COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1359

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SEAN P. McDONALD, M.D., LICENSE NO. 36051, 6420 TUSCAN ROAD, PADUCAH, KENTUCKY 42001

AGREED ORDER

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

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, Sean P. McDonald, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is neurological surgery.
3. At all relevant times prior to October 4, 2010, the licensee maintained privileges to practice at Lourdes Hospital, in Paducah Kentucky.
4. According to Patient A, on or about September 26, 2010, the licensee entered Patient A's room at Lourdes Hospital around midnight and told her that he was there to check her Medtronic pain pump but would not explain to her why it was necessary. The licensee took a syringe with needle out of his coat pocket and poked around the site of her pump multiple times until he extracted a clear liquid with what appeared to be some blood in it. The procedure was very painful,

causing Patient A to scream and requiring nurses to come into the room and hold her hand to calm her down. The licensee left the room after the patient told him not to touch her anymore. Patient A reported the incident to her pain management physician, Riley Love, M.D., who took pictures of the needle marks around her pump site and refilled her pain pump.

5. On or about October 1, 2010, Patient A made an official complaint about her encounter with the licensee to Lourdes Hospital.

6. According to Riley Love, M.D., the pain management physician for Patient A, he never asked the licensee to see Patient A but did speak to the licensee after the events of September 26, 2010. The licensee told Dr. Riley that he saw Patient A's x-ray at the hospital and thought there may have been a problem with her pump and that after checking the pump, he concluded that the pain medication had been infused in the area around her the pump and not directly into it. Dr. Love noted that it is very important to check the port side of the pump if one is trying to determine if the pump is working correctly, but there is simply no reason to access the injection site except for the purpose of adding or removing medication. Based upon Dr. Love's physical examination of Patient A, it was clear that the licensee actually tried multiple times to access Patient A's injection site rather than the port side of the device. In addition, Dr. Love stated that providers typically use a clear plastic device which is placed on the skin over the injection site and clearly shows where to insert the needle. However, it was apparent that the licensee did not use such a device, which would account for his multiple attempts.

7. According to Patient B, on or about June 25, 2010, the licensee placed a pain pump in him at Lourdes Hospital. On or about July 16, 2010, the licensee replaced Patient B's pump at Western Baptist Hospital. In August 2010, Patient B became concerned that the pain pump was not functioning properly. Patient B told the licensee of his concerns when he ran into the licensee at Lourdes Hospital while visiting his mother there. The licensee told Patient B to go to Western Baptist Hospital and he would check his pain pump there. At Western Baptist Hospital, the licensee stuck Patient B with a needle at the pump site and explained that he was checking for a kink in the catheter. The licensee also told Patient B that he would "turn up" the pain pump. Patient B noticed that the licensee did not use any of the same instruments for adjusting the pain pump as used by his usual pain management physician, Riley Love, M.D. After leaving Western Baptist Hospital, Patient B suffered extreme pain. Patient B's mother and brother told him that the licensee was looking for him and wanted him to report to the emergency room at Lourdes Hospital. When he presented at Lourdes, the licensee again stuck Patient B with a needle at the pump site and explained that he was checking for a kink in the catheter. The licensee told Patient B that he would go to the pharmacy to get some medicine to put in to the pump to see if he could use it to pull any medicine back out of it. He returned a short time later and injected medicine into Patient B's pump and then left again. The licensee returned with one of Dr. Love's nurses and then explained that he would refill Patient B's pain pump so that Dr. Love would not have to do it in a couple of days. Patient B believed it to be odd that the licensee then filled his pain pump, because the

nurses usually did that task. Patient B did not see the licensee again. Patient B's pain pump was replaced by another provider in January 2011.

8. In the fall of 2010, Laura Madison, Pharmacy Director at Lourdes Hospital, was notified by her staff that the licensee had not accounted for Dilaudid that he obtained from the hospital pharmacy for administration to a patient. After reviewing pharmacy records, she reported the incident to the Lourdes Hospital administration.

9. On or about October 4, 2010, Joseph Pittard, M.D., President of Lourdes Medical Staff called the licensee to his office to inquire about suspicions that the licensee had signed Dilaudid out of the hospital pharmacy without accounting for its use and an allegation that the licensee removed Dilaudid from a patient's pain pump.

10. During the interview, the licensee agreed to a physical exam. Tracking marks and injection sites were noted on his body. A ziplock bag containing a syringe with needle and a vial of saline and a vial of Dilaudid were found hidden in the licensee's left sock.

11. The licensee admitted to illegal drug usage and dependence and was admitted to Lourdes Hospital for psychiatric intervention and drug detoxification.

12. Following these events, and also on October 4, 2010, the Lourdes Medical Executive Committee suspended the licensee's privileges at Lourdes Hospital.

13. On or about October 13, 2010, the licensee was evaluated at the Kentucky Physicians Health Foundation ("the Foundation") and, upon its recommendation, entered into residential treatment at Metro Atlanta Recovery Residences ("MARR") on or about October 19, 2010.

14. On or about January 22, 2011, the licensee successfully completed residential treatment at MARR and was discharged with an Axis I diagnosis of Opioid Dependence.

15. Upon discharge, MARR concluded that Dr. McDonald was "physically and mentally fit and competent to fully retire any and all responsibilities as a Medical Doctor."

16. On or about January 25, 2011, the licensee entered into an Aftercare Contract with the Foundation.

17. During the Board's investigation of this matter, Patient A's and Patient B's medical records were forwarded to a Board consultant for review. The Board consultant concluded that the licensee failed to conform to or deviated from acceptable medical practices in his treatment of both Patients A and B. According to the Board consultant, the medical reports, pictorial images and medical attendants corroborate the licensee's behaviors as alleged by Patients A and B. Protocol demands witness by one (preferably two) R.N.s or M.D.s when delivery or wasting of injectable narcotics takes place; however, multiple incidents of the receipt, delivery and wasting of injectable narcotics were not properly documented in the licensee's practice.

18. In November 2011, the Board allowed the licensee to resume the practice of medicine, pursuant to terms and conditions set forth in an Agreed Order of Indefinite Restriction which restricted him from the practice of surgery or the professional utilization of controlled substance until he completed certain education and training requirements.

19. On January 25-27, 2012, the licensee completed the "Prescribing Controlled Drugs" course at Vanderbilt University School of Medicine.
20. On February 15-17, 2012, the licensee completed the "Maintaining Proper Boundaries" course at Vanderbilt University School of Medicine.
21. On April 12-14, 2012, the licensee participated in and unconditionally passed ProBe, an individualized ethics program offered through the Center for Personalized Education for Physicians.
22. On April 10, 2012, the Foundation submitted a letter to the Board which stated that the licensee was in compliance with his Foundation contract and that it did not believe that allowing him to resume the practice of surgery or the professional utilization of controlled substance would present a threat to his patients, the public or the licensee's recovery.
23. In May 2012, the Board amended the Agreed Order of Indefinite Restriction to allow the licensee to practice according to terms and conditions set forth in 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 regarding the licensee's opioid dependence and suspension from Lourdes Hospital, the licensee has engaged in conduct which violates the provisions of KRS 311.595(6), (8) and (21), as well as KRS

311.595(9), as illustrated by KRS 311.597(1)(a) and (c). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.

3. While the licensee denies any wrongdoing or violation, he acknowledges and agrees that based upon the Stipulations of Fact regarding the licensee's alleged diversion of medications from the pain pumps of Patients A and B and the licensee's deviation from or failure to conform to acceptable and prevailing medical practices as stated in the Board consultant's report, the Hearing Panel could find that the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (c) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order.
4. 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.

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 this pending grievance without an evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER:**

1. The license to practice medicine within the Commonwealth of Kentucky held by Sean P. McDonald, M.D., SHALL BE SUBJECT to this Agreed Order for a period of five (5) years from the date of filing of the Agreed Order.

2. During the effective period of this Agreed Order, the licensee's 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," 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 to ensure patient safety;

   b. 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 provisions as a condition of it granting approval for a new practice location;

   c. The licensee SHALL arrange for his employer or a supervising physician at the approved practice location to provide written reports to the Panel,

every six (6) months during the effective period of this Agreed Order, detailing the licensee's clinical competence;

d. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed or professionally utilized. The controlled substances log must include date, patient name, patient complaint, medication prescribed/dispensed/professionally utilized, when it was last prescribed/dispensed/professionally utilized and how much on the last encounter. 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;

e. 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;

f. 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;

g. The licensee understands and agrees that at least one consultant review must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Agreed Order;

h. The licensee SHALL maintain his contractual relationship with the Kentucky Physicians Health Foundation and shall fully comply with all requirements of that contractual relationship;

a. The licensee SHALL completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. The licensee must ensure that any such medical treatment and prescribing is reported directly to the Board in writing by my treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this responsibility and ensure timely compliance. The licensee's failure to inform the treating physician of this responsibility shall be considered a violation of this Agreed Order;

b. The licensee SHALL be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, and under the conditions specified by the Board's testing agent, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports will be paid by the licensee, and the licensee will pay those costs under the terms fixed by the Board's agent for testing. The

licensee's failure to fully reimburse the Board's agent within that time frame shall constitute a violation of this Agreed Order; and

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

3. The licensee 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 30 day of May, 2012.

FOR THE LICENSEE:

SEAN P. McDONALD, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1359

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SEAN P. McDONALD, M.D., LICENSE NO. 36051, 6420 TUSCAN ROAD, PADUCAH, KENTUCKY 42001

AGREED ORDER OF INDEFINITE RESTRICTION

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

STIPULATIONS OF FACT

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

1. At all relevant times, Sean P. McDonald, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is neurological surgery.
3. At all relevant times prior to October 4, 2010, the licensee maintained privileges to practice at Lourdes Hospital, in Paducah Kentucky.
4. According to Patient A, on or about September 26, 2010, the licensee entered Patient A's room at Lourdes Hospital around midnight and told her that he was there to check her Medtronic pain pump but would not explain to her why it was necessary. The licensee took a syringe with needle out of his coat pocket and poked around the site of her pump multiple times until he extracted a clear liquid

with what appeared to be some blood in it. The procedure was very painful, causing Patient A to scream and requiring nurses to come into the room and hold her hand to calm her down. The licensee left the room after the patient told him not to touch her anymore. Patient A reported the incident to her pain management physician, Riley Love, M.D., who took pictures of the needle marks around her pump site and refilled her pain pump.

5. The licensee denies the allegations stated in ¶ 4 above.

6. On or about October 1, 2010, Patient A made an official complaint about her encounter with the licensee to Lourdes Hospital.

7. According to Riley Love, M.D., the pain management physician for Patient A, he never asked the licensee to see Patient A but did speak to the licensee after the events of September 26, 2010. The licensee told Dr. Riley that he saw Patient A's x-ray at the hospital and thought there may have been a problem with her pump and that after checking the pump, he concluded that the pain medication had been infused in the area around her the pump and not directly into it. Dr. Love noted that it is very important to check the port side of the pump if one is trying to determine if the pump is working correctly, but there is simply no reason to access the injection site except for the purpose of adding or removing medication. Based upon Dr. Love's physical examination of Patient A, it was clear that the licensee actually tried multiple times to access Patient A's injection site rather than the port side of the device. In addition, Dr. Love stated that providers typically use a clear plastic device which is placed on the skin over the injection site and clearly shows where to insert the needle. However, it was apparent that

the licensee did not use such a device, which would account for his multiple attempts.

8. The licensee denies the allegations stated in ¶ 7 above.

9. According to Patient B, on or about June 25, 2010, the licensee placed a pain pump in him at Lourdes Hospital. On or about July 16, 2010, the licensee replaced Patient B's pump at Western Baptist Hospital. In August 2010, Patient B became concerned that the pain pump was not functioning properly. Patient B told the licensee of his concerns when he ran into the licensee at Lourdes Hospital while visiting his mother there. The licensee told Patient B to go to Western Baptist Hospital and he would check his pain pump there. At Western Baptist Hospital, the licensee stuck Patient B with a needle at the pump site and explained that he was checking for a kink in the catheter. The licensee also told Patient B that he would "turn up" the pain pump. Patient B noticed that the licensee did not use any of the same instruments for adjusting the pain pump as used by his usual pain management physician, Riley Love, M.D. After leaving Western Baptist Hospital, Patient B suffered extreme pain. Patient B's mother and brother told him that the licensee was looking for him and wanted him to report to the emergency room at Lourdes Hospital. When he presented at Lourdes, the licensee again stuck Patient B with a needle at the pump site and explained that he was checking for a kink in the catheter. The licensee told Patient B that he would go to the pharmacy to get some medicine to put in to the pump to see if he could use it to pull any medicine back out of it. He returned a short time later and injected medicine into Patient B's pump and then left again. The licensee returned with

one of Dr. Love's nurses and then explained that he would refill Patient B's pain pump so that Dr. Love would not have to do it in a couple of days. Patient B believed it to be odd that the licensee then filled his pain pump, because the nurses usually did that task. Patient B did not see the licensee again. Patient B's pain pump was replaced by another provider in January 2011.

10. The licensee denies the allegations stated in ¶ 9 above.

11. In the fall of 2010, Laura Madison, Pharmacy Director at Lourdes Hospital, was notified by her staff that the licensee had not accounted for Dilaudid that he obtained from the hospital pharmacy for administration to a patient. After reviewing pharmacy records, she reported the incident to the Lourdes Hospital administration.

12. On or about October 4, 2010, Joseph Pittard, M.D., President of Lourdes Medical Staff called the licensee to his office to inquire about suspicions that the licensee had signed Dilaudid out of the hospital pharmacy without accounting for its use and an allegation that the licensee removed Dilaudid from a patient's pain pump.

13. During the interview, the licensee agreed to a physical exam. Tracking marks and injection sites were noted on his body. A ziplock bag containing a syringe with needle and a vial of saline and a vial of Dilaudid were found hidden in the licensee's left sock.

14. The licensee admitted to the non-medical use of and dependence upon Dilaudid. He was admitted to Lourdes Hospital for psychiatric intervention and drug detoxification.

15. Following these events, and also on October 4, 2010, the Lourdes Medical Executive Committee suspended the licensee's privileges at Lourdes Hospital.

16. On or about October 13, 2010, the licensee was evaluated at the Kentucky Physicians Health Foundation ("the Foundation") and, upon its recommendation, entered into residential treatment at Metro Atlanta Recovery Residences ("MARR") on or about October 19, 2010.

17. On or about January 22, 2011, the licensee successfully completed residential treatment at MARR and was discharged with an Axis I diagnosis of Opioid Dependence.

18. Upon discharge, MARR concluded that Dr. McDonald was "physically and mentally fit and competent to fully retire any and all responsibilities as a Medical Doctor."

19. On or about January 25, 2011, the licensee entered into an Aftercare Contract with the Foundation.

20. During the Board's investigation of this matter, Patient A's and Patient B's medical records were forwarded to a Board consultant for review. The Board consultant concluded that the licensee failed to conform to or deviated from acceptable medical practices in his treatment of both Patients A and B. According to the Board consultant, the medical reports, pictorial images and medical attendants corroborate the licensee's behaviors as alleged by Patients A and B. According to the Board consultant, protocol demands witness by one (preferably two) R.N.s or M.D.s when delivery or wasting of injectable narcotics takes place;

however, multiple incidents of the receipt, delivery and wasting of injectable narcotics were not properly documented in the licensee's practice.

21. The licensee has not practiced medicine since October 2010.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact regarding the licensee's opioid dependence and suspension from Lourdes Hospital, the licensee has engaged in conduct which violates the provisions of KRS 311.595(6), (8) and (21), as well as KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (c). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.
3. While the licensee denies any wrongdoing or violation, he acknowledges and agrees that based upon the Stipulations of Fact regarding the licensee's alleged diversion of medications and alleged deviations from acceptable and prevailing medical practices, all of which are denied by the licensee, the Hearing Panel could find that the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (c) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.

4. 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 Sean P. McDonald, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;
2. During the effective period of this Agreed Order of Indefinite Restriction, the licensee's Kentucky medical/osteopathic 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 an act or practice which may constitute the practice of surgery unless and until approved to do so by the Panel;
    b. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel;

c. The Panel will not consider a request by the licensee to resume the practice of surgery or the professional utilization of controlled substances unless and until the following conditions have been satisfied:

   i. At least six (6) months have elapsed since the filing of this Agreed Order of Indefinite Restriction;

   ii. The licensee has successfully completed the "Prescribing Controlled Drugs" course at The Center for Professional Health at Vanderbilt University Medical Center, Nashville, TN, (615) 936-0678 or the University of South Florida, 3515 E. Fletcher Avenue, Tampa, Florida 33613 (813) 396-9217, at his expense;

   iii. The licensee has successfully completed the "Maintaining Proper Boundaries" course at The Center for Professional Health at Vanderbilt University Health Center, Nashville, TN, (615) 936-0678, at his expense; and

   iv. The licensee has successfully completed and passed the ProBe Program at the Center for Personalized Education for Physicians (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230 – 303/577-3232, at his expense.

d. The licensee SHALL provide the Board's staff with written verification that he has successfully completed the courses and programs detailed in ¶¶2(c)(ii)-(iv) above, promptly upon their completion;

e. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that the courses and

programs detailed in ¶¶2(c)(ii)-(iv) above will provide a copy of any reports or evaluations of the licensee's participation in those course and programs to the Board's Legal Department;

f. The licensee shall maintain his contractual relationship with the Kentucky Physicians Health Foundation and shall fully comply with all requirements of that contractual relationship;

g. The licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. The licensee must ensure that any such medical treatment and prescribing is reported directly to the Board in writing by my treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this responsibility and ensure timely compliance. The licensee's failure to inform the treating physician of this responsibility shall be considered a violation of this Agreed Order;

h. The licensee shall be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, and under the conditions specified by the Board's testing agent, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports will be paid by the licensee, and the licensee will pay those costs under the terms fixed by the Board's agent for testing. The licensee's

failure to fully reimburse the Board's agent within that time frame SHALL constitute a violation of this Agreed Order; and

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

3. The licensee agrees that it is within the discretion of the Panel to reinstate his ability to resume the practice of surgery or to prescribe, dispense or professionally utilize controlled substances and that if the Panel should grant the licensee's request to resume the practice of surgery or the professional utilization of controlled substances, it SHALL do so by an Amended Agreed Order of Indefinite Restriction, which may require that the licensee obtain practice location approval prior to resuming such practice and may 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 upon request, along with any other conditions deemed necessary by the Panel at that time.

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

the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Indefinite Restriction.

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

SO AGREED on this 13th day of December, 2011.

FOR THE LICENSEE:

SEAN P. McDONALD, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

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