COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1465

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY DARRYL L. DOCHTERMAN, M.D., LICENSE NO. 15263, 604 TALLY ROAD, LEXINGTON, KENTUCKY 40502

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Darryl L. Dochterman, M.D., ("the licensee"), and, based upon their mutual desire to fully and finally resolve this pending grievance without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Indefinite Restriction:

1. At all relevant times, Darryl L. Dochterman, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is radiology.
3. On or about June 18, 2012, a Medical Review Officer ("MRO"), Occupational Medicine Center in Richmond, Kentucky, reported to the Board that while reviewing a urine drug screen and prescribing history for Patient A she learned that the licensee had frequently prescribed hydrocodone and Xanax to Patient A over a two-year period; when inquired about her physician-patient relationship with the licensee, Patient A stated that she did not have an established physician-patient relationship with the licensee and that the licensee is a family friend and

dates someone that she knows; Patient A stated that she had been trying to cut down on her drug use and had used an old suboxone to try and help; and Patient A also stated that her most recent prescription from the licensee was for Tramadol, a narcotic-like substance.

4. On or about August 14, 2012, Paula York, R.Ph., Drug Enforcement and Professional Practices Branch of the Cabinet for Health Services ("Drug Enforcement"), reviewed and analyzed the licensee's KASPER records (dated August 9, 2009 through August 8, 2012) and noted several patterns which may indicate inappropriate prescribing, including:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated; and
   - Controlled substances prescribed at intervals which appear to be inappropriate.

   Ms. York noted that the licensee's specialty is radiology; that his employer is Kentucky Rehabilitation Clinics; and that several prescriptions for hydrocodone containing cough syrups, medications to treat ADHD and testosterone products may not be appropriate for his area of practice. It was also noted that the licensee self-prescribed testosterone products, diphenoxylate and a hydrocodone containing cough syrup.

5. The Board's medical investigator, Doug Wilson, and Ms. York interviewed the licensee and provided him a copy of the MRO's grievance and the Drug Enforcement KASPER review. During the interview and in a written response (dated September 2012), the licensee stated the following:

- In regard to Patient A, the licensee considers her to be a personal friend and he has dropped by her home on occasions. The licensee acknowledged seeing her one time at Kentucky Medical Rehabilitation Clinic and doing a cursory exam, but he had no medical chart on her. The licensee relied on Patient A to tell him when she had last obtained prescriptions for hydrocodone and that he would telephone in prescriptions for her accordingly. After Patient A informed him that she went for an evaluation because of concerns with her being impaired at work and they found out about her hydrocodone prescriptions and that she was taking Xanax, the licensee told her that he would not write her anymore hydrocodone prescriptions. After discovering that she had issues with hydrocodone, the licensee felt comfortable prescribing Tramadol. The licensee had no knowledge that Patient A had taken suboxone.

- In regard to Patient B, the licensee acknowledged her to be a friend to whom he had prescribed "mild stuff" (Tramadol and hydrocodone) but did not maintain a medical chart on.

- In regard to Patient C (the sister of Patient A), the licensee acknowledged her to be a friend; that he did write up one medical visit (dated November 11, 2011); that Patient C had sciatic pain down the right leg and occasionally the left leg; that she needed to go for surgery but had minimal insurance and no money; that he tried to keep her pain under control with hydrocodone; and that he occasionally prescribed her antibiotics for dental problems.

- In regard to Patient D, the licensee had two EMR entries (dated January 25 and August 23, 2012). The licensee prescribed Patient D Valium to treat ADHD, which had been diagnosed in Florida.

- In regard to Patient E, the licensee acknowledged her to be a close relative; that he prescribed her Clonazepam for anxiety on at least one occasion; and that he did not maintain a medical chart on her.

- In regard to Patient F, the licensee acknowledged him to be a friend, who was in an auto accident years ago, and that he had only one recorded office visit (dated January 5, 2011).

- In regard to Patient G, the licensee acknowledged that she was an employee with only one recorded medical visit (dated April 30, 2012).

- In regard to Patient H, the licensee identified him as his personal physician to whom he prescribed testosterone and acknowledged that he did not maintain a medical chart on him.

- In regard to Patient I, the licensee identified her as a friend to whom he had prescribed but had to cut off. There was one medical visit entry (dated November 9, 2011).

- In regard to Patient J, the licensee identified him as a long-time patient at Kentucky Medical Rehabilitation Clinic and there was an extensive medical chart on this patient.

- In regard to Patient K, the licensee acknowledged her to be an ex-wife; that he prescribed her Imitrex, Meclizine and cough syrup; and that he did not maintain a medical chart on her.

- In regard to Patient L, the licensee acknowledged her to be a close relative; that he occasionally prescribed her Clonazepam and Lomotil; and that he did not maintain a medical chart on her.

- In regard to Patient M, the licensee acknowledged her to be an ex-wife; that he regularly prescribed her Valium and occasionally Tussionex; and that he did not maintain a medical chart on her.

- In regard to Patient N, the licensee acknowledged her to be a former stepdaughter to whom he prescribed Tussionex for bronchitis and cough and that he did not maintain a medical chart on her.

- In regard to Patient O, the licensee acknowledged him to be a friend, who suffers from arthritis of the spine; that he regularly prescribed him hydrocodone and Xanax and once Lomotil; and that he did not maintain a medical chart on him.

- In regard to Patient P, the licensee acknowledged him to be a friend and believed he had maintained a medical chart on him.

- In regard to Patient Q, the licensee acknowledged her to be a former colleague to whom he prescribed diet aid pills and once hydrocodone and that he did not maintain a medical chart on her.

- In regard to Patient R, the licensee acknowledged her to be an employee of Kentucky Medical Rehabilitation Clinic to whom he prescribed Xanax and that he did not maintain a medical chart on her.

The licensee also acknowledged that he occasionally self-prescribed testosterone, Lomotil, and Valium.

6. A Board Consultant reviewed the information and records obtained in the course of the Board's investigation and found overall that

> With regards to the documentation of the prescription of controlled substances including, but not limited to hydrocodone, oxycodone and various benzodiazepines, on aggregate there was a clear and pervasive pattern of gross negligence, especially with regards to the activities outside the context of the doctor's established medical practice.
>
> With regards to the diagnosis or indication for the prescription of these controlled substances, on aggregate there was also a clear picture of negligence, bordering upon and at times meeting that of gross negligence.
> ...

The Board Consultant's summary narrative report is attached hereto and incorporated herewith in its entirety.

7. In a letter, dated February 2, 2013, the licensee responded to the Board Consultant's report, stating in part

> ... Recently, I have been guilty of transgression in my practice by writing prescriptions for patients and my family for addicting drugs without complete follow up and without full disclosure in medical records, which resulted in incomplete medical records. I fully recognize the fact that people, including family, must find their own physician and not rely on me to provide them with their medications, even if warranted. I do feel that I have been foolish and have been taken advantage of to some degree by the patients. I realize that I needed to be much more careful of people's requests, personalities and intents when prescribing medications.
>
> I was working at a clinic which saw injured clients from auto accidents and other general injuries. The people I saw were financially disadvantaged and had little or no insurance. I was trying to be their family doctor as well as taking care of them regarding recent injuries. This was a mistake, as I could not cover all fronts at once.
>
> It is important for the board to know that I was not receiving any wage or salary at the time in question. My services were pro bono. I certainly was not scamming the patients or receiving any

> compensation from them. From the time I was approached by the board till now I have not written any prescriptions, nor will I write any more.
>
> Since I have run into trouble with Rx writing, I would be happy to not prescribe at all and give up my DEA rights. Perhaps in this manner I could maintain my license and continue to help people.
> ...

8. On or about February 21, 2013, the Board's Inquiry Panel A reviewed the investigation and chose to allow the licensee to continue practicing medicine pursuant to the terms and conditions set forth in this Agreed Order of Indefinite Restriction.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(d), (3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending grievance without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Indefinite Restriction.

AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending grievance

without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Darryl L. Dochterman, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;

2. During the effective period of this Agreed Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:

    a. The license SHALL SURRENDER his DEA registration number and any other prescribing rights and/or privileges forever and permanently, effective immediately upon the filing of this Agreed Order of Indefinite Restriction;

    b. From the date of filing of this Agreed Order of Indefinite Restriction forward, the licensee SHALL NEVER prescribe, dispense, or otherwise professionally utilize controlled substances within the Commonwealth of Kentucky;

    c. Within six (6) months from the date of entry of this Agreed Order of Indefinite Restriction, the licensee SHALL REIMBURSE the Board the full costs of the investigation in the amount of $1,537.50; and

    d. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. If the Board should receive information that, after the date of filing of this Agreed Order of Indefinite Restriction, the licensee has prescribed, dispensed, or otherwise professionally utilized controlled substances within the Commonwealth of Kentucky, it will aggressively pursue the criminal prosecution of the licensee for such acts, to the full extent of the law.

4. As an express condition for the entry of this Agreed Order of Indefinite Restriction, each party understands and agrees that neither Panel of the Board will ever consider any petition for reinstatement of the license's prescribing privileges, any motion or request for modification or change of the terms of this Agreed Order of Indefinite Restriction or special request for consideration for relief filed by the licensee. This Agreed Order of Indefinite Restriction is expressly designed to serve as the complete and final termination of the legal relationship between this Board and this licensee in regard to the licensee's prescribing rights, privileges or abilities. Any communication by the licensee and/or his agents to the Board attempting to revive that legal relationship will be returned without being provided or forwarded to any Board member.

5. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare

and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Indefinite Restriction.

6. The licensee understands and agrees that any violation of the terms of this Agreed Order of Indefinite Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 7 day of March, 2013.

FOR THE LICENSEE:

DARRYL L. DOCHTERMAN, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

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Medical Record Review of Dr Darryl Dochterman,

Summary Findings

1/18/13

Reviewer: Russell J Bird, M.D.

Findings

With regards to the documentation of the prescription of controlled substances including, but not limited to hydrocodone, oxycodone and various benzodiazepines, on aggregate there was a clear, pervasive pattern of gross negligence, especially with regards to the activities outside the context of the doctor's established medical practice.

With regards to the diagnosis or indication for the prescription of these controlled substances, on aggregate there was also a clear picture of negligence, bordering upon and at times meeting that of gross negligence.

Sources

Eleven patient charts and a KASPER enquiry provided by the KBML coupled with a number of separate letters or documents entitled "Comprehensive Evaluation" provided by Darryl Dochterman, M.D.

Methodology

Patients reviewed are divided into two groups, both of which met criteria for negligence and gross negligence

Group 1. Those seen at the doctor's clinic (with actual medical records).

Group 2. Those seen by the doctor privately, "at large" in the community (without acceptable medical records).

Group 1. Patients seen at the doctor's clinic.

Of the first group, those with actual medical records seen in-clinic, there is clear evidence of gross failure to document indications for initial and continuing prescription of controlled substances. Some patients were prescribed opiods with no mention made in the progress notes. Diagnoses were often vague, such as only listing the patient's

symptoms and physical findings- without the doctor making a specific diagnosis. Other times, the diagnosis provided did not indicate the use of chronic opiods (such as lumbar strain, a typically acute, self-limiting diagnosis).

Many prescriptions were called in with no documentation as to why. Some patients had opiods continued even after they were discharged from the practice. One patient, [redacted], was continued on opiods for months even after the doctor clearly documented all symptoms were resolved and all medications were to be discontinued. Another patient, [redacted] had an alarming amount of opiods (#180 hydrocodone 10mg/acetaminophen 325-500mg) called in (without documentation as to why) within an eight day period in November of 2011. The acetaminophen load itself could have been life threatening. **The charts provided strongly show the doctor practiced a clear, 'fast and loose' behavior of over-prescription of controlled substances.** In addition, standard pain management protocols such as drug screens were never documented and likely never performed. In addition routine KASPER enquiries (even considering the standard of care pre-KY HB#1) were nearly never performed.

Furthermore, with regards to the clinic charts provided, there was a definite pattern of careless record keeping. Progress notes were often no more than a 'cut and paste' of the previous patient visit with only a few changes made or added. This 'cut and paste' was often indiscriminate with regards to chronology. At times, the medical record contradicted itself; for example, the continuation of certain medications previously discontinued. One patient, [redacted] had the same vital signs recorded every visit, including an remarkably steady blood pressure of 145/90!

Group 2: Patients (alleged) seen outside the context of the doctor's established clinic.

The doctor provided to the Board a number of post dated narratives entitled "*Comprehensive Evaluation*" in which he describes why he prescribed multiple controlled substances to multiple persons (including himself) who may or may not have been patients of his. All narratives were dated 9/24/11, whereas the 'services' provided were as early as 2009. The KAPSER record demonstrates that the doctor wrote multiple prescriptions for controlled substances for multiple people over a period of months to

years. One "patient," [redacted] received multiple prescriptions of hydrocodone 10mg at a frequency of two to four times a month over a period of more than two years; all without any standard-of-care, acceptable form of medical record. Nor was this an isolated event. Of the 'patients' the doctor described in his narratives, multiple underwent the same 'treatment'- months of undocumented repeated prescriptions for controlled substances (see [redacted]

In addition, there were multiple persons who received controlled substances for a shorter period of time. For example in one narrative, that of [redacted] the doctor writes that he "*Prescribed Xanax only on 3 occasions.*" A peer group of physicians would likely state that "only" prescribing a benzodiazepine three times outside the context of a well documented, well reasoned patient/doctor relationship is three times too many; especially given the pattern of how often the doctor "only" prescribed a few medicines- (the KASPER record demonstrates the number of prescriptions to these individuals ranged anywhere from once to a dozen times). Furthermore, the doctor prescribed himself controlled substances (testosterone preparations). Generally speaking, the medical community frowns upon physician self prescription; no matter what the medication. Self-prescription of controlled substances is way off the spectrum of acceptable activity.

Most concerning, the narratives the doctor provided (his apparent rebuttal to the investigation by the Board) appear to be no more than subjective, vague, retroactive recollections as to why the doctor prescribed these medications in such an unorthodox manner. These 'documents' cannot be considered acceptable, standard of care medical records.

<u>The standard of care in the prescription of a controlled substance (or any medication for that matter) would require:</u>

a. A defined patient-physician relationship (not firmly documented, although it <u>may</u> be retroactively implied in the physician's recollections).
b. A clearly documented, <u>ongoing</u> medical record (not found).
c. Where (i.e.: clinic, hospital, house call) drugs were prescribed (rarely documented).

d. A history and physical exam. (Only documented vaguely in the context of recollection. No on the date-of-service chart entry, and hence cannot reliably accepted as objective. Most physician's would agree that it would be very difficult to recall the exact details of a physical exam performed month's earlier.)

e. An independent assessment of the patient's medical condition. (Not documented- only found was a retroactive discussion of what the patient told the physician and what a medical record may have demonstrated.)

f. A clear indication for the prescription of a controlled substance (not found, no medical record to base indication).

In particular, there is no medical record to support that these "patients" warranted these repeated prescriptions for controlled substances and, conversely, there is no documentation that the "patients" were not harmed by the prolonged prescription of these drugs, which carry a high risk of adverse effects (abuse, divergence, toxicity). Finally, these drugs are "controlled" for good reason. Dr Dochterman's prescribing of these medications cannot be supported by any reading of the documents provided.

Furthermore, the chronicity of many of these prescriptions, combined with the complete lack of acceptable documentation and the general sense of oddness about all this raises the possibility of professional impairment on the part of Dr Dochterman; such as ambiguous boundary issues, emotional entanglement, or some other motivation.

The Board may further wish to investigate further; Why were these medications prescribed outside the context of a standard-of-care doctor/patient relationship? What was the doctor's motivation? Were these transactions entirely legal?

In essence, what was the 'Quid Pro Quo?'

Signed: _____ **Date: 1/18/13**

Russell J Bird, M.D.