IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

STATE OF OKLAHOMA, ex rel., OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
vs.	)	**CASE NO. 06-08-3161**
SUZANNE WAYMAN, P.A. LICENSE NO. PA1048,	)	
Defendant.	)	

COMPLAINT

COMES NOW the plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Suzanne Wayman, P.A., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physician assistants in the State of Oklahoma pursuant to 59 Okla. Stat. §§ 480 *et seq.* and 887.1 *et seq.*

2. Beginning October 10, 2002 and continuing through August 30, 2006, Defendant practiced as a physician assistant at the Choctaw Nation Clinic in Hugo, OK under the supervision of Tracy Kidwell, D.O.

3. On or about August 23, 2006, Defendant wrote three (3) prescriptions to Patient SSM. This patient was not a patient at the Choctaw Nation Clinic and was not eligible to be seen at the clinic, but was a friend of the Defendant's brother. Patient SSM resided in Pennsylvania and was working temporarily in the area. The prescriptions written include Hydrocodone 7.5 mg., for thirty (30) dosage units, Flexeril, for thirty (30) dosage units, and a Medrol Dose Pak. Defendant kept no chart on Patient SSM and kept no record of the prescriptions in the name of Patient SSM as is required by narcotics laws. The lack of any records reflects that Defendant did not establish a legitimate medical need for the medical treatment, that she did not perform any

examination prior to prescribing the medication, and that she failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

4. On or about July 3, 2006, Defendant wrote two (2) prescriptions to Patient LFM. This patient was not a patient at the Choctaw Nation Clinic and was not eligible to be seen at the clinic, but was a friend of the Defendant. The prescriptions include Lortab 10 mg., for thirty (30) dosage units, with one (1) refill, and Phentermine 37.5 mg., for thirty (30) dosage units, with one (1) refill. Defendant kept no chart on Patient LFM and kept no record of the prescriptions in the name of Patient LFM as is required by narcotics laws. The lack of any records reflects that Defendant did not establish a legitimate medical need for the medical treatment, that she did not perform any examination prior to prescribing the medication, and that she failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

5. On or about July 12, 2006, Defendant authorized a prescription to Patient JSM. This patient was not a patient at the Choctaw Nation Clinic and was not eligible to be seen at the clinic, but was Defendant's cousin's wife. The prescription was for Adipex 37.5 mg. Defendant kept no chart on Patient JSM and kept no record of the prescription in the name of Patient JSM as is required by narcotics laws. The lack of any records reflects that Defendant did not establish a legitimate medical need for the medical treatment, that she did not perform any examination prior to prescribing the medication, and that she failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

6. On or about August 26, 2006, Defendant wrote a prescription to Patient SWM. This patient was not a patient at the Choctaw Nation Clinic and was not eligible to be seen at the clinic. The prescription was for Xanax 2mg., for forty (40) dosage units with one (1) refill. Defendant kept no chart on Patient SWM and kept no record of the prescription in the name of Patient SWM as is required by narcotics laws. The lack of any records reflects that Defendant did not establish a legitimate medical need for the medical treatment, that she did not perform any examination prior to prescribing the medication, and that she failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

7. On or about November 17, 2005, and then again on or about March 10, 2006, Defendant authorized prescriptions to Patient CBM, with three (3) refills each time. The patient was not a patient at the Choctaw Nation Clinic and was not eligible to be seen at the clinic, but was the wife of a deceased patient. The medication prescribed was Glucotrol for the treatment of the patient's diabetes. Defendant kept no chart on Patient CBM. Defendant admitted that she had never seen Patient CBM as a patient, had never reviewed her lab work, did not know what her Hemoglobin AIC level was, and did not know what her blood glucose levels were. The lack of any records reflects that Defendant did not establish a legitimate medical need for the medical treatment, that she did not perform any examination prior to prescribing the medication, and that

she failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

8. On or about August 30, 2006, Defendant was confronted by Jason Hill, D.O., the Chief Medical Officer for the Choctaw Nation Health Services Authority, about these improper prescriptions. When asked about the prescriptions, she denied knowing any of the patients. At that time, she was placed on administrative leave. Defendant's supervising physician, Tracy Kidwell, D.O., also withdrew her supervision of Defendant at this time.

9. On or about August 30, 2006, Defendant contacted Gayla McClenney, Investigator for the Board. During this conversation, Defendant advised Ms. McClenney about the action taken by the Choctaw Nation Clinic. Defendant again denied knowing any of the patients who received the prescriptions at issue and advised Ms. McClenney that someone may have taken a prescription pad from her purse.

10. On or about September 5, 2006, Ms. McClenney interviewed the Defendant at the Board offices. During this interview, Defendant changed her story and admitted that she had in fact written the subject prescriptions. Defendant also identified each of the persons who received the prescriptions as her friends or acquaintances.

11. Based on the allegations stated above, Defendant is guilty of unprofessional conduct in that she has:

A. Violated a provision of the Medical Practice Act or the rules promulgated by the Board in violation of OAC 435:15-5-11(7).

B. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public in violation of 59 O.S. §509(8) and OAC 435:10-7-4(11).

C. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of OAC 435:10-7-4(39) and 59 O.S. §509(13).

D. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509(12).

E. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509(18).

F. Violated any state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27).

G. Engaged in the improper management of medical records in violation of OAC 435:10-7-4(36).

H. Failed to furnish the Board, its investigators or representatives, information lawfully requested by the Board in violation of OAC 435:10-7-4(37).

I. Failed to cooperate with a lawful investigation conducted by the Board in violation of OAC 435:10-7-4(38).

J. Failed to maintain adequate medical records to support treatment or prescribed medications in violation of OAC 435:10-7-4(41).

K. Performed health care services in patient care settings not authorized by or independent of her supervising physician in violation of 59 O.S. §519.6(E), 59 O.S. §519.2(3)(h), OAC 435:15-5-1(b), OAC 435:15-9-1(a), and OAC 435:15-5-2.

L. Prescribed written and oral prescriptions and orders not under the direction of her supervising physician in violation of 59 O.S. §519.6(D)(1).

12. These allegations raise serious concerns about Defendant's ability to practice as a physician assistant in the State of Oklahoma with reasonable skill and safety.

WHEREFORE, plaintiff requests that the Board conduct a hearing, and upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation, the assessment of costs and fees incurred in this action, and any other appropriate action with respect to Defendant's license to practice as a physician assistant in the State of Oklahoma.

Dated this 7th day of November, 2006.

Respectfully submitted,

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Attorney for State ex rel.
Oklahoma Board of Medical Licensure and
Supervision