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

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff	)	
v.	)	**Case No. 05-07-2971**
DAVID PAUL CRASS, M.D., LICENSE NO. 11365	)	
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, David Paul Crass, M.D., Oklahoma license no. 11365, 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 physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq*.

2. Defendant, David Paul Crass, M.D., holds Oklahoma license no. 11365 and practices psychiatry in Tulsa, Oklahoma.

3. From August 31, 2004 until June 12, 2007, Defendant treated Patient RFM for alleged ADHD, migraines, sleep apnea, insomnia and marital dysfunction. During 2006, Defendant wrote or authorized thirty-eight (38) prescriptions for controlled dangerous drugs to Patient RFM. These prescriptions include twenty-four (24) prescriptions for Endocet and Methylphenidate, Schedule II controlled dangerous drugs, for a total of 11,512 dosage units, and fourteen (14) prescriptions for Ambien and Diazepam, Schedule IV controlled dangerous drugs, for a total of 1,440 dosage units, for an average of **40.22 dosage units per day of controlled dangerous drugs.** During 2007, Defendant wrote or authorized thirty (30) prescriptions for controlled dangerous drugs to Patient RFM. These prescriptions include eighteen (18) prescriptions for Methylphenidate, Percocet, and Endocet, Schedule II controlled dangerous drugs, for a total of 8,640 dosage units, eleven (11) prescriptions for Diazepam and Temazepam,

Schedule IV controlled dangerous drugs, for a total of 1,005 dosage units, and one (1) prescription for Promethazine, a Schedule V controlled dangerous drug, for a total of 20 dosage units, for an average of **44.95 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. From Patient RFM's initial office visit on August 31, 2004 until April 22, 2005, Defendant had only five (5) office visits. For the remainder of 2005, 2006 and 2007, all contact between Defendant and Patient RFM was by telephone while Patient RFM lived in North Carolina. During 2006 and 2007, as set forth above, Defendant continued to prescribe massive amounts of controlled dangerous drugs to Patient RFM without any contact in person.

4. From February 17, 2004 until at least September 14, 2007, Defendant treated Patient ACM for alleged major depression, generalized anxiety disorder and probable costochondritis. During 2007, Defendant wrote or authorized four (4) prescriptions for Oxycodone, a Schedule II controlled dangerous drug, for a total of 180 dosage units, nine (9) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 1890 dosage units, and seventeen (17) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 2580 dosage units, for an average of **20.13 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, including but not limited to diagnostic tests for chest pain, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

5. From September 24, 2003 until April 8, 2005, Defendant treated Patient TVM for alleged ADHD, Major Depression-Chronic, generalized anxiety disorder and chronic low back pain. During seventy-three (73) days in 2005, Defendant wrote or authorized one (1) prescription for Endocet, a Schedule II controlled dangerous drug, for a total of 40 dosage units, four (4) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 840 dosage units, and nine (9) prescriptions for Soma, Valium and Xanax, Schedule IV controlled dangerous drugs, for 840 dosage units, for an average of **23.56 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. While Defendant diagnosed the patient with Major Depression-Chronic, he failed to order any antidepressant medication. Additionally, all x-rays and MRIs obtained from previous physicians showed no abnormalities, yet Defendant continued to treat the patient with pain medications.

6. From May 20, 2003 until May 9, 2005, Defendant treated Patient EFM for alleged Major Depression-Moderate, Panic Disorder, Generalized Anxiety Disorder, ADHD, acute pain of the shoulder and chronic pain of the shoulders and back. During this time, Defendant prescribed Patient EFM Lortab, Methadone, Soma, Xanax, Valium, Prozac, Percocet, Restoril, Seroquel and Klonopin. Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects that he prescribed three (3) benzodiazepines at the same time, and that he prescribed three (3) pain medications for an undocumented injury. Additionally, Defendant began prescribing Methadone to the patient after the patient admitted using some Methadone he obtained from a friend. Defendant continued to prescribe controlled dangerous drugs to the patient for two (2) years without the patient ever getting any physical examination by Defendant or any other physician. **On June 9, 2005, Patient EFM overdosed on Xanax and Methadone and died.**

7. From May 23, 2006 until July 10, 2007, Defendant treated Patient CJM for Major Depression, Severe General Anxiety Disorder, Chronic Sinusitis and chronic back and neck pain. During 2007, Defendant wrote or authorized five (5) prescriptions for Methadone and Oxycodone, Schedule II controlled dangerous drugs, for a total of 150 dosage units, five (5) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 980 dosage units, twelve (12) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 1,470 dosage units, and seven (7) prescriptions for Promethazine w/codeine, a Schedule V controlled dangerous drug, for 420 dosage units, for an average of **20.27 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, including but not limited to diagnostic tests for her persistent cough, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. **On or about July 18, 2007, Patient CJM overdosed on Methadone and died.** Although Defendant initially diagnosed Patient CJM with Major Depression, he did not treat her depression with any medication until just before her death when he finally provided her samples of Cymbalta and Seroquel. With respect to the Methadone, Defendant first prescribed it on July 10, 2007 and Patient CJM overdosed on it on July 18, 2007. At the time Patient CJM was prescribed the Methadone, she was already taking Hydrocodone, Xanax, Soma and Promethazine w/codeine. Additionally, Defendant's prescription log for this patient reflects that Methadone was prescribed to her on August 9, 2007, a month **after** she overdosed on the Methadone.

8. From January 18, 2004 until January 3, 2007, Defendant treated Patient ALM for alleged Major Depression-chronic-mild, Social Anxiety Disorder and chronic leg and back pain. During 2006, Defendant wrote or authorized twelve (12) prescriptions for Methadone, a Schedule II controlled dangerous drug, for 1,470 dosage units, six (6) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 1,440 dosage units, and twelve (12)

prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 2,060 dosage units, for an average of **13.96 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. The only physical examination in Defendant's chart was an examination performed by another physician over five (5) years prior to Defendant's treatment of the patient. Additionally, although this previous physician had noted in the patient record that the patient was "analgesic dependent", Defendant nevertheless prescribed large amounts of Lortab, Xanax and Soma beginning at the patient's first visit and continuing throughout his treatment. Defendant then prescribed large amounts of Methadone while he continued to prescribe Lortab, Xanax and Soma to this patient. While prescribing these medications, Defendant never addressed the patient's addiction issues.

9. From February 24, 2002 until February 24, 2004, Defendant treated Patient DDM for alleged ADHD, Social Anxiety Disorder, Major Depression-Chronic and Poly-substance abuse-chronic. During this time, Defendant prescribed Patient DDM Lortab, Methadone, Soma, Xanax, Valium, Prozac, Percocet, Restoril, Seroquel and Klonopin. Defendant's chart on this patient reveals that he failed to perform any physical examination or obtain any vital signs on this patient prior to or after prescribing the controlled dangerous drugs, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects that he prescribed three (3) benzodiazepines at the same time as well as numerous narcotics, regardless of the fact that the patient had previously abused benzodiazepines and marijuana and had gone through detoxification at a treatment center.

10. Defendant is guilty of unprofessional conduct in that he:

A. 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).

B. Engaged in gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4 (15).

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 59 O.S. §509 (13) and OAC 435:10-7-4(39).

D. 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) and OAC 435:10-7-4(41).

E. 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).

F. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).

G. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

H. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

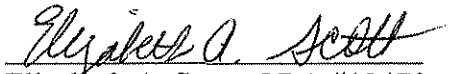
I. Except as otherwise permitted by law, prescribed, sold, administered, distributed, ordered, or gave to a habitué or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug in violation of OAC 435:10-7-4(25).

Conclusion

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 the revocation or suspension of the Defendant's license to practice as a physician and surgeon in the State of Oklahoma, 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 and surgeon in the State of Oklahoma.

Dated this 13th day of June, 2008 at 8:00 a.m.

Respectfully submitted,



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