FILED OF RECORD

JUN 27 2022

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1349

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PAUL V. BROOKS, M.D., LICENSE NO. 32337, 3677 BOLD BIDDER DRIVE, LEXINGTON, KENTUCKY 40517

AGREED ORDER

Come now the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, and Paul V. Brooks, M.D. ("the licensee"), and, based upon their mutual desire allow the licensee to resume the practice of medicine, 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, Paul V. Brooks, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Physical Medicine and Rehabilitation.
3. The licensee has not practiced medicine for more than ten (10) years.
4. In or around In March 2007, the licensee submitted an online Application for Renewal of Kentucky Medical License to the Kentucky Board of Medical Licensure upon which he falsely answered "No" to Question No. 10, which asked, "Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?" In addition, the licensee falsely answered "No" to Question No. 11 on the application, which asked, "Since you last registered to your knowledge, are you the

subject of an investigation for a criminal act?" In reality, the licensee had been arrested and charged with driving under the influence and carrying a concealed deadly weapon in Jessamine County, Kentucky in December 2006; he entered a guilty plea to carrying a concealed weapon and a reduced charge of reckless driving in February 2007.

5. On December 9, 2010, the licensee's paramour ("Patient A") died from a drug overdose. Shortly thereafter, Patient A's mother filed a grievance with the Board alleging that Patient A went to the licensee for medical treatment and started dating him. Eventually, the two moved in together. Patient A's mother stated she believed the licensee was responsible for Patient A's death because, she alleged, he wrote prescriptions for pain medications for Patient A; wrote prescriptions for pain medications to himself using another doctor's name and gave those medications to Patient A; wrote prescriptions for Patient A using other patients' names; and stole pain medications from his place of employment for Patient A.
6. The Board opened an investigation.
7. During the investigation, the Drug Enforcement and Professional Practices Branch of the Office of the Inspector General ("Drug Enforcement") identified patterns of concern regarding the licensee's prescription patterns, including the following: long-term use of one or more controlled substances; combinations of controlled substances favored by persons who abuse or divert controlled substances; patients traveling long distances to obtain medications; young patients on high doses of narcotic analgesics; family members receiving same or similar controlled substance prescriptions; and background investigation. Based on those concerns, Drug Enforcement identified twenty-six (26) patients whose records it recommended for further review.

8. A Board consultant reviewed the identified records and opined that the licensee engaged in conduct which departs from and fails to conform to the standards of acceptable and prevailing medical practices within the Commonwealth of Kentucky; demonstrated a lack of integrity; violated his prescription authority; engaged in fraud and acted with gross negligence. The consultant also opined that the licensee's practice of medicine constitutes a danger to the health, welfare and safety of anyone who might present to him for care.
9. On or about September 2, 2011, the Board issued a Complaint, charging the licensee with five separate counts of violations of KRS7 311.595, and an Emergency Order of Suspension against the licensee's medical license pending resolution of the Complaint.
10. The licensee did not challenge the Emergency Order of Suspension.
11. The licensee also faced criminal charges in Montgomery and Jessamine Counties, as well as a medical malpractice lawsuit filed by Patient A's family.
12. An administrative hearing on the Board's Complaint was scheduled for March 6, 2012.
13. In or around February 2012, at the licensee's request, the hearing was continued indefinitely, because – as he argued - "it would be prejudicial to his interests to compel him to testify in the administrative hearing at a time which proceeds [sic] the criminal trial in the same or similar matters."
14. In October 2013, the licensee's criminal issues were still not resolved, and a hearing on the Board's Complaint had not occurred. At that time, it was also over two years since the licensee had engaged in the active practice of medicine. Pursuant to KRS 311.604, the Board ordered the licensee to undergo a clinical skills assessment by the Center for

Personalized Education for Physicians ("CPEP") in order to determine whether he was competent to resume the practice of medicine.

15. Prior to expiration of the twenty-day deadline to schedule the assessment imposed by the Board, the licensee became incarcerated. Due to his circumstances, the Board issued an amended order requiring the licensee to schedule the assessment within twenty days of his release from custody.

16. After his release, the licensee contacted CPEP to inquire about costs but did not schedule the assessment. The licensee submitted information to KBML regarding the cost of the assessment and his current income. He argued that he was unable to afford the cost. In April 2014, after considering the licensee's financial information and arguments, the Board issued a second amended order which ordered the licensee to schedule the clinical assessment within three months of the resolution of his criminal charges, regardless of how the charges were resolved.

17. In or around April 2015, the criminal charges in both cases against the licensee were dismissed.

18. The licensee failed to schedule the skills assessment as ordered.

19. On or about August 26, 2015, the Board issued a default order of indefinite restriction for his failure to complete the clinical skills assessment pursuant to KRS 311.604.

20. On the licensee's petition for judicial review, the Jefferson Circuit Court affirmed the Board's order in June 2019.

21. On the licensee's appeal, the Kentucky Court of Appeals also affirmed the Board's order in October 2020.

22. In September 2021, the licensee finally submitted to a clinical skills assessment at CPEP. CPEP found that the licensee demonstrated several strengths as well as areas of educational need and, given his extended absence from practice, recommended that he resume practice under a structured remedial education plan to include:

    - Being subject to point-of-Care observation and supervision in a clinical setting with graduated levels toward independence;
    - Engagement with a preceptor to meet with regularly to review and discuss cases, documentation and plan for ongoing learning; and
    - Coaching and continuing education components specific to identified educational needs in medical knowledge, clinical judgment and reasoning, communication skills and documentation.

23. In April 2022, the Board allowed the licensee to resume the practice of medicine contingent upon him entering into this Agreed Order.

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 is in violation of the provisions of KRS 311.595(1), (5) and (8). 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 this matter and allow the licensee to resume the practice of medicine 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 allow the licensee to resume the practice of medicine, the parties hereby ENTER INTO the following **AGREED ORDER:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Paul V. Brooks, 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:

    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine or osteopathy," 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 and the licensee has entered in an agreement with a qualified CPEP-approved preceptor at the practice location;

        i. 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 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;

        ii. 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;

        iii. The licensee SHALL NOT request and shall not be approved to practice in any location in which he is not engaged with a qualified CPEP-approved preceptor;

b. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel;

   i. The Panel will not consider a request by the licensee to resume the professional utilization of controlled substances unless and until CPEP advocates for such privilege on his behalf based upon the licensee's progress in an Educational Intervention Plan (see below);

   ii. If the Panel should allow the licensee to resume the professional utilization of controlled substances in the future, it will do so by an amended agreed order, which shall provide for the licensee to maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for periodic review of the log and relevant records by Board agents, along with any other conditions deemed necessary by the Panel at that time;

c. Within twenty (20) days of entry of this Agreed Order, the licensee SHALL take all necessary steps to arrange for CPEP to develop an Educational Intervention Plan, at his expense, to facilitate remediation of his education needs and oversight of his return to practice;

   i. Upon receipt of an Educational Intervention Plan by the licensee, the licensee SHALL comply with and successfully complete all requirements of that Educational Intervention Plan, at his expense and as directed by CPEP;

   ii. If deemed necessary and appropriate by CPEP, the licensee SHALL successfully complete the Post-Education Assessment, at his expense and as directed by CPEP;

   iii. 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;

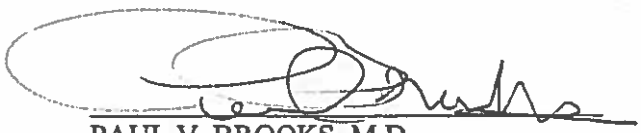
   iv. The licensee understands and agrees that any failure to comply with the directives and instructions of CPEP during the duration of the Educational Intervention Plan shall constitute a violation of this Agreed Order and shall be grounds for immediate and automatic suspension of his license to practice medicine in the Commonwealth of Kentucky; and

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

3. This Agreed Order is not subject to termination prior to the licensee's completion of its substantive terms and conditions, as determined by the Board or its agents.
4. 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.
5. 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 27th day of ~~May~~ June, 2022.

FOR THE LICENSEE:



PAUL V. BROOKS, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1349

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PAUL V. BROOKS, M.D., LICENSE NO. 32337, 1013 LEMON RUE WAY, LEXINGTON, KENTUCKY 40515

ORDER OF INDEFINITE RESTRICTION

On August 20, 2015, the Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, took up this case to consider the licensee's failure to submit to a clinical skills assessment ordered pursuant to KRS 311.604. The Panel reviewed a memorandum from General Counsel, dated August 10, 2015; a Second Amended Order to Complete Clinical Skills Assessment, dated April 22, 2014; Dismissal of *Com. v. Brooks*, Jessamine Circuit Court, Case No. 11-CR-00190, dated April 13, 2015; Dismissal of *Com. v. Brooks*, Montgomery Circuit Court, Case No. 13-CR-00021, filed April 20, 2015 and amended June 24, 2015; and e-mail correspondence between the Board and the Center for Personalized Education for Physicians, dated August 7, 2015. On October 17, 2013, the Panel reviewed a memorandum from General Counsel, dated September 24, 2013, and the Emergency Order of Suspension, filed of record September 2, 2011. On April 17, 2014, the Panel reviewed a memorandum from General Counsel, dated March 28, 2014; the Emergency Order of Suspension, filed of record September 2, 2011; an Amended Order to Complete Clinical Skills Assessment, dated November 21, 2013; e-mail correspondence from the licensee's counsel, dated December 13, 2013; the licensee's 2011 and 2012 tax return information; a statement from the licensee to his counsel regarding his income sources; a Commonwealth of Kentucky, Cabinet for Health and Family Services, Statement of Support Due, dated December 8, 2013; and e-mail

correspondence between the licensee, his counsel and the Center for Personalized Education for Physicians, dated February 3, 2014.

Having considered all of the relevant information available to it and being sufficiently advised, the Panel makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Paul V. Brooks, M.D. ("the licensee"), has not engaged in the active practice of medicine since September 2011.
2. On or about July 29, 2011, the licensee was indicted in Jessamine County, Kentucky, on two felony counts of Criminal Falsification of a Medical Record, according to which was alleged that he falsified, altered or created medical records in the names of two (2) patients for the purpose of obtaining controlled substances.
3. On September 2, 2011, the Board issued a Complaint and Emergency Order of Suspension against the licensee's Kentucky medical license, alleging violations of KRS 311.595 and 311.597.
4. On or about February 8, 2013, the licensee was indicted in Montgomery County, Kentucky, on two felony counts of Assuming a False Title to Obtain Controlled Substances and Theft of Identity of Another Without Consent.
5. The administrative hearing on the Board's Complaint was originally scheduled to begin on January 10, 2012 but the hearing was rescheduled, at the licensee's request, to March 6, 2012 in order to allow the licensee sufficient time prior to the hearing to review the twenty-nine (29) patient records at issue in the Board's

Complaint. In February 2012, at the licensee's request that he not be required to testify prior to his criminal trial, the administrative hearing on the Board's Complaint was postponed indefinitely.

6. By October 2013, the licensee had not engaged in the active practice of medicine for at least two (2) years.
7. On or about October 28, 2013, pursuant to KRS 311.604, the Board ordered the licensee to schedule, within twenty (20) days, a board-approved clinical skills assessment at the Center for Personalized Education for Physicians ("CPEP") for the next available date.
8. On or about October 31, 2013, the licensee became incarcerated in the Lexington-Fayette County Detention Center for Contempt of Court, and thus, was unable, due to circumstances beyond his control, to comply with the twenty (20) day time limit set forth in the Board's October 28 Order to Complete Clinical Skills Assessment.
9. On or about November 21, 2013, the Board issued an Amended Order to Complete Clinical Skills Assessment, which ordered that the licensee schedule a clinical skills assessment for the next available date within twenty (20) days of his release, for any reason or under any circumstances, from the custody of the Lexington-Fayette County Detention Center.
10. After his release from the Lexington-Fayette County Detention Center, the licensee contacted CPEP to inquire about the costs of a clinical skills assessment but he did not schedule a clinical skills assessment for the next available date.

11. On or about April 22, 2014, pursuant to KRS 311.604, the Board issued a Second Amended Order to Complete Clinical Skills Assessment, which ordered the licensee to schedule a clinical skills assessment at CPEP for the earliest date available within three (3) months of resolution, for any reason or under any conditions, of his criminal charges in Jessamine Circuit Court and Montgomery Circuit Court.
12. On or about April 13, 2015, the licensee's criminal charges in *Com. v. Brooks*, Jessamine Circuit Court, Case No. 11-CR-00190, were dismissed.
13. On or about April 20, 2015, the licensee's criminal charges in *Com. v. Brooks*, Montgomery Circuit Court, Case No. 13-CR-00021, were dismissed.
14. Within three (3) months of the resolution of his criminal charges, the licensee did not schedule a clinical skills assessment at CPEP for the earliest date available.
15. The licensee failed to comply with the Second Amended Order to Complete Clinical Skills Assessment. Furthermore, the licensee has failed to demonstrate that his failure to do so was due to circumstances beyond his control.

CONCLUSIONS OF LAW

1. KRS 311.604 provides, in part,

> (1) When a hearing or inquiry panel receives information that a physician has not been engaged in the active practice of medicine for at least two (2) years, the panel may order the physician to successfully complete a board-approved clinical competency examination or a board-approved clinical skills assessment program at the expense of the physician. The Panel shall review the results of the examination or assessment and determine whether the physician may resume the practice of medicine without undue risk or danger to the patients or the public.
>
> (2) Failure of a physician to successfully complete the clinical competency examination or the clinical skills assessment when directed shall constitute an admission that the physician is unable to

> practice medicine according to accepted and prevailing standards, unless the failure was due to circumstances beyond the control of the physician. The failure shall constitute a default and a final order may be entered without presentation of additional evidence.
> ...

2. When the Panel issued the Order to Complete Clinical Skills Assessment in October 2013, it made the requisite findings under KRS 311.604 that there was probable cause to believe that the licensee had not been engaged in the active practice of medicine for at least two (2) years. The Panel made the same requisite findings when it issued the Amended and then Second Amended Order to Complete Clinical Skills Assessment in November 2013 and April 2014.
3. The licensee received actual notice of the orders and was fully aware of the dates by which to schedule the assessment. Particularly, the licensee received notice of the Second Amended Order to Complete Clinical Skills Assessment and was fully aware of the date by which to schedule the assessment, more than a year in advance.
4. The licensee's failure to schedule the assessment pursuant to the Second Amended Order to Complete Clinical Skills Assessment was not due to circumstances beyond the licensee's control.
5. Pursuant to KRS 311.604, by failing to successfully complete a clinical skills assessment as directed by the Board, the licensee has admitted that he is unable to practice medicine according to accepted and prevailing standards.
6. Pursuant to KRS 311.604, the licensee's failure to successfully complete a clinical skills assessment as directed by the Board constitutes a default and this final order

may be entered without additional testimony or without presentation of additional evidence.

ORDER OF INDEFINITE RESTRICTION

Based upon the Findings of Fact and Conclusions of Law, and Panel A hereby **ORDERS**:

1. The license to practice medicine in the Commonwealth of Kentucky held by Paul V. Brooks, M.D., is hereby RESTRICTED FOR AN INDEFINITE PERIOD OF TIME to begin immediately upon the date of filing of this Order and continuing until further Order of the Panel;

2. During the effective period of restriction, the licensee SHALL 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 – unless and until approved to do so by the Panel;

3. The licensee SHALL be afforded the opportunity at reasonable intervals to demonstrate that he can resume the competent practice of medicine with reasonable skill and safety to patients and the burden of persuasion on that issue rests solely upon the licensee. The Panel shall not consider any request by the licensee to resume the active practice of medicine unless he has successfully completed a clinical skills assessment by the Center for Personalized Education for Physicians (CPEP), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, and the Board has received a copy of the written Clinical Skills Assessment Report from CPEP. The decision whether to grant a request to resume the active practice of medicine lies solely within the Board's discretion.

SO ORDERED this 26th day of August, 2015.

C. William Briscoe MD

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

CERTIFICATE OF SERVICE

I certify that the original of this Order of Indefinite Restriction was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return-receipt requested to Paul V. Brooks, M.D., 1013 Lemon Rue Way, Lexington, Kentucky 40515 and his counsel, J. Fox DeMoisey, Esq., 905 Baxter Avenue, Louisville, Kentucky 40204, on this 26th day of August, 2015.

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

EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, the effective date of this Order will be thirty (30) days after this Order of Indefinite Restriction is received by the licensee or the licensee's attorney, whichever shall occur first. The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested, along with a copy of this Order.

FILED OF RECORD

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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1349

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PAUL V. BROOKS, M.D., LICENSE NO. 32337, 540 SUNDROP PATH, LEXINGTON, KENTUCKY 40509

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, considered this matter at its August 18, 2011 meeting. At that meeting, Inquiry Panel A considered a memorandum by Doug Wilson, Medical Investigator, dated July 22, 2011; a grievance from Patient A's mother, received January 20, 2011; a letter from Paula York, Office of the Inspector General, Drug Enforcement & Professional Practices Branch, dated March 11, 2011; an investigative report from Paula York, Office of the Inspector General, Drug Enforcement & Professional Practices Branch, dated May 13, 2011; the Fayette County Coroner's report, autopsy report, toxicology report and evidence list regarding its investigation into the death of Patient A; the Lexington Police Department reports regarding the death of Patient A; a December 2005 Addendum to Employment Agreement between the New Lexington Clinic and Paul V. Brooks, M.D. ("the licensee"); a disability request for Patient A submitted to the Cabinet for Health and Family Services by the licensee; a February 21, 2011 printout of the licensee's Facebook page; a typed "timeline" regarding Patient A from the licensee, amended/revised on March 10, 2011; the licensee's Application for Renewal of Kentucky Medical/Osteopathic License for Year 2007; an e-mail from the licensee regarding answers on his 2007 application, dated April 13, 2011; memorandum from Dawn Beahl, Registration Coordinator, dated May 12, 2011; the licensee's summaries regarding

twenty-six patient charts selected for review by the Board; the Investigative Physician Profile/Background provided by the licensee; and a Board consultant report, dated July 11, 2011. In addition, the licensee was given notice of the Panel's August 18 meeting and both the licensee and his counsel appeared and were heard by the Panel.

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, Paul V. Brooks, M.D. ("the licensee"), was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Physical Medicine and Rehabilitation.
3. On December 9, 2010, Patient A was found dead in her home. Autopsy results determined her death to be due to acute combined effects of morphine and hydrocodone.
4. The Fayette County Deputy Coroner gathered evidence from Patient A's residence following her death, including various loose pills (including morphine); professional sample drugs; prescription bottles with the labels torn off; a bottle marked Ciprofloxacin which contained three (3) Tramadol; a prescription bottle for Patient B from the licensee for #60 Nexium with fourteen (14) remaining and dated December 11, 2008; and a prescription bottle for Patient B from the licensee for #100

Diphenoxylate/Atropine with twenty-seven (27) remaining, dated December 17, 2008.

5. On or about January 14, 2011, Patient A's mother filed a grievance with the Kentucky Board of Medical Licensure in which she alleged that the licensee had prescribed and otherwise obtained pain medications for Patient A while he was dating Patient A, living with her and knowing that she had a drug addiction problem; that he wrote prescriptions for pain medications for Patient A using other patients' names; that the licensee gave pain medicines to Patient A from the clinic where he worked; and that the licensee was at Patient A's home the night before and the morning of the day Patient A was found dead in her home.

6. The Board's Medical Investigator interviewed Patient A's sister, B.A., who stated substantially as follows: the licensee had prescribed and otherwise obtained pain and sleep medications for Patient A while he was dating Patient A, living with her and knowing that she had a drug addiction problem; that in June 2010, she was with Patient A when Patient A called the licensee and told the licensee that she needed pain pills; that she was then with Patient A when the licensee came outside of his office and gave Patient A a handful of pills; that the licensee instructed Patient A to save the capsules so that he could put powdered gelatin into them so that the pills would be present for a pill count; and that the licensee asked B.A. if he could start a patient chart on her so that he could write prescriptions in her name.

7. The Board's Medical Investigator interviewed Patient A's sister, T.A., who stated substantially as follows: the licensee prescribed and otherwise obtained pain and sleep medications for Patient A while he was dating Patient A, living with her and

knowing that she had a drug addiction problem; that she lived with Patient A and the licensee in Patient A's house for a period of time; that the licensee knew that T.A. had a drug addiction and that she went to Florida to obtain medications from pill mill clinics; that the licensee gave T.A. $300 to buy 30mg Percocet pills during one of her trips to Florida; that upon her return to Kentucky she delivered the pills to the licensee; that the licensee told T.A. that he would put them in a safe and administer them to Patient A.

8. The Board's Medical Investigator interviewed Patient A's widower, J.S., who stated substantially as follows: that the licensee prescribed and otherwise obtained controlled substances to Patient A while involved in a sexual relationship with her.

9. The Board's Medical Investigator interviewed Rosa Hicks, who stated substantially as follows: that she worked with Patient A at the Lexington Clinic Kidney Center from approximately March 2006 until approximately April 2007; that during the time that they worked together, Patient A told her about flirtations and sexual encounters with the licensee and that the licensee gave Patient A certain drugs.

10. On August 14, 2009, an ultrasound was performed on Patient A which showed her to be approximately eighteen (18) weeks pregnant.

11. On August 16, 2009, the licensee phoned in, from his cell phone, two prescriptions (#60 Cytotec 200 mg and #60 Ultracet) for Patient B to the Kroger Pharmacy in Mt. Sterling, Kentucky. The pharmacist contacted the licensee to verify the Cytotec prescription due to the high dose. The person who signed for and picked up the prescriptions as Patient B matched the licensee's description and not Patient B's description.

12. The use of Cytotec is contraindicated during pregnancy because it can cause abortion or premature birth.

13. On August 16, 2009, the licensee visited Patient A at the Shepherd's Shelter in Mt. Sterling, Kentucky.

14. The next day, August 17, 2009, Patient A was taken from Shepherd's Shelter to St. Joseph Mt. Sterling Hospital ER with complaints of nausea, vomiting, abdominal pain and abnormal vaginal bleeding.

15. The Board's Medical Investigator and a Drug Enforcement investigator interviewed Patient B and reviewed with him his prescribing records and medical chart, which had been obtained via subpoena. Upon review, Patient B denied that he had requested or received from the licensee prescriptions for Ambien, generic zolpidem, Ultram, generic tramadol, Phenergan suppositories, generic promethazine suppositories, Oxycontin, oxycodone, Wellbutrin, generic buproprion, prednisone, Neurontin, generic gabapentin, Lomotil, generic diphenoxylate/atropine, generic misoprostol or Cytotec.

16. In December 2009, Patient B did not injure his knee and did not request or receive a prescription for Lortab, even though there was a notation of such events in his medical record.

17. Patient B's primary pharmacy was the Kroger Pharmacy on Richmond Road in Lexington, Kentucky and he had insurance coverage for prescription costs.

18. Patient B never filled a prescription at the Kroger Pharmacy in Mt. Sterling, Kentucky.

19. Pharmacy records from Walgreen's and Kroger and a KASPER report reflecting the licensee's prescribing for Patient B reveal several incidents in which the licensee called in prescriptions for Patient B, which are disputed by Patient B; that the licensee or Patient A picked up said prescriptions from the pharmacies; that some prescriptions are unsupported by corresponding office visits in the patient record; and that some prescriptions were paid for with large amounts of cash.

20. On or about April 30, 2008, a prescription was filled at Kroger Pharmacy for oxycodone/APAP 5/325mg, #40, written by the licensee for Patient B. The licensee picked up the prescription at the pharmacy. Patient B did not receive the prescription for Percocet or generic oxycodone/APAP.

21. On or about December 17, 2008, the licensee called in a prescription for Lomotil #100 for Patient B. The licensee picked up the prescription at the pharmacy. Patient B did not receive the prescription for Lomotil or generic diphenoxylate/atropine. The bottle for this prescription was found in Patient A's home after her death, with 27 remaining tablets.

22. On or about February 3, 2009, a person with Patient A's first name called in a prescription for Ambien 10mg, #30, to the Kroger Pharmacy for Patient B. The licensee picked up the prescription at the pharmacy. Patient B did not receive the prescription for Ambien or generic zolpidem.

23. On or about July 4, 2009, prescriptions were filled for Combivent Inhaler and generic Wellbutrin XL 300mg at Walgreen's, Plaudit Place, Lexington, in Patient B's name. The prescription for Combivent Inhaler was $147.99 and the prescription for generic Wellbutrin XL 300mg was $265.99, even though Patient B had insurance coverage

which paid for his prescriptions. Patient B did not receive the prescription for Combivent Inhaler or generic Wellbutrin XL 300mg. An unlabeled Combivent Inhaler was found at the residence of Patient A after her death.

24. On or about September 19 and 30, October 4 and 25, and November 23, 2009, prescriptions were filled for tramadol/APAP or tramadol in Patient B's name. On or about September 30, 2009, the licensee approved the prescription to be filled early. The licensee picked up said prescriptions on two occasions and Patient A picked up said prescriptions on two other occasions. Patient B did not receive the prescriptions for Ultracet, Ultram or generic tramadol.

25. On or about November 26, 2009, a prescription was filled for Ambien 10mg, #30, at Walgreen's, Plaudit Place, Lexington, in Patient B's name. Patient B did not receive the prescription for Ambien.

26. On or about March 18, 2010, a prescription was filled for Oxycontin 15mg, #30, in Patient B's name. The prescription was picked up by Patient A. Patient B did not receive the prescriptions for Oxycontin.

27. The Board's Medical Investigator and a Drug Enforcement investigator interviewed Patient A's son, Patient C, who stated substantially as follows: that his mother dated and lived with the licensee; that he had never been examined or treated by the licensee; that he was unaware that a patient chart had been made on him at the licensee's practice; that he had never received any prescriptions for Lortab pain pills from the licensee; and that he saw bottles of prescription pills in Patient B's name in his mother's house before her death.

28. On or about October 5, 2008, Patient A filled out patient information/intake forms on Patient C at the licensee's practice. The licensee documented an examination of Patient C on the same date and assessed him as suffering an ankle strain which occurred while deer hunting. The licensee prescribed Lortab 10/500mg, #30. The prescription was filled on the same date at Walgreen's, Plaudit Place, Lexington, in Patient C's name. However, Patient C did not suffer an ankle injury while deer hunting, was not examined or treated by the licensee for an ankle strain and did not receive a prescription for Lortab.

29. On or about November 26, 2008, the licensee documented an examination of Patient C for ankle pain and prescribed Lortab 10/500mg, #30. The prescription was filled on November 27, 2008 at Walgreen's, Plaudit Place, Lexington, in Patient C's name. Patient C did not suffer an ankle injury, was not examined or treated by the licensee for an ankle strain and did not receive a prescription for Lortab.

30. On or about March 30, 2009, the licensee documented an examination of Patient C for ankle pain "same as previous" and wrist pain due to a skateboarding accident. The licensee prescribed Lortab 10/500mg, #30. The prescription was filled on the same date at Walgreen's, Plaudit Place, Lexington, in Patient C's name. Patient C did not suffer an ankle injury or a wrist injury due to a skateboarding accident; he was not examined or treated by the licensee for either; and he did not receive a prescription for Lortab.

31. The licensee prescribed Lortab 7.5/500mg, #30, to Patient C, which was filled on January 9, 2010 at Walgreen's, Plaudit Place, Lexington. There is no corresponding

chart documentation in Patient C's medical chart for this prescription. Patient C did not receive a prescription for Lortab.

32. Among the loose pills collected by the Fayette County Deputy Coroner from Patient A's residence following her death, was a capsule for Embeda 50mg, a long-acting morphine product. A review of the licensee's KASPER report for the twelve months prior to Patient A's death revealed one instance in which the licensee prescribed Embeda 50mg to one patient, Patient D.

33. The Board's Medical Investigator and a Drug Enforcement investigator interviewed Patient D, who stated substantially that on or about October 25, 2010, the licensee prescribed him Embeda 50mg, #30; that the Embeda caused him severe side effects, including dizziness, nausea and sweating; that on or about October 27, 2010, he returned to the licensee's office and gave the licensee the unused Embeda capsules in order to obtain a prescription for Opana ER 40mg, #30, in hopes that it would relieve his pain without side effects; that the Opana also caused him severe side effects, including nightmares, insomnia and sweating; that on or about November 1, 2010, he returned to the licensee's office and gave the licensee the unused Opana in order to obtain a prescription for Oxycontin, 30mg, in hopes that it would relieve his pain without side effects.

34. There was no documentation of the return or destruction of Patient D's Embeda or Opana medications in the patient's medical charts.

35. On or about March 29, 2011, the licensee was terminated from Commonwealth Physical Therapy and Rehabilitation, Inc. and Heartland Rehabilitation Services due

to bringing a weapon on the property and accepting return of patients' medications without appropriately destroying them, in violation of corporate policy.

36. Following the licensee's termination, administrators at Heartland Rehabilitation Services recovered from the licensee's office two (2) mason jars, which contained clear liquid with a strong smell of alcohol. The licensee's certified medical assistant (CMA), April Breiner, informed administrators that the licensee used the liquid to give injections to Patients E and F.

37. At the Board's request, Drug Enforcement analyzed the licensee's prescribing patterns for the period January 1, 2007 through February 21, 2011. Drug Enforcement identified the following concerns in the licensee's prescribing patterns: long-term use of one or more controlled substances; combinations of controlled substances favored by persons who abuse or divert controlled substances; patients traveling long distances to obtain medications; young patients on high doses of narcotic analgesics; family members receiving same or similar controlled substance prescriptions; and background investigation. Based on those concerns, Drug Enforcement identified twenty-six (26) patients, including Patients A, B and C, whose records it recommended for further review to determine whether the licensee provided appropriate medical care.

38. A consultant reviewed the Board's investigation report, the Drug Enforcement investigation report, a KASPER report on the licensee's prescribing between January 1, 2008 and January 31, 2011, and the identified patient records and concluded that the licensee engaged in conduct which departs from and fails to conform to the

standards of acceptable and prevailing medical practices within the Commonwealth of Kentucky.

39. The consultant also concluded that the licensee demonstrated a lack of integrity, violated his prescription authority, engaged in fraud, and acted with gross negligence.

40. The consultant also concluded that the licensee's practice of medicine constitutes a danger to the health, welfare and safety of anyone who might present to him for care.

41. The consultant's report is attached herewith and incorporated herein in its entirety.

42. In December 2006, the licensee was arrested and charged with driving under the influence and carrying a concealed deadly weapon in Jessamine County, Kentucky.

43. In February 2007, the licensee entered a guilty plea to carrying a concealed weapon and a reduced charge of reckless driving.

44. In March or April of 2007, the licensee submitted an online Application for Renewal of Kentucky Medical License to the Kentucky Board of Medical Licensure.

45. The licensee answered "No" to Question No. 10 on the application, which asked, "Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?"

46. The licensee also answered "No" to Question No. 11 on the application, which asked, "Since you last registered to your knowledge, are you the subject of an investigation for a criminal act?"

47. The licensee did not submit, in any other manner or form, a revised 2007 Application for Renewal of Kentucky Medical License to the Kentucky Board of Medical Licensure.

48. On or about July 29, 2011, the licensee was indicted in Jessamine County, Kentucky on two felony counts of Criminal Falsification of a Medical Record, according to which it is alleged that he falsified, altered or created medical records in the names of Patient B and Patient C for the purpose of obtaining controlled substances.

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), (5), (10) and (9), as illustrated by KRS 311.597(1)(a) and (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).

7. 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 Paul V. Brooks, M.D., is SUSPENDED and Dr. Brooks 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 2nd day of September, 2011.

C. William Briscoe MD

C. WILLIAM BRISCOE, 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 copies were mailed via certified mail return-receipt requested to Paul V. Brooks, 540 Sundrop Path, Lexington, Kentucky 40509 and J. Fox DeMoisey, Esq., 905 Baxter Avenue, Louisville, Kentucky 40204 on this 2nd day of September, 2011.

Leanne K. Diakov

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

July 11, 2011

To: Kentucky Board of Medical Licensure

Attention: Doug Wilson, Medical Investigator

RE: Paul V. Brooks M.D. Grievance # 11269

From: Linda H. Gleis M.D. Consultant

I have reviewed the following materials provided to me by Doug Wilson, medical investigator for KBML in reference to grieve # 11269 against Paul V. Brooks M.D.:

1. Brooks investigation report including 7 exhibits
2. Brooks interviews(2) and 9 exhibits
3. York-OIG investigation report and 13 attachments
4. Kasper report on Dr. Paul V. Brooks (1/1/08 to 1/31/11)
5. Twenty-nine patient records selected for review

[redacted] Review.

* Violation of the physician to patient relationship for [redacted] whereas Ms. [redacted] was initially a patient and subsequently they became intimately involved. Dr. Brooks continued prescription for controlled substances as well a supply of controlled substances without a prescription subsequent to the change from a physician-patient relationship.

*There is additional testimony that controlled substances were prescribed for other individuals, some without their knowledge, and then given to Ms. [redacted] ([redacted] son of Ms. [redacted]; [redacted] acquaintance). Additionally based on the interview with [redacted] and the diary entries of [redacted] the relationship between [redacted] and Dr. Brooks tended to be an abusive relationship and one that further aggravated drug abuse by Ms. [redacted] Following one such incident at a restaurant Ms. [redacted] attempted suicide by cutting her wrist.

*There is also the prescription of Cytotec (misoprostol) and Ultracet dated 8-16-09 in the name of [redacted] but picked up by an individual matching the description of Dr Brooks as noted in the Ky Drug Enforcement's investigation. Pharmacist also contacted Dr Brooks on his cell phone to verify prescription of Cytotec due to the high dose prescribed. There is documentation later that day of Dr Brooks visiting Ms [redacted] (who was pregnant at this time estimated at 18 weeks) at the Shepherds Center and listed his cell as the same one that the pharmacist used to contact Dr Brooks for the verification of the Cytotec dosage. This mediation is contraindicated in pregnancy per the black box warning. The following morning Ms [redacted] was taken to the ER with nausea/vomiting, abdominal pain and abnormal vaginal bleeding. (While not substantiated inquiries were also made about Dr. Brooks surrounding the death of Ms. [redacted])

[redacted] Review.
*Only several visits were noted in the medical record: IE 8-22-07, visits 4-30-08, 8-19-08, 10-2-08, 12-31-08, 2-27-09, 4-1-09, 5-4-09, 11-13-09, 3-2-10. There are discrepancies between the patient's report of care, the prescriptions generated in the patient 's name and discrepancies between the medical record.
*During this time there were numerous prescriptions for controlled substances and no accompanying office evaluation as per Dr Brooks written office policy.
*Mr. [redacted] testified that Dr. Brooks would sometimes pick up the prescriptions from the pharmacy for Mr. [redacted] and personally dropped the medication off at Mr [redacted] house.
*Doug Wilson's interview with Mr [redacted] found numerous instances of medications prescribed that Mr. [redacted] stated he had never requested or received these medications.
*According to Mr. [redacted] there is also falsification of his medical record regarding injuries sustained based on the medical record entry December 27, 2009 and the subsequent generation of a prescription for Lortab. Mr. [redacted] stated he had not sustained any injury or evaluation on that date. (Mr [redacted] testified to Doug Wilson, KBML that the medical record entry 2009 for evaluation of knee pain was false: 2-27-09 per my review, I did not find entry for 12-27-09).
Based on the interview of [redacted] conducted by KBML there are also instances of prescription generate for Mr. [redacted] without his knowledge and being picked up by [redacted] or Dr Brooks. There is also prescription generation 8-16-2009 for Cytotec 200mcg #60 and Ultracet #60 telephoned in by Dr Brooks per pharmacist. Mr [redacted] denies that he requested or received having this prescription. There is definite violation of prescription authority and fraud.

[redacted] Review.
*There is documentation of evaluation October 5, 2008, November 26, 2008 and March 30, 2009. Dr. Brooks summarizes each of these visits including medication prescription in the report Dr Brooks prepared for the investigation by KBML.
[redacted] in his testimony to Doug Wilson, KBML, denies having ever been treated as a patient by Dr. Brooks. There were prescriptions generated for controlled substances in the name of [redacted] [redacted] following each of these visits. January 9, 2010 where there was no documentation of office evaluation but there was a prescription for a controlled substance generated.
*There is fraud in the patient record and fraud in prescription authority.
* I did not find any documentation that insurance was filled for these office visits.

[redacted] Review.
*Prescriptions corresponded to office visits October 2009 to April 8 2010. Notation is made that the number of tablets prescribed increased from 60 to 90 with the office examination documentation noting back symptoms similar to previous visits. The patient was discontinued from care in May of 2010 but there was an additional prescription generated in his name September 20, 2010 noted to be filled by a different pharmacy than the previous.

[redacted] Review.

*Found problems with Dr Brooks following office policy for return of unused medication and the documentation of such.

*There is documentation of return of medication Demerol as signed by April Breiner.

*There is no documentation in the chart of the return of the Embeda or Opana. Based on interview with Doug Wilson, KBML, Mr. [redacted] was certain he returned these medications as he knew he would not be of get another prescription without returning these.

[redacted] and [redacted] Review.

*Concern issues of trigger point injections with the use of ETOH from a mason jar (described as jars of moonshine) stored in the office personal mini refrigerator of Dr. Brooks. There are signed statements from April Breiner stating that she had witnessed on multiple occasions Dr. Paul Brooks draw and administer ETOH via injection to patient [redacted] and to patient [redacted]. For [redacted] ETOH injections were noted for December 3, 2008 and March 4, 2009. It was also noted that the scheduled office visit for August 31, 2009 was canceled but part of the patient's symptoms were already listed as better or worse on the sheet prepared for that days visit. For [redacted] 17 injections with ETOH were noted starting from August 9, 2007 to January 28, 2011.

*ETOH is not the usual choice for trigger point injections. When an alcohol based solution is used, the usual choice is phenol which is prepared in a sterile manner.

[redacted] Review.

*Documents an ETOH injection March 6, 2008 and June 15, 2009. However there is no documentation of witnesses as to where the ETOH was obtained.

[redacted] Review.

*Notes a canceled appointment October 26, 2009 that the evaluation sheet already has circled aspects regarding the patient's symptoms ie completed prior to the patient's presentation to the office. Patient is seen every 4 weeks many times with no change in noted symptoms however this is consistent with Dr. Brooks office policy of monthly office evaluations for those on controlled substances.

Remaining medical records.

*While monthly patient evaluation for chronic non-changing pain management seems excessive to me, it is per Dr Brooks written office policy that prescription for controlled substance requires the monthly

physician evaluation.
*More often than not, when a patient called and cancelled an office appointment, the prepared clinic sheet was already partially completed with the patient's symptoms and the degree of symptoms.

*There were many instances where patient symptoms were recorded as no significant change but an increase was made in the numbers of pills prescribed per month.
* I did not review for billing practices.

In Summary:

It is my opinion, based on review of the above information that Dr. Brooks has engaged in conduct which departs from and fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.

It is my opinion that Dr. Paul Brooks has shown a pattern of behavior consistent with a lack of integrity, gross negligence, fraud and violation of prescription authority.

It is my opinion that Dr Brook's practice of medicine constitutes a danger to the health welfare and safety of anyone who might present to him for care.

Linda H Lewis MD
7-11-11

FILED OF RECORD

SEP 02 2011

K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1349

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY PAUL V. BROOKS, M.D., LICENSE NO. 32337, 540 SUNDROP PATH, LEXINGTON, KENTUCKY 40509

COMPLAINT

Comes now the Complainant C. William Briscoe, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on August 18, 2011, states for its Complaint against the licensee, PAUL V. BROOKS, M.D, as follows:

1. At all relevant times, Paul V. Brooks, M.D. ("the licensee"), was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Physical Medicine and Rehabilitation.
3. On December 9, 2010, Patient A was found dead in her home. Autopsy results determined her death to be due to acute combined effects of morphine and hydrocodone.
4. The Fayette County Deputy Coroner gathered evidence from Patient A's residence following her death, including various loose pills (including morphine); professional sample drugs; prescription bottles with the labels torn off; a bottle marked Ciprofloxacin which contained three (3) Tramadol; a prescription bottle for Patient B from the licensee for #60 Nexium with fourteen (14) remaining and dated December 11, 2008; and a prescription bottle for Patient B from the licensee for #100 Diphenoxylate/Atropine with twenty-seven (27) remaining, dated December 17, 2008.

5. On or about January 14, 2011, Patient A's mother filed a grievance with the Kentucky Board of Medical Licensure in which she alleged that the licensee had prescribed and otherwise obtained pain medications for Patient A while he was dating Patient A, living with her and knowing that she had a drug addiction problem; that he wrote prescriptions for pain medications for Patient A using other patients' names; that the licensee gave pain medicines to Patient A from the clinic where he worked; and that the licensee was at Patient A's home the night before and the morning of the day Patient A was found dead in her home.

6. The Board's Medical Investigator interviewed Patient A's sister, B.A., who stated substantially as follows: the licensee had prescribed and otherwise obtained pain and sleep medications for Patient A while he was dating Patient A, living with her and knowing that she had a drug addiction problem; that in June 2010, she was with Patient A when Patient A called the licensee and told the licensee that she needed pain pills; that she was then with Patient A when the licensee came outside of his office and gave Patient A a handful of pills; that the licensee instructed Patient A to save the capsules so that he could put powdered gelatin into them so that the pills would be present for a pill count; and that the licensee asked B.A. if he could start a patient chart on her so that he could write prescriptions in her name.

7. The Board's Medical Investigator interviewed Patient A's sister, T.A., who stated substantially as follows: the licensee prescribed and otherwise obtained pain and sleep medications for Patient A while he was dating Patient A, living with her and knowing that she had a drug addiction problem; that she lived with Patient A and the licensee in Patient A's house for a period of time; that the licensee knew that T.A. had

a drug addiction and that she went to Florida to obtain medications from pill mill clinics; that the licensee gave T.A. $300 to buy 30mg Percocet pills during one of her trips to Florida; that upon her return to Kentucky she delivered the pills to the licensee; that the licensee told T.A. that he would put them in a safe and administer them to Patient A.

8. The Board's Medical Investigator interviewed Patient A's widower, J.S., who stated substantially as follows: that the licensee prescribed and otherwise obtained controlled substances to Patient A while involved in a sexual relationship with her.

9. The Board's Medical Investigator interviewed Rosa Hicks, who stated substantially as follows: that she worked with Patient A at the Lexington Clinic Kidney Center from approximately March 2006 until approximately April 2007; that during the time that they worked together, Patient A told her about flirtations and sexual encounters with the licensee and that the licensee gave Patient A certain drugs.

10. On August 14, 2009, an ultrasound was performed on Patient A which showed her to be approximately eighteen (18) weeks pregnant.

11. On August 16, 2009, the licensee phoned in, from his cell phone, two prescriptions (#60 Cytotec 200 mg and #60 Ultracet) for Patient B to the Kroger Pharmacy in Mt. Sterling, Kentucky. The pharmacist contacted the licensee to verify the Cytotec prescription due to the high dose. The person who signed for and picked up the prescriptions as Patient B matched the licensee's description and not Patient B's description.

12. The use of Cytotec is contraindicated during pregnancy because it can cause abortion or premature birth.

13. On August 16, 2009, the licensee visited Patient A at the Shepherd's Shelter in Mt. Sterling, Kentucky.

14. The next day, August 17, 2009, Patient A was taken from Shepherd's Shelter to St. Joseph Mt. Sterling Hospital ER with complaints of nausea, vomiting, abdominal pain and abnormal vaginal bleeding.

15. The Board's Medical Investigator and a Drug Enforcement investigator interviewed Patient B and reviewed with him his prescribing records and medical chart, which had been obtained via subpoena. Upon review, Patient B denied that he had requested or received from the licensee prescriptions for Ambien, generic zolpidem, Ultram, generic tramadol, Phenergan suppositories, generic promethazine suppositories, Oxycontin, oxycodone, Wellbutrin, generic buproprion, prednisone, Neurontin, generic gabapentin, Lomotil, generic diphenoxylate/atropine, generic misoprostol or Cytotec.

16. In December 2009, Patient B did not injure his knee and did not request or receive a prescription for Lortab, even though there was a notation of such events in his medical record.

17. Patient B's primary pharmacy was the Kroger Pharmacy on Richmond Road in Lexington, Kentucky and he had insurance coverage for prescription costs.

18. Patient B never filled a prescription at the Kroger Pharmacy in Mt. Sterling, Kentucky.

19. Pharmacy records from Walgreen's and Kroger and a KASPER report reflecting the licensee's prescribing for Patient B reveal several incidents in which the licensee called in prescriptions for Patient B, which are disputed by Patient B; that the licensee

or Patient A picked up said prescriptions from the pharmacies; that some prescriptions are unsupported by corresponding office visits in the patient record; and that some prescriptions were paid for with large amounts of cash.

20. On or about April 30, 2008, a prescription was filled at Kroger Pharmacy for oxycodone/APAP 5/325mg, #40, written by the licensee for Patient B. The licensee picked up the prescription at the pharmacy. Patient B did not receive the prescription for Percocet or generic oxycodone/APAP.

21. On or about December 17, 2008, the licensee called in a prescription for Lomotil #100 for Patient B. The licensee picked up the prescription at the pharmacy. Patient B did not receive the prescription for Lomotil or generic diphenoxylate/atropine. The bottle for this prescription was found in Patient A's home after her death, with 27 remaining tablets.

22. On or about February 3, 2009, a person with Patient A's first name called in a prescription for Ambien 10mg, #30, to the Kroger Pharmacy for Patient B. The licensee picked up the prescription at the pharmacy. Patient B did not receive the prescription for Ambien or generic zolpidem.

23. On or about July 4, 2009, prescriptions were filled for Combivent Inhaler and generic Wellbutrin XL 300mg at Walgreen's, Plaudit Place, Lexington, in Patient B's name. The prescription for Combivent Inhaler was $147.99 and the prescription for generic Wellbutrin XL 300mg was $265.99, even though Patient B had insurance coverage which paid for his prescriptions. Patient B did not receive the prescription for Combivent Inhaler or generic Wellbutrin XL 300mg. An unlabeled Combivent Inhaler was found at the residence of Patient A after her death.

24. On or about September 19 and 30, October 4 and 25, and November 23, 2009, prescriptions were filled for tramadol/APAP or tramadol in Patient B's name. On or about September 30, 2009, the licensee approved the prescription to be filled early. The licensee picked up said prescriptions on two occasions and Patient A picked up said prescriptions on two other occasions. Patient B did not receive the prescriptions for Ultracet, Ultram or generic tramadol.

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26. On or about March 18, 2010, a prescription was filled for Oxycontin 15mg, #30, in Patient B's name. The prescription was picked up by Patient A. Patient B did not receive the prescriptions for Oxycontin.

27. The Board's Medical Investigator and a Drug Enforcement investigator interviewed Patient A's son, Patient C, who stated substantially as follows: that his mother dated and lived with the licensee; that he had never been examined or treated by the licensee; that he was unaware that a patient chart had been made on him at the licensee's practice; that he had never received any prescriptions for Lortab pain pills from the licensee; and that he saw bottles of prescription pills in Patient B's name in his mother's house before her death.

28. On or about October 5, 2008, Patient A filled out patient information/intake forms on Patient C at the licensee's practice. The licensee documented an examination of Patient C on the same date and assessed him as suffering an ankle strain which occurred while deer hunting. The licensee prescribed Lortab 10/500mg, #30. The

prescription was filled on the same date at Walgreen's, Plaudit Place, Lexington, in Patient C's name. However, Patient C did not suffer an ankle injury while deer hunting, was not examined or treated by the licensee for an ankle strain and did not receive a prescription for Lortab.

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30. On or about March 30, 2009, the licensee documented an examination of Patient C for ankle pain "same as previous" and wrist pain due to a skateboarding accident. The licensee prescribed Lortab 10/500mg, #30. The prescription was filled on the same date at Walgreen's, Plaudit Place, Lexington, in Patient C's name. Patient C did not suffer an ankle injury or a wrist injury due to a skateboarding accident; he was not examined or treated by the licensee for either; and he did not receive a prescription for Lortab.

31. The licensee prescribed Lortab 7.5/500mg, #30, to Patient C, which was filled on January 9, 2010 at Walgreen's, Plaudit Place, Lexington. There is no corresponding chart documentation in Patient C's medical chart for this prescription. Patient C did not receive a prescription for Lortab.

32. Among the loose pills collected by the Fayette County Deputy Coroner from Patient A's residence following her death, was a capsule for Embeda 50mg, a long-acting morphine product. A review of the licensee's KASPER report for the twelve months

prior to Patient A's death revealed one instance in which the licensee prescribed Embeda 50mg to one patient, Patient D.

33. The Board's Medical Investigator and a Drug Enforcement investigator interviewed Patient D, who stated substantially that on or about October 25, 2010, the licensee prescribed him Embeda 50mg, #30; that the Embeda caused him severe side effects, including dizziness, nausea and sweating; that on or about October 27, 2010, he returned to the licensee's office and gave the licensee the unused Embeda capsules in order to obtain a prescription for Opana ER 40mg, #30, in hopes that it would relieve his pain without side effects; that the Opana also caused him severe side effects, including nightmares, insomnia and sweating; that on or about November 1, 2010, he returned to the licensee's office and gave the licensee the unused Opana in order to obtain a prescription for Oxycontin, 30mg, in hopes that it would relieve his pain without side effects.

34. There was no documentation of the return or destruction of Patient D's Embeda or Opana medications in the patient's medical charts.

35. On or about March 29, 2011, the licensee was terminated from Commonwealth Physical Therapy and Rehabilitation, Inc. and Heartland Rehabilitation Services due to bringing a weapon on the property and accepting return of patients' medications without appropriately destroying them, in violation of corporate policy.

36. Following the licensee's termination, administrators at Heartland Rehabilitation Services recovered from the licensee's office two (2) mason jars, which contained clear liquid with a strong smell of alcohol. The licensee's certified medical assistant

(CMA), April Breiner, informed administrators that the licensee used the liquid to give injections to Patients E and F.

37. At the Board's request, Drug Enforcement analyzed the licensee's prescribing patterns for the period January 1, 2007 through February 21, 2011. Drug Enforcement identified the following concerns in the licensee's prescribing patterns: long-term use of one or more controlled substances; combinations of controlled substances favored by persons who abuse or divert controlled substances; patients traveling long distances to obtain medications; young patients on high doses of narcotic analgesics; family members receiving same or similar controlled substance prescriptions; and background investigation. Based on those concerns, Drug Enforcement identified twenty-six (26) patients, including Patients A, B and C, whose records it recommended for further review to determine whether the licensee provided appropriate medical care.

38. A consultant reviewed the Board's investigation report, the Drug Enforcement investigation report, a KASPER report on the licensee's prescribing between January 1, 2008 and January 31, 2011, and the identified patient records and concluded that the licensee engaged in conduct which departs from and fails to conform to the standards of acceptable and prevailing medical practices within the Commonwealth of Kentucky.

39. The consultant also concluded that the licensee demonstrated a lack of integrity, violated his prescription authority, engaged in fraud, and acted with gross negligence.

40. The consultant also concluded that the licensee's practice of medicine constitutes a danger to the health, welfare and safety of anyone who might present to him for care.

41. The consultant's report is attached herewith and incorporated herein in its entirety.

42. In December 2006, the licensee was arrested and charged with driving under the influence and carrying a concealed deadly weapon in Jessamine County, Kentucky.

43. In February 2007, the licensee entered a guilty plea to carrying a concealed weapon and a reduced charge of reckless driving.

44. In March or April of 2007, the licensee submitted an online Application for Renewal of Kentucky Medical License to the Kentucky Board of Medical Licensure.

45. The licensee answered "No" to Question No. 10 on the application, which asked, "Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?"

46. The licensee also answered "No" to Question No. 11 on the application, which asked, "Since you last registered to your knowledge, are you the subject of an investigation for a criminal act?"

47. The licensee did not submit, in any other manner or form, a revised 2007 Application for Renewal of Kentucky Medical License to the Kentucky Board of Medical Licensure.

48. On or about July 29, 2011, the licensee was indicted in Jessamine County, Kentucky on two felony counts of Criminal Falsification of a Medical Record, according to which it is alleged that he falsified, altered or created medical records in the names of Patient B and Patient C for the purpose of obtaining controlled substances.

49. On August 18, 2011, the Board's Inquiry Panel A found probable cause to believe that the licensee's practices constitute a danger to the health, welfare and safety of his

patients or the general public. As a result, the licensee was suspended from the practice medicine in the Commonwealth of Kentucky.

50. By his conduct, the licensee has violated KRS 311.595(1), (5), (10) and (9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.

51. 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.

52. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for January 10, 11, 12 & 13, 2012 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 PAUL V. BROOKS, M.D.

This 2nd day of September, 2011.

C. William Briscoe MD

C. WILLIAM BRISCOE, 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; a copy was mailed to Thomas J. Hellmann, Esq., 415 West Main Street, P.O. Box 676, Frankfort, Kentucky 40602-0676 and copies were mailed via certified mail return-receipt requested to Paul V. Brooks, 540 Sundrop Path, Lexington, Kentucky 40509 and J. Fox DeMoisey, Esq., 905 Baxter Avenue, Louisville, Kentucky 40204 on this 2nd day of September, 2011.

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

July 11, 2011

To: Kentucky Board of Medical Licensure

Attention: Doug Wilson, Medical Investigator

RE: Paul V. Brooks M.D. Grievance # 11269

From: Linda H. Gleis M.D. Consultant

I have reviewed the following materials provided to me by Doug Wilson, medical investigator for KBML in reference to grieve # 11269 against Paul V. Brooks M.D.:

1. Brooks investigation report including 7 exhibits
2. Brooks interviews(2) and 9 exhibits
3. York-OIG investigation report and 13 attachments
4. Kasper report on Dr. Paul V. Brooks (1/1/08 to 1/31/11)
5. Twenty-nine patient records selected for review

[redacted] Review.

* Violation of the physician to patient relationship for [redacted] whereas Ms. [redacted] was initially a patient and subsequently they became intimately involved. Dr. Brooks continued prescription for controlled substances as well a supply of controlled substances without a prescription subsequent to the change from a physician-patient relationship.

*There is additional testimony that controlled substances were prescribed for other individuals, some without their knowledge, and then given to Ms. [redacted] ([redacted] son of Ms. [redacted]; [redacted] acquaintance). Additionally based on the interview with [redacted] and the diary entries of [redacted] the relationship between [redacted] and Dr. Brooks tended to be an abusive relationship and one that further aggravated drug abuse by Ms. [redacted] Following one such incident at a restaurant Ms. [redacted] attempted suicide by cutting her wrist.

*There is also the prescription of Cytotec (misoprostol) and Ultracet dated 8-16-09 in the name of [redacted] but picked up by an individual matching the description of Dr Brooks as noted in the Ky Drug Enforcement's investigation. Pharmacist also contacted Dr Brooks on his cell phone to verify prescription of Cytotec due to the high dose prescribed. There is documentation later that day of Dr Brooks visiting Ms [redacted] (who was pregnant at this time estimated at 18 weeks) at the Shepherds Center and listed his cell as the same one that the pharmacist used to contact Dr Brooks for the verification of the Cytotec dosage. This mediation is contraindicated in pregnancy per the black box warning. The following morning Ms [redacted] was taken to the ER with nausea/vomiting, abdominal pain and abnormal vaginal bleeding. (While not substantiated inquiries were also made about Dr. Brooks surrounding the death of Ms. [redacted])

[redacted] Review.

*Only several visits were noted in the medical record: IE 8-22-07, visits 4-30-08, 8-19-08, 10-2-08, 12-31-08, 2-27-09, 4-1-09, 5-4-09, 11-13-09, 3-2-10. There are discrepancies between the patient's report of care, the prescriptions generated in the patient 's name and discrepancies between the medical record.

*During this time there were numerous prescriptions for controlled substances and no accompanying office evaluation as per Dr Brooks written office policy.

*Mr. [redacted] testified that Dr. Brooks would sometimes pick up the prescriptions from the pharmacy for Mr. [redacted] and personally dropped the medication off at Mr [redacted] house.

*Doug Wilson's interview with Mr [redacted] found numerous instances of medications prescribed that Mr. [redacted] stated he had never requested or received these medications.

*According to Mr. [redacted] there is also falsification of his medical record regarding injuries sustained based on the medical record entry December 27, 2009 and the subsequent generation of a prescription for Lortab. Mr. [redacted] stated he had not sustained any injury or evaluation on that date. (Mr [redacted] testified to Doug Wilson, KBML that the medical record entry 2009 for evaluation of knee pain was false: 2-27-09 per my review, I did not find entry for 12-27-09).

Based on the interview of [redacted] conducted by KBML there are also instances of prescription generate for Mr. [redacted] without his knowledge and being picked up by [redacted] or Dr Brooks. There is also prescription generation 8-16-2009 for Cytotec 200mcg #60 and Ultracet #60 telephoned in by Dr Brooks per pharmacist. Mr [redacted] denies that he requested or received having this prescription. There is definite violation of prescription authority and fraud.

[redacted] Review.

*There is documentation of evaluation October 5, 2008, November 26, 2008 and March 30, 2009. Dr. Brooks summarizes each of these visits including medication prescription in the report Dr Brooks prepared for the investigation by KBML.

[redacted] in his testimony to Doug Wilson, KBML, denies having ever been treated as a patient by Dr. Brooks. There were prescriptions generated for controlled substances in the name of [redacted] following each of these visits. January 9, 2010 where there was no documentation of office evaluation but there was a prescription for a controlled substance generated.

*There is fraud in the patient record and fraud in prescription authority.

* I did not find any documentation that insurance was filled for these office visits.

[redacted] Review.

*Prescriptions corresponded to office visits October 2009 to April 8 2010. Notation is made that the number of tablets prescribed increased from 60 to 90 with the office examination documentation noting back symptoms similar to previous visits. The patient was discontinued from care in May of 2010 but there was an additional prescription generated in his name September 20, 2010 noted to be filled by a different pharmacy than the previous.

[redacted] Review.

*Found problems with Dr Brooks following office policy for return of unused medication and the documentation of such.

*There is documentation of return of medication Demerol as signed by April Breiner.

*There is no documentation in the chart of the return of the Embeda or Opana. Based on interview with Doug Wilson, KBML, Mr. [redacted] was certain he returned these medications as he knew he would not be of get another prescription without returning these.

[redacted] and [redacted] Review.

*Concern issues of trigger point injections with the use of ETOH from a mason jar (described as jars of moonshine) stored in the office personal mini refrigerator of Dr. Brooks. There are signed statements from April Breiner stating that she had witnessed on multiple occasions Dr. Paul Brooks draw and administer ETOH via injection to patient [redacted] and to patient [redacted]. For [redacted] ETOH injections were noted for December 3, 2008 and March 4, 2009. It was also noted that the scheduled office visit for August 31, 2009 was canceled but part of the patient's symptoms were already listed as better or worse on the sheet prepared for that days visit. For [redacted] 17 injections with ETOH were noted starting from August 9, 2007 to January 28, 2011.

*ETOH is not the usual choice for trigger point injections. When an alcohol based solution is used, the usual choice is phenol which is prepared in a sterile manner.

[redacted] Review.

*Documents an ETOH injection March 6, 2008 and June 15, 2009. However there is no documentation of witnesses as to where the ETOH was obtained.

[redacted] Review.

*Notes a canceled appointment October 26, 2009 that the evaluation sheet already has circled aspects regarding the patient's symptoms ie completed prior to the patient's presentation to the office. Patient is seen every 4 weeks many times with no change in noted symptoms however this is consistent with Dr. Brooks office policy of monthly office evaluations for those on controlled substances.

Remaining medical records.

*While monthly patient evaluation for chronic non-changing pain management seems excessive to me, it is per Dr Brooks written office policy that prescription for controlled substance requires the monthly

physician evaluation.
*More often than not, when a patient called and cancelled an office appointment, the prepared clinic sheet was already partially completed with the patient's symptoms and the degree of symptoms.

*There were many instances where patient symptoms were recorded as no significant change but an increase was made in the numbers of pills prescribed per month.
* I did not review for billing practices.

In Summary:

It is my opinion, based on review of the above information that Dr. Brooks has engaged in conduct which departs from and fails to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky.

It is my opinion that Dr. Paul Brooks has shown a pattern of behavior consistent with a lack of integrity, gross negligence, fraud and violation of prescription authority.

It is my opinion that Dr Brook's practice of medicine constitutes a danger to the health welfare and safety of anyone who might present to him for care.

Linda H Lewis MD
7-11-11