

STATE OF MAINE BOARD OF LICENSURE IN MEDICINE

In Re: Stephen H. Doane, M.D.

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AMENDED  
DECISION AND ORDER

Complaint CR 12-103

**I. PROCEDURAL HISTORY**

Pursuant to the authority found in 5 M.R.S. §§ 9051 et seq., 10 M.R.S. § 8003(5), and 32 M.R.S. § 3269 and § 3282-A, the State of Maine Board of Licensure in Medicine (“Board”) met in public session at its offices in Augusta, Maine, on January 13, 2015. A second day of hearing was held on February 10, 2015. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether grounds existed to impose discipline on the medical license of Stephen H. Doane, M.D., and to determine whether his application for renewal should be granted.

On April 30, 2014, a Scheduling Order was issued setting prehearing deadlines. On July 22, 2014, a Prehearing Order was issued denying the Licensee’s motion for discovery. On August 6, 2014, an amended Notice of Hearing was issued by the Board setting the hearing date for September 9, 2014. On August 12, 2014, a Prehearing Order was issued denying the Licensee’s request for voir dire. On September 4, 2014, a Scheduling Order was issued granting the Licensee’s request to continue the hearing date. On October 17, 2014, an amended Notice of Hearing was issued by the Board setting the hearing date for November 10, 2014. On October 27, 2014, an amended Notice of Hearing was issued by the Board rescheduling the hearing date for January 13, 2015, due to lack of availability of one of the Licensee’s witnesses on November 10, 2014. On December 15, 2014, a Notice of Recusal Decision was issued informing the parties that Board member David Jones, M.D., had recused himself from hearing the matter upon the Licensee’s

motion. On December 30, 2014, an Evidentiary Order was issued. On January 7, 2015, an Order was issued granting the State's request to utilize Dr. David Jones as a resource during the Board hearing.<sup>1</sup> On January 15, 2015, a Conference Order was issued and a Scheduling Order was issued setting the second day for February 10, 2015.

A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were David R. Andrews, M.D.; Louisa Barnhart, M.D.; David H. Dumont, M.D.; David Nyberg, Ph.D., Public Member; Christopher Ross, P.A.-C; and Chair Maroulla Gleaton, M.D. Peter Sacchetti, M.D., participated in the first day of hearing but was not able to attend the second day of hearing and therefore did not take part in deliberations. David D. Jones, M.D., recused himself. Cheryl Clukey, M.Ed., Public Member, recused herself upon motion of the Licensee following the State's opening statement as noted in a Conference Order of January 15, 2015.

Dr. Doane was present and was represented by Christopher Taintor, Esq. Dennis Smith, Esq., Assistant Attorney General, represented the State of Maine. Rebekah Smith, Esq., served as Hearing Officer. The hearing was held in accordance with the requirements of the Administrative Procedures Act, 5 M.R.S. §§ 9051 et seq.

State Exhibits #1 to #15 and State Exhibit #17 were admitted without objection. State Exhibit #18 was marked but not offered for admission. Licensee Exhibits #2 through #11 and #13A through #17D were admitted without objection. Licensee Exhibits #1 and #12 and State Exhibit #16 were excluded.

The Board took notice of its statutes and rules and confirmed that no participating member had any conflict of interest or bias that would prevent him or her from rendering an impartial decision in this matter. Each party presented an opening statement. The State presented James

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<sup>1</sup> Dr. Jones did not assist the State during its presentation.

Cardi, M.D., as an expert witness, and the Licensee. The Licensee presented Richard Kahn, M.D., who had treated patient A.H., and Richard Raskin, M.D., the Licensee's supervisor at Genesis Health Care. Each party made a closing statement. The Board then deliberated and made the following findings of fact and conclusions of law by a preponderance of the credible evidence regarding the allegations against Dr. Doane.

## **II. FINDINGS OF FACTS**

1. Stephen H. Doane, M.D., was first granted a Maine medical license in November 1985. (State Exh. #13.) Since finishing his residency in the 1970s, Dr. Doane has practiced general internal medicine. (Testimony of Doane.) In the 1980s, Dr. Doane developed an interest in geriatric medicine. (Testimony of Doane.)
2. A.H. was born on October 15, 1964. (State Exh. #4, page 1.) A.H. became a patient of Dr. Doane's in approximately 2003. (Testimony of Doane.) A.H. had multiple diagnoses including Post Traumatic Stress Disorder, chronic obstructive pulmonary disease, morbid obesity, panic disorder, carpal tunnel, and agoraphobia. (Testimony of Doane.) A.H. had nightmares, was very depressed, and smoked two packs of cigarettes per day. (Testimony of Doane.) Dr. Doane's primary practice was at PrimeCare Physicians in Biddeford, which was affiliated with Southern Maine Medical Center. (Testimony of Doane.) Dr. Doane was also the medical director at various skilled medical facilities owned by Genesis Health Care in Maine beginning in the 1990s and continuing throughout the period of time that he treated A.H. (Testimony of Doane.)
3. Early in his treatment of A.H., Dr. Doane prescribed her opiates for traumatic injury, including a car accident, after determining that nonsteroidal anti-inflammatory drugs were not tolerated by or useful for A.H. (Testimony of Doane.) A.H. reported increased functionality when she was taking opiate medications but negative impacts when she

attempted to decrease them, including difficulty sleeping. (Testimony of Doane.) In 2008, Dr. Doane referred A.H. to a physical medicine specialist to try to understand ongoing pain A.H. reported. (Testimony of Doane.) Also in 2008, Beth Michaels began to provide home care for A.H. (Testimony of Doane.) Dr. Doane interacted with Ms. Michaels frequently in his care of A.H. (Testimony of Doane.) Ms. Michaels facilitated the scheduling of A.H.'s appointments, provided A.H. with rides to appointments, and attended all appointments with A.H. (Testimony of Doane.) Ms. Michaels also often made arrangements to pick up prescriptions for A.H. at Dr. Doane's office because it was difficult for A.H. to get around. (Testimony of Doane.) Although Dr. Doane was not aware of how many hours Ms. Michaels spent at A.H.'s home each week or her licensing credentials, he relied on her to make sure that A.H. was taking her medications as he had prescribed them. (Testimony of Doane.)

4. Dr. Richard Kahn is a pulmonary care and sleep physician who is board-certified in several areas, with a practice also at PrimeCare Physicians. (Testimony of Kahn.) Dr. Kahn evaluated A.H. in 2007 for symptoms of insomnia and coughing. (Testimony of Kahn.) When A.H. arrived for her first sleep study in July 2007, she was taking Percocet, Flexeril, and clonazepam, prescribed by Dr. Doane. (Testimony of Kahn.) A.H. was being prescribed narcotics at the morphine equivalent dosage of 90 milligrams per day. (Testimony of Kahn.) Dr. Kahn concluded that A.H. had mild obstructive sleep apnea caused by her airway anatomy. (Testimony of Kahn.) Dr. Kahn recommended a CPAP machine, which resulted in much better sleep quality for A.H. in her sleep studies. (Testimony of Kahn.)
5. On June 10, 2010, A.H. reported to Dr. Doane that she had fallen down the stairs several months earlier and obtained multiple contusions and was sore everywhere. (State Exh. #4, page 346.) A.H. stated that she had continued to fall from time to time, experienced

bruising and continued low back pain, and was continuing to use a TENS unit to manage back pain although it was malfunctioning at the time of her visit. (State Exh. #4, page 346.) A.H. reported that the TENS unit helped her back pain but did not completely resolve it. (State Exh. #4, page 346.) She reported back pain of 6 on a scale of 1 to 10 and inquired about a stronger medication. (State Exh. #4, page 346.) A.H. indicated that she continued to smoke. (State Exh. #4, page 346.) Dr. Doane assessed A.H. with low back pain, among other conditions, and refilled her prescription for Percocet (10mg/325mg), 2 tablets to be taken every 3 hours as needed. (State Exh. #4, page 348.)

6. On June 11, 2010, A.H. was found unresponsive with blue lips by her daughter, who called an ambulance to A.H.'s home. (State Exh. #4, page 292.) Although unresponsive when medical care arrived, A.H. became responsive after being given Narcan during the ambulance ride, an indication that she had overdosed on opiates. (State Exh. #4, page 292; Testimony of Doane.) A.H. indicated that she had not feel well that day and as a result had taken 2 Percocet and 2 Klonopin. (State Exh. #4, page 292 & 316.) A.H. also reported that her CPAP machine had been broken for a couple of days. (State Exh. #4, page 316.) She denied that she was trying to hurt herself. (State Exh. #4, page 292.) At Southern Maine Medical Center, A.H. again reported that she had taken extra pain medication to help her sleep and was diagnosed as having accidentally overdosed. (State Exh. #4, page 303.) A.H. was discharged with instructions to follow-up with Dr. Doane the next business day, to use her CPAP machine at home as directed, and to take medications only as prescribed. (State Exh. #4, page 314.) At hearing, Dr. Doane denied knowledge of A.H.'s June 11, 2010, emergency room visit until much later. (Testimony of Doane.) He stated that if he had known of her overdose, he would have had more discussion with A.H. about taking her

medications appropriately and would have decreased her medications. (Testimony of Doane.)

7. Because PrimeCare Physicians was affiliated with Southern Maine Medical Center, Dr. Doane had online access to medical records at Southern Maine Medical Center including discharge summaries. (Testimony of Doane.) Although emergency room records were not online, he could obtain them by going to the emergency room, which was across the street from his office. (Testimony of Doane.)
8. A.H. did not schedule an appointment with Dr. Doane for the next business day following her discharge. (State Exh. #4.)
9. A.H. then cancelled her previously scheduled appointment for July 8, 2010, with Dr. Doane on the day of the appointment, due to a death in the family. (State Exh. #4, page 282.) Dr. Doane authorized A.H.'s daughter to pick up A.H.'s Percocet prescription at his office that day. (State Exh. #4, page 281.)
10. A.H. did not see Dr. Doane again until August 5, 2010. (State Exh. #4, page 277.) The first two pages of visit notes duplicate notes from her June 10, 2010, appointment. (State Exh. #4, pages 277-278.) It was noted that A.H. had ongoing right foot pain and swelling after numerous falls but exams were normal and there had been a complete healing of the proximal phalanx of the third toe. (State Exh. #4, page 278.) A.H.'s general examination revealed moderate tenderness at the sacroiliac joint bilaterally. (State Exh. #4, page 278.) Dr. Doane referred A.H. to a podiatrist and refilled her Percocet prescription for low back pain. (State Exh. #4, page 279.)
11. On August 27, 2010, Ms. Michaels reported to Dr. Doane that due to a trip she was taking she needed to pick up A.H.'s prescriptions that day. (State Exh. #4, page 270.) Dr. Doane

approved the request for an early refill of Percocet (10mg/325mg) to be taken 2 tablets every 3 hours as needed. (State Exh. #4, page 270.)

12. On September 23, 2010, A.H. saw Dr. Doane for a four-week follow-up and medication refill visit. (State Exh. #4, page 264.) A.H. reported that the TENS unit helped her manage her back pain. (State Exh. #4, page 264.) A.H. reported low back pain at a level of 6 on a scale of 1 to 10 and inquired about stronger pain medication. (State Exh. #4, page 264.)  
With regard to the condition of depression, A.H. reported that she had been crying more with difficulty sleeping and experiencing PTSD symptoms and night terrors, but Dr. Doane noted improvement. (State Exh. #4, page 264.) A.H. stated that she was waiting for medical marijuana. (State Exh. #4, page 264.) In the general examination, Dr. Doane noted continuing tenderness at the sacroiliac joint. (State Exh. #4, page 266.) He ordered a refill of A.H.'s Percocet of 360 tablets at the previously prescribed level. (State Exh. #4, page 266.)
13. On September 25, 2010, A.H.'s daughter called an ambulance because A.H. was not acting right and fell asleep standing up and while smoking a cigarette. (State Exh. #4, page 215 & 230.) A.H.'s daughter was extremely upset and stated that the last time she found A.H. like this she was unresponsive and not breathing. (State Exh. #4, page 215.) A.H. agreed to be transported by ambulance. (State Exh. #4, page 215.) A.H. stated that she took many pain medications and did not know if she had taken too many that day by accident but she had done so before. (State Exh. #4, page 230.) A.H. was given Narcan, after which she seemed easier to arouse, a strong indicator that she was experiencing an opiate overdose. (State Exh. #4, page 231; Testimony of Doane.)
14. The emergency physician record of Southern Maine Medical Center indicated that A.H. exhibited an altered mental status, was hard to wake, and was too sleepy. (State Exh. #4,

page 223.) The emergency room physician, Renee Sarett, concluded that A.H. was sedated and overmedicated. (State Exh. #4, page 224.) Dr. Sarett noted that it was A.H.'s second oversedation event and he counseled her on the lethality of her medications. (State Exh. #4, page 224.) Dr. Sarett also ordered a limit on the medications A.H. was taking. (State Exh. #4, page 224.) Dr. Sarett noted on A.H.'s discharge instructions that the medications she was taking would kill her and instructed her to take only half of her current dosages of Klonopin, Ativan, and Percocet and to stop taking Flexeril entirely. (State Exh. #4, page 225.) He made a note that her family would control her use of medications. (State Exh. #4, page 225.) Dr. Sarett also instructed A.H. to speak with her primary care provider, Dr. Doane, on Monday. (State Exh. #4, page 225.) A.H. left the hospital against medical advice. (State Exh. #4, page 253.)

15. On September 26, 2010, Paul Laprise, M.D., a partner of Dr. Doane's at PrimeCare Physicians, authored a telephone encounter record indicating that the previous evening he had received a call from the emergency room physician at Southern Maine Medical Center. (State Exh. #4, page 214.) The emergency room physician reported that A.H. was in the emergency room with altered mental status. (State Exh. #4, page 214.) The emergency room physician reported to Dr. Laprise that he felt very strongly that A.H. was overmedicated and wanted to make sure that his message was passed on to her primary care physician, Dr. Doane. (State Exh. #4, page 214.)
16. On September 26, 2010, at 3:11 p.m., Dr. Doane electronically noted that he had reviewed the message from Dr. Laprise recounting his conversation with the emergency room physician. (State Exh. #4, page 214.) Dr. Doane did not, however, attempt to get in touch with the emergency room physician. (Testimony of Doane.) Dr. Doane did not schedule an immediate visit for A.H. but could not explain why not. (Testimony of Doane.) He planned



- to consider the note at A.H.'s next visit. (Testimony of Doane.) Dr. Doane felt that A.H. was in good hands because he thought that Ms. Michaels was at her home every day so he simply made a mental note of the emergency room physician's call. (Testimony of Doane.)
17. In hindsight, Dr. Doane wishes that he had obtained the emergency room record of A.H. from her September 25, 2010, hospitalization. (Testimony of Doane.) Dr. Doane reiterated that if he had obtained the record, he would have changed A.H.'s care plan by discussing her medication use with her and decreasing her dosages of opiates. (Testimony of Doane.) Dr. Doane acknowledged that if he had gotten the emergency room record from the September 2010 event, he would have learned of the June 2010 event as well. (Testimony of Doane.)
18. On October 11, 2010, Ms. Michaels called Dr. Doane's office to request that A.H. skip her appointment that day and pick up prescriptions instead because she was not feeling well. (State Exh. #4, page 208.) Dr. Doane approved the continued order for TENS pads and a refill of A.H.'s Percocet at the same level she was prescribed by him prior to her hospitalization and Dr. Sarett's order to decrease her dosage by half. (State Exh. #4, page 208.) Dr. Doane had forgotten about the emergency room physician's call by this time. (Testimony of Doane.)
19. On October 18, 2010, upon receiving a call from A.H.'s pharmacy that she was seeking refills, Dr. Doane ordered refills of A.H.'s Flexeril and lorazepam (identified as Ativan in the Southern Maine Medical Center emergency room record) at the same dosage prescribed before A.H.'s September 25, 2010, emergency room visit and Dr. Sarett's subsequent order to reduce the dosage of lorazepam by half and to discontinue Flexeril entirely. (State Exh. #4, page 203.)
20. On November 4, 2010, A.H. saw Dr. Doane for the first time since her second hospitalization for oversedation from opiates in September 2010. (State Exh. #4, page 194.)

It was noted that A.H. was stable on her CPAP machine and had undergone further testing with her CPAP machine under the direction of Dr. Richard Kahn, a pulmonologist and sleep medicine doctor. (State Exh. #4, page 194.) Dr. Doane noted that Ms. Michaels attended the visit with A.H. and provided a full explanation of issues. (State Exh. #4, page 194.) A.H. reported that she had right-sided chest pain daily and thought she might have broken a rib in a severe coughing episode. (State Exh. #4, page 194.) In a general examination, Dr. Doane noted moderate tenderness at sacroiliac joint but did not examine A.H.'s ribs. (State Exh. #4, page 195.) He ordered a refill of Percocet for low back pain at the same dosage as previously prescribed. (State Exh. #4, page 196.)

21. On March 1, 2011, Dr. Doane authorized a refill of 360 tablets of Percocet (10mg/325mg) for A.H. (State Exh. #6.)
22. On April 5, 2011, Ms. Michaels phoned Dr. Doane's office to report that things were getting out of control at A.H.'s house. (State Exh. #4, page 155.) She stated that if Adam Caron called, Dr. Doane should not believe what he reported. (State Exh. #4, page 155.) Ms. Michaels stated that Mr. Caron would try to tell Dr. Doane that A.H. was doing funny things with medications and not letting Ms. Michaels in. (State Exh. #4, page 155.)
23. On April 15, 2011, Dr. Doane refilled A.H.'s prescription for Flexeril (10mg) for 1 tablet 3 times a day. (State Exh. #4, page 148.) He also refilled her prescriptions for clonazepam, citalopram, and lorazepam at that time. (State Exh. #4, page 149.)
24. On April 18, 2011, Dr. Doane ordered a refill of A.H.'s Percocet (10mg/325mg) for 2 tablets every 3 hours as needed. (State Exh. #4, page 150.) Dr. Doane authorized 360 tablets. (State Exh. #4, page 150.)
25. On April 18, 2011, an individual named Tom called Dr. Doane's office to report that A.H. and Ms. Michaels were selling A.H.'s medication. (State Exh. #4, page 147.) Tom reported

that A.H. was bragging that she had Dr. Doane under her thumb because when he asked her to come in for a pill count she had a friend who would replace the pills she sold in order to make her pill count correct. (State Exh. #4, page 147.) Tom reported that A.H. was selling her medication near a school, which concerned him. (State Exh. #4, page 147.) He also stated that A.H. brought her daughter's urine with her to medical appointments in case she was asked to give a urine sample. (State Exh. #4, page 147.) Tom stated that A.H. would give her daughter one pill so that the medication would show up in her urine. (State Exh. #4, page 147.) Tom indicated that A.H. had quite a racket going and requested that someone do something to stop it. (State Exh. #4, page 147.)

26. Within a half hour of Tom's call to Dr. Doane's office, Ms. Michaels called to ask if A.H.'s prescription for Percocet was available for pick up. (State Exh. #4, page 146.)
27. Dr. Doane indicated on the telephone encounter note summarizing Tom's call that A.H. should come in and undergo a urine screen and then he would consider ordering a refill. (State Exh. #4, page 147.) Dr. Doane also noted that an individual named Melissa from risk management had advised him to confront A.H. with the information from the caller Tom, get a pain medication contract in place, and check A.H.'s urine in front of a witness. (State Exh. #4, page 147.)
28. On April 19, 2011, Tom again called Dr. Doane's office to confirm that his call the day before had been received. (State Exh. #4, page 144.) Tom indicated that he was aware that A.H. had an appointment that day. (State Exh. #4, page 144.) Tom provided the additional information that A.H. was driving around until 8 p.m. the prior evening trying to purchase an oxycodone tablet so that she would pass her urine test that day. (State Exh. #4, page 144.) Tom stated that although A.H. reported being claustrophobic, she was out at bars frequently and smoked marijuana all the time. (State Exh. #4, page 144.) Tom also

indicated that Ms. Michaels was in A.H.'s home only approximately three hours per month and was helping A.H. to sell her medications. (State Exh. #4, page 144.) According to the telephone encounter record, the phone call was on speaker phone with Dr. Doane listening. (State Exh. #4, page 144.)

29. Dr. Doane considered Tom's information to be suspect and it did not cause him much concern. (Testimony of Doane.) He would have been concerned if he believed that A.H. was smoking marijuana while taking her prescription medications. (Testimony of Doane.)
30. On April 19, 2011, A.H. was seen by Dr. Doane for medication issues. (State Exh. #4, page 142.) Dr. Doane planned to require A.H. to enter into a pain medication contract. (Testimony of Doane.) Support staff did a pill count of all A.H.'s medications, except Percocet, which she did not bring with her. (State Exh. #4, page 142.) There was no indication in the record of why A.H. did not bring her Percocet. (State Exh. #4, page 142.) While waiting in the office, A.H. was found to be cyanotic and slumped over, with oxygen saturation in the 70s. (State Exh. #4, page 142.) She was given nasal oxygen with some improvement and rescue was called. (State Exh. #4, page 142.) Dr. Doane discussed with the emergency department physician the possibility that A.H. had accidentally overdosed or taken the wrong medication in light of the messages from Tom that A.H. was not correctly taking her medication and then sought medication to pass her urine test. (State Exh. #4, page 143.) Dr. Doane did not recall the message regarding A.H.'s overdose in September 2010 at the time of this incident. (Testimony of Doane.)
31. Patrick Tangney, M.D., the emergency department physician at Southern Maine Medical Center who treated A.H. concluded that A.H. had taken excessive benzodiazepines. (State Exh. #4, pages 140-141.) A.H. reported that she did not remember that the friend who acted as her nurse had given her her medications the day before and she had taken them again

herself, resulting in a double dose. (State Exh. #4, page 135.) It was noted that A.H. had been treated with Narcan with no effect and BiPAP therapy without improvement. (State Exh. #4, page 135.) A.H. was then given flumazenil with immediate results and was awake. (State Exh. #4, page 135.) Dr. Tangney indicated that it was not clear from his discussion with A.H. whether she intended to take more benzodiazepines than prescribed, but she denied this was the case. (State Exh. #4, page 141.) A.H. reported significant fear that Dr. Doane thought she bought street drugs which caused her overdose. (State Exh. #4, page 135.) Dr. Tangney recommended that A.H. explain how the situation occurred to Dr. Doane. (State Exh. #4, page 135.) Dr. Tangney also explained to A.H. that she had been on too many medications over too long a period of time. (State Exh. #4, page 136.) Dr. Tangney opined that A.H. relied far too much on medications to relieve her symptomatology. (State Exh. #4, page 136.)

32. A.H. was discharged from Southern Maine Medical Center on April 20, 2011. (State Exh. #4, page 135.) After reviewing her medication list, Dr. Tangney discharged A.H. with substantially less of both benzodiazepines and narcotics. (State Exh. #4, page 136.) Dr. Tangney prescribed low dose benzodiazepines and narcotics (Percocet) to ensure that A.H. did not have significant withdrawal but wanted to be judicious in the use of these medications. (State Exh. #4, page 141.) Dr. Tangney informed A.H. that his recommended amounts of medications might not be the final resolution but she should not return to the high levels she was taking previously. (State Exh. #4, page 136.) Dr. Tangney discharged A.H. with instructions not to take her Klonopin, Percocet, or Ativan as previously prescribed but to take Klonopin (2mg) 1 tablet in the morning and 1 in the afternoon, Percocet (5mg/325mg) 1 tablet every 4 hours as needed, Motrin (600mg) 1 tablet 3 times a day with meals, and Tylenol (1,000 mg) at bedtime. (State Exh. #4, page 136.) Dr. Tangney also

reduced the frequency of A.H.'s Flexeril (10mg) prescription to 1 tablet 3 times per day as needed only. (State Exh. #4, page 136.) Dr. Tangney noted that A.H. became agitated when she realized that some of her prescriptions were for over-the-counter medications that she would need to pay for herself. (State Exh. #4, page 136.) A.H. was also instructed to follow-up with Dr. Doane in approximately 72 hours, which she stated she would do. (State Exh. #4, page 136.) Dr. Doane was copied on the emergency room record. (State Exh. #4, page 141.)

33. On April 21, 2011, Dr. Doane's office was notified that A.H. had been released on April 20 with instructions to see Dr. Doane on April 21. (State Exh. #4, page 130.) A.H.'s discharge summary was printed and provided to Dr. Doane by his office staff. (State Exh. #4, page 130; Testimony of Doane.)

34. A.H. was seen by Dr. Doane on April 21, 2011. (State Exh. #4, page 126.) A.H.'s lab work revealed the presence of marijuana. (State Exh. #4, page 128.) Dr. Doane informed A.H. that he would taper her Percocet prescription because she was using marijuana and advised her to stop. (State Exh. #4, page 128.) Dr. Doane warned A.H. that if future urine tests showed marijuana use he would discontinue prescribing Percocet altogether. (State Exh. #4, page 128.) Dr. Doane refilled A.H.'s Percocet at the level prescribed by Dr. Tangney of 5mg/325mg to be taken 1 tablet every 4 hours as needed. (State Exh. #4, page 128.) The 60 tablet prescription would have lasted 15 days at the prescribed amount. (State Exh. #4, page 128.) For the first time, Dr. Doane required A.H. to sign a written pain contract, although the pain contract itself does not appear in the record. (State Exh. #4, page 126; Testimony of Doane.)

35. On April 25, 2011, A.H. reported by phone call to Dr. Doane's office that she was not taking the Percocet as prescribed but instead was taking 2 tablets every 3 hours and therefore

needed an early refill. (State Exh. #4, page 122.) Dr. Doane approved a prescription refill for Percocet (5mg/325 mg) to be taken 2 tablets (instead of 1 tablet prescribed by Dr. Tangney) every 4 hours as needed. (State Exh. #4, pages 122 & 779.) He authorized 240 pills. (State Exh. #4, page 122.)

36. On May 5, 2011, A.H. called Dr. Doane's office to report that her back pain was excruciating and the lower dosage of Percocet was insufficient. (State Exh. #4, page 121.) Dr. Doane approved A.H. to come in for an appointment. (State Exh. #4, page 121.)

37. On May 19, 2011, A.H. reported to Dr. Doane that she was very disappointed at the rapid decrease in her pain medications, referencing the reduced potency of the Percocet from 10mg/325mg prior to her hospitalization to 5mg/325mg afterwards. (State Exh. #4, page 115.) She stated that she had overdosed on benzodiazepines not opiates and that her quality of life was slipping away. (State Exh. #4, page 115.) She reported that she had been out of Percocet for a few days because she had been taking it at higher amounts than prescribed. (State Exh. #4, page 115.) A.H. reported that she was waiting for medical marijuana but was smoking it illegally in the meantime. (State Exh. #4, page 115.) Despite the facts that A.H. reported that she was smoking marijuana and that she was taking Percocet at more frequent intervals than prescribed, both presumably violations of her recently signed pain contract with Dr. Doane, Dr. Doane increased the dosage of A.H.'s Percocet to 10mg/325mg (from 5mg/325mg) taken 2 tablets every 3 hours (from every 4 hours) as needed on the basis that she reported that she was not responding well to the reduction. (State Exh. #4, page 116; Testimony of Doane.)

38. On July 25, 2011, Ms. Michaels called Dr. Doane's office to report that A.H. needed a refill of Percocet because she had taken her 30 day allocation in 22 days. (State Exh. #4, page 82.) Dr. Doane approved a refill with a note that she should not take more than 12 tablets

total in a day so the 360 pill supply should last for 30 days. (State Exh. #4, page 82.) Dr. Doane believed that A.H. had taken the pills too quickly by accident and was taking more than the maximum of 12 tablets per day. (Testimony of Doane.) Dr. Doane wrote the maximum of 12 tablets per day on the refill to make sure A.H. understood but did not have her come into his office to explain the limitation. (Testimony of Doane.)

39. A.H. cancelled her July 29, 2011, appointment with Dr. Doane because she woke up ill. (State Exh. #4, page 79.)

40. On August 22, 2011, Dr. Doane refilled A.H.'s Percocet prescription when Ms. Michaels called his office to request a refill. (State Exh. #4, page 76.)

41. On September 15, 2011, A.H. reported to Dr. Doane that she believed she fractured a rib sneezing recently but declined an x-ray. (State Exh. #4, page 72.) She also requested an increase in her Percocet. (State Exh. #4, page 72.) A.H. reported that her back pain was an 8 out of 10 without use of Percocet but 6 out of 10 with it. (State Exh. #4, page 73.) A.H.'s urine screen taken on June 7, 2011, which was noted in the September 15, 2011, record, indicated that no opiates appeared in her urine although benzodiazepines did. (State Exh. #4, page 73.) Dr. Doane refilled A.H.'s Percocet (10mg/325mg) prescription to be taken 2 tablets every 3 hours as needed, with a 360 pill count for a 30 day supply. (State Exh. #4, page 74.) Dr. Doane also started A.H. on a prescription for oxycodone (5 mg) to be taken 1 tablet every 3 hours as needed, with 120 pills for a 14 day supply. (State Exh. #4, page 74.) Dr. Doane did not examine A.H.'s ribs. (Testimony of Doane.) Dr. Doane added the additional opiate prescription for oxycodone based on A.H.'s self-report of a fractured rib. (Testimony of Doane.) Dr. Doane did not recall if he advised A.H. about the risks of taking the additional opiate in light of her other conditions and medications. (Testimony of Doane.) Dr. Doane would not have prescribed oxycodone if he had obtained the records from A.H.'s



June and October 2010 opiate overdose visits to the emergency room. (Testimony of Doane.)

42. On November 11, 2011, A.H. saw Dr. Doane for a follow-up appointment. (State Exh. #4, page 54.) Dr. Doane refilled her Percocet (10mg/325mg) prescription to be taken 2 tablets every 3 hours as needed, at 360 pills intended to last 30 days. (State Exh. #4, page 55.) He also refilled her prescription for oxycodone (5mg) to be taken 1 tablet every 3 hours as needed, at 240 pills to last 30 days. (State Exh. #4, page 55.) A.H.'s urine screen, taken on November 11, 2011, was positive for benzodiazepines and negative for opiates. (State Exh. #4, page 56.)
43. On February 16, 2012, Dr. Doane filed an application for renewal of his license. (State Exh. #12.) His license was due to expire on March 31, 2012. (State Exh. #13.)
44. On February 10, 2012, Ms. Michaels called Dr. Doane's office to complain that the last 2 times she had called in to obtain refills of A.H.'s medications, office staff had called A.H. to let her know that she had a habit of missing appointments after she obtained refills. (State Exh. #4, page 36.) Ms. Michaels expressed frustration that A.H. was being told that because it agitated A.H. (State Exh. #4, page 36.) Dr. Doane responded electronically to his staff questions as to whether he normally saw A.H. only every three months by stating that follow-up was variable but that if she wanted to continue treatment with him, A.H. needed to attend follow-up appointments within the time frame he specified. (State Exh. #4, page 36.) Dr. Doane indicated that he would not continue to prescribe refills for her if she did not keep future appointments. (State Exh. #4, page 36.)
45. On February 10, 2012, A.H. saw Dr. Doane for a follow-up appointment. (State Exh. #4, page 37.) A.H. indicated that she was no longer using the TENS machine for pain management because she could not get supplies for it and her back pain was worse. (State

Exh. #4, page 37.) A.H. reported that she had not been able to tolerate oxycodone without Tylenol in the past. (State Exh. #4, page 38.) Her November 15, 2011, lab results were noted to be positive for opiates, oxycodone, and oxymorphone. (State Exh. #4, page 38.) Dr. Doane noted that he had reviewed A.H.'s Prescription Drug Monitoring report and the results were consistent with her pain contract and the prescriptions he had been giving A.H. (State Exh. #4, page 38.) Dr. Doane indicated that he would consider a taper of A.H.'s opiate medications at her next visit since she already had a prescription for that month. (State Exh. #4, page 39.) Dr. Doane testified that the reason he contemplated a taper was that it was then known that it was beneficial for patients to gradually reduce doses of opiates, although he did not record the reason for a taper in A.H.'s medical records. (Testimony of Doane.)

46. On February 22, 2012, A.H. contacted Dr. Doane's office seeking a refill of her prescriptions for Percocet and oxycodone. (State Exh. #4, page 35.) A nurse in Dr. Doane's office informed A.H. that Dr. Doane would begin the taper of those medications as they had discussed at a prior visit. (State Exh. #4, page 35.) Dr. Doane refilled A.H.'s prescriptions for Percocet (10mg/325mg) to be taken 2 tablets every 3 hours as needed up to a maximum of 11 per day and oxycodone (5mg) to be taken 1 tablet every 3 hours as needed up to a maximum of 7 per day. (State Exh. #4, page 35.) Dr. Doane prescribed a 30 day supply of both Percocet and oxycodone. (State Exh. #4, page 35.)

47. On March 23, 2012, Ms. Michaels called Dr. Doane's office to request a refill of A.H.'s prescriptions. (State Exh. #4, page 31.) Dr. Doane refilled A.H.'s prescription for oxycodone (5mg) to be taken 1 tablet every 3 hours as needed with a maximum of 4 per day (14 day supply), Percocet (10mg/325mg) to be taken 2 tablets every 3 hours as needed with

a maximum of 11 per day (14 day supply), Flexeril, and clonazepam. (State Exh. #4, page 31.)

48. On April 4, 2012, A.H. called to request refills of Percocet and oxycodone. (State Exh. #4, page 29.) A.H. acknowledged that she was calling in a weekly early for her prescriptions, but no explanation was given. (State Exh. #4, page 29.) Dr. Doane refilled A.H.'s prescriptions for 2 week supplies of Percocet and oxycodone at the prior levels. (State Exh. #4, page 29; Testimony of Doane.)

49. On April 17, 2012, A.H. called to request a refill of her prescriptions for Percocet and oxycodone. (State Exh. #4, page 28.) Dr. Doane declined to provide A.H.'s requested refills on the basis that she did not have an appointment with him in March 2012. (State Exh. #4, page 28.) A.H. made an appointment to see Dr. Doane later that day, although no visit record appears for that date. (State Exh. #4, page 28.) Dr. Doane refilled A.H.'s prescriptions for oxycodone and Percocet at the previously prescribed levels. (State Exh. #4, page 28.)

50. On April 23, 2012, A.H. saw Dr. Doane for multiple issues regarding her medications, living situation, daughter, and home health care provider. (State Exh. #4, page 25.) A.H. reported that she was no longer smoking marijuana. (State Exh. #4, page 25.) Dr. Doane informed A.H. that he would continue her Percocet prescription but it would be the last time he prescribed it. (State Exh. #4, page 26.) Dr. Doane indicated to A.H. that he would refer her to Goodall Hospital Pain Clinic for further consideration since he would no longer be prescribing controlled substances for chronic pain. (State Exh. #4, page 26.) Dr. Doane indicated on her prescriptions that they were final. (State Exh. #4, page 26.) He prescribed Percocet (10mg/325 mg) to be taken 1 to 2 tablets every 3 hours as needed up to a maximum

of 10 per day (28 day supply) and oxycodone (5mg) to be taken 1 tablet every 3 hours as needed (28 day supply). (State Exh. #4, page 26.)

51. On May 4, 2012, A.H. saw Barbara Logan, N.P., in Dr. Doane's office for anxiety. (State Exh. #4, page 19.) A.H. was tearful and expressing suicidality. (State Exh. #4, page 19.) A.H. reported that she was contemplating overdosing on her pain medications. (State Exh. #4, page 19.) A.H. refused to go to the emergency room. (State Exh. #4, page 19.) Nurse Logan informed the emergency room of A.H.'s status and contacted the police to transport her to the emergency room. (State Exh. #4, page 19.) A.H. left Dr. Doane's office, however, before the police arrived. (State Exh. #4, page 19.)

52. On May 7, 2012, Dr. Doane phoned A.H. to express his concern about her. (State Exh. #4, page 14.) He spoke with Ms. Michaels who reported that A.H. was not suicidal at that time. (State Exh. #4, page 14.) Dr. Doane requested that A.H. make an appointment to see him. (State Exh. #4, page 14.) Dr. Doane reviewed A.H.'s record and asked his staff to call Ms. Michaels back to indicate that he had given A.H. a month's supply of medication as of April 23, 2012, so he would not provide a refill prescription at that time but might in the future if needed. (State Exh. #4, page 14.)

53. On May 15, 2012, A.H. saw Dr. Doane for follow-up for acute bronchitis. (State Exh. #4, page 5.) A.H. reported that she was down to Percocet (10mg/325mg) 12 tablets per day and oxycodone (5mg) 16 tablets per day, although both of those amounts were higher than the maximums prescribed by Dr. Doane most recently. (State Exh. #4, page 5; Testimony of Doane.) At hearing, Dr. Doane testified that the maximum of oxycodone should have been 9 per day and that 16 tablets per day would have been an alarming amount. (Testimony of Doane.) In the visit note, Dr. Doane reported that he had reviewed the Prescription Monitoring Program ("PMP") report for A.H., the results of which were consistent with her

pain contract and the prescriptions he had been providing. (State Exh. #4, page 5.) Her urine sample, taken that day, indicated the presence of benzodiazepines but not opiates. (State Exh. #4, page 6.) Dr. Doane informed A.H. that he would be able to prescribe controlled medications for her until July 8, 2012. (State Exh. #4, page 6.) He noted that she was planning to be seen at the Goodall Hospital Pain Clinic and there was also a possibility that he could refer her to a new primary care physician who could prescribe controlled substances for her thereafter. (State Exh. #4, page 6.) Dr. Doane refilled A.H.'s prescriptions for Percocet (10mg/325mg) to be taken 1 to 2 tablets every 3 hours as needed up to a max of 12 per day (28 day supply) and oxycodone (5mg) to be taken 1 tablet every 3 hours as needed (28 day supply). (State Exh. #4, page 6.) Dr. Doane's intention was to obtain psychiatric help for A.H. before tapering down her medications but he was under a time restriction from a consent agreement being negotiated with the Medical Board to wind up any patients to whom he was prescribing narcotics for chronic pain. (Testimony of Doane.) Because A.H. expressed a desire to remain on her prior dose, and because Dr. Doane was going to be able to prescribe narcotics until July 8, 2012, under the consent agreement being negotiated with the Board, he refilled her prescriptions at that level. (Testimony of Doane.)

54. Effective May 18, 2012, Dr. Doane entered into a consent agreement with the Board and the Maine Office of the Attorney General resolving complaint CR11-397. (State Exh. #10.) In the agreement, Dr. Doane agreed that the Board had sufficient evidence from which it could conclude that he failed to adhere to Board Rule Chapter 21, governing the use of controlled substances for treatment by failing to review a patient's previous medical records prior to prescribing controlled medications to the patient; failing to access and review the PMP prior to prescribing the amount and dosage of controlled substances to the patient; failing to recall

a telephone message that the patient had recently been hospitalized and experienced accompanying respiratory distress prior to prescribing medications to the patient; and increasing the dosage (doubling), frequency, and amount (doubling) of narcotics prescribed to the patient only 4 days after initially prescribing 15 days worth of narcotics to the patient, without obtaining the patient's previous records or reviewing the PMP. (State Exh. #10.) As a result of his conduct, which he conceded could constitute grounds for discipline and denial of his application to renew his Maine medical license for unprofessional conduct pursuant to 32 M.R.S. § 3282-A(2)(F), the Licensee accepted a reprimand, reimbursed the Board \$1,185 in actual costs of investigation, and accepted several practice restrictions, including ceasing prescribing any controlled medications, including opiates and benzodiazepines, for the treatment of chronic pain except for patients in skilled nursing facilities or long-term care facilities, patients in hospice care, or patients with metastatic cancer; prescribing controlled substances for no more than 10 consecutive days to treat acute conditions; and permitting the Board to inspect his medical practice, including patient medical records as allowed by law. (State Exh. #10.) The consent agreement and practice restrictions remain in effect. (State Exh. #10.)

55. On May 19, 2012, A.H. passed away. (State Exh. #4, page 4.) A.H.'s cause of death was identified by the medical examiner to be oxycodone and cyclobenzaprine intoxication.

(State Exh. #7.) Her death was categorized as accidental. (State Exh. #7.)

56. Dr. Doane testified that although he did not note it in A.H.'s records, he did have a conversation with A.H. about the high levels of narcotics she was taking. (Testimony of Doane.) He agreed that as her primary care provider and the prescriber of such medications he was charged with reviewing that information with A.H. (Testimony of Doane.)

57. Dr. Kahn treated A.H. from his initial evaluation in 2007 until her death in 2012.

(Testimony of Kahn.) Throughout his treatment of A.H., Dr. Kahn recommended smoking cessation and was concerned about her psychiatric illnesses. (Testimony of Kahn.) Dr. Kahn was aware that A.H. was taking opiate medications chronically. (Testimony of Kahn.) Dr. Kahn did not have any concerns about the medications that Dr. Doane was prescribing for A.H. (Testimony of Kahn.) Dr. Kahn was not concerned that A.H.'s respiratory function was being compromised by opiate medications. (Testimony of Kahn.) He had an ongoing concern about her compliance with medical instructions, exacerbated by her not allowing him to view her CPAP machine information, likely indicating that she was not utilizing it as prescribed. (Testimony of Kahn.) At the time of hearing, Dr. Kahn was not aware of A.H.'s overdoses or her acute respiratory failure. (Testimony of Kahn.)

58. By letter dated May 24, 2012, Dr. Doane informed the Board that he was accelerating the terms of his consent agreement and would no longer prescribe controlled medications for pain, including all opioids and benzodiazepines, except for patients in skilled nursing facilities or long-term care facilities, patients in hospice care, or patients with metastatic cancer. (State Exh. #9.)

59. By letter dated July 6, 2012, the Board notified Dr. Doane that it had reviewed the records regarding his treatment of patient A.H. at its June 12, 2012, meeting and had voted to initiate a complaint against his license on the basis of alleged unprofessional conduct and incompetence based on inappropriate prescribing practices with regard to patient A.H. (State Exh. #2.)

60. On October 10, 2012, through counsel, Dr. Doane responded to the Board complaint. (State Exh. #3.)

61. On October 21, 2013, Dr. James Cardi filed with the Board a report of his review of Dr. Doane's treatment of patient A.H. (State Exh. #8.) Dr. Cardi is a primary care physician in Rhode Island who has been practicing for 23 years. (Testimony of Cardi.) Dr. Cardi is certified by the American Board of Internal Medicine. (Testimony of Cardi.)
62. Dr. Cardi reviewed A.H.'s medical records going back to 2003, her Prescription Monitoring Program reports, and the medical examiner's report following her death. (Testimony of Cardi.) Dr. Cardi concluded that A.H.'s multiple medical conditions, which included emphysema, obstructive sleep apnea, anxiety, depression, chronic bronchitis, tobacco addiction, and morbid obesity, put her at risk of respiratory complications from medications. (Testimony of Cardi.)
63. Dr. Cardi concluded that most of the non-opiate care that Dr. Doane provided to A.H. was reasonable. (State Exh. #8.) Dr. Cardi also concluded, however, that the opiate treatment for pain management that Dr. Doane provided to A.H. showed poor judgment and decision-making regarding prescriptions that was well outside the standard of care. (State Exh. #8.) Dr. Cardi defined the standard of care as what a minimally competent physician would do in the same circumstances with similar resources. (Testimony of Cardi.)
64. Dr. Cardi noted that certain of the medications prescribed to A.H. by Dr. Doane could cause respiratory depression. (Testimony of Cardi.) Dr. Cardi opined that in order to meet the standard of care, Dr. Doane should have discussed with A.H. the risks of compromised respiratory function from the benzodiazepine and opioid medications that he prescribed her. (Testimony of Cardi.) Dr. Cardi opined that it was a violation of the standard of care for Dr. Doane not to discuss those risks with A.H., but that A.H.'s medical records did not indicate that Dr. Doane had discussed the risks with her. (Testimony of Cardi.) With particular regard to A.H.'s condition of sleep apnea, Dr. Cardi noted that 2010 Veterans'



Administration guidelines indicated that there were significant additional risks from opioid therapy for patients with sleep apnea. (Testimony of Cardi.)

65. Dr. Cardi noted that the use of opioids for pain management was a complicated issue that had evolved over time and that treatment with opioids needed to be reviewed over the course of a patient's care. (Testimony of Cardi.) Dr. Cardi noted that Dr. Doane had increased the dosage of opioids prescribed to A.H. with minimal documentation and sometimes conflicting documentation that did not justify the high doses prescribed especially given the patient's complicating conditions. (State Exh. #8; Testimony of Cardi.) He noted in his report that when the opiate doses that Dr. Doane prescribed for A.H. began to escalate, there was little documentation of the risks, benefits, and potential interactions with other drugs. (State Exh. #8.) Dr. Cardi opined that Dr. Doane should have looked at the combination of the patient's conditions when considering the risks of opioid treatment. (Testimony of Cardi.)
66. Dr. Cardi opined that A.H.'s records did not support the high dosage of opiates that Dr. Doane was prescribing for her, particularly given Dr. Doane's finding on examination of A.H. in February 2010 that there was no longer tenderness at the sacroiliac joint, the original purpose for the prescription. (Testimony of Cardi.) Dr. Cardi found that Dr. Doane's records regarding A.H. were varying, redundant, and contained few or no physical findings. (Testimony of Cardi.) Dr. Cardi opined that even in the records where Dr. Doane found moderate musculoskeletal tenderness during his examination of A.H., the findings did not warrant the high doses of opiates he prescribed A.H., the equivalent to 240 milligrams of morphine at their peak. (Testimony of Cardi.) Dr. Cardi also noted that A.H.'s record also included notation of a prior cocaine addiction that was not carried forward. (Testimony of Cardi.)

67. Dr. Cardi noted that it is generally agreed that a morphine equivalent dose of below 120 mg per day in divided doses is acceptable, but that doses above that level are associated with increased morbidity and mortality, with support for a cutoff of morphine equivalent doses at 200 milligrams per day. (State Exh. #8.) Dr. Cardi calculated that Dr. Doane prescribed A.H. the morphine equivalent dose of 230.67 milligrams per day on average between January 6, 2012, and May 15, 2012, in Percocet and oxycodone. (State Exh. #8.) During the period of higher dosages within that period, Dr. Cardi calculated that Dr. Doane prescribed A.H. the morphine equivalent dose of 240 milligrams per day. (State Exh. #8.)

68. Dr. Cardi opined that Dr. Doane did not take sufficient note of A.H.'s hospitalizations for overdoses, the first two of which indicated that she was overdosing on opiates, which made it harder for her to breathe. (State Exh. #8.) Dr. Cardi emphasized that this was particularly so with regard to the September 25, 2010, note from the emergency room physician reporting his strong feeling that A.H. was overmedicated, which Dr. Doane signed off on. (Testimony of Cardi.) Dr. Cardi noted that there was no evidence to suggest that Dr. Doane followed up with the treatment providers in the emergency department, obtained the emergency department records, reviewed the causes of the overdoses with A.H., closely monitored her prescription usage by screens and pill counts, or entered into or altered a pain medication contract with A.H. following each of her opiate overdoses. (Testimony of Cardi.) Dr. Cardi believed that Dr. Doane's prescribing of benzodiazepines and opiates was necessary and reasonable at the outset but the emergency room visits warranted the need for discussion, medication review, and dosage adjustments, and Dr. Doane's failure to do so was outside the standard of care. (State Exh. #8.)

69. Richard Raskin, Vice President of Medical Affairs for the Northeast at Genesis Health Care, testified that he hired Dr. Doane as the medical director for the River Ridge facility in

Kennebunk, a skilled and long-term care facility that also specializes in traumatic brain injury in September 2010. (Testimony of Raskin.) Dr. Raskin testified that Dr. Doane's role had expanded since his initial hire to include the medical director role at several Genesis Health Care facilities. (Testimony of Raskin.) Dr. Raskin testified that he was satisfied with Dr. Doane's performance and clinical care. (Testimony of Raskin.) Dr. Doane made Dr. Raskin aware of the prescribing limitations in the consent agreement he entered into with the Board in May 2012. (Testimony of Raskin.) Dr. Raskin testified that he conducted periodic peer review of Dr. Doane, including record compliance and clinical care, which he has found to be exemplary. (Testimony of Raskin.) Dr. Raskin testified that Dr. Doane was a significant asset to the residents of Genesis facilities and that it was hard to find good geriatricians in the state of Maine. (Testimony of Raskin.)

70. Dr. Raskin testified that he and Dr. Doane had discussed several times the practice of prescribing narcotics for chronic pain and that they agreed that narcotics were not the ideal way to treat chronic pain. (Testimony of Raskin.)

71. In his current role as a medical director at various Genesis Health Care facilities, Dr. Doane has employed a strategy of tapering patients who are admitted on narcotic medications and to use narcotics only when needed. (Testimony of Doane; Lic. Exh. #16.) Dr. Doane helped some patients successfully transition off of narcotic medications. (Testimony of Doane.)

72. As of February 10, 2015, the Board had incurred in excess of \$12,000 in costs of expert witness review of A.H.'s records and associated expenses. (State Exh. #17.)

### **III. GOVERNING STATUTES AND RULES**

1. The State of Maine Board of Licensure in Medicine may modify, restrict, suspend, revoke, or refuse to renew a license if the licensee demonstrated incompetence in the practice for which he is licensed. A licensee is considered incompetent in the practice if he engaged in

conduct that evidenced a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public or if he engaged in conduct that evidenced a lack of knowledge or inability to apply principles or skills to carry out the practice for which he is licensed. 32 M.R.S. § 3282-A(2)(E)(1) & (2).

2. The Board may modify, restrict, suspend, revoke, or refuse to renew a license if the licensee engaged in unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if he violates a standard of professional behavior that has been established in the practice for which he is licensed. 32 M.R.S. § 3282-A(2)(F).
3. The Board may modify, restrict, suspend, revoke, or refuse to renew a license if the licensee violated a rule adopted by the Board. 32 M.R.S. § 3282-A(2)(H).
4. The Board has adopted the following criteria when evaluating a clinician's treatment of pain including the use of controlled substances. Each of these principles is essential in the treatment of patients with pain.

1. Evaluation of the Patient - A medical history and appropriate physical examination must be obtained, evaluated and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function and history of substance abuse. It is recommended that the State's Controlled Substance Prescription Monitoring Program Database (PMP) be utilized. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan - The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are

planned. After treatment begins, the clinician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment - The clinician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one clinician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse or substance dependence, the clinician should use a written agreement between clinician and patient outlining patient responsibilities, including:

- a. urine/serum medication levels screening when requested;
- b. pill count when requested;
- c. number and frequency of all prescription refills; and
- d. reasons for which drug therapy may be discontinued (e.g., violation of agreement).

4. Periodic Review of Treatment Efficacy - The clinician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the clinician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the clinician should assess the appropriateness of

continued use of the current treatment plan and consider the use of other therapeutic modalities. Likewise, the clinician should periodically review the course of treatment where psychoactive drugs are used for the treatment of components of chronic pain, e.g., emotional, psychological, or psychosocial stressors, and assess the appropriateness of continued use of the current treatment plan if the patient's progress is unsatisfactory.

5. Consultation or Referral - The clinician should consult or refer, as necessary, for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. Chronic pain often has, as a component, emotional, psychological, or psychosocial stress. In these situations, a number of patients may benefit from psychoactive medications, as well as controlled substances for pain control. The combination of opiates with psychoactive medications, e.g., benzodiazepines, may place the patient at greater risk. The risk may be associated with drug interaction, potentiation, or abuse. In these situations, consultation with or referral to an expert in the management of such patients may be required.

6. Medical Records - The clinician should keep accurate and complete records to include:

- a. the medical history and appropriate physical examination;
- b. diagnostic, therapeutic and laboratory results;
- c. evaluations and consultations;
- d. treatment objectives;
- e. discussion of risks and benefits;
- f. informed consent;
- g. treatments;

- h. medications (including date, type, dosage and quantity prescribed);
- i. instructions and agreements; and
- j. periodic reviews.

Records should remain current and be maintained in an accessible manner, readily available for review. (02-373) Board Rule Chapter 21, Use of Controlled Substances for Treatment of Pain, Section III, Principles of Proper Pain Management.

- 5. For each violation of applicable laws, rules, or conditions of licensure, the Board may issue a warning, censure, or reprimand. Each warning, censure, and reprimand issued must be based upon a violation of a single applicable law, rules, or conditions of licensure or must be based upon a single instance of actionable conduct or activity. 10 M.R.S. § 8003(5)(A-1)(1).
- 6. For each violation of applicable laws, rules, or conditions of licensure, the Board may impose conditions of probation upon a licensee. The probation may run for such time period as the Board determines appropriate. Costs incurred in the performance of terms of probation are borne by the licensee. 10 M.R.S. § 8003(5)(A-1)(4).
- 7. When there is a finding of a violation, the Board may assess the licensee for all or part of the actual expenses incurred by the Board or its agent for investigations and enforcement duties and may set a timeframe for payment of the assessment. 10 M.R.S. § 8003-D.

#### **IV. CONCLUSIONS OF LAW**

The Board, considering the above facts and those alluded to in the record but not referred to herein, determined that it had jurisdiction over Licensee Stephen H. Doane and concluded as follows with regard to the allegations in the notice of hearing:

- 1. By unanimous vote, that the Licensee demonstrated incompetence in his treatment and record keeping regarding patient A.H. by not being more aware of the hazards associated with the medications he was prescribing to A.H., not apprising A.H. of such hazards, not

documenting in A.H.'s record his recognition and communication of such hazards or the objective basis for prescribing opiate medications, not considering the combination of the medications prescribed to A.H. in the context of the conditions she experienced, and practicing outside of his range of competency.

2. By vote of five to one, that the Licensee committed unprofessional conduct by failing to appropriately follow-up on and respond to information obtained from other doctors and reporters as well as from events that occurred in his own office regarding A.H.'s overdoses on the medications he was prescribing for her.
3. By unanimous vote, that the Licensee violated Board Rule Chapter 21, Section III, governing the use of controlled substances for the treatment of pain by failing to conduct all aspects required for evaluation of the patient; failing to create a written treatment plan; failing to discuss the risks and benefits of the use of controlled substances with the patient; failing to implement a written agreement outlining patient responsibilities including urine/medication serum level screening, pill counts, the number and frequency of all prescription refills, and the reasons for which drug therapy would be discontinued; and failing to keep accurate and complete medical records.
4. By unanimous vote, granted the Licensee's renewal application.
5. By unanimous vote, as a result of the violations, imposed the following sanctions:
  - a. a censure;
  - b. terms of probation as follows:
    - i. the Licensee may oversee only one mid-level practitioner at a time for the remainder of his licensure;
    - ii. the Licensee may oversee no more than 200 beds in a maximum of 2 facilities for the remainder of his licensure, although this may be exceeded when providing



coverage for other physicians for up to six weeks annually and for shared call duty for weeknights and weekends;

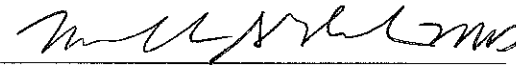
iii. the Licensee may provide no longer than a 7 day prescription for patients leaving a facility he is employed at for the remainder of his licensure; and

iii. the Licensee will engage a practice monitor, approved by the Board, who will review all cases in which the Licensee writes prescriptions for more than one week of controlled substances and report to the Board every four months for a period of one year from the effective date of the original Decision and Order in this matter of March 10, 2015; and

c. assessment of \$12,000 in actual costs that have already been incurred by the Board in the execution of its investigation and enforcement duties in this matter, payable within 12 months of the effective date of the original Decision and Order in this matter of March 10, 2015.

The consent agreement entered into by the Licensee in the matter of Complaint Number CR11-397 remains in effect, including the additional limitations on prescribing controlled substances. Furthermore, the Licensee may petition the Board if he seeks any modification to the terms of probation imposed in this decision or the additional practice restrictions identified in the May 18, 2012, consent agreement.

Dated: April 21, 2015



Maroulla S. Gleaton, M.D.  
Chair, State of Maine Board of Licensure in Medicine

## **V. APPEAL RIGHTS**

Pursuant to the provisions of 10 M.R.S. § 8003(5) and 5 M.R.S. § 11002(3), any party that appeals this Decision and Order must file a Petition for Review in the Superior Court within 30 days

of receipt of this Order. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by certified mail, return receipt requested, upon the State of Maine Board of Licensure in Medicine, all parties to the agency proceedings, and the Attorney General.

STATE OF MAINE BOARD OF LICENSURE IN MEDICINE

In Re: Stephen H. Doane, M.D.

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DECISION AND ORDER

Complaint CR 12-103

**I. PROCEDURAL HISTORY**

Pursuant to the authority found in 5 M.R.S. §§ 9051 et seq., 10 M.R.S. § 8003(5), and 32 M.R.S. § 3269 and § 3282-A, the State of Maine Board of Licensure in Medicine (“Board”) met in public session at its offices in Augusta, Maine, on January 13, 2015. A second day of hearing was held on February 10, 2015. The purpose of the meeting was to conduct an adjudicatory hearing to determine whether grounds existed to impose discipline on the medical license of Stephen H. Doane, M.D., and to determine whether his application for renewal should be granted.

On April 30, 2014, a Scheduling Order was issued setting prehearing deadlines. On July 22, 2014, a Prehearing Order was issued denying the Licensee’s motion for discovery. On August 6, 2014, an amended Notice of Hearing was issued by the Board setting the hearing date for September 9, 2014. On August 12, 2014, a Prehearing Order was issued denying the Licensee’s request for voir dire. On September 4, 2014, a Scheduling Order was issued granting the Licensee’s request to continue the hearing date. On October 17, 2014, an amended Notice of Hearing was issued by the Board setting the hearing date for November 10, 2014. On October 27, 2014, an amended Notice of Hearing was issued by the Board rescheduling the hearing date for January 13, 2015, due to lack of availability of one of the Licensee’s witnesses on November 10, 2014. On December 15, 2014, a Notice of Recusal Decision was issued informing the parties that Board member David Jones, M.D., had recused himself from hearing the matter upon the Licensee’s

motion. On December 30, 2014, an Evidentiary Order was issued. On January 7, 2015, an Order was issued granting the State's request to utilize Dr. David Jones as a resource during the Board hearing.<sup>1</sup> On January 15, 2015, a Conference Order was issued and a Scheduling Order was issued setting the second day for February 10, 2015.

A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were David R. Andrews, M.D.; Louisa Barnhart, M.D.; David H. Dumont, M.D.; David Nyberg, Ph.D., Public Member; Christopher Ross, P.A.-C; and Chair Maroulla Gleaton, M.D. Peter Sacchetti, M.D., participated in the first day of hearing but was not able to attend the second day of hearing and therefore did not take part in deliberations. David D. Jones, M.D., recused himself. Cheryl Clukey, M.Ed., Public Member, recused herself upon motion of the Licensee following the State's opening statement as noted in a Conference Order of January 15, 2015.

Dr. Doane was present and was represented by Christopher Taintor, Esq. Dennis Smith, Esq., Assistant Attorney General, represented the State of Maine. Rebekah Smith, Esq., served as Hearing Officer. The hearing was held in accordance with the requirements of the Administrative Procedures Act, 5 M.R.S. §§ 9051 et seq.

State Exhibits #1 to #15 and State Exhibit #17 were admitted without objection. State Exhibit #18 was marked but not offered for admission. Licensee Exhibits #2 through #11 and #13A through #17D were admitted without objection. Licensee Exhibits #1 and #12 and State Exhibit #16 were excluded.

The Board took notice of its statutes and rules and confirmed that no participating member had any conflict of interest or bias that would prevent him or her from rendering an impartial decision in this matter. Each party presented an opening statement. The State presented James

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<sup>1</sup> Dr. Jones did not assist the State during its presentation.

Cardi, M.D., as an expert witness, and the Licensee. The Licensee presented Richard Kahn, M.D., who had treated patient A.H., and Richard Raskin, M.D., the Licensee's supervisor at Genesis Health Care. Each party made a closing statement. The Board then deliberated and made the following findings of fact and conclusions of law by a preponderance of the credible evidence regarding the allegations against Dr. Doane.

## **II. FINDINGS OF FACTS**

1. Stephen H. Doane, M.D., was first granted a Maine medical license in November 1985. (State Exh. #13.) Since finishing his residency in the 1970s, Dr. Doane has practiced general internal medicine. (Testimony of Doane.) In the 1980s, Dr. Doane developed an interest in geriatric medicine. (Testimony of Doane.)
2. A.H. was born on October 15, 1964. (State Exh. #4, page 1.) A.H. became a patient of Dr. Doane's in approximately 2003. (Testimony of Doane.) A.H. had multiple diagnoses including Post Traumatic Stress Disorder, chronic obstructive pulmonary disease, morbid obesity, panic disorder, carpal tunnel, and agoraphobia. (Testimony of Doane.) A.H. had nightmares, was very depressed, and smoked two packs of cigarettes per day. (Testimony of Doane.) Dr. Doane's primary practice was at PrimeCare Physicians in Biddeford, which was affiliated with Southern Maine Medical Center. (Testimony of Doane.) Dr. Doane was also the medical director at various skilled medical facilities owned by Genesis Health Care in Maine beginning in the 1990s and continuing throughout the period of time that he treated A.H. (Testimony of Doane.)
3. Early in his treatment of A.H., Dr. Doane prescribed her opiates for traumatic injury, including a car accident, after determining that nonsteroidal anti-inflammatory drugs were not tolerated by or useful for A.H. (Testimony of Doane.) A.H. reported increased functionality when she was taking opiate medications but negative impacts when she

attempted to decrease them, including difficulty sleeping. (Testimony of Doane.) In 2008, Dr. Doane referred A.H. to a physical medicine specialist to try to understand ongoing pain A.H. reported. (Testimony of Doane.) Also in 2008, Beth Michaels began to provide home care for A.H. (Testimony of Doane.) Dr. Doane interacted with Ms. Michaels frequently in his care of A.H. (Testimony of Doane.) Ms. Michaels facilitated the scheduling of A.H.'s appointments, provided A.H. with rides to appointments, and attended all appointments with A.H. (Testimony of Doane.) Ms. Michaels also often made arrangements to pick up prescriptions for A.H. at Dr. Doane's office because it was difficult for A.H. to get around. (Testimony of Doane.) Although Dr. Doane was not aware of how many hours Ms. Michaels spent at A.H.'s home each week or her licensing credentials, he relied on her to make sure that A.H. was taking her medications as he had prescribed them. (Testimony of Doane.)

4. Dr. Richard Kahn is a pulmonary care and sleep physician who is board-certified in several areas, with a practice also at PrimeCare Physicians. (Testimony of Kahn.) Dr. Kahn evaluated A.H. in 2007 for symptoms of insomnia and coughing. (Testimony of Kahn.) When A.H. arrived for her first sleep study in July 2007, she was taking Percocet, Flexeril, and clonazepam, prescribed by Dr. Doane. (Testimony of Kahn.) A.H. was being prescribed narcotics at the morphine equivalent dosage of 90 milligrams per day. (Testimony of Kahn.) Dr. Kahn concluded that A.H. had mild obstructive sleep apnea caused by her airway anatomy. (Testimony of Kahn.) Dr. Kahn recommended a CPAP machine, which resulted in much better sleep quality for A.H. in her sleep studies. (Testimony of Kahn.)
5. On June 10, 2010, A.H. reported to Dr. Doane that she had fallen down the stairs several months earlier and obtained multiple contusions and was sore everywhere. (State Exh. #4, page 346.) A.H. stated that she had continued to fall from time to time, experienced

bruising and continued low back pain, and was continuing to use a TENS unit to manage back pain although it was malfunctioning at the time of her visit. (State Exh. #4, page 346.) A.H. reported that the TENS unit helped her back pain but did not completely resolve it. (State Exh. #4, page 346.) She reported back pain of 6 on a scale of 1 to 10 and inquired about a stronger medication. (State Exh. #4, page 346.) A.H. indicated that she continued to smoke. (State Exh. #4, page 346.) Dr. Doane assessed A.H. with low back pain, among other conditions, and refilled her prescription for Percocet (10mg/325mg), 2 tablets to be taken every 3 hours as needed. (State Exh. #4, page 348.)

6. On June 11, 2010, A.H. was found unresponsive with blue lips by her daughter, who called an ambulance to A.H.'s home. (State Exh. #4, page 292.) Although unresponsive when medical care arrived, A.H. became responsive after being given Narcan during the ambulance ride, an indication that she had overdosed on opiates. (State Exh. #4, page 292; Testimony of Doane.) A.H. indicated that she had not feel well that day and as a result had taken 2 Percocet and 2 Klonopin. (State Exh. #4, page 292 & 316.) A.H. also reported that her CPAP machine had been broken for a couple of days. (State Exh. #4, page 316.) She denied that she was trying to hurt herself. (State Exh. #4, page 292.) At Southern Maine Medical Center, A.H. again reported that she had taken extra pain medication to help her sleep and was diagnosed as having accidentally overdosed. (State Exh. #4, page 303.) A.H. was discharged with instructions to follow-up with Dr. Doane the next business day, to use her CPAP machine at home as directed, and to take medications only as prescribed. (State Exh. #4, page 314.) At hearing, Dr. Doane denied knowledge of A.H.'s June 11, 2010, emergency room visit until much later. (Testimony of Doane.) He stated that if he had known of her overdose, he would have had more discussion with A.H. about taking her

medications appropriately and would have decreased her medications. (Testimony of Doane.)

7. Because PrimeCare Physicians was affiliated with Southern Maine Medical Center, Dr. Doane had online access to medical records at Southern Maine Medical Center including discharge summaries. (Testimony of Doane.) Although emergency room records were not online, he could obtain them by going to the emergency room, which was across the street from his office. (Testimony of Doane.)
8. A.H. did not schedule an appointment with Dr. Doane for the next business day following her discharge. (State Exh. #4.)
9. A.H. then cancelled her previously scheduled appointment for July 8, 2010, with Dr. Doane on the day of the appointment, due to a death in the family. (State Exh. #4, page 282.) Dr. Doane authorized A.H.'s daughter to pick up A.H.'s Percocet prescription at his office that day. (State Exh. #4, page 281.)
10. A.H. did not see Dr. Doane again until August 5, 2010. (State Exh. #4, page 277.) The first two pages of visit notes duplicate notes from her June 10, 2010, appointment. (State Exh. #4, pages 277-278.) It was noted that A.H. had ongoing right foot pain and swelling after numerous falls but exams were normal and there had been a complete healing of the proximal phalanx of the third toe. (State Exh. #4, page 278.) A.H.'s general examination revealed moderate tenderness at the sacroiliac joint bilaterally. (State Exh. #4, page 278.) Dr. Doane referred A.H. to a podiatrist and refilled her Percocet prescription for low back pain. (State Exh. #4, page 279.)
11. On August 27, 2010, Ms. Michaels reported to Dr. Doane that due to a trip she was taking she needed to pick up A.H.'s prescriptions that day. (State Exh. #4, page 270.) Dr. Doane



approved the request for an early refill of Percocet (10mg/325mg) to be taken 2 tablets every 3 hours as needed. (State Exh. #4, page 270.)

12. On September 23, 2010, A.H. saw Dr. Doane for a four-week follow-up and medication refill visit. (State Exh. #4, page 264.) A.H. reported that the TENS unit helped her manage her back pain. (State Exh. #4, page 264.) A.H. reported low back pain at a level of 6 on a scale of 1 to 10 and inquired about stronger pain medication. (State Exh. #4, page 264.) With regard to the condition of depression, A.H. reported that she had been crying more with difficulty sleeping and experiencing PTSD symptoms and night terrors, but Dr. Doane noted improvement. (State Exh. #4, page 264.) A.H. stated that she was waiting for medical marijuana. (State Exh. #4, page 264.) In the general examination, Dr. Doane noted continuing tenderness at the sacroiliac joint. (State Exh. #4, page 266.) He ordered a refill of A.H.'s Percocet of 360 tablets at the previously prescribed level. (State Exh. #4, page 266.)

13. On September 25, 2010, A.H.'s daughter called an ambulance because A.H. was not acting right and fell asleep standing up and while smoking a cigarette. (State Exh. #4, page 215 & 230.) A.H.'s daughter was extremely upset and stated that the last time she found A.H. like this she was unresponsive and not breathing. (State Exh. #4, page 215.) A.H. agreed to be transported by ambulance. (State Exh. #4, page 215.) A.H. stated that she took many pain medications and did not know if she had taken too many that day by accident but she had done so before. (State Exh. #4, page 230.) A.H. was given Narcan, after which she seemed easier to arouse, a strong indicator that she was experiencing an opiate overdose. (State Exh. #4, page 231; Testimony of Doane.)

14. The emergency physician record of Southern Maine Medical Center indicated that A.H. exhibited an altered mental status, was hard to wake, and was too sleepy. (State Exh. #4,

page 223.) The emergency room physician, Renee Sarett, concluded that A.H. was sedated and overmedicated. (State Exh. #4, page 224.) Dr. Sarett noted that it was A.H.'s second oversedation event and he counseled her on the lethality of her medications. (State Exh. #4, page 224.) Dr. Sarett also ordered a limit on the medications A.H. was taking. (State Exh. #4, page 224.) Dr. Sarett noted on A.H.'s discharge instructions that the medications she was taking would kill her and instructed her to take only half of her current dosages of Klonopin, Ativan, and Percocet and to stop taking Flexeril entirely. (State Exh. #4, page 225.) He made a note that her family would control her use of medications. (State Exh. #4, page 225.) Dr. Sarett also instructed A.H. to speak with her primary care provider, Dr. Doane, on Monday. (State Exh. #4, page 225.) A.H. left the hospital against medical advice. (State Exh. #4, page 253.)

15. On September 26, 2010, Paul Laprise, M.D., a partner of Dr. Doane's at PrimeCare Physicians, authored a telephone encounter record indicating that the previous evening he had received a call from the emergency room physician at Southern Maine Medical Center. (State Exh. #4, page 214.) The emergency room physician reported that A.H. was in the emergency room with altered mental status. (State Exh. #4, page 214.) The emergency room physician reported to Dr. Laprise that he felt very strongly that A.H. was overmedicated and wanted to make sure that his message was passed on to her primary care physician, Dr. Doane. (State Exh. #4, page 214.)
16. On September 26, 2010, at 3:11 p.m., Dr. Doane electronically noted that he had reviewed the message from Dr. Laprise recounting his conversation with the emergency room physician. (State Exh. #4, page 214.) Dr. Doane did not, however, attempt to get in touch with the emergency room physician. (Testimony of Doane.) Dr. Doane did not schedule an immediate visit for A.H. but could not explain why not. (Testimony of Doane.) He planned

to consider the note at A.H.'s next visit. (Testimony of Doane.) Dr. Doane felt that A.H. was in good hands because he thought that Ms. Michaels was at her home every day so he simply made a mental note of the emergency room physician's call. (Testimony of Doane.)

17. In hindsight, Dr. Doane wishes that he had obtained the emergency room record of A.H. from her September 25, 2010, hospitalization. (Testimony of Doane.) Dr. Doane reiterated that if he had obtained the record, he would have changed A.H.'s care plan by discussing her medication use with her and decreasing her dosages of opiates. (Testimony of Doane.) Dr. Doane acknowledged that if he had gotten the emergency room record from the September 2010 event, he would have learned of the June 2010 event as well. (Testimony of Doane.)
18. On October 11, 2010, Ms. Michaels called Dr. Doane's office to request that A.H. skip her appointment that day and pick up prescriptions instead because she was not feeling well. (State Exh. #4, page 208.) Dr. Doane approved the continued order for TENS pads and a refill of A.H.'s Percocet at the same level she was prescribed by him prior to her hospitalization and Dr. Sarett's order to decrease her dosage by half. (State Exh. #4, page 208.) Dr. Doane had forgotten about the emergency room physician's call by this time. (Testimony of Doane.)
19. On October 18, 2010, upon receiving a call from A.H.'s pharmacy that she was seeking refills, Dr. Doane ordered refills of A.H.'s Flexeril and lorazepam (identified as Ativan in the Southern Maine Medical Center emergency room record) at the same dosage prescribed before A.H.'s September 25, 2010, emergency room visit and Dr. Sarett's subsequent order to reduce the dosage of lorazepam by half and to discontinue Flexeril entirely. (State Exh. #4, page 203.)
20. On November 4, 2010, A.H. saw Dr. Doane for the first time since her second hospitalization for oversedation from opiates in September 2010. (State Exh. #4, page 194.)

It was noted that A.H. was stable on her CPAP machine and had undergone further testing with her CPAP machine under the direction of Dr. Richard Kahn, a pulmonologist and sleep medicine doctor. (State Exh. #4, page 194.) Dr. Doane noted that Ms. Michaels attended the visit with A.H. and provided a full explanation of issues. (State Exh. #4, page 194.)

A.H. reported that she had right-sided chest pain daily and thought she might have broken a rib in a severe coughing episode. (State Exh. #4, page 194.) In a general examination, Dr. Doane noted moderate tenderness at sacroiliac joint but did not examine A.H.'s ribs. (State Exh. #4, page 195.) He ordered a refill of Percocet for low back pain at the same dosage as previously prescribed. (State Exh. #4, page 196.)

21. On March 1, 2011, Dr. Doane authorized a refill of 360 tablets of Percocet (10mg/325mg) for A.H. (State Exh. #6.)
22. On April 5, 2011, Ms. Michaels phoned Dr. Doane's office to report that things were getting out of control at A.H.'s house. (State Exh. #4, page 155.) She stated that if Adam Caron called, Dr. Doane should not believe what he reported. (State Exh. #4, page 155.) Ms. Michaels stated that Mr. Caron would try to tell Dr. Doane that A.H. was doing funny things with medications and not letting Ms. Michaels in. (State Exh. #4, page 155.)
23. On April 15, 2011, Dr. Doane refilled A.H.'s prescription for Flexeril (10mg) for 1 tablet 3 times a day. (State Exh. #4, page 148.) He also refilled her prescriptions for clonazepam, citalopram, and lorazepam at that time. (State Exh. #4, page 149.)
24. On April 18, 2011, Dr. Doane ordered a refill of A.H.'s Percocet (10mg/325mg) for 2 tablets every 3 hours as needed. (State Exh. #4, page 150.) Dr. Doane authorized 360 tablets. (State Exh. #4, page 150.)
25. On April 18, 2011, an individual named Tom called Dr. Doane's office to report that A.H. and Ms. Michaels were selling A.H.'s medication. (State Exh. #4, page 147.) Tom reported

that A.H. was bragging that she had Dr. Doane under her thumb because when he asked her to come in for a pill count she had a friend who would replace the pills she sold in order to make her pill count correct. (State Exh. #4, page 147.) Tom reported that A.H. was selling her medication near a school, which concerned him. (State Exh. #4, page 147.) He also stated that A.H. brought her daughter's urine with her to medical appointments in case she was asked to give a urine sample. (State Exh. #4, page 147.) Tom stated that A.H. would give her daughter one pill so that the medication would show up in her urine. (State Exh. #4, page 147.) Tom indicated that A.H. had quite a racket going and requested that someone do something to stop it. (State Exh. #4, page 147.)

26. Within a half hour of Tom's call to Dr. Doane's office, Ms. Michaels called to ask if A.H.'s prescription for Percocet was available for pick up. (State Exh. #4, page 146.)

27. Dr. Doane indicated on the telephone encounter note summarizing Tom's call that A.H. should come in and undergo a urine screen and then he would consider ordering a refill. (State Exh. #4, page 147.) Dr. Doane also noted that an individual named Melissa from risk management had advised him to confront A.H. with the information from the caller Tom, get a pain medication contract in place, and check A.H.'s urine in front of a witness. (State Exh. #4, page 147.)

28. On April 19, 2011, Tom again called Dr. Doane's office to confirm that his call the day before had been received. (State Exh. #4, page 144.) Tom indicated that he was aware that A.H. had an appointment that day. (State Exh. #4, page 144.) Tom provided the additional information that A.H. was driving around until 8 p.m. the prior evening trying to purchase an oxycodone tablet so that she would pass her urine test that day. (State Exh. #4, page 144.) Tom stated that although A.H. reported being claustrophobic, she was out at bars frequently and smoked marijuana all the time. (State Exh. #4, page 144.) Tom also

indicated that Ms. Michaels was in A.H.'s home only approximately three hours per month and was helping A.H. to sell her medications. (State Exh. #4, page 144.) According to the telephone encounter record, the phone call was on speaker phone with Dr. Doane listening. (State Exh. #4, page 144.)

29. Dr. Doane considered Tom's information to be suspect and it did not cause him much concern. (Testimony of Doane.) He would have been concerned if he believed that A.H. was smoking marijuana while taking her prescription medications. (Testimony of Doane.)
30. On April 19, 2011, A.H. was seen by Dr. Doane for medication issues. (State Exh. #4, page 142.) Dr. Doane planned to require A.H. to enter into a pain medication contract. (Testimony of Doane.) Support staff did a pill count of all A.H.'s medications, except Percocet, which she did not bring with her. (State Exh. #4, page 142.) There was no indication in the record of why A.H. did not bring her Percocet. (State Exh. #4, page 142.) While waiting in the office, A.H. was found to be cyanotic and slumped over, with oxygen saturation in the 70s. (State Exh. #4, page 142.) She was given nasal oxygen with some improvement and rescue was called. (State Exh. #4, page 142.) Dr. Doane discussed with the emergency department physician the possibility that A.H. had accidentally overdosed or taken the wrong medication in light of the messages from Tom that A.H. was not correctly taking her medication and then sought medication to pass her urine test. (State Exh. #4, page 143.) Dr. Doane did not recall the message regarding A.H.'s overdose in September 2010 at the time of this incident. (Testimony of Doane.)
31. Patrick Tangney, M.D., the emergency department physician at Southern Maine Medical Center who treated A.H. concluded that A.H. had taken excessive benzodiazepines. (State Exh. #4, pages 140-141.) A.H. reported that she did not remember that the friend who acted as her nurse had given her her medications the day before and she had taken them again

herself, resulting in a double dose. (State Exh. #4, page 135.) It was noted that A.H. had been treated with Narcan with no effect and BiPAP therapy without improvement. (State Exh. #4, page 135.) A.H. was then given flumazenil with immediate results and was awake. (State Exh. #4, page 135.) Dr. Tangney indicated that it was not clear from his discussion with A.H. whether she intended to take more benzodiazepines than prescribed, but she denied this was the case. (State Exh. #4, page 141.) A.H. reported significant fear that Dr. Doane thought she bought street drugs which caused her overdose. (State Exh. #4, page 135.) Dr. Tangney recommended that A.H. explain how the situation occurred to Dr. Doane. (State Exh. #4, page 135.) Dr. Tangney also explained to A.H. that she had been on too many medications over too long a period of time. (State Exh. #4, page 136.) Dr. Tangney opined that A.H. relied far too much on medications to relieve her symptomatology. (State Exh. #4, page 136.)

32. A.H. was discharged from Southern Maine Medical Center on April 20, 2011. (State Exh. #4, page 135.) After reviewing her medication list, Dr. Tangney discharged A.H. with substantially less of both benzodiazepines and narcotics. (State Exh. #4, page 136.) Dr. Tangney prescribed low dose benzodiazepines and narcotics (Percocet) to ensure that A.H. did not have significant withdrawal but wanted to be judicious in the use of these medications. (State Exh. #4, page 141.) Dr. Tangney informed A.H. that his recommended amounts of medications might not be the final resolution but she should not return to the high levels she was taking previously. (State Exh. #4, page 136.) Dr. Tangney discharged A.H. with instructions not to take her Klonopin, Percocet, or Ativan as previously prescribed but to take Klonopin (2mg) 1 tablet in the morning and 1 in the afternoon, Percocet (5mg/325mg) 1 tablet every 4 hours as needed, Motrin (600mg) 1 tablet 3 times a day with meals, and Tylenol (1,000 mg) at bedtime. (State Exh. #4, page 136.) Dr. Tangney also

reduced the frequency of A.H.'s Flexeril (10mg) prescription to 1 tablet 3 times per day as needed only. (State Exh. #4, page 136.) Dr. Tangney noted that A.H. became agitated when she realized that some of her prescriptions were for over-the-counter medications that she would need to pay for herself. (State Exh. #4, page 136.) A.H. was also instructed to follow-up with Dr. Doane in approximately 72 hours, which she stated she would do. (State Exh. #4, page 136.) Dr. Doane was copied on the emergency room record. (State Exh. #4, page 141.)

33. On April 21, 2011, Dr. Doane's office was notified that A.H. had been released on April 20 with instructions to see Dr. Doane on April 21. (State Exh. #4, page 130.) A.H.'s discharge summary was printed and provided to Dr. Doane by his office staff. (State Exh. #4, page 130; Testimony of Doane.)

34. A.H. was seen by Dr. Doane on April 21, 2011. (State Exh. #4, page 126.) A.H.'s lab work revealed the presence of marijuana. (State Exh. #4, page 128.) Dr. Doane informed A.H. that he would taper her Percocet prescription because she was using marijuana and advised her to stop. (State Exh. #4, page 128.) Dr. Doane warned A.H. that if future urine tests showed marijuana use he would discontinue prescribing Percocet altogether. (State Exh. #4, page 128.) Dr. Doane refilled A.H.'s Percocet at the level prescribed by Dr. Tangney of 5mg/325mg to be taken 1 tablet every 4 hours as needed. (State Exh. #4, page 128.) The 60 tablet prescription would have lasted 15 days at the prescribed amount. (State Exh. #4, page 128.) For the first time, Dr. Doane required A.H. to sign a written pain contract, although the pain contract itself does not appear in the record. (State Exh. #4, page 126; Testimony of Doane.)

35. On April 25, 2011, A.H. reported by phone call to Dr. Doane's office that she was not taking the Percocet as prescribed but instead was taking 2 tablets every 3 hours and therefore



needed an early refill. (State Exh. #4, page 122.) Dr. Doane approved a prescription refill for Percocet (5mg/325 mg) to be taken 2 tablets (instead of 1 tablet prescribed by Dr. Tangney) every 4 hours as needed. (State Exh. #4, pages 122 & 779.) He authorized 240 pills. (State Exh. #4, page 122.)

36. On May 5, 2011, A.H. called Dr. Doane's office to report that her back pain was excruciating and the lower dosage of Percocet was insufficient. (State Exh. #4, page 121.) Dr. Doane approved A.H. to come in for an appointment. (State Exh. #4, page 121.)

37. On May 19, 2011, A.H. reported to Dr. Doane that she was very disappointed at the rapid decrease in her pain medications, referencing the reduced potency of the Percocet from 10mg/325mg prior to her hospitalization to 5mg/325mg afterwards. (State Exh. #4, page 115.) She stated that she had overdosed on benzodiazepines not opiates and that her quality of life was slipping away. (State Exh. #4, page 115.) She reported that she had been out of Percocet for a few days because she had been taking it at higher amounts than prescribed. (State Exh. #4, page 115.) A.H. reported that she was waiting for medical marijuana but was smoking it illegally in the meantime. (State Exh. #4, page 115.) Despite the facts that A.H. reported that she was smoking marijuana and that she was taking Percocet at more frequent intervals than prescribed, both presumably violations of her recently signed pain contract with Dr. Doane, Dr. Doane increased the dosage of A.H.'s Percocet to 10mg/325mg (from 5mg/325mg) taken 2 tablets every 3 hours (from every 4 hours) as needed on the basis that she reported that she was not responding well to the reduction. (State Exh. #4, page 116; Testimony of Doane.)

38. On July 25, 2011, Ms. Michaels called Dr. Doane's office to report that A.H. needed a refill of Percocet because she had taken her 30 day allocation in 22 days. (State Exh. #4, page 82.) Dr. Doane approved a refill with a note that she should not take more than 12 tablets

total in a day so the 360 pill supply should last for 30 days. (State Exh. #4, page 82.) Dr. Doane believed that A.H. had taken the pills too quickly by accident and was taking more than the maximum of 12 tablets per day. (Testimony of Doane.) Dr. Doane wrote the maximum of 12 tablets per day on the refill to make sure A.H. understood but did not have her come into his office to explain the limitation. (Testimony of Doane.)

39. A.H. cancelled her July 29, 2011, appointment with Dr. Doane because she woke up ill. (State Exh. #4, page 79.)

40. On August 22, 2011, Dr. Doane refilled A.H.'s Percocet prescription when Ms. Michaels called his office to request a refill. (State Exh. #4, page 76.)

41. On September 15, 2011, A.H. reported to Dr. Doane that she believed she fractured a rib sneezing recently but declined an x-ray. (State Exh. #4, page 72.) She also requested an increase in her Percocet. (State Exh. #4, page 72.) A.H. reported that her back pain was an 8 out of 10 without use of Percocet but 6 out of 10 with it. (State Exh. #4, page 73.) A.H.'s urine screen taken on June 7, 2011, which was noted in the September 15, 2011, record, indicated that no opiates appeared in her urine although benzodiazepines did. (State Exh. #4, page 73.) Dr. Doane refilled A.H.'s Percocet (10mg/325mg) prescription to be taken 2 tablets every 3 hours as needed, with a 360 pill count for a 30 day supply. (State Exh. #4, page 74.) Dr. Doane also started A.H. on a prescription for oxycodone (5 mg) to be taken 1 tablet every 3 hours as needed, with 120 pills for a 14 day supply. (State Exh. #4, page 74.) Dr. Doane did not examine A.H.'s ribs. (Testimony of Doane.) Dr. Doane added the additional opiate prescription for oxycodone based on A.H.'s self-report of a fractured rib. (Testimony of Doane.) Dr. Doane did not recall if he advised A.H. about the risks of taking the additional opiate in light of her other conditions and medications. (Testimony of Doane.) Dr. Doane would not have prescribed oxycodone if he had obtained the records from A.H.'s

June and October 2010 opiate overdose visits to the emergency room. (Testimony of Doane.)

42. On November 11, 2011, A.H. saw Dr. Doane for a follow-up appointment. (State Exh. #4, page 54.) Dr. Doane refilled her Percocet (10mg/325mg) prescription to be taken 2 tablets every 3 hours as needed, at 360 pills intended to last 30 days. (State Exh. #4, page 55.) He also refilled her prescription for oxycodone (5mg) to be taken 1 tablet every 3 hours as needed, at 240 pills to last 30 days. (State Exh. #4, page 55.) A.H.'s urine screen, taken on November 11, 2011, was positive for benzodiazepines and negative for opiates. (State Exh. #4, page 56.)
43. On February 16, 2012, Dr. Doane filed an application for renewal of his license. (State Exh. #12.) His license was due to expire on March 31, 2012. (State Exh. #13.)
44. On February 10, 2012, Ms. Michaels called Dr. Doane's office to complain that the last 2 times she had called in to obtain refills of A.H.'s medications, office staff had called A.H. to let her know that she had a habit of missing appointments after she obtained refills. (State Exh. #4, page 36.) Ms. Michaels expressed frustration that A.H. was being told that because it agitated A.H. (State Exh. #4, page 36.) Dr. Doane responded electronically to his staff questions as to whether he normally saw A.H. only every three months by stating that follow-up was variable but that if she wanted to continue treatment with him, A.H. needed to attend follow-up appointments within the time frame he specified. (State Exh. #4, page 36.) Dr. Doane indicated that he would not continue to prescribe refills for her if she did not keep future appointments. (State Exh. #4, page 36.)
45. On February 10, 2012, A.H. saw Dr. Doane for a follow-up appointment. (State Exh. #4, page 37.) A.H. indicated that she was no longer using the TENS machine for pain management because she could not get supplies for it and her back pain was worse. (State

Exh. #4, page 37.) A.H. reported that she had not been able to tolerate oxycodone without Tylenol in the past. (State Exh. #4, page 38.) Her November 15, 2011, lab results were noted to be positive for opiates, oxycodone, and oxymorphone. (State Exh. #4, page 38.) Dr. Doane noted that he had reviewed A.H.'s Prescription Drug Monitoring report and the results were consistent with her pain contract and the prescriptions he had been giving A.H. (State Exh. #4, page 38.) Dr. Doane indicated that he would consider a taper of A.H.'s opiate medications at her next visit since she already had a prescription for that month. (State Exh. #4, page 39.) Dr. Doane testified that the reason he contemplated a taper was that it was then known that it was beneficial for patients to gradually reduce doses of opiates, although he did not record the reason for a taper in A.H.'s medical records. (Testimony of Doane.)

46. On February 22, 2012, A.H. contacted Dr. Doane's office seeking a refill of her prescriptions for Percocet and oxycodone. (State Exh. #4, page 35.) A nurse in Dr. Doane's office informed A.H. that Dr. Doane would begin the taper of those medications as they had discussed at a prior visit. (State Exh. #4, page 35.) Dr. Doane refilled A.H.'s prescriptions for Percocet (10mg/325mg) to be taken 2 tablets every 3 hours as needed up to a maximum of 11 per day and oxycodone (5mg) to be taken 1 tablet every 3 hours as needed up to a maximum of 7 per day. (State Exh. #4, page 35.) Dr. Doane prescribed a 30 day supply of both Percocet and oxycodone. (State Exh. #4, page 35.)

47. On March 23, 2012, Ms. Michaels called Dr. Doane's office to request a refill of A.H.'s prescriptions. (State Exh. #4, page 31.) Dr. Doane refilled A.H.'s prescription for oxycodone (5mg) to be taken 1 tablet every 3 hours as needed with a maximum of 4 per day (14 day supply), Percocet (10mg/325mg) to be taken 2 tablets every 3 hours as needed with

a maximum of 11 per day (14 day supply), Flexeril, and clonazepam. (State Exh. #4, page 31.)

48. On April 4, 2012, A.H. called to request refills of Percocet and oxycodone. (State Exh. #4, page 29.) A.H. acknowledged that she was calling in a weekly early for her prescriptions, but no explanation was given. (State Exh. #4, page 29.) Dr. Doane refilled A.H.'s prescriptions for 2 week supplies of Percocet and oxycodone at the prior levels. (State Exh. #4, page 29; Testimony of Doane.)
49. On April 17, 2012, A.H. called to request a refill of her prescriptions for Percocet and oxycodone. (State Exh. #4, page 28.) Dr. Doane declined to provide A.H.'s requested refills on the basis that she did not have an appointment with him in March 2012. (State Exh. #4, page 28.) A.H. made an appointment to see Dr. Doane later that day, although no visit record appears for that date. (State Exh. #4, page 28.) Dr. Doane refilled A.H.'s prescriptions for oxycodone and Percocet at the previously prescribed levels. (State Exh. #4, page 28.)
50. On April 23, 2012, A.H. saw Dr. Doane for multiple issues regarding her medications, living situation, daughter, and home health care provider. (State Exh. #4, page 25.) A.H. reported that she was no longer smoking marijuana. (State Exh. #4, page 25.) Dr. Doane informed A.H. that he would continue her Percocet prescription but it would be the last time he prescribed it. (State Exh. #4, page 26.) Dr. Doane indicated to A.H. that he would refer her to Goodall Hospital Pain Clinic for further consideration since he would no longer be prescribing controlled substances for chronic pain. (State Exh. #4, page 26.) Dr. Doane indicated on her prescriptions that they were final. (State Exh. #4, page 26.) He prescribed Percocet (10mg/325 mg) to be taken 1 to 2 tablets every 3 hours as needed up to a maximum

of 10 per day (28 day supply) and oxycodone (5mg) to be taken 1 tablet every 3 hours as needed (28 day supply). (State Exh. #4, page 26.)

51. On May 4, 2012, A.H. saw Barbara Logan, N.P., in Dr. Doane's office for anxiety. (State Exh. #4, page 19.) A.H. was tearful and expressing suicidality. (State Exh. #4, page 19.) A.H. reported that she was contemplating overdosing on her pain medications. (State Exh. #4, page 19.) A.H. refused to go to the emergency room. (State Exh. #4, page 19.) Nurse Logan informed the emergency room of A.H.'s status and contacted the police to transport her to the emergency room. (State Exh. #4, page 19.) A.H. left Dr. Doane's office, however, before the police arrived. (State Exh. #4, page 19.)

52. On May 7, 2012, Dr. Doane phoned A.H. to express his concern about her. (State Exh. #4, page 14.) He spoke with Ms. Michaels who reported that A.H. was not suicidal at that time. (State Exh. #4, page 14.) Dr. Doane requested that A.H. make an appointment to see him. (State Exh. #4, page 14.) Dr. Doane reviewed A.H.'s record and asked his staff to call Ms. Michaels back to indicate that he had given A.H. a month's supply of medication as of April 23, 2012, so he would not provide a refill prescription at that time but might in the future if needed. (State Exh. #4, page 14.)

53. On May 15, 2012, A.H. saw Dr. Doane for follow-up for acute bronchitis. (State Exh. #4, page 5.) A.H. reported that she was down to Percocet (10mg/325mg) 12 tablets per day and oxycodone (5mg) 16 tablets per day, although both of those amounts were higher than the maximums prescribed by Dr. Doane most recently. (State Exh. #4, page 5; Testimony of Doane.) At hearing, Dr. Doane testified that the maximum of oxycodone should have been 9 per day and that 16 tablets per day would have been an alarming amount. (Testimony of Doane.) In the visit note, Dr. Doane reported that he had reviewed the Prescription Monitoring Program ("PMP") report for A.H., the results of which were consistent with her

pain contract and the prescriptions he had been providing. (State Exh. #4, page 5.) Her urine sample, taken that day, indicated the presence of benzodiazepines but not opiates. (State Exh. #4, page 6.) Dr. Doane informed A.H. that he would be able to prescribe controlled medications for her until July 8, 2012. (State Exh. #4, page 6.) He noted that she was planning to be seen at the Goodall Hospital Pain Clinic and there was also a possibility that he could refer her to a new primary care physician who could prescribe controlled substances for her thereafter. (State Exh. #4, page 6.) Dr. Doane refilled A.H.'s prescriptions for Percocet (10mg/325mg) to be taken 1 to 2 tablets every 3 hours as needed up to a max of 12 per day (28 day supply) and oxycodone (5mg) to be taken 1 tablet every 3 hours as needed (28 day supply). (State Exh. #4, page 6.) Dr. Doane's intention was to obtain psychiatric help for A.H. before tapering down her medications but he was under a time restriction from a consent agreement being negotiated with the Medical Board to wind up any patients to whom he was prescribing narcotics for chronic pain. (Testimony of Doane.) Because A.H. expressed a desire to remain on her prior dose, and because Dr. Doane was going to be able to prescribe narcotics until July 8, 2012, under the consent agreement being negotiated with the Board, he refilled her prescriptions at that level. (Testimony of Doane.)

54. Effective May 18, 2012, Dr. Doane entered into a consent agreement with the Board and the Maine Office of the Attorney General resolving complaint CR11-397. (State Exh. #10.) In the agreement, Dr. Doane agreed that the Board had sufficient evidence from which it could conclude that he failed to adhere to Board Rule Chapter 21, governing the use of controlled substances for treatment by failing to review a patient's previous medical records prior to prescribing controlled medications to the patient; failing to access and review the PMP prior to prescribing the amount and dosage of controlled substances to the patient; failing to recall

a telephone message that the patient had recently been hospitalized and experienced accompanying respiratory distress prior to prescribing medications to the patient; and increasing the dosage (doubling), frequency, and amount (doubling) of narcotics prescribed to the patient only 4 days after initially prescribing 15 days worth of narcotics to the patient, without obtaining the patient's previous records or reviewing the PMP. (State Exh. #10.) As a result of his conduct, which he conceded could constitute grounds for discipline and denial of his application to renew his Maine medical license for unprofessional conduct pursuant to 32 M.R.S. § 3282-A(2)(F), the Licensee accepted a reprimand, reimbursed the Board \$1,185 in actual costs of investigation, and accepted several practice restrictions, including ceasing prescribing any controlled medications, including opiates and benzodiazepines, for the treatment of chronic pain except for patients in skilled nursing facilities or long-term care facilities, patients in hospice care, or patients with metastatic cancer; prescribing controlled substances for no more than 10 consecutive days to treat acute conditions; and permitting the Board to inspect his medical practice, including patient medical records as allowed by law. (State Exh. #10.) The consent agreement and practice restrictions remain in effect. (State Exh. #10.)

55. On May 19, 2012, A.H. passed away. (State Exh. #4, page 4.) A.H.'s cause of death was identified by the medical examiner to be oxycodone and cyclobenzaprine intoxication. (State Exh. #7.) Her death was categorized as accidental. (State Exh. #7.)

56. Dr. Doane testified that although he did not note it in A.H.'s records, he did have a conversation with A.H. about the high levels of narcotics she was taking. (Testimony of Doane.) He agreed that as her primary care provider and the prescriber of such medications he was charged with reviewing that information with A.H. (Testimony of Doane.)



57. Dr. Kahn treated A.H. from his initial evaluation in 2007 until her death in 2012.

(Testimony of Kahn.) Throughout his treatment of A.H., Dr. Kahn recommended smoking cessation and was concerned about her psychiatric illnesses. (Testimony of Kahn.) Dr. Kahn was aware that A.H. was taking opiate medications chronically. (Testimony of Kahn.) Dr. Kahn did not have any concerns about the medications that Dr. Doane was prescribing for A.H. (Testimony of Kahn.) Dr. Kahn was not concerned that A.H.'s respiratory function was being compromised by opiate medications. (Testimony of Kahn.) He had an ongoing concern about her compliance with medical instructions, exacerbated by her not allowing him to view her CPAP machine information, likely indicating that she was not utilizing it as prescribed. (Testimony of Kahn.) At the time of hearing, Dr. Kahn was not aware of A.H.'s overdoses or her acute respiratory failure. (Testimony of Kahn.)

58. By letter dated May 24, 2012, Dr. Doane informed the Board that he was accelerating the terms of his consent agreement and would no longer prescribe controlled medications for pain, including all opioids and benzodiazepines, except for patients in skilled nursing facilities or long-term care facilities, patients in hospice care, or patients with metastatic cancer. (State Exh. #9.)

59. By letter dated July 6, 2012, the Board notified Dr. Doane that it had reviewed the records regarding his treatment of patient A.H. at its June 12, 2012, meeting and had voted to initiate a complaint against his license on the basis of alleged unprofessional conduct and incompetence based on inappropriate prescribing practices with regard to patient A.H. (State Exh. #2.)

60. On October 10, 2012, through counsel, Dr. Doane responded to the Board complaint. (State Exh. #3.)

61. On October 21, 2013, Dr. James Cardi filed with the Board a report of his review of Dr. Doane's treatment of patient A.H. (State Exh. #8.) Dr. Cardi is a primary care physician in Rhode Island who has been practicing for 23 years. (Testimony of Cardi.) Dr. Cardi is certified by the American Board of Internal Medicine. (Testimony of Cardi.)
62. Dr. Cardi reviewed A.H.'s medical records going back to 2003, her Prescription Monitoring Program reports, and the medical examiner's report following her death. (Testimony of Cardi.) Dr. Cardi concluded that A.H.'s multiple medical conditions, which included emphysema, obstructive sleep apnea, anxiety, depression, chronic bronchitis, tobacco addiction, and morbid obesity, put her at risk of respiratory complications from medications. (Testimony of Cardi.)
63. Dr. Cardi concluded that most of the non-opiate care that Dr. Doane provided to A.H. was reasonable. (State Exh. #8.) Dr. Cardi also concluded, however, that the opiate treatment for pain management that Dr. Doane provided to A.H. showed poor judgment and decision-making regarding prescriptions that was well outside the standard of care. (State Exh. #8.) Dr. Cardi defined the standard of care as what a minimally competent physician would do in the same circumstances with similar resources. (Testimony of Cardi.)
64. Dr. Cardi noted that certain of the medications prescribed to A.H. by Dr. Doane could cause respiratory depression. (Testimony of Cardi.) Dr. Cardi opined that in order to meet the standard of care, Dr. Doane should have discussed with A.H. the risks of compromised respiratory function from the benzodiazepine and opioid medications that he prescribed her. (Testimony of Cardi.) Dr. Cardi opined that it was a violation of the standard of care for Dr. Doane not to discuss those risks with A.H., but that A.H.'s medical records did not indicate that Dr. Doane had discussed the risks with her. (Testimony of Cardi.) With particular regard to A.H.'s condition of sleep apnea, Dr. Cardi noted that 2010 Veterans'

Administration guidelines indicated that there were significant additional risks from opioid therapy for patients with sleep apnea. (Testimony of Cardi.)

65. Dr. Cardi noted that the use of opioids for pain management was a complicated issue that had evolved over time and that treatment with opioids needed to be reviewed over the course of a patient's care. (Testimony of Cardi.) Dr. Cardi noted that Dr. Doane had increased the dosage of opioids prescribed to A.H. with minimal documentation and sometimes conflicting documentation that did not justify the high doses prescribed especially given the patient's complicating conditions. (State Exh. #8; Testimony of Cardi.) He noted in his report that when the opiate doses that Dr. Doane prescribed for A.H. began to escalate, there was little documentation of the risks, benefits, and potential interactions with other drugs. (State Exh. #8.) Dr. Cardi opined that Dr. Doane should have looked at the combination of the patient's conditions when considering the risks of opioid treatment. (Testimony of Cardi.)

66. Dr. Cardi opined that A.H.'s records did not support the high dosage of opiates that Dr. Doane was prescribing for her, particularly given Dr. Doane's finding on examination of A.H. in February 2010 that there was no longer tenderness at the sacroiliac joint, the original purpose for the prescription. (Testimony of Cardi.) Dr. Cardi found that Dr. Doane's records regarding A.H. were varying, redundant, and contained few or no physical findings. (Testimony of Cardi.) Dr. Cardi opined that even in the records where Dr. Doane found moderate musculoskeletal tenderness during his examination of A.H., the findings did not warrant the high doses of opiates he prescribed A.H., the equivalent to 240 milligrams of morphine at their peak. (Testimony of Cardi.) Dr. Cardi also noted that A.H.'s record also included notation of a prior cocaine addiction that was not carried forward. (Testimony of Cardi.)

67. Dr. Cardi noted that it is generally agreed that a morphine equivalent dose of below 120 mg per day in divided doses is acceptable, but that doses above that level are associated with increased morbidity and mortality, with support for a cutoff of morphine equivalent doses at 200 milligrams per day. (State Exh. #8.) Dr. Cardi calculated that Dr. Doane prescribed A.H. the morphine equivalent dose of 230.67 milligrams per day on average between January 6, 2012, and May 15, 2012, in Percocet and oxycodone. (State Exh. #8.) During the period of higher dosages within that period, Dr. Cardi calculated that Dr. Doane prescribed A.H. the morphine equivalent dose of 240 milligrams per day. (State Exh. #8.)

68. Dr. Cardi opined that Dr. Doane did not take sufficient note of A.H.'s hospitalizations for overdoses, the first two of which indicated that she was overdosing on opiates, which made it harder for her to breathe. (State Exh. #8.) Dr. Cardi emphasized that this was particularly so with regard to the September 25, 2010, note from the emergency room physician reporting his strong feeling that A.H. was overmedicated, which Dr. Doane signed off on. (Testimony of Cardi.) Dr. Cardi noted that there was no evidence to suggest that Dr. Doane followed up with the treatment providers in the emergency department, obtained the emergency department records, reviewed the causes of the overdoses with A.H., closely monitored her prescription usage by screens and pill counts, or entered into or altered a pain medication contract with A.H. following each of her opiate overdoses. (Testimony of Cardi.) Dr. Cardi believed that Dr. Doane's prescribing of benzodiazepines and opiates was necessary and reasonable at the outset but the emergency room visits warranted the need for discussion, medication review, and dosage adjustments, and Dr. Doane's failure to do so was outside the standard of care. (State Exh. #8.)

69. Richard Raskin, Vice President of Medical Affairs for the Northeast at Genesis Health Care, testified that he hired Dr. Doane as the medical director for the River Ridge facility in

Kennebunk, a skilled and long-term care facility that also specializes in traumatic brain injury in September 2010. (Testimony of Raskin.) Dr. Raskin testified that Dr. Doane's role had expanded since his initial hire to include the medical director role at several Genesis Health Care facilities. (Testimony of Raskin.) Dr. Raskin testified that he was satisfied with Dr. Doane's performance and clinical care. (Testimony of Raskin.) Dr. Doane made Dr. Raskin aware of the prescribing limitations in the consent agreement he entered into with the Board in May 2012. (Testimony of Raskin.) Dr. Raskin testified that he conducted periodic peer review of Dr. Doane, including record compliance and clinical care, which he has found to be exemplary. (Testimony of Raskin.) Dr. Raskin testified that Dr. Doane was a significant asset to the residents of Genesis facilities and that it was hard to find good geriatricians in the state of Maine. (Testimony of Raskin.)

70. Dr. Raskin testified that he and Dr. Doane had discussed several times the practice of prescribing narcotics for chronic pain and that they agreed that narcotics were not the ideal way to treat chronic pain. (Testimony of Raskin.)

71. In his current role as a medical director at various Genesis Health Care facilities, Dr. Doane has employed a strategy of tapering patients who are admitted on narcotic medications and to use narcotics only when needed. (Testimony of Doane; Lic. Exh. #16.) Dr. Doane helped some patients successfully transition off of narcotic medications. (Testimony of Doane.)

72. As of February 10, 2015, the Board had incurred in excess of \$12,000 in costs of expert witness review of A.H.'s records and associated expenses. (State Exh. #17.)

### **III. GOVERNING STATUTES AND RULES**

1. The State of Maine Board of Licensure in Medicine may modify, restrict, suspend, revoke, or refuse to renew a license if the licensee demonstrated incompetence in the practice for which he is licensed. A licensee is considered incompetent in the practice if he engaged in

conduct that evidenced a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public or if he engaged in conduct that evidenced a lack of knowledge or inability to apply principles or skills to carry out the practice for which he is licensed. 32 M.R.S. § 3282-A(2)(E)(1) & (2).

2. The Board may modify, restrict, suspend, revoke, or refuse to renew a license if the licensee engaged in unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if he violates a standard of professional behavior that has been established in the practice for which he is licensed. 32 M.R.S. § 3282-A(2)(F).
3. The Board may modify, restrict, suspend, revoke, or refuse to renew a license if the licensee violated a rule adopted by the Board. 32 M.R.S. § 3282-A(2)(H).
4. The Board has adopted the following criteria when evaluating a clinician's treatment of pain including the use of controlled substances. Each of these principles is essential in the treatment of patients with pain.

1. Evaluation of the Patient - A medical history and appropriate physical examination must be obtained, evaluated and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function and history of substance abuse. It is recommended that the State's Controlled Substance Prescription Monitoring Program Database (PMP) be utilized. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan - The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are

planned. After treatment begins, the clinician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment - The clinician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one clinician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse or substance dependence, the clinician should use a written agreement between clinician and patient outlining patient responsibilities, including:
  - a. urine/serum medication levels screening when requested;
  - b. pill count when requested;
  - c. number and frequency of all prescription refills; and
  - d. reasons for which drug therapy may be discontinued (e.g., violation of agreement).
4. Periodic Review of Treatment Efficacy - The clinician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the clinician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the clinician should assess the appropriateness of

continued use of the current treatment plan and consider the use of other therapeutic modalities. Likewise, the clinician should periodically review the course of treatment where psychoactive drugs are used for the treatment of components of chronic pain, e.g., emotional, psychological, or psychosocial stressors, and assess the appropriateness of continued use of the current treatment plan if the patient's progress is unsatisfactory.

5. Consultation or Referral - The clinician should consult or refer, as necessary, for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. Chronic pain often has, as a component, emotional, psychological, or psychosocial stress. In these situations, a number of patients may benefit from psychoactive medications, as well as controlled substances for pain control. The combination of opiates with psychoactive medications, e.g., benzodiazepines, may place the patient at greater risk. The risk may be associated with drug interaction, potentiation, or abuse. In these situations, consultation with or referral to an expert in the management of such patients may be required.

6. Medical Records - The clinician should keep accurate and complete records to include:

- a. the medical history and appropriate physical examination;
- b. diagnostic, therapeutic and laboratory results;
- c. evaluations and consultations;
- d. treatment objectives;
- e. discussion of risks and benefits;
- f. informed consent;
- g. treatments;



- h. medications (including date, type, dosage and quantity prescribed);
- i. instructions and agreements; and
- j. periodic reviews.

Records should remain current and be maintained in an accessible manner, readily available for review. (02-373) Board Rule Chapter 21, Use of Controlled Substances for Treatment of Pain, Section III, Principles of Proper Pain Management.

5. For each violation of applicable laws, rules, or conditions of licensure, the Board may issue a warning, censure, or reprimand. Each warning, censure, and reprimand issued must be based upon a violation of a single applicable law, rules, or conditions of licensure or must be based upon a single instance of actionable conduct or activity. 10 M.R.S. § 8003(5)(A-1)(1).

6. For each violation of applicable laws, rules, or conditions of licensure, the Board may impose conditions of probation upon a licensee. The probation may run for such time period as the Board determines appropriate. Costs incurred in the performance of terms of probation are borne by the licensee. 10 M.R.S. § 8003(5)(A-1)(4).

7. When there is a finding of a violation, the Board may assess the licensee for all or part of the actual expenses incurred by the Board or its agent for investigations and enforcement duties and may set a timeframe for payment of the assessment. 10 M.R.S. § 8003-D.

#### **IV. CONCLUSIONS OF LAW**

The Board, considering the above facts and those alluded to in the record but not referred to herein, determined that it had jurisdiction over Licensee Stephen H. Doane and concluded as follows with regard to the allegations in the notice of hearing:

1. By unanimous vote, that the Licensee demonstrated incompetence in his treatment and record keeping regarding patient A.H. by not being more aware of the hazards associated with the medications he was prescribing to A.H., not apprising A.H. of such hazards, not

documenting in A.H.'s record his recognition and communication of such hazards or the objective basis for prescribing opiate medications, not considering the combination of the medications prescribed to A.H. in the context of the conditions she experienced, and practicing outside of his range of competency.

2. By vote of five to one, that the Licensee committed unprofessional conduct by failing to appropriately follow-up on and respond to information obtained from other doctors and reporters as well as from events that occurred in his own office regarding A.H.'s overdoses on the medications he was prescribing for her.
3. By unanimous vote, that the Licensee violated Board Rule Chapter 21, Section III, governing the use of controlled substances for the treatment of pain by failing to conduct all aspects required for evaluation of the patient; failing to create a written treatment plan; failing to discuss the risks and benefits of the use of controlled substances with the patient; failing to implement a written agreement outlining patient responsibilities including urine/medication serum level screening, pill counts, the number and frequency of all prescription refills, and the reasons for which drug therapy would be discontinued; and failing to keep accurate and complete medical records.
4. By unanimous vote, granted the Licensee's renewal application.
5. By unanimous vote, as a result of the violations, imposed the following sanctions:
  - a. a censure;
  - b. terms of probation as follows:
    - i. the Licensee may oversee only one mid-level practitioner at a time for the remainder of his licensure;
    - ii. the Licensee may oversee no more than 200 beds in a maximum of 2 facilities for the remainder of his licensure;

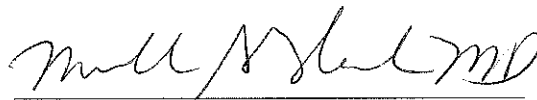
iii. the Licensee may provide no longer than a 7 day prescription for patients leaving a facility he is employed at for the remainder of his licensure; and

iii. the Licensee will engage a practice monitor, approved by the Board, who will review all cases in which the Licensee writes prescriptions for more than one week of controlled substances and report to the Board every four months for a period of one year; and

c. assessment of \$12,000 in actual costs that have already been incurred by the Board in the execution of its investigation and enforcement duties in this matter, payable within 12 months.

The consent agreement entered into by the Licensee in the matter of Complaint Number CR11-397 remains in effect, including the additional limitations on prescribing controlled substances. Furthermore, the Licensee may petition the Board if he seeks any modification to the terms of probation imposed in this decision or the additional practice restrictions identified in the May 18, 2012, consent agreement.

Dated: March 10, 2015



Maroulla S. Gleaton, M.D.  
Chair, State of Maine Board of Licensure in Medicine

## **V. APPEAL RIGHTS**

Pursuant to the provisions of 10 M.R.S. § 8003(5) and 5 M.R.S. § 11002(3), any party that appeals this Decision and Order must file a Petition for Review in the Superior Court within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by

certified mail, return receipt requested, upon the State of Maine Board of Licensure in Medicine, all parties to the agency proceedings, and the Attorney General.