

**STATE OF VERMONT
BOARD OF MEDICAL PRACTICE**

In re: John R. Bookwalter, M.D.) Docket Nos. MPC 19-0209
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SPECIFICATION OF CHARGES

NOW COMES, the State of Vermont, by and through Attorney General William H. Sorrell and undersigned Assistant Attorney General, Terry Lovelace, and for its Specification of Charges allege as follows.

1. John R. Bookwalter, M.D., (hereafter "Respondent") holds license No. 042-0004468, issued by the Vermont Board of Medical Practice (hereafter "Board") on November 29, 1971.

2. Respondent's specialty is thoracic surgery and he also performs gastric bypass surgery for weight control. His medical practice in Brattleboro, Vermont includes patients seeking weight-loss.

3. Jurisdiction in these matters vests with the Vermont Board of Medical Practice pursuant to Vermont Board of Medical Practice Rule 4.3, and Vermont laws 26 V.S.A. §§ 1353-1361, 1398, 3 V.S.A. §§ 809-814 and others.

4. This matter began with a telephone complaint from the New Hampshire Board of Pharmacy on February 10, 2009 alleging unsafe or questionable prescribing practices. The matter was investigated by Board Investigator Philip Ciotti. *See attached Affidavit of Board Investigator Ciotti addressing Respondent's diet practice, attached and incorporated by reference herein.*

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5. The Board opened this case on April 3, 2009, alleging (a) improper prescribing practices, and (b) on multiple occasions prescribing non-controlled substances and medication listed on DEA Schedules IV for himself and for members of his family.

I. Diet Practice:

6. Investigator Ciotti obtained Respondent's prescribing profiles from Brattleboro area pharmacies. Ciotti found multiple prescriptions for the diet drug phentermine, and medication used to treat thyroid disease and diabetes. He also found prescriptions DEA Schedule IV medication and non-controlled medication written by Respondent for members of his family. *See attached Affidavit of Board Investigator Ciotti addressing Respondent's prescribing for family members, attached and incorporated by reference herein.*

7. Board Investigator Ciotti identified 25 patients with what appeared to be improper prescribing due to the profile of the combination of medications to the individual patients. Ciotti obtained these patients' records by subpoena for review.

8. These medical records were then sent to Edward Saltzman, M.D. (*See attached CV*) for review and an expert opinion in regard to Respondent's use of Armour Thyroid, metformin, phentermine, topiramate, xenadrine, topomax and DHEA to treat obesity. Dr. Saltzman was also asked to assess Respondent's overall patient management including documentation to medical records. Dr. Saltzman was not asked to render an opinion as to Respondent's alleged self-prescribing and prescribing for family members.

9. On February 1, 2011 Dr. Saltzman issued his written opinion regarding the records reviewed at Petitioner's request. Below is a synopsis of his findings:

Patient A: Dr. Saltzman states: "Patient A underwent gastric bypass surgery in 2001 at a weight of 318 pounds. Following surgery her weight loss was deemed suboptimal and she was prescribed Armour thyroid. She was intermittently prescribed metformin, phentermine, topiramate, xenadrine and DHEA in various combinations. In notes for some clinical visits it appears that the patient had been started on medication prior to that visit or an existing medication had been stopped, but there was no documentation of these changes in the provided notes. Records did not contain documentation of vital signs such as heart rate or blood pressure at clinic visits during the period of time when medications were being prescribed."

Patient B: Dr. Saltzman states "Patient B was provided with Metformin on one occasion ... her weight was 188 pounds. No height or body mass index was noted in the records provided."

Patient C: Dr. Saltzman states: "This patient was attending 'Curves' and was following a South Beach diet plan." Dr. Saltzman notes "She was initially prescribed phentermine. At a later date metformin was added to phentermine but the exact date is not clear from clinic notes." Dr. Saltzman noted that over a two year period, Patient C had been prescribed "combinations of medications" including phentermine, fluoxetine, metformin, topiramate, and Armour Thyroid. Dr. Saltzman states: "There is no discussion of hypothyroidism as an existing or new diagnosis in outpatient notes, nor was there documentation of vital signs, physical exam or laboratory assessment."

Patient D: Dr. Saltzman states: "At the last clinic visit for Patient D in 2009 the patient was prescribed metformin and Armour thyroid for obesity. At that time her weight was 172 pounds, and using height from a prior visit her body mass index would be 30.5 kg/m². There is no discussion of thyroid disorders in the records. TSH ordered in 2006 was within normal limits. A specific plan for diet or lifestyle plan did not appear in clinic notes, but the issue of weight is mentioned in some notes."

Patient E: Dr. Saltzman states: "Patient E was treated for obesity with combinations of phentermine, fenfluramine, dexfenfluramine, caffeine, ephedrine, Cytomel, DHEA, and Armour Thyroid. Her initial weight was 187 pounds. At some clinic visits the medications and their doses that were being prescribed are not documented. There is no documentation of vital signs. There are no laboratory tests in the record. Some diet recommendations were documented in clinic notes."

Patient F: Dr. Saltzman states: "Patient F's initial weight was 287 pounds. She was prescribed combinations of phentermine, L-thyroxine, metformin, and "thyroid". Lab tests conducted in May 2008 indicate the patient was euthyroid. No documentation of vital signs appears in clinic notes."

Patient G : Dr. Saltzman states: "Patient G was initially noted to be 192 pounds. She was noted to have an elevated TSH in a discharge summary for appendicitis in November 2008. She was treated with L-thyroxine and then Armour

thyroid and metformin were added at the last clinic visit for which records were provided.”

Patient H: Dr. Saltzman states: “Patient H was treated for obesity. Notes for one [office] visit in September 2008 were provided. She weighed 182 pounds at a height of 67 inches, with a body mass index of 28.5 kg/m². There is no documentation of weight related comorbidities. She was prescribed Armour Thyroid and phentermine. Five refills were given for phentermine as a result of the distance she lived from the clinic. No vital signs, exam or laboratory tests were documented. No diet or lifestyle counseling was documented.”

Patient I: Dr. Saltzman states: “Patient I was treated intermittently between May 2006 and February 2009. Her initial weight was 182 pounds at a height of 66 inches, with a body mass index of 29.4 kg/m². No weight related comorbidities were documented. She was treated with phentermine, metformin and Armour Thyroid. No vital signs, physical examination or laboratory tests were documented.”

Patient J: Dr. Saltzman states: “Patient J was treated between December 2008 and March 2009. Her initial weight was 197 pounds. She was prescribed phentermine, metformin and Armour Thyroid. No vital signs, physical examination or laboratory tests were documented.”

Patient K: Dr. Saltzman states: “Patient K initially had a weight of 180 pounds and height of 60 inches. The record states that she was prescribed ‘metformin, thyroid and Phentermine on the usual dose.’ She was instructed to call for any trouble and to return in two months. The record states that ‘if she gets too rived up she will back off first on the thyroid and then the Phentermine.’ No vital signs, physical exam or laboratory tests were documented.”

Patient L: Dr. Saltzman states: “Patient L initially weighed 237 pounds at a height of 63 inches. She was prescribed combinations of phentermine, Armour Thyroid, and metformin. It is not clear from clinic notes when these medications were started or stopped or what doses were prescribed. A medication preauthorization form states that the South Beach Diet and regular exercise were recommended. Vital signs and physical exam were not documented.”

Patient M: Dr. Saltzman states: “Patient M’s initial weight was 217 pound at a height of 64.5 inches. She was prescribed phentermine and metformin. Diarrhea was noted as a side effect from metformin and fiber was recommended. Vital signs and physical exam were not documented.”

Patient N: Dr. Saltzman states: “Patient N initially weighed 244 pounds at a height of 63.5 inches. Thyroid function tests from November 2006 (prior to starting treatment) were normal. She was treated with Armour Thyroid, metformin, and phentermine. On this regimen clinic notes indicate that she experienced an increased energy level but that the reason for this was unclear. Lifestyle was initially described as healthy. Vital signs were not documented.”

Patient O: Dr. Saltzman states: "Patient O had an initial body index was of 33 kg/m². She was treated with combinations of phentermine, Armour Thyroid, metformin and DHEA. Thyroid function tests during the course of treatment were within normal limits. A letter from another provider states that despite his obtaining a normal TSH that the patient was found to be hypothyroid by Dr. Bookwalter. There was no further documentation of history, exam or laboratory tests regarding the diagnosis of hypothyroidism. There was no documentation of vital signs."

Patient P: Dr. Saltzman states: "Patient P was treated intermittently between August 2003 and March 2005. Her initial weight was 204 pounds at a height of 69.5 inches. Thyroid function tests in 2003 were normal. Records indicate that she was following the Atkins or the South Beach Diet. No vital signs are documented."

Patient Q: Dr. Saltzman states: "Patient Q was treated between December 2005 and February 2007. She initially weighed 183 pounds at a height of 58.5 inches. Consumption of the South Beach Diet was encouraged at several visits. She was treated with combinations of phentermine, Armour Thyroid, fluoxetine, and metformin. She was noted to be allergic to metformin. In 2007 she had normal thyroid function tests. No vital signs or physical examination are documented during the period of time she was treated with medications for obesity."

Patient R: Dr. Saltzman states: "Patient R's initial weight was 216 pounds at a height of 63 inches. Although not specifically documented in the clinic notes, a medication preauthorization form for phentermine states that she had failed exercise and Weight Watchers. She was prescribed phentermine but the record states that she was not able to obtain the medication."

Patient S: Dr. Saltzman states: "Patient S was treated from September-October 2008. Her initial weight was 146 pounds at a height of 62 inches, with a body mass index of 27 kg/m². No weight related comorbidities, vital signs, physical exam or laboratory tests were found in the records provided. She was treated with metformin, to which Armour Thyroid and phentermine were then added."

Patient T: Dr. Saltzman states: "Patient T was not weighed at her initial visit and plans to weigh her at the next visit were noted, and she was prescribed phentermine at that first visit. At the next visit she was stated to have weighed 308 pounds previously. She was treated with phentermine, Armour Thyroid, and metformin. She was seen approximately every three months. At some visits it was noted that she was no longer taking medications when she returned and at the visit medications were restarted. There is one notation that she will decrease from "2% to 1%". No vital signs, physical exam, or laboratory tests were documented."

Patient U: Dr. Saltzman states: "Patient U's initial weight was 172 pounds. She had recently been hospitalized for cholecystectomy. At her clinic visit for weight loss she was prescribed 'some Thyroid and metformin.' 'Some phentermine' was

subsequently added to this regimen. Doses of medications were not documented in these notes. No vital signs, physical exam or laboratory tests were documented.”

Patient V: Dr. Saltzman states: “Patient V was seen once in April 2009, at which time her weight was 250 pounds at a height of 67 inches. She was treated with Armour Thyroid, metformin and phentermine. The medication preauthorization form for phentermine stated that she had not been to any weight loss programs previously, but that she was being instructed to decrease intake and exercise, and that she had severe arthritis. No vital signs, physical exam or laboratory tests were documented.”

Patient W: Dr. Saltzman states: “Patient W initially weighed 213 pounds at a height of 66 inches, and was noted to have type 2 diabetes. Her initial visit documents diet counseling. A clinic note in December 2008 stated that Armour Thyroid would be restarted. From the records provided it was unclear when this medication had been initially prescribed.”

Patient X: Dr. Saltzman states: “Ms. NG was treated intermittently over several decades for obesity by surgical and other means. In 2005 thyroid function tests were normal. She underwent revision of gastric banding to gastric bypass in February 2006 at a weight of 332 pounds. In October 2006 she had lost 70 pounds but the rate of loss was unsatisfactory to the patient, and metformin was started. In May 2008 thyroid function tests were normal. In June 2008 metformin and Armour Thyroid were started. At the next visit the patient was experiencing nausea and the clinic note states that Armour Thyroid would be stopped since the patient’s thyroid tests were previously normal. However at the next visit it appears that it was metformin that had been stopped and the patient remained on Armour Thyroid. In March 2009 the patient was noted to have been experiencing sleep difficulties and had been on phentermine; the date when phentermine was started was unclear from the records provided. The patient was noted to be walking for exercise and increased activity was encouraged.”

Patient Y: Dr. Saltzman states: “Patient Y was diagnosed by another provider to have borderline hypothyroidism on the basis of a low thyroxine, positive antithyroglobulin antibodies and normal TSH and was started by that provider on L-thyroxine. She was subsequently seen by Dr. Bookwalter at a weight of 180 pounds. At that time Armour Thyroid was added to L-thyroxine. At the next visit, metformin was added. Repeat assessment of thyroid tests was not documented, nor were vital signs.”

10. In his report dated February 1, 2011, Dr. Saltzman expressed his professional opinion of Respondent’s care in the matters above referenced as patients “A” through “Y” as summarized above. In the conclusion of his report Dr. Saltzman identified two broad areas where Respondent failed to meet the standard of care: (1)

improper pharmacological treatment of obesity and (2) lab reports, patient education regarding diet and lifestyle changes and vital signs were inconsistently documented to the medical records.

COUNTS 1 through 25
Improper Prescribing

As to the following: Patients A through Patient Y

Contrary to Vermont law, 26 V.S.A. §1354(b)(1)-(2), Respondent performed unsafe or unacceptable patient care and/or failed to conform to the essential standards of acceptable and prevailing practice, one count for each of the 25 patients identified above. Respondent's prescribing of Armour Thyroid, metformin, phentermine, topiramate, xenadrine, topomax and DHEA to treat obesity was unsafe or unacceptable patient care and does not conform to the essential standards of acceptable and prevailing practice. Respondent failed to adequately document patient education regarding weight loss and potential side effects of the medications prescribed. This is unprofessional conduct. The Vermont Board of Medical Practice possesses authority to suspend or revoke the license to practice medicine of a physician who has been found to have engaged in unprofessional conduct.

COUNTS 26 through 42
Failure to take or record vital signs

As to the following patients identified as: A, C, H, I, J, K, L, M, N, O, P, Q, S, T, U,
V and Y

Contrary to Vermont law, 26 V.S.A. §1354 (22), Respondent failed to 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 occurred. In office encounters Respondent failed to take or to record patient vital signs. Respondent's actions are unprofessional conduct, one count as to each patient identified above. The Vermont Board of Medical Practice possesses authority to suspend or revoke the license to practice medicine of a physician who has been found to have engaged in unprofessional conduct.

COUNTS 43 through 55
Failure to order or to record laboratory tests

As to the following patients: C, E, H, I, J, K, O, S, T, U, V and Y

Contrary to Vermont law, 26 V.S.A. §1354(22) Respondent failed to 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 occurred. Petitioner brings one count for each of the twelve patients identified above. Respondent failed to perform laboratory tests to diagnose and treat hypothyroidism in patients receiving thyroid therapy. Respondent failed to monitor patients receiving thyroid therapy for cardiovascular complications and loss of lean mass and bone. Respondent's actions are unprofessional conduct as to each patient. The Vermont Board of Medical Practice possesses authority to suspend or revoke the license to practice medicine of a physician who has been found to have engaged in unprofessional conduct.

II. Prescribing for Family Members, Failure to Document:

11. Vermont Medical Practice Board Rule 4.3 states:

“It is unacceptable medical practice and unprofessional conduct for a licensee to prescribe controlled substances listed in DEA Schedules II, III, and IV for his or her own use. Such conduct constitutes a violation of 26 V.S.A. §1398. It also is unacceptable medical practice and unprofessional conduct for a licensee to prescribe Schedule II, III, and IV controlled substances to a member of his or her immediate family, except in a bona fide emergency, of short term and unforeseeable character.”

12. In interviews conducted by telephone and in-person with pharmacists from the Brattleboro area, including Walgreens and Hotel Pharmacy, Investigator Ciotti discovered prescriptions written by Respondent for himself and members of his family. *See attached Supplemental Affidavit of Board Investigator Ciotti addressing Respondent’s alleged self-prescribing and prescribing for family members, attached and incorporated by reference here in.*

13. In total, forty-seven prescriptions for controlled and non-controlled drugs were written by Respondent for himself and four members of his family.

Written to Respondent John Bookwalter	24
Written to Respondent’s family members	23

Investigator Ciotti’s investigation found that two family members, identified as F1 and F2 in his Supplemental Report, were prescribed controlled substances by Respondent.

Patient F1 was prescribed phentermine, a Schedule IV drug, on a single occasion on June 3, 2006. F1’s medical records show a single office visit on June 27, 2006. In that encounter F1’s height, weight and BMI were recorded, but the record failed to

state a diagnosis or treatment plan and made no reference to the June 3, 2006 prescription for phentermine.

Patient F2 was prescribed Ambien and Diazepam, Schedule IV medications, on February 25, 2006. Respondent prescribed Schedule IV medications Lunesta and Ambien for patient F2 on September 19, 2006. Respondent prescribed Rozerem, also a Schedule IV medication, on November 20, 2006. The medical records showed no office notes whatsoever for Patient F2.

14. Petitioner brings the following counts against Respondent for unprofessional conduct by prescribing controlled medications for family members:

COUNTS 56 through 61
Prescribing for family members

Contrary to Vermont Board of Medical Practice Rule 4.3, Respondent prescribed Schedule IV medication for two members of his immediate family. One count as to each of the five prescriptions written by Respondent for members of his immediate family¹ identified as F1 and F2. Respondent's actions are unprofessional conduct. The Vermont Board of Medical Practice possesses authority to suspend or revoke the license to practice medicine of a physician who has been found to have engaged in unprofessional conduct.

COUNTS 62 through 67
Failure to document Patient Encounters

Contrary to Vermont law, 26 V.S.A. Section 1354(9), Respondent prescribed Schedule IV medication for two members of his immediate family and willfully failed to document these prescriptions to their medical records. One count as to each of

¹ As defined in Rule 4.3 – spouse, parent, grandparent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling.

the five prescriptions written by Respondent for members of his immediate family identified above as F1 and F2. Respondent's actions are unprofessional conduct. The Vermont Board of Medical Practice possesses authority to suspend or revoke the license to practice medicine of a physician who has been found to have engaged in unprofessional conduct.

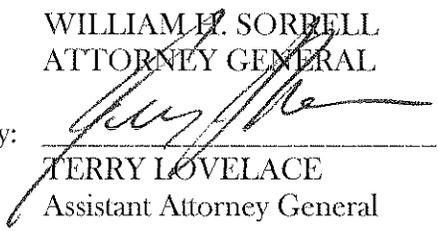
WHEREFORE, Petitioner, the State of Vermont, brings its Specification of Charges under 26 V.S.A. §1356, alleging unprofessional conduct by Respondent, and moves the Board of Medical Practice and its Secretary to set this matter for a contested hearing as provided for in 26 V.S.A. §1357. Allegations contained in Counts #1 through #61 are brought under Medical Practice Board Rule 4.3 and/or 26 V.S.A. §§ 1354 –1361 and/or § 1398. Petitioner seeks a contested hearing, findings of fact, conclusions and order to take such disciplinary action available under 26 V.S.A. §1361, as the board determines is proper and as warranted by the facts as to the medical license of Respondent, John Bookwalter, M.D.

Dated at Montpelier, Vermont this 4th day of May, 2011.

STATE OF VERMONT

WILLIAM H. SORBELL
ATTORNEY GENERAL

by:


TERRY LOVELACE
Assistant Attorney General

Foregoing Charges Issued: Margaret Funk Markin

Secretary, for the Board of Medical Practice

Signed and Dated at Randolph, Vermont this 4th day of May 2011.

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