

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1695

FILED OF RECORD

FEB 18 2013

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH
OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO.
26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Hearing Panel A, and James H. Heaphy, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally resolve the Complaint without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER**:

STIPULATIONS OF FACT

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

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend

the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.
5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on

several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.

6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management Seminar II Note: This is an attendance sheet not a	March 12-16, 2004	May, 1998	None: Due to no attendance sheet submit-	None: Due to no attendance sheet submitted.

certificate			ted.	
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee

has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found

that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.
12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07,

07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise,

vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.

15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-amputation of his residual limb. The patient believed that the six week delay

resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was

closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was

seeing a podiatrist, Dr Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-

up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.
20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010 and the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
21. In July 2010, the Panel deferred consideration of Dr. Heaphy's request for reinstatement of his license until Dr. Heaphy completed the CPEP ProBe Program and the completion of an audit of his CMEs.
22. In September 2010, Dr. Heaphy attended CPEP's Patient Care Documentation Seminar and an audit of his CME credits showed that he had successfully completed the required hours.

23. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM~E* (Professional Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.
24. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in an Agreed Order of Probation, which required (in part) that he maintain a controlled substance log, that his practice be subject to periodic reviews by a Board consultant and that he practice within acceptable and prevailing medical practices in the Commonwealth of Kentucky.
25. In February 2012, a Board consultant reviewed a KASPER report of Dr. Heaphy's prescribing from January 1 through October 26, 2011 and sixteen (16) medical charts of Dr. Heaphy's patients and found that

... These patient charts show a consistent recurrent pattern of inexplicably high dose chronic narcotic prescribing nearly universally coupled with equally inexplicably high dose chronic benzodiazepine prescribing. A typical patient of Dr. Heaphy's in the sample charts is prescribed Valium 10mg TID to QID or Xanax 1 to 2 mg TID to QID coupled with Lortab 10mg TID to QID. After greater than six months of regular monthly visits, a few of the patients are prescribed common non-addictive anxiolytics, such as Celexa, but no significant or sustained effort is made to wean these patients off of their potentially addictive anxiolytics in the subsequent visits. The high dose chronic narcotics prescribed follow a similarly disturbing pattern. The overwhelming majority of patients in these 16 charts of Dr. Heaphy are receiving high dose narcotics such as Lortab 10 mg TID to QID for chronic back pain. Some of them have little evidence of significant disease on their MRIs that would suggest a need for high dose chronic narcotics due to their claimed chronic back/neck pain. Again, virtually no effort is made by Dr. Heaphy in weaning these addictive pain medications. ...

Although it is difficult to point to any one patient and prove a trend ... In aggregate these 16 charts of Dr. Heaphy's patients paint a clear picture of reckless medically irresponsible prescribing of controlled substances, both in dose, frequency, and chronicity practiced by Dr. Heaphy. This overprescribing clearly deviates from standards of acceptable and prevailing medical practice. Further, Dr. Heaphy's inappropriate prescribing places his patient's health and wellbeing at grave risk.

In summary, after careful review of the provided material, I believe Dr. Heaphy's pattern of narcotic and benzodiazepine prescribing deviates grossly from acceptable standard of care and poses a serious threat to the health of his patients and his community.

26. In response to the Board consultant review, Dr. Heaphy explained that he had not assumed the medical management of the 16 patients, whose charts were reviewed, until June 1, 2011 and that, even then, he treated all of the patients (except for one) for pain only and did not serve as their primary care physician. Therefore, because Dr. Heaphy treated the patients only for pain, he did not believe that any criticisms of the primary care were validly directed toward him. In addition, because he did not assume care of these patients until June 1, he did not believe that any criticism of the prescribing protocols established by the previous pain physician should be attributable to the care he provided.

27. In addition, Dr. Heaphy obtained an independent consultant review of his practice. Dr. Heaphy's consultant reviewed three patient charts, which the Board consultant opined were representative of all charts reviewed, and found that

... The three patient charts I reviewed indicated stable clinical courses. There were not any significant advancement in the medications over time, nor were there any deleterious outcomes as a result of their treatment. ...

My review of Dr. Heaphy's three charts indicates that he documented the majority of the necessary elements contained in Kentucky's current guidelines. Dr. Heaphy's documentation

indicates that he prescribed controlled substance for pain in a legitimate manner and in doses that did not exceed acceptable norms. Dr. Heaphy addressed the risk of abuse and diversion; he documented urine drug screens, psychological/addiction assessments and appropriate treatment agreements. Consultations with specialists were documented. The patients were seen often enough to monitor their progress and assess for deterioration in function. There were ample patient-physician treatment agreements that inferred adequate informed consent with appropriate behavioral boundaries. The prescriptions were copied, available for review, and prescribed lawfully. Sufficient information was documented to justify the prescription medication furnished to the patients. Over the course of treatment, it is apparent that these patients were monitored for signs of addiction/diversion. ...

In my opinion, based upon the available documentation, Dr. Heaphy's prescription of controlled substances did not depart from the boundaries of acceptable practice and was consistent with the current Kentucky guidelines. Dr. Heaphy's practice did not violate an acceptable standard of care. Furthermore, Dr. Heaphy's documented would not be classified as gross incompetence, negligence or malpractice. Dr. Heaphy's care did not constitute a danger to the health and safety of his patients or the general public. Overall, the records adequately justified the care being rendered by Dr. Heaphy.

28. On April 19, 2012, the Board's Inquiry Panel B considered whether the licensee was non-compliant with the Agreed Order of Probation. In light of the consultant reviews of Dr. Heaphy's practices, the Panel determined that there was probable cause to believe that the licensee's prescribing of controlled substances constitutes a danger to the health, welfare and safety of his patients or the general public. In lieu of emergency action, the parties agreed to enter into an Agreed Order of Indefinite Restriction, which restricted the licensee from prescribing, dispensing, or otherwise professionally utilizing controlled substances unless and until approved to do so by the Panel; required that he complete a CPEP clinical skills assessment and have an Educational Plan developed, if recommended; and

required that he reimburse to the Board the costs of the investigation in the amount of \$1,500.00.

29. By April 2013, nearly one year later, the licensee had neither contacted CPEP for a clinical skills assessment nor reimbursed the Board's costs. The case was returned to the Panel for non-compliance action. By the time the Panel convened, the licensee had scheduled a CPEP clinical skills assessment. The Panel directed that a Complaint and Emergency Order of Suspension be issued against his license if he failed to appear for that assessment on the scheduled dates and that the Assessment Report and Educational Plan be brought back to the Panel when completed.

30. On July 1-2, 2013, the licensee participated in a CPEP clinical skills assessment in the specialty of chronic pain management. CPEP found that

... Dr. Heaphy demonstrated a reasonable foundation of knowledge of pain management, but his knowledge was superficial in some respects. Dr. Heaphy's clinical judgment and reasoning were adequate in most respects, with some notable lapses in application of knowledge and approach to treatment. Dr. Heaphy's communication skills were adequate with room for improvement with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted from his practice was inadequate; his documentation of the SP encounters was acceptable with room for improvement.

...

... [A]nalyzes of specific subtest performances raised some concerns about his memory, visual attention, and ability to perform mental calculations. While these results, in isolation, do not indicate the need for further neuropsychological evaluation, Dr. Heaphy and the Board should consider if there are any additional concerns or observations that, in combination with these screening test results, would warrant further evaluation. CPEP did not make any such observations.

...

31. In November 2013, CPEP developed an Education Plan for the licensee in the specialty of chronic pain management, the components of which include self-

study, CME, and coaching and review by a Preceptor. It was noted that in order to optimally review the licensee's clinical judgment in the area of pain management and the prescribing of controlled substances, his prescribing privileges would need to be reinstated.

32. In February 2014, the Panel reinstated the licensee's prescribing privileges subject to an Amended Agreed Order of Indefinite Restriction pursuant to which he was required, in part, to have practice location approval; maintain a "controlled substances log" for all controlled substances prescribed; complete a Board-approved course relating to HB1; participate in and successfully complete his CPEP Educational Intervention Plan, and pay a fine of \$1,000 within six (6) months.
33. In September 2014, the licensee completed a Board-approved HB1 course and on or about September 10, 2014 (more than six months after the Amended Agreed Order of Indefinite Restriction), he paid the fine in full.
34. Between February 2014 and January 2015, the licensee began practicing medicine at Chambers Medical Group and Morris Medical Group locations without the Panel's approval. The licensee stated that he assumed that he had approval to practice because at those locations because the Board's investigator had been in contact with him and CPEP knew that he was working with his Preceptor, Jerry Morris, D.O. (Morris Medical Group), in order to progress through his education plan.
35. In January 2015, pursuant to a Second Amended Agreed Order, the Panel approved the licensee to practice "no more than a total of 18 hours/per week at

one or more of the Chambers Medical Group offices in Louisville, Florence, Lexington and Richmond, Kentucky” and “no more than 8 hours per week for Morris Medical Group, at either 3292 Eagle View Lane, Suite 310, Lexington, Kentucky or 1949 Goldsmith Lane, Louisville, Kentucky, under the supervision of Jerry Morris, D.O.” The licensee was again required, in part, to maintain practice location approval; maintain a “controlled substances log” for all controlled substances prescribed; to participate in and successfully complete his CPEP Educational Intervention Plan; and to not violate any provision of KRS 311.595 and/or .597. The licensee agreed that any violation of any term or condition of the Second Amended Agreed Order would constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125.

36. On or about August 31, 2015, the Board received information from CPEP that the licensee had become non-compliant with the directives of his CPEP Educational Intervention Plan (“the Plan”), such that the Plan had become suspended. According to CPEP, for the period of January through August 2015:

- The licensee did not submit charts in accordance with the terms of the Plan – submitting charts only half as frequently as required;
- The licensee falsely reported ongoing Preceptor meetings through June 2015. The Plan required that the licensee meet with his Preceptor twice monthly for at least two hours and the Preceptor provide reports in order to collaborate Plan progress with the CPEP Associate Medical Director. On or about July 1, 2015, the Preceptor reported to CPEP that he and the licensee had severed their working relationship “a month or so ago” and that the Preceptor had neither reviewed any of the licensee’s charts nor completed any reports to CPEP for “6 months or so”;
- The licensee failed to integrate previously provided feedback from the education process into his practice, including but not limited to the licensee continuing to use subjective over objective information and non-specific and non-differential diagnoses; and

- The licensee failed to identify a new Preceptor in accordance with CPEP's directives and did not respond to communications from CPEP.

37. The Board's medical investigator interviewed Jerry Morris, D.O., who stated substantially as follows: He severed his ties with the licensee in May 2015 for several reasons, including unsatisfactory work performances; the licensee repeatedly did not attend scheduled office coverage and missed seeing patients, did not complete charts at time of visit and hindered billing; and there were repeated complaints from referral sources about the licensee's quality of care, integrity, licensure status and his slow unreliable and nonresponse to medical record inquiries and reports. Dr. Morris also reported that the licensee entered his EMR after his dismissal to acquire information about patients. According to Dr. Morris, the licensee engaged in conduct which comprised of a lack of character and presence of moral turpitude, attempted fraud and unethical behavior.

38. On or about August 31, 2015, when contacted by the Board's medical investigator and asked for a response and explanation to the alleged events, the licensee stated that he and Dr. Morris had severed their working relationship at the end of June 2015 but that they had engaged in chart reviews within the past couple of months. After the medical investigator asked the licensee to submit a written response, the licensee failed to submit the response each time that he indicated that he would and the licensee stopped responding to the investigator's communications. However, in response to the Complaint in this matter the licensee disputed most of the allegations contained in numerical paragraphs 36 and 37 and stated:

Every monthly report submitted to CPEP from the preceptor was favorable. In Dr. Morris' November 2014 report, he recommended "release from oversight/monitoring" for the licensee. In his last report

submitted on December 15, 2014, Dr. Morris stated that the licensee: "has a comprehensive professional grasp of all facets of internal medicine as it applies to our general practice, including routine use of narcotics" and characterized the CPEP monitoring process as "punitive." After submitting this favorable report to CPEP, Dr. Morris stopped submitting monthly reports and engaging in phone calls with CPEP every two months as required under the licensee's education plan. Despite Dr. Morris' failure to maintain contact with CPEP, the licensee worked to maintain compliance with his education plan.

On April 29, 2015, Dr. Morris provided the licensee with a partnership contract which would confer a 1/3 ownership interest in his medical practice to the licensee if certain conditions were met. The proposed partnership contract had an expected signature date of May 14, 2015. The licensee declined to sign the contract. As a result, Dr. Morris severed ties with the licensee in June 2015. Dr. Morris subsequently relayed false information to the Board's medical investigator that comprises most of the allegations contained herein against the licensee. Dr. Morris also failed to disclose to the Board's medical investigator that he had offered the licensee a partnership agreement. Dr. Morris' favorable monthly reports, his partnership offer and his decision to conceal the partnership offer from the Board's medical investigator undercut his allegations.

The licensee was not aware of Dr. Morris' decision to cease communication with CPEP until June 2015. The licensee does acknowledge that he should have reported to CPEP the issues with his preceptor in a timely manner, including Dr. Morris' attempt to use his power as a preceptor to formalize a business relationship with him.

39. On or about September 21, 2015, an Emergency Order of Suspension was issued against the licensee's license to practice medicine in the Commonwealth of Kentucky.

STIPULATED CONCLUSIONS OF LAW

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

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(13). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the Complaint without an evidentiary hearing by entering into an informal resolution such as this Agreed Order.

AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve the Complaint without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER**:

1. The license to practice medicine in the Commonwealth of Kentucky held by James H. Heaphy, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Agreed Order;
2. During the effective period of this Agreed Order, 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 to practice medicine in the Commonwealth of Kentucky held by James H. Heaphy, M.D., is hereby SUSPENDED for a period of six (6) months, effective from September 21, 2015. During the period of suspension, the licensee SHALL NOT perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;
 - b. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions,

ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – unless and until the Panel or its Chair has approved, *in writing*, the practice location at which he will practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include specific conditions/restrictions to ensure patient safety. Once approved, the licensee shall not change practice locations without first obtaining *written* approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new practice location;

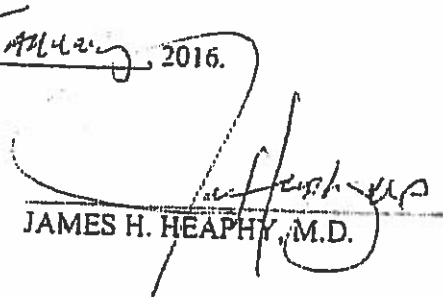
- c. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;
 - i. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;
 - ii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order;
 - iii. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order;
- d. Within three (3) months from the date of entry of this Agreed Order, the licensee SHALL reactivate and re-engage in his CPEP Educational Intervention Plan;

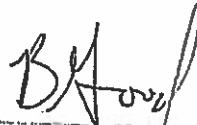
- i. The licensee SHALL comply with all directives and instructions of CPEP during the duration of the Educational Intervention Plan;
 - ii. The licensee understands and agrees that he SHALL BE responsible for ensuring that his preceptors comply with all directives and instructions of CPEP during the duration of the Educational Intervention Plan and he SHALL immediately report any noncompliance directly to CPEP;
 - iii. The licensee understands and agrees that any failure to comply with the directives and instructions of CPEP during the duration of the Educational Intervention Plan shall constitute a violation of this Agreed Order and shall be grounds for immediate suspension of his license to practice medicine in the Commonwealth of Kentucky;
 - iv. In the event that the licensee's CPEP Educational Intervention Plan should be come suspended for any reason, the licensee SHALL immediately cease the "practice of medicine," as that term is defined in KRS 311.550(10), until further order of the Panel. His failure to do so, shall constitute a violation of this Agreed Order and shall be grounds for immediate suspension of his license to practice medicine in the Commonwealth of Kentucky;
- e. The licensee SHALL SUCCESSFULLY complete all requirements of the CPEP Educational Intervention Plan, at his expense and as directed by CPEP, a copy of which is attached hereto;
 - i. If deemed necessary and appropriate by CPEP, the licensee SHALL SUCCESSFULLY COMPLETE the Post-Education Assessment, at his expense and as directed by CPEP;
 - ii. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention Plan; and
- f. Within six (6) months from the date of entry of this Agreed Order, the licensee SHALL pay a FINE of one-thousand dollars (\$1,000.00) to the Board, pursuant to KRS 311.565(1)(v);
- g. Within six (6) months from the date of entry of this Agreed Order, the licensee SHALL REIMBURSE the Board the costs of these proceedings in the amount of one hundred and twenty-five dollars (\$125.00), pursuant to KRS 311.565(1)(v); and
- h. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, 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, 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 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.
4. The licensee understands and agrees that any violation of the terms of this Agreed Order 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 23rd day of January, 2016.

FOR THE LICENSEE:


JAMES H. HEAPHY, M.D.



BRIAN GOOD, ESQ.
COUNSEL FOR THE LICENSEE

FOR THE BOARD:



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



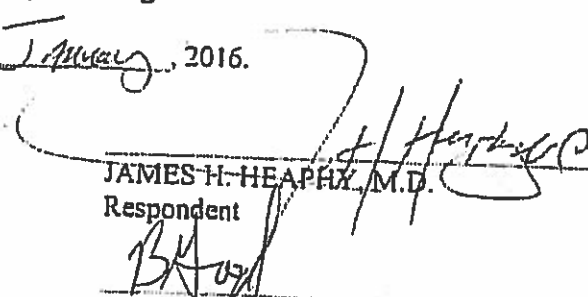
LEANNE K. DIAKOV
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

WAIVER OF RIGHTS

I, James H. Heaphy, M.D., am presently the Respondent in Kentucky Board of Medical Licensure Case No. 1695. I understand that, under 201 KAR 9:082, I must waive certain rights if I wish to resolve this matter by informal dispensation. Accordingly, I WAIVE my right to raise any constitutional, statutory or common law objection(s) I may have to the Hearing Panel rejecting the proposed informal dispensation or to the curtailment of such a settlement by the Board's General Counsel or Assistant General Counsel.

Furthermore, if the Hearing Panel accepts the proposed Agreed Order, as submitted, I WAIVE my right to demand an evidentiary hearing or to raise additional constitutional or statutory objections in this matter. However, if the Hearing Panel should reject the proposed Agreed Order, I understand that further proceedings will be conducted in accordance with KRS 311.530, *et seq.*, and I will have the right to raise any objections normally available in such proceedings.

Executed this 23rd day of January, 2016.



JAMES H. HEAPHY, M.D.
Respondent



BRIAN GOOD, ESQ.
COUNSEL FOR THE RESPONDENT

SEP 21 2015

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1695

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH
OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO.
26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

COMPLAINT

Comes now the Complainant Randel C. Gibson, D.O., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on September 17, 2015, states for its Complaint against the licensee, James H. Heaphy, M.D., as follows:

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.
5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-

May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.

6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management Seminar II Note: This is an attendance sheet not a certificate	March 12-16, 2004	May, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Physician in Management Seminar I Note: This is an attendance	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet	None: Due to no attendance sheet submitted.

sheet not a certificate			submitted.	
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to

December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.

12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no

notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing

relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled

substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.
15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their

grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-amputation of his residual limb. The patient believed that the six week delay resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office

without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was seeing a podiatrist, Dr Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine

Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.
20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010 and the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
21. In July 2010, the Panel deferred consideration of Dr. Heaphy's request for reinstatement of his license until Dr. Heaphy completed the CPEP ProBe Program and the completion of an audit of his CMEs.
22. In September 2010, Dr. Heaphy attended CPEP's Patient Care Documentation Seminar and an audit of his CME credits showed that he had successfully completed the required hours.
23. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM-E* (Professional

Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.

24. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in an Agreed Order of Probation, which required (in part) that he maintain a controlled substance log, that his practice be subject to periodic reviews by a Board consultant and that he practice within acceptable and prevailing medical practices in the Commonwealth of Kentucky.
25. In February 2012, a Board consultant reviewed a KASPER report of Dr. Heaphy's prescribing from January 1 through October 26, 2011 and sixteen (16) medical charts of Dr. Heaphy's patients and found that

... These patient charts show a consistent recurrent pattern of inexplicably high dose chronic narcotic prescribing nearly universally coupled with equally inexplicably high dose chronic benzodiazepine prescribing. A typical patient of Dr. Heaphy's in the sample charts is prescribed Valium 10mg TID to QID or Xanax 1 to 2 mg TID to QID coupled with Lortab 10mg TID to QID. After greater than six months of regular monthly visits, a few of the patients are prescribed common non-addictive anxiolytics, such as Celexa, but no significant or sustained effort is made to wean these patients off of their potentially addictive anxiolytics in the subsequent visits. The high dose chronic narcotics prescribed follow a similarly disturbing pattern. The overwhelming majority of patients in these 16 charts of Dr. Heaphy are receiving high dose narcotics such as Lortab 10 mg TID to QID for chronic back pain. Some of them have little evidence of significant disease on their MRIs that would suggest a need for high dose chronic narcotics due to their claimed chronic back/neck pain. Again, virtually no effort is made by Dr. Heaphy in weaning these addictive pain medications. ...

Although it is difficult to point to any one patient and prove a trend ... In aggregate these 16 charts of Dr. Heaphy's patients paint a clear picture of reckless medically irresponsible prescribing of controlled substances, both in dose, frequency, and chronicity practiced by Dr. Heaphy. This overprescribing clearly deviates from standards of acceptable and prevailing medical practice.

Further, Dr. Heaphy's inappropriate prescribing places his patient's health and wellbeing at grave risk.

In summary, after careful review of the provided material, I believe Dr. Heaphy's pattern of narcotic and benzodiazepine prescribing deviates grossly from acceptable standard of care and poses a serious threat to the health of his patients and his community.

26. In response to the Board consultant review, Dr. Heaphy explained that he had not assumed the medical management of the 16 patients, whose charts were reviewed, until June 1, 2011 and that, even then, he treated all of the patients (except for one) for pain only and did not serve as their primary care physician. Therefore, because Dr. Heaphy treated the patients only for pain, he did not believe that any criticisms of the primary care were validly directed toward him. In addition, because he did not assume care of these patients until June 1, he did not believe that any criticism of the prescribing protocols established by the previous pain physician should be attributable to the care he provided.

27. In addition, Dr. Heaphy obtained an independent consultant review of his practice. Dr. Heaphy's consultant reviewed three patient charts, which the Board consultant opined were representative of all charts reviewed, and found that

... The three patient charts I reviewed indicated stable clinical courses. There were not any significant advancement in the medications over time, nor were there any deleterious outcomes as a result of their treatment. ...

My review of Dr. Heaphy's three charts indicates that he documented the majority of the necessary elements contained in Kentucky's current guidelines. Dr. Heaphy's documentation indicates that he prescribed controlled substance for pain in a legitimate manner and in doses that did not exceed acceptable norms. Dr. Heaphy addressed the risk of abuse and diversion; he documented urine drug screens, psychological/addiction assessments and appropriate treatment agreements. Consultations with specialists were documented. The patients were seen often

enough to monitor their progress and assess for deterioration in function. There were ample patient-physician treatment agreements that inferred adequate informed consent with appropriate behavioral boundaries. The prescriptions were copied, available for review, and prescribed lawfully. Sufficient information was documented to justify the prescription medication furnished to the patients. Over the course of treatment, it is apparent that these patients were monitored for signs of addiction/diversion. ...

In my opinion, based upon the available documentation, Dr. Heaphy's prescription of controlled substances did not depart from the boundaries of acceptable practice and was consistent with the current Kentucky guidelines. Dr. Heaphy's practice did not violate an acceptable standard of care. Furthermore, Dr. Heaphy's documented would not be classified as gross incompetence, negligence or malpractice. Dr. Heaphy's care did not constitute a danger to the health and safety of his patients or the general public. Overall, the records adequately justified the care being rendered by Dr. Heaphy.

28. On April 19, 2012, the Board's Inquiry Panel B considered whether the licensee was non-compliant with the Agreed Order of Probation. In light of the consultant reviews of Dr. Heaphy's practices, the Panel determined that there was probable cause to believe that the licensee's prescribing of controlled substances constitutes a danger to the health, welfare and safety of his patients or the general public. In lieu of emergency action, the parties agreed to enter into an Agreed Order of Indefinite Restriction, which restricted the licensee from prescribing, dispensing, or otherwise professionally utilizing controlled substances unless and until approved to do so by the Panel; required that he complete a CPEP clinical skills assessment and have an Educational Plan developed, if recommended; and required that he reimburse to the Board the costs of the investigation in the amount of \$1,500.00.

29. By April 2013, nearly one year later, the licensee had neither contacted CPEP for a clinical skills assessment nor reimbursed the Board's costs. The case was returned to the Panel for non-compliance action. By the time the Panel convened, the licensee had scheduled a CPEP clinical skills assessment. The Panel directed that a Complaint and Emergency Order of Suspension be issued against his license if he failed to appear for that assessment on the scheduled dates and that the Assessment Report and Educational Plan be brought back to the Panel when completed.

30. On July 1-2, 2013, the licensee participated in a CPEP clinical skills assessment in the specialty of chronic pain management. CPEP found that

... Dr. Heaphy demonstrated a reasonable foundation of knowledge of pain management, but his knowledge was superficial in some respects. Dr. Heaphy's clinical judgment and reasoning were adequate in most respects, with some notable lapses in application of knowledge and approach to treatment. Dr. Heaphy's communication skills were adequate with room for improvement with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted from his practice was inadequate; his documentation of the SP encounters was acceptable with room for improvement.

...

... [A]nalysis of specific subtest performances raised some concerns about his memory, visual attention, and ability to perform mental calculations. While these results, in isolation, do not indicate the need for further neuropsychological evaluation, Dr. Heaphy and the Board should consider if there are any additional concerns or observations that, in combination with these screening test results, would warrant further evaluation. CPEP did not make any such observations.

...

31. In November 2013, CPEP developed an Education Plan for the licensee in the specialty of chronic pain management, the components of which include self-study, CME, and coaching and review by a Preceptor. It was noted that in order to optimally review the licensee's clinical judgment in the area of pain

management and the prescribing of controlled substances, his prescribing privileges would need to be reinstated.

32. In February 2014, the Panel reinstated the licensee's prescribing privileges subject to an Amended Agreed Order of Indefinite Restriction pursuant to which he was required, in part, to have practice location approval; maintain a "controlled substances log" for all controlled substances prescribed; complete a Board-approved course relating to HB1; participate in and successfully complete his CPEP Educational Intervention Plan, and pay a fine of \$1,000 within six (6) months.
33. In September 2014, the licensee completed a Board-approved HB1 course and on or about September 10, 2014 (more than six months after the Amended Agreed Order of Indefinite Restriction), he paid the fine in full.
34. Between February 2014 and January 2015, the licensee began practicing medicine at Chambers Medical Group and Morris Medical Group locations without the Panel's approval. The licensee stated that he assumed that he had approval to practice because at those locations because the Board's investigator had been in contact with him and CPEP knew that he was working with his Preceptor, Jerry Morris, D.O. (Morris Medical Group), in order to progress through his education plan.
35. In January 2015, pursuant to a Second Amended Agreed Order, the Panel approved the licensee to practice "no more than a total of 18 hours/per week at one or more of the Chambers Medical Group offices in Louisville, Florence, Lexington and Richmond, Kentucky" and "no more than 8 hours per week for

Morris Medical Group, at either 3292 Eagle View Lane, Suite 310, Lexington, Kentucky or 1949 Goldsmith Lane, Louisville, Kentucky, under the supervision of Jerry Morris, D.O.” The licensee was again required, in part, to maintain practice location approval; maintain a “controlled substances log” for all controlled substances prescribed; to participate in and successfully complete his CPEP Educational Intervention Plan; and to not violate any provision of KRS 311.595 and/or .597. The licensee agreed that any violation of any term or condition of the Second Amended Agreed Order would constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125.

36. On or about August 31, 2015, the Board received information from CPEP that the licensee had become non-compliant with the directives of his CPEP Educational Intervention Plan (“the Plan”), such that the Plan had become suspended. According to CPEP, for the period of January through August 2015:

- The licensee did not submit charts in accordance with the terms of the Plan – submitting charts only half as frequently as required;
- The licensee falsely reported ongoing Preceptor meetings through June 2015. The Plan required that the licensee meet with his Preceptor twice monthly for at least two hours and the Preceptor provide reports in order to collaborate Plan progress with the CPEP Associate Medical Director. On or about July 1, 2015, the Preceptor reported to CPEP that he and the licensee had severed their working relationship “a month or so ago” and that the Preceptor had neither reviewed any of the licensee’s charts nor completed any reports to CPEP for “6 months or so”;
- The licensee failed to integrate previously provided feedback from the education process into his practice, including but not limited to the licensee continuing to use subjective over objective information and non-specific and non-differential diagnoses; and
- The licensee failed to identify a new Preceptor in accordance with CPEP’s directives and did not respond to communications from CPEP.

37. The Board's medical investigator interviewed Jerry Morris, D.O., who stated substantially as follows: He severed his ties with the licensee in May 2015 for several reasons, including unsatisfactory work performances; the licensee repeatedly did not attend scheduled office coverage and missed seeing patients, did not complete charts at time of visit and hindered billing; and there were repeated complaints from referral sources about the licensee's quality of care, integrity, licensure status and his slow unreliable and nonresponse to medical record inquiries and reports. Dr. Morris also reported that the licensee entered his EMR after his dismissal to acquire information about patients. According to Dr. Morris, the licensee engaged in conduct which comprised of a lack of character and presence of moral turpitude, attempted fraud and unethical behavior.
38. On or about August 31, 2015, when contacted by the Board's medical investigator and asked for a response and explanation to the alleged events, the licensee stated that he and Dr. Morris had severed their working relationship at the end of June 2015 but that they had engaged in chart reviews within the past couple of months. After the medical investigator asked the licensee to submit a written response, the licensee failed to submit the response each time that he indicated that he would and the licensee stopped responding to the investigator's communications.
39. On or about September 21, 2015, an Emergency Order of Suspension was issued against the licensee's license to practice medicine in the Commonwealth of Kentucky.

40. By his conduct, the licensee has violated KRS 311.595(13). Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.

41. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

- (a) His failure to respond may be taken as an admission of the charges;
- (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

42. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for January 19, 2016, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine in the Commonwealth of Kentucky held by JAMES H. HEAPHY, M.D.

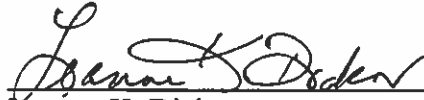
This 21st day of September, 2015.

A handwritten signature in black ink, reading "Randel C. Gibson" followed by a stylized "DO".

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601; and a copy was mailed via certified mail return-receipt requested to the licensee, James H. Heaphy, M.D., 1625 Ferguson Road, Lexington, Kentucky 40511-8309, on this 21st day of September, 2015.



Leanne K. Diakov

General Counsel

Kentucky Board of Medical Licensure

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Louisville, Kentucky 40222

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SEP 21 2015

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1695

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH
OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO.
26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, considered this matter at its September 17, 2015, meeting. At that meeting, Inquiry Panel B considered a memorandum by Jon Marshall, Medical Investigator; the Second Amended Agreed Order with attached CPEP Educational Intervention Plan, filed of record January 28, 2015; email correspondence from Mary Minobe of CPEP, dated August 31, 2015; a CPEP Progress Report III for the period January-August 2015; email correspondence between Jerry Morris, D.O., and CPEP; email correspondence from Jerry Morris, D.O., dated September 9, 2015; and compliance inspection reports, dated April 8, 2015 and September 8, 2015. The licensee was given notice of the September 17, 2015, meeting and he appeared before and was heard by the Panel.

Having considered all of this information and being sufficiently advised, Inquiry Panel B ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1).

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available, Inquiry Panel B concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of Suspension:

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.
4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker,

Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.

5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.
6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of

contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management Seminar II Note: This is an attendance sheet not a certificate	March 12-16, 2004	May, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart	April 07, 2004	Unknown	Unknown	Unknown

Association/ ACLS				
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7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.
8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists

expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:

- Long-term use of one or more controlled substances;
- Combinations of controlled substances favored by persons who abuse or divert controlled substances;
- Patients using multiple pharmacies
- Long-term use of a controlled substance for which short-term use is generally indicated; and
- Improper refills of controlled substances based on days supply

10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations

on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.

12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant

circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were

partial recordings (blood pressure and pulse along, “blood pressure 120” without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions “filled” or “refilled” does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician’s responsibility to completely identify and address his patient’s health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include “narcotic” or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant.

There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.
15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to

schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-amputation of his residual limb. The patient believed that the six week delay resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he

was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was seeing a podiatrist, Dr Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.

20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010 and the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
21. In July 2010, the Panel deferred consideration of Dr. Heaphy's request for reinstatement of his license until Dr. Heaphy completed the CPEP ProBe Program and the completion of an audit of his CMEs.
22. In September 2010, Dr. Heaphy attended CPEP's Patient Care Documentation Seminar and an audit of his CME credits showed that he had successfully completed the required hours.
23. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM~E* (Professional Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.
24. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in an Agreed Order of Probation, which required (in part) that he maintain a controlled substance log, that his practice be subject to periodic reviews by a Board consultant and that he practice within acceptable and prevailing medical practices in the Commonwealth of Kentucky.
25. In February 2012, a Board consultant reviewed a KASPER report of Dr. Heaphy's prescribing from January 1 through October 26, 2011 and sixteen (16) medical charts of Dr. Heaphy's patients and found that

... These patient charts show a consistent recurrent pattern of inexplicably high dose chronic narcotic prescribing nearly universally coupled with equally inexplicably high dose chronic benzodiazepine prescribing. A typical patient of Dr. Heaphy's in the sample charts is prescribed Valium 10mg TID to QID or Xanax 1 to 2 mg TID to QID coupled with Lortab 10mg TID to QID. After greater than six months of regular monthly visits, a few of the patients are prescribed common non-addictive anxiolytics, such as Celexa, but no significant or sustained effort is made to wean these patients off of their potentially addictive anxiolytics in the subsequent visits. The high dose chronic narcotics prescribed follow a similarly disturbing pattern. The overwhelming majority of patients in these 16 charts of Dr. Heaphy are receiving high dose narcotics such as Lortab 10 mg TID to QID for chronic back pain. Some of them have little evidence of significant disease on their MRIs that would suggest a need for high dose chronic narcotics due to their claimed chronic back/neck pain. Again, virtually no effort is made by Dr. Heaphy in weaning these addictive pain medications. ...

Although it is difficult to point to any one patient and prove a trend ... In aggregate these 16 charts of Dr. Heaphy's patients paint a clear picture of reckless medically irresponsible prescribing of controlled substances, both in dose, frequency, and chronicity practiced by Dr. Heaphy. This overprescribing clearly deviates from standards of acceptable and prevailing medical practice. Further, Dr. Heaphy's inappropriate prescribing places his patient's health and wellbeing at grave risk.

In summary, after careful review of the provided material, I believe Dr. Heaphy's pattern of narcotic and benzodiazepine prescribing deviates grossly from acceptable standard of care and poses a serious threat to the health of his patients and his community.

26. In response to the Board consultant review, Dr. Heaphy explained that he had not assumed the medical management of the 16 patients, whose charts were reviewed, until June 1, 2011 and that, even then, he treated all of the patients (except for one) for pain only and did not serve as their primary care physician. Therefore, because Dr. Heaphy treated the patients only for pain, he did not believe that any criticisms of the primary care were validly directed toward him. In addition,

because he did not assume care of these patients until June 1, he did not believe that any criticism of the prescribing protocols established by the previous pain physician should be attributable to the care he provided.

27. In addition, Dr. Heaphy obtained an independent consultant review of his practice. Dr. Heaphy's consultant reviewed three patient charts, which the Board consultant opined were representative of all charts reviewed, and found that

... The three patient charts I reviewed indicated stable clinical courses. There were not any significant advancement in the medications over time, nor were there any deleterious outcomes as a result of their treatment. ...

My review of Dr. Heaphy's three charts indicates that he documented the majority of the necessary elements contained in Kentucky's current guidelines. Dr. Heaphy's documentation indicates that he prescribed controlled substance for pain in a legitimate manner and in doses that did not exceed acceptable norms. Dr. Heaphy addressed the risk of abuse and diversion; he documented urine drug screens, psychological/addiction assessments and appropriate treatment agreements. Consultations with specialists were documented. The patients were seen often enough to monitor their progress and assess for deterioration in function. There were ample patient-physician treatment agreements that inferred adequate informed consent with appropriate behavioral boundaries. The prescriptions were copied, available for review, and prescribed lawfully. Sufficient information was documented to justify the prescription medication furnished to the patients. Over the course of treatment, it is apparent that these patients were monitored for signs of addiction/diversion. ...

In my opinion, based upon the available documentation, Dr. Heaphy's prescription of controlled substances did not depart from the boundaries of acceptable practice and was consistent with the current Kentucky guidelines. Dr. Heaphy's practice did not violate an acceptable standard of care. Furthermore, Dr. Heaphy's documented would not be classified as gross incompetence, negligence or malpractice. Dr. Heaphy's care did not constitute a danger to the health and safety of his patients or the general public. Overall, the records adequately justified the care being rendered by Dr. Heaphy.

28. On April 19, 2012, the Board's Inquiry Panel B considered whether the licensee was non-compliant with the Agreed Order of Probation. In light of the consultant reviews of Dr. Heaphy's practices, the Panel determined that there was probable cause to believe that the licensee's prescribing of controlled substances constitutes a danger to the health, welfare and safety of his patients or the general public. In lieu of emergency action, the parties agreed to enter into an Agreed Order of Indefinite Restriction, which restricted the licensee from prescribing, dispensing, or otherwise professionally utilizing controlled substances unless and until approved to do so by the Panel; required that he complete a CPEP clinical skills assessment and have an Educational Plan developed, if recommended; and required that he reimburse to the Board the costs of the investigation in the amount of \$1,500.00.
29. By April 2013, nearly one year later, the licensee had neither contacted CPEP for a clinical skills assessment nor reimbursed the Board's costs. The case was returned to the Panel for non-compliance action. By the time the Panel convened, the licensee had scheduled a CPEP clinical skills assessment. The Panel directed that a Complaint and Emergency Order of Suspension be issued against his license if he failed to appear for that assessment on the scheduled dates and that the Assessment Report and Educational Plan be brought back to the Panel when completed.
30. On July 1-2, 2013, the licensee participated in a CPEP clinical skills assessment in the specialty of chronic pain management. CPEP found that

... Dr. Heaphy demonstrated a reasonable foundation of knowledge of pain management, but his knowledge was superficial in some respects. Dr. Heaphy's clinical judgment and reasoning were adequate in most respects, with some notable lapses in application of knowledge and approach to treatment. Dr. Heaphy's communication skills were adequate with room for improvement with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted from his practice was inadequate; his documentation of the SP encounters was acceptable with room for improvement.

...

... [A]nalyzes of specific subtest performances raised some concerns about his memory, visual attention, and ability to perform mental calculations. While these results, in isolation, do not indicate the need for further neuropsychological evaluation, Dr. Heaphy and the Board should consider if there are any additional concerns or observations that, in combination with these screening test results, would warrant further evaluation. CPEP did not make any such observations.

...

31. In November 2013, CPEP developed an Education Plan for the licensee in the specialty of chronic pain management, the components of which include self-study, CME, and coaching and review by a Preceptor. It was noted that in order to optimally review the licensee's clinical judgment in the area of pain management and the prescribing of controlled substances, his prescribing privileges would need to be reinstated.
32. In February 2014, the Panel reinstated the licensee's prescribing privileges subject to an Amended Agreed Order of Indefinite Restriction pursuant to which he was required, in part, to have practice location approval; maintain a "controlled substances log" for all controlled substances prescribed; complete a Board-approved course relating to HB1; participate in and successfully complete his CPEP Educational Intervention Plan, and pay a fine of \$1,000 within six (6) months.

33. In September 2014, the licensee completed a Board-approved HB1 course and on or about September 10, 2014 (more than six months after the Amended Agreed Order of Indefinite Restriction), he paid the fine in full.
34. Between February 2014 and January 2015, the licensee began practicing medicine at Chambers Medical Group and Morris Medical Group locations without the Panel's approval. The licensee stated that he assumed that he had approval to practice because at those locations because the Board's investigator had been in contact with him and CPEP knew that he was working with his Preceptor, Jerry Morris, D.O. (Morris Medical Group), in order to progress through his education plan.
35. In January 2015, pursuant to a Second Amended Agreed Order, the Panel approved the licensee to practice "no more than a total of 18 hours/per week at one or more of the Chambers Medical Group offices in Louisville, Florence, Lexington and Richmond, Kentucky" and "no more than 8 hours per week for Morris Medical Group, at either 3292 Eagle View Lane, Suite 310, Lexington, Kentucky or 1949 Goldsmith Lane, Louisville, Kentucky, under the supervision of Jerry Morris, D.O." The licensee was again required, in part, to maintain practice location approval; maintain a "controlled substances log" for all controlled substances prescribed; to participate in and successfully complete his CPEP Educational Intervention Plan; and to not violate any provision of KRS 311.595 and/or .597. The licensee agreed that any violation of any term or condition of the Second Amended Agreed Order would constitute an immediate

danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125.

36. On or about August 31, 2015, the Board received information from CPEP that the licensee had become non-compliant with the directives of his CPEP Educational Intervention Plan (“the Plan”), such that the Plan had become suspended. According to CPEP, for the period of January through August 2015:

- The licensee did not submit charts in accordance with the terms of the Plan – submitting charts only half as frequently as required;
- The licensee falsely reported ongoing Preceptor meetings through June 2015. The Plan required that the licensee meet with his Preceptor twice monthly for at least two hours and the Preceptor provide reports in order to collaborate Plan progress with the CPEP Associate Medical Director. On or about July 1, 2015, the Preceptor reported to CPEP that he and the licensee had severed their working relationship “ a month or so ago” and that the Preceptor had neither reviewed any of the licensee’s charts nor completed any reports to CPEP for “6 months or so”;
- The licensee failed to integrate previously provided feedback from the education process into his practice, including but not limited to the licensee continuing to use subjective over objective information and non-specific and non-differential diagnoses; and
- The licensee failed to identify a new Preceptor in accordance with CPEP’s directives and did not respond to communications from CPEP.

37. The Board’s medical investigator interviewed Jerry Morris, D.O., who stated substantially as follows: He severed his ties with the licensee in May 2015 for several reasons, including unsatisfactory work performances; the licensee repeatedly did not attend scheduled office coverage and missed seeing patients, did not complete charts at time of visit and hindered billing; and there were repeated complaints from referral sources about the licensee’s quality of care, integrity, licensure status and his slow unreliable and nonresponse to medical record inquiries and reports. Dr. Morris also reported that the licensee entered his EMR after his dismissal to acquire information about patients. According to Dr.

Morris, the licensee engaged in conduct which comprised of a lack of character and presence of moral turpitude, attempted fraud and unethical behavior.

38. On or about August 31, 2015, when contacted by the Board's medical investigator and asked for a response and explanation to the alleged events, the licensee stated that he and Dr. Morris had severed their working relationship at the end of June 2015 but that they had engaged in chart reviews within the past couple of months. After the medical investigator asked the licensee to submit a written response, the licensee failed to submit the response each time that he indicated that he would and the licensee stopped responding to the investigator's communications.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an agreed order or disciplinary order; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(13).

4. The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
5. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general. Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.
6. The United States Supreme Court has ruled that it is not a violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel B hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by James H. Heaphy, M.D., is SUSPENDED and Dr. Heaphy is prohibited from performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

Inquiry Panel B further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

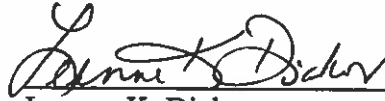
SO ORDERED this 26th day of September, 2015.



RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed via certified mail return-receipt requested to the licensee, James H. Heaphy, M.D., 1625 Ferguson Road, Lexington, Kentucky 40511-8309, on this 21st day of September, 2015.



Leanne K. Diakov

General Counsel

Kentucky Board of Medical Licensure

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Louisville, Kentucky 40222

(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1386

FILED OF RECORD

JAN 28 2015

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH
OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO.
26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, and James H. Heaphy, M.D. ("the licensee"), and, based upon the licensee's request for practice location approval, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Second Amended Agreed Order:

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend

the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.
5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on

several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.

6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management Seminar II Note: This is an attendance sheet not a	March 12-16, 2004	May, 1998	None: Due to no attendance sheet submit-	None: Due to no attendance sheet submitted.

certificate			ted.	
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee

has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found

that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.
12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07,

07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise,

vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also, together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.

15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-amputation of his residual limb. The patient believed that the six week delay

resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was

closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was

seeing a podiatrist, Dr. Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-

up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.
20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010 and the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
21. In July 2010, the Panel deferred consideration of Dr. Heaphy's request for reinstatement of his license until Dr. Heaphy completed the CPEP ProBe Program and the completion of an audit of his CMEs.
22. In September 2010, Dr. Heaphy attended CPEP's Patient Care Documentation Seminar and an audit of his CME credits showed that he had successfully completed the required hours.

23. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM-E* (Professional Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.
24. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in an Agreed Order of Probation, which required (in part) that he maintain a controlled substance log, that his practice be subject to periodic reviews by a Board consultant and that he practice within acceptable and prevailing medical practices in the Commonwealth of Kentucky.
25. In February 2012, a Board consultant reviewed a KASPER report of Dr. Heaphy's prescribing from January 1 through October 26, 2011 and sixteen (16) medical charts of Dr. Heaphy's patients and found that

... These patient charts show a consistent recurrent pattern of inexplicably high dose chronic narcotic prescribing nearly universally coupled with equally inexplicably high dose chronic benzodiazepine prescribing. A typical patient of Dr. Heaphy's in the sample charts is prescribed Valium 10mg TID to QID or Xanax 1 to 2 mg TID to QID coupled with Lortab 10mg TID to QID. After greater than six months of regular monthly visits, a few of the patients are prescribed common non-addictive anxiolytics, such as Celexa, but no significant or sustained effort is made to wean these patients off of their potentially addictive anxiolytics in the subsequent visits. The high dose chronic narcotics prescribed follow a similarly disturbing pattern. The overwhelming majority of patients in these 16 charts of Dr. Heaphy are receiving high dose narcotics such as Lortab 10 mg TID to QID for chronic back pain. Some of them have little evidence of significant disease on their MRIs that would suggest a need for high dose chronic narcotics due to their claimed chronic back/neck pain. Again, virtually no effort is made by Dr. Heaphy in weaning these addictive pain medications. ...

Although it is difficult to point to any one patient and prove a trend ... In aggregate these 16 charts of Dr. Heaphy's patients paint a clear picture of reckless medically irresponsible prescribing of controlled substances, both in dose, frequency, and chronicity practiced by Dr. Heaphy. This overprescribing clearly deviates from standards of acceptable and prevailing medical practice. Further, Dr. Heaphy's inappropriate prescribing places his patient's health and wellbeing at grave risk.

In summary, after careful review of the provided material, I believe Dr. Heaphy's pattern of narcotic and benzodiazepine prescribing deviates grossly from acceptable standard of care and poses a serious threat to the health of his patients and his community.

26. In response to the Board consultant review, Dr. Heaphy explained that he had not assumed the medical management of the 16 patients, whose charts were reviewed, until June 1, 2011 and that, even then, he treated all of the patients (except for one) for pain only and did not serve as their primary care physician. Therefore, because Dr. Heaphy treated the patients only for pain, he did not believe that any criticisms of the primary care were validly directed toward him. In addition, because he did not assume care of these patients until June 1, he did not believe that any criticism of the prescribing protocols established by the previous pain physician should be attributable to the care he provided.

27. In addition, Dr. Heaphy obtained an independent consultant review of his practice. Dr. Heaphy's consultant reviewed three patient charts, which the Board consultant opined were representative of all charts reviewed, and found that

... The three patient charts I reviewed indicated stable clinical courses. There were not any significant advancement in the medications over time, nor were there any deleterious outcomes as a result of their treatment. ...

My review of Dr. Heaphy's three charts indicates that he documented the majority of the necessary elements contained in Kentucky's current guidelines. Dr. Heaphy's documentation

indicates that he prescribed controlled substance for pain in a legitimate manner and in doses that did not exceed acceptable norms. Dr. Heaphy addressed the risk of abuse and diversion; he documented urine drug screens, psychological/addiction assessments and appropriate treatment agreements. Consultations with specialists were documented. The patients were seen often enough to monitor their progress and assess for deterioration in function. There were ample patient-physician treatment agreements that inferred adequate informed consent with appropriate behavioral boundaries. The prescriptions were copied, available for review, and prescribed lawfully. Sufficient information was documented to justify the prescription medication furnished to the patients. Over the course of treatment, it is apparent that these patients were monitored for signs of addiction/diversion. ...

In my opinion, based upon the available documentation, Dr. Heaphy's prescription of controlled substances did not depart from the boundaries of acceptable practice and was consistent with the current Kentucky guidelines. Dr. Heaphy's practice did not violate an acceptable standard of care. Furthermore, Dr. Heaphy's documented would not be classified as gross incompetence, negligence or malpractice. Dr. Heaphy's care did not constitute a danger to the health and safety of his patients or the general public. Overall, the records adequately justified the care being rendered by Dr. Heaphy.

28. On April 19, 2012, the Board's Inquiry Panel B considered whether the licensee was non-compliant with the Agreed Order of Probation. In light of the consultant reviews of Dr. Heaphy's practices, the Panel determined that there was probable cause to believe that the licensee's prescribing of controlled substances constitutes a danger to the health, welfare and safety of his patients or the general public. In lieu of emergency action, the parties agreed to enter into an Agreed Order of Indefinite Restriction, which restricted the licensee from prescribing, dispensing, or otherwise professionally utilizing controlled substances unless and until approved to do so by the Panel; required that he complete a CPEP clinical skills assessment and have an Educational Plan developed, if recommended; and

required that he reimburse to the Board the costs of the investigation in the amount of \$1,500.00.

29. By April 2013, nearly one year later, the licensee had neither contacted CPEP for a clinical skills assessment nor reimbursed the Board's costs. The case was returned to the Panel for non-compliance action. By the time the Panel convened, the licensee had scheduled a CPEP clinical skills assessment. The Panel directed that a Complaint and Emergency Order of Suspension be issued against his license if he failed to appear for that assessment on the scheduled dates and that the Assessment Report and Educational Plan be brought back to the Panel when completed.

30. On July 1-2, 2013, the licensee participated in a CPEP clinical skills assessment in the specialty of chronic pain management. CPEP found that

... Dr. Heaphy demonstrated a reasonable foundation of knowledge of pain management, but his knowledge was superficial in some respects. Dr. Heaphy's clinical judgment and reasoning were adequate in most respects, with some notable lapses in application of knowledge and approach to treatment. Dr. Heaphy's communication skills were adequate with room for improvement with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted from his practice was inadequate; his documentation of the SP encounters was acceptable with room for improvement.

...

... [A]nalyzes of specific subtest performances raised some concerns about his memory, visual attention, and ability to perform mental calculations. While these results, in isolation, do not indicate the need for further neuropsychological evaluation, Dr. Heaphy and the Board should consider if there are any additional concerns or observations that, in combination with these screening test results, would warrant further evaluation. CPEP did not make any such observations.

...

31. In November 2013, CPEP developed an Education Plan for the licensee in the specialty of chronic pain management, the components of which include self-study, CME, and coaching and review by a Preceptor. It was noted that in order to optimally review the licensee's clinical judgment in the area of pain management and the prescribing of controlled substances, his prescribing privileges would need to be reinstated.
32. In February 2014, the Panel reinstated the licensee's prescribing privileges subject to an Amended Agreed Order of Indefinite Restriction pursuant to which he was required to have practice location approval; maintain a "controlled substances log" for all controlled substances prescribed; complete a Board-approved course relating to HB1; participate in and successfully complete his CPEP Educational Intervention Plan, and pay a fine of \$1,000.
33. In September 2014, the licensee completed a Board-approved HB1 course and paid the fine in full.
34. After February 2014, the licensee began practicing at Chambers Medical Group and Morris Medical Group, with the Board's knowledge. This Second Amended Agreed Order is entered to reflect the Board's approval of those practice locations.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical license is subject to regulation and discipline by the Board.

2. While the licensee denies any wrongdoing or violation, he acknowledges and agrees that, based upon the Stipulations of Fact, the Hearing Panel could find that he engaged in conduct which violates the provisions of KRS 311.595(9) - as illustrated by KRS 311.597(3) and (4) - and KRS 311.595(13). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Indefinite Restriction and now this Second Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter by entering into an informal resolution such as this Second Amended Agreed Order.

SECOND AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request for practice location approval, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER**:

1. The license to practice medicine in the Commonwealth of Kentucky held by James H. Heaphy, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Second Amended Agreed Order ("Agreed Order");
2. During the effective period of this Agreed Order, 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 licensee SHALL NOT perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) - the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods,

devices, or instrumentalities – unless and until the Panel or its Chair has approved, in writing, the practice location at which he will practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include specific conditions/restrictions to ensure patient safety. The licensee shall not change practice locations without first obtaining written approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new practice location.

The licensee is HEREBY APPROVED to continue his practice at and as follows:

- No more than a total of 18 hours/per week at one or more of the **Chambers Medical Group** offices in Louisville, Florence, Lexington and Richmond, Kentucky;
 - No more than 8 hours per week for **Morris Medical Group**, at either 3292 Eagle View Lane, Suite 310, Lexington, Kentucky or 1949 Goldsmith Lane, Louisville, Kentucky, under the supervision of Jerry Morris, D.O.;
- b. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;
- i. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;
 - ii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order;

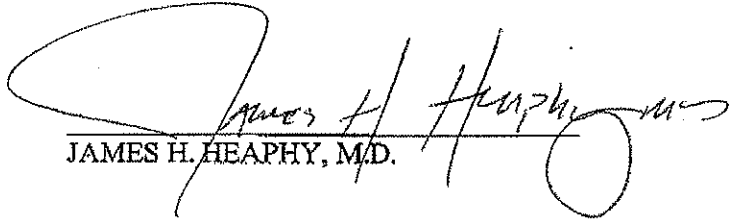
- iii. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order;
 - c. The licensee SHALL SUCCESSFULLY complete all requirements of the CPEP Educational Intervention Plan, at his expense and as directed by CPEP, a copy of which is attached hereto;
 - i. If deemed necessary and appropriate by CPEP, the licensee SHALL SUCCESSFULLY COMPLETE the Post-Education Assessment, at his expense and as directed by CPEP;
 - ii. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention Plan; and
 - d. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, 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, 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 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.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order 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 28th day of January, 2015.

FOR THE LICENSEE:


JAMES H. HEAPHY, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

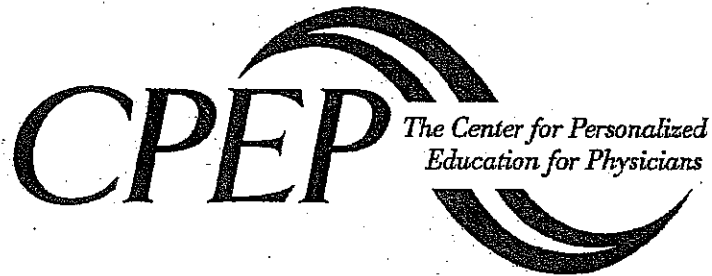
FOR THE BOARD:



RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B



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EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed November 2013

for

James H. Heaphy, M.D.

NATIONALLY RECOGNIZED ■ PROVEN LEADER ■ TRUSTED RESOURCE

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EDUCATION PLAN

OVERVIEW

- Section I Introduction and Plan Design
- Section II Individual Learning Goals
- Specific areas of educational need
- Section III Performance Objectives (Modules A and B)
- Self-study, CME, Preceptor Meetings
- Section IV Initiation of the Plan and Preceptor Approval
- Determining the start of activities
 - Education Notebook
 - Preceptor Approval Process
- Section V Participation and Monitoring
- Participation Expectations
 - Evaluation Process
- Section VI Duration

APPENDICES

- Appendix A Practice Profile
- Appendix B Federal Regulations of Privacy of Individually Identifiable Health Information
- Appendix C Glossary and Educational Terms

I. INTRODUCTION

In accordance with Kentucky Board of Medical Licensure (Board) Agreed Order of Indefinite Restriction (Order), dated April 2012, James H. Heaphy, M.D., was ordered to complete a clinical skills Assessment and any subsequent recommended education plan with CPEP. In July 2013, Dr. Heaphy completed an Assessment, which identified areas of educational need. The development of this Education Plan (Plan) was based on those needs. The Plan was also based on data gathered by CPEP and information obtained from Dr. Heaphy. The purpose of this Plan is to provide a framework in which Dr. Heaphy can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

Dr. Heaphy's Assessment was designed to evaluate the practice of chronic pain management, based on his stated desire to evaluate only the areas requested by the Board in the Order. Thus, this Plan addresses Dr. Heaphy's practice of pain management and does not address the areas of internal medicine or emergency medicine, areas in which Dr. Heaphy has worked in the past and may work in the future. If educational needs related to Dr. Heaphy's current or prospective practice (that were outside of the scope of the Assessment) are identified during the Plan, CPEP will notify the Board and Dr. Heaphy and determine if the educational needs can be addressed within the context of this Plan. CPEP may not be able to address those needs without further Assessment activities or expansion of the scope of the Plan.

LIMITATIONS

CPEP cannot guarantee that a Preceptor and/or an appropriate setting can be identified to address this Plan.

- Dr. Heaphy reported to CPEP that he is unable to write prescriptions for controlled substances. The optimum way to address Dr. Heaphy's clinical judgment in the areas of pain management and prescribing of controlled substances is through the review of actual patient charts. However, if Dr. Heaphy's limitation to prescribing continues, CPEP will not be able to assess his application of knowledge in practice, and it may be necessary to address these objectives with hypothetical scenarios.

LICENSING

Because CPEP Education plans are practice-based, physician-participants must have a medical license in order to complete a Plan. Some activities, such as self-study, may be completed without a medical license. *It is the participant's responsibility* to ensure that he practices within the parameters of his/her licensure status.

DESIGN

The individual Learning Goals described below in *Section II* were derived from the findings of the Assessment. This Plan was designed to address those Learning Goals through Medical Knowledge Enhancement and Patient Care Enhancement educational activities described in *Section III* as Modules A and B. Evaluation of Dr. Heaphy's progress and oversight of his

participation will be provided by the CPEP Associate Medical Director. The Plan is designed around continuous and timely participation so that maximum educational benefit is received and ongoing progress is made. Following is more detailed information about the Modules and the Associate Medical Director oversight.

Note: The requirements of this Plan are not intended to supersede or exclude any requirements specific to his employer, credentialing, or licensure regulations. However, some activities may be applicable to both the Plan and such requirements.

A. Medical Knowledge Enhancement (Module A)

The Medical Knowledge Enhancement Learning Goals are addressed independently by the participant as well as through discussions with the Preceptor. The activities are designed to improve the participant's medical knowledge specific to the Learning Goals. Other improvements are generally realized as a result of the activities. A Preceptor is not needed to begin the activities described in Module A. CPEP encourages Dr. Heaphy to begin the activities as soon as he has initiated the Plan. The recommended activities include:

- Independent/unsupervised self-study;
- Evidence-based research;
- Continuing medical education activities and/or courses.

B. Patient Care Enhancement (Module B)

Dr. Heaphy will work with a Preceptor who has a practice similar to his. Subsequently, Dr. Heaphy will participate in a longitudinal learning experience that is reliant on regularly scheduled Preceptor Meetings. During this experience Dr. Heaphy will:

- Retrospectively review charts with the Preceptor of patients for whom Dr. Heaphy provided independent/unsupervised care;
- Receive one-on-one coaching and constructive feedback with regard to medical knowledge, clinical judgment and documentation, particularly with regard to those areas identified in the Plan Learning Goals (see *Section II*);
- Discuss and reinforce new information and skills gained for full integration into daily patient care;
- Appreciate the value of lifelong learning, peer relationships, and self-assessment to the quality of patient care.

C. Oversight

The Associate Medical Director oversight includes Preceptor training, consideration of the feedback provided by the Preceptor and review of educational materials submitted by Dr. Heaphy (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Heaphy and the Preceptor with regard to Dr. Heaphy's progress.

II. LEARNING GOALS

A. Medical Knowledge

To improve evidenced-based medical knowledge including, but not limited to, the following areas:

1. Pathophysiology of pain and the diagnosis of painful conditions:
 - a. Nociceptive and neuropathic pain;
 - b. Myofascial pain;
 - c. Fibromyalgia;
 - d. Specific radicular distributions;
2. Pharmacology:
 - a. Adverse effects of various medications, including benzodiazepines and antidepressants;*
 - b. Opioids:
 - 1) Knowledge of a broad enough range of opioids to facilitate opioid optimization and rotation;
 - 2) Role and use of short- versus long-acting;
 - 3) Pharmacokinetics: duration of action of opioids;
 - 4) Adverse effects of morphine;
 - 5) Management of constipation;
 - 6) Types of abuse-deterrent formulations of opioids;
3. Non-pharmacologic modalities;
4. Controlled substance agreement:
 - a. Thorough understanding of the important elements of a controlled substance agreement;
 - b. Concept of an agreement versus a contract;
5. Basic knowledge of addiction, including but not limited to:
 - a. Screening, brief intervention, and referral to treatment (SBIRT);
 - b. Definitions of addiction and pseudoaddiction;
 - c. Basic knowledge of treatment options and alternatives;
 - d. Risk evaluation;
 - e. Spectrum of behavioral aberrancies;
6. Other focussed topics:
 - a. Causes of a false-positive urine test for THC;
 - b. Definition of diversion;
 - c. Risks of the use of particulate steroids around the vascular structures of the head and neck.

*Topic summary not required. Other educational activities required and described in *III.C* below.

(See III.B below for description of topic summaries.)

B. Clinical Judgment

To *consistently* demonstrate appropriate clinical judgment in the areas that include, but are not limited to, the following:

1. Consistently obtain a thorough history, including social history, history of substance abuse, and history of psychiatric disorders;
2. Consistently obtain an adequately comprehensive physical exam;
3. Adequate risk assessment prior to prescribing drugs at increased risk of addiction or diversion;
4. Application of knowledge:
 - a. Use of controlled substance agreements;
 - b. Monitoring patients on opioids with urine drug testing and reviews of prescription drug monitoring program reports;
 - c. Address incidental clinical abnormalities such as elevated blood pressure;
5. Treatment approach:
 - a. Adequate emphasis on non-pharmacologic interventions;
 - b. Non-opioid optimization;
 - c. Identification of conditions that may not warrant opioid therapy and formulation of alternative treatment approaches;
 - d. Find appropriate balance of risks and benefits to opioid therapy in each individual case.

C. Documentation

The participant will learn principles of documentation that are based on recommendations and requirements of nationally recognized organizations such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) and recommendations of national specialty societies and will *consistently* demonstrate appropriate patient care documentation that includes, but is not limited to, the following:

1. Improved legibility;
2. Consistent use of problem lists;
3. Inclusion of controlled substance agreements and documentation of review of prescription drug monitoring database reports in appropriate cases;
4. Expanded/adequate documentation of complaints/review of systems, pertinent physical exam findings, impression, plan, and clinical thinking;
5. Inclusion of at least the names of the drugs for which prescriptions were provided on the encounter note, even if details of the prescription are found elsewhere;
6. Consistent documentation of substance use history, psychiatric history, and relevant family history.

Guideline

Adequate documentation requires inclusion of sufficient detail in visit notes such that the notes "stand alone" and determination of the level of care provided does not require verbal input from the documenting physician to be fully understood. Ultimately, adequate documentation includes chart organization and systems tools that allow another physician to easily assume care of a patient.

D. Practice-based Learning

1. Adequate attention to CME activities;
2. If not already in place, consider implementation of a system to allow easy access to information about his patient population for practice improvement opportunities.

E. Physician-Patient Communication Skills

To *consistently* demonstrate appropriate communication skills in the areas that include, but are not limited to, the following:

1. Knock before entering a patient room;
2. Be cognizant that casual attire will impact a patient's impression of professionalism;
3. Inform patients about what will be done during the physical exam;
4. Enhanced clarity when discussing different treatment options;
5. Avoid medical jargon.

III. PERFORMANCE OBJECTIVES

Performance Objectives are specific educational activities that provide focused learning experiences designed to assist the participant with achievement of the Learning Goals (*Section II*). The participant will integrate newly learned information into his daily practice and demonstrate long-term improved patient care during Module B Activities.

MODULE A MEDICAL KNOWLEDGE ENHANCEMENT

Module A activities do not require approval of a Preceptor to initiate. Dr. Heaphy will:

- Document all activities, including ongoing case-based activities, continuing medical education activities (CME) and self-study on an Education Log provided by CPEP;
- Participate in self-study activities during participation in the Plan that demonstrate lifelong learning skills;
- Submit certificates of completion for any courses, if applicable.

Timelines

The timelines below are recommended to maximize participation in the Plan.

- Independent/unsupervised activities, such as self-study, should be initiated immediately once the Plan has been signed.
- Topic/subtopic summaries should be completed by the third month of beginning the Plan activities.
- Courses and/or CME activities should be completed no later than the sixth month of participation.

Associate Medical Director Approval of Resources

Dr. Heaphy may identify resources other than those mentioned below; however, the Associate Medical Director must approve those resources in order for the activities to be applicable to the Plan. If Dr. Heaphy identifies a course(s) other than those recommended below, he must submit

a brochure at least 60 days prior to the course date if the course is date specific. He should receive approval of resources prior to incorporating those resources into his Plan activities.

A. Courses

Dr. Heaphy will:

1. Complete a comprehensive pain management course,* such as "Prescribing Controlled Drugs," offered on various dates through the Vanderbilt Center for Professional Health, Nashville, Tennessee
<http://www.mc.vanderbilt.edu/root/vumc.php?site=cph&doc=36613>
2. Attend a documentation seminar within the first two quarters of participation in the Education Plan.** If ongoing documentation deficiencies are identified, the Associate Medical Director will make further recommendations. Dr. Heaphy should submit the following to CPEP:
 - a. Course brochure within 30 days of signing the Plan for approval;
 - b. Certificate of attendance upon completion.

*If Dr. Heaphy has recently completed a pain management course, or is enrolled in an upcoming course, he should provide information for Associate Medical Director review to determine if the course will fulfill this requirement.

**If an approved course is not available within this timeframe, Dr. Heaphy should provide evidence of *enrollment* in the earliest available course within this time. It will be important for Dr. Heaphy to attend the seminar early in his participation in the Plan rather than later so that he has time to integrate newly learned skills and sufficiently demonstrate his maintenance improvements in charts reviewed.

B. Evidence-Based Self-Study

The purpose of this module is to demonstrate self-directed learning and to create educational resources for reference. Dr. Heaphy will:

1. Within the first three months of beginning the Plan activities, submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
 - a. In preparing the submission, Dr. Heaphy will use *at least two resources for each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks). The submission should explain the applicability of knowledge to his practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale;
 - 1) Appropriate resources are current, peer-reviewed, evidence-based medical references. Notes from a pertinent conference may be utilized with prior Associate Medical Director approval;
2. Identify and become familiar with the resources for current guidelines relevant to the Medical Knowledge Learning Goals;
 - a. Document and submit appropriate clinical guideline resources on an Education Log;
3. Participate in self-study relevant to his practice for the duration of the Plan.

C. Pharmacology Review Activities

In addition to completing a CPEP approved comprehensive pain management course, Dr. Heaphy will:

1. With respect to adverse effects of various medications, including benzodiazepines and antidepressants, (Medical Knowledge Learning Goal 2.a.) *on a monthly basis*:
 - a. Provide examples of how he is attending to potential adverse events from prescribed treatments in patients, and record on Education Logs;
 - b. Participate in self-study and record on Education Logs;
2. Subscribe to *The Medical Letter* or *Prescriber's Letter* or similar service for current pharmacology review.

D. Case-Based Activities

Dr. Heaphy will:

1. Participate in case-based self-study activities such as those offered by the Cleveland Clinic Center for Continuing Education, <http://www.clevelandclinicmeded.com>.

E. Practice-based Learning

Dr. Heaphy will:

1. Review current peer-reviewed, evidence-based medical literature pertinent to pain management throughout the duration of the Plan;
2. Utilize appropriate Internet web sites and other medical resources.

F. Computer-Based Medical Information Resources

Dr. Heaphy will:

1. If he does not already do so, utilize electronic resources at the point of care such as a handheld device and/or computer with access to the Internet. Software or web sites should assist with immediate access to up-to-date medical information relevant to medication prescribing and drug interactions, and patient care decisions, including formulating an adequate differential diagnosis, interpreting test results and evaluating treatment options.

G. Communication

Dr. Heaphy will:

1. Be observed by the Preceptor for a minimum of five patient encounters, at least two of which should be new patients, and receive Preceptor coaching and feedback as a result of the observed patient encounters;
2. Discuss with Preceptor chapters and sections that would be beneficial to read in Field Guide to the Difficult Patient Interview by Frederic W. Platt, M.D., and Geoffrey H. Gordon, M.D. Discuss with the Associate Medical Director during scheduled phone calls;
3. Participate in more structured communication educational experience if, based on Preceptor feedback, the Associate Medical Director determines that Dr. Heaphy would benefit from such an experience. More information would be provided if such a recommendation is made.

MODULE B

PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Heaphy with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr. Heaphy to integrate improved knowledge, decision-making and documentation into daily patient care. All meetings and activities will be documented on an Education Log provided by CPEP.

Timeline

- See *Section IV* for complete time frames for the Preceptor approval process and initiation of Preceptor Meetings.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. PRECEPTED EDUCATION

It will be important that the Preceptor Meetings and activities are thorough and that the Preceptor provides objective feedback sufficient to support Dr. Heaphy's improvement with regard to the specific Plan Learning Goals. All meetings and activities will be documented on an Education Log provided by CPEP.

Guideline

Having knowledge is distinct from applying knowledge. It is essential that, when reviewing charts, the Preceptor determine whether or not the participant *applied* his knowledge to actual patient care.

PRECEPTOR MEETINGS

Dr. Heaphy will:

1. Meet with the Preceptor weekly twice monthly for the duration of the Plan. To provide a quality learning experience, CPEP recommends that each meeting be a minimum of two hours;
2. With the Preceptor and in conjunction with the activities described below in *Preceptor Meeting Activities*, utilize the following to address the Learning Goals:
 - a. Chart review and case-based discussions;
 - b. Hypothetical case discussions;
 - c. Topic discussions;
 - d. Current medical literature reviews;
 - e. Utilization of appropriate Internet web sites and other medical resources.

Note: Although impromptu collegial discussions may occur outside of Preceptor Meetings, such discussions are separate from the Preceptor Meeting requirement.

PRECEPTOR MEETING ACTIVITIES

Chart Review Objectives

Charts are the primary method of evaluating the participant's application of knowledge and clinical judgment and reasoning. Therefore, charts submitted to the Preceptor and the Associate

Medical Director as described below should demonstrate the participant's integration of feedback and information learned as a result of completing Module A activities. Submitted charts should reflect consistent improvements in overall patient care.

Charts reviewed during Preceptor Meetings will be those of patients for whom Dr. Heaphy provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. Heaphy will:

1. Retrospective Chart Reviews:

- a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
4. The Preceptor may specify cases to be reviewed;
5. Redacted* copies of charts should be submitted to the Preceptor in time for the Preceptor to review them before the meetings;
- b. Submit to CPEP by the fifth of *every other* month (month to be determined), six of the 24 redacted* charts used in the Preceptor Meetings;
 - 1) The Associate Medical Director may specify charts to be submitted;
- c. Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. Heaphy's practice as much as possible.

2. Didactic Discussions and Coaching:

- a. Clinical Judgment:
 - 1) With the Preceptor, discuss the Clinical Judgment Learning Goals and application of knowledge to patient care;
 - 2) Develop and discuss with the Preceptor systems (protocols, algorithms, and/or chart templates) or other strategies for organizing the clinical evaluation to ensure that the Clinical Judgment Learning Goals are addressed and that improvements are integrated into his daily patient care;
- b. Documentation:
 - 1) Receive coaching from the Preceptor that addresses general documentation principles as well as the specific areas of need described in Learning Goal C, *Documentation*, including strategies and/or use of chart templates for improved documentation;
- c. Medical Knowledge:
 - 1) Discuss with the Preceptor each topic and subtopic identified in Module A, including applicable and current evidence-based guidelines as available. Dr. Heaphy should also discuss his topic/subtopic summaries with the Preceptor;
- d. Communication:
 - 1) Receive coaching and review reference materials described in the Plan related to communication skills;

3. Lifelong Learning:

- a. Develop lifelong learning skills:
 - 1) Discuss and develop a plan with the Preceptor for maintaining current standards in pain management after conclusion of the Educational Intervention. Discuss the plan with the Associate Medical Director and demonstrate ongoing learning throughout the duration of the Plan. The plan should:

- a) Incorporate computer-based resources;
 - b) Integrate evidence-based medicine resources;
 - c) Promote lifelong learning;
 - d) Include activities that address clinical decision-making, such as case studies and Grand Rounds;
- b. CPEP recommends that Dr. Heaphy:
- 1) Review and reflect on the status of his learning and improvements on an ongoing basis;
 - 2) Keep a learning journal on his reflections, including which activities were beneficial, or not beneficial, and why.

** Refer to Appendix B, Privacy of Individually Identifiable Health Information*

Guidelines

- During the Preceptor Meetings, the Preceptor should provide coaching and recommendations to the participant to ensure that improvements in all Learning Goals identified in the Plan are collectively and consistently applied to Dr. Heaphy's actual patient care.
- The participant's progress will be determined based on the achievement of the Learning Goals and in consideration with generally accepted standards of care. The constraints of a physician's practice circumstances, such as the availability of local medical resources, are taken into consideration when reviewing a physician's actual practices.

IV. INITIATING THE PLAN

A. Determining the Start Date and Beginning Educational Activities

1. Dr. Heaphy will sign and return the Plan to CPEP by December 9, 2013. He will then:
 - a. Initiate the Plan the first day of the month following the review of Dr. Heaphy's Assessment Report and Plan by the Board and CPEP's receipt of the signed Plan.
 - b. Receive an Education Notebook from CPEP with directions, Education Logs, resources, and other information to complete the educational activities;
 - c. Initiate and document self-study activities and course participation;
 - d. *After reviewing* the Preceptor qualifications described in the *Preceptor Job Description* (attached) identify a Preceptor candidate if Dr. Heaphy has not already done so;
 - 1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Heaphy's;
2. Provide a copy of the Plan, the attached *Preceptor Job Description* and Confidentiality Statement, and a copy of the Assessment Report to the proposed Preceptor so that the approval process, as described below, can progress accordingly.

B. Preceptor Approval

1. Within the first month of participation in the Plan, Dr. Heaphy will submit to CPEP:
 - a. The proposed Preceptor curriculum vitae (CV) including the Preceptor name and contact information;

- b. Signed CPEP Authorization to Release/Receive Information form authorizing CPEP to communicate with the Preceptor;
 - 1) A telephone call with the Preceptor and the Associate Medical Director will then be scheduled as part of the approval process;
 - 2) The participant will be notified of the approval;
2. Upon notification of approval, Dr. Heaphy will begin meeting regularly with the Preceptor. He should document meetings on an Education Log.

Guideline

For the participant's educational benefit, the Preceptor must meet the qualifications as described in the *Preceptor Job Description*. Additionally, CPEP must approve the Preceptor in order for any precepted activities to be applicable to the Plan.

V. PARTICIPATION AND MONITORING

Consistent participation in educational activities, including regular and timely submission of materials and participation in scheduled CPEP conference calls, enhances the educational experience. Such participation may also impact the duration of the Plan. Because the Associate Medical Director must be able to evaluate the participant's ongoing progress and provide timely and pertinent feedback, Dr. Heaphy will:

1. Maintain Education Case Logs:
 - a. Education Logs should document all educational activities including Preceptor Meetings and the content of the Meetings, and those activities that are outside of the scope of the Plan but relevant to his practice;
2. Submit materials:
 - a. By the fifth of every month, submit:
 - 1) Education Logs;
 - 2) Preceptor Report forms completed by the Preceptor;
 - 3) Other materials relevant to the Plan or as requested by the Associate Medical Director;
 - b. By the fifth of every month and until the following has been completed, submit:
 - 1) Topic/subtopic summaries;
 - 2) CME certificates and/or other documentation of completed activities specified in the Plan (if applicable);
3. Submit Charts:
 - a. Every other month, as directed by CPEP, submit charts,* as described in Module B. Charts must be complete and if possible, include one year of patient care. More information will be provided when the Plan is initiated;
 - b. At the request of the Associate Medical Director, submit randomly selected charts for review from Dr. Heaphy appointment and hospital schedule;
4. Be responsible for his and his Preceptor's participation in the Plan activities and his educational progress;
5. Demonstrate maintenance of improvements for all Learning Goals prior to conclusion of the Patient Care Enhancement activities.

*See *Module B, Retrospective Chart Review* to determine if charts should be submitted monthly or every other month

FORMATIVE EVALUATION

Evaluation of Educational Progress

Ongoing progress is measured using formative evaluation tools such as regular chart reviews, review of topic/subtopic summaries, participant and Preceptor discussions with the Associate Medical Director, and written Preceptor Reports.

Approximately every four months, Progress Reports will be generated and provided to Dr. Heaphy and to other entities for which Dr. Heaphy has provided authorization. The Progress Reports will capture Dr. Heaphy's progress as demonstrated during Formative Evaluations conducted during that reporting period.

SUMMATIVE EVALUATION

Post-Education Evaluation

Following the completion of the Plan activities, Dr. Heaphy will participate in a Post-Education Evaluation (Evaluation) to demonstrate that he achieved the Learning Goals and successfully completed the Educational Intervention. The Evaluation will be focused on the areas identified as Learning Goals in the Plan and will consider Dr. Heaphy's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Heaphy will schedule the Evaluation no sooner than two months, and no later than four months, following notification from CPEP that he has completed the Plan activities.

VI. ESTIMATED DURATION

Plan Learning Goals and Performance Objectives

Most participants complete an Education Plan in approximately 12-18 months. The actual duration varies depending on many factors including the scope of educational needs identified.

CONDITIONS

- Modifying an approach to overall patient care, specifically application of knowledge, clinical judgment and documentation may be challenging. Additionally, certain aspects of the Plan cannot be predicted, such as spectrum of patients and cases presented, as well as the participant's dedication to the educational activities. Therefore, the duration of the Plan can only be estimated.
- CPEP reserves the right to change the content and/or duration of the Education Plan.
- CPEP is not responsible for ensuring that the participant obtains any required privileges or credentials while participating in the Education Plan; this is the responsibility of the participant.

- Once the participant has completed the Education Plan and/or has been authorized to complete the Post-Education Evaluation, CPEP is no longer reviewing charts or providing educational services to the participant.
- If Dr. Heaphy does not engage in this Plan by January 1, 2015, CPEP may require completion of additional Assessment activities to ensure that Dr. Heaphy's current educational needs are addressed.

SIGNATURES

James H. Heaphy, M.D.

Date

Abigail C. Anderson, M.D.
Associate Medical Director

Date

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Preceptor candidates.

FEB 19 2014

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1386

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH
OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO.
26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, and James H. Heaphy, M.D. ("the licensee"), and, based upon the licensee's request to have his prescribing privileges reinstated for the purpose of participating in a CPEP Educational Plan, hereby ENTER INTO the following
AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:

STIPULATIONS OF FACT

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

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a

complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.

5. Ms. Brooks went on to state that after checking the remaining certificates Dr.

Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.

6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management	March 12-16, 2004	May, 1998	None: Due to no	None: Due to no

Seminar II Note: This is an attendance sheet not a certificate			attendance sheet submitted.	attendance sheet submitted.
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him.

Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on

February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.
12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07,

03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and

would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care.

Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical

sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of

Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.

15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-

amputation of his residual limb. The patient believed that the six week delay resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he

gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked

to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was seeing a podiatrist, Dr Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg

Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.
20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010 and the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
21. In July 2010, the Panel deferred consideration of Dr. Heaphy's request for reinstatement of his license until Dr. Heaphy completed the CPEP ProBe Program and the completion of an audit of his CMEs.
22. In September 2010, Dr. Heaphy attended CPEP's Patient Care Documentation Seminar and an audit of his CME credits showed that he had successfully completed the required hours.

23. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM-E* (Professional Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.
24. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in an Agreed Order of Probation, which required (in part) that he maintain a controlled substance log, that his practice be subject to periodic reviews by a Board consultant and that he practice within acceptable and prevailing medical practices in the Commonwealth of Kentucky.
25. In February 2012, a Board consultant reviewed a KASPER report of Dr. Heaphy's prescribing from January 1 through October 26, 2011 and sixteen (16) medical charts of Dr. Heaphy's patients and found that

... These patient charts show a consistent recurrent pattern of inexplicably high dose chronic narcotic prescribing nearly universally coupled with equally inexplicably high dose chronic benzodiazepine prescribing. A typical patient of Dr. Heaphy's in the sample charts is prescribed Valium 10mg TID to QID or Xanax 1 to 2 mg TID to QID coupled with Lortab 10mg TID to QID. After greater than six months of regular monthly visits, a few of the patients are prescribed common non-addictive anxiolytics, such as Celexa, but no significant or sustained effort is made to wean these patients off of their potentially addictive anxiolytics in the subsequent visits. The high dose chronic narcotics prescribed follow a similarly disturbing pattern. The overwhelming majority of patients in these 16 charts of Dr. Heaphy are receiving high dose narcotics such as Lortab 10 mg TID to QID for chronic back pain. Some of them have little evidence of significant disease on their MRIs that would suggest a need for high dose chronic narcotics due to their claimed chronic back/neck pain. Again, virtually no effort is made by Dr. Heaphy in weaning these addictive pain medications. ...

Although it is difficult to point to any one patient and prove a trend ... In aggregate these 16 charts of Dr. Heaphy's patients paint a clear picture of reckless medically irresponsible prescribing of controlled substances, both in dose, frequency, and chronicity practiced by Dr. Heaphy. This overprescribing clearly deviates from standards of acceptable and prevailing medical practice. Further, Dr. Heaphy's inappropriate prescribing places his patient's health and wellbeing at grave risk.

In summary, after careful review of the provided material, I believe Dr. Heaphy's pattern of narcotic and benzodiazepine prescribing deviates grossly from acceptable standard of care and poses a serious threat to the health of his patients and his community.

26. In response to the Board consultant review, Dr. Heaphy explained that he had not assumed the medical management of the 16 patients, whose charts were reviewed, until June 1, 2011 and that, even then, he treated all of the patients (except for one) for pain only and did not serve as their primary care physician. Therefore, because Dr. Heaphy treated the patients only for pain, he did not believe that any criticisms of the primary care were validly directed toward him. In addition, because he did not assume care of these patients until June 1, he did not believe that any criticism of the prescribing protocols established by the previous pain physician should be attributable to the care he provided.

27. In addition, Dr. Heaphy obtained an independent consultant review of his practice. Dr. Heaphy's consultant reviewed three patient charts, which the Board consultant opined were representative of all charts reviewed, and found that

... The three patient charts I reviewed indicated stable clinical courses. There were not any significant advancement in the medications over time, nor were there any deleterious outcomes as a result of their treatment. ...

My review of Dr. Heaphy's three charts indicates that he documented the majority of the necessary elements contained in Kentucky's current guidelines. Dr. Heaphy's documentation

indicates that he prescribed controlled substance for pain in a legitimate manner and in doses that did not exceed acceptable norms. Dr. Heaphy addressed the risk of abuse and diversion; he documented urine drug screens, psychological/addiction assessments and appropriate treatment agreements. Consultations with specialists were documented. The patients were seen often enough to monitor their progress and assess for deterioration in function. There were ample patient-physician treatment agreements that inferred adequate informed consent with appropriate behavioral boundaries. The prescriptions were copied, available for review, and prescribed lawfully. Sufficient information was documented to justify the prescription medication furnished to the patients. Over the course of treatment, it is apparent that these patients were monitored for signs of addiction/diversion. ...

In my opinion, based upon the available documentation, Dr. Heaphy's prescription of controlled substances did not depart from the boundaries of acceptable practice and was consistent with the current Kentucky guidelines. Dr. Heaphy's practice did not violate an acceptable standard of care. Furthermore, Dr. Heaphy's documented would not be classified as gross incompetence, negligence or malpractice. Dr. Heaphy's care did not constitute a danger to the health and safety of his patients or the general public. Overall, the records adequately justified the care being rendered by Dr. Heaphy.

28. On April 19, 2012, the Board's Inquiry Panel B considered whether the licensee was non-compliant with the Agreed Order of Probation. In light of the consultant reviews of Dr. Heaphy's practices, the Panel determined that there was probable cause to believe that the licensee's prescribing of controlled substances constitutes a danger to the health, welfare and safety of his patients or the general public. In lieu of emergency action, the parties agreed to enter into an Agreed Order of Indefinite Restriction, which restricted the licensee from prescribing, dispensing, or otherwise professionally utilizing controlled substances unless and until approved to do so by the Panel; required that he complete a CPEP clinical skills assessment and have an Educational Plan developed, if recommended; and

required that he reimburse to the Board the costs of the investigation in the amount of \$1,500.00.

29. By April 2013, nearly one year later, the licensee had neither contacted CPEP for a clinical skills assessment nor reimbursed the Board's costs. The case was returned to the Panel for non-compliance action. By the time the Panel convened, the licensee had scheduled a CPEP clinical skills assessment. The Panel directed that a Complaint and Emergency Order of Suspension be issued against his license if he failed to appear for that assessment on the scheduled dates and that the Assessment Report and Educational Plan be brought back to the Panel when completed.

30. On July 1-2, 2013, the licensee participated in a CPEP clinical skills assessment in the specialty of chronic pain management. CPEP found that

... Dr. Heaphy demonstrated a reasonable foundation of knowledge of pain management, but his knowledge was superficial in some respects. Dr. Heaphy's clinical judgment and reasoning were adequate in most respects, with some notable lapses in application of knowledge and approach to treatment. Dr. Heaphy's communication skills were adequate with room for improvement with Simulated Patients (SPs) and professional with peers. His documentation in patient charts submitted from his practice was inadequate; his documentation of the SP encounters was acceptable with room for improvement.

...

... [A]nalyzes of specific subtest performances raised some concerns about his memory, visual attention, and ability to perform mental calculations. While these results, in isolation, do not indicate the need for further neuropsychological evaluation, Dr. Heaphy and the Board should consider if there are any additional concerns or observations that, in combination with these screening test results, would warrant further evaluation. CPEP did not make any such observations.

...

31. In November 2013, CPEP developed an Education Plan for the licensee in the specialty of chronic pain management, the components of which include self-study, CME, and coaching and review by a Preceptor. It was noted that in order to optimally review the licensee's clinical judgment in the area of pain management and the prescribing of controlled substances, his prescribing privileges would need to be reinstated.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical license is subject to regulation and discipline by the Board.
2. While the licensee denies any wrongdoing or violation, he acknowledges and agrees that, based upon the Stipulations of Fact, the Hearing Panel could find that he engaged in conduct which violates the provisions of KRS 311.595(9) - as illustrated by KRS 311.597(3) and (4) -- and KRS 311.595(13). Accordingly, there are legal grounds for the parties to enter into this Amended 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 Amended Agreed Order of Indefinite Restriction.

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the licensee's request to have his prescribing privileges reinstated for the purpose of participating in a CPEP Educational Plan,, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION**:

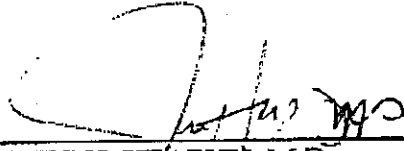
1. The license to practice medicine in the Commonwealth of Kentucky held by James H. Heaphy, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Amended Agreed Order of Indefinite Restriction ("Agreed Order");
2. During the effective period of this Agreed Order, 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 licensee SHALL NOT perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – unless and until the Panel or its Chair has approved, in writing, the practice location at which he will practice medicine. The decision whether to approve a particular practice location lies in the sole discretion of the Panel or its Chair. In determining whether to approve a particular practice location, the Panel or its Chair will particularly consider whether there will be appropriate supervision of the licensee, and may also consider the nature of the practice, including the licensee's proposed duties and hours to be worked. In approving such practice location, the Panel or its Chair may include specific conditions/restrictions to ensure patient safety;
 - i. The licensee shall not change practice locations without first obtaining written approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new practice location;

- b. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;
- i. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants;
 - ii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order;
 - iii. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order;
- c. Within six (6) months of the date of entry of this Agreed Order, the licensee SHALL successfully complete a Board-approved course relating to HB1 from the approved course list available on the Board's website at <http://kbml.ky.gov> and SHALL provide written certification of said completion to the Board's Legal Department;
- d. The licensee SHALL SUCCESSFULLY complete all requirements of the CPEP Educational Intervention Plan, at his expense and as directed by CPEP, a copy of which is attached hereto;
- i. If deemed necessary and appropriate by CPEP, the licensee SHALL SUCCESSFULLY COMPLETE the Post-Education Assessment, at his expense and as directed by CPEP;
 - ii. The licensee SHALL TAKE ALL NECESSARY STEPS, including the execution of waivers and/or releases, to ensure that CPEP provides timely written reports to the Board outlining his compliance with the Educational Intervention Plan;

- e. Pursuant to KRS 311.565(1)(v), the licensee SHALL pay a FINE to the Board in the amount of one thousand dollars (\$1,000.00), within six (6) months of the date of filing of this Agreed Order; and
 - f. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, 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, 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 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.
4. The licensee understands and agrees that any violation of the terms of this Agreed Order 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 24th day of January, 2014.

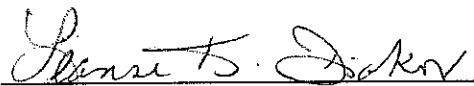
FOR THE LICENSEE:

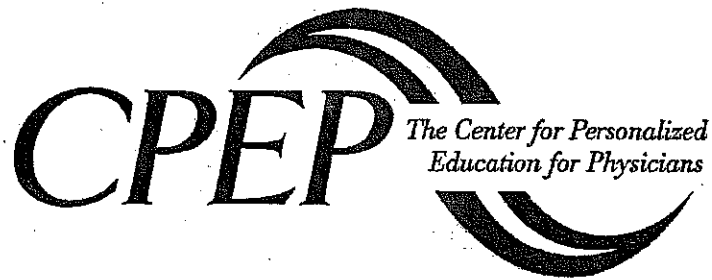

JAMES H. HEAPHY, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:


RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B


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EDUCATIONAL INTERVENTION PROGRAM

EDUCATION PLAN

Developed November 2013

for

James H. Heaphy, M.D.

NATIONALLY RECOGNIZED ■ PROVEN LEADER ■ TRUSTED RESOURCE

**7351 Lowry Boulevard, Suite 100
Denver, Colorado 80230
Phone: 303-577-3232
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EDUCATION PLAN

OVERVIEW

- | | |
|--------------------|---|
| <u>Section I</u> | Introduction and Plan Design |
| <u>Section II</u> | Individual Learning Goals <ul style="list-style-type: none">• Specific areas of educational need |
| <u>Section III</u> | Performance Objectives (Modules A and B) <ul style="list-style-type: none">• Self-study, CME, Preceptor Meetings |
| <u>Section IV</u> | Initiation of the Plan and Preceptor Approval <ul style="list-style-type: none">• Determining the start of activities• Education Notebook• Preceptor Approval Process |
| <u>Section V</u> | Participation and Monitoring <ul style="list-style-type: none">• Participation Expectations• Evaluation Process |
| <u>Section VI</u> | Duration |

APPENDICES

- | | |
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| Appendix A | Practice Profile |
| Appendix B | Federal Regulations of Privacy of Individually Identifiable Health Information |
| Appendix C | Glossary and Educational Terms |

I. INTRODUCTION

In accordance with Kentucky Board of Medical Licensure (Board) Agreed Order of Indefinite Restriction (Order), dated April 2012, James H. Heaphy, M.D., was ordered to complete a clinical skills Assessment and any subsequent recommended education plan with CPEP. In July 2013, Dr. Heaphy completed an Assessment, which identified areas of educational need. The development of this Education Plan (Plan) was based on those needs. The Plan was also based on data gathered by CPEP and information obtained from Dr. Heaphy. The purpose of this Plan is to provide a framework in which Dr. Heaphy can address his educational needs.

A glossary of Educational Intervention terms is enclosed.

FOCUS OF PLAN

Dr. Heaphy's Assessment was designed to evaluate the practice of chronic pain management, based on his stated desire to evaluate only the areas requested by the Board in the Order. Thus, this Plan addresses Dr. Heaphy's practice of pain management and does not address the areas of internal medicine or emergency medicine, areas in which Dr. Heaphy has worked in the past and may work in the future. If educational needs related to Dr. Heaphy's current or prospective practice (that were outside of the scope of the Assessment) are identified during the Plan, CPEP will notify the Board and Dr. Heaphy and determine if the educational needs can be addressed within the context of this Plan. CPEP may not be able to address those needs without further Assessment activities or expansion of the scope of the Plan.

LIMITATIONS

CPEP cannot guarantee that a Preceptor and/or an appropriate setting can be identified to address this Plan.

- Dr. Heaphy reported to CPEP that he is unable to write prescriptions for controlled substances. The optimum way to address Dr. Heaphy's clinical judgment in the areas of pain management and prescribing of controlled substances is through the review of actual patient charts. However, if Dr. Heaphy's limitation to prescribing continues, CPEP will not be able to assess his application of knowledge in practice, and it may be necessary to address these objectives with hypothetical scenarios.

LICENSING

Because CPEP Education plans are practice-based, physician-participants must have a medical license in order to complete a Plan. Some activities, such as self-study, may be completed without a medical license. *It is the participant's responsibility* to ensure that he practices within the parameters of his/her licensure status.

DESIGN

The individual Learning Goals described below in *Section II* were derived from the findings of the Assessment. This Plan was designed to address those Learning Goals through Medical Knowledge Enhancement and Patient Care Enhancement educational activities described in *Section III* as Modules A and B. Evaluation of Dr. Heaphy's progress and oversight of his

participation will be provided by the CPEP Associate Medical Director. The Plan is designed around continuous and timely participation so that maximum educational benefit is received and ongoing progress is made. Following is more detailed information about the Modules and the Associate Medical Director oversight.

Note: The requirements of this Plan are not intended to supersede or exclude any requirements specific to his employer, credentialing, or licensure regulations. However, some activities may be applicable to both the Plan and such requirements.

A. Medical Knowledge Enhancement (Module A)

The Medical Knowledge Enhancement Learning Goals are addressed independently by the participant as well as through discussions with the Preceptor. The activities are designed to improve the participant's medical knowledge specific to the Learning Goals. Other improvements are generally realized as a result of the activities. A Preceptor is not needed to begin the activities described in Module A. CPEP encourages Dr. Heaphy to begin the activities as soon as he has initiated the Plan. The recommended activities include:

- Independent/unsupervised self-study;
- Evidence-based research;
- Continuing medical education activities and/or courses.

B. Patient Care Enhancement (Module B)

Dr. Heaphy will work with a Preceptor who has a practice similar to his. Subsequently, Dr. Heaphy will participate in a longitudinal learning experience that is reliant on regularly scheduled Preceptor Meetings. During this experience Dr. Heaphy will:

- Retrospectively review charts with the Preceptor of patients for whom Dr. Heaphy provided independent/unsupervised care;
- Receive one-on-one coaching and constructive feedback with regard to medical knowledge, clinical judgment and documentation, particularly with regard to those areas identified in the Plan Learning Goals (see *Section II*);
- Discuss and reinforce new information and skills gained for full integration into daily patient care;
- Appreciate the value of lifelong learning, peer relationships, and self-assessment to the quality of patient care.

C. Oversight

The Associate Medical Director oversight includes Preceptor training, consideration of the feedback provided by the Preceptor and review of educational materials submitted by Dr. Heaphy (see *Section V*). The Associate Medical Director will regularly communicate with and provide ongoing feedback and coaching to Dr. Heaphy and the Preceptor with regard to Dr. Heaphy's progress.

II. LEARNING GOALS

A. Medical Knowledge

To improve evidenced-based medical knowledge including, but not limited to, the following areas:

1. Pathophysiology of pain and the diagnosis of painful conditions:
 - a. Nociceptive and neuropathic pain;
 - b. Myofascial pain;
 - c. Fibromyalgia;
 - d. Specific radicular distributions;
2. Pharmacology:
 - a. Adverse effects of various medications, including benzodiazepines and antidepressants;*
 - b. Opioids:
 - 1) Knowledge of a broad enough range of opioids to facilitate opioid optimization and rotation;
 - 2) Role and use of short- versus long-acting;
 - 3) Pharmacokinetics: duration of action of opioids;
 - 4) Adverse effects of morphine;
 - 5) Management of constipation;
 - 6) Types of abuse-deterrent formulations of opioids;
3. Non-pharmacologic modalities;
4. Controlled substance agreement:
 - a. Thorough understanding of the important elements of a controlled substance agreement;
 - b. Concept of an agreement versus a contract;
5. Basic knowledge of addiction, including but not limited to:
 - a. Screening, brief intervention, and referral to treatment (SBIRT);
 - b. Definitions of addiction and pseudoaddiction;
 - c. Basic knowledge of treatment options and alternatives;
 - d. Risk evaluation;
 - e. Spectrum of behavioral aberrancies;
6. Other focussed topics:
 - a. Causes of a false-positive urine test for THC;
 - b. Definition of diversion;
 - c. Risks of the use of particulate steroids around the vascular structures of the head and neck.

*Topic summary not required. Other educational activities required and described in *III.C* below.

(See III.B below for description of topic summaries.)

B. Clinical Judgment

To *consistently* demonstrate appropriate clinical judgment in the areas that include, but are not limited to, the following:

1. Consistently obtain a thorough history, including social history, history of substance abuse, and history of psychiatric disorders;
2. Consistently obtain an adequately comprehensive physical exam;
3. Adequate risk assessment prior to prescribing drugs at increased risk of addiction or diversion;
4. Application of knowledge:
 - a. Use of controlled substance agreements;
 - b. Monitoring patients on opioids with urine drug testing and reviews of prescription drug monitoring program reports;
 - c. Address incidental clinical abnormalities such as elevated blood pressure;
5. Treatment approach:
 - a. Adequate emphasis on non-pharmacologic interventions;
 - b. Non-opioid optimization;
 - c. Identification of conditions that may not warrant opioid therapy and formulation of alternative treatment approaches;
 - d. Find appropriate balance of risks and benefits to opioid therapy in each individual case.

C. Documentation

The participant will learn principles of documentation that are based on recommendations and requirements of nationally recognized organizations such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) and recommendations of national specialty societies and will *consistently* demonstrate appropriate patient care documentation that includes, but is not limited to, the following:

1. Improved legibility;
2. Consistent use of problem lists;
3. Inclusion of controlled substance agreements and documentation of review of prescription drug monitoring database reports in appropriate cases;
4. Expanded/adequate documentation of complaints/review of systems, pertinent physical exam findings, impression, plan, and clinical thinking;
5. Inclusion of at least the names of the drugs for which prescriptions were provided on the encounter note, even if details of the prescription are found elsewhere;
6. Consistent documentation of substance use history, psychiatric history, and relevant family history.

Guideline

Adequate documentation requires inclusion of sufficient detail in visit notes such that the notes "stand alone" and determination of the level of care provided does not require verbal input from the documenting physician to be fully understood. Ultimately, adequate documentation includes chart organization and systems tools that allow another physician to easily assume care of a patient.

D. Practice-based Learning

1. Adequate attention to CME activities;
2. If not already in place, consider implementation of a system to allow easy access to information about his patient population for practice improvement opportunities.

E. Physician-Patient Communication Skills

To *consistently* demonstrate appropriate communication skills in the areas that include, but are not limited to, the following:

1. Knock before entering a patient room;
2. Be cognizant that casual attire will impact a patient's impression of professionalism;
3. Inform patients about what will be done during the physical exam;
4. Enhanced clarity when discussing different treatment options;
5. Avoid medical jargon.

III. PERFORMANCE OBJECTIVES

Performance Objectives are specific educational activities that provide focused learning experiences designed to assist the participant with achievement of the Learning Goals (*Section II*). The participant will integrate newly learned information into his daily practice and demonstrate long-term improved patient care during Module B Activities.

MODULE A

MEDICAL KNOWLEDGE ENHANCEMENT

Module A activities do not require approval of a Preceptor to initiate. Dr. Heaphy will:

- Document all activities, including ongoing case-based activities, continuing medical education activities (CME) and self-study on an Education Log provided by CPEP;
- Participate in self-study activities during participation in the Plan that demonstrate lifelong learning skills;
- Submit certificates of completion for any courses, if applicable.

Timelines

The timelines below are recommended to maximize participation in the Plan.

- Independent/unsupervised activities, such as self-study, should be initiated immediately once the Plan has been signed.
- Topic/subtopic summaries should be completed by the third month of beginning the Plan activities.
- Courses and/or CME activities should be completed no later than the sixth month of participation.

Associate Medical Director Approval of Resources

Dr. Heaphy may identify resources other than those mentioned below; however, the Associate Medical Director must approve those resources in order for the activities to be applicable to the Plan. If Dr. Heaphy identifies a course(s) other than those recommended below, he must submit

a brochure at least 60 days prior to the course date if the course is date specific. He should receive approval of resources prior to incorporating those resources into his Plan activities.

A. Courses

Dr. Heaphy will:

1. Complete a comprehensive pain management course,* such as "Prescribing Controlled Drugs," offered on various dates through the Vanderbilt Center for Professional Health, Nashville, Tennessee
<http://www.mc.vanderbilt.edu/root/vumc.php?site=cph&doc=36613>
2. Attend a documentation seminar within the first two quarters of participation in the Education Plan.** If ongoing documentation deficiencies are identified, the Associate Medical Director will make further recommendations. Dr. Heaphy should submit the following to CPEP:
 - a. Course brochure within 30 days of signing the Plan for approval;
 - b. Certificate of attendance upon completion.

*If Dr. Heaphy has recently completed a pain management course, or is enrolled in an upcoming course, he should provide information for Associate Medical Director review to determine if the course will fulfill this requirement.

**If an approved course is not available within this timeframe, Dr. Heaphy should provide evidence of *enrollment* in the earliest available course within this time. It will be important for Dr. Heaphy to attend the seminar early in his participation in the Plan rather than later so that he has time to integrate newly learned skills and sufficiently demonstrate his maintenance improvements in charts reviewed.

B. Evidence-Based Self-Study

The purpose of this module is to demonstrate self-directed learning and to create educational resources for reference. Dr. Heaphy will:

1. Within the first three months of beginning the Plan activities, submit a brief paragraph, case based discussion, outline, or algorithm to summarize the major points learned;
 - a. In preparing the submission, Dr. Heaphy will use *at least two resources for each of the topics and subtopics* listed in the Medical Knowledge Enhancement Learning Goals (except for those indicated with asterisks). The submission should explain the applicability of knowledge to his practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale;
 - 1) Appropriate resources are current, peer-reviewed, evidence-based medical references. Notes from a pertinent conference may be utilized with prior Associate Medical Director approval;
2. Identify and become familiar with the resources for current guidelines relevant to the Medical Knowledge Learning Goals;
 - a. Document and submit appropriate clinical guideline resources on an Education Log;
3. Participate in self-study relevant to his practice for the duration of the Plan.

C. Pharmacology Review Activities

In addition to completing a CPEP approved comprehensive pain management course, Dr. Heaphy will:

1. With respect to adverse effects of various medications, including benzodiazepines and antidepressants, (Medical Knowledge Learning Goal 2.a.) *on a monthly basis*:
 - a. Provide examples of how he is attending to potential adverse events from prescribed treatments in patients, and record on Education Logs;
 - b. Participate in self-study and record on Education Logs;
2. Subscribe to *The Medical Letter* or *Prescriber's Letter* or similar service for current pharmacology review.

D. Case-Based Activities

Dr. Heaphy will:

1. Participate in case-based self-study activities such as those offered by the Cleveland Clinic Center for Continuing Education, <http://www.clevelandclinicmeded.com>.

E. Practice-based Learning

Dr. Heaphy will:

1. Review current peer-reviewed, evidence-based medical literature pertinent to pain management throughout the duration of the Plan;
2. Utilize appropriate Internet web sites and other medical resources.

F. Computer-Based Medical Information Resources

Dr. Heaphy will:

1. If he does not already do so, utilize electronic resources at the point of care such as a handheld device and/or computer with access to the Internet. Software or web sites should assist with immediate access to up-to-date medical information relevant to medication prescribing and drug interactions, and patient care decisions, including formulating an adequate differential diagnosis, interpreting test results and evaluating treatment options.

G. Communication

Dr. Heaphy will:

1. Be observed by the Preceptor for a minimum of five patient encounters, at least two of which should be new patients, and receive Preceptor coaching and feedback as a result of the observed patient encounters;
2. Discuss with Preceptor chapters and sections that would be beneficial to read in Field Guide to the Difficult Patient Interview by Frederic W. Platt, M.D., and Geoffrey H. Gordon, M.D. Discuss with the Associate Medical Director during scheduled phone calls;
3. Participate in more structured communication educational experience if, based on Preceptor feedback, the Associate Medical Director determines that Dr. Heaphy would benefit from such an experience. More information would be provided if such a recommendation is made.

MODULE B

PATIENT CARE ENHANCEMENT

During the activities described in this Module the Preceptor will provide feedback to Dr. Heaphy with regard to improvements in all areas of the Learning Goals. The Preceptor will coach Dr. Heaphy to integrate improved knowledge, decision-making and documentation into daily patient care. All meetings and activities will be documented on an Education Log provided by CPEP.

Timeline

- See *Section IV* for complete time frames for the Preceptor approval process and initiation of Preceptor Meetings.
- Once initiated, Preceptor Meetings and chart reviews will continue for the duration of the Plan.

A. PRECEPTED EDUCATION

It will be important that the Preceptor Meetings and activities are thorough and that the Preceptor provides objective feedback sufficient to support Dr. Heaphy's improvement with regard to the specific Plan Learning Goals. All meetings and activities will be documented on an Education Log provided by CPEP.

Guideline

Having knowledge is distinct from applying knowledge. It is essential that, when reviewing charts, the Preceptor determine whether or not the participant *applied* his knowledge to actual patient care.

PRECEPTOR MEETINGS

Dr. Heaphy will:

1. Meet with the Preceptor weekly twice monthly for the duration of the Plan. To provide a quality learning experience, CPEP recommends that each meeting be a minimum of two hours;
2. With the Preceptor and in conjunction with the activities described below in *Preceptor Meeting Activities*, utilize the following to address the Learning Goals:
 - a. Chart review and case-based discussions;
 - b. Hypothetical case discussions;
 - c. Topic discussions;
 - d. Current medical literature reviews;
 - e. Utilization of appropriate Internet web sites and other medical resources.

Note: Although impromptu collegial discussions may occur outside of Preceptor Meetings, such discussions are separate from the Preceptor Meeting requirement.

PRECEPTOR MEETING ACTIVITIES

Chart Review Objectives

Charts are the primary method of evaluating the participant's application of knowledge and clinical judgment and reasoning. Therefore, charts submitted to the Preceptor and the Associate

Medical Director as described below should demonstrate the participant's integration of feedback and information learned as a result of completing Module A activities. Submitted charts should reflect consistent improvements in overall patient care.

Charts reviewed during Preceptor Meetings will be those of patients for whom Dr. Heaphy provided independent/unsupervised care. Charts as described below should address the Plan Learning Goals as much as possible.

During the Precepted Education, Dr. Heaphy will:

1. Retrospective Chart Reviews:
 - a. Submit to the Preceptor for review no fewer than 24 redacted* charts per month (12 charts per twice-monthly sessions);
 4. The Preceptor may specify cases to be reviewed;
 5. Redacted* copies of charts should be submitted to the Preceptor in time for the Preceptor to review them before the meetings;
 - b. Submit to CPEP by the fifth of *every other* month (month to be determined), six of the 24 redacted* charts used in the Preceptor Meetings;
 - 1) The Associate Medical Director may specify charts to be submitted;
 - c. Cases should be specifically relevant to the Plan as well as representative of the scope of Dr. Heaphy's practice as much as possible.
2. Didactic Discussions and Coaching:
 - a. Clinical Judgment:
 - 1) With the Preceptor, discuss the Clinical Judgment Learning Goals and application of knowledge to patient care;
 - 2) Develop and discuss with the Preceptor systems (protocols, algorithms, and/or chart templates) or other strategies for organizing the clinical evaluation to ensure that the Clinical Judgment Learning Goals are addressed and that improvements are integrated into his daily patient care;
 - b. Documentation:
 - 1) Receive coaching from the Preceptor that addresses general documentation principles as well as the specific areas of need described in Learning Goal C, *Documentation*, including strategies and/or use of chart templates for improved documentation;
 - c. Medical Knowledge:
 - 1) Discuss with the Preceptor each topic and subtopic identified in Module A, including applicable and current evidence-based guidelines as available. Dr. Heaphy should also discuss his topic/subtopic summaries with the Preceptor;
 - d. Communication:
 - 1) Receive coaching and review reference materials described in the Plan related to communication skills;
3. Lifelong Learning:
 - a. Develop lifelong learning skills:
 - 1) Discuss and develop a plan with the Preceptor for maintaining current standards in pain management after conclusion of the Educational Intervention. Discuss the plan with the Associate Medical Director and demonstrate ongoing learning throughout the duration of the Plan. The plan should:

- a) Incorporate computer-based resources;
 - b) Integrate evidence-based medicine resources;
 - c) Promote lifelong learning;
 - d) Include activities that address clinical decision-making, such as case studies and Grand Rounds;
- b. CPEP recommends that Dr. Heaphy:
- 1) Review and reflect on the status of his learning and improvements on an ongoing basis;
 - 2) Keep a learning journal on his reflections, including which activities were beneficial, or not beneficial, and why.

** Refer to Appendix B, Privacy of Individually Identifiable Health Information*

Guidelines

- During the Preceptor Meetings, the Preceptor should provide coaching and recommendations to the participant to ensure that improvements in all Learning Goals identified in the Plan are collectively and consistently applied to Dr. Heaphy's actual patient care.
- The participant's progress will be determined based on the achievement of the Learning Goals and in consideration with generally accepted standards of care. The constraints of a physician's practice circumstances, such as the availability of local medical resources, are taken into consideration when reviewing a physician's actual practices.

IV. INITIATING THE PLAN

A. Determining the Start Date and Beginning Educational Activities

1. Dr. Heaphy will sign and return the Plan to CPEP by December 9, 2013. He will then:
 - a. Initiate the Plan the first day of the month following the review of Dr. Heaphy's Assessment Report and Plan by the Board and CPEP's receipt of the signed Plan.
 - b. Receive an Education Notebook from CPEP with directions, Education Logs, resources, and other information to complete the educational activities;
 - c. Initiate and document self-study activities and course participation;
 - d. *After reviewing* the Preceptor qualifications described in the *Preceptor Job Description* (attached) identify a Preceptor candidate if Dr. Heaphy has not already done so;
 - 1) The Preceptor must be board certified in the same specialty and have a practice similar to Dr. Heaphy's;
2. Provide a copy of the Plan, the attached *Preceptor Job Description* and Confidentiality Statement, and a copy of the Assessment Report to the proposed Preceptor so that the approval process, as described below, can progress accordingly.

B. Preceptor Approval

1. Within the first month of participation in the Plan, Dr. Heaphy will submit to CPEP:
 - a. The proposed Preceptor curriculum vitae (CV) including the Preceptor name and contact information;

- b. Signed CPEP Authorization to Release/Receive Information form authorizing CPEP to communicate with the Preceptor;
 - 1) A telephone call with the Preceptor and the Associate Medical Director will then be scheduled as part of the approval process;
 - 2) The participant will be notified of the approval;
2. Upon notification of approval, Dr. Heaphy will begin meeting regularly with the Preceptor. He should document meetings on an Education Log.

Guideline

For the participant's educational benefit, the Preceptor must meet the qualifications as described in the *Preceptor Job Description*. Additionally, CPEP must approve the Preceptor in order for any precepted activities to be applicable to the Plan.

V. PARTICIPATION AND MONITORING

Consistent participation in educational activities, including regular and timely submission of materials and participation in scheduled CPEP conference calls, enhances the educational experience. Such participation may also impact the duration of the Plan. Because the Associate Medical Director must be able to evaluate the participant's ongoing progress and provide timely and pertinent feedback, Dr. Heaphy will:

1. Maintain Education Case Logs:
 - a. Education Logs should document all educational activities including Preceptor Meetings and the content of the Meetings, and those activities that are outside of the scope of the Plan but relevant to his practice;
2. Submit materials:
 - a. By the fifth of every month, submit:
 - 1) Education Logs;
 - 2) Preceptor Report forms completed by the Preceptor;
 - 3) Other materials relevant to the Plan or as requested by the Associate Medical Director;
 - b. By the fifth of every month and until the following has been completed, submit:
 - 1) Topic/subtopic summaries;
 - 2) CME certificates and/or other documentation of completed activities specified in the Plan (if applicable);
3. Submit Charts:
 - a. Every other month, as directed by CPEP, submit charts,* as described in Module B. Charts must be complete and if possible, include one year of patient care. More information will be provided when the Plan is initiated;
 - b. At the request of the Associate Medical Director, submit randomly selected charts for review from Dr. Heaphy appointment and hospital schedule;
4. Be responsible for his and his Preceptor's participation in the Plan activities and his educational progress;
5. Demonstrate maintenance of improvements for all Learning Goals prior to conclusion of the Patient Care Enhancement activities.

*See *Module B, Retrospective Chart Review* to determine if charts should be submitted monthly or every other month

FORMATIVE EVALUATION

Evaluation of Educational Progress

Ongoing progress is measured using formative evaluation tools such as regular chart reviews, review of topic/subtopic summaries, participant and Preceptor discussions with the Associate Medical Director, and written Preceptor Reports.

Approximately every four months, Progress Reports will be generated and provided to Dr. Heaphy and to other entities for which Dr. Heaphy has provided authorization. The Progress Reports will capture Dr. Heaphy's progress as demonstrated during Formative Evaluations conducted during that reporting period.

SUMMATIVE EVALUATION

Post-Education Evaluation

Following the completion of the Plan activities, Dr. Heaphy will participate in a Post-Education Evaluation (Evaluation) to demonstrate that he achieved the Learning Goals and successfully completed the Educational Intervention. The Evaluation will be focused on the areas identified as Learning Goals in the Plan and will consider Dr. Heaphy's scope of practice. (See Section 5.1(e) of the CPEP *Educational Intervention Participation Agreement* for more information.)

- Dr. Heaphy will schedule the Evaluation no sooner than two months, and no later than four months, following notification from CPEP that he has completed the Plan activities.

VI. ESTIMATED DURATION

Plan Learning Goals and Performance Objectives

Most participants complete an Education Plan in approximately 12-18 months. The actual duration varies depending on many factors including the scope of educational needs identified.

CONDITIONS

- Modifying an approach to overall patient care, specifically application of knowledge, clinical judgment and documentation may be challenging. Additionally, certain aspects of the Plan cannot be predicted, such as spectrum of patients and cases presented, as well as the participant's dedication to the educational activities. Therefore, the duration of the Plan can only be estimated.
- CPEP reserves the right to change the content and/or duration of the Education Plan.
- CPEP is not responsible for ensuring that the participant obtains any required privileges or credentials while participating in the Education Plan; this is the responsibility of the participant.

- Once the participant has completed the Education Plan and/or has been authorized to complete the Post-Education Evaluation, CPEP is no longer reviewing charts or providing educational services to the participant.
- If Dr. Heaphy does not engage in this Plan by January 1, 2015, CPEP may require completion of additional Assessment activities to ensure that Dr. Heaphy's current educational needs are addressed.

SIGNATURES

James H. Heaphy, M.D.

Date

Abigail C. Anderson, M.D.
Associate Medical Director

Date

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Preceptor candidates.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1386

MAY 16 2012

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH
OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO.
26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, and James H. Heaphy, M.D. ("the licensee"), and, based upon their mutual desire to fully and finally resolve this pending matter 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, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a

complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.

5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.
6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management	March 12-16, 2004	May, 1998	None: Due to no	None: Due to no

Seminar II Note: This is an attendance sheet not a certificate			attendance sheet submitted.	attendance sheet submitted.
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him.

Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on

February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.

12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07,

03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and

would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care.

Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical

sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of

Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.

15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-

amputation of his residual limb. The patient believed that the six week delay resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he

gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked

to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was seeing a podiatrist, Dr. Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg

Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.
20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010 and the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
21. In July 2010, the Panel deferred consideration of Dr. Heaphy's request for reinstatement of his license until Dr. Heaphy completed the CPEP ProBe Program and the completion of an audit of his CMEs.
22. In September 2010, Dr. Heaphy attended CPEP's Patient Care Documentation Seminar and an audit of his CME credits showed that he had successfully completed the required hours.

23. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM-E* (Professional Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.
24. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in an Agreed Order of Probation, which required (in part) that he maintain a controlled substance log, that his practice be subject to periodic reviews by a Board consultant and that he practice within acceptable and prevailing medical practices in the Commonwealth of Kentucky.
25. In February 2012, a Board consultant reviewed a KASPER report of Dr. Heaphy's prescribing from January 1 through October 26, 2011 and sixteen (16) medical charts of Dr. Heaphy's patients and found that

... These patient charts show a consistent recurrent pattern of inexplicably high dose chronic narcotic prescribing nearly universally coupled with equally inexplicably high dose chronic benzodiazepine prescribing. A typical patient of Dr. Heaphy's in the sample charts is prescribed Valium 10mg TID to QID or Xanax 1 to 2 mg TID to QID coupled with Lortab 10mg TID to QID. After greater than six months of regular monthly visits, a few of the patients are prescribed common non-addictive anxiolytics, such as Celexa, but no significant or sustained effort is made to wean these patients off of their potentially addictive anxiolytics in the subsequent visits. The high dose chronic narcotics prescribed follow a similarly disturbing pattern. The overwhelming majority of patients in these 16 charts of Dr. Heaphy are receiving high dose narcotics such as Lortab 10 mg TID to QID for chronic back pain. Some of them have little evidence of significant disease on their MRIs that would suggest a need for high dose chronic narcotics due to their claimed chronic back/neck pain. Again, virtually no effort is made by Dr. Heaphy in weaning these addictive pain medications. ...

Although it is difficult to point to any one patient and prove a trend ... In aggregate these 16 charts of Dr. Heaphy's patients paint a clear picture of reckless medically irresponsible prescribing of controlled substances, both in dose, frequency, and chronicity practiced by Dr. Heaphy. This overprescribing clearly deviates from standards of acceptable and prevailing medical practice. Further, Dr. Heaphy's inappropriate prescribing places his patient's health and wellbeing at grave risk.

In summary, after careful review of the provided material, I believe Dr. Heaphy's pattern of narcotic and benzodiazepine prescribing deviates grossly from acceptable standard of care and poses a serious threat to the health of his patients and his community.

26. In response to the Board consultant review, Dr. Heaphy explained that he had not assumed the medical management of the 16 patients, whose charts were reviewed, until June 1, 2011 and that, even then, he treated all of the patients (except for one) for pain only and did not serve as their primary care physician. Therefore, because Dr. Heaphy treated the patients only for pain, he did not believe that any criticisms of the primary care were validly directed toward him. In addition, because he did not assume care of these patients until June 1, he did not believe that any criticism of the prescribing protocols established by the previous pain physician should be attributable to the care he provided.

27. In addition, Dr. Heaphy obtained an independent consultant review of his practice. Dr. Heaphy's consultant reviewed three patient charts, which the Board consultant opined were representative of all charts reviewed, and found that

... The three patient charts I reviewed indicated stable clinical courses. There were not any significant advancement in the medications over time, nor were there any deleterious outcomes as a result of their treatment. ...

My review of Dr. Heaphy's three charts indicates that he documented the majority of the necessary elements contained in Kentucky's current guidelines. Dr. Heaphy's documentation

indicates that he prescribed controlled substance for pain in a legitimate manner and in doses that did not exceed acceptable norms. Dr. Heaphy addressed the risk of abuse and diversion; he documented urine drug screens, psychological/addiction assessments and appropriate treatment agreements. Consultations with specialists were documented. The patients were seen often enough to monitor their progress and assess for deterioration in function. There were ample patient-physician treatment agreements that inferred adequate informed consent with appropriate behavioral boundaries. The prescriptions were copied, available for review, and prescribed lawfully. Sufficient information was documented to justify the prescription medication furnished to the patients. Over the course of treatment, it is apparent that these patients were monitored for signs of addiction/diversion. ...

In my opinion, based upon the available documentation, Dr. Heaphy's prescription of controlled substances did not depart from the boundaries of acceptable practice and was consistent with the current Kentucky guidelines. Dr. Heaphy's practice did not violate an acceptable standard of care. Furthermore, Dr. Heaphy's documented would not be classified as gross incompetence, negligence or malpractice. Dr. Heaphy's care did not constitute a danger to the health and safety of his patients or the general public. Overall, the records adequately justified the care being rendered by Dr. Heaphy.

28. On April 19, 2012, the Board's Inquiry Panel B considered whether the licensee was non-compliant with the Agreed Order of Probation. In light of the consultant reviews of Dr. Heaphy's practices, the Panel determined that there was probable cause to believe that the licensee's prescribing of controlled substances constitutes a danger to the health, welfare and safety of his patients or the general public. In lieu of emergency action, the parties agreed to enter into 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 medical license is subject to regulation and discipline by the Board.
2. While the licensee denies any wrongdoing or violation, he acknowledges and agrees that, based upon the Stipulations of Fact, the Hearing Panel could find that he engaged in conduct which violates the provisions of KRS 311.595(9) - as illustrated by KRS 311.597(3) and (4) -- and KRS 311.595(13). 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 James H. Heaphy, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Agreed Order;
2. During the effective period of this Agreed Order, 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 licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel or the Panel Chair;
- b. Within twenty (20) days of the filing of this Agreed Order, the licensee shall contact CPEP, 7351 Lowry Boulevard, Suite 100, Denver Colorado 80230 (303) 577-3232 Fax: (303) 577-3241, to schedule a clinical skills assessment, in the specialty of pain management, for the earliest dates available to both CPEP and the licensee;
- c. Both parties may provide relevant information to CPEP for consideration as part of the clinical skills assessment. In order to permit the Board to provide such relevant information, the licensee shall immediately notify the Board's Legal Department of the assessment dates once the assessment is scheduled;
- d. The licensee shall travel to CPEP and complete the assessment as scheduled, at his expense;
- e. Both parties will be provided a copy of the draft Assessment Report for their review. The licensee shall complete any necessary waiver/release so that the Board may receive a copy of the draft Assessment Report for review. However, CPEP will issue its final Assessment Report, in accordance with its internal policies;
- f. If the Assessment Report recommends development of an Educational Plan, the licensee shall take all necessary steps to arrange for CPEP to immediately develop such a plan, at the licensee's expense, so that the

proposed Educational Plan may be presented to the Panel for review along with the Assessment Report;

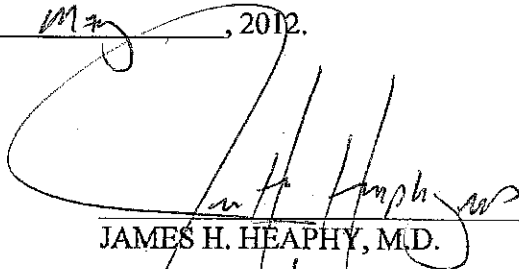
- g. Within sixty (60) days of the filing of this Agreed Order, the licensee SHALL reimburse to the Board the costs of the investigation in the amount of \$1,500.00; and
 - h. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
- 3. The Panel will not consider a petition to restore the licensee's prescribing privileges unless it is accompanied by a copy of the CPEP Assessment Report, a copy of the Educational Plan (if one is recommended by CPEP) and proof of payment of the Board's investigative costs.
- 4. The licensee expressly acknowledges and agrees that if the Panel should, in the future, allow the licensee to resume the professional utilization of controlled substances, it will do so by an Amended Agreed Order of Indefinite Restriction, which shall include any terms and conditions deemed appropriate by the Panel at that time. Such terms and conditions may include that the licensee be required to complete the CPEP Educational Plan, that the licensee obtain practice location approval from the Panel, that the licensee maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and provide for periodic review of the log and relevant records by Board agents upon request.
- 5. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order, the licensee's practice will constitute an immediate danger to

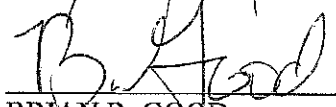
the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction 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 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.

6. The licensee understands and agrees that any violation of the terms of this Agreed Order 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 4/12 day of May, 2012.

FOR THE LICENSEE:

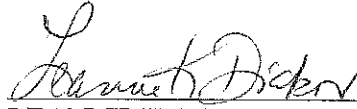

JAMES H. HEAPHY, M.D.


BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:



RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B



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FEB 22 2011

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1170

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO. 26270, 1625 FERGUSON, LEXINGTON, KENTUCKY 40511

AGREED ORDER OF PROBATION

Come now the Kentucky Board of Medical Licensure (hereinafter "the Board"), acting by and through its Hearing Panel B, and James H. Heaphy, M.D. (hereinafter "the licensee"), and, based upon the Panel's decision to grant the licensee's request for reinstatement of his medical license, hereby ENTER INTO the following **AGREED ORDER OF PROBATION**:

STIPULATIONS OF FACT

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

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a

complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.

5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.
6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management	March 12-16, 2004	May, 1998	None: Due to no	None: Due to no

Seminar II Note: This is an attendance sheet not a certificate			attendance sheet submitted.	attendance sheet submitted.
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him.

Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.

9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:

- Long-term use of one or more controlled substances;
- Combinations of controlled substances favored by persons who abuse or divert controlled substances;
- Patients using multiple pharmacies
- Long-term use of a controlled substance for which short-term use is generally indicated; and
- Improper refills of controlled substances based on days supply

10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on

February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.

12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07,

03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and

would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care.

Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical

sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of

Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.

15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-

amputation of his residual limb. The patient believed that the six week delay resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he

gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient. The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked

to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was seeing a podiatrist, Dr Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg

Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. On April 16, 2009, Dr. Heaphy entered into an Agreed Order of Surrender. He had not practiced medicine since issuance of the Emergency Order of Suspension in the summer of 2008.
20. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Family Practice Review Course at University of Kentucky on May 9-14, 2010.
21. In contemplation of seeking reinstatement of his medical license, Dr. Heaphy completed the Prescribing Controlled Substances Course at the University of South Florida on June 2-4, 2010.
22. On or about June 18, 2010, Dr. Heaphy requested reinstatement of his license. The Panel first considered Dr. Heaphy's request in July 2010 and chose to defer action pending Dr. Heaphy's completion of the CPEP ProBe Program and an audit of his CMEs.

23. Dr. Heaphy paid the investigative costs of \$1568.75 on July 2, 2010.
24. On September 30, 2010, an audit of Dr. Heaphy's CME credits showed that he had successfully completed the required hours.
25. Dr. Heaphy attended CPEP's Patient Care Documentation Seminar on September 24, 2010.
26. Dr. Heaphy attended and successfully completed CPEP's ProBe Program on November 19-21, 2010. In addition, on his own volition, Dr. Heaphy enrolled in and completed another professional ethics course, *PRIM~E* (Professional Renewal in Medicine [through] Ethics) on October 1-3, 2010 in Bridgewater, New Jersey.
27. On January 20, the Panel chose to reinstate Dr. Heaphy's medical license pursuant to the terms and conditions set forth in this Agreed Order of Probation.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical license is subject to regulation and discipline by the Board.
2. While the licensee denies engaging in any unprofessional or illegal conduct generally, and specifically denies the conduct alleged by the patients, he agrees that, based upon the fact issues raised by these individuals, sufficient grounds exist to impose sanctions against his Kentucky medical license pursuant to KRS 311.595(1), (10), and (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 Probation.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending Complaint without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Probation.

AGREED ORDER OF PROBATION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's decision to grant the licensee's request for reinstatement of his medical license, the parties hereby ENTER INTO the following AGREED ORDER OF PROBATION:

1. The license to practice medicine held by James H. Heaphy, M.D., is hereby PLACED ON PROBATION FOR A PERIOD OF THREE (3) YEARS, with that period of probation to become effective immediately upon the filing of this Agreed Order of Probation.
2. During the effective period of this Agreed Order of Probation, the licensee's medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:
 - a. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect

“call-in” and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;

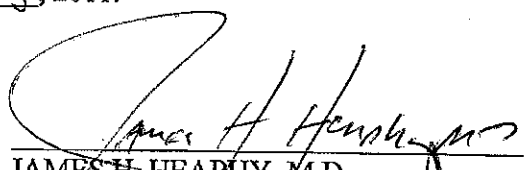
- b. The licensee SHALL permit the Board’s agents to inspect, copy and/or obtain the controlled substance log and other relevant records, including patient charts, upon request, for review by the Board’s agents and/or consultants;
 - c. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order of Probation. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant’s identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board’s written notice. The licensee’s failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order of Probation;
 - d. The licensee understands and agrees that at least one consultant review must be performed, on terms determined by the Panel or its staff, and three (3) years must pass before the Panel will consider a request to terminate this Agreed Order of Probation; and
 - e. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.
3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Probation, the licensee’s practice will constitute an

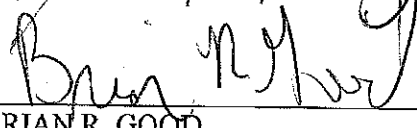
immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Probation, the Panel Chair is authorized by law to enter an Emergency 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 Probation 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 Probation.

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

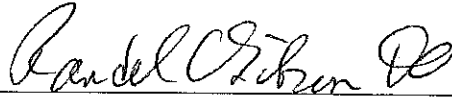
SO AGREED on this 2nd day of January, 2011.

FOR THE LICENSEE:

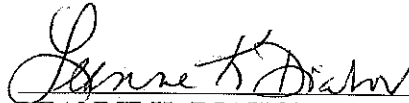

JAMES H. HEAPHY, M.D.


BRIAN R. GOOD
L. CHAD ELDER
COUNSEL FOR THE LICENSEE

FOR THE BOARD:



RANDEL C. GIBSON, D.O.
CHAIR, HEARING PANEL B



LEANNE K. DIAKOV
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APR 16 2009

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1170

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO. 26270,
2375 PROFESSIONAL HEIGHTS DRIVE, SUITE 210, LEXINGTON,
KENTUCKY 40503

AGREED ORDER OF SURRENDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"),
acting by and through its Hearing Panel B, and James H. Heaphy, M.D., ("the licensee"),
and, based upon their mutual desire to fully and finally resolve this pending Complaint
without an evidentiary hearing, hereby ENTER INTO the following **AGREED ORDER
OF SURRENDER:**

STIPULATIONS OF FACT

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

1. At all relevant times, James H. Heaphy, M.D., was licensed by the Board to
practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is internal medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph.,
Office of Drug Control, Cabinet for Health and Family Services, alleging that the
licensee continued to prescribe controlled substances to a patient even after
becoming aware that the patient was obtaining prescriptions from other sources.
After investigating the grievance, Inquiry Panel A issued a Letter of
Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that

the grievance disclosed misconduct but it did not warrant the issuance of a complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.

5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.
6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Exhibit #3 Quick reference for certificates

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management	March 12-16, 2004	May, 1998	None: Due to no	None: Due to no

Seminar II Note: This is an attendance sheet not a certificate			attendance sheet submitted.	attendance sheet submitted.
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those

seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances:
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be

altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.
12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in

the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications

and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these

patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent

drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

14. On May 15, 2008, the Inquiry Panel reviewed the licensee's case and voted to ask the licensee to enter into an Agreed Order of Surrender in lieu of revocation, and, if the licensee should refuse, to issue a Complaint and an Emergency Order of Suspension. The licensee chose not to enter into the proposed Agreed Order of Surrender, and on June 9, 2008, a Complaint and an Emergency Order of Suspension were issued against his license.
15. On July 9, 2008, the Board received two grievances filed against the licensee by a husband and wife who had been the licensee's patients. The patients filed their grievances because of their dissatisfaction with the treatment and care provided by the licensee. The patients were interviewed by the Board investigator. They had been the licensee's patients for several years, with the husband being treated

by the licensee for diabetes, a heart condition, and MRSA (a recurring infection resulting from the diabetes). The husband stated that it was virtually impossible to contact the licensee at his office. No one would answer the office telephone, and a message machine would announce that the person who the caller was trying to reach cannot take messages. He indicated that the licensee had never taken a complete history, conducted a full examination, followed up, or made any referrals. On February 28, 2008, the patient had made several attempts to schedule an appointment with the licensee due to a small wound on his leg. The appointment was scheduled for March 5, 2008. The patient believed that the licensee considered the wound to be minor. The licensee prescribed an oral antibiotic for the patient. However, the wound did not heal and the patient sought a second opinion. A culture was ordered, but the patient believed that it was delayed about a week due to the antibiotic treatment provided by the licensee. The culture results indicated that the MRSA was active and he was referred to an infection disease specialist and orthopedic surgeon. At that point, the infection had spread and invaded the leg bone, and the patient had a revision or re-amputation of his residual limb. The patient believed that the six week delay resulting from the licensee's inaccurate diagnosis was the underlying cause of his amputation.

16. Dr. Heaphy, through counsel, responded to the grievance as follows:

Patient has a long history of insulin dependent diabetes, CAD, and peripheral vascular disease, with a remote history of MRSA in his right lower extremity, which led ultimately to the removal of his right lower limb. He was seen in Dr. Heaphy's office episodically during 2006 and 2007 only when he was in town visiting his girlfriend.

The patient was initially seen in Dr. Heaphy's office for severe cellulites in his right lower extremity on 1/23/06. Dr. Heaphy treated the cellulites, which was advanced, with PO Levaquin 750 mg daily, and Rocephin 1 gm IM, just before he returned to his out of state home. As he was leaving for home, Dr. Heaphy discussed the necessity for follow-up with his regular physician while he was in the office for this visit.

When he was seen in Dr. Heaphy's office on 1-24-07, the patient stated that he would be moving some time in the future to Lexington, and asked Dr. Heaphy to be his physician. Dr. Heaphy asked him to request his medical records from his previous physician, and to schedule an appointment for a physical and routine blood work.

The patient returned to Dr. Heaphy's office on May 2, 2007. He presented with a small oozing stump ulceration, which he admitted had been occurring for at least a month. Patient reported he was being seen by his prosthetic specialist who had ordered him off weight bearing and use of his prosthesis. The patient showed Dr. Heaphy a small ulcer on his stump that was not healing but was draining a small amount of serosanguinous fluid. The amputated leg had no swelling or erythema but Dr. Heaphy still treated him with levaquin and IM rocephin. The patient followed up closely for the next month and the wound healed nicely.

The patient then was seen on 3-05-08 for right wrist and elbow pain, secondary to overuse syndrome from using crutches. Dr. Heaphy treated him with NSAID's. At that time patient made no initial complaint of his leg ulcer, but when Dr. Heaphy questioned him about his lower leg and why he was on crutches, he then told Dr. Heaphy about problems he had been having with a new ulcer for the last month. The ulcer was small, < 1cm, but on his stump and scabbed over. There was a small amount of serosanguinous fluid but no swelling or erythema. Dr. Heaphy asked him why he had not followed up earlier with all his past complications but he gave no comprehensible answer. Dr. Heaphy told the patient that he would presumptively start him on antibiotic therapy since the wound was closed and without erythema and tried to impress upon him the fact that it was important to return immediately if his ulcer worsened in any way before his scheduled follow-up appointment. The patient was again given a 7-day course of Levoquin 750 mg PO. At the time of this appointment he was again asked to also schedule an additional appointment for a physical exam and blood work. However, the patient left the office without scheduling either his follow-up or physical appointment as he had agreed verbally to do.

The patient called on 3/18/2008 to finally schedule his follow-up appointment and was told to come into the office ASAP, and that Dr. Heaphy could see him that day as a walk-in. However, the patient did not come into the office that day or call to reschedule an appointment.

On March 25, the patient's wife (who filed the other grievance resulting in the instant investigation) left a message requesting an appointment for the patient.

The appointment was made for 10:30 am on the following day. The patient did not show up for that appointment.

Instead, the patient then presented at the office during the lunch hour on 3-26-08 (the same day as his scheduled appointment) demanding to be seen as he had an emergency. He was then seen in the office with an ulceration of his stump that was less than 1 cm in diameter. There was mild warmth, but no discernible erythema, and draining a small amount of clear serosanguinous fluid. Patient stated that the ulcer had improved while he was on the antibiotics, but worsened again after he had been off the antibiotics. On examination the wound still looked superficial but slightly deeper than on 3/05/2008 as the scab had been removed. There was no evidence of any deeper tracks. Because the patient had a good response to the Levoquin and Rocephin in his previous cellulites episodes, and had no recent reoccurrence of MRSA, he was again started on 750 mg Levoquin once daily for 10 days, and Rocephin 1 gm IM. The patient was told to return in 7 days for follow up, or sooner if his symptoms worsened. He was scheduled for a follow up appointment in 7 days. Dr. Heaphy did not culture the wound that day as surface cultures are often not very diagnostic because of the polyflora contamination in diabetic ulcers. If the ulcer worsened by follow-up, Dr. Heaphy planned to consult a specialist to perform a deep tissue biopsy for culture as well as a bone scan. Dr. Heaphy also knew that MRSA, by its very nature, would be able to be cultured even after he was on antibiotics. Dr. Heaphy again asked the patient why he failed to follow-up much sooner, and he just shrugged his shoulders and did not answer. Dr. Heaphy was shocked that despite his previous complication with MRSA and a secondary amputation that the patient would wait so long to be seen. The patient was also asked to schedule an appointment for a regular physical exam and routine blood work screening as this was long overdue. The patient stated that he was seeing a podiatrist, Dr Morrill, and already had a follow up appointment with his podiatrist. The patient was asked if he had seen his orthopedic doctor, Dr. DeGnore, and he answered no. He was asked to make a follow-up appointment with her since she had followed his BKA.

The patient did not show up to his follow up appointment on April 4, 2008. Around that same time Dr. Greenwell's office called asking for medical records for the patient, stating that he was transferring to Dr. Greenwell's office. Dr. Heaphy assumed the patient's follow up was with Dr. Greenwell. However, the patient never signed a release for his medical records to be transferred. This was consistent with his behavior in Dr. Heaphy's office, as Dr. Heaphy had never received any records from the patient's original physician.

The patient was seen for acute care episodes, and had never scheduled his appointment for the physical exam as requested during previous visits. He also never provided copies of his medical records from his previous doctor as requested.

In summary, the patient was a non-compliant patient who refused to either make or keep appointments for routine preventative medical care, and sought the

services of Dr. Heaphy only when he had episodic emergencies, and then would not make or keep follow up appointments.

17. The wife also filed a grievance concerning the treatment provided to her by the licensee. Like her husband, she asserted that the licensee had never taken her complete history, conducted a full examination, followed up, or made referrals. She also indicated that contacting the licensee was virtually impossible. She stated that the licensee did not have a professional answering service, but only an answering machine which did not permit any messages to be left. She believed that the licensee "has no compassion for the welfare of his patients."

18. Dr. Heaphy, through counsel, responded to the grievance as follows:

The patient had only 2 office visits to Dr. Heaphy's practice. The first visit was on 12/01/2005 as a new patient for acute elevated bp. The elevated bp was 150/90 mm Hg and patient stated that it had been fluctuating for several months as she had quit taking her blood pressure medication. The elevated blood pressure was addressed with 75/50 mg Maxide once daily. Old records from her previous physician showed last lab work was on 3-31-04. There was no evidence of lab work or follow-up with any physician from that date in 2004 until her 12/1/05 office visit with Dr. Heaphy. It is of note that there is a letter from her previous physician, Dr. E. Bak, stating that she was overdue for her mammogram. There is no evidence that the study was ever done. Patient did return to Dr. Heaphy's office on 1/05/2006 to recheck her blood pressure. Routine Blood work was ordered on that date. The patient was asked to schedule another appointment for a complete physical, at which time a mammogram and a Bone Density scan would be ordered. However, the patient became irate at Dr. Heaphy's staff because her phone call message requesting an appointment was not returned immediately. The patient never returned to Dr. Heaphy's office as a patient.

Moreover, the licensee noted that the Board did not engage a medical expert to evaluate the allegations relating to his medical treatment of the patients who filed the grievance. Accordingly, the licensee asserts that the grievances reflect the subjective opinions of the grievant's, rather than the opinion of a medical expert.

19. Since the issuance of the Emergency Order of Suspension, the licensee has not engaged in the practice of medicine.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's medical license is subject to regulation and discipline by the Board.
2. While the licensee denies engaging in any unprofessional or illegal conduct generally, and specifically denies the conduct alleged by the patients, he agrees that, based upon the fact issues raised by these individuals, sufficient grounds exist to impose sanctions against his Kentucky medical license pursuant to KRS 311.595(1), (10), and (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 Surrender.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending Complaint without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Surrender.

AGREED ORDER OF SURRENDER

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 Complaint without an evidentiary hearing, the parties hereby ENTER INTO the following

AGREED ORDER OF SURRENDER:

1. The licensee shall SURRENDER his Kentucky medical license, in lieu of revocation, with that surrender to become effective immediately upon the filing of this Agreed Order of Surrender, and continuing until further Order of the Panel.

2. Following the effective date of the surrender of his license, the licensee may not engage in any act which would constitute the “practice of medicine” as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – until approved to do so by the Panel.
3. The licensee SHALL pay the costs of the investigation in the amount of \$1568.75 within twelve (12) months from entry of this Agreed Order of Indefinite Restriction.
4. The Panel will not consider a request by the licensee for approval to resume the active practice of medicine for a minimum period of two years from the date of the Emergency Order of Suspension filed on June 9, 2008. The provisions of KRS 311.607 shall apply to any request for reinstatement filed by the licensee. The burden shall be upon the licensee to satisfy the Panel that he is presently of good moral character and is qualified both physically and mentally to resume the practice of medicine, without undue risk or danger to his patients or the public.
5. The licensee understands and agrees that the Panel may require the licensee to undergo evaluations and/or assessments, at the licensee’s expense, to assist the Panel in considering any petition for reinstatement.
6. If the Panel should grant the petition for reinstatement, its shall do so by issuing an Order of Probation or Order of Indefinite Restriction, for a period of time to be determined by the Panel with terms and conditions fixed by the Panel, based upon the information available to the Panel at that time. As a condition of granting the

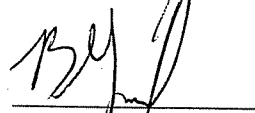
petition for reinstatement, the Panel may require the licensee to enter into an Agreed Order of Probation or Indefinite Restriction, with appropriate terms and conditions.

7. The licensee expressly agrees that if he should violate any term or condition of the Agreed Order of Surrender, 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 Surrender, 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 Order 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 Surrender.
8. The licensee understands and agrees that any violation of the terms of this Agreed Order of Surrender 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 for practicing medicine without a license.

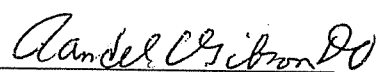
SO AGREED on this 17th day of Feb, 2009.

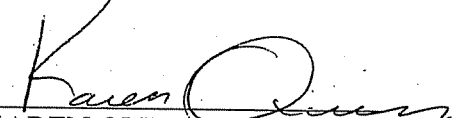
FOR THE LICENSEE:


JAMES H. HEAPHY, M.D.


BRIAN R. GOOD
L. CHAD ELDER
COUNSEL FOR DR. HEAPHY

FOR THE BOARD:


RANDEL C. GIBSON, D.O.
CHAIR, HEARING PANEL B

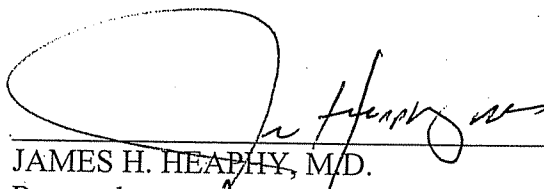

KAREN QUINN
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

WAIVER OF RIGHTS

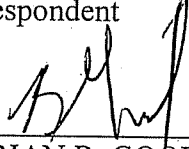
I, James H. Heaphy, M.D., am presently the Respondent in Kentucky Board of Medical Licensure Case No. 1170. I understand that, under 201 KAR 9:082, I must waive certain rights if I wish to resolve this matter by informal dispensation. Accordingly, I WAIVE my right to raise any constitutional, statutory or common law objection(s) I may have to the Hearing Panel rejecting the proposed informal dispensation or to the curtailment of such a settlement by the Board's General Counsel or Assistant General Counsel.

Furthermore, if the Hearing Panel accepts the proposed Agreed Order of Surrender as submitted, I WAIVE my right to demand an evidentiary hearing or to raise additional constitutional or statutory objections in this matter. However, if the Hearing Panel should reject the proposed Agreed Order of Surrender, I understand that further proceedings will be conducted in accordance with KRS 311.530 et seq., and I will have the right to raise any objections normally available in such proceedings.

Executed this 17th day of Feb, 2009.



JAMES H. HEAPHY, M.D.
Respondent



BRIAN R. GOOD
L. CHAD ELDER
COUNSEL FOR THE RESPONDENT

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1170

FILED OF RECORD

JUN 10 2008

K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO. 26270,
2375 PROFESSIONAL HEIGHTS DRIVE, SUITE 210, LEXINGTON,
KENTUCKY 40503

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, considered this matter at its May 15, 2008 meeting. At that meeting, Inquiry Panel A considered Memoranda prepared by Eric Tout, Medical Investigator; a grievance from Paula York, R.Ph, Cabinet For Health & Family Service, dated November 8, 2007; a Board Consultant report dated April 22, 2008; a copy of licensee's Letter of Admonishment dated August 31, 2007; a memorandum prepared by Michael Rodman, Assistant Executive Director dated May 14, 2008; in a grievance dated September 25, 2007 regarding CME audit; Seven CME Certificates/Attendance Sheets; a quick reference chart for certificates; correspondence from seven programs regarding altered CME attendance dates; the licensee's Medical/Osteopathic 2006 and 2003 renewal Applications; and the licensee's response with online CME credits information attached.

Having considered all of this information and being sufficiently advised, Inquiry Panel A ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Suspension:

1. At all relevant times, JAMES H. HEAPHY, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph., Office of Drug Control, Cabinet for Health and Family Services, alleging that the licensee continued to prescribe controlled substances to a patient even after becoming aware that the patient was obtaining prescriptions from other sources. After investigating the grievance, Inquiry Panel A issued a Letter of Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that the grievance disclosed misconduct but it did not warrant the issuance of a complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" at Vanderbilt University Medical Center or the University of South Florida.
4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education ("CME") course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was

issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee's CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.

5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.
6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled

American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management Seminar II Note: This is an attendance sheet not a certificate	March 12-16, 2004	May, 1998	None: Due to no attend- ance sheet submit- ted.	None: Due to no attend- ance sheet submitted.
Physician in Management Seminar I Note: This is an attendance sheet not a certificate	April 27- May 1, 2003	April, 1998	None: Due to no attend- ance sheet submit- ted.	None: Due to no attend- ance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28; 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.
8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:

- Long-term use of one or more controlled substances;
- Combinations of controlled substances favored by persons who abuse or divert controlled substances;
- Patients using multiple pharmacies
- Long-term use of a controlled substance for which short-term use is generally indicated; and
- Improper refills of controlled substances based on days supply

10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated

05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.

12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be

deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions “filled” or “refilled” does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician’s responsibility to completely identify and address his patient’s health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaphy did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include “narcotic” or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient’s pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy’s use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations.

For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

The consultant's report is attached herein as Exhibit 1 and incorporated in its entirety.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel A finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(1), (10), and (9) as illustrated by KRS 311.597(1)(d), (3), and (4).
4. The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
5. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general.

Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.

6. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

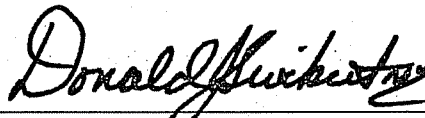
EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by JAMES H. HEAPHY, M.D., is SUSPENDED and Dr. HEAPHY is prohibited from performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means,

methods, devices, or instrumentalities - until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

Inquiry Panel A further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 10th day of June, 2008.



DONALD J. SWIKERT, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed via certified mail return-receipt requested to James H. Heaphy, M.D., 2375 Professional Heights Drive, Suite 210, Lexington, Kentucky 40503 on this 10th day of June, 2008.



KAREN QUINN
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150



April 22, 2008

Mr. Eric Tout
Kentucky Board of Medical Licensure
310 Whittington Parkway
Suite 1B
Louisville, KY 40222

RE: Consultation on James H. Heaphy, M.D.
GRIEVANCE #: 08124

Dear Mr. Tout,

I have reviewed the enclosed materials including grievance received from Mrs. York, investigative notes, individual KASPERs attached to the charts, and twenty patient charts. My conclusions are as follows:

I do not feel that Dr. Heaphy has prescribed or dispensed medications with the intent or knowledge that this medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose. I also do not find any evidence to suggest that this physician prescribed or dispensed medication for the licensee's personal use or for the use of his immediate family when the licensee knew or had reason to know that an abuse of controlled substances was occurring or may result from such practice. However, I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Exhibit 1



TOUT, ERIC

04/22/2008

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Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screening laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatric history. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every reviewed chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse alone, "blood pressure 120" without diastolic determinations, absent height, weight, and respirations).

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Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is this physician's responsibility to completely identify and address his patient's health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

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It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity - for which there was no screening.

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TOUT, ERIC

04/22/2008

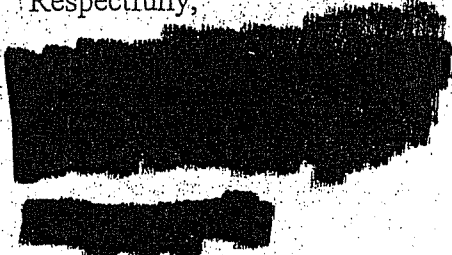
Page 5

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used as a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

I appreciate being able to help you with this review. If you have further questions, please feel free to contact me.

Respectfully,

A large, irregular black redaction mark covering the signature and name of the sender. Below it is a smaller, horizontal black redaction mark.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1170

FILED OF RECORD
JUN 10 2008
K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF
KENTUCKY HELD BY JAMES H. HEAPHY, M.D., LICENSE NO. 26270,
2375 PROFESSIONAL HEIGHTS DRIVE, SUITE 210, LEXINGTON,
KENTUCKY 40503

COMPLAINT

Comes now the Complainant Donald J. Swikert, M.D., Chair of the Kentucky
Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on
May 15, 2008, states for its Complaint against the licensee, JAMES H. HEAPHY, M.D.,
as follows:

1. At all relevant times, JAMES H. HEAPHY, M.D., was licensed by the Kentucky
Board of Medical Licensure (hereafter "the Board") to practice medicine in the
Commonwealth of Kentucky.
2. The licensee's medical specialty is Internal Medicine.
3. On September 20, 2006, the Board received a grievance from Paula York, R.Ph.,
Office of Drug Control, Cabinet for Health and Family Services, alleging that the
licensee continued to prescribe controlled substances to a patient even after
becoming aware that the patient was obtaining prescriptions from other sources.
After investigating the grievance, Inquiry Panel A issued a Letter of
Admonishment to the licensee on August 31, 2007. Inquiry Panel A found that
the grievance disclosed misconduct but it did not warrant the issuance of a
complaint. Inquiry Panel A also voted to strongly suggest that the licensee attend
the prescribing course entitled "Prescribing Controlled Drugs: Critical Issues and

Common Pitfalls” at Vanderbilt University Medical Center or the University of South Florida.

4. On September 25, 2007, Sandy Brooks, Board Office Manager, reported to Board Executive Director Bill Schmidt that it appeared that the licensee had fraudulently altered the attendance and/or completion date of Continuing Medical Education (“CME”) course certificates he had submitted to the Board. Ms. Brooks stated that the licensee was audited for CMEs due to a grievance being filed against him in 2006. The licensee failed to respond to the audit, so on March 13, 2007, the licensee was issued a CME Order of Fine. The Order of Fine granted the licensee a six-month period, until September 13, 2007, to come into compliance with his CME hours and to pay his \$400 fine. On September 13, 2007, Patty Wacker, Board CME Coordinator, received copies of CME certificates for the licensee’s CME hours as well as his \$400 fine. After reviewing the copies of the CME certificates, it became obvious that the HIV course the licensee allegedly had completed on September 16, 2004, had expired in August 1999. The Kentucky Cabinet for Health and Family Services requires providers of courses to print approval numbers on their certificates so Board staff can determine if the certificate is valid. After noticing the course expired in 1999, it became evident that the date the course was taken may have been modified since the course was purportedly taken five years after it expired.
5. Ms. Brooks went on to state that after checking the remaining certificates Dr. Heaphy submitted, the date of course completion also seemed to be modified on several certificates. Two certificates totaling 62 hours were checked for

authenticity. After contacting the American College of Physician Executives (ACPE), it appears the courses that the licensee stated he completed on April 27-May 1, 2003 and March 12-16, 2004 were also modified. Staff at ACPE indicated that the licensee only showed a record of completing the courses in 1998.

6. An investigation was undertaken by the Board concerning the licensee's CME credits. The Board investigator verified that six of the seven certificates presented by the licensee to the Board on September 13, 2007, had had their attendance and/or completion dates altered. The dates on the seventh CME certificate, entitled American Heart Association/ACLS, could not be verified due to a lack of contact information. The summary of the fraudulently altered CME certificates is as follows:

Certificate Title	Altered Date	Date Attended	Hours	Category
Finch University of Health Sciences/ The Chicago Medical School	January 10, 2004	December 19, 2001	One	One
The KY Aids Training & Education Center	September 16, 2004	August, 1999	Two	One
Physician in Management Seminar II Note: This is an attendance sheet not a certificate	March 12-16, 2004	May, 1998	None: Due to no attendance sheet submitted.	None: Due to no attendance sheet submitted.
Physician in Management Seminar I	April 27- May 1, 2003	April, 1998	None: Due to no attend-	None: Due to no attend-

Note: This is an attendance sheet not a certificate			ance sheet submitted.	ance sheet submitted.
Continuing Medical Education Credit/ATLS Student Course	December 6, 2004	March 28, 1996	Eighteen	One
Emergency Medical & Acute Care A Critical Appraisal/ Series 6	February 6-10, 2003	February 6-10, 1993	Twenty	2A AOA Credits
American Heart Association/ ACLS	April 07, 2004	Unknown	Unknown	Unknown

7. Ms. Brooks contacted Debi Marsh, Production Services Director, American College of Physician Executives regarding the two Records of Attendance for CMEs in Management Seminar I and II. Ms. Marsh informed Ms. Brooks that these courses were both offered in 1998. Robin Doty, Vice President and General Counsel, American College of Physician Executives stated that while the licensee was registered for the management seminars in 1998, he never submitted to them a record of attendance claiming CMEs for those programs. Therefore, the American College of Physician Executives did not issue a CME certificate to him. Since no certificate was issued for the management seminars, since those seminars were offered back in 1998, and since they totaled 62 credits, the licensee has not been in compliance with his CME requirements since 1998. However, in his 2003 medical licensure application (January 1, 2000 to December 31, 2002 CME cycle) and in his 2006 medical license application (January 1, 2000 to

December 31, 2002 CME cycle), the licensee answered questions indicating that he had completed his CME requirements.

8. The licensee provided a written response to the Board and admitted fraudulently altering the dates on the CME certificates he had presented to the Board in September, 2007.
9. On November 13, 2007, the Board received another grievance from Paula York, R.Ph. at the Cabinet for Health and Family Services, concerning the licensee. Ms. York stated that "this office has received numerous complaints from pharmacists expressing concern over Dr. James Heaphy's prescribing practices." She indicated that after reviewing the licensee's KASPER records, several concerns became apparent:
 - Long-term use of one or more controlled substances;
 - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
 - Patients using multiple pharmacies
 - Long-term use of a controlled substance for which short-term use is generally indicated; and
 - Improper refills of controlled substances based on days supply
10. On January 22, 2008, the Board investigator visited the licensee's office and took notes concerning the patient files referenced in Ms. York's grievance. After issuing a subpoena for those charts, the Board investigator received them on February 14, 2008. The investigator noted that two patient charts appeared to be altered from when he first examined them. Specifically, the investigator found that Patient A and Patient B's charts were inconsistent with the notes taken prior to receiving the medical files.

11. On January 22, 2008, Patient A's file contained three drug log sheets. The first entry on the first drug log sheet's date was not legible and the last entry date was 12/17/07. The second drug log sheet had two entries dated 02/06/07 and the third sheet had six entries dated 01/05/07. The medical file received February 14, 2008 contained two drug log sheets. The first entry date began at 11/29/06 and ended at 10/24/07. The second drug log sheet entry date began at 10/24/07 and ended at 01/14/08. The following exam sheets contained in the medical file on Patient A were not complete on January 22, 2008: a) there were no notations on the front or back except for the date and name on exam sheet dated 11/02/07; b) no notations on the back of the exam sheets on the following dates: 10/24/07, 10/12/07, 09/24/07, and 09/10/07; and c) there were no notations on the right front side and back of the exam sheet dated 05/07/07. In contrast, Patient A's medical file received on February 14, 2008 regarding the same exam sheets had notations.
12. The investigator noted similar discrepancies regarding Patient B's medical file. In the file viewed on January 22, 2008, the first drug log sheet began with a date of 03/06/07 and ended with the same date 03/06/07. Patient B's medical file received on February 14, 2008, contained two drug logs, one starting 03/06/07 and ending 02/05/08 and the second starting 08/21/06 and ending 03/06/07. When viewed on January 22, 2008, the exam sheets on 06/01/07, 05/17/07, 03/26/07, and 03/06/07 contained in Patient B's medical file had notations only in the chief complaint section. When viewed on January 22, 2008, the 10/01/07, 07/17/07, 06/01/07, 05/17/07, 03/26/07, and 03/06/07 exam sheets had no notations on the back. On January 22, 2008, the exam sheet for 08/10/07 had no

notations on the front or back other than the name and date. Patient B's medical file received on February 14, 2008 regarding the above aforementioned exam sheets had notations.

13. A Board consultant reviewed the licensee's charts and concluded that the licensee not only failed to meet acceptable and prevailing standards of medical care, but that he presented a danger to the health, welfare, and safety of his patients and the general public. He also noted a concern that that records appeared to have been falsified and altered. Specifically, the consultant found as follows:

...I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Relative to the charts reviewed, I find that Dr. Heaphy's evaluation of medical issues was limited and limited solely to pain related issues. There was suggestion that a history of present illness, social history, family history, review of systems, and past medical history were obtained and that a complete physical examination was performed. Because proper diagnostics including screen laboratory (complete blood count, chemistry) and radiologics did not accompany these evaluations, diagnosis was often suspect. Dr. Heaphy would identify a primary concern at the outset and would treat acute illnesses as they developed. However, considering the long-term relationship of these patients with Dr. Heaphy, other issues were not discovered or not addressed.

Diagnoses of hypertension, diabetes, hypercholesterolemia among others require standard screening and follow-up. Safety suffers with chronic use of medications and no screens for toxicity. Treatment was initiated with potentially harmful medications without obtaining old records, developing relationships with patients, and additional investigation such as substance use history or psychiatry. Treatment was initiated without the substantiation of organic and physical disease.

Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse along, "blood pressure 120" without diastolic determinations, absent height, weight and respirations).

The history of present illness at times did not record a physician notation. There were variances from note to note in several charts which identified concerns and conflicts (drug allergies, past history). Apparently some chart notes were only copies and not originals. Chart notes had conflicting dates. Suspicious was the fact that the great majority of office visits included a complete physical exam which was not necessary, laborious, and time consuming. Correlation of KASPER reported prescriptions revealed prescriptions filled prior to the date of office visit rather than the day of or soon following.

Records did not reflect the plan and actions that were taken. Prescriptions "filled" or "refilled" does not adequately identify the actions without noting dose, frequency of dose, and quantity of pills.

Treatment provided to these patients was inadequate, inappropriate, and/or dangerous. As the identified primary care physician, it is the physician's responsibility to completely identify and address his patient's health care. Health maintenance issues were rarely if ever addressed including gynecologic evaluations, screening mammograms, bone density, colon cancer screens, prostate cancer screens, smoking cessation, stroke, and heart disease prevention (including aspirin therapy, diet, exercise, vaccinations). General screens for cardiac risk, and medication toxicity did not occur and therefore were not identified or treated.

All of these charts identified patients treated for chronic pain issues. Dr. Heaply did not follow standards for proper evaluation, monitoring, and treatment of these patients. Chronic pain treatment, especially with chronic opioid therapy, mandates standard office policies understood and followed by the physician, his staff, and patients. This would include "narcotic" or medication agreements, pharmacy agreements, screening for addiction (including an expanded history for substance use/abuse) and monitoring for substance abuse and addiction. Routine drug screens, KASPER reports, pill counts are to be obtained. Attention to clues

for improper medication use such as lost or stolen medications, overuse, and running out of medications are to be discussed.

Treatment with opioids needs to be preceded by a clear understanding of the disease state, especially when dealing with noncancer pain. Alternative methods are to be used before or at least in coordination with opioids. Among these are lifestyle changes, physical methods of treatment (i.e., physical therapy), CAM (acupuncture, yoga, etc.), interventional pain management, surgical options, non opioid medications. Although some patients seemed to access these, it was rare and inconsistent.

It was obvious there were strong emotional components to the patient's pain as many were treated with psychotropics. Treatment of these emotional issues was mandatory again before or at least concomitantly with the use of chronic opioids and needed to include psychiatry and counseling services. These were rarely employed. Antidepressants were intermittently prescribed but difficult to follow with incomplete records. The use of benzodiazepines was overwhelming, seemingly excessive in number, but definitely excessive in length of treatment. Benzodiazepines generally are indicated for short-term use. Long-term use needs to be evaluated and coordinated with psychiatric consultation. Combination with other sedative hypnotics and opiates is extremely dangerous.

Dr. Heaphy's use of opiates is also problematic. There was occasional use of extended release opiates, but also together with immediate relief formulations. For better and safer treatment, proper dosing requires escalation of extended release doses with minimization of immediate release dosing. This did not occur. In many instances, only immediate release formulations were used. At times, there was use of different immediate release formulations at the same time, making no practical sense, not standard treatment, and dangerous. Higher doses of these immediate release formulations exposed patients to excessive acetaminophen and potential toxicity – for which there was no screening.

Polypharmacy issues were also a problem. Many patients were treated with multiple mood altering substances, also used alcohol, and cautions were not given. Prescribing followed patterns of refills of controlled substances without office visits, refills by telephone, refills prior to intended date and therefore use greater than intended. KASPER reports, not followed by Dr. Heaphy, showed these patterns as well as use by patients of multiple pharmacies. With this, as well as lack of screening for addiction, failure to obtain addiction consult, absent drug screens, signature events such as lost medications, it is suggested that patients abused prescriptions creating personal as well as community risks.

A final polypharmacy issue is directed at the combination of medications used. Although prescriptions were not used as intended, nor were patients screened adequately, I cannot say that the numbers of pills prescribed consistently exceeded standard safety over the course of KASPER reporting. However, the

use of multiple opiates (immediate release and extended release), multiple sedative hypnotics (benzodiazepines and carisoprodol), is outside standard acceptable policy and highly dangerous. Dr. Heathy would use two or more immediate release opiate prescriptions along with an extended release opiate, a benzodiazepine (for anxiety), occasionally a benzodiazepine for insomnia, and carisoprodol. Carisoprodol holds little therapeutic benefit but is used a muscle relaxant. There is no scientific basis for efficacy and, as well, with all muscle relaxants, is to be used for only short periods and in an acute or subacute situation, not chronically. It is well known as an abused drug in the addiction population.

In summary, I feel that Dr. Heathy's practice does not meet standards for evaluation, diagnosis, treatment, or maintenance of health care. Prescribing practices particularly with opiates and benzodiazepines are below acceptable standards, likely harmful to his patients, and the community at large. Polypharmacy is evidenced regularly.

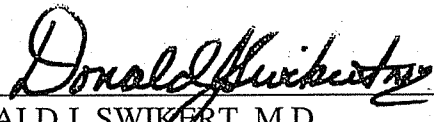
The consultant's report is attached herein as Exhibit 1 and incorporated in its entirety.

14. By his conduct, the licensee has violated KRS 311.595(1), (10), and (9) as illustrated by KRS 311.597(1)(d), (3), and (4). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.
15. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:
 - (a) His failure to respond may be taken as an admission of the charges;
 - (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.
16. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for November 12, 13 & 14, 2008 at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical

Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

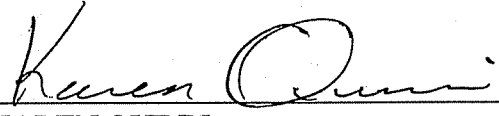
WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by JAMES H. HEAPHY, M.D.

This 10th day of June, 2008.


DONALD J. SWIKERT, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed via certified mail return-receipt requested to James H. Heaphy, M.D., 2375 Professional Heights Drive, Suite 210, Lexington, Kentucky 40503 on this 10th day of June, 2008.


KAREN QUINN
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
502/429-7150



April 22, 2008

Mr. Eric Tout
Kentucky Board of Medical Licensure
310 Whittington Parkway
Suite 1B
Louisville, KY 40222

RE: Consultation on James H. Heaphy, M.D.
GRIEVANCE #: 08124

Dear Mr. Tout,

I have reviewed the enclosed materials including grievance received from Mrs. York, investigative notes, individual KASPERs attached to the charts, and twenty patient charts. My conclusions are as follows:

I do not feel that Dr. Heaphy has prescribed or dispensed medications with the intent or knowledge that this medication would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose. I also do not find any evidence to suggest that this physician prescribed or dispensed medication for the licensee's personal use or for the use of his immediate family when the licensee knew or had reason to know that an abuse of controlled substances was occurring or may result from such practice. However, I do feel that Dr. Heaphy prescribed or dispensed medications in such amounts that the licensee knew or had reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed were excessive under accepted and prevailing medical practice standards. I do feel that Dr. Heaphy engaged in conduct which departs from or fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky. I feel Dr. Heaphy committed a serious act, or a pattern of acts, during the course of the physician's medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross ignorance, gross negligence, or malpractice. I do feel that this physician's practice constitutes a danger to the health, welfare, and safety of the physician's patients and to the general public.

Exhibit 1



TOUT, ERIC

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Record keeping, as well, did not meet standards. Development of problem lists and active medication lists was absent, and likely led to poor patient care including lack of attention to ancillary problems and polypharmacy. Medication logs were a part of every reviewed chart, but were regularly incomplete and inaccurate. Prescriptions noted in logs at times were not reflected as filled per KASPER report or dates were not matched. Many prescriptions were written and filled per KASPER, but not identified in the logs. Considering the quantities and combinations of medications, this was a highly dangerous practice.

Also of concern was possible falsification and alteration of records. References to "see nurse's notes" and "see old chart" are only acceptable if these records are part of the active chart (which they were not). Vital signs regularly were missing from office notes, and if obtained, were partial recordings (blood pressure and pulse alone, "blood pressure 120" without diastolic determinations, absent height, weight, and respirations).

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I appreciate being able to help you with this review. If you have further questions, please feel free to contact me.

Respectfully,

