The State has three theories of unprofessional conduct. All are based on allegations that
Respondent prescribed non-controlled drugs to an immediate family member on multiple
occasions from 1999 -2003 and 2004-2007.

- (1) First, the State contends that this practice, in itself, is a violation of 26 VSA §1354 (b) (2)
- failing to “practice competently” which, if the Board so concludes, may include “failure
to conform to the essential standards of acceptable and prevailing practice.”
- (2) Second, it charges that this conduct is unprofessional under 26 VSA §1354 (b) (2) because
it violates American Medical Association Opinion No.8-19 which says, in part, that
physicians generally should not treat “members of their immediate families.”
- (3) Finally, the State contends that the Respondent engaged in unprofessional conduct under
26 VSA §1354 (a)(22) (“ . . . 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 . . .”)

Facts

27. Respondent prescribed non-controlled substances for an immediate family member on at
least 29 occasions from 2004 through 2007. State’s Exhibits 11, 12 and 13
28. Respondent admitted at the hearing that he prescribed non-controlled substances to an
immediate family member on multiple occasions during periods from 1999-2001 and
2004-2007. Respondent, T (12/6) pp. 243-48

Conclusions

- The State *has* proven that Respondent engaged in unprofessional conduct in violation of
26 VSA §1354 (b) (2) - failing to “practice competently” which, if the Board so
concludes, may include “failure to conform to the essential standards of acceptable and
prevailing practice.”
- The State *has* proven the Respondent engaged in unprofessional conduct in violation of
26 VSA §1354 (a)(22) (“ . . . 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 . . .”)

Count VII

The State has two theories of unprofessional conduct. Both are based on allegations that Respondent prescribed a controlled substance - Ambien 10 mg (quantity 20) - to an acquaintance, Person A, on April 5, 2004 without taking a medical history or conducting an examination.

- (1) The State alleges that this was unprofessional conduct under 26 VSA §1354 (a)(22) (“ gross failure to use and exercise . . . that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions . . .”).
- (2) It also contends that it was unprofessional conduct under 26 VSA §1354 (b) (2) by failing to “practice competently” which, if the Board so concludes, may include “failure to conform to the essential standards of acceptable and prevailing practice.”

Fact

29. Respondent admitted that he engaged in the conduct alleged. Respondent, T (12/6) pp. 240-41; State’s Exhibit 16

Conclusions

- The State *has* proven that Respondent engaged in unprofessional conduct in violation of 26 VSA §1354 (a)(22) (“ gross failure to use and exercise . . . that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions . . .”)
- The State *has* proven that Respondent engaged in unprofessional conduct in violation of 26 VSA §1354 (a)(22) (“ gross failure to use and exercise . . . that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions . . .”)

Count VIII

The State has two theories of unprofessional conduct. Both are based on claims that Respondent prescribed a controlled substance - Lorazepam 1 mg (quantity 10) - on August 11,

2005 to another acquaintance, Person B, another non family member, without taking a medical history or conducting an examination.

- (1) The State alleges that this was unprofessional conduct under 26 VSA §1354 (a)(22) (“ gross failure to use and exercise . . . that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions . . .”)
- (2) It also maintains this was unprofessional conduct 26 VSA §1354 (b) (2) by failing to “practice competently” which, if the Board so concludes, may include failure to conform to the essential standards of acceptable and prevailing practice.

Facts

30. Respondent admitted that he engaged in the conduct alleged. Respondent, T (12/6) pp. 241-42; State’s Exhibit 16
31. Respondent acknowledged that his conduct was “wrong” under “the rules and regulations of practice. But, he went on to insist- “In my heart I’ll never be wrong. Respondent, T (12/6) p. 243
32. When asked later why he did not “write a brief paragraph” explaining why he had prescribed the Ambien and Lorazepam, Respondent explained that he did not regard either person A, or person B, as his patients. “I was seeing them as a friend and as – you know, I would call it a corridor consultation.” Respondent, T (12/7) pp. 47-48

Conclusions

- The State *has* proven that Respondent engaged in unprofessional conduct in violation of 26 VSA §1354 (a)(22) (“ gross failure to use and exercise . . . that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions . . .”)
- The State *has* proven that Respondent in violation of 26 VSA §1354 (b) (2) by failing to “practice competently” which, if the Board so concludes, may include “failure to conform to the essential standards of acceptable and prevailing practice.”

Count IX

The State has two theories of unprofessional conduct. Both are based allegations that on September 3, 2003, Respondent used his DEA number to order 100 tablets of the controlled substance Hydrocodone w/APAP 7.5 / 750 (Vicodin) and treated himself with the tablets.

- (1) The State charges that such self-treatment violates Board Rule 4.3 which provides that such self-treatment constitutes unprofessional conduct. And, because it violates Board Rule 4.3, it also constitutes unprofessional conduct under 26 VSA §1354 (a) (27) (“failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery”).
- (2) The State also claims that the Respondent’s violated 26 VSA §1354 (b) (2) by failing to “practice competently” which, if the Board so concludes, may include “failure to conform to the essential standards of acceptable and prevailing practice.”

Facts

33. Respondent admitted the conduct alleged. He told Investigator Ciotti in 2007 that the Vicodin ordered from Henry Schein Medical Supply on September 3, 2003 was “actually for himself” to help with pain he was experiencing from a series of surgeries. Ciotti, T (12/6) pp. 64 - 65
34. As noted earlier, this order of 100 tablets of Vicodin from Henry Schein Medical Supply on September 3, 2003 was part of the same Henry Schein Medical Supply order that also called for 500 tablets of Lorazepam. Ciotti, T (12/6) pp. 65-66
35. Respondent told Investigator Ciotti in 2007 that the Vicodin order “was a one-time thing.” Once the Vicodin tablets were “gone he had no further use for them.” Ciotti, T (12/6) p.p. 64-65
36. Respondent testified at the hearing on December that the “46” Vicodin tablets in the bottle that his counsel had introduced as Respondent’s Exhibit O at the hearing were, in fact, left over from the pills that he had ordered from Henry Schein Medical Supply on September 3, 2003. Respondent, T (12/7) p. 13
37. Respondent later admitted that the tablets in Respondent’s exhibit O *were not* from the “one-time” September 3, 2003 order. He said they were tablets that he had received in 2007, perhaps from a prescription written by Dr. Bullock. Respondent, T (12/7) pp. 54-55 and p. 63

Conclusions

- The State *has* proven that Respondent engaged in unprofessional conduct in violation because he because his self-treatment violated Board Rule 4.3. This, in turn, constitutes unprofessional conduct under 26 VSA §1354 (a) (27) (“failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery”)
- The State *has* proven that Respondent engaged in unprofessional conduct in violation of 26 VSA §1354 (b) (2) by failing to “practice competently” which, if the Board so concludes, may include “failure to conform to the essential standards of acceptable and prevailing practice.”

Count X

The State alleges that the Respondent violated 18 VSA §4210 by failing to keep a record of regulated drugs received by him – “20 pills of Ambien” - and thereby engaged in unprofessional conduct under 26 VSA §1354 (a) (27) (“failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery”)

Fact

38. Respondent admitted at the hearing that he had 20 pills of Ambien in his office and that he had not kept a record of these pills because he did not know that he was required to. Respondent, T (12/6) pp. 249-50

Conclusion

- Respondent violated 18 VSA §4210 (a), (d) by failing to keep a record of regulated drugs received by his. This, in turn, constitutes unprofessional conduct in violation of 26 VSA §1354 (a) (27) (“failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery”).

Recommended Order

As proposed findings of fact 1-38 demonstrate, Respondent engaged in unprofessional conduct over a period from 1999-2007. This conduct included: (1) practicing medicine after his license had lapsed, (2) lying to a Board Investigator; (3) making false representations in a letter to the Board; (4) failing to exercise reasonable care with regulated drugs, including failure to keep detailed records of the manner in which regulated drugs were disposed of, as required by

Vermont law; (5) prescribing for persons who were not his patients and (6) treating himself and immediate family members with regulated drugs in violation of a Board Rule.

The Committee recommends that the Board enter the following Order pursuant to its authority under 26 VSA §1361 (b)⁴:

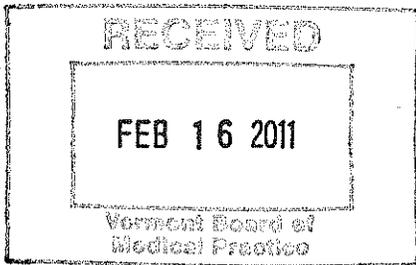
- (1) Respondent shall end any, and all, private, independent practice of medicine in the State of Vermont and shall close out such practice within sixty days of his receipt of this order;
- (2) Respondent's license to practice medicine in the State of Vermont shall be suspended for sixty days as soon as the Board receives notice from the Respondent that he has closed out all independent, private practice; or at sixty days from receipt of this order, whichever is first;
- (3) Upon completion of his sixty day suspension period, Respondent may resume the practice of medicine in Vermont *only as an employee* of a licensed Vermont medical services provider. Any such employment shall be approved in advance by the Board;
- (4) Within one year of receipt of this order, Respondent shall successfully complete a Board approved course in Medical Ethics which includes specific training regarding the prescribing of medications;
- (5) If Respondent fails to renew his license in a timely fashion as required by law, Respondent's license to practice medicine shall be terminated without right to reinstatement;
- (6) If Respondent writes any prescription that is not directly attributable to his responsibilities as an employee of a licensed Vermont medical services provider,

⁴ 26 VSA §1361 (b) "In such order, the board may reprimand the person complained against, as it deems appropriate; condition, limit, suspend or revoke the license or practice of the person complained against; or take such other action relating to discipline or practice as the board determines is proper."

Respondent's license to practice medicine shall be terminated without right to reinstatement;

- (7) Members of the Board investigative staff are directed to monitor compliance with this order.

Hearing Committee:



Margaret Funk Martin
Margaret Funk Martin

Harvey S. Reich
Harvey S. Reich, M.D.

William Stouch
William Stouch, M.D.