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

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| **STATE OF OKLAHOMA, *ex rel.* OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,** | ) | |
| **Plaintiff,** | ) | |
| **v.** | ) | **Case No. 14-11-5068** |
| **WALTER JAY EXON, M.D., LICENSE NO. MD 10770,** | ) | |
| **Defendant.** | ) | |



## ORDER OF REVOCATION OF MEDICAL LICENSE

This matter came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (the "Board") on May 10, 2018, at the office of the Board, 101 N.E. 51st Street, Oklahoma City, Oklahoma 73105, pursuant to notice given as required by law and rules of the Board, the Oklahoma Administrative Procedures Act, 75 O.S. §§ 250-323 and the Oklahoma Open Meetings Act, 25 O.S. §§ 301-314.

Joseph L. Ashbaker, Assistant Attorney General, appeared on behalf of Plaintiff, Rachel A. Rogers, Assistant Attorney General, appeared as second chair for Plaintiff, and Walter Jay Exon, M.D. ("Defendant"), appeared in person and through counsel Daniel J. Gamino, of Daniel J. Gamino and Associates, P.C. (collectively, the "Parties").

The following exhibits were admitted into evidence:

- Plaintiff's Exhibits 1, 3, 5 and 6

The following exhibits were admitted into evidence, *under seal*:

- Plaintiff's Exhibits 2 and 4

The following witnesses were sworn and testified: Stephen Washbourne, Board Investigator, John Frank Raizen, M.D, as expert witness, and Walter Jay Exon, Defendant.

The Board *en banc*, after hearing the parties' arguments, hearing sworn testimony of witnesses, considering stipulations of counsel, reviewing the exhibits admitted and being fully advised of the premises, finds that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

## Findings of Fact

1. Defendant holds Oklahoma medical license no. 10770, issued March 15, 1976.

2. On August 23, 2017, an Amended Verified Complaint and Citation were each filed, setting hearing on March 8, 2018.

3. On September 13, 2017, Defendant filed an Answer to Amended Verified Complaint.

4. On January 8, 2018, Defendant's Motion to Strike Portions of the Amended Verified Complaint ("Defendant's Motion to Strike"), was filed. Plaintiff's *unfiled* response to Defendant's Motion to Strike was transmitted to Mr. Gamino by letter dated January 23, 2018, to minimize the chance of inadvertent review by the Board prior to ruling on Defendant's Objection to Hearing.

5. On January 10, 2018, Defendant's Objection to Board *en banc* Hearing Motion to Strike ("Defendant's Objection to Hearing"), was filed. Plaintiff's response to Defendant's Objection to Hearing was filed on January 24, 2018.

6. On January 23, 2018, Respondent's Motion to Compel Answers to Discovery Requests ("Defendant's Motion to Compel"), was filed. Plaintiff's response to Defendant's Motion to Compel was filed on February 5, 2018.

7. Notice of hearing on Defendant's three motions filed January 8, 2018, January 10, 2018, and January 23, 2018 was mailed to Mr. Gamino, advising hearing on March 8, 2018.

8. At the March 8, 2018 Board meeting, after Board review of Defendant's Motion to Strike, Plaintiff's Response to Defendant's Motion to Strike was filed. The Board having considered arguments of counsel and evidence presented, **DENIED** Defendant's three motions.

9. On March 26, 2018, an Order Denying Defendant's Objection to Hearing, and, Denying Defendant's Motion to Strike was filed. An Order Denying Respondent's Motion to Compel Answers to Discovery was also filed.

10. An Order of Continuance of Amended Verified Complaint was filed February 13, 2018, rescheduling hearing to the May 10, 2018 Board meeting, and resetting all deadlines in accordance with the May 2018 Scheduling Order.

11. Board Investigator Steve Washbourne was called as a witness for the State, and he explained that he has been an investigator for the Board for 27 years; during which he has investigated thousands of cases. Investigator Washbourne testified that after receiving a complaint about Defendant, he got a subpoena for patient medical records. The Board's medical adviser, Dr. Eric Frische reviewed the medical records. The Board subsequently subpoenaed additional medical records.

12. All of the patient medical records subpoenaed by the Board were delivered to Dr. John Raizen for review.

13. Dr. Raizen is qualified by his learning, training and experience to testify as an expert and render opinions. Dr. Raizen was declared an expert during the hearing without objection.

14. After reviewing patient medical records of Defendant, Dr. Raizen concluded the records lacked histories, assessments, testing and there was excessive medications being prescribed.

15. At the May 10, 2018 Board meeting, the parties stipulated that based on his review of patient medical records (admitted in Exhibit 1), Dr. Raizen would testify to the following facts, circumstances and conclusions:

    a. Patient K.C.W. received 60 mg of Adderall and 100 mg of Vyvanse per day. The maximum daily amount per the FDA guideline is 40 mg of Adderall and 70 mg of Vyvanse. There was a lack of, (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, (3) lack of sufficient justification for Controlled Dangerous Substance ("CDS") dosages and increases, and (4) lack of informed consent regarding the medications prescribed. There was no rationale for treating with the two stimulants given to this patient contained in the records. K.C.W. records note, "Very good at math", "Great grades" and "doing well," yet Defendant gave increased stimulant dosages.

    b. Patient A.D.W. was increased for Xanax XR from 0.5 mg to the highest amount recommended by the FDA guideline of 2.0 mg in only 4 months. There was no informed consent for medications including the risks, benefits and alternatives available. Further, there was no inquiry into possible past or current substance abuse to accompany the prescribing of CDS. There was (1) a lack of documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, and (3) lack of sufficient justification for CDS dosages and increases. Defendant gave increased stimulant dosages in spite of patient reporting "doing well."

    c. Patient S.E.W., who is 16 years old, was receiving 150 mg of Adderall. FDA guidelines suggest an adolescent should not have more than 40 mg per day. There was no informed consent for medications including the risks, benefits and alternatives. There was no documented history to support the diagnoses given of ADHD, Oppositional Defiance Disorder (ODD), Conduct Disorder, Bipolar Disorder and NOS. There was insufficient monitoring of this patient especially given evidence indicative of possible concurrent substance abuse, non-compliance and diversion as well as the risk of side effects of such high doses of CDS. There was a lack of, (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, and (3) lack of sufficient justification for CDS dosages and increases. Defendant gave increased stimulant dosages which did not correlate to the patient reporting "doing well" noted in the record.

    d. Patient B.H.W. received 220 mg of Ritalin per day for over 3 years, which is 4 times the FDA maximum recommendation of 60 mg per day. Key findings

were lack of informed consent for medications including the risks, benefits and alternatives available, no detailed history elicited to support the diagnoses of ADHD and Autistic Spectrum Disorder (ASD), lack of sufficient follow up monitoring and lack of sufficient justification for CDS dosages and increases. There was insufficient follow up monitoring and lack of sufficient justification for the sustained high doses of CDS prescribed.

e. Patient H.H.W. received 320 mg of Zenzedi per day, which is 6 times the FDA maximum recommendation. There was a lack of, (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, (3) lack of sufficient justification for CDS dosages and increases, and (4) lack of informed consent regarding the medications prescribed. There was no documented history to support the diagnoses given of ADHD, OCD and Anxiety. There was insufficient monitoring of this patient especially given evidence indicative of possible abuse of his prescribed CDS.

f. Patient D.I.W.'s prescription was increased for Adderall without documentation to support.

g. Patient P.K.W. received 360 mg of Adderall, which is 6 times the FDA maximum recommendation of 60 mg per day. Patient record lacked adequate documentation to support diagnosis of ADHD, Mood Disorder, NOS, OCD, Depression and Anxiety disorder. No documentation to support a massive dosage of Adderall. There is no evidence of informed consent regarding the medications prescribed and their known potential side effects. There was no inquiry of discussion of past or present substance abuse issues.

h. Patient J.L.W. averaged between 12 mg to 18 mg of Xanax XR. The FDA guideline maximum recommendation is 10 mg for anxiety. There was a lack of (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, (3) lack of sufficient justification for CDS dosages and increases, and (4) lack of informed consent regarding the medications prescribed. Defendant did not document any history supporting the diagnoses of Generalized Anxiety Disorder and Cyclothymia and no information regarding history of or current substance abuse. Continued prescriptions of long term benzodiazepine while opiates were being prescribed to patient from 12 different doctors in 12 months.

i. Patient K.M.W., who was 15 years old, received 108 mg per day of Ritalin. The FDA guideline recommended maximum dosage for that drug is 72 mg per day. There was no informed consent for medications including the risks, benefits and alternatives. There was insufficient patient history and monitoring of this patient, whose parent stated she "almost acts intoxicated". There was a lack of, (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, and (3) lack of sufficient justification for CDS dosages and increases especially considering evidence of noncompliance.

j. Patient A.N.W. had an increase in the dosage of Focalin, with insufficient justification and the records on this patient were substandard. There was a lack of, (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, (3) lack of sufficient justification for CDS dosages and increases, (4) and lack of informed consent regarding the medications prescribed. Defendant did not document sufficient evidence supporting the diagnoses of Bipolar Disorder, Cylothymia, ADHD and Depressive Disorder.

k. Patient J.T.W. patient records were very poorly maintained. There were no records for the period of January 2012 to January 2014, though patient was filling prescriptions for Adderall prescribed by Defendant. The records that are available do not provide detail or support for the prescribed CDS.

l. Patient R.W.W. averaged 16 mg of Xanax XR while the FDA guideline maximum recommendation is IO mg for Panic Disorder. She was also prescribed Adderall. Defendant increased R.W.W.'s prescription for Adderall over 400 percent in a 48 day period with insufficient justification. There was a lack of, (1) documentation to support the treatment rendered, (2) lack of sufficient follow up monitoring, (3) lack of sufficient justification for CDS dosages and increases, and (4) lack of informed consent regarding the medications prescribed. Defendant did not document any history supporting the diagnoses of ADHD and Generalized Anxiety Disorder. Defendant continued to prescribe Xanax in spite of evidence that the patient was exhibiting clear substance abuse behavior and side effects.

m. Patient D.L.W. was taking 10mg of Xanax and 80mg of Adderall. There was a lack of documentation to support the treatment rendered, lack of sufficient follow up monitoring, lack of sufficient justification for CDS dosages and increases and lack of infom1ed consent regarding the medications prescribed. Defendant did not document any history supporting the diagnoses of GAD. There was no documentation regarding inquiries into past or present substance abuse in spite of evidence that the patient was exhibiting clear substance abuse behavior and side effects.

n. Patient B.D.W. was taking 12mg/day dosage of Xanax in spite of continued signs of substance abuse as well as familial reports of substance abuse.

16. The Parties also made the following stipulations: (a) Dr. Raizen would opine that the actions or inactions taken by Defendant were below the accepted standard of care, (b) there has never been an emergency hearing filed or heard in this case, (c) there is no requirement in any statute requiring a doctor to check court records on all patients, and (d) none of the patient criminal activity, in and of itself, is attributable to this doctor, nor was he required to look up criminal activity before treatment.

17. Defendant Dr. Exon prescribed medications to a former colleague without a formal doctor-patient relationship. Defendant described his own medical charts for this patient as "woefully inadequate." *See* Exhibit 4, ¶¶ 1-2.

18. Defendant Dr. Exon prescribed high dosages of a drugs legally classified as controlled substances or recognized as addictive or dangerous drugs, to patients despite recognizing their issues with substance abuse and addiction. *See* Exhibits 2, 3 and 5.

19. At the May 10, 2018 Board meeting, Defendant asked the Board for a stay, and that request was denied.

20. Any conclusion of law below which is more properly characterized as a finding of fact is hereby incorporated as a finding of fact.

## Conclusions of Law

21. The Board has jurisdiction over the subject matter and is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma. 59 O.S. § 480 *et seq.* and Okla. Admin. Code §§ 435:5-1-1 *et seq.*

22. Notice was given as required by law and the rules of the Board. 75 O.S. § 309(A); 59 O.S. § 504; Okla. Admin. Code §§ 435:3-3-5, 3-3-6.

23. The Board is authorized to suspend, revoke or order any other appropriate sanctions against the license of any physician or surgeon holding a license to practice medicine in the State of Oklahoma for unprofessional conduct. 59 O.S. §§ 503, 513(A)(1). The Board's action is authorized by 59 O.S. §§ 509.1(A)(1), Okla. Admin. Code § 435:5-1-3.

24. Based upon the evidence, exhibits, testimony and stipulations discussed in the Findings of Fact, the Board finds that Plaintiff has proven by clear and convincing evidence, that Defendant is guilty of unprofessional conduct as follows:

    a. Dishonorable or immoral conduct likely to deceive, defraud, or harm the public, in violation of 59 O.S. § 509(8) and Okla. Admin. Code § 435:10-7-4(11);

    b. Prescribing or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship, in violation of 59 O.S. § 509(12);

    c. Prescribing, dispensing or administering of controlled substances or narcotic drugs in excess of the amount considered good medical practice, or prescribing, dispensing or administering controlled substances or narcotic drugs without medical need in accordance with published standards, in violation of 59 O.S. § 509(16) and Okla. Admin. Code § 435:10-7-4(2);

d. Failure 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);

e. Failure to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act, including but not limited to an initial in-person patient examination, office surgery, diagnostic service or any other medical procedure or treatment. Adequate medical records to support diagnosis, procedure, treatment or prescribed medications must be produced and maintained, in violation of 59 O.S. § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

f. Indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs, in violation of Okla. Admin. Code § 435:10-7-4(1);

g. Dispensing, prescribing or administering a controlled substance or narcotic drug without medical need, in violation of and Okla. Admin. Code § 435:10-7-4(6);

h. Except as otherwise permitted by law, prescribing, selling, administering, distributing, ordering or giving a habitue or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, in violation of and Okla. Admin. Code § 435:10-7-4(25);

i. Improper management of medical records, in violation of Okla. Admin. Code § 435:10-7-4(36).

25. Immediate revocation of license prior to Attorney General antitrust review is necessary to protect public health and safety.

## Orders

**IT IS THEREFORE ORDERED** by the Oklahoma State Board of Medical Licensure and Supervision as follows:

1. Oklahoma medical license no. 10770 of **WALTER JAY EXON, M.D.**, is **REVOKED**, effective immediately, May 10, 2018, to protect the public health and safety.

2. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and costs, investigation costs, staff time, salary and travel expenses, witness fees and attorney's fees.

3. A copy of this Order shall be provided to Defendant as soon as it is processed.

**This Order is subject to review and approval by the Oklahoma Attorney General, and this Order shall become final upon completion of the review by the Oklahoma Attorney General unless disapproved, in which case this Order shall be null and void.**

Dated this 12th day of June, 2018.

Billy H. Stout, M.D., Board Secretary
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

**Certificate of Service**

This is to certify that on the 13th day of June, 2018, a true and correct copy of this Order was transmitted as specified, postage prepaid, to the following:

*U.S. Certified Mail*
Walter Jay Exon, M.D.
5272 South Lewis Avenue
Tulsa, Oklahoma 74105
***Defendant***

*U.S. First Class Mail*
Daniel J. Gamino
DANIEL. J. GAMINO & ASSOCIATES, P.C.
Jamestown Office Park, North Building
3035 NW 63rd Street, Suite 214
Oklahoma City, OK 73116
Telephone: (405) 840-3741
Facsimile: (405) 840-3744
dgamino@coxinet.net
***Attorney for Defendant,***
***Walter Jay Exon, M.D.***

Nancy Thiemann, Legal Assistant

OFFICE OF ATTORNEY GENERAL
STATE OF OKLAHOMA

**ATTORNEY GENERAL OPINION**
**2018-184A**

Billy H. Stout, M.D., Board Secretary
State Board of Medical Licensure and Supervision
101 N.E. 51st Street
Oklahoma City, OK 73105

June 8, 2018

Dear Dr. Billy H. Stout, M.D., Board Secretary:

This office has received your request for a written Attorney General Opinion regarding action that the State Board of Medical Licensure and Supervision intends to take with respect to medical doctor licensee 10770 in case number 14-11-5068. After a hearing, the Board found by clear and convincing evidence that the licensee prescribed controlled dangerous substances ("CDS") to patients without a sufficient examination in an amount that exceeded good medical practice and without a medical need, failed to maintain sufficient office records for each patient, and prescribed CDS to an addict. The Board proposes to immediately revoke the license and to require the licensee to pay all costs of the action.

The Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act authorizes the Board to revoke a license or impose other sanctions for unprofessional conduct. 59 O.S.Supp.2017, § 503. Unprofessional conduct includes "[d]ishonorable or immoral conduct which is likely to deceive, defraud, or harm the public," "[p]rescribing, or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship," the "[p]rescribing, dispensing or administering of controlled substances or narcotic drugs in excess of the amount considered good medical practice," and "[f]ailure to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient." 59 O.S. 2011, § 509(8), (12), (16), (18). The Board may reasonably believe that the proposed action is necessary to protect public health and prevent future violations.

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It is, therefore, the official opinion of the Attorney General that the State Board of Medical Licensure and Supervision has adequate support for the conclusion that this action advances the State's policy to ensure the adequate regulation of dangerous substances and to require that medical doctors observe minimum standards of professionalism.

MIKE HUNTER
ATTORNEY GENERAL OF OKLAHOMA

ETHAN SHANER
DEPUTY ASSISTANT ATTORNEY GENERAL