COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1492

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOHN R. BAIRD, M.D., LICENSE NO. 36869, 9204 TAYLORSVILLE ROAD, SUITE 206, LOUISVILLE, KENTUCKY 40299

SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Panel A, and John R. Baird, M.D. (hereafter "the licensee"), and, based upon their mutual desire to fully and finally resolve this matter without an evidentiary hearing, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER**:

STIPULATIONS OF FACT

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

1. At all relevant times, John R. Baird, 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. At its November 18, 2010 meeting, Inquiry Panel A reviewed an investigation into allegations that the licensee was inappropriately prescribing controlled substances. While the Panel failed to find a violation at that time, it issued a Letter of Concern to the licensee, recommending that he comply with the Board's Opinion Regarding the Use of Controlled Substances in Pain Treatment.
4. On September 7, 2011, the Board received a grievance from a pharmacist, who alleged that the licensee was prescribing large amounts of controlled substances and

combinations of several controlled substances. The pharmacist also noted that patients were getting early refills of these prescriptions.

5. On February 21, 2012, the Board received a toxicology report regarding the death of Patient A, from the Clay County Coroner. The Coroner stated, in part,

   ...The blood serum levels indicate Alprazolam/Xanax in significant quantities, over 6 X maximum therapeutic range and Fentanyl/Duragesic at nearly 6X maximum therapeutic range as well as Oxycodone at 1.85 X therapeutic range...Further morphine is present in the urine screen as well. My opinion is this patient was consuming prescriptions medications in large quantities on a regular basis...Death will be ruled accidental and due to Acute Combined Narcotic Drug Toxicity, (Alprazolam, Oxycodone, Fentanyl, and Morphine).
   Providers are ... and Dr. John R. Baird, Healing Options, in Louisville, KY (Fentanyl, Oxycodone) ....

6. The Board requested a review of the licensee's prescribing patterns. In a report dated January 12, 2010 (sic – 2012), the reviewer identified the following issues:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated, and
   - Family members obtaining the same or similar controlled substances; and,
   - Dr. Baird is also prescribing amphetamines for the majority of his patients which may or may not be in accordance with the diagnosis/purpose outlined in 201 KAR 9:016.

   The reviewer selected 25 patient records for review by a Board consultant.

7. In a report dated March 30, 2012, one Board consultant concluded, in part, regarding his review of the four patients identified by the pharmacist initially,

   Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. In his evaluation which should have been comprehensive, I think he did not meet the quality expected. On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the records,

how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure of or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-

6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of

the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of the medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his discretion to start with higher does when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficient diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may not be significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a advantageous to the patient and him rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [Patient B]. The patient had the diagnosis of hepatitis C, neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump. A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at the time were penicillin, sulfa, latex and morphine. I have searched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion. Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc., is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he

has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems...

8. A second Board consultant reviewed 22 of the licensee's patient records. This reviewer concluded, in part,

...My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.
...There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr. Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids; 2) combinations of three and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazapines and 3) the use of opioids for fibromyalgia at all.
From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best. The use of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.

Patients suffering from fibromyalgia may also have altered endogenous opioid activity. A study utilizing position emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing. There are two possible explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain. Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors.

Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia. In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.

Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates. In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern with patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

While this consultant consistently marked "within minimum standards" on the Expert Review Worksheets for Records and Diagnosis, he made the following finding or similar finding in 19 of the 20 cases reviewed,

There is minimal documentation of physical exam which is required under the KBML regulations....A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

This consultant also made the following specific findings in individual Expert Review Worksheets,

....
...Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriateness of initial therapy.
...It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids....The dismissal of the patient on high dose opioids without taper breaches ethics.
....
I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guidelines. Dr. Baird provides no intensive monitoring of function and minimal physical exam....This combination of medications is non-standard and risky in a patient with obstructive sleep apnea....Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable.
....Use of 2 short acting opioids in an alternating fashion is not standard care but Dr. Baird monitors outcomes and appears to be evaluating the patient's response.
...."Tender all over" does not constitute a physical exam.
....Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax. This is a clear harbinger for substance misuse/abuse....High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion ....Though this patient was ultimately dismissed for non-compliance the original medication is questionable.
....The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards...."Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr. Baird that his patient likely has a personality DO....It is generally accepted that combinations of opioids and benzodiazapines plus Soma is high risk for addiction and adverse outcomes.... I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr. Baird may be helpful.
....The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/da. I am unsure of any rationale that supports this Rxn practice.
....Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an aberrant behavior in that the patient took her child's adderall and no action was taken.

....High dose opioid therapy is maintained though hypogonadism a clear complication of high dose opioid therapy is diagnosed. Again a stimulant is prescribed for fatigue and somnolence rather than...
....I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid. This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr. Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case....This combination of medications is non-standard and dangerous.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

9. The licensee makes the following observations about the consultants' reviews,

   The Board's first consultant reviewed a total of 4 patient charts. The Board's second consultant reviewed the same 4 patient charts. The second consultant found that the licensee met the standard of care relating to 3 of the 4 patient charts for all categories of review included in the Expert Review Worksheets, including "diagnosis," "treatment," "records" and "overall" medical management. In addition, the second consultant found that the licensee met the standard of care relating to the remaining patient chart for diagnosis, treatment and records. However, the consultant found his overall medical care for this patient to be borderline.
   The second consultant reviewed an additional 18 patient charts, including the chart for Patient A. In a narrative report, the consultant did not find the licensee's medical management of the patient to be the cause of the patient's death. The consultant completed Expert Review Worksheets for 20 of the remaining patient charts. The consultant found that the licensee met the standard of care for "diagnosis" and "records" for all 20 patient charts reviewed and that he met the standard of care for "treatment" for 14 of the patient charts. The consultant made the following findings regarding the licensee's overall medical management of the 20 patients that were the subjects of Expert Review Worksheets: 8 clearly within the standard of care, 11 borderline, and 1 below standard of care. The reviewer did not find the licensee to be a danger to his patients or the public.

10. Following its review of this information at its May 16, 2013 meeting, the Board's Inquiry Panel B issued this Complaint and an Emergency Order of Restriction on May 28, 2013, prohibiting him "from prescribing, dispensing, or otherwise utilizing controlled substances until the resolution of the Complaint."

11. Immediately after the Panel issued its Emergency Order of Restriction, the licensee shifted his practice to southern Indiana, just across the Ohio River from Kentucky. He

encouraged his Kentucky patients to travel to Indiana so that he could prescribe controlled substances to them, in spite of the Emergency Order's prohibition. The licensee's stated purpose in doing so was to assist the patients in safely weaning off their existing prescriptions. The licensee did not have a valid DEA permit for southern Indiana at the time he issued these controlled substance prescriptions, so used his Kentucky DEA permit. The licensee stated that he was not aware that he was lawfully required to have a separate DEA permit to prescribe controlled substances in southern Indiana.

12. In or around October 2013, the licensee resolved the Complaint and Emergency Order of Restriction by entering into an Agreed Order of Indefinite Restriction, pursuant to which he is indefinitely restricted from utilizing opiates for the treatment of fibromyalgia; required to obtain and fully document an appropriate history of present illness for each patient encounter and to prescribe controlled substances appropriate only for a validly diagnosed medical condition; indefinitely restricted from prescribing, dispensing or administering more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner; required to maintain a "controlled substances log" for all controlled substances prescribed, subject to Board review, at the licensee's expense; and required to reimburse the Board's costs and pay a fine within four (4) years.
13. On or about October 16, 2017, the licensee paid the assigned fine and reimbursed the Board's costs.
14. In or around July 2018, the licensee became indicted on and pled guilty to charges pertaining to a scheme in which he accepted approximately $567,609.36 in kickbacks

from a clinical drug testing and drug screening laboratory in return for referring his patients' lab work (including that of Medicare and Medicaid beneficiaries) between May 2012 and July 2013.

15. On or about October 26, 2018, the licensee entered into an Amended Agreed Order which included, in part, terms and conditions prohibiting him from utilizing opiates for treatment of fibromyalgia, restricting him to prescribing no more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition without consultation with a Board-certified physician and required him to maintain a controlled substances log.

16. After entering into the Amended Agreed Order, the licensee shifted the focus of his practice to hormone replacement therapy, including the prescribing of testosterone, a controlled substance.

17. In or around Spring 2022, a Board consultant reviewed sixteen (16) of the licensee's patient charts and found that he departed from or failed to conform to acceptable and prevailing medical practices in regard to diagnoses in twelve (12) cases, in regard to treatment in twelve (12) cases, and in regard to recordkeeping in thirteen (13) cases. The consultant also opined that the licensee demonstrated gross ignorance ten (10) cases and gross incompetence in one (1) case. The consultant was unable to form an opinion in regard to three (3) cases due to limited data.

18. On or about May 30, 2022, the licensee responded to the consultant's report and provided additional explanation for his practice.

19. On or about November 21, 2022, the consultant reviewed the licensee's response and information and found that it did not change her opinion.

20. On or about February 16, 2023, the licensee chose to enter into this Second Amended Agreed Order in lieu of the issuance of a Complaint and Emergency Order of Restriction.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4), (9) - as illustrated by KRS 311.597(1)(a) and (d), (3) and (4) – and KRS 311.595(13). Accordingly, the licensee agrees that there are legal grounds for the parties to enter into this Second Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter without an evidentiary hearing by entering into an informal resolution such as this Second Amended Agreed Order.

SECOND AMENDED AGREED ORDER

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

1. The license to practice medicine in the Commonwealth of Kentucky held by John R. Baird, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF

TIME, effective immediately upon the filing of this Second Amended Agreed Order;

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

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

    b. The Panel SHALL NOT consider a request by the licensee to resume the professional utilization of controlled substances unless and until:

        i. The Board has received an assessment report (and educational or remediation plan, if recommended) following the licensee's completion of a clinical skills assessment in endocrinology at *either* Center for Personalized Education for Professionals ("CPEP"), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, or LifeGuard, 400 Winding Creek Boulevard, Mechanicsburg, Pennsylvania, 17050, Tel. (717) 909-2590; and
        ii. The licensee has reimbursed the Board's costs in the amount of $1,750.00; and

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

3. The licensee understands and agrees that if the Panel should grant the licensee's request to resume the professional utilization of controlled substances in the future, it will do so contingent upon the licensee entering into a Third Amended Agreed Order, which shall include at least the following terms and conditions:

    a. The licensee shall not utilize opiates for the treatment of fibromyalgia. The licensee understands and agrees that a decision whether to modify or terminate this condition in the future lies within the sole discretion of the Panel and that, in considering any such request for modification or termination, the Panel may consider that this condition was imposed based upon the recommendation of one of the Board consultants, who also

recommended that the restriction remain in place for the duration of the licensee's practice;

b. The licensee shall 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;

c. The licensee shall obtain and fully document an appropriate history of present illness for each patient encounter;

d. The licensee shall only prescribe controlled substances that are appropriate for a validly diagnosed medical condition;

e. The licensee shall not prescribe, dispense or administer more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner, in a manner that meets the following requirements, prior to prescribing, dispensing or administering an amount of controlled substance that exceeds that dosage level for a specific diagnosed condition for a specific patient:
    i. The Board has previously approved the Board-certified physician to consult with the licensee in such cases;
    ii. The licensee has provided all relevant information regarding the specific patient and the specific condition, and any other conditions that bear on treatment decisions, to the approved physician;
    iii. The licensee has clearly advised the approved physician of the following information regarding the proposed professional utilization of an excess amount of controlled substances to the specific patient: the condition being treated; the controlled substance(s) being used to treat the condition; the strength of the controlled substance(s); the dosage units and dosage instruction for each controlled substance(s); and, the medical justification for using excess dosing for the specific patient and the specific condition(s);
    iv. Following adequate review, the approved physician has approved the use of controlled substance(s) in amounts that exceed 40 MED/day for the specific patient for the specific condition(s), in writing;
    v. The licensee has incorporated the written approval in the patient record;
    vi. The licensee reduces the controlled substance(s) used to 40 MED/day or less as soon as medically appropriate and safe; and

f. Any other terms/conditions deemed appropriate by the Panel at the time.

4. The licensee expressly agrees that if he should violate any term or condition of this Second Amended 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 Second Amended 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 Second Amended 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 Second Amended Agreed Order.

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

SO AGREED on this 28th day of February 2023.

FOR THE LICENSEE:

JOHN R. BAIRD, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

LEANNE K. DIAKOV
General Counsel
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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1492

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOHN R. BAIRD, M.D., LICENSE NO. 36869, 9204 TAYLORSVILLE ROAD, SUITE 206, LOUISVILLE, KENTUCKY 40299

AMENDED AGREED ORDER

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

STIPULATIONS OF FACT

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

1. At all relevant times, John R. Baird, 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. At its November 18, 2010 meeting, Inquiry Panel A reviewed an investigation into allegations that the licensee was inappropriately prescribing controlled substances. While the Panel failed to find a violation at that time, it issued a Letter of Concern to the licensee, recommending that he comply with the Board's Opinion Regarding the Use of Controlled Substances in Pain Treatment.
4. On September 7, 2011, the Board received a grievance from a pharmacist, who alleged that the licensee was prescribing large amounts of controlled substances and

combinations of several controlled substances. The pharmacist also noted that patients were getting early refills of these prescriptions.

5. On February 21, 2012, the Board received a toxicology report regarding the death of Patient A, from the Clay County Coroner. The Coroner stated, in part,

> ...The blood serum levels indicate Alprazolam/Xanax in significant quantities, over 6 X maximum therapeutic range and Fentanyl/Duragesic at nearly 6X maximum therapeutic range as well as Oxycodone at 1.85 X therapeutic range...Further morphine is present in the urine screen as well. My opinion is this patient was consuming prescriptions medications in large quantities on a regular basis...Death will be ruled accidental and due to Acute Combined Narcotic Drug Toxicity, (Alprazolam, Oxycodone, Fentanyl, and Morphine).
> Providers are ... and Dr. John R. Baird, Healing Options, in Louisville, KY (Fentanyl, Oxycodone) ....

6. The Board requested a review of the licensee's prescribing patterns. In a report dated January 12, 2010 (sic – 2012), the reviewer identified the following issues:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated, and
   - Family members obtaining the same or similar controlled substances; and,
   - Dr. Baird is also prescribing amphetamines for the majority of his patients which may or may not be in accordance with the diagnosis/purpose outlined in 201 KAR 9:016.

   The reviewer selected 25 patient records for review by a Board consultant.

7. In a report dated March 30, 2012, one Board consultant concluded, in part, regarding his review of the four patients identified by the pharmacist initially,

> Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. <u>In his evaluation which should have been comprehensive, I think he did not meet the quality expected.</u> On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the records,

how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure of or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-

6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of

the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of the medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his discretion to start with higher does when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficient diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may not be significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a advantageous to the patient and him rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [Patient B]. The patient had the diagnosis of hepatitis C, neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump. A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at the time were penicillin, sulfa, latex and morphine. I have searched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion. Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc., is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he

has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems...

8. A second Board consultant reviewed 22 of the licensee's patient records. This reviewer concluded, in part,

...My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.
...There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr. Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids; 2) combinations of three and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazapines and 3) the use of opioids for fibromyalgia at all.
From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best. The use of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.

Patients suffering from fibromyalgia may also have altered endogenous opioid activity. A study utilizing position emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing. There are two possible explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain. Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors.

Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia. In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.

Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates. In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern with patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

While this consultant consistently marked "within minimum standards" on the Expert Review Worksheets for Records and Diagnosis, he made the following finding or similar finding in 19 of the 20 cases reviewed,

There is minimal documentation of physical exam which is required under the KBML regulations....A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

This consultant also made the following specific findings in individual Expert Review Worksheets,

....
...Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriateness of initial therapy.
...It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids....The dismissal of the patient on high dose opioids without taper breaches ethics.
....
I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guidelines. Dr. Baird provides no intensive monitoring of function and minimal physical exam....This combination of medications is non-standard and risky in a patient with obstructive sleep apnea....Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable.
....Use of 2 short acting opioids in an alternating fashion is not standard care but Dr. Baird monitors outcomes and appears to be evaluating the patient's response.
...."Tender all over" does not constitute a physical exam.
....Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax. This is a clear harbinger for substance misuse/abuse....High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion ....Though this patient was ultimately dismissed for non-compliance the original medication is questionable.
....The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards...."Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr. Baird that his patient likely has a personality DO....It is generally accepted that combinations of opioids and benzodiazapines plus Soma is high risk for addiction and adverse outcomes.... I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr. Baird may be helpful.
....The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/da. I am unsure of any rationale that supports this Rxn practice.
....Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an aberrant behavior in that the patient took her child's adderall and no action was taken.

....High dose opioid therapy is maintained though hypogonadism a clear complication of high dose opioid therapy is diagnosed. Again a stimulant is prescribed for fatigue and somnolence rather than...
....I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid. This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr. Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case....This combination of medications is non-standard and dangerous.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

9. The licensee makes the following observations about the consultants' reviews,

The Board's first consultant reviewed a total of 4 patient charts. The Board's second consultant reviewed the same 4 patient charts. The second consultant found that the licensee met the standard of care relating to 3 of the 4 patient charts for all categories of review included in the Expert Review Worksheets, including "diagnosis," "treatment," "records" and "overall" medical management. In addition, the second consultant found that the licensee met the standard of care relating to the remaining patient chart for diagnosis, treatment and records. However, the consultant found his overall medical care for this patient to be borderline.
The second consultant reviewed an additional 18 patient charts, including the chart for Patient A. In a narrative report, the consultant did not find the licensee's medical management of the patient to be the cause of the patient's death. The consultant completed Expert Review Worksheets for 20 of the remaining patient charts. The consultant found that the licensee met the standard of care for "diagnosis" and "records" for all 20 patient charts reviewed and that he met the standard of care for "treatment" for 14 of the patient charts. The consultant made the following findings regarding the licensee's overall medical management of the 20 patients that were the subjects of Expert Review Worksheets: 8 clearly within the standard of care, 11 borderline, and 1 below standard of care. The reviewer did not find the licensee to be a danger to his patients or the public.

10. Following its review of this information at its May 16, 2013 meeting, the Board's Inquiry Panel B issued this Complaint and an Emergency Order of Restriction on May 28, 2013, prohibiting him "from prescribing, dispensing, or otherwise utilizing controlled substances until the resolution of the Complaint."

11. Immediately after the Panel issued its Emergency Order of Restriction, the licensee shifted his practice to southern Indiana, just across the Ohio River from Kentucky. He

encouraged his Kentucky patients to travel to Indiana so that he could prescribe controlled substances to them, in spite of the Emergency Order's prohibition. The licensee's stated purpose in doing so was to assist the patients in safely weaning off their existing prescriptions. The licensee did not have a valid DEA permit for southern Indiana at the time he issued these controlled substance prescriptions, so used his Kentucky DEA permit. The licensee stated that he was not aware that he was lawfully required to have a separate DEA permit to prescribe controlled substances in southern Indiana.

12. In or around October 2013, the licensee resolved the Complaint and Emergency Order of Restriction by entering into an Agreed Order of Indefinite Restriction, pursuant to which he is indefinitely restricted from utilizing opiates for the treatment of fibromyalgia; required to obtain and fully document an appropriate history of present illness for each patient encounter and to prescribe controlled substances appropriate only for a validly diagnosed medical condition; indefinitely restricted from prescribing, dispensing or administering more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner; required to maintain a "controlled substances log" for all controlled substances prescribed, subject to Board review, at the licensee's expense; and required to reimburse the Board's costs and pay a fine within four (4) years.
13. On or about October 16, 2017, the licensee paid the assigned fine and reimbursed the Board's costs.
14. In or around July 2018, the licensee became indicted on and pled guilty to charges pertaining to a scheme in which he accepted approximately $567,609.36 in kickbacks

from a clinical drug testing and drug screening laboratory in return for referring his patients' lab work (including that of Medicare and Medicaid beneficiaries) between May 2012 and July 2013.

STIPULATED CONCLUSIONS OF LAW

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

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4), (9) - as illustrated by KRS 311.597(1)(a) and (d), (3) and (4) – and KRS 311.595(13). Accordingly, the licensee agrees that there are legal grounds for the parties to enter into this Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter without an evidentiary hearing by entering into an informal resolution such as this Amended Agreed Order.

AMENDED 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 matter without an evidentiary hearing, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER:**

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

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

   a. The licensee SHALL NOT utilize opiates for the treatment of fibromyalgia. The licensee further agrees that he may not request modification or termination of this condition for a minimum period of five (5) years from October 17, 2013, and that the Panel will not consider a request to modify or terminate this condition prior to that time. The licensee further agrees that the decision whether to grant such a request lies within the sole discretion of the Panel and that, in considering any such request, the Panel may consider that this condition was imposed based upon the recommendation of one of the Board consultants, who also recommended that the restriction remain in place for the duration of the licensee's practice;

   b. The licensee SHALL obtain and fully document an appropriate history of present illness for each patient encounter;

   c. The licensee SHALL only prescribe controlled substances that are appropriate for a validly diagnosed medical condition;

   d. The licensee SHALL NOT prescribe, dispense or administer more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner, in a manner that meets the following requirements, prior to prescribing, dispensing or administering an amount of controlled substance that exceeds that dosage level for a specific diagnosed condition for a specific patient:
      - The Board has previously approved the Board-certified physician to consult with the licensee in such cases;
      - The licensee has provided all relevant information regarding the specific patient and the specific condition, and any other conditions that bear on treatment decisions, to the approved physician;
      - The licensee has clearly advised the approved physician of the following information regarding the proposed professional utilization of an excess amount of controlled substances to the specific patient: the condition being treated; the controlled substance(s) being used to treat the condition; the strength of the controlled substance(s); the dosage units and dosage instruction for each controlled substance(s); and, the medical justification for

using excess dosing for the specific patient and the specific condition(s);
- Following adequate review, the approved physician has approved the use of controlled substance(s) in amounts that exceed 40 MED/day for the specific patient for the specific condition(s), in writing;
- The licensee has incorporated the written approval in the patient record
- The licensee reduces the controlled substance(s) used to 40 MED/day or less as soon as medically appropriate and safe.

e. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;

f. 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;

g. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Amended 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 Amended Agreed Order;

h. Within twenty (20) days of the filing of this Amended Agreed Order, the licensee SHALL make all necessary arrangements to enroll in the *ProBE* Program offered through the Center for Personalized Education for Professionals (CPEP), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, at the earliest time;

   i. The licensee SHALL complete and "unconditionally pass" the *ProBE* Program at the time and date(s) scheduled, at his expense and as directed by CPEP's staff;
   ii. The licensee SHALL provide the Board's staff with written verification that he has completed and "unconditionally passed" CPEP's *ProBE* Program, promptly after completing the program;

iii. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations, reports or essays from the *ProBE* Program to the Board's Legal Department promptly after their completion; and

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

3. The licensee expressly agrees that if he should violate any term or condition of this Amended 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 Amended 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 Amended 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 Amended Agreed Order.

4. The licensee understands and agrees that any violation of the terms of this Amended 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 22 day of October 2018.

FOR THE LICENSEE:

JOHN R. BAIRD, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

DALE E. TONEY, M.D.
CHAIR, INQUIRY/HEARING PANEL A

LEANNE K. DIAKOV
General Counsel
Kentucky Board of Medical Licensure
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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1492

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOHN R. BAIRD, M.D., LICENSE NO. 36869, 3012 EASTPOINT PARKWAY, LOUISVILLE, KENTUCKY 40223

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Hearing Panel A, and John R. Baird, M.D. (hereafter "the licensee"), and, based upon their mutual desire to fully and finally resolve this pending Complaint without an evidentiary hearing, hereby ENTER INTO the following

AGREED ORDER OF 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, John R. Baird, 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. At its November 18, 2010 meeting, Inquiry Panel A reviewed an investigation into allegations that the licensee was inappropriately prescribing controlled substances. While the Panel failed to find a violation at that time, it issued a Letter of Concern to the licensee, recommending that he comply with the Board's Opinion Regarding the Use of Controlled Substances in Pain Treatment.
4. On September 7, 2011, the Board received a grievance from a pharmacist, who alleged that the licensee was prescribing large amounts of controlled substances and

combinations of several controlled substances. The pharmacist also noted that patients were getting early refills of these prescriptions.

5. On February 21, 2012, the Board received a toxicology report regarding the death of Patient A, from the Clay County Coroner. The Coroner stated, in part,

> ...The blood serum levels indicate Alprazolam/Xanax in significant quantities, over 6 X maximum therapeutic range and Fentanyl/Duragesic at nearly 6X maximum therapeutic range as well as Oxycodone at 1.85 X therapeutic range...Further morphine is present in the urine screen as well. My opinion is this patient was consuming prescriptions medications in large quantities on a regular basis...Death will be ruled accidental and due to Acute Combined Narcotic Drug Toxicity, (Alprazolam, Oxycodone, Fentanyl, and Morphine).
> Providers are ... and Dr. John R. Baird, Healing Options, in Louisville, KY (Fentanyl, Oxycodone) ....

6. The Board requested a review of the licensee's prescribing patterns. In a report dated January 12, 2010 (sic – 2012), the reviewer identified the following issues:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated, and
   - Family members obtaining the same or similar controlled substances; and,
   - Dr. Baird is also prescribing amphetamines for the majority of his patients which may or may not be in accordance with the diagnosis/purpose outlined in 201 KAR 9:016.

   The reviewer selected 25 patient records for review by a Board consultant.

7. In a report dated March 30, 2012, one Board consultant concluded, in part, regarding his review of the four patients identified by the pharmacist initially,

> Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. In his evaluation which should have been comprehensive, I think he did not meet the quality expected. On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the

records, how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure of or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All

that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed

Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of the medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his discretion to start with higher does when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficient diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may not be significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a

advantageous to the patient and him rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [Patient B]. The patient had the diagnosis of hepatitis C, neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump. A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at the time were penicillin, sulfa, latex and morphine. I have searched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion.

Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc., is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems...

8. A second Board consultant reviewed 22 of the licensee's patient records. This

reviewer concluded, in part,

...My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.
...There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr. Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids; 2) combinations of three

and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazapines and 3) the use of opioids for fibromyalgia at all. From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best. The use of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.
Patients suffering from fibromyalgia may also have altered endogenous opioid activity. A study utilizing position emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing. There are two possible explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain. Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors.
Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia. In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.
Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates. In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern with patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

While this consultant consistently marked "within minimum standards" on the Expert Review Worksheets for Records and Diagnosis, he made the following finding or similar finding in 19 of the 20 cases reviewed,

There is minimal documentation of physical exam which is required under the KBML regulations....A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

This consultant also made the following specific findings in individual Expert Review

Worksheets,

....
...Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriateness of initial therapy.
...It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids....The dismissal of the patient on high dose opioids without taper breaches ethics.
....
I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guidelines. Dr. Baird provides no intensive monitoring of function and minimal physical exam....This combination of medications is non-standard and risky in a patient with obstructive sleep apnea....Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable.
....Use of 2 short acting opioids in an alternating fashion is not standard care but Dr. Baird monitors outcomes and appears to be evaluating the patient's response.
...."Tender all over" does not constitute a physical exam.
....Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax. This is a clear harbinger for substance misuse/abuse....High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion ....Though this patient was ultimately dismissed for non-compliance the original medication is questionable.
....The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards...."Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr. Baird that his patient likely has a personality DO....It is generally accepted that combinations of opioids and benzodiazapines plus Soma is high risk for addiction and adverse outcomes.... I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr. Baird may be helpful.

....The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/da. I am unsure of any rationale that supports this Rxn practice.
....Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an aberrant behavior in that the patient took her child's adderall and no action was taken.
....High dose opioid therapy is maintained though hypogonadism a clear complication of high dose opioid therapy is diagnosed. Again a stimulant is prescribed for fatigue and somnolence rather than...
....I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid. This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr. Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case....This combination of medications is non-standard and dangerous.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

9. The licensee makes the following observations about the consultants' reviews,

The Board's first consultant reviewed a total of 4 patient charts. The Board's second consultant reviewed the same 4 patient charts. The second consultant found that the licensee met the standard of care relating to 3 of the 4 patient charts for all categories of review included in the Expert Review Worksheets, including "diagnosis," "treatment," "records" and "overall" medical management. In addition, the second consultant found that the licensee met the standard of care relating to the remaining patient chart for diagnosis, treatment and records. However, the consultant found his overall medical care for this patient to be borderline.
The second consultant reviewed an additional 18 patient charts, including the chart for Patient A. In a narrative report, the consultant did not find the licensee's medical management of the patient to be the cause of the patient's death. The consultant completed Expert Review Worksheets for 20 of the remaining patient charts. The consultant found that the licensee met the standard of care for "diagnosis" and "records" for all 20 patient charts reviewed and that he met the standard of care for "treatment" for 14 of the patient charts. The consultant made the following findings regarding the licensee's overall medical management of the 20 patients that were the subjects of Expert Review Worksheets: 8 clearly within the standard of care, 11 borderline, and 1 below standard of care. The reviewer did not find the licensee to be a danger to his patients or the public.

10. Following its review of this information at its May 16, 2013 meeting, the Board's

Inquiry Panel B issued this Complaint and an Emergency Order of Restriction on

May 28, 2013, prohibiting him "from prescribing, dispensing, or otherwise utilizing

controlled substances until the resolution of the Complaint." The licensee has been subject to the terms of that Emergency Order of Restriction since that time.

11. Immediately after the Panel issued its Emergency Order of Restriction, the licensee shifted his practice to southern Indiana, just across the Ohio River from Kentucky. He encouraged his Kentucky patients to travel to Indiana so that he could prescribe controlled substances to them, in spite of the Emergency Order's prohibition. The licensee's stated purpose in doing so was to assist the patients in safely weaning off their existing prescriptions. The licensee did not have a valid DEA permit for southern Indiana at the time he issued these controlled substance prescriptions, so used his Kentucky DEA permit. The licensee has since stated that he was not aware that he was lawfully required to have a separate DEA permit to prescribe controlled substances in southern Indiana.

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. While the licensee denies committing any violation, he agrees that, based upon the Stipulations of Fact, the Hearing Panel could conclude that he has engaged in conduct which violates the provisions of KRS 311.595(13) and (9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, the licensee agrees that there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending Complaint 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 Complaint 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 John L. Baird, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;
2. During the effective period of this Agreed Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:
    a. The licensee SHALL NOT utilize opiates for the treatment of fibromyalgia. The licensee further agrees that he may not request modification or termination of this condition for a minimum period of five (5) years from the date of filing of this Agreed Order of Indefinite Restriction and that the Panel will not consider a request to modify or terminate this condition prior to that time. The licensee further agrees that the decision whether to grant such a request lies within the sole discretion of the Panel and that, in considering any such request, the Panel may

consider that this condition was imposed based upon the recommendation of one of the Board consultants, who also recommended that the restriction remain in place for the duration of the licensee's practice;

b. The licensee SHALL obtain and fully document an appropriate history of present illness for each patient encounter;

c. The licensee SHALL only prescribe controlled substances that are appropriate for a validly diagnosed medical condition;

d. The licensee SHALL NOT prescribe, dispense or administer more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner, in a manner that meets the following requirements, prior to prescribing, dispensing or administering an amount of controlled substance that exceeds that dosage level for a specific diagnosed condition for a specific patient:

- The Board has previously approved the Board-certified physician to consult with the licensee in such cases;
- The licensee has provided all relevant information regarding the specific patient and the specific condition, and any other conditions that bear on treatment decisions, to the approved physician;
- The licensee has clearly advised the approved physician of the following information regarding the proposed professional utilization of an excess amount of controlled substances to the specific patient: the condition being treated; the controlled substance(s) being used to treat the condition; the strength of the controlled substance(s); the dosage units and dosage instruction for each controlled substance(s); and, the medical justification for using excess dosing for the specific patient and the specific condition(s);
- Following adequate review, the approved physician has approved the use of controlled substance(s) in amounts that exceed 40

MED/day for the specific patient for the specific condition(s), in writing;
- The licensee has incorporated the written approval in the patient record
- The licensee reduces the controlled substance(s) used to 40 MED/day or less as soon as medically appropriate and safe.

e. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed. The controlled substances log must include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log.

f. 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.

g. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Agreed Order of Indefinite Restriction. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Agreed Order of Indefinite Restriction.

h. The licensee SHALL pay a fine in the amount of Five Thousand Dollars ($5,000.00) within four (4) years of the date of filing of this Agreed Order of Indefinite Restriction.

i. The licensee SHALL pay the costs of the investigation in the amount of $3,387.98 within four (4) years from entry of this Agreed Order of Indefinite Restriction;

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

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of 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.

4. 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 11 day of Sept, 2013.

FOR THE LICENSEE:

JOHN R. BAIRD, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
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Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1492

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWALTH OF KENTUCKY HELD BY JOHN R. BAIRD, M.D., LICENSE NO. 36869, 3012 EASTPOINT PARKWAY, LOUISVILLE, KENTUCKY 40223

EMERGENCY ORDER OF RESTRICTION

The Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, considered this matter at its May 16, 2013 meeting. At that meeting, Inquiry Panel B considered a February 13, 2013 memorandum by Betty Prater, Medical Investigator, which included: a September 7, 2011 email from Trish Roberts, Pharm-D, Kroger; Clay County Toxicology Report CCC641-07-12; a website page for the licensee; grievance filed April 17, 2012; January 12, 2012 report by Paula York, Investigator, OIG Division of Audits and Investigations; Clay County Coroner Report CCC-641-07-12; written responses by the licensee dated January 29, March 29 and June 4, 2012; the licensee's curriculum vitae, with attachments; March 30, 2012 report by Board's Pain Medicine consultant; September 19, 2012 report by Board's second Pain Management consultant; supplemental response by the licensee dated October 12, 2012, with attachments; and, a December 29, 2010 Letter of Concern issued to the licensee by Inquiry Panel A. The licensee also appeared, in response to a Due Process letter, and addressed the Panel members.

Having considered all of this information and being sufficiently advised, Inquiry Panel B ENTERS the following EMERGENCY ORDER OF RESTRICTION, 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 B concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Restriction:

1. At all relevant times, John R. Baird, M.D., 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. At its November 18, 2010 meeting, Inquiry Panel A reviewed an investigation into allegations that the licensee was inappropriately prescribing controlled substances. While the Panel failed to find a violation at that time, it issued a Letter of Concern to the licensee, recommending that he comply with the Board's Opinion Regarding the Use of Controlled Substances in Pain Treatment.
4. On September 7, 2011, the Board received a grievance from a pharmacist, who alleged that the licensee was prescribing large amounts of controlled substances and combinations of several controlled substances. The pharmacist also noted that patients were getting early refills of these prescriptions.
5. On February 21, 2012, the Board received a toxicology report regarding the death of Patient A, from the Clay County Coroner. The Coroner stated, in part,

   ...The blood serum levels indicate Alprazolam/Xanax in significant quantities, over 6 X maximum therapeutic range and Fentanyl/Duragesic at nearly 6X maximum therapeutic range as well as Oxycodone at 1.85 X therapeutic range...Further morphine is present in the urine screen as well. My opinion is this patient was consuming prescriptions medications in large quantities on a regular basis...Death will be ruled accidental and due to Acute Combined Narcotic Drug Toxicity, (Alprazolam, Oxycodone, Fentanyl, and Morphine).
   Providers are ... and Dr. John R. Baird, Healing Options, in Louisville, KY (Fentanyl, Oxycodone) ....

6. The Board requested a review of the licensee's prescribing patterns. In a report dated January 12, 2010 (sic – 2012), the reviewer identified the following issues:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated, and
   - Family members obtaining the same or similar controlled substances; and,
   - Dr. Baird is also prescribing amphetamines for the majority of his patients which may or may not be in accordance with the diagnosis/purpose outlined in 201 KAR 9:016.

   The reviewer selected 25 patient records for review by a Board consultant.

7. In a report dated March 30, 2012, one Board consultant concluded, in part, regarding his review of the four patients identified by the pharmacist initially,

   Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. In his evaluation which should have been comprehensive, I think he did not meet the quality expected. On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the records, how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure of or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an

arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of the medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his discretion to start with higher does when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated

and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficient diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may not be significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a advantageous to the patient and him rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [Patient B]. The patient had the diagnosis of hepatitis C, neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump.

A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at the time were penicillin, sulfa, latex and morphine. I have searched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion. Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc., is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems...

8. A second Board consultant reviewed 22 of the licensee's patient records. This

reviewer concluded, in part,

...My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.
...There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr. Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids; 2) combinations of three and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazapines and 3) the use of opioids for fibromyalgia at all. From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best. The use of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.
Patients suffering from fibromyalgia may also have altered endogenous opioid activity. A study utilizing position emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing. There are two possible

explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain. Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors. Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia. In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.
Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates. In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern with patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

While this consultant consistently marked "within minimum standards" on the

Expert Review Worksheets for Records and Diagnosis, he made the following finding

or similar finding in 19 of the 20 cases reviewed,

There is minimal documentation of physical exam which is required under the KBML regulations....A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

This consultant also made the following specific findings in individual Expert Review

Worksheets,

....
...Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriateness of initial therapy.
...It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids....The dismissal of the patient on high dose opioids without taper breaches ethics.
....

I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guidelines. Dr. Baird provides no intensive monitoring of function and minimal physical exam....This combination of medications is non-standard and risky in a patient with obstructive sleep apnea....Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable.

....Use of 2 short acting opioids in an alternating fashion is not standard care but Dr. Baird monitors outcomes and appears to be evaluating the patient's response.

...."Tender all over" does not constitute a physical exam.

....Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement.

....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax. This is a clear harbinger for substance misuse/abuse....High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion ....Though this patient was ultimately dismissed for non-compliance the original medication is questionable.

....The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards...."Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr. Baird that his patient likely has a personality DO....It is generally accepted that combinations of opioids and benzodiazapines plus Soma is high risk for addiction and adverse outcomes.... I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr. Baird may be helpful.

....The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/da. I am unsure of any rationale that supports this Rxn practice.

....Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an aberrant behavior in that the patient took her child's adderall and no action was taken.

....High dose opioid therapy is maintained though hypogonadism a clear complication of high dose opioid therapy is diagnosed. Again a stimulant is prescribed for fatigue and somnolence rather than...

....I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid. This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr. Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case....This combination of medications is non-standard and dangerous.

....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid

therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

9. The consultants' reports are attached hereto and hereby incorporated into this Emergency Order.

10. The Panel finds and concludes that controlled substances are controlled and regulated by the General Assembly because they are, by their very nature, dangerous to the public if not handled appropriately. They present a danger to the health, welfare and safety of patients if they are not prescribed or are not taken in an appropriate manner. Controlled substances create a danger to the health, welfare and safety of the public if they are diverted for illegal sale and/or use. The Panel specifically finds and concludes that the prescribing of controlled substances to patients creates a danger to the public health, safety and/or welfare if a physician prescribes such substances inappropriately.

11. The Panel has reviewed the investigation and finds that the licensee's failure to meet minimum standards of care in the overall treatment of patients and documentation of treatment demonstrates that the licensee has not exhibited the ability to practice medicine safely.

CONCLUSIONS OF LAW

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

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(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).

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 RESTRICTION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel B hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by John R. Baird, M.D., is RESTRICTED and Dr. Baird is prohibited from prescribing, dispensing or otherwise utilizing controlled substances until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

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

SO ORDERED this 28th day of May, 2013.

Randel C Gibson DO

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

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Restriction was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed via certified mail return-receipt requested to John R. Baird, M.D., License No. 36869, 3012 Eastpoint Parkway, Louisville, Kentucky 40223 and L. Chad Elder, Esq., Brian R. Good, Esq., Elder & Good, PLLC, 159 St. Matthews Avenue, Suite 1, Louisville, Kentucky 40207 on this 30th day of May, 2013.

C. Lloyd Vest

C. LLOYD VEST II
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March 30, 2012

Ms. Betty Prater
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

RE: Letter from Betty Prater dated 02/07/2012 regarding John R. Baird, M.D.

Dear Ms. Prater:

Thank you for asking me to review the material regarding Dr. John Baird. I have exercised the best ability I have in this matter, reviewing the material you have sent me. I have reviewed each item and I am recording my impression on each item. There will be a summation at the end. There are a few reference materials I have also enclosed and these will be attached in the appendix and they will be noted. I will review the patient records initially and then the other materials; the patient records first. This will be the patient's records of four patients only and they are [redacted] and [redacted] Unfortunately, there is a multitude of pages and I will try to be as brief as I can. Unfortunately, I was not able to follow the particular format you have sent me to follow for various reasons.

PATIENT ONE: [redacted]
DOB: [redacted] age 57, [redacted]

There are three sections of records marked chart one, chart two and chart three. They are for dates as follows.

1. From 04/08/2008 to 07/06/2009.
2. From 08/04/2009 to 09/10/2010.
3. From 10/10/2010 to 12/08/2011.

For convenience I will start from the beginning, 04/08/2008.

The first assessment as on 04/08/2008. She was 56 years old. She was a furniture salesperson. Her symptoms started from 1997 after a motor vehicle accident. I suppose she had symptoms from the age of 20. She had fibromyalgia and she met the ACR criteria for fibromyalgia. She had a pain level of 9 on a scale of 10. She was on hydrocodone 10/325 mg. She had trigger point therapy and physical therapy. She never tried Lyrica or Cymbalta. The patient had a previous hysterectomy. She had IM magnesium therapy, B complex, etc. Apparently the patient's husband was on chronic dialysis and was ill. The patient had symptoms of mood problems, irritability, fatigue, insomnia, poor memory and difficulty in concentration. The physical examination was not anything significant. The impression was fibromyalgia. The

consideration was for laboratory investigations, treatment with female hormones, trial of Lyrica 75 mg twice a day, consider Lunesta for sleep, consider Duragesic or Opana extended release for pain, considerer Vyvanse trial for fibro fog and ADD symptoms and follow up in one week.

COMMENTS: There is no mention of the patient's prior narcotic experience; but there was already consideration of Duragesic or Opana ER. It is quite surprising that the initial assessment did not include a commentary on the patient's prior narcotic experience before a decision was made to consider Duragesic or Opana ER treatment.

The next follow-up visit was on 04/17/2008. The patient's vital signs were normal. The pain score was 8 on a scale of 10. The impression was hypothyroid and the decision was to increase the Armour to 90 mg per day. The menopausal symptoms were treated with Estradiol 40/2.5 cc one cc IM injection. Fibromyalgia to start on anxiolytic with Klonopin for sleep and to give a trial of methadone 10 mg q.8 h. and to increase Lyrica as tolerated to 100 mg b.i.d. and vitamin D 50,000 units weekly.

COMMENTS: Once again there is no definite mention of the patient's previous narcotic experience in the commentary and the patient was started on fairly significant doses of methadone 10 mg every 8 hours.

The Next follow-up visit was on 05/16/2008. Of course, the diagnosis from 1997 was fibromyalgia. The patient was already on methadone. The current medication regimen was continued. Aquatherapy was recommended. The patient did not have any side effects from methadone and it was noted that the KASPER and urine drug screen were consistent. The patient had nocturnal myoclonus and recommended magnesium 500 mg at night. The patient had insomnia. A trial of Ambien was started at that time. Menopausal symptoms were treated with Estradiol IM injection and for mood disorder a trial of Cymbalta 30 mg daily was started.

The next follow-up visit was on 06/17/2008. The pain score was 6 on a scale of 10. Vital signs were unremarkable. The patient had no side effects on methadone. The patient apparently had nightmares from Cymbalta. Insomnia improved with Ambien. Nocturnal myoclonus improved with magnesium. Mood disorder, started on Effexor XR 75 mg daily. Menopausal symptoms were treated again with IM injection of Estradiol.

The next follow-up visit was again in one month on 07/07/2008. This time here again, she was feeling better even though the pain level recorded was 6 on a scale of 10. B12 injection was given for fatigue. Methadone was refilled. Ambien was refilled. There was a question of a funny thing, that was on 06/10/2008 the patient took one of her sister's Soma and it helped. It is stated that the Effexor, Pristiq and Cymbalta did not help, but the Soma helped. Therefore, the patient's impression seems to be that Ambien and Soma are better and I believe the doctor agreed to prescribe Soma.

COMMENTS: I do not understand the rationale of introducing another drug which seems to be very popular in the community, but is one of questionable pharmacological and therapeutic significance in my personal opinion.

The next follow-up visit was on 08/18/2008. No particular remarks could be made. The pain score was 6 on a scale of 10. The methadone dose was increased from three doses to four doses, that was 10 mg four times a day. The Soma, Zoloft and Ambien were continued.

The next visit was on 09/09/2008. The pain score was 6 on a scale of 10. This time the methadone was increased to *one or two q.6 h. p.r.n. and 180 doses were prescribed for 30 days*. That meant the patient can *take 60 mg per day*.

The next visit was on 10/09/2008. This time the pain level was 4 on a scale of 10. This time the methadone was *increased to 10 mg q.3 h., that was 8 doses per day. That was 80 mg of methadone.*

COMMENT: From a period of 08/18/2008 to 10/09/2008, that was a period of 60 days, the patient's methadone was increased from 3 doses per day to 8 doses per day. When it was increased to 8 doses per day the patient's pain score was 4 on a scale of 10. I personally think this was a huge dose increase of a very potent pain medication in a short period of time. To say the least, it looked like methadone was going out of style and I do not see the medical rationale in increasing the dose of such potent opioid medication at such high rates. There was no documentation of justification in increasing the dose at such a rate in a chronic musculoskeletal pain situation. The medical records do not indicate the justification in my opinion on 08/18/2008 or 09/09/2008 or 10/09/2008, except on 10/09/2008 it was stated that the patient was requesting an increase of methadone from 6 daily doses to 8 daily doses for better pain management. It *does not make sense*.

The next follow-up visit was on 11/06/2008. The pain score was 4 on a scale of 10. This time the methadone was not increased.

The next visit was on 12/08/2008. Stable on medication in spite of cold weather.

Next visit was on 01/09/2009. This time the only significant change was that the patient was undergoing a divorce after eight years. The pain level was 6 on a scale of 10.

The next visit was on 02/09/2009. The pain score was 5 on a scale of 10. No change.

The next visit was on 03/09/2009. The pain scale was 5 on a scale of 10. At this time it was mentioned she was markedly worse off Lyrica which Humana refused to fill. The pain level was 5, even though the patient was worse. At this time Dr. Baird apparently discussed OxyContin protocol and the new drug Savella. The patient's vital signs were not abnormal. There was no change in vital signs. The physical examination was unchanged. The impression was fibromyalgia. A trial of OxyContin and Neurontin with followup in one month was recommended. Even though OxyContin was discussed, methadone was refilled. Apparently in retrospect no prescription for OxyContin was written, because the patient forgot to call for the prescription of OxyContin.

COMMENTS: It appears that neither the doctor nor the patient thought it was such an urgent thing to prescribe the OxyContin. If it was such an urgent thing, either the patient or the doctor should have remembered to make the prescription. The fact that the patient did not call indicates

that this patient's musculoskeletal pain did not require such intense mega doses of opioid treatment. I have not come across a patient in my entire practice who forgot to call for a pain medication if they needed one.

The next follow-up visit was on 04/09/2009. This time strangely the pain level was 4 on a scale of 10 and the OxyContin was no more discussed. The Neurontin was stopped because of side effects and was changed to Lyrica. The methadone was continued. A trial of Amitiza for constipation was recommended and Adderall for ADD was recommended.

The next follow-up visit was on 05/04/2009. The pain level was 5 on a scale of 10. She was taking methadone 10 mg 8 doses per day. She was also taking Adderall for ADD with no side effects. Sleep was good. Energy level was fair. Her overall function was moderately affected by the pain and fatigue. She was going to be tried on Savella. The patient was already on Zoloft. She was not approved for Lyrica. The side effects of Neurontin were continuing. But here the impression/plan states insurance had denied Lyrica despite side effects to Lyrica and her symptoms are worsened with increasing suffering. I believe this is a typo or a dictation which was not corrected, even though it was signed. I am sure the physician meant side effects of Neurontin not Lyrica. In any case, the patient was on a sufficient amount of medication, so I do not think the patient suffered here because of the lack of medication.

The next follow-up visit was on 06/01/2009. Here the pain level was 4 on a scale of 10. Now she was better on Savella and methadone, but then the physician states that her pain is worse while she is off Lyrica.

COMMENTS: This is very hard for me to understand. On the one side the physician states her pain level is 4 on a scale of 10 and she is better with Savella and methadone and then he states that she is worse off without Lyrica. I do not know what Dr. Baird is trying to prove or disprove. It is not worth it for me to investigate because I would not find out.

The next follow-up visit was on 07/06/2009. This time the pain level was 5 on a scale of 10. She was on Savella and methadone. She was also on Adderall for ADD with no side effects. The plan was to continue the current plan. She had constipation due to dysmotility and she claimed to have an evaluation of the GI system. She was still off the Lyrica. This is the end of chart one.

CHART TWO
We will now go to chart two on [redacted]. The patient is a 58-year-old now. This chart two is from 08/04/2009 to 09/10/2010.

The first follow-up visit was on 08/04/2009. Of course, this was for chronic pain syndrome with this time osteoarthritis and fibromyalgia. Continue current medication and stay active. She also had ADD. Changed Adderall to extended release, that was XR. The pain level was 5 on a scale of 10. No change in vital signs. No change in physical examination findings.

The next follow-up visit was on 09/04/2009. This time the pain level was 4 on a scale of 10. This time the diagnosis of irritable bowel syndrome had been added. She was on probiotic and going to consider Xifaxan 200 mg b.i.d. for 7 days and rotation diet. Her fibromyalgia was

doing well with methadone with no side effects. UDS was good. ADD doing well with Adderall.

The next follow-up visit was on 10/05/2009. Again fibromyalgia was doing well. There was no problem with UDS. Requesting copy of EKG. ADD doing well. The pain level was 6 on a scale of 10. Vital signs normal.

The next follow-up visit was on 10/05/2009. Here the pain score was 6. Fibromyalgia was doing well. Current regimen good. No side effects. EKG fine. UDS fine.

Next follow-up visit was on 10/20/2009. Here pain score was 10 on a scale of 10. This was from the flare in her lower back and legs. She was on methadone 80 mg, Cymbalta and Adderall with no side effects. She took a Medrol Dosepak which did not help. This time the treatment was changed. In addition to all of the above medications, she was put on Percocet 10/325 mg and was to be followed in two weeks. The note states that the patient had tried hydrocodone before, so try Percocet this time. No mention of the starting dose, except to start her on Percocet 325 mg. When I looked at the KASPER, the starting dose was 10 mg of Percocet 8 doses per day. The prescription read Percocet 10/325 mg, 120, two q.4-6 h.

COMMENTS: I do not know why the record did not indicate what the starting dose should be. I do not know why one has to start on such a mega dose of two q.4-6 h. The patient is on large doses of methadone, being given the liberty to start with a humongous dose without any explanation whatsoever. I cannot for the life of me understand the rationale here and what this physician was thinking or what was the basis of his starting the patient on a large dose of medication in a patient who was already on mega doses of methadone. More comments here to follow later.

The next follow-up visit was on 11/02/2009. This time the pain score was 5 on a scale of 10. It states that the patient had osteoarthritis and fibromyalgia and she was here for followup. Her knee was feeling better after a few days of pain. Her pain was now more in the back. Her pain level was 5 on a scale of 10. She was on methadone, Cymbalta and Adderall with no side effects. She was due to methadone refill with Percocet not helping her much. The conclusion in the chart states impression/plan, fibromyalgia was doing better and back on her usual pain medications with no aberrant behavior.

COMMENTS: I do not know why this patient was asked to come back in two weeks for a follow-up visit if no remark was really made what the Percocet did for her in detail and what was the purpose of her coming back in two weeks if this was not mentioned. It looks like the physician had the right intent, but did not execute the purpose of the intent in the medical record.

The next visit was on 11/30/2009. This time the impression was chronic pain syndrome with fibromyalgia. The pain level was 5 on a scale of 10. She was doing well with methadone, but needed Percocet for breakthrough pain and will continue stimulant. Will change back to Adderall, non time release.

COMMENTS: Here again I see the indication that the patient needs frequent stimulation rather than pain relief. The patient does not like the time release Adderall and the patient needed

frequent doses of Percocet, not the constant pain relief with methadone. The pain management physician should have gotten the message from the patient that she preferred the immediate release form of medication rather than the time release. That was a definite indication what the patient was looking for. Obviously it was missed; at least that is my personal opinion. I do not think there was anything wrong in that situation. It would have been a valuable point in the long-term care of patients.

The next visit was on 12/28/2009. This time she was doing well. The pain level was 3 on a scale of 10. She was doing well with Adderall immediate release form. Chronic pain syndrome and fibromyalgia doing well also with the current regimen with occasional irritable bowel syndrome. Vital signs normal. No change.

The next visit was on 01/27/2010. The pain level was 5 on a scale of 10. The same vital signs basically. The patient's pain apparently was worse with cold weather, but everything else seemed to be okay, except that she was in a mini flare. The blood pressure was 160/80. The impression/plan said ADD, watch blood pressure with Adderall not taken today, but feels bad. I am not sure what the physician meant by this. I did not see anything really wrong with the vital signs. For fibromyalgia she was supposed to be in a mini flare with continued pain medications and absence of side effects with trial of OxyContin at night for severe pain that helps her sister. There are no more details about this, except the comment that her sister seems to be helped with OxyContin and Dr. Baird is going to try OxyContin on this patient because it helps her sister. This is for the fibromyalgia flare. Hopefully we will see the result in the next follow-up visit.

The next follow-up visit was on 02/22/2010. Obviously the patient is 58 years old now. She is in a flare due to cold weather. She takes methadone 80 mg per day, that is 8 doses of 10 mg. She takes OxyContin at night. Obviously the OxyContin was prescribed for night during the last visit. The blood pressure was checked today and it was 120/80, as opposed to the previous month blood pressure which was 160/80. There was only a change in the systolic blood pressure, not in the diastolic blood pressure. When compared to the previous visit, the pulse rate was 80 and this time the pulse rate was 80, but systolic blood pressure had come down. I cannot attach much significance to this myself. Otherwise, everything seemed to be in good order. This particular visit does not indicate a pain level, whereas all of the others did indicate a pain level, except it says she is in a flare due to cold weather, but the blood pressure had come down and that indicated that her pain was better to me at least. The OxyContin dose level was not noted in the chart, but if the patient was in a flare and the blood pressure had come down, and it was better and OxyContin was helping and if her sleep was good, but the problem she has was low energy, night sweats, nightmares and moderate functional loss, but the patient was off her sleep medications and it was written to see the pain sheet. Unfortunately, the pain sheet was only half filled and it looked like everything seemed to be better in the pain sheet, at least from what I can read. In other words, one cannot attach too much importance to the medical records as documented.

The next visit was on 03/22/2010. This time her pain level was 4 on a scale of 10. She was taking methadone 80 mg, Cymbalta 60 mg, and overall function was good. She was taking OxyContin 40 mg q.12 h., Percocet 10/325 mg four per day and that seemed to be a huge dose of medication. In morphine equivalent it was an equivalent of 420 per day. That was methadone 80

mg per day, OxyContin 80 mg per day and on top of that Percocet 40 mg per day. Both the physician and the patient seemed to be happy.

The next visit was on 04/19/2010. The pain score was 5 on a scale of 10. Vital signs were perfectly normal. Picture perfect. The patient was doing well.

The next visit was on 05/14/2010. Here again the pain score was 5 on a scale of 10. Everything was picture perfect.

The next visit was on 06/14/2010. The pain level was 4 on a scale of 10. Here she was on OxyContin 40 mg daily, Percocet 10 mg four per day, methadone 10 mg eight per day. Here the patient's blood pressure was 150/100, pulse 70 and respirations 15. The recommendation was to check the blood pressure and if it remains high to go off, I believe, the medication for ADD.

The next visit was on 07/12/2010. Here the patient had a pain level of 5 on a scale of 10. She was taking OxyContin 40 mg daily, Percocet four per day, methadone 10 mg eight per day. She was doing fine. She was getting estrogen gel for menopausal symptoms. She was going to be restarted on thyroid and was on Adderall. Vital signs were perfect.

The next visit was on 08/11/2010. The pain level was 8 on a scale of 10. Apparently she went on vacation and left her pain medication at the hotel, so she went through withdrawal and had to go to the hospital for morphine IV. The patient had no pain medication except Cymbalta when the patient was seen in the office. When seen in the office, the patient had been in withdrawal with diarrhea, chills, nausea and cramps and was given a refill on pain medication and was urine drug screened. The patient was kept off her Adderall because her blood pressure was 140/90 because of whatever reason. It was thought it was from the Adderall. Most likely it was from the withdrawal, but no rationale was given except reaction.

The next visit was on 09/10/2010. Here the pain score was 7 on a scale of 10. Nothing was mentioned about the previous month's withdrawal symptoms, but her UDS was fine at that time, even though she was not on any particular medication or she had not taken her medication. Her leg pain was increased due to flare and the weather. She lost some weight. She apparently had a motor vehicle accident and lost her car, but no further details about this were mentioned.

COMMENTS: It is surprising that the patient totaled her car and lost her car when she was traveling and she had withdrawal symptoms when the patient was seen in the office last time. It is really surprising. It was also stated that the patient wanted to use Adderall once per day because her blood pressure is fine at home apparently.

Here we have a situation where the patient had a confluence of things that she missed or lost her drugs in the hotel where she stayed, when she was in drug withdrawal, then she totaled her car and no comments were made. More on this in summation.

CHART THREE: [redacted] is from 10/11/2010 to 12/08/2011.
The next follow-up visit was on 10/11/2010. Vital signs were perfectly normal. Pain level was 5 on a scale of 10. She was doing fine with the current regimen. She was taking Percocet 10 mg four per day, OxyContin 40 mg at bedtime and methadone 10 mg eight per day.

The next visit was on 11/08/2010. Here the pain level was 5 on a scale of 10. The patient was doing well. Vital signs were perfect. Clean as a whistle. Medications same.

Next visit was on 12/06/2010. The pain level was 4 on a scale of 10. She was using the same medication.

Next visit was on 01/07/2011. The pain level was 5 on a scale of 10. Vital signs perfect. Medications same.

The next visit was on 02/07/2011. The pain level was 6 on a scale of 10. It stated that she had 70% relief. Vital signs were perfect.

The next visit was on 03/07/2011. The pain level was 5 on a scale of 10. This time she was unable to afford Cymbalta. She had a flare of pain so the Cymbalta was changed to Effexor 75 mg twice a day. Now the patient was going to fill out disability paperwork.

The next visit was on 04/11/2011. The pain level was 4 on a scale of 10. She was taking methadone 10 mg eight per day, Percocet 10 mg four per day, OxyContin 40 mg at bedtime with good relief; but the impression/plan stated may need to change the OxyContin to 80 mg for better pain relief with refill. UDS today with need to continue pain medications with improvement in function. This does not make sense. Even though the impression/plan stated to change to OxyContin 80 mg, the KASPER review and the prescription review do not show that the OxyContin was increased to 80 mg. Therefore, I cannot explain the doctor's statement.

The next visit was on 05/10/2012. It states that the patient was doing some work with her brother and she was enjoying it. The pain now is well controlled with the visual analog scale rate 6 on a scale of 10. Methadone 10 mg eight per day, OxyContin 40 mg at bedtime, Percocet 10, dose unknown, Adderall for ADD with no side effects. The impression states that the patient going back to work seemed to have helped her, even though there was flare with the weather. The impression also stated that she was feeling better with Adderall.

The next visit was on 06/08/2011. She had a pain level of 6 on a scale of 10. She remained disabled and the doctor encouraged her to remain active. Pain level was 6. No medication change. It appeared that there was 50% relief, but the vital signs were perfect. Clean as a whistle.

The next visit was on 07/06/2011. The patient was in for followup. She had sleep problems. She used more Percocet and she keeps running out of Percocet, but her sister uses Opana and the patient wants to try this with the OxyContin not working very well at all. Pain level was 7 on a scale of 10. Methadone was eight per day. The pain was less relief with OxyContin and Percocet. Function, sleep and mood poor. The plan was to change OxyContin to Opana with continued use of methadone; but no mention of what dose or how gradual the change was not written in the record. Also, there was no mention of whether a pill count was done or UDS was done to see why the patient's medication intake was not helping, just to change from one set of huge doses of medication to another type. More comments in summation.

The next visit was on 08/05/2011. Here the format of the medical record had changed and it seemed to be more detailed in a decent format. There was more history written here, even in the follow-up visit, including family history and previous history. The medications were listed and on 08/05/2011 the medications were vitamins, Adderall 10 mg b.i.d., OxyContin 40 mg once daily, Percocet 10 mg or 6-8 per day, methadone 10 mg 6-8 per day, Armour 90 mg per day, Bentyl 30 mg daily, Soma 350 mg q.8 h., Ambien 10 mg. Physical examination was normal. Here it stated that she had more pain while she was on Opana. Again, the dose of Opana was not specified; but the patient requested that the Opana trial did not work and she wanted to go back on her previous regimen; that was the OxyContin, Percocet and methadone. It looks like that was done.

The next visit was on 09/06/2011. On 09/06/2011 it stated that the patient had failed the Opana and OxyContin, so the plan was to add Duragesic 25 to the methadone and Percocet, Adderall and Soma. The pain was worse at night. The plan here was for 25 mcg fentanyl patch, methadone and Percocet. Once again, no formula or methodology as to how 25 mcg of fentanyl per hour had been determined to replace the OxyContin or Opana was stated.

The next visit was on 10/06/2011. Here there were normal vital signs, except the respiratory rate was 20. The patient's weight was recorded to be 147, blood pressure normal at 120/80 and pulse 80. The medication was methadone 10 mg eight per day, Duragesic 25 every 3 days, Percocet 10 mg eight per day, Adderall also. Here we have methadone eight per day, Duragesic 25 and Percocet now eight per day and not four and then the Duragesic.

COMMENTS: Obviously even though the OxyContin was discontinued, it was substituted by another dose of Percocet 40 mg.

The next visit was on 11/09/2011. Here nothing really had changed, except the patient had been doing well with her current regimen.

The next visit was on 01/04/2012. Here there is a note in the medical record in addition to Dr. John Baird that APRN, Bridget Buckman was added to the list in the medical team. The patient was doing fine or better or fair. Since her pain was 8 on a scale of 10, they were going to increase Duragesic to 50 mcg q.3 days. Methadone and Percocet were continuing. Menopausal symptoms were treated with hormones. Drug screen was done.

The last visit on the chart was on 12/08/2011. This was the last follow-up note. At this time obviously the lady was 59 years old. Pain was 5 on a scale of 10. She was on methadone, Percocet and Duragesic patch. She had stress over money and was unable to work. She was taking Ambien, vitamins, methadone 10 mg six to eight per day, Armour 90 mg, Adderall 10 mg twice a day, Percocet 10 mg six to eight per day, Pepcid 30 mg daily and Soma 350 q.8 h. Obviously the patient's mega dose medication management continued.

This has completed the charts one, two and three on [redacted] and the **comments on the entire medical record are as follows**:

This lady was 57 to 58 years old. She had the diagnosis of fibromyalgia and possibly osteoarthritis, female menopausal symptoms and question of chronic fatigue or attention deficit

disorder. I do not know whether chronic fatigue was chronic fatigue syndrome or whether her attention deficit disorder was depression from the mega doses of opioid medications she was taking.

These following comments are in addition to my general comments regarding the use of opioid medication in general, which is in the final summation.

Specifically in this lady, when methadone was started she was started on 10 mg three times a day right off the bat. I am not sure such heavy doses were necessary in a patient whose weight was in the 140 range. It was so surprising that in the initial assessment the patient's initial narcotic experience had not been documented to any degree of elaboration. That is an adverse remark against the physician and it is a serious adverse remark. This patient could have been started on dose such as 5 mg of methadone three times a day, if not even a lesser amount, for chronic musculoskeletal pain unless the patient had been narcotic tolerant. Even if the patient were narcotic tolerant, the starting dose of methadone did not have to be 10 mg three times a day straight off the bat.

In addition, it does not appear to be any problem for this particular physician to treat patients with large doses of opioids by any stretch of the imagination. Say for example, I calculated the morphine equivalent of the dose of opioids this patient was receiving on 03/22/2010. The calculation indicated that she was receiving a morphine equivalent of 420, when all of the narcotics she was getting were put together. On top of that, she might have been getting other depressant drugs such as Ambien and/or Soma.

OTHER COMMENTS: The patient was tried on Opana ER, and here again the patient was tried on extended release Opana all on a sudden rather than a trial of immediate acting or immediate release Opana on a dose titration as the manufacturer has recommended. Obviously Dr. Baird is very familiar with these drugs, but he straight away went to try Opana extended release because the patient's sister had experience with using Opana and the patient's OxyContin was not working and, therefore, he thought it was appropriate to try Opana. This dosage did not work out after a one-month trial, which was a brief trial. I, for that matter, would not do it that way. I would try Opana immediate release around the clock for at least a month before starting somebody on extended release medication.

The other situation which I came across is the escalation of dose. Say for example, on 09/09/2008 the pain score was 6 on a scale of 10 and the patient was taking methadone 10 mg six per day. On 10/09/2008 the pain score was 4 on a scale of 10. In spite of the pain score coming down, the patient was given methadone 10 mg eight per day. That means there was an increase in the dose of methadone when the pain was less according to the medical record. In a period of two months the patient's dose of methadone was raised from 40 mg per day to 80 mg per day. That is a 100% increase for reasons that are not explained in the medical record. When using opioids, especially when the dosage is doubled in a short period of time, there has to be some justification. It is very well known that such dose escalation in short periods of time will be adversely affecting the patient in the long term in long-term pain management. By the same token, on 10/20/2009 the patient for whatever reason had a pain score of 10 on a scale of 10. At that time the patient was taking methadone 80 mg, Adderall and Cymbalta. The medical record states that the patient had had hydrocodone before, therefore, Percocet would be tried. At this

time, the starting dose was 10/325 mg of Percocet and the KASPER indicates that it was started on 10 mg eight per day. The prescription read 10 mg, 180, take one to two q.4-6 h. p.o. on a p.r.n. basis. That is giving the patient exposure to a fairly large dose of Percocet in a dangerous way. The patient could have been given a dose in a simpler format, such as one q.4 h. on an as-needed basis, so that the patient would not have the risk of overdosing. How would the patient know how to titrate if a wide latitude of dosing was prescribed. This patient also was taking at the same time Ambien at bedtime and Soma 350 mg q.8 h. This patient was on multiple drug therapy and the physician should have been more careful in exposing the patient to another depressant drug which has definite implication when adding onto preexisting doses, especially when potent drugs are used. It is always better to err on the side of being a lower dose than a higher dose. My comment is that the physician should have used a better caution and discretion in this matter. It is the wrong way of challenging a patient's opioid tolerance by issuing a large dose prescription.

A couple more notes on the medical record keeping and follow-up visits. On quite a few of the follow-up notes on multiple occasions the vital signs appeared to be the same, such as the respiratory rate either 15 per minute or pulse rate 80 per minute on repeated visits where blood pressure basically was the same. As someone who has been recording patient vital signs for over 50 years as an anesthesiologist in all sorts of circumstances, it is very difficult to see exactly the same vitals on repeated follow-up notes on patients. This has to be very unusual. I am not trying to question the integrity of the person who keeps the medical records, but to me it looks very unusual that you can reproduce the same figures on each visit with the same patient.

The patient who is on large doses of opioid medication and other medications, including sedatives, hypnotics and stimulants, the body weight and height are not recorded for many years in a row. The first page I could find the body weight was on the urine drug testing report, which was recorded by the person who filled up that form. It was not included in the medical records until a few years had passed after the patient was enrolled in the medical records.

The other comment that I have is that there is nowhere in the medical record a detailed report about the KASPER review had been entered. I am sure Dr. Baird had looked at the KASPER, but I have not seen a comment on the KASPER except the KASPER and UDS are consistent.

The final comment I have about this record is not about the mega doses of opioid medication this patient had, but the report on 09/10/2010 when there is a note that the patient lost the automobile from an automobile accident where she totaled the car. One visit before that the patient had lost her medication in the hotel where she was staying while on vacation. When the patient was seen in the office she was suffering from major drug withdrawal symptoms. The question had not been raised whether the automobile accident happened while she was driving or someone else was driving, whether any drugs were involved and any adjunct medication which the patient was prescribed or any other medication which the patient was taking were involved or whether someone else was driving or if there was any alcohol involved. None of these were mentioned and I think it would have served useful purpose when these things come to whether any of those were involved, especially when the Dr. Baird was prescribing for this patient a combination of methadone, oxycodone, Ambien, Soma and other drugs which have a bearing on her ability to focus, concentrate and take necessary action in times of fright and flight. It would have been nice and it would have shown that Dr. Baird is a knowledgeable physician in the field of

prescribing opioid medication if he had thought about it and made a note about whether the medications the patient was taking while she was driving or the accident occurred were involved, or whether she was driving at all when this happened. If she was not driving, it would have been entered in the medical record, which would have been even better for everyone concerned. The fact that nothing was mentioned, except to state that the loss of automobile increased her anxiety, is an incomplete medical record.

PATIENT TWO: [redacted]
DOB: [redacted], 52-year-old [redacted]

This patient's record is in two separate charts, chart one and chart two. The first chart starts from 08/29/2008 to 08/26/2010. Chart number two starts from 09/20/2010 to 01/23/2012.

CHART ONE: [redacted]
The first visit was on 08/29/2008. The patient was seen for evaluation and treatment for fibromyalgia of eight plus years duration, or having had the diagnosis that long. The initial history indicates a multitude of symptoms of major psychiatric illness for which she was on Prozac with stable mood. She had a history of DVT and she was on Coumadin. She had a history of having had sexual abuse and current marital problems at the time when Dr. Baird saw her. She had a history of mitral valve prolapse, cardiomyopathy, migraine headaches, gastroesophageal reflux disease, hiatal hernia, cervical degenerative disk disease, lumbar degenerative disk disease, temporomandibular joint disease, pelvic pain, anxiety disorder, etc.

The patient was on Darvocet N100, Prozac, Ambien and Coumadin. She was 5'5" tall and weighed 188 pounds. There was a cardiac diagnosis of mitral valve prolapse. There was no arrhythmia and no murmur present. The findings were that she met the ACR criteria for fibromyalgia and there were no objective findings for any other disease for which she had a plethora of symptoms. The plan according to Dr. Baird was to start aquatherapy, start on Lyrica and to see her in three to four weeks. The record indicates that she was on Darvocet, Prozac, warfarin, Ambien, atenolol, Nexium, Singulair, Zyrtec, Combigan, Mucinex, Azor and Prevacid, but not on any opioid medication.

The next follow-up visit was on 09/22/2008. The impression was fibromyalgia, Hashimoto's disease, manic depressive symptoms and the plan was to have a trial of Armour, thyroid hormone supplement, female hormone supplement, vitamin D, change the Prozac to Cymbalta and increase the dose of Lyrica at night and then to follow up in three weeks. The pain level was 5 on a scale of 10. The vital signs were just perfect. There were no other physical examination findings.

The next follow-up visit was on 10/22/2008. This was a follow-up visit. Fibromyalgia was better. Manic depressive symptoms and she was started on Testadiol.

The next follow-up visit was on 01/20/2009. The pain score was 8 on a scale of 10. The diagnosis of attention deficit disorder was added. Her mood had been fine. No real explanation for the good mood, the attention deficit disorder, but was started on Vyvanse 50 mg daily. Her fibromyalgia and the Hashimoto's were doing well. Vital signs were perfect. Physical

examination was perfect, except that she had minimal right fourth rib dysfunction, probably from coughing from bronchitis. No specific treatment or x-rays were done I believe.

The next follow-up visit was on 03/18 2009. In spite of having a lot of problems, including no electric power for up to eight days, her energy level was better. She had less brain fog. She had a pain score of 2 on a scale of 10 and she did not have her hormone prescription filled. She was off Cymbalta, but back to Prozac and her attention deficit disorder apparently was still ongoing. She was to continue on her Vyvanse.

The next follow-up visit was on 03/18/2009. Pain score was 7 on a scale of 10. She continued to have normal vital signs, the same as before. Physical examination was not changed. She had some pain in the left arm where she had the hormone shot. The plan was to continue the Vyvanse and the hormone treatment, etc. No particular change was done. Overall she was doing well.

Next follow-up visit was on 04/21/2009. Headache resolved. Mood disorder continued. Pain level, body pain, 7 on a scale of 10. The decision was made to add hydrocodone for increased pain and she was advised to stay active. She was started on hydrocodone 10/325 mg two a day. There was no particular reason given for the decision to give hydrocodone 10 mg twice a day. I am not quite sure how this was done because one dose does not cover 12 hours as far as I know. Maybe she only has pain for a few hours a day. This was not explained in the record.

The next follow-up visit was on 05/18/2009. The diagnosis again was chronic pain syndrome with headaches and fibromyalgia with high stress and there was nothing really abnormal in the vital signs. They were clean as before, basically the same as before. The lower back pain was improved after treatment and the medication was continued.

The next follow-up visit on 06/17/2009. Again no change. Vital signs again were basically the same. Diagnosis the same. The medications were not changed, including the medication for ADD.

The next follow-up visit was on 07/16/2009. Here again the vital signs were perfectly normal as before. Physical examination did not change very much. The pain score was 6 on a scale of 10. The patient was on Vyvanse for ADD and the question was raised whether this needed to continue because of heart racing, but there was no indication in the vital signs. The chronic pain syndrome with headache and fibromyalgia. Myalgia was the same. No aberrant behavior. Good pain control. Hyperthyroidism was treated. Vitamin B level was replaced. Coumadin level was fine. Hyperlipidemia was treated with krill oil and high fiber diet, etc. It looks like Dr. Baird is able to treat symptoms like hyperlipidemia also, not only pain management.

The next follow-up visit was on 08/13/2009. The pain score was 3 on a scale of 10. The patient apparently had headaches due to mold. Fibromyalgia was doing well. ADD continued on Vyvanse. Here again the vital signs were perfectly normal and the same as before.

The next follow-up visit was on 09/15/2009. The pain score was 5 on a scale of 10. There was no problem.

The subsequent follow-up visit was on 10/15/2009. The pain score was 5 on a scale of 10. The patient had some increase of pain because of the cold weather, but UDS was okay and ADD was treated well. There was good pain relief with hydrocodone. This time it states the hydrocodone was two to three per day. It provided good pain relief also. The patient apparently wanted to go off the Vyvanse due to fear.

The next follow-up visit was on 11/17/2009. This time the ADD was bothering her and the Vyvanse was to be started again. The fibromyalgia pain was well controlled. Once again the vital signs were just perfect.

The next follow-up visit was on 01/13/2010. This time the patient was off the hydrocodone due to missed appointment. She was placed back on hydrocodone with no side effects. The Vyvanse was restarted. Of course, the pain score was 1 on a scale of 10. This was interesting in that this was even when the patient was not on hydrocodone. One always wonders why the hydrocodone had to be restarted.

Subsequent follow-up visit was on 02/12/2010. Everything was the same. The vital signs were perfectly normal. The pain score was 7 on a scale of 10.

The next follow-up visit was on 03/10/2010. At this time the patient had a DVT problem with clotting disorder and they were going to check PT/INR levels. Mood disorder seemed to have reappeared and they were going to start her on Wellbutrin 100 mg trial b.i.d. Vyvanse was continued for ADD. The fibromyalgia pain was worse due to colder weather. Her mood was terrible. Apparently there was reason why the pain was even worse because of issues with her teeth, but no details were given.

The next visit was on 04/13/2010. This time the pain score was 8 on a scale of 10. The vitals were perfectly normal as before. This time she was started on Neurontin 300 to 600 mg at bedtime for the fibromyalgia. The mood disorder was due to stress and there was a plan to reduce the Wellbutrin. There was a flare of IBS. The Vyvanse was to continue. Thyroid and vitamin B treatments continued. There was going to be a sleep study done for assessment of fatigue.

The next follow-up visit was on 05/13/2010. This time the pain score was 6 on a scale of 10. Vital signs were perfect as before. She was given a Medrol Dosepak for whatever. Sleep study was still not reported. ADD was to continue and mood disorder. Apparently she was worse after being off of the Wellbutrin and so the Cymbalta was increased to 90 mg.

The next follow-up visit was on 06/10/2010. This time the pain score was 8 on a scale of 10. The plan was to continue the same treatment, but to consider chiropractic treatment on top.

The next follow-up visit was on 07/12/2010. This time the pain score was apparently not recorded, but the hydrocodone use had gone up to 10/325 mg six per day with no side effects, along with Lyrica. The vital signs were again perfectly normal as before. She was getting physical therapy at Baptist East Hospital. Wellbutrin was now helping. This time work shift disorder was diagnosed and a trial of Nuvigil 150 mg per day was started.

COMMENTS: There was no explanation why the hydrocodone dose was raised to six doses per day. The dose escalation seems to be interesting. Originally she was started on two doses of hydrocodone on 04/21/2009. By 07/12/2010 it was six doses per day. There appears to be no change of any significance in her pain score, at least not on the average, and there was no real change in her vital signs or pulse rate at any time in spite of being on stimulant drugs also. Therefore, no explanation provided for the mega doses of hydrocodone increase. Then on 07/12/2010 work shift disorder had been diagnosed and Nuvigil started 150 mg daily. I have not seen evidence of discussion as to how this new diagnosis of work shift disorder was arrived at. If the hydrocodone were used for low back pain, there was no diagnostic test performed as far as I am concerned as to why the low back pain was increased and why the doses were increased without the diagnosis or revised diagnosis. The prescription dated 07/12/2010 for Norco 10/325 mg indicates one to two q.4-6 h. p.o. p.r.n. for pain, #120. This is giving the patient a license to use hydrocodone on a discretional basis.

The next follow-up visit was on 08/26/2010. This time the pain score again was not reported, but the pain was well controlled with hydrocodone 10/325 mg six per day with Lyrica and this was apparently making 60% pain relief. The pain was mainly in the lower back. Once again, no further diagnostic testing was done. Sleep study was normal. Physical therapy with pool therapy was started. Once again vital signs were essentially the same as before. Everything seemed to be better at this time, on 08/26/2010.

CHART TWO: [redacted]
The first follow-up visit for chart two was on 09/20/2010. Again, the patient is a 54-year-old seen in followup. The diagnosis was fibromyalgia and attention deficit disorder or ADD, for followup. The pain score was 6 on a scale of 10. The patient was taking hydrocodone 10 mg six per day with Lyrica with only 30% relief this time. She had gastric disturbance with oral steroids and, therefore, she was going to be given intramuscular. Vital signs again were perfect, as before. Abdomen was soft. Impression/plan, the patient's stress may be due to her husband running for elective office and because of this she needs continued pain medication. Obviously that is an interesting observation.

The next follow-up visit was on 10/18/2010. This time the pain score was 8 on a scale of 10. In addition to a flare of pain, sleep has been worse. The patient was taking Wellbutrin 75 mg twice a day and apparently she was taking hydrocodone 10 mg and Lyrica without side effects. She apparently slept all day Saturday after working all week and sleep was not good. Once again, the vital signs were perfect as before. No change at all. The impression was fibromyalgia, headaches, flare with seasonal change. The plan was to give her a Medrol Dosepak and then increase Wellbutrin with encouragement to get the patient into sunlight, etc. and to continue stimulants. The interesting thing here is that *the patient's husband thinks she is over medicated* and is sleeping too much.

This is an *interesting comment* in a patient who is on multiple medications including stimulant. Obviously the husband is somebody who sees her on a daily basis much longer than the office staff or the doctor and when a husband makes such suggestions or reports, someone has to pay attention. If the husband thinks the patient is over medicated, there should be more discussion or decision made on that statement rather than have it left alone without any resolution, other than giving the patient a Medrol Dosepak and stimulants.

The next follow-up visit was on 11/18/2010. This time the pain score was 7 on a scale of 10. She apparently ran out of medication and that may be the reason why the pain was worse, but that was not mentioned in the report, except to say that the patient needed stronger pain medication at night. The report says that the function was worse and there was a flare up. In my opinion, all of this could be explained when the patient ran out of medication rather than other devious explanations, but with all of these changes of pain, lack of pain relief and flare, the patient's vital signs were perfectly the same as the time before and the time before or multiple visits. The statement was said that the patient ran out of medication, but the vital signs have not changed. It was decided to add OxyContin to the pain medication. The decision was to add OxyContin 20 mg q.12 h. with consideration of Medrol Dosepak.

The next follow-up was on 12/17/2010. Here it was a surprise. The vital signs exactly the same as previous visit when the patient ran out of medication and obviously there was no pain score mentioned. The surprise, surprise was that the OxyContin was not approved by the insurance. No other medication was used in its place, but nothing seemed to happen to the patient. Sleep was good. The flare remained. The patient continued to work and apparently her neck was out of alignment. Her moods energy and function were variable, but headaches had been worse. Once again, with all of these things going on, her vital signs were perfectly the same as before. No change in the past many months. This time it was decided to try MS Contin and Norco refill. There was a suggestion with continued body work by husband. I do not know what that means. I suppose it may be massage; but that was not a medical language which I can understand.

The next office visit was on 01/17/2011, a month after the previous visit. This time the pain score was 7, but once again the vital signs were exactly the same as the month before. Pain had been worse to 7 on a scale of 10. The patient was on hydrocodone same dose, MS Contin, apparently the patient had pleuritis, but 70% pain control. The pain was in the left leg and lower back. At this time side effects from morphine was the impression and changed the Percocet for severe pain episodes with Norco for every day pain and try to do stretching or yoga.

The next follow-up visit was on 02/14/2011. This time the patient's pain scale was not recorded. Her back had been more painful with tightness. GI issues had gotten worse. She had gained 7 pounds with possible effect on hernia. Her appetite was too high and she could not take stimulants, so would try OTC. Once again, vital signs were perfect as before. The impression was fibromyalgia, still having pain due to stress in the area of thought HCP program and refilled medication. Obviously nothing had been done in the form of investigation.

The next follow-up visit was on 03/15/2011. This time the pain score was noted and was 3 on a scale of 10, a major improvement. The patient had sinus allergy. The patient was on hydrocodone and Percocet and seemed to have some autoimmune neuropathy. Surprisingly, fibromyalgia was doing well with alternating hydrocodone and Percocet and UDS was fine. She had cardiomyopathy. She was supposed to have a followup with cardiologist about new Coumadin dose, getting a 2-D echo and use of CO Q10 daily. The patient was supposed to be having 80% pain relief.

The next follow-up visit was on 04/08/2011. The patient's pain score was 5 on a scale of 10. She was taking hydrocodone and Percocet, 4 hydrocodone 10 and 4 Percocet 10. The patient

was supposedly to be doing well, but was hit with hayfever and then the fatigue increased. Once again the vital signs were good.

The next follow-up visit was on 05/23/2011. This time she had a 60% to 80% pain relief, but then the VAS score was 7 on a scale of 10 with Norco and Percocet alternating. Vital signs again were perfectly good. There was neuropathy disorder, ADD and fibromyalgia in the diagnostic column. Surprisingly, the patient still takes about eight tablets of hydrocodone or Percocet together and this still had a significant amount of daily Tylenol intake.

The next follow-up visit was on 07/26/2011. This time there was a change in the format of the medical record. The patient now had allergy to morphine noted. Diagnosis was still chronic pain and fibromyalgia. Medication was Norco and Percocet. Dose was not mentioned. The pain level was 6 on a scale of 10. The impression was that the patient was on good treatment. No aberrant behavior. She would be sent to physical therapy and home exercises. Prescription was for Percocet and hydrocodone. Quantity was not mentioned.

The next follow-up visit was on 08/25/2011. Again chronic pain syndrome, fibromyalgia with small flare and autonomic nerve system dysfunction with atrial fibrillation.

The next follow-up visit was on 09/23/2011. Here the diagnosis was hypothyroid, menopausal symptoms, fibromyalgia and the pain score was not mentioned. There was a note that the cardiac workup was underway.

The next follow-up visit was on 09/23/2011. Here again fibromyalgia, atrial fibrillation and nothing seems to have changed.

The next follow-up visit was on 12/22/2011. Basically the pain score was 5 on a scale of 10. The diagnosis was chronic pain syndrome with fibromyalgia. She was doing well, considering the high stress and workload. Pain medication was refilled.

The next follow-up visit was on 11/22/2011. Another followup was on 12/22/2011. Both were similar workups. The diagnosis was the same. The pain level was 4 or 5 on a scale of 10. The medications were not changed.

The last follow-up visit was on 01/22/2012. Here again the pain level was 7 on a scale of 10. The medications seemed to be multiple again, which included Coumadin, zolpidem, fluticasone, vitamin D, Zyrtec, thyroid, Cymbalta, bupropion, Norvasc, Norco, Lyrica, flecainide and for some reason I do not see the Percocet. I do not know if the Percocet was missed in this dictation or not, but it was present the month before. The dictation said her average pain had been 7 on a scale of 10 on Percocet and hydrocodone and that means she was taking both. The KASPER obviously proves that she was taking both. This is the end of the month-by-month review and the summation follows.

SUMMATION: The summation can be very brief and to the point. The patient's husband very succinctly reported that she was over medicated and for the pain of fibromyalgia, back pain and leg pain, without further investigation all the physician did was hydrocodone in five significant doses, OxyContin was added and the insurance company refused to give it. Therefore, morphine

was substituted and that produced allergic response. Thus it was discontinued. None of this made a whole lot of difference in the pain. Then when morphine was disallowed the patient was given Percocet 40 mg per day in divided doses on top of hydrocodone 10 mg four times a day also. In spite of significant amount of exposure to Tylenol on a daily basis, this seems to have helped the patient and it has been continued since the start. I do not know if effort was made to reduce the dose and in spite of the patient's husband complaining she was over medicated. I did not see anywhere any effort being made to redo any of the investigations to see if something else was contributing to increasing pain in the back and leg. No consideration was here about the total amount of Tylenol consumed by the patient, even though it was only 2600 mg per day. It looks like this lady had been on this high dose of oxycodone/hydrocodone management for more than a year and how long was it going to go. No effort was being made to change to other drugs or reduce the drugs or investigate her for some other diagnosis or treatment. The other surprising situation here was the patient's vital signs for many months in a row. The patient's vital signs were static whether the patient's pain was 4 on a scale of 10 or 8 or 10 on a scale of 10. Even when the patient was out of medication the vital signs had not changed. On 11/08/2010 the patient's pain score was 7 on a scale of 10. She admitted and it was reported that she had run out of pain medication and her function was worse. She was diagnosed with a flare of fibromyalgia, but this was not explained by the patient running out of pain medication, but due to flare. No effort was made to see whether the patient had any pain medication in her system by UDT. Not a discussion was even made on this matter, except to start the patient on OxyContin which the insurance company refused to provide. The fact that the insurance company did not provide the OxyContin and the patient did not take additional pain medication, that also did not change the vital signs. There was a series of these vital signs month after month which were basically the same. On 07/26/2011 the format of the medical records was changed. For the next five visits from 07/26/2011 the patient had only similar vital signs on two occasions, but on the other three she had different vital signs. I do not know what to say about these things, but this type of vital sign recording which I see in the majority of entries, I would not have much faith in. I will not go much more than that in this matter. I do not want to make remarks on healthcare worker sensitivities, but it certainly is an unusual phenomenon that every time a patient visits each month they have very similar vital signs. It is a surprise to me.

In summary, this 56-year-old, as of the date of last review, was under treatment with high dose opioid therapy for fibromyalgia or chronic musculoskeletal pain with other adjunct drugs and stimulants and hormones and antidepressants with borderline control of pain. The disappointing fact is that the prescriptions were written in such a way, as for example on 05/23/2011, a sample prescription reads; Norco 10/325 mg, number 120, signature, 1-2 p.o. q.4-6 h. p.r.n. and the same date Percocet 10/325 mg, number 120, signature, 1-2 p.o. q.4-6 h. p.r.n. To me that means a patient can take 12 pills of hydrocodone 10/325 mg a day and 12 pills of Percocet 10/325 mg per day, a total of 24 pills a day. I do not understand the rationale for such a prescription of such a short-acting medication for around-the-clock pain control. It just does not make sense under any circumstances. I do not know how a pharmacist or physician or nurse can explain to the patient what this prescription means or how the patient should take this medication. This was not for acute pain, this was for chronic pain on a maintenance dose. If this is the level of education and standard of practice in somebody who specializes in pain management, I feel sorry for everyone involved.

PATIENT THREE: [redacted]
DOB: [redacted] 45-year-old [redacted]

The first date of engagement was 01/14/2009. The referring physician was Dr. Margaret Altman. Consulting hepatologist was Dr. Cecil.

The patient obviously was a 45-year-old female. The patient was seen in consultation for genotype 1 hepatitis C and neuropathy. The hepatitis was diagnosed in 1982. Apparently she was a lab technician at that time. She was a patient of Dr. Cecil. The patient had widespread chronic musculoskeletal and joint pain. Other symptoms were fatigue, headache, irritable bowel syndrome and irritable bladder syndrome. The patient had a lot of muscle spasm and muscle pain, depression and anxiety. There was a statement that the patient had a morphine pump in 2002 and that was explanted or removed in 2003. The cause of explant was mentioned as due to pancreatitis. There was no explanation how the morphine pump caused pancreatitis. I did not see anywhere in the chart that there was a causal relationship of the morphine pump to pancreatitis. Apparently the patient had tried hydrocodone, Duragesic, methadone and Demerol before without relief. Therefore, the primary care physician, Dr. Nigam, had prescribed for her hydrocodone 10 mg twice a day. The last dose was taken the day before the patient was seen by Dr. Baird. That should have been 01/13/2009. Apparently the patient took Percocet the day when she saw Dr. Baird. The pain level was 8 on a scale of 10. The patient apparently stated that she was granted disability in 1995 and at the same time the patient was pursuing a degree in counseling at Jefferson Community College. She also apparently stated that she had manic depression after losing her life, her husband and her career. Apparently she was tearful in the office and mourning the loss of her husband after he committed suicide five years earlier. The patient apparently stated that her mood was otherwise stable on Cymbalta and Seroquel. She also was status post complete hysterectomy at age 21 for cervical cancer. She was recently taken off of Premarin by her primary care physician for complaints of intermittent hot flashes. The patient had chronic pancreatitis, neuropathy, cervical cancer, chronic otitis media and hypertension in the past and HCV in 1982. The previous surgery included morphine pump placement in 2002 and removal in 2003.

The patient had a history of allergy to penicillin and sulfa as reported on this particular date, 01/14/2009. The medications listed were hydroeodone, Cymbalta, Valium, Lunesta, Seroquel, Protonix, metoprolol and Phenergan. The physical examination did not report any definite diagnostic finding.

The assessment was chronic pain with neuropathy. The evidence of neuropathy was not documented. It was stated that the patient had hepatitis and was followed by Dr. Cecil. It was also stated that the patient was interested in acupuncture and the office was ready to start. The office also assumed the response for pain management, awaiting urine drug testing results. The patient would have the menopausal symptoms treated by a trial of Vivelle dot patch.

COMMENTS: I do not see the previous opioid use review since apparently this had been going on since 2002 at least or 2003, since she had a morphine pump placement. Since this had been done by someone, I thought this medical record or this assessment, since it was an elective case, should have involved the notation where this was done and the details of the previous pain management treatment, the rationale and the explanation why it was explanted, etc. Otherwise, it

would be my definite statement that this chart is incomplete. Why should a new pain management physician who specializes in pain management take over the case from another physician or physicians if it is not an improvement. Obviously many years ago somebody had placed or implanted a pain pump in a patient and had it explanted and the reason for explantation was documented to be pancreatitis. That is hard to believe. Other than making a blanket statement that the patient had tried multiple medications and failed and the pump was tried and explanted and had failed, these statements do not make sense unless details are investigated, obtained and documented. I do not see that. At the same time, the physician who was taking over the case had agreed to symptom management. I believe this was a half hearted attempt unless the physician taking over was going to start from scratch, ignoring everything else.

There was a KASPER report in the file with no comment and this was dated 01/31/2008 to 01/30/2009. Obviously this was obtained after the initial visit. This KASPER was for one year before Dr. Baird saw the patient. In this one particular one-year report there were various prescribers and there was a documentation that hydrocodone 10 mg was prescribed 14 to 16 per day, Percocet 10 mg was prescribed 8 per day and Fentanyl patches 100 mcg per hour, 50 mcg per hour and 25 mcg per hour, etc were tried. Klonopin, Lunesta and nifedipine also were tried along with diazepam. None of this was documented in Dr. Baird's initial assessment.

The patient saw Dr. Baird this time on 01/14/2009. According to the KASPER report, the patient filled on 01/16/2009 Percocet 10/325 mg 120 pills prescribed by Dr. Nigam from Walgreen's in Corydon. On the same day she filled clonazepam 0.5 mg 90 pills from Dr. Nigam at the same pharmacy, but 5 days later on 01/21/2009, she filled a prescription from Dr. John Baird for oxycodone 15 mg 90 pills from RiteAid Pharmacy in Louisville. This KASPER report was dated 01/30/2008 to 01/30/2009. That was where I got the information. In other words, this patient obviously had been filling prescriptions from Dr. Nigam even after Dr. Baird had agreed to take over her pain management. So, that was one example. I do not know whether Dr. Baird had checked her KASPER before he had agreed to take care of her. At least the KASPER which was in the file had been documenting many years of prescription from various physicians. Going through the records, it appeared that the urine drug testing done on the day of visit for the first time with Dr. Baird showed only benzodiazepines and no opioid medication, even when Dr. Baird reported that she was taking hydrocodone at that time 10 mg twice daily. Again, I do not see any remarks about this in the file. In any case, there will be more on this toward the end of the report.

The first follow-up visit was on 01/21/2009, that was 7 days after the first visit. The history on this day was different seven days after the first visit. No mention of the first visit seven days ago. No mention about the urine drug testing or the KASPER, except what the primary care physician did about her white blood cell count and how her fluid buildup was treated by the primary care physician and that the patient did not follow instructions to see Dr. Cecil. Then it mentioned that her pain medication was switched from hydrocodone to Percocet by the primary care physician and the pain level was 7 on a scale of 10 while taking Percocet 10 mg 4-6 weeks with some constipation. This time it was also mentioned that she was tried on Lyrica which produced weight gain, Demerol which continued pain, Duragesic which continued pain, morphine pump produced pancreatitis, Dilaudid was helpful, Neurontin worsened depression, methadone produced somnolence and hydrocodone produced headache without relief. Therefore, she remained on Cymbalta and was instructed that this could cause worsening of her

liver disease. She stated that she had discussed this with Dr. Cecil as well. She had tried Paxil, Prozac, Wellbutrin and Zoloft without relief. Current medications listed were Percocet 10 mg four to six, Cymbalta 30 mg daily, Protonix 40 mg daily, Lunesta 3 mg at bedtime, acyclovir 400 mg, Seroquel 200 mg, Klor-Con 10 mEq, metoprolol 100 mg, furosemide 20 mg, Klonopin 0.5 p.r.n. and Phenergan 25 mg p.r.n. I believe this had been changed from the previous week, but I do not know how. The surprising thing today was that one week later she was allergic to morphine also. Previously one week ago she was allergic to penicillin and sulfa only. Now she is allergic to morphine. There was no explanation given. Also, it was stated that this lady had a morphine pump implanted and was explanted after one year due to pancreatitis. The impression this time was, one week after the first visit, she remained in a significant amount of pain on chronic Percocet use. She had tried Lyrica, Duragesic, morphine pump, Demerol, Dilaudid, methadone and hydrocodone. Various treatment options were discussed. She would be given a trial of Roxicodone 15 mg one p.o. q.6 h., 90 pills. She returned the Percocet to the office for proper disposal. There was no particular rationale made or stated in this switching.

COMMENTS: In this particular follow-up visit, one week ago when the patient was first seen she was allergic to penicillin and sulfa. A week later the allergy list included morphine. It was also stated that the patient had a morphine pump implanted in 2002 and this was explanted in 2003 due to pancreatitis. There were no further details on this. This confuses me. Therefore I reviewed the entire chart by scanning the entire chart and I came upon a history and physical for this patient from St. Mary's Hospital in this file and this was dated 04/18/2010. This was a full five page typewritten history and physical with Wendy Barker, APRN for Dr. Kusum Nigam, M.D. dated 04/19/2010. The allergies written in this record from St. Mary's Hospital were penicillin, sulfa and latex, but morphine was not included. Therefore, I am unable to figure out what exactly is going on. I had hoped somebody had the wisdom to figure this thing out before it threw the reviewer into unlimited confusion. If the patient already had a morphine pump implanted and the reason for explanting the pump was pancreatitis, how can the patient be allergic to morphine, unless the morphine pump was used as a generic pump and the drug used in the morphine pump was something other than morphine, but then again nobody has documented that.

The second comment is switching from Percocet 10 mg every 6 hours to oxycodone 15 mg every 6 hours. I agree that this is an increase in 5 mg of oxycodone per pill, but the Tylenol small dose is missing. I do not know how much difference this had made. Calculating morphine equivalent and ignoring the Tylenol content in the Percocet, this would be as follows; The Percocet would be 60 versus the oxycodone which would be 90. I believe an improvement of 50%, but obviously that rationale was not documented. Maybe it is not important.

The next follow-up visit was on 02/10/2009. It reports that the patient had 50% improvement in pain with switching from Percocet 10/325 q.6 h. to oxycodone 15 mg q.6 h. That was from 40 mg to 60 mg of oxycodone per day. The pain level was 6 on a scale of 10. There was some somnolence intermittently. The Roxicodone 15 mg was lasting 4-5 hours. The sleep was improved. Constipation was relieved with Senokot. Her KASPER and UDS from January were consistent.

The next follow-up visit was on 03/04/2009. The patient continued to be better on Roxicodone three to four per day. The pain level was 2.

The next visit was on 03/18/2009. There was a flare of neuropathy of the hands and feet. The patient was put on a trial of physical therapy for the treatment of neuropathy and to continue pain medication.

The next visit was on 04/01/2009. The pain level this time was 7 on a scale of 10. This time the patient apparently had pancreatitis with a recent bout and she took more of the Roxicodone and she would be out of pain medication in two days. She was taking Roxicodone 15 mg two tablets two to four times per day with continued pain. I do not understand this at all. One has to make the statement how many tablets on the average the patient takes rather than range as it is related to the dose and effect. But, then the patient apparently thinks that the Roxicodone was not helping and, therefore, various treatment options were discussed. Therefore, at this time the decision was made to start back on the Duragesic patch 50 mcg per hour every 3 days and to stop Roxicodone. Apparently the patient wanted to increase Percocet also, but that was denied with the statement that that was only for breakthrough pain. The reason why this was for breakthrough pain was because of the acetaminophen content of the Percocet. In any case, to make a long story short, the dose calculation of changing the oxycodone to fentanyl patch was not discussed. In my calculation Roxicodone 15 mg six doses was equal to the morphine equivalent of 120 mg. Fentanyl patch 50 mcg per hour was also equal to 120 mg morphine equivalent. Therefore, whether Dr. Baird thought about it but did not record it, switching the Roxicodone to fentanyl did not make any difference in the strength of the pain medication, but only the brand of the pain medication. I wonder whether switching from one medication to the other wether it was the brand which was important or the potency of the morphine equivalent which was important in a patient who was complaining of lack of relief. The physician did not make that point clear.

The next follow-up visit was on 04/28/2009. This time the pain score was 7 on a scale of 10. She stopped the physical therapy. The patient apparently wanted to go back to Roxicodone and try Neurontin at night. Obviously the patient here has more experience than the physician. The patient's pain level was high in spite of Duragesic. It says that the patient also is taking Percocet 10 mg three times a day with no side effects. I thought that the patient was denied to continue the Percocet. Only God knows what was given and what was taken.

The next visit was on 05/22/2009. At this time the pain level was 4 on a scale of 10. This time the patient had chronic pain syndrome with hepatitis and neuropathy and *fibromyalgia*. I am not sure where this new diagnosis came from. She also had allergy to Duragesic adhesive. Therefore, they were going to something else. The pain level was 4 on a scale of 10. It states now this time she was on Duragesic 50 and Roxicodone 50 mg six per day with no side effects, except she had hst of allergy. Here again, what the patient was taking and what the previous record stated were not the same. This time the treatment plan was to start the patient increased. She will be increased to MS Contin 100 mg three times a day and Roxicodone 15 mg six per day. Now this time when we calculated morphine equivalent from the original of Duragesic 50 mcg and Roxicodone to MS Contin and oxycodone, prior the change she was on morphine equivalent of 240 and after the change she was on morphine 420. That was almost double the narcotic potency. The pain level was 4 on a scale of 10 and when the pain was better we will take care of the patient who had allergy to the tape which was part of the medication regimen. The dose of medication was doubled. That is basically foolhardy.

Whatever happened to morphine allergy here – who is confused?

The next visit was on 06/02/2009. This time the pain level was 3 on a scale of 10. The patient was supposed to be taking MS Contin 100 two times a day with oxycodone 15 mg I believe six per day. There was initial sedation. Then everything was fine. Obviously my remarks regarding the previous follow-up visit were true, that the patient was rewarded with double dose of pain medication when the pain level was less. Doubling the dose of pain medication did not improve the pain relief a whole lot, except that the pain level which was 4 on a scale of 10 was decreased to 3 on a scale of 10. Not a whole lot of big difference. But, the price that was paid was sedation.

Here again, the patient had a diagnosis of chronic pain syndrome with fibromyalgia, hepatitis C and neuropathy. She was considered doing better with no aberrant behavior, good function with the current regimen. Here again was the problem in this practice that all the decisions were made, or the majority of the decisions were made on an arbitrary basis and not related to cause and effect or pros and effect, but by fancy of the imagination. This does not qualify as rational medical decision making.

The next visit was on 07/29/2009. This time the paint level was 3 on a scale of 10. The medications were MS Contin 100 two times a day, oxycodone 15 mg six per day. Sleep was poor, but good energy and brain fog with ADD symptoms were the new diagnoses. She had not tried stimulant and she does not like Ambien, but her overall function was good. Here the diagnosis was chronic pain syndrome with failed low back pain syndrome, neuropathy, fibromyalgia and hepatitis C. She was doing well except for constipation and brain fog and sleep. This time they were going to try Amitiza for constipation and Adderall 10 mg b.i.d. for ADD and Valium for sleep.

COMMENTS: I cannot for the life of me understand why the ADD diagnosis had crept up here, except the patient and the medical records state that the patient was sleepy with large doses of pain medication. Dr. Baird had diagnosed ADD all of the sudden and started the patient on Adderall 10 mg b.i.d. and the same time started the patient on Valium on top of her being already sleepy. It did not stand to my type of reasoning and obviously Dr. Baird's reasoning was certainly different than mine. Dr. Baird had not established a diagnosis of ADD except written that the patient was sleepy and she had brain fog. I believe the woman was being loaded with narcotic medication and that was the only conclusion I can draw from reviewing the patient's record so far.

The next follow-up visit was on 08/20/2009. Here the pain level was 3 on a scale of 10. The pain was well controlled. Medications were Roxicodone 10 mg, MS Contin 100 three times, Neurontin, Adderall for ADD with no side effects. Her sleep, mood and energy were fine. The patient was, according to Dr. Baird, in excellent shape.

The next visit was on 09/14/2009. This time the pain level was 8 on a scale of 10 and this time her symptoms were worse. Dr. Baird thought she had severe neck pain and abdominal pain. She had not eaten for three days. Therefore, wanted to change to Dilaudid 4 mg one to two q.4 h. with Phenergan for nausea and vomiting. She wanted Percocet for headache. Dr. Baird had diagnosed acute pancreatitis. Obviously the records indicated that the patient had suggested the

treatment. When I looked at the record, the vital signs were blood pressure 120/70, pulse 80, respirations 15. This was the blood pressure on the last three or four visits before today's visit. There was no change in vital signs. The patient knew what the treatment was. Dr. Baird apparently agreed and allowed the patient to change to Dilaudid 4 to 8 mg every 4-6 hours and to increase Valium to 10 mg three times a day with change to Percocet 10/325 from Roxicodone, all at the patient's request. She would have Phenergan suppository for nausea. I do not know what Dr. Baird was doing here. He was going to follow the patient's instructions. Was there a role reversal here that the patient was the doctor and the doctor was the patient? I cannot understand this at all. I shall discuss this further at the end under summation. I cannot believe that this was a record composed by a physician for dictation. When he decided to treat the diagnosis of acute pancreatitis at the discretion of the patient and as per the patient's direction. Dr. Baird stipulated that he was in pain management.

The next follow-up visit was on 10/13/2009, one month after the diagnosis of acute pancreatitis. The diagnosis this time was failed low back pain syndrome, hepatitis C, pancreatitis, neuropathy, fibromyalgia for followup. She apparently went to the emergency room with chest pain and abdominal pain with a pulse of 139. She was not on Adderall at that time and she was given beta blocker with the diagnosis of anxiety attack. She had an anxiety attack recently as well. Her pain level was 5 on a scale of 10 on Dilaudid 4 mg six per day, Percocet 10/325 mg eight per day, Valium 10 mg three per day, Cymbalta 50 mg with increased liver function and Neurontin two per day with no side effects. Urine drug screen fine. Her hand burning affects her pain issues. She may need to follow up with psychiatry for anxiety.

With all the above statement, the vital signs are still the same as the month before when she had acute pancreatitis and the month before when she had no problems. Vitals signs were still the same. The impression/plan waschronic pain syndrome. She would be this time considered for OxyContin 60 mg q.12 h. and the Dilaudid would be stopped with Percocet for breakthrough pain and to reduce the Valium. There was something else which I do not understand.

The comments here are once again there were no details about the patient having had an angioplasty and heart rate of 139 and the patient being prescribed Adderall and her anxiety attacks, etc, etc. There are no details mentioned.

The next visit was on 10/29/2009. Here the diagnosis was still the same and she had a pain level of 10 on a scale of 10. This was from an abscess tooth. The patient was on OxyContin 60 mg. This lasted for four to five hours. Percocet 10 mg six per day and this lasted for 4 hours as well. She was on Neurontin and Valium with continued pain. Her abdomen was bloated and she had gained weight and abdominal girth. This time the vital signs were basically the same, except blood pressure was only systolic 100 and everything else was the same. Chronic pain was still the same diagnosis. She had a flare with a lot of swelling of the arm and abdomen. This may be related to the liver issues. Therefore, the treatment has been to increase the OxyContin to 80 mg three times a day instead of 60 mg twice a day and to change Percocet to Roxicodone and to see a liver specialist.

COMMENTS: This may be kind to the patient, but this was the part of kindness which kills people too. Her acute pain from tooth abscess was treated I believe the wrong way. Instead of giving her a short-acting drug for a short-term prescription, her OxyContin was doubled and her

Percocet was probably increased also, but changed from Percocet to Roxicodone. I do not understand what type of practice this is. There was no workup except to ask the patient to go and see a liver specialist. This was the physician who claimed that he was thorough in his workup and he treats everything because he does not want to send the patient to everybody else, including his ability to treat hormonal deficiency, thyroid function, attention deficit disorder and mood changes, etc. He cannot treat simple things like an abscess tooth and its pain.

The next follow-up visit was on 11/25/2009. This time the pain was 7 on a scale of 10. She was on OxyContin 80 mg three times a day, Roxicodone 15 mg 8 to 10 per day, and she had tooth abscess with fracture. She refused to continue liver treatment and she remained on Adderall for fatigue.

With all of this going on her vital signs were perfectly the same as before. The patient had on examination edema with blisters of the left foot with erythema. The impression was chronic pain syndrome with neuropathy due to fracture, cellulitis of the foot, fibromyalgia. Apparently the plan was to reduce the OxyContin to 60 mg, but this was taken out and it was because of the sedation but it was discontinued. The hepatitis was not responsive to treatment. At the same time, it stated that the patient refused to continue treatment. The patient was on Adderall.

The next visit was on 12/23/2009. This time she had a pain score of 7 on a scale of 10. Medications were the same. This time she had neuropathy of the foot with an insect bite and she ran out of pain medication due to leg pain. This time the doctor thought that there was high risk for abuse so they were refilled and encouraged her to have PCP visit for foot problem. With all of these things again, the vital signs were absolutely perfectly normal.

The next visit was on 01/21/2010. At this time the medications still remained high dose OxyContin and oxycodone. The pain level was 5 on a scale of 10. Apparently the patient was doing better. Vital signs were still the same.

The next visit was on 02/18/2010. Here the pain level was 2 on a scale of 10 on current medications. This time the patient wanted to reduce the OxyContin, but wanted to increase her Roxicodone to reduce nausea. Dr. Baird had reduced the OxyContin to 50 mg three per day, but the Roxicodone was increased to 30 mg four times a day, so obviously the patient wanted a boost in the immediate release variety of medication and reducing the time release. I think this is playing games. Both the doctor and the patient were playing games with each other with narcotic medication. I do not think this is pain management. This is a game of chess with narcotic medication. I do not know what else to qualify this as.

The next visit was on 03/15/2010. Here the pain score was 2 on a scale of 10. She was taking Roxicodone 30 mg four to six per day, OxyContin 60 mg three per day, Valium 10 mg three per day and no side effects. Urine drug testing was good. Dr. Baird said this was "the best regimen she had been on." She was controlled well with Adderall. Her pain was controlled 90%. This time Dr. Baird stated she was doing well and this time she may need a trial of Marinol for anorexia of the pancreatitis. She needed trigger point injections for right arm pain in the scapular area. She was going to have a trial of Marinol 2.5 mg daily for anorexia. I personally thought Marinol was for control of nausea rather than for improved appetite. Of course, there are various off-label uses for drugs.

The next visit was on 04/12/2010. The patient was upset with the insurance company denying Marinol. The patient was also upset that medicare was not paying the doctor. Pain level was 2. She was taking Roxicodone 30 mg four to six per day and OxyContin 60 mg three per day, Valium 10 mg three per day with 80% pain relief. She had anorexia and was able to eat every three days with the Marinol with caused abdominal pain. The impression was that she had fibromyalgia and pancreatitis. She was worse without the Marinol. No new change had been proposed.

Next visit was on 05/10/2010. Here the patient's pain was 7-8. Vital signs were still perfect. She had painful hematuria this time. She was going to see a urologist.

The next visit was on 06/08/2010. Her liver function test apparently was worse. Her renal function was fine. Pain was 6. This time the Roxicodone was 30 mg, six per day and oxycodone 80 mg three per day with no side effects. She had neuropathy, but the pain relief was 90%. No new findings. The vital signs once again were perfect.

The next visit was on 07/01/2010. Here the pain level was 8 on a scale of 10. This time she apparently had an emergency visit for foot pain. Then she went to a podiatrist and was diagnosed foot fracture and she was placed in a cast. She was unable to use crutches due to neuropathy, so she was using a walker. She needed home care. Pain level was 8. This time the OxyContin was increased to 80 mg four times per day, the Roxicodone 30 mg and Valium with no side effects. This time she was started on Ambien for insomnia on top of the Valium.

The next visit was on 07/28/2010. The pain level was 6 on a scale of 10. She was again on the mega doses of OxyContin and the Roxicodone and the patient had 90% relief.

The next visit was on 08/24/2010. This time the pain score was 5 on a scale of 10. She had urinary retention and the pain level was 5. She had a 80% pain control. She was now on a vegetarian diet. She had abdominal distension, severe. There was mention that she had urinary retention with renal cysts and needed to do self catheterization or go to the emergency room for followup. She was apparently well controlled as far as her pain was concerned.

The next visit was on 09/16/2010. Apparently the patient saw Dr. Pitmon, who was the podiatrist and possible RSD was diagnosed and osteoarthritis of the joints. The pain diagnosis on the foot was either Charcot joint or RSD. The pain level was 7. OxyContin 80 mg four times daily, Roxicodone 30 mg six, Valium in larges doses with no side effects. Vital signs were perfectly normal for the past many months or years. The impression was right foot pain with no evidence of RSD. The patient was going to have a fusion of the ankle for severe osteoarthritis. The plan was to add Nucynta to the rest of the medications and consideration was given go going to the hospital with new onset of diabetes, etc. But, Dr. Baird is to fill the pain medication anyway and her vital signs were perfect, as usual.

CHART TWO: [redacted]
DOB: [redacted] 45-year-old [redacted]

REMARKS: I have no records for the months of October and November 2010. The records start with December 2, 2010.

The next follow-up visit was on 12/02/2010. The diagnosis had not changed. The neuropathic pain has been worse. She was there for followup. The patient apparently was clumsy and falling and was on Dilaudid. Therefore, they stopped the Dilaudid. Pain level was 8 on a scale of 10. OxyContin and Roxicodone for buttocks and back pain. She had back spasms due to cold weather. Urine drug testing was fine. Depression better. The patient's sleep had been poor. They were going to try her on Seconal barbiturate. Once again the vital signs were exactly as they were three months ago, on 09/16/2010. The impression was chronic pain syndrome and they were going to stop the Dilaudid and maintain her on other medications.

COMMENTS: There was no criteria established how and when she went on Dilaudid, etc, in the medical record. If it was there, it was not in the chart.

The next follow-up visit was on 12/23/2010. This time the diagnosis was the same. There was flare in the pain with increased stress. Apparently she tried to reunite with her abusive mother and apparently there was an altercation and the mother called the police and the patient was put in jail for domestic violence. I am not sure exactly what happened, but the pain level was 6, and somehow it was written that her visual analog scale for pain level was 6 out of 20, on Neurontin 300 mg six to eight per day, OxyContin 80 mg four per day, Roxicodone 30 mg six per day with 60% relief. "My pain medication is no longer working." She had tried Duragesic patches in the past with local dermatitis. She had also tried morphine with allergy reaction, Dilaudid with complaints of frequent falls and Opana ER with no relief. She said that oxycodone 60 mg was more effective than 80 mg of OxyContin. She was having muscle spasms and back pain and her glucose levels had been running around 400. Her focus and concentration were better on Adderall. Her mood was depressed. She had to catheterize herself. She was not on dialysis. She was tearful. This time for the first time her vital signs were different and her treatment plan had been also changed.

COMMENTS: This time the medical record was apparently made by the Leslie Bieckhoff, APRN, in consultation with Dr. Baird and that might be the reason why the vital signs were changed and different than the previous ones. The medications had been changed. This time with a new focus. The OxyContin 80 mg 2 tabs twice per day has been changed to OxyContin 60 mg three tabs twice daily, that is instead of 160 mg she is going to get 180 three times daily. Roxicodone was continued for breakthrough pain. A trial of soma was started for muscle spasm. Here again we got another controlled drug being introduced, as if she had not been on enough of them.

The next visit was on 01/04/2011. This was an early follow-up visit and the patient had a recent seizure problem and memory loss. The patient was to see a neurologist. The patient was supposed to go to Dr. Arar. She apparently was hospitalized. The patient was seen in the office last time. She was unstable when walking. She did not have an EEG yet and was unable to tolerate scan of the brain. Her medicare would only cover 120 mg of OxyContin. The patient's vital signs reverted back to the good old stable steady vital signs this time. Dr. Baird reported that the patient thought that Dr. Baird was Dr. Arar, the neurologist. Obviously that meant the patient did not even recognize her own doctor who had been treating her with all these fancy medications. I do not know what to make out of that. There was no mention in the chart that any effort was made to get the record from the hospital as to what happened in the hospital. I thought this should have been done, especially when the patient did not even recognize the

doctor and the patient had seizure disorder and she had been dosed with pretty heavy doses of opioid medication and other medications which influence patients' sensorium.

Subsequent visit had been on 01/25/2011. This time the patient was there early due to recent hospitalization with chest pain and palpitations, left arm tingling and headaches. She had a failed stress test, EEG, MRI of the brain and blood tests., they increased Keppra to two per day due to abnormal EEG and was to have followup with Dr. Arar, who did nerve conduction study with severe right CPS and neuropathy and sent her to surgeon, Dr. Nawab. Her Neurontin was increased. This time, once again, the vital signs were perfect. The patient had the diagnosis of anxiety, chronic pain syndrome and fibromyalgia, but the medications were refilled. She was not getting the OxyContin fully filled. The medical record was not very complete. There was no mention of what happened in the hospital again.

The next follow-up visit was on 02/17/2011. Apparently the patient fractured her foot at Sears and she was scheduled for surgery. Now she was being followed by the home health nurse. This time her arm and foot were killing her. Her pain was 8. She was on Neurontin, OxyContin, Roxicodone with 40% relief. OxyContin apparently was not working for her. She was interested in a trial of Opana. Of course, the patient seems to know these things much more than the doctor. Here Dr. Baird agreed to try Opana. This time her blood pressure was higher than usual and this time Leslie Bieckhoff was involved as an assistant with Dr. Baird. The vital signs obviously were different. Opana ER 40 mg had been started on top of the Roxicodone and I believe the OxyContin had been discontinued. Once again, no rationale as to what formula was used to change the drug dose from one drug to the other and what was the morphine equivalent, etc.

The next visit was on 03/15/2011. This time the pain was better with Opana, but the patient was receiving home healthcare and apparently the patient was inquiring about Hospice. Apparently her pain medication had been recently stollen by her boyfriend's nephew. Otherwise her pain was well controlled with Opana. This time the diagnosis was changed from chronic pain syndrome with diabetic neuropathy to liver and kidney failure. The home health was to continue.

The next follow-up visit was on 04/15/2011. Pain level was 6. The patient had hand surgery for carpal tunnel and nothing more was added.

The next visit was on 05/11/2011. The pain level was 7 on a scale of 10, but then she had 80% pain control and the vital signs were okay. They were going to continue the pain medication.

The next visit was on 05/11/2011. She was getting 80% pain relief and they were going to continue the Opana and oxycodone. The pain level was 7 on a scale of 10.

PATIENT FOUR: [redacted]
DOB: [redacted], 49-year-old [redacted]

The patient was first seen on 10/19/2010. There is a KASPER report in the file dated from 10/14/2009 to 10/14/2010. The patient, according to the initial history and physical, was seen and I am going to quote from the history and physical. The whole first paragraph is quoted.

"HPI: She is a 49-year-old MWF from [redacted] a recovering alcoholic for years, here for evaluation and treatment of fibromyalgia in 2009. She was fine until her daughter got married, followed by liver failure with normalization now. She was then told she had EBV with liver specialist following her closely. She was tried on Savella and then Neurontin with edema, was stopped. She went on Lyrica and Percocet 10/325 mg with pain level of VAS 10/10 with no relief with anything so far. She had a total hysterectomy nine years ago for BUB and fibroid tumors on Premarin now. She feels like an orphan as an only child, and parents dead with parents CZECH and KIWI, born in Australia. Her current issues are constant pain all over like a toothache. Her sleep is affected by the pain and she had fatigue and mood disorder. She has a low sex drive. She tried the Vivelle dot patch, but never did stick well with never tried gels."

I do not know what this paragraph really means; this appears as if it is composed by a third grader; except that the patient is a recovering alcoholic there are no details in it. It appears that she had some emotional breakdown. She had some liver disease with Epstein Barr virus and she apparently was seeing a liver specialist and liver function apparently was normal. She was being treated with Savella and Neurontin. She had edema as a complication, I believe. Then she was on Percocet and Lyrica, etc, etc. But, this whole history was an exercise in confusion as far as I can tell. In any case, the history and physical does not have any mention of the KASPER which was in the patient's file, which was dated form 10/14/2009 to 10/14/2010. There was no mention whether it was reviewed. In addition, the patient was supposed to be a recovering alcoholic, but there was no detail about this at all anywhere. There was mention about liver failure and it was normalized as of now, as mentioned, but again there were no details. There was a mention that the patient was tried on Percocet 10/325, but there again there were no details of what dose and for what duration and no further details.

Further down the history there was a statement that the PMH and PSH - allergies SH - SH- ROS, see sheet and reviewed. This I believe was about previous history, previous medications, etc. I do not know where or what this means. None of these records were attached to the material I have reviewed. Therefore, my impression is that these are not there. The patient's vital signs were recorded and these were perfectly normal and the physical examination did not show any abnormality whatsoever. The report on the physical examination was absolutely brief in two lines and the vital signs were blood pressure 120/80, pulse 70, and respirations 16. No weight. No height. No temperature. The impression/plan was chronic pain syndrome with fibromyalgia and she met the ACR criteria and the plan was to wean her off Lyrica and there would be balancing hormones and consideration of different sleep medication and there would a "change to time release medication with Opana extended release 10 mg q.12 h. and Percocet as needed for breakthrough." "Will be tried on treatment with previously high libido." "I will assume her pain management with UDS pain agreement," also APT, high risk with alcoholism and KASPER. Then with all that in mind, the physician goes to prescribing Percocet 10/325 mg 120, 1-2 tablets q.4-6 h. and Opana extended release 10 b.i.d. It seems to be the same M.D. who said the Percocet 10/325 mg did not help. I do not quite understand the rationale of giving the patient a wide range of p.r.n. medications in the form of the same medication which did not work before, allowing the patient to take up to 12 pills per day on top of Opana extended release without documenting the patient's previous narcotic history in detail. How can one start Opana extended release 10 mg b.i.d. rather than trying the patient on small doses of immediate release of the compound around the clock and deciding how much of this drug would the patient need for effective pain control if that was the goal of treating the patient.

The second visit was on 11/03/2010. This was a follow-up visit. Once again the document does not make any sense what the physician was trying to say. It stated that the patient was worked in for followup. She had to continue using hydrocodone at the same rate despite Opana, so we will increase the dose. She had breast soreness from the hormone injection and her libido level remained the same. Her pain level was visual analog scale 7/10 on Opana ER 10 mg and hydrocodone 10/325 mg six per day with UDS fine and repeated today. She broke her left second toe and told her to use cast shoe and buddy tape it. The above were quotes from the physician's history. Obviously the patient was not on hydrocodone and I do not know how the physician got the impression that she was on hydrocodone rather than Percocet. Percocet was what was prescribed. Other than that, the patient's vital signs were the same as on the original day the patient was seen. In any case, under impression the patient had fibromyalgia and the Opana was increased from 10 mg to 30 mg q.12 h. and continue the Norco for now with UDS today and followup and then the Norco was taken off and Percocet was put in as correction. Obviously the physician realized the mistake when he signed the chart, but the thing remains kind of complicated and not decipherable by the reviewer.

COMMENT: The dose of Opana was jumped from 10 mg b.i.d. to 30 mg b.i.d.! That is a threefold increase rather than a twofold increase.

The next visit was on 11/16/2010. This time the pain score was 5 on a scale of 10 while on Opana 30 mg b.i.d. and Percocet 10 mg four to six per day with 70% relief. This time it states that the patient ran out of Percocet since she was not given a Percocet prescription last time. She apparently ran out of Percocet one week ago. This time the vital signs were a tad different than the previous one. Otherwise everything basically was the same. The impression indicated that the physician wanted to increase the Opana extended release for her pain, but the patient herself wanted to finish the current prescription before the increase.

COMMENT: Here it was very difficult for the reviewer to understand why the patient did not want the pain medication to be increased. She was the one who suffered from pain and the pain management physician wanted the narcotic dose to be increased, but the patient wanted to finish the current prescription medication which she had on hand. Therefore, it was very obvious that the patient's pain was not such an issue which requires increasing pain medication dosing. I am a yet to see a patient who refused an increase in pain medication if needed. Therefore, I think it was the physician who needed the increasing pain medication, not the patient. I think that is one of the problems with this practice.

The next follow-up visit was on 11/29/2010. This time the patient had the pain running high with Opana ER 30 mg q.12 h. and Percocet 10 mg five to six per day. Then it stated pain was well controlled with minimal side effects. Here the patient's vital signs were exactly the same as at the time of the first admission. The physical examination was not changed. The impression was fibromyalgia and there was no increase in pain medication this time. So, at one place it says the pain was remaining high and the other place it said the pain was well controlled. Unfortunately, there was no scoring of the pain.

The next visit was on 01/03/2011. The pain score was 4 on a scale of 10. The patient's vital signs were exactly the same as at the time of admission. The medication was not changed and she had 70% pain relief.

The next visit was on 01/31/2011. At this time the patient had a pain score of 7 on a scale of 10. The pain was increased due to her daughter getting into the drugs and alcohol. The pain was increased due to stress. Her pills were short with her daughter coming over and her not keeping her medications locked up. But then, it said she had 70% relief. Her sleep, mood and energy were fine with overall function good. The vital signs were perfectly normal as at the time of the original admission.

COMMENTS: Here there is a question of the patient's stress going up, the pain scale 7 on a scale of 10 and then it says that the patient's pain and mood and everything were good and she had 70% relief. Then it states that her pills were short with her daughter coming over and the patient not keeping her medication under lock and key. No action was taken. No discussion apparently occurred or no discussion that occurred was documented. No further action on this matter was taken. On the whole, this is a problem of major significance. Does a patient who is reporting a problem with the family member getting into major pain medication supply and the prescribing physician does not seem to have any particular action. When you look at the typewritten notes further down, there is a note which I believe is saying KASPER fine. This just does not make sense.

The next follow-up visit was on 02/28/2011. The patient's pain was worse. The pain level was 6 on a scale of 10. The medication was Opana ER 30 mg and Percocet 10 mg 6 per day with 80% relief. When the patient has 80% relief, the pain is worse. When the patient had 70% relief the pain was worse also. I do not know what this means according to this physician. The patient's vital signs were perfectly normal. No change from previous records from the time of admission. The impression says the patient was going to be sent to physical therapy, application of topical pain cream such as Tiger Balm and to teach yoga. There was no mention, absolutely no mention of the previous report of the patient's daughter getting involved in sharing the medication or apparent sharing of the medication.

The next visit was on 03/29/2011. Here again the pain was worse because of stress at home. Medication was tried for one month. Apparently the patient slept better because of the memory foam mattress. Pain score was 8 on a scale of 10. Medication was Opana 30 mf and Percocet four to six with 90% relief. Here again the physician said that the pain was 8 on a scale of 10 and she had 90% relief. This time, for the first time, there is a handwritten addition to the vital signs that the weight was 125 pounds. The impression was pain was worse due to stress and change in weather. The patient will continue the Epson salt bath, Tiger Balm and medication. Increased Opana to 40 mg b.i.d. and may continue the Percocet as needed. It also states that UDS is consistent with the prescribed medication.

COMMENT: It is kind of illogical to me for the physician to say that the pain relief was 90%, but the visual analog scale was 8 on a scale of 10, then there was increased domestic stress and then there was increasing Opana dosing. These things do not go together. Obviously there is no method to the madness.

The next visit was on 04/27/2011. This time the pain score was 4 on a scale of 10. The pain was well controlled. This was 90% relief also. The patient was on Opana 40 mg b.i.d. and Percocet 10 mg six per day. The patient's diagnosis was fibromyalgia, kyphosis with osteoarthritis of the shoulder and elbow and with this diagnosis the patient was on glucosamine also. She now was

riding her own motorcycle. So, one should assume that she was very active and the medication was helping her almost 100% and this had to be a success story for the treatment. The additional diagnoses had been added such as kyphosis and the osteoarthritis of the shoulder and elbow which were not there a few months ago.

The next visit was on 05/25/2011. This time she was well and had been riding her motorcycle to Memphis. This was a six hour ride. It does not say if she was the driver or a passenger on the motorcycle. Pain level as 80% controlled with pain score of 3 on a scale of 10. Medications were Opana ER 40 mg twice a day and Percocet 10 mg six per day. She was doing very well and was riding the motorcycle. Unfortunately, there was no mention about the motorcycle safety while the patient was riding and taking medications and there was no mention whether she was taking the medication while she was riding, whether she was riding alone or she was riding with a passenger or she was the passenger.

The next visit was on 06/15/2011. The patient was in for followup. Pain was well controlled. On the trip to Memphis she used the pain cream. Pain level was 3 on a scale of 10 while Opana and Percocet were used and 90% relief. She had tenderness over the medial epicondyle which was related to her riding the motorcycle. The vital signs were perfect. There was no other action taken, except that on this particular visit the patient was suddenly documented to be a 60-year-old female, whereas she was 49 during the visit a few weeks ago. I hope this is a typo.

The next visit was on 07/11/2011. This time the patient once again was 60 years old, but there was a change in the format of the medical record keeping and this was kept by the APRN and Dr. Baird together. The patient had 80% to 90% pain relief. Nothing else was changed. Vital signs were this time quite different than the previously recorded vital signs, namely blood pressure was 110/85, pulse 76, respiration 19, weight 97 pounds, height 61 inches. Pain level was 4/10. This was the first time in this patient's many visits where a vital sign change was noted and there was no particular reason, except there was a different person involved in the medical record keeping.

The next visit was on 08/09/2011. The patient was now documented to be 50 years old, which is the correct age. She had good pain control. Her medications had not changed, which were Percocet six per day, Opana ER 40 per day and testosterone estrogen combined. This apparently gave 80% pain relief and her lifestyle was very good. She was continuing to work full time and was able to ride her motorcycle, which she was not able to do before she was put on pain medication. Vital signs were also normal, but not like the admission vital signs, which were persisting for many months.

The next visit was on 09/01/2011. Well controlled pain with Opana and Percocet. The patient was doing so well that she was considering a bike riding to Florida, that was Louisville to Florida all the way. Her vital signs were normal. She only had some morning stiffness.

COMMENTS: The patient with chronic intractable pain on mega doses of pain medication was doing so well, she was taking a morphine equivalent of 420 for pain control and she was going to go on a prolonged motorcycle ride to Florida, close to a 1000 mile trip. None of the risks were discussed. None of the consequences were discussed. It looked like everybody was happy. On top of that, this patient was a recovering alcoholic. During the whole follow-up visits that were

recorded in the practice of Dr. Baird, no mention of alcohol, even though there were repeated notes about domestic trouble or stress at home. Alcohol was never mentioned or discussed.

The next visit was on 09/12/2011. This actually was not a visit. The patient was terminated. The reason for termination was missed or failed pill count. This was considered a violation of the drug agreement. There were no details about this patient not coming for the pill count that were available in the record as far as I can trace it down. The patient was terminated and there was a letter from the patient complaining about her dismissal from the practice. There was no reply from the physician. Unfortunately, the reviewer has no insight into why she was dismissed and what were the circumstances under which she was called in for a pill count, etc. Whether this was the practice of the group also I do not know. There was no suspicion raised. Everything was hunky dory when the patient was seen the last time, but reviewing the chart which I have done, there was only indication there was some hanky panky going on at home with other people getting into her pill bottle, her daughter.

FINAL IMPRESSION
This is a 49 to 50-year-old female diagnosed with fibromyalgia and eventually diagnoses with kyphosis and osteoarthritis was added and I do not know why. The patient had a history of alcoholism and she was a recovering alcoholic. No details were ever recorded during her follow-up time with Dr. Baird or treatment time with Dr. Baird. The initial assessment and history and her previous records were poor. The patient was managed with fairly large doses of pain medication for chronic benign pain, namely morphine and equivalent of 300 to 420 level. The patient's pain was perfectly controlled. There was subsequent indication that the patient had domestic stress at home and her daughter were getting into drug use and getting into the patient's medications. The patient was on two medications, namely Opana and Percocet which are both highly sought after medication in the community where the patient and the physician live and practiced respectively. The comments so far also, looked that the patient was given liberal doses of medications in spite of her not really needing or wanting increasing doses at least one time. There was no absolute rationale for the increasing the dose of pain medication, at least the type of increase at least in the initial increase from 10 mg of extended release Opana to 40 mg in one step was noticed. Therefore, this physician was very liberal and the patient seemed to have enjoyed the liberal prescription of two highly sought after pain medications. Obviously there was no wonder that the patient was disappointed when she was terminated. I would say that both the patient and the physician are equally responsible in failure of the treatment plan and they not only needed to share the blame and the responsibility, but both deserved to be reprimanded for their behavior.

SECTION B.
KASPER RECORDS FOR DR. BAIRD FROM 12/10/2010 TO 12/11/2011
There are four patients here. We shall look at the KASPER only for the period of the 12 months which are available.

PATIENT ONE: [redacted]
DOB: [redacted]
The patient at the onset was receiving oxycodone controlled release 40 mg once daily, Zolpidem 10 mg once daily, carisoprodol 350 mg three per day, methadone 10 mg four per day and

oxycodone 10/325 mg four per day. If one excludes the effects Zolpidem and carisoprodol and takes the oxycodone controlled release, methadone and the oxycodone 10/325 mg, it would come to a morphine equivalent of 480. Of course, the consideration that the carisoprodol and zolpidem producing sedative effect is excluded here. On the outset it is pretty hard to figure out what the M.D. is trying to do here, because oxycodone controlled release is a drug which is used for around-the-clock pain control and usually it is prescribed twice a day or in serious cases once every eight hours when a patient has severe neuropathic pain or cancer pain, when the oxycodone controlled release may not last a whole 12 hours with one dose, unless the single dose is huge.

Then the prescription for oxymorphone, that is Opana, 10 mg 12 per day was started, I believe in the place of OxyContin 40 mg. Then I believe it was replaced by Opana 40 mg extended release two per day, that is 80 mg of Opana or oxymorphone per day.

Here, if one calculates morphine equivalent, 40 mg of oxycodone is replaced by 120 mg of oxymorphone, which is equal to 360 of the morphine equivalent. There is no justification in doing so. But, if we consider the morphine equivalency of Opana extended release 40 mg twice daily, that would be 80 mg per day, that would be only 240 in morphine equivalent. That would even be higher than the original dose of drugs which it replaced. So, there seems to be no rule or understanding or formula which this physician is using to replace the drug, except some form of random numbers being assigned to the mg of the drug irrespective of the strength or its therapeutic effect.

Then this was replaced by fentanyl 25 mcg per hour. That is a morphine equivalent of 60. The patient was also regularly getting zolpidem, amphetamine 2.5/2.5 and carisoprodol was to be started.

CONCLUSION

Here we see real high dose opioid therapy according to the definition earlier provided under section A. Multiple drugs were used, a combination of stimulants and depressants. No definite dose equivalency rationale was followed in switching from one drug to the other. It is very difficult to figure out what formula the physician was using, but looking at the KASPER or even after reviewing the medical records. I believe the dose prescribed was based on an arbitrary idea which the physician had in mind, which was not documented.

PATIENT TWO: [redacted]
DOB: [redacted]

The first prescription was for MS Contin or morphine sulfate extended release 30 mg, two per day and then hydrocodone 10/325 mg six per day for a morphine equivalency of 120. After the first dose of morphine, then this disappeared and this was replaced on 01/18/2011 with hydrocodone 10/325 six per day and then on 02/01/2011 the Percocet 10/325 mg six per day for the next two months. The prescription for hydrocodone and oxycodone 10/325 mg was six per day irrespective of which drug. In other words, the strength of hydrocodone 10 was thought to be the equivalent to the strength of oxycodone 10 mg I believe. The use of hydrocodone and oxycodone 10/325 mg six per day is something like a discretional use of the drug for chronic pain. I am not sure what type of indication or clinical situation this is, looking at the KASPER.

Further comments, in this matter as it relates to each patient in the KASPER will be in the patient review.

PATIENT THREE: [redacted]
DOB: [redacted]
The patient was receiving Opana extended release 40 mg three per day and oxycodone 30 mg eight per day. This comes to a morphine equivalent of 900. Then she filled, on 07/02/2010 oxycodone 30 mg 150 for 13 days. Then on 07/09/2010 another refill of the same drug 150 doses. I do not know why she filled and got 300 pills of oxycodone 30 mg in a period of 7 days. It looks like she filled for 26 days during a period of 7 days. On 12/05/2010 she filled OxyContin 60 mg 120 for 30 days. Usually OxyContin is not prescribed this way. In my experience, I never had any pharmacist who would fill this way, even though I have not prescribed. I have a hard time having a pharmacy prescribe 3 doses of OxyContin controlled release in 24 hours.

Then on 01/28/2011 OxyContin 80 mg, 90 of them prescribed for 30 days, while on oxycodone as before. Usually the dose of OxyContin 80 mg is reserved for the patient who is opioid tolerant and usually a cancer patient, but here this physician was able to get this filled for a patient with chronic musculoskeletal pain 80 mg three per day on top of large doses of oxycodone also. Then before the OxyContin filled on 01/28/2011 runs out, on 02/17/2011 the patient filled Opana extended release 40 mg, 90, 3 per day. This is the same morphine equivalent of 360 as the OxyContin. Here again, Opana extended release is usually filled twice a day, but this patient got it for three times a day. Obviously this physician seems to have an influence or ability to make the pharmacist fill this medication the way he wants. Further, the patient was getting all of these depressant drugs, namely opioids, carisoprodol 350 mg every 8 hours also was prescribed along with the Valium 10 mg every 8 hours. Then the patient was given stimulants also on top of that. Here again it is difficult for me to figure out from the KASPER why all of these medications were added in such rapid succession to the same patient.

PATIENT FOUR: [redacted]
DOB: [redacted]
Here the first prescription was on 01/05/2011, Opana ER two per day and Percocet 10/325 mg 12 per day for a morphine equivalency value of 360. This continued until 04/27/2011, when the Opana ER was 40 mg twice daily with the Percocet and here the morphine equivalency was 420. This is basically high dose opioid therapy. It looks like the patient had been filling these medications on a regular basis.

SECONTION D
01/29/2012 RESPOSNE PROVIDED BY DR. BAIRD

This is a five page letter and the letter is dated 01/29/2012 from Dr. Baird, addressed to Whom It May Concern. It is in reference to letter of concern by pharmacist Trish Roberts. I will be as brief as I can in my remarks.

I was not aware of the largest study to date of 300 patients with fibromyalgia, etc, with 80% relief with judicious use of opioids which Dr. Baird mentions. I believe this is a study which Dr. Baird himself did. It would have been nice and helpful to this reviewer if Dr. Baird had made

this study available and included the study as a reference in this letter, or at least informed the reviewer where the study was published. I have in this connection requested the Kentucky Board of Medical Licensure to forward to me a copy of Dr. John Baird's curriculum vitae and this was received by the Kentucky Board of Medical Licensure on 03/01/2012 and this was forwarded to me. In this curriculum vitae I did not see a publication of this study anywhere. I did not see that Dr. Baird had presented this study anywhere before a medical audience. Therefore, I have to consider this study as a personal study of Dr. Baird, not peer reviewed and, therefore, I am unable to comment on that study. Therefore, this study has no validity in my opinion as far as it applies to application in patients in an important subject like this.

As an interventional pain specialist who has been in practice in Louisville, Kentucky since 1972, I have been treating patients with fibromyalgia, thought not focusing exclusively in fibromyalgia patients. I have been using prescription of opioid medication as part of their total management. I am not against the use of opioid medication in the disease, for there is no universal agreement on this matter. I have attached a few publications in this matter in support and unfortunately not in support of this position. The literature as of the current plan in 2012 is not in the majority supporting the use of opioids in routine treatment of fibromyalgia, even though a lot of pain management physicians do prescribe this medication in realistic doses. I have not come across any study where high doses of opioid medication is used exclusively in the treatment of fibromyalgia and a high dose opioid is defined as morphine equivalent of 120.

Dr. Baird remarks about the pharmacist calling the doctor and discussing the doctor's prescription habits. In my opinion this is entirely up to the pharmacist and his or her discretion. I do not believe that there is a guideline in the pharmacologist's practical book of guidelines in doing so. I do not believe the pharmacist has a supervising role in this regard. They have an advisory role in this regard. If a physician has made a mistake or an error in a prescription they should be able to point that out. If a pharmacist is unhappy or if the pharmacist thinks that a physician's prescription habit is dangerous to a patient, it is up to the pharmacist to talk with that physician directly or approach another controlling agency in this matter. Dr. Baird's statement about what a particular patient stated about the conduct of the pharmacist is irrelevant here, or whether the pharmacist violated any HIPAA RULES, etc, is not relevant here because that is not what we are discussing and that is not what I am asked to review. If a pharmacist has violated the HIPAA rules and if there is a grievance from the patient or the physician, they could take action in that matter and that is not under discussion here. If Dr. Baird has a grievance against a particular pharmacist, it is appropriate for him to complain to the authorities in this matter. Dr. Baird's general complaint about pharmacist and the emergency room physicians about the adjusting the patient or about them building bias, again it is not relevant in my review. It is my hope and expectation that all patients would be given respect which they deserve.

It is quite possible that KASPER reports are sometimes delayed and sometimes entries are delayed and sometimes KASPER reports are not up to date, but lately there has not been very much delay in getting the reports if one tries. If the physician is in a pinch, the physician calls the pharmacy in question and gets the report from the pharmacist regarding any particular patient regarding opioid medication prescription as long as the patient would give the physician the permission to do so. That should be part of the agreement to treat. That is the physician has the right to collect information on the patient regarding the patient's previous medication habits.

Further, the discussion regarding the four patients in this letter will be addressed with each patient.

SECTION E
PRIOR LETTER OF CONCERN SENT TO DR. BAIRD BY PANEL A ON 12/29/2010.
I have gone through this letter and this is a letter which contains the opinion regarding the use of controlled substances in pain treatment and this letter is a reflection on the standards originally adopted and published by the Board on 03/22/2001, modified and published on 09/13/2003 and published as a Board opinion on 10/10/2008. This information is available for all practicing physicians as far as I know and it basically stipulates or mentions the standard of care and management in the matter of controlled substance in pain treatment. Here I will not need to make any remarks about it as it applies in current review.

SECTION F
DR. BAIRD'S 05/25/2009 RESPONSE TO PREVIOUS PRESCRIBING ALLEGATIONS.
This letter is nearly 15 pages and it has two sections. One section is dated 05/25/2009 of two pages and the other section dated 10/05/2009. The first section is addressed To Whom It May Concern and the second section is addressed to the Esteemed Board Members. Since this letter contained a lot of material, I have tried again my level best to review it in detail.

There is a Whom It May Concern two-page section stating that Dr. Baird is a speaker for various drug manufacturers, etc. and that fibromyalgia is his passion, etc. Dr. Baird states that he has ongoing data on fibromyalgia which supports his practice. He has not enclosed that with the letter. I personally do not think that I know the entire literature on fibromyalgia. I have reviewed some. I do read from time to time on this matter because I do treat patients with fibromyalgia in my practice, which I have been doing since 1972 in this town when fibromyalgia was not even a diagnosed clinical entity. But, I have not seen any publication from Dr. Baird's side on this matter. Therefore, as stated earlier somewhere in this review, on 03/01/2012 the Kentucky Board of Medical Licensure received a copy of Dr. Baird's curriculum vitae and it does not appear that Dr. Baird has presented this data anywhere before a medical audience. If he has published that or presented that, I could not locate that in his curriculum vitae. It would have been nice for the reviewer and the physician interested in daily practice of pain medicine and those who prescribe opioid medication for patients with fibromyalgia if this literature and data was made public.

Dr. Baird's claim that he is working hard on behalf of the 30% to 35% of people in whom the FDA approved medications do not work is a great hope for all. But the jury is still out on this claim, I believe. It is a matter of Dr. Baird's personal opinion that he is doing so and I have not heard from anyone else and the data is not published yet. If it is published somewhere, I am not aware of it. I hope that Dr. Baird would have shown us the data if he had published it, rather than claim he has the data.

The other part of his communication is addressed to the Esteemed Members of the Board of the Kentucky Board of Medical Licensure. I have a few comments in this matter.

Dr. Baird's claim that only he and a couple of other M.D.'s in Kentucky only treat patients with fibromyalgia is not true. He believes that he is the last hope of the patients who come to see him.

I do not know how he can make that claim. There are other M.D.'s practicing in pain medicine, or practicing pain medicine, who treat patients with the diagnosis of fibromyalgia and that includes this reviewer. I know others also, but none of us claim that we are specialists in this disease. I do not believe that it is a fact at this time that fibromyalgia is a specialty in itself. It may be fashionable to think so by those who focus their attention on fibromyalgia only.

Treatment of disease states, especially newer ones, goes through a process of evolution and concepts are developed over a period of years, but Dr. Baird's claim that he has the last word on fibromyalgia is not based on any published literature. Fibromyalgia Network Newsletter is a customer information communication publication. It is not a scientific publications. It is, I believe, everyone's privilege to think ou side the box, but that does not mean the product of such thinking always be considered scientific conclusion.

Dr. Baird states, "Most of the patients who come to me are already on some narcotic like hydrocodone and because I am a pain management physician with the interest and knowledge in fibromyalgia, I assume their pain management." I wonder what special qualification Dr. Baird has as a specialist in pain management. I understand the curriculum of residency training in physiatry or physical medicine includes training in pain management. I do not know how extensive it is as far as the content of pain management is, but Dr. Baird's curriculum vitae does not indicate that he has undergone any special training or fellowship training in pain management, neither is there any indication that he has been certified by any specialty board in pain management or he has taken any special courses where he has had specialty training in opioid management or any particular training in interventional pain management. I am not making this remark to discredit Dr. Baird as a pain management specialist, but since he repeatedly makes the claim that he is a pain management specialist, I would have liked to see his special qualifications other than his basic training in physical medicine and rehabilitation.

Dr. Baird claims that he was in the past a speaker for Botox, intrathecal baclofen and Zanaflex as in spasticity management. I would like to know how many baclofen pumps he has implanted or how many baclofen pumps he has managed over the years and what makes him as an expert in intrathecal baclofen therapy, etc. to make him an expert in this field.

Dr. Baird is in the process of compiling data on fibromyalgia patients because they have 80% improvement. This was as of 05/25/2009. Is his data out yet? It would be interesting to see the followup on this data. Obviously it is not available to the reviewer. Therefore, I cannot use this data in Dr. Baird's defense, however much I would like to use it. But, if the four cases I reviewed in this matter along with this report, I have serious doubts about his claim, his methodology and conclusions.

Dr. Baird states "I could have done interventional pain management and made a lot more money and had a lot less headache than caring for patients with fibromyalgia." In my opinion this is a silly argument and does not answer any of the questions that was the rationale for his practice. Why take a swipe on somebody else or some other type of practice? If Dr. Baird wanted to become an interventionalist, he could have become one. I do not think anybody would have prevented him becoming one. Blaming someone else or criticizing someone else for his problems is not a defense. I quite agree that not every physician in practice believes that fibromyalgia is a real disease and there are patients who suffer from fibromyalgia; but that would

not answer Dr. Baird's problems or the questions the Board is asking Dr. Baird to explain in his practice.

Dr. Baird states "In my practice I have actually found that increasing the opioids to a therapeutic level may take higher doses like [redacted] but the results are impressive." This higher dose needs definition, does it not. Dr. Baird has not provided this therapeutic level and his higher doses in his reply and if the answer is in the four cases I reviewed, that is totally impractical and medically not feasible.

With reference to the comment "I prescribe excessive narcotics." Dr. Baird asked the question what exactly does excessive mean and who decides this.

I do not know how or why all of the arguments should be there. For all drugs, antibiotics and vitamins there are recommended effective minimum doses and maximum therapeutic doses. For anesthetic drugs and drugs that alter recipients sensorium or behavior and organ function above a certain level, toxicity or dose escalation, whether instituted by the prescriber or the patient himself or herself. That is the reason the maximum dose is recommended for certain drugs. As specific indications for opioids there is a safe maximum dose. This may vary from patient to patient depending on the various factors, but one would be flirting with patient safety if one takes the attitude that "I am in pain management and I decide what is good for my patients." Of course, none of these rules are written in stone, but rules for patient safety are written in stone. Opiates and narcotics cannot be compared with nonsteroidal anti-inflammatory medications or DMARDS or biological agents in this regard. That is the reason why they are classified as controlled drugs. That probably is the reason why we are having this investigation, I believe. In this particular instance, Dr. Baird has lost the argument for sure. Dr. Baird's statement that "His data speaks for itself" is difficult to believe because he only has his data and nobody else has it.

"Once again, I speak for all the FDA approved drugs and have educated hundreds of physicians." This is a statement with no particular value here. Publication in a peer review journal would be better validation of one's qualification. If there is a lack of medical documentation in the records of patients under treatment by Dr. Baird, he cannot blame a novice nurse practitioner for that. Even if the patients loved the nurse practitioner, it does no absolve Dr. Baird or the lack of medical documentation. Dr. Baird's argument that the lack of medical examination did not impact on the treatment of patients cannot hold water. Then why do we examine patients and keep medical records. In this context, Dr. Baird's statement that "90% of doctors do not take the time to listen to their patients" does not absolve him or his unitiated nurse practitioner whom his patients loved, but it insults the intelligence of the rest of the medical profession also and makes it appear that Dr. Baird is the only righteous one. Dr. Baird could have done a better job of defending the reviewer's claim that notes appear to be pre-entered notes. More on this on my individual patient review later.

Further, Dr. Baird's statement "Every day patients tell me they see physicians that never have touched them" etc. is a silly one because they are not the physician being reviewed here, but it is Dr. Baird who is being reviewed. Again, Dr. Baird has gone on to state "I am a physician of high moral character and would never and could not document something I did not do. Many others do this daily and I have seen EMR record, etc, etc. This, I believe, is in very poor taste, even though made in desperate attempt to prove his feeling of certified self righteous.

I shall not touch on individual patients since I do not have them and I have not reviewed them. That is the one that Dr Baird is talking about; even the patient whose name appeared, [redacted] The last sentence is "Medications were written by my nurse practitioner to keep up with what most people were on and I know of no physician in pain management who keeps record of what they give versus what others give." This statement is the worst hypocrisy I have heard. Dr. Baird, if he meant what he wrote is dead wrong. If that is what he preaches and practices, he should quit doing so. Medication reconciliation is one of the most important steps all physicians should do and do when they evaluate and treat patients. That is especially true in the field of pain management and also what I have seen in the hospitals where I practice. Here I enclose a few of the medication reconciliation forms I come across in the places I practice for your consideration. I still cannot believe Dr. Baird would make a statement like this and I am not even sure whether he realized what he wrote. In this matter, if Dr. Baird takes the position that his role in pain management as a physician of exceptional merit since he believes and prescribes controlled drugs such as opiates, and does not care to keep up with what the other physicians are giving the patient, he should certainly be disqualified as a competent physician as he claims to be. Dr. Baird elsewhere in this letter, stated "I practice progressive research based excellent life changing treatment for the group of patients few if any want to treat effectively. I am assessing my patients comprehensively and completely." This above statement does not gel with the statement which Dr. Baird just made that he has no time to worry about what other doctors give or prescribe to his patients, then how can he state that he is unique in his comprehensive assessment of his patients whom nobody else would treat. There is a great misfit here.

Again, not to and stay on the same issue, but on the next patient, [redacted] Dr. Baird states "documentation may have been lacking due to the sheer amount of issues she wished to cover in each appointment. Many of these notes with issues are again, the nurse practitioner's. These statements again do not bode well in favor or Dr. Baird, who had been claiming that he is a superior physician in general and that everybody else is not doing what he does and they are all delinquent, whereas he is not. Therefore, Dr. Baird is defeating himself by criticizing others and not doing his own work, except to claim that he is super.

SECTION G

DR. BAIRD'S PREIVOUS INDEPENDNET REVIEW BY JENNIFER SCHNEIDER, M.D. (NATIONAL PAIN MANAGEMETN PHYSICAIN) PROVIDED AT THE REQURSET OF DR. BAIRD.

This is a letter to L. Chad Elder dated 03/14/2010. The letter is a review by Jennifer Schneider, M.D. and it is a multipage document covering 14 pages. I have not reviewed any of the medical records of the patients discussed in this letter. First: comments about the concern about the use of opioids for treatment of fibromyalgia, there is no collective agreement or consensus regarding the use of opioids in fibromyalgia; but many physicians, including the pain management specialists such as the reviewer, use opioids for the symptom management of the pain of fibromyalgia, the type of pain which is not otherwise controlled. Opioids are not the first line of treatment. There are drugs specifically approved by the FDA for fibromyalgia which are not 100% effective. It is also true that some patients are exposed to opiate and analgesic drugs early in the management of fibromyalgia and due to ignorance or impatience or due to other factors, some of these may have developed a drug habit and their management might have been difficult in the long term. But, the point here should be that one does not need to burn the house down to kill a mouse. The argument about relationship of opioids and neuropathic pain need not be and

cannot be extrapolated to fibromyalgia and opioids. Opioids are not the only defense against neuropathic pain, like antibiotics are against bacteria. Whereas one feels comfortable in starting a patient with the diagnosis of neuropathic pain on opioid medications on the first day of diagnosis, I do not feel it is appropriate to start the patient with fibromyalgia on opioid medications on the first day of diagnosis. That is all the argument, otherwise a patient who had tried multiple modes of treatment or modalities of treatment in managing the symptoms of fibromyalgia, it would be not inappropriate to start treating symptoms of pain with opioid medications. So, it is agreed that without preconditions that opioid medications are useful and maybe the only way out in certain patients with fibromyalgia.

It is also agreed that breakthrough pain may also occur and may have to be managed, but one has to be sure that we are dealing with young people with a long life to lead and not a geriatric population. For a study from a geriatric population may not be translated to young people with fibromyalgia. In other words, a 75 or 80-year-old resident of a rehabilitation or nursing facility who has chronic intractable musculoskeletal pain being treated with chronic opioid therapy is not equal to a 16-year-old girl with fibromyalgia who wants hydrocodone six doses per day around the clock because she has the diagnosis of fibromyalgia. The discussion as to excessive narcotics by the author was not very clear to me since this can only be applicable to each particular case in my opinion. General impressions are just general impressions.

Second: Concern about the elements of treatment of specific patients. I do not know anything about these patients. The author of this letter is absolutely complimentary about Dr. Baird and his exemplary performance in pain relief and every aspect of his management. I shall reserve my comments further in this matter of the patients I review or I will review later in this section, namely the four patients which I am reviewing for this particular review regarding Dr. Baird's practice. That will follow later in this documentation.

SECTION H

05/03/2010 OPINOIN OF JOHN B. WINFIELD, M.D., PREVIOUSLY PROVIDED AT THE REQUEST OF DR. BAIRD.

This particular letter, which has multiple pages, has reference to Dr. Winfield's publications and his qualifications and this letter supports Dr. Baird's contention that opioids prescribed for fibromyalgia are an exceptionally useful part of the treatment. This statement was made and this review is made at the request of Dr. Baird. This particular letter makes all kinds of general statements and it summarizes with the statement, and I quote, "In short, Dr. Baird appears to manage pain in fibromyalgia the same way I do." That does not mean that both of these doctors are perfect or their word is the absolute truth. There is no disagreement from the reviewer that opioid medications are useful in the symptom management of fibromyalgia. I do not think the Board has ever raised the question that opioids should not be prescribed for fibromyalgia. It was other things in Dr. Baird's practice that have been questioned. This letter also gives some idea or commentary about pain and arthritis. I think that is a pretty good general dissertation and is worthwhile reading, but I do not think that applies for today's review of Dr. Baird's practice. But, it was very nice of Dr. Winfield to give his opinion and there are quite a few points which he has raised. But, the problem is that we are not discussing whether patients with arthritis or musculoskeletal pain are neglected or not. We are discussing the pattern of Dr. Baird's practice, not whether other physicians are neglecting patients or the population is neglected in pain management, etc. Therefore, this letter has only limited application in support of Dr. Baird.

SECTION I

APRIL 2010 FIBROMYALGIA NETWORK ARTICLE PREVIOUSLY PROVIDED BY DR. BAIRD

This publication from Fibromyalgia Network is a survey from customers suffering from fibromyalgia. The document states that they ranked this class of drugs, that is opioids, are best in their list, especially the long-acting ones. This at best has no real relevance in the matter we are discussing I believe. It is seldom, or at least rare, that one finds a patient in a clinic who does not like opioid drugs and is against them, so I do not think there is a whole lot of point in this particular article. If one invites 100 people who are on opioid medication and asks them whether they like the medication which they take, I have a suspicion that the majority of them would go for it. Unfortunately, that is the nature of these drugs, the effect of these drugs on the particular part of the brain which deals with the sense of wellbeing.

CONCLUSIVE REMARKS

I have reviewed the material so far and now it is to the difficult task of the conclusion or attempt at conclusion.

I understand the job which I have is one which carries a tremendous responsibility and I also understand that I am reviewing the work of a fellow physician and will impact his work in the future. I am trying to be as objective as I can. I will make some initial remarks before the final conclusive remarks. I have reviewed quite a bit of material, some of this relevant and some not relevant. I have looked at some literature and I have enclosed some literature also. I have also reviewed four patients. One patient had fibromyalgia with a history of previous alcoholism. The next patient had fibromyalgia and multiple medical problems including psychiatric illness and migraine, etc. A third patient had fibromyalgia and the fourth patient had no real fibromyalgia problem, but chronic pain from hepatitis C and neuropathy and also had diagnosis of pancreatitis. This patient also had a previous morphine pump implant, intrathecal morphine delivery system implant that was then explanted. Then Dr. Baird took over her care due to the circumstances, I believe. My review of each patient is accompanied by comments regarding each visit to some extent and final conclusive remark on each patient. I could not say that any one of these four patients was managed in a flawless or seamless manner or an impressive manner. In fact all; of them were managed poorly.

Now some remarks about management of chronic pain, especially pain of musculoskeletal origin. As stated earlier, the question of prescribing opioid medication for the pain of fibromyalgia or musculoskeletal pain of fibromyalgia is still debated. There is some indication that the pain of fibromyalgia is associated with central summation or lowered pain threshold or augmented sensory perception in the pain control system. The majority of people now believe the patients are really suffering from pain and the associated untoward suffering. There are only very few studies which show some efficacy of tramadol in the treatment of pain associated with fibromyalgia. There are some studies, mainly anecdotal, which indicate that the other opioids, that is the major opioids in the market, stop the pain of fibromyalgia. Even though there is no conclusive evidence supporting clinical effectiveness of opioids in fibromyalgia, prescription opioids are incorporated in the treatment of patients with this condition. The approximate estimate in a Canadian study appears that one-third of patients are prescribed opioid medications. On the other hand, there are others who completely are against the prescription of opioid medications in this form of disease. In addition to the above, the disease fibromyalgia itself

causes a lot of symptoms in patients. These involve the cognitive function, their mood and their ability to function daily, problems with fatigue, sleep disturbances, hyperalgesia and generalized disability. Unfortunately, sometimes large doses of opioid medications may mimic some of these symptoms. In summary, it is appropriate in my opinion for physicians to prescribe realistic doses of opioid medications for symptom management of fibromyalgia and that it is up to the physician to decide at his/her discretion and their ability and manage the patient with these medications. That being said, I did not come across any study in the peer reviewed journals or even literature which has promoted high dose opioid therapy in fibromyalgia, even though there are anecdotal evidences or statements attributed to various pain physicians. I would think Dr. Baird was also in that group of physicians who subscribe to the theory that high dose opiate therapy would be beneficial in fibromyalgia. I have already defined high dose opioid therapy, which is a morphine equivalent of 120. I have included some literature to support the above statements, which I obtained through the internet.

I have not made any other remarks on the management of patients with other chronic pain, such as the patient I have reviewed who has the pain of hepatitis C, neuropathy and pain of pancreatitis, because that is not an uncommon situation. It is a common pain problem in our community.

REMARKS

Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. In his evaluation which should have been comprehensive, I think he did not meet the quality expected. On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the records, how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs

during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients I reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his discretion to start with higher doses when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficit disorder diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may be not significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able

to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a advantageous to the patient and himself rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [redacted] The patient had the diagnosis of hepatitis C, neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump. A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at that time were penicillin, sulfa, latex and morphine. I have researched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed, they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion. Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc, is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems. Therefore, my best recommendation is as follows:

The Board should solicit another opinion from another pain management specialist and if that is not possible, recommend Dr. Baird to undergo a course in management of patients who are under treatment with opioid medication. There may be plenty of courses available. I can suggest the course offered by the American Society of Interventional Pain Physicians for example. This would be a competency certification in controlled substance management. This course I think is still being offered and this would probably help Dr. Baird to revise some of his thinking and hopefully help him in his future practice. At this time, it is my hope that I have tried to help Dr. Baird with this review rather than criticize him only.

Sincerely,

Kunnathu P. Geevarghese, M.D. FRCPC

Enclosure

Dear KBML Investigator:

I have completed the comprehensive review of the medical records provided for physician Dr John Baird. Enclosed are my findings with regard to the requested chart review.

Physician education- Dr Baird is a graduate of the University of Louisville School of Medicine with residency in Physical Medicine and Rehabilitation from Medical of Virgina.

Documentation

Chief Complaint, History of Present Illness, Pain quality, physical exam, diagnosis and treatment plan- Dr Baird performs a reasonable history of present illness, his monitoring meets KBML standards. He does genetic testing to determine or asses lack of opioid efficacy. The vast majority of the patients are treated for fibromyalgia. My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.

KASPER and Monitoring- There does appear to be extensive use of KASPER and frequent compliance monitoring with UDS. On several occasions patients are dismissed from the practice based on results of the UDS suggesting the desire to limit and address adherent behavior.

Opioid dosing, selection and rotation- It is clear that Dr Baird is attempting to treat patients and relieve suffering. Dr Baird uses a variety of medications and clearly titrates the dose to his perceived end point of analgesia. There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids, 2) combinations of three and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazepines and 3) the use of opioids for fibromyalgia at all.

From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best.[32] The use of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores

the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.
Patients suffering from fibromyalgia may also have altered

endogenous opioid activity. A study utilizing positron emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing.[48] There are two possible explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain.[49] Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors.

Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia.[50] In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.[50]

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Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates.[51] In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern in patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

Jacob Painter University of Kentucky College of Pharmacy 2012

And also **Opioid Use, Misuse, and Abuse in Patients Labeled as Fibromyalgia**

- Mary-Ann Fitzcharles, MB, ChB[a,b,*], [image], [image],
- Peter A. Ste-Marie, BA[c],
- Ann Gamsa, PhD[b],
- Mark A. Ware, MBBS[b],

- Yoram Shir, MD

While Dr Baird lists a publication outlining his approach to fibromyalgia treatment I cannot find it on standard PubMed medical literature access sites. In any case it would be a minority opinion to treat fibromyalgia even if the publication was published in a peer-reviewed journal.

Multimodal approach- Dr Baird relies heavily on high or escalated dose opioids and benzodiazapines and less on adjunctive medications and therapy which is unusual for a PM&R physician.

I agree with the previous reviewer that Dr Baird over relies (the previous reviewer stated had too much self-confidence) in a method of treatment with dubious value according to the latest in medical literature. Dr Baird's record keeping is as noted neat and organized and he utilizes compliance screening to monitor and discharge patients. It is clear that there is no business model that relies on opioid prescribing as we have seen with pill mills thus it really becomes a matter of determining whether I a pain physician think his treatment meets the standard of care. As the other reviewer noted this is a difficult proposition when evaluating a clinician such as Dr Baird. As a trainer of pain management physicians I have seen high dose opioid therapy working well for virtually no patients referred to our center. I believe, and recent reviews on the subject (See ASIPP guidelines for opioid prescribing July 2012) have born out, that the literature suggests high dose (>100mg morphine equivalent) per day is exceptionally risky and should be undertaken rarely and with caution in carefully selected patients. These recommendations are for chronic benign pain, most pain physicians believe that fibromyalgia is a unique subset of chronic benign pain the hallmark of which is physical dysfunction, sleep disorder, anxiety and depression and endocrine disorder. Since all of these are associated with high dose opioid therapy I believe that utilization of these medicines falls below the generally accepted standard of care for pain physicians caring for fibromyalgia. Did Dr Baird monitor opioid therapy appropriately, yes. Was his patient selection and use of high doses of opioids standard of care; on a spectrum of regional physicians there are few others in my experience that would practice this way. I believe the adverse outcomes of overdose in the face of high dose therapy should give Dr Baird pause concerning his approach.

I believe, based on the records supplied, this man is a thoughtful and caring physician trying to treat difficult diseases. I believe the fault, if any, lies in the application of a marginal therapy (opioids) in poorly defined pathology (the syndrome of fibromyalgia) applying principles with scant scientific evidence (high dose therapy). I believe it is incumbent upon the state to use education to reorient his practice to more standard therapy.

Sincerely,

Jay S Grider DO/PhD

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Diagnosis: Fibromyalgia,

Treated with Durgesic 75 mcg, Oxycodone 90 mg/day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

There is minimal documentation of physical exam which is required under the KBML regulations. UDS, KASPER and pill counts suggest thoughtful practice.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. Opioids for fibromyalgia are again controversial though this patient reports reasonable results.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Treated with Oxycontin 80 mg, Nucynta 100 mg,

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

This exam is better than previous records and treatment for this problem is reasonable.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/21/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Treated with Percocet 70 mg/day and oxycodone 105 mg/day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Again there is minimal documentation of physical exam which is required. UDS, KASPER and pill counts suggest thoughtful practice.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Diagnosis: Low back pain

Treated with Norco 60 mg/day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Again there is minimal documentation of physical exam which is required. UDS, KASPER and pill counts suggest thoughtful practice. Patient was dismissed for inappropriate UDS and violation of drug agreement

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Treated with OxyContin 160 mg, 60 mg/day Percocet

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

__X__ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

__X__ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

__X__ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

__X__ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Again there is minimal documentation of physical exam which is required. There is genetic testing for drug metabolis rate coupled with UDS, KASPER and pill counts suggest thoughtful practice.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board,
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment:

Fibromyalgia,

Treatment with methadone 80 mg/day, morphine 150 mg/day, and fentanyl 600 mcg/day

Patient was dismissed for non-payment without opioid taper

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_X_ Below minimum standards

_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriatness of initial therapy

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids.

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Based on documentation I believe Dr Baird to be practicing medicine and thus is not intentionally attempting to harm a patient.

The dismissal of the patient on high dose opioids without taper breaches ethics

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: Spinal Stenosis, Treated with Oxycontin 160 mg/d, Dilaudid 16 mg/day, oxycodone 360 mg/day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

____ No, I cannot form an opinion.

____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_X_ Below minimum standards

____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

____ Clearly below minimum standards.

____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guide lines. Dr Baird provides no intensive monitoring of function and minimal physical exam

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. This combination of medications is non-standard and risky in a patient with obstructive sleep apena

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD

1. Brief description of symptom, dx and course of treatment: _____

Fibromyalgia

Treatment with Norco 10 mg 4 x per day

Percocet 10 mg 4x per day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

None

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. "Tender all over" does not constitute a physical exam. Use of 2 short acting opioids in an alternating fashion is not standard care but Dr Baird monitors outcomes and appears to be evaluating the patient's respon:

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids.

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD

1. Brief description of symptom, dx and course of treatment: _____

Fibromyalgia,

Treatment with

Opana 40 mg BID, Percocet 10 mg 6x per day,

Patient was dismissed for inappropriate Pill count and UDS

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. "Tender all over" does not constitute a physical exam.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids.

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Based on documentation I believe Dr Baird to be practicing medicine and thus is not intentionally attempting to harm a patient. The dismissal of the patient for noncompliance suggests clinical judgement and appropriate action

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment:

Diagnosis: Fibromyalgia

Treated with Oxycontin 160mg/day, oxycodone 150mg/day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

____ No, I cannot form an opinion.

____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_X_ Below minimum standards

_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. While this statement appears continuously it is because on most visits there is minimal exam documented related to the treating problem

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

No

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/21/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Treated with oxycodone 150 mg/d,

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_X_ Below minimum standards

_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths, dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax This is a clear harbinger for substance misuse/abuse

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion pot

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Though this patient was ultimately dismissed for non-compliance the original medication is questionable

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD

1. Brief description of symptom, dx and course of treatment: _____

Fibromyalgia, pancreatitis, diabetic neuropathy

Treatment with various opioid combinations most recently

Opana 40 mg BID, Oxycodone 30mg 6x per day, Valium, Soma ,

Cymbalta, Adderall, Gabapentin,

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

____ Clearly below minimum standards.

____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. "Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr Baird that his patient likely has a personality DO

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids. It is generally accepted that combinations of opioids and benzodiazepines plus Soma is high risk for addiction and adverse outcomes.

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Based on documentation I believe Dr Baird to be practicing medicine and thus is not intentionally attempting to harm a patient. I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr Baird may be helpful

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No,_____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Diagnosis: Fibromyalgia, Degenerative disc disease

Treated with Norco up to 100 mg/day, previous treatment with

Opana 80 mg/day, Soma

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_X_ Clearly below minimum standards.

_____ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Again there is minimal documentation of physical exam which is required. UDS, KASPER and pill counts suggest thoughtful practice. The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/day I am unsure of any rationale that supports this Rxn practice.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._____ Patient Nam[redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Diagnosis: Fibromyalgia,

Treated with 260 mg/day Oxycontin; 240mg/day Oxycodone

No mention of physical therapy or other conservative treatment for this disorder

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

____ No, I cannot form an opinion.

____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Again there is minimal documentation of physical exam which is required. UDS, KASPER and pill counts suggest thoughtful practice. The use of high dose opioids in fibromayalgia would at best be considered controversial Lack of documentation of other conservative measures.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Diagnosis: Fibromyalgia,

Treated with Oxycodone 90 mg/day, Oxycontin 160 mg/day and

xannax

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

There is minimal documentation of physical exam which is required under the KBML regulations. UDS, KASPER and pill counts suggest thoughtful practice.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an abberant behavior in that the patient took her child's adderall and no action was taken.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Diagnosis: Cervical spondylosis and myelopathy,

Treated with MS Contin 90 mg/day, Oxycodone 160 mg/day and

xannax

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

There is minimal documentation of physical exam which is required under the KBML regulations. UDS, KASPER and pill counts suggest thoughtful practice.

4. Other questions from the Medical Board (ignore if blank):

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. High dose opioid therapy is maintained though hypoganadism a clear complication of high dose opioid therapy is diagnosed Again a stimulant is prescribed for fatigue and somnolence rather thai

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment:

Diagnosis: Fibromylagia, Cervical spondylosis,

Treated with 60 mg/d Norco and valium

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths, dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

There is minimal documentation of physical exam which is required under the KBML regulations. UDS, KASPER and pill counts suggest thoughtful practice.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/19/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Osteogenesis Imperfecta,

Treated with Opana 80 mg/day, Morphine 60 mg/day IR, Percocet

10 mg 4-6 hours, Dilaudid 4mg 4-6 hours

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_X_ Below minimum standards

_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not..."; you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard. This combination of medications is non-standard and dangerous

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Name [redacted]

Expert's Name Jay S Grider DO/PhD

1. Brief description of symptom, dx and course of treatment: _____

Fibromyalgia

Treatment with Duragesic 25 mcg

Percocet 10 mg 8x per day

Methadone 10 mg 8x per day

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards

_X_ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.

_X_ Clearly within minimum standards

_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

None

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

I suggest that a physical exam with each visit be documented. From a compliance standpoint the visits seem appropriate.

UDS was done and KASPER was consulted

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is if your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids. The use of high dose opioid therapy as employed by Dr Baird must be closely monitored. He appears to document that the patient was not having somnolence and had a thorough psychological evaluation

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. _____ Patient Nam[redacted]

Expert's Name Jay S Grider DO/PhD for Licensee John Baird MD

1. Brief description of symptom, dx and course of treatment: _____

Treated with MsContin 200 mg/d, oxycodone 75 mg/d,

2. Can you form an opinion? Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

X Yes, I can form an opinion.

_____ No, I cannot form an opinion.

_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

____ Below minimum standards

_X_ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_X_ Below minimum standards

____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

____ Below minimum standards

_X_ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

____ Clearly below minimum standards.

____ Clearly within minimum standards

_X_ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

4. Other questions from the Medical Board (ignore if blank): _____

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board.
Or,
Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger?

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable

9/20/12
Date of Review

Signature of Expert

Revised Feb/2009

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1492

FILED OF RECORD
MAY 28 2013
K.B.M.L.

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOHN R. BAIRD, M.D., LICENSE NO. 36869, 3012 EASTPOINT PARKWAY, LOUISVILLE, KENTUCKY 40223

COMPLAINT

Comes now the Complainant Randel C. Gibson, D.O., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on May 16, 2013, states for its Complaint against the licensee, John R. Baird, M.D., as follows:

1. At all relevant times, John R. Baird, M.D., 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. At its November 18, 2010 meeting, Inquiry Panel A reviewed an investigation into allegations that the licensee was inappropriately prescribing controlled substances. While the Panel failed to find a violation at that time, it issued a Letter of Concern to the licensee, recommending that he comply with the Board's Opinion Regarding the Use of Controlled Substances in Pain Treatment.
4. On September 7, 2011, the Board received a grievance from a pharmacist, who alleged that the licensee was prescribing large amounts of controlled substances and combinations of several controlled substances. The pharmacist also noted that patients were getting early refills of these prescriptions.
5. On February 21, 2012, the Board received a toxicology report regarding the death of Patient A, from the Clay County Coroner. The Coroner stated, in part,

...The blood serum levels indicate Alprazolam/Xanax in significant quantities, over 6 X maximum therapeutic range and Fentanyl/Duragesic at nearly 6X maximum therapeutic range as well as Oxycodone at 1.85 X therapeutic range...Further morphine is present in the urine screen as well. My opinion is this patient was consuming prescriptions medications in large quantities on a regular basis...Death will be ruled accidental and due to Acute Combined Narcotic Drug Toxicity, (Alprazolam, Oxycodone, Fentanyl, and Morphine).
Providers are ... and Dr. John R. Baird, Healing Options, in Louisville, KY (Fentanyl, Oxycodone) ....

6. The Board requested a review of the licensee's prescribing patterns. In a report dated January 12, 2010 (sic – 2012), the reviewer identified the following issues:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated, and
   - Family members obtaining the same or similar controlled substances; and,
   - Dr. Baird is also prescribing amphetamines for the majority of his patients which may or may not be in accordance with the diagnosis/purpose outlined in 201 KAR 9:016.

   The reviewer selected 25 patient records for review by a Board consultant.

7. In a report dated March 30, 2012, one Board consultant concluded, in part, regarding his review of the four patients identified by the pharmacist initially,

   Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. In his evaluation which should have been comprehensive, I think he did not meet the quality expected. On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the records, how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure of

or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and

this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of the medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his

discretion to start with higher does when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficient diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may not be significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a advantageous to the patient and him rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [Patient B]. The patient had the diagnosis of hepatitis C,

neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump. A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at the time were penicillin, sulfa, latex and morphine. I have searched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion. Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc., is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in

Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems...

8. A second Board consultant reviewed 22 of the licensee's patient records. This

reviewer concluded, in part,

...My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.
...There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr. Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids; 2) combinations of three and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazapines and 3) the use of opioids for fibromyalgia at all. From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best. The use

of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.
Patients suffering from fibromyalgia may also have altered endogenous opioid activity. A study utilizing position emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing. There are two possible explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain. Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors.
Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia. In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.
Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates. In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern with patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

While this consultant consistently marked "within minimum standards" on the

Expert Review Worksheets for Records and Diagnosis, he made the following finding

or similar finding in 19 of the 20 cases reviewed,

There is minimal documentation of physical exam which is required under the KBML regulations....A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

This consultant also made the following specific findings in individual Expert Review Worksheets,

....
...Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriateness of initial therapy.
...It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids....The dismissal of the patient on high dose opioids without taper breaches ethics.
....
I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guidelines. Dr. Baird provides no intensive monitoring of function and minimal physical exam....This combination of medications is non-standard and risky in a patient with obstructive sleep apnea....Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable.
....Use of 2 short acting opioids in an alternating fashion is not standard care but Dr. Baird monitors outcomes and appears to be evaluating the patient's response.
...."Tender all over" does not constitute a physical exam.
....Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax. This is a clear harbinger for substance misuse/abuse....High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion ....Though this patient was ultimately dismissed for non-compliance the original medication is questionable.
....The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards...."Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr. Baird that his patient likely has a personality DO....It is generally accepted that combinations of opioids and benzodiazapines plus Soma is high risk for addiction and adverse outcomes.... I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr. Baird may be helpful.
....The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/da. I am unsure of any rationale that supports this Rxn practice.
....Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an aberrant behavior in that the patient took her child's adderall and no action was taken.

....High dose opioid therapy is maintained though hypogonadism a clear complication of high dose opioid therapy is diagnosed. Again a stimulant is prescribed for fatigue and somnolence rather than...
....I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid. This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr. Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case....This combination of medications is non-standard and dangerous.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

9. By his conduct, the licensee has violated KRS 311.595(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.

10. 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.

11. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for August 27, 28, 29 & 30, 2013 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 John R. Baird, M.D.

This 28th day of May, 2013.

Randel C. Gibson DO
RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and 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 John R. Baird, M.D., License No. 36869, 3012 Eastpoint Parkway, Louisville, Kentucky 40223 and L. Chad Elder, Esq., Brian R. Good, Esq., Elder & Good, PLLC, 159 St. Matthews Avenue, Suite 1, Louisville, Kentucky 40207 on this 28th day of May, 2013.

C. Lloyd Vest

C. LLOYD VEST II
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