IN THE MATTER OF	*	**BEFORE THE**
JACK D. BLAINE, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D04502	*	**Case Number: 2014-0876A**

* * * * * * * * * * * * *

CONSENT ORDER

On March 17, 2017, Disciplinary Panel A of the Maryland State Board of Physicians (the "Board"), charged **Jack D. Blaine,** M.D. (the "Respondent"), under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. II ("H.O.") §§ 14-101 et seq. The pertinent provisions of the Act provide the following:

> (a) *In general.* Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> > (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital or any other location in this State;
> >
> > (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On June 14, 2017, a conference with regard to this matter was held before Panel A of the Board's Disciplinary Committee for Case Resolution ("DCCR"). As a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all relevant times, the Respondent was a physician licensed to practice medicine in the State of Maryland. He was initially licensed to practice medicine in Maryland on November 24, 1969, under license D04502. His license is active.

2. The Respondent is a psychiatrist. He is board-certified in psychiatry. The Respondent also has a sub-specialty in addiction psychiatry, but that board certification expired in 2003.

3. The Respondent does not have any hospital privileges.

4. The Respondent is a solo practitioner in Bethesda, Maryland.

II. COMPLAINT AND INVESTIGATION

5. On or about May 1, 2014, the Board received a complaint from a pharmacist in Oakland, Maryland advising that patients had been coming into the pharmacy to fill prescriptions written by the Respondent, whose office is located three hours away. The pharmacist had not previously seen these patients. The pharmacist also stated that some of the patients were from out-of-state (West Virginia) and were filling prescriptions such as Xanax and Subutex.[1] The pharmacist further stated that he had one patient attempt an early refill and when the pharmacist called another pharmacy to follow-up on the prescription, the other pharmacy informed him that it no longer fills prescriptions written by the Respondent.

6. Thereafter, the Board initiated an investigation.

7. On or about December 16, 2014, the Board notified the Respondent of its full investigation and issued a subpoena for ten patient medical records chosen from various drug surveys. The Board also requested summaries of care for the ten patients and a written response to the complaint, which the Respondent provided.

[1] Xanax is a Schedule IV Controlled Dangerous Substance ("CDS") benzodiazepine. Subutex is a Schedule III CDS narcotic used to treat opioid dependence.

8. On or about February 11, 2015, in furtherance of its investigation, the Board transmitted the ten patient records (and other relevant documents) received from the Respondent for peer review by two physicians, both board-certified in addiction psychiatry ("the reviewers" or "the peer reviewers"). The results of the peer review are summarized below.

9. The reviewers submitted their respective reports on July 29, 2015. The reviewers concurred that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care and failed to keep adequate medical records for all ten patients.

10. Based on their review of the Respondent's records, the peer reviewers found that the Respondent's practice deficiencies include, but are not limited to, a consistent lack of documentation at the initial evaluation or follow-up appointments for risk assessments including suicidal ideation, accidental overdose, safe handling and storage, and sedation risks, particularly while driving. The Respondent's practice lacked a formal mental status exam, which resulted in a lack of objective data regarding speech, appearance, thought process, and thought content. The Respondent consistently failed to conduct urine toxicology screens at both the initial and follow-up appointments. Finally, of concern to the peer reviewers was the continuation of monthly prescriptions for narcotics and sedatives numbering hundreds of tablets, despite suspected misuse.

11. The Board sent a copy of both reviewers' reports to the Respondent. On August 24, 2015, the Board received the Respondent's supplemental response to the peer review reports.

III. PATIENT-SPECIFIC ALLEGATIONS

Examples of the above investigative findings are set forth in the following patient specific findings. These summaries are not intended as, and do not represent, a complete description of the evidence with respect to the Respondent's conduct in this matter.

PATIENT A[2]

1. Patient A, a male in his early 40s, began seeing the Respondent in October 2012 after his former psychiatrist retired. The Respondent diagnosed Patient A with Adjustment Disorder with Anxiety and possible Generalized Anxiety Disorder. The Respondent followed Patient A approximately every three months through June 2014.

2. The Respondent prescribed Xanax 0.5mg three times daily.

3. At the Respondent's initial appointment with Patient A, the Respondent failed to conduct or failed to document conducting a formal psychiatric evaluation with mental status examination to substantiate his working diagnosis.

4. The Respondent failed to document collateral information to substantiate his working diagnosis.

5. At the Respondent's initial appointment and at subsequent follow-up visits with Patient A, the Respondent failed to conduct, or failed to document conducting, a risk assessment for suicide.

6. The Respondent failed to address or failed to document addressing subjective and objective comments including suicidal ideation, homicidal ideation, psychosis or medication tolerability, risk/benefit profile discussion or potential side effects.

7. Patient A reported that his dosing schedule was Xanax .75mg at bedtime and .25mg PRN. Despite Patient A's self-report that he was consistently taking less than the prescribed dosage, the Respondent continued to prescribe Xanax .5mg three times daily. The Respondent failed to document his treatment rationale for continuing Patient A on the stated dosage.

[2] In order to maintain confidentiality, names will not be used in these Charges. The Respondent may obtain a list of the names referenced in the Charges by contacting the Administrative Prosecutor.

8. The Respondent failed to conduct, or failed to document conducting, a discussion with Patient A concerning overdose and safe storage or disposal of excess medications.

9. The Respondent's long-term prescription of a twice-daily benzodiazepine for the primary diagnosis of Adjustment Disorder was inappropriate. The Respondent did not document a change in Patient A's diagnosis to substantiate his long term use of this medication for Patient A.

10. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient A.

11. The Respondent failed to adequately document in the medical records of Patient A.

PATIENT B

12. Patient B, a female in her 30s, began seeing the Respondent in November 2011. Patient B was previously diagnosed with attention deficit hyperactivity disorder, inattentive type ("ADHD") and prescribed methylphenidate.[3] The Respondent confirmed Patient B's diagnosis and added a possible diagnosis of mood disorder. The Respondent initially prescribed methylphenidate 20mg TID.[4]

13. The Respondent saw Patient B monthly for the first six months of treatment, after which he saw her every three months.

14. The Respondent failed to conduct, or failed to document conducting, a comprehensive initial or follow-up evaluations that included a mental status examination specifically addressing appearance, speech, thought process, thought content, insight or judgment.

15. The Respondent failed to conduct, or failed to document conducting, a risk assessment pertaining to suicide or accidental overdose.

[3] Methylphenidate is a Schedule II CDS used to treat ADHD.
[4] TID is an abbreviate for three times a day.

16. The Respondent failed to conduct, or failed to document conducting, discussions with Patient B regarding therapeutic alternatives.

17. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient B.

18. The Respondent failed to adequately document in the medical records of Patient B.

PATIENT C

19. Patient C, a male in his 40s, began seeing the Respondent in October 2006 for the treatment of mood disorder, ADHD and alcohol dependence, for which Patient C had recently completed an intensive outpatient program. Patient C had a history of previous treatment for alcohol and benzodiazepine dependence, ADHD, Major Depressive Disorder and possibly Social Anxiety Disorder. Patient C was being treated with Lexapro[5], Campral[6] and Strattera[7] at various times during treatment.

20. The Respondent failed to conduct, or failed to document conducting, a comprehensive initial examination that included a mental status examination specifically addressing appearance, speech, thought process, thought content, insight or judgment.

21. The Respondent failed to conduct or failed to document conducting a risk assessment for harm to self or others. The only suicide risk assessments that the Respondent documented were in March and April of 2011, despite restarting an antidepressant for depressive symptoms in March of 2011. The Respondent failed to conduct, or document conducting, any risk assessments for the following three years.

[5] Lexapro is a selective serotonin and norepinephrine reuptake inhibitor antidepressant.

[6] Campral is used together with behavior modification and counseling support to help a person who has recently quit drinking alcohol continue to choose not to drink.

[7] Strattera is used to treat ADHD.

22. The Respondent failed to conduct any toxicology studies during any point in treatment, despite Patient C's history of alcohol dependence, history of sedative hypnotic dependence and current prescriptions for stimulants.

23. The Respondent measured and monitored Patient C's blood pressure at Patient C's initial evaluation and at follow up visits through March of 2007, and was included in his treatment rationale for changing Patient C's medications. The Respondent failed to conduct or document and blood pressure readings from 2008 to 2014, and failed to document a rationale for the change in monitoring.

24. Patient C reported migraines in February of 2013, and the Respondent prescribed Patient C medication as a result. The Respondent failed to document whether there were any adverse effects. Neither the medication, nor migraines were documented at any subsequent visits.

25. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient C.

26. The Respondent failed to adequately document in the medical records of Patient C.

PATIENT D

27. Patient D, a female in her 20s, began seeing the Respondent in October 2006 for the treatment of opioid dependence, ADHD, and an anxiety disorder with insomnia. . Patient D was being treated with clonazepam,[8] Suboxone,[9] Quetiapine,[10] and Adderall.[11] Patient D's treatment was complicated with numerous negative events such as injuries, theft and incarceration, which influenced her compliance.

[8] Clonazepam is a Schedule IV benzodiazepine.
[9] Suboxone is a Schedule III CDS used to treat opiate addiction.
[10] Quetipine is an antipsychotic medicine.
[11] Adderall is a Schedule II CDS used to treat ADHD.

28. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination at the initial appointment or at any subsequent appointments.

29. The Respondent failed to conduct, or failed to document conducting, an initial urine toxicology, despite Patient D's polysubstance abuse.

30. The Respondent failed to discuss sedation, and the increased risk of combining sedatives with narcotics with Patient D. The Respondent failed to conduct, or failed to document conducting, suicide or overdose risk assessments with Patient D.

31. The Respondent failed to conduct urine toxicology screens at any time, despite Patient D's history of polysubstance abuse upon presentation and throughout treatment.

32. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient D.

33. The Respondent failed to adequately document in the medical records of Patient D.

PATIENT E

34. Patient E, a male in his 20s, began treatment with the Respondent in October of 2013. Patient E presented with a history of opioid dependence, post-traumatic stress disorder ("PTSD"), and social anxiety. Patient E was being treated with buprenorphine,[12] Lexapro,[13] and alprazolam.[14] Patient E's treatment by the Respondent ended in May of 2014, when Patient E entered a residential program. Patient E's treatment was marked with instances of stolen prescriptions and missed appointments.

[12] Buprenorphine is a Schedule III narcotic analgesic.

[13] Lexapro (escitalopram) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors.

[14] Alprazolam is a Schedule IV benzodiazepine.

35. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination at the initial appointment or at any subsequent appointments.

36. The Respondent failed to discuss sedation, increased risk of combining sedatives with narcotics with Patient E. The Respondent failed to conduct, or failed to document conducting, suicide or overdose risk assessments with Patient E.

37. The Respondent failed to conduct, or failed to document conducting, an initial urine toxicology screen or at any time during treatment, despite a history of polysubstance abuse throughout treatment.

38. The Respondent failed to require the use of social support networks.

39. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient E.

40. The Respondent failed to adequately document in the medical records of Patient E.

PATIENT F

41. Patient F, a male patient in his 20s, began seeing the Respondent for the treatment of opioid dependence, panic disorder, ADHD, and a mood disorder. During his treatment, Patient F was treated with, at various times, Suboxone, clonazepam, Concerta[15], Cymbalta, diazepam,[16] and Zubsolv.[17] The Respondent followed Patient F regularly and medication changes where clinically indicated.

[15] Concerta is a Schedule II central nervous system stimulant used to treat ADHD.
[16] Diazepam is a Schedule IV benzodiazepine.
[17] Zubsolv is a Schedule III medication indicated for use as maintenance treatment for people suffering from opioid dependence.

42. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination at the initial appointment or at any subsequent appointments.

43. The Respondent failed to discuss with Patient F, or document discussing, sedation, accidental overdose, any discussion of adverse effects for Suboxone, Clonazepam, or Diazepam, assessments for self-harm.

44. The Respondent failed to conduct, or failed to document conducting, an initial urine toxicology screen despite Patient F's history of illicit drug use and opiate prescriptions by another provider. The Respondent only conducted a single toxicology screen on January 7, 2015, 28 months after starting Suboxone.

45. The Respondent failed to conduct, or document conducting, any assessment for self-harm.

46. The Respondent did not require the use of social support networks for Patient F's treatment.

47. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient F.

48. The Respondent failed to adequately document in the medical records of Patient F.

PATIENT G

49. Patient G, a female patient in her 30s, began seeing the Respondent in March of 2013, and presented with a history of opioid dependence, generalized anxiety disorder, and major depression. Patient G was prescribed at various times during her treatment Suboxone,

alprazolam, Soma, and Sertraline[18] for her respective conditions. The Respondent followed Patient G regularly and medication changes where clinically indicated.

50. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination. The Respondent failed to discuss, or document discussing, sedation and increased risk of combining sedatives with narcotics with Patient G. The Respondent failed to conduct, or document conducting, suicide or overdose risk assessments.

51. The Respondent failed to involve social support networks such as Narcotics Anonymous ("NA") or Alcoholic Anonymous ("AA"), in Patient G's treatment.

52. The Respondent did not conduct urine toxicology reports as part of his comprehensive assessment, despite Patient G's history of polysubstance abuse.

53. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient G.

54. The Respondent failed to adequately document in the medical records of Patient G.

PATIENT H

55. Patient H, a female patient in her 60s, began treatment with the Respondent in June of 2010. Patient H presented with a history of opioid dependence on methadone, adjustment disorder, and a history of polysubstance abuse. Patient H was prescribed clonazepam, Soma (carisoprodol), [19] and Valium.[20] During treatment, Patient H relapsed, and was started on Suboxone in place of methadone. The Respondent followed Patient H regularly and medication changes were made when clinically indicated.

[18] Sertraline is an antidepressant selective serotonin reuptake inhibitor.
[19] Carisoprodol is a Schedule IV muscle relaxer.
[20] Valium is a Schedule IV benzodiazepine.

56. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination at intake, or at any subsequent appointment.

57. The Respondent failed to discuss, or document discussing, sedation or the increased risk of combining sedatives with narcotics with Patient H. The Respondent performed only limited suicide risk assessments, which were done sporadically.

58. The Respondent prescribed Elavil[21] for Patient H's depression, but did not examine an electrocardiogram ("EKG") before or after starting this medication, despite the patient receiving methadone.

59. The Respondent failed to involve social support networks such as NA or AA, in Patient H's treatment even after Patient H was started on Suboxone due to relapse.

60. The Respondent did not conduct, or did not document conducting, urine toxicology screen at any time, including at the initial appointment, despite Patient H's history of polysubstance abuse history and later discharge from Patient H's methadone program.[22]

61. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient H.

62. The Respondent failed to adequately document in the medical records of Patient H.

PATIENT I

63. Patient I, a male patient in his 20s, sought treatment from the Respondent beginning in October 2006. Patient I presented with a history of opioid dependence, mood disorder and anxiety. Patient I was diagnosed with opioid dependence and prescribed buprenorphine,

[21] Elavil is a tricyclic antidepressant.

[22] The patient care summary provided by the Respondent does indicate negative urine toxicology reports, but no documentation was found within the medical record.

citalopram,[23] and diazepam. Additionally, the Respondent diagnosed Patient I with ADHD and prescribed methylphenidate for a period of time during treatment. The Respondent followed Patient I regularly through January of 2015. Patient I's treatment was marked with instances of running out of medications, incarcerations, and missed appointments.

64. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination at intake, or at any subsequent appointment. The Respondent failed to discuss, or document discussing, sedation or the increased risk of combining sedatives and narcotics. The Respondent did not regularly document suicidal or homicidal ideation within the initial assessment, or during the majority of follow up visits.

65. Patient I reportedly used I 00 tablets of valium over a four-day period; however, the Respondent continued to prescribe 120 tablets of valium at each subsequent visit.

66. The Respondent conducted limited overdose risk assessments on Patient I, despite the fact that Patient I admitted to drinking and using heroin.

67. The Respondent did not conduct a single urine toxicology screen at any time, including at the initial appointment, despite Patient I's polysubstance abuse history, and self-reported concurrent use of opiates and alcohol during treatment.

68. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient I.

69. The Respondent failed to adequately document in the medical records of Patient I.

PATIENT J

70. Patient J, a female who began treatment with the Respondent in her 20s, presented in May of 2010 with a history of opioid dependence, mood disorder and anxiety. The Respondent

[23] Citalopram is an antidepressant.

diagnosed Patient I with major depression, recurrent, severe anxiety disorder, and opioid dependence. During her treatment, at various times, she was prescribed Sertraline, alprazolam, Suboxone, diazepram, Librium and Cymbalta. Patient J's course of treatment was marked with instances of running out of medications, incarcerations and missed appointments.

71. The Respondent failed to conduct, or failed to document conducting, a comprehensive assessment that included a mental status examination at intake, or at any subsequent appointment.

72. The Respondent failed to discuss, or document discussing, sedation or the increased risk of combining sedatives and narcotics, even with Patient J's prior conviction for driving influence of alcohol.

73. The Respondent conducted limited suicide risk assessments, even after Patient J was hospitalized.

74. The Respondent did not require Patient J to be involved in social support networks (such as NA or AA) before or after Patient J was started on Suboxone.

75. The Respondent did not conduct, or did not document conducting, an urine toxicology report at any time, despite polysubstance abuse and reported diversion/theft by Patient J's roommate.

76. The Respondent did not document potential drug interactions regarding using benzodiazepines and Suboxone.

77. The Respondent failed to meet the appropriate standards for the delivery of quality medical care for Patient J.

78. The Respondent failed to adequately document in the medical records of Patient J.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to meet appropriate standards for the delivery of quality medical care, in violation of Md. Code Ann., Health Occ. II § 14-404(a)(22), and failed to keep adequate medical records, in violation of § 14-404(a)(40).

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby

ORDERED that the Respondent is **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **ONE** YEAR.[24] During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

(1) Within **SIX (6) months,** the Respondent shall successfully complete a Board disciplinary-panel approved course in prescribing controlled dangerous substances. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing medical education credits required for license renewal. The Respondent must provide documentation to the panel that the Respondent has successfully completed the course.

(2) Within **SIX (6) months,** the Respondent shall successfully complete a Board disciplinary-panel approved course in medical documentation. The panel will not accept a course taken over the Internet. The course may not be used to fulfill the continuing

[24] If the Respondent's license expires while the Respondent is on probation, the probationary period and any probationary conditions will be tolled.

medical education credits required for license renewal. The Respondent must provide documentation to the panel that the Respondent has successfully completed the course.

(3) During the probationary period, the Respondent is subject to a chart and/or peer review conducted by the Board or Board disciplinary panel or its agents. An unsatisfactory chart and/or peer review will constitute a violation of probation; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or Panel A; and it is further

ORDERED that, after the appropriate hearing, if the Board or Panel A determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or Panel A may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or Panel A may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that there is no early termination of probation; and it is further

ORDERED that, after one year, the Respondent may submit a written petition to the Board or Panel A requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board or Panel A. The

Board or Panel A will grant the petition to terminate the probation if the Respondent has complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. II §14-101 - §14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

ORDERED that unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel A; and it is further

ORDERED that this Consent Order is a public document pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 *et seq.* (2014)

August 17, 2017
Date

Christine A. Farrelly
Christine A. Farrelly, Executive Director

CONSENT

I, Jack D. Blaine, M.D., acknowledge that Iam represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of a disciplinary panel of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of a disciplinary panel of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

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Date (D. Blaine, M.D.

Read and approved by:

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Attorney for Dr. Blaine

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF fr1; .,c e,, beo'86:

I HEREBY CERTIFY that on this ay of Aug , 201/before me, a Notary Public of the foregoing State personally appeared Jack D. Blaine, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Notary Publi

My Commission Expires: 7/27/2020