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. 06-12-3219**
CAN DINH PHUNG, M.D., LICENSE NO. 15171,	)	
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, Can Dinh Phung, M.D., Oklahoma license no. 15171, 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, Can Dinh Phung, M.D., holds Oklahoma license no. 15171.

3. From November 4, 2006 until April 2, 2007, Defendant wrote or authorized thirty-one (31) prescriptions for controlled dangerous drugs to Patient JJL for alleged herniated disk and anxiety. These prescriptions include one (1) prescription for Oxycodone, a Schedule II controlled dangerous drug, for a total of 80 dosage units, thirteen (13) prescriptions for Hydrocodone, H-C Tussive, and Histinex HC, Schedule III controlled dangerous drugs, for a total of 1,964 dosage units, eleven (11) prescriptions for Ambien, Soma, Alprazolam and Temazepam, Schedule IV controlled dangerous drugs, for a total of 535 dosage units, and six (6) prescriptions for Promethazine w/codeine, a Schedule V controlled dangerous drug, for a total of 324 dosage units, for an average of **19.48 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination, nor did he record any vital signs on this patient prior to prescribing the controlled dangerous drugs, that he failed to obtain a full history of the patient, 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 multiple visits and a diagnosis of vague pain without any physical findings.

4. From January 12, 2007 until March 30, 2007, Defendant wrote or authorized twenty-one (21) prescriptions for controlled dangerous drugs to Patient KDL for alleged back and knee pain. These prescriptions include ten (10) prescriptions for Oxycontin, Endocet and Oxycodone, Schedule II controlled dangerous drugs, for 730 dosage units, three (3) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 260 dosage units, and eight (8) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 410 dosage units, for an average of **18.18 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not record any vital signs in the patient's chart, that he failed to obtain a full history of the patient, 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 numerous visits with no documentation other than a listing of drugs prescribed. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any physical findings.

5. From October 12, 2006 until March 5, 2007, Defendant wrote or authorized thirty-one (31) prescriptions for controlled dangerous drugs to Patient CYL for alleged muscle pain due to paralysis. These prescriptions include ten (10) prescriptions for Marinol and Oxycodone 40 mg., Schedule II controlled dangerous drugs, for a total of 600 dosage units, nine (9) prescriptions for Hydrocodone and Tussionex Susp., Schedule III controlled dangerous drugs, for 858 dosage units, eight (8) prescriptions for Soma and Diazepam, Schedule IV controlled dangerous drugs, for a total of 275 dosage units, and four (4) prescriptions for Promethazine/Codeine, a Schedule V controlled dangerous drug, for 414 dosage units, for an average of **14.91 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not record any vital signs in the patient's chart, that he failed to obtain a full history of the patient, 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 multiple visits and a diagnosis of vague pain without any physical findings.

6. From February 3, 2007 until April 2, 2007, Defendant wrote or authorized eleven (11) prescriptions for controlled dangerous drugs to Patient DKL for alleged depression, migraines, and knee pain. These prescriptions include four (4) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 430 dosage units, and seven (7) prescriptions for Soma and Valium, Schedule IV controlled dangerous drugs, for 395 dosage units, for an average of **14.22 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination, nor did he record vital

signs on this patient prior to prescribing the controlled dangerous drugs, that he failed to obtain a full history of the patient, 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 visits with no documentation other than the patient's weight and a listing of drugs prescribed. Defendant's chart additionally reflects multiple visits and a diagnosis of vague pain without any physical findings.

7. From October 10, 2006 until February 13, 2007, Defendant wrote or authorized fourteen (14) prescriptions for controlled dangerous drugs to MWL for alleged back pain. These prescriptions include eleven (11) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 1,200 dosage units, and three (3) prescriptions for Alprazolam, Diazepam and Lorazepam, Schedule IV controlled dangerous drugs, for 110 dosage units, for an average of **10.40 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination, nor did he record any vital signs on this patient prior to prescribing the controlled dangerous drugs, that he failed to obtain a full history of the patient, 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 multiple visits and a diagnosis of vague pain without any physical findings.

8. From October 16, 2006 until April 3, 2007, Defendant wrote or authorized twenty-three (23) prescriptions for controlled dangerous drugs to Patient LAL for alleged back and shoulder pain. These prescriptions include seven (7) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 600 dosage units, and sixteen (16) prescriptions for Soma and Valium, Schedule IV controlled dangerous drugs, for 830 dosage units, for an average of **8.17 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he recorded only minimal vital signs on the patient, that he did not establish a legitimate medical need for the medications, that he did not order appropriate tests, 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 multiple visits and a diagnosis of vague pain without any physical findings.

9. From October 16, 2006 until April 3, 2007, Defendant wrote or authorized seventeen (17) prescriptions for controlled dangerous drugs to Patient VAL, the wife of Patient LAL in paragraph 8 above, for alleged back, hip and knee pain and anxiety. These prescriptions include ten (10) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 738 dosage units, and seven (7) prescriptions for Soma, Xanax and Valium, Schedule IV controlled dangerous drugs, for 290 dosage units, for an average of **6.12 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not record any vital signs in the patient's chart other than her weight on limited visits, that he failed to obtain a full history of the patient, 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 multiple visits and a diagnosis of vague pain without any physical findings.

10. From November 9, 2006 until April 3, 2007, Defendant wrote or authorized fourteen (14) prescriptions for controlled dangerous drugs to Patient THL for alleged back pain. These prescriptions include five (5) prescriptions for Oxycodone, a Schedule II controlled dangerous drugs, for 270 dosage units, five (5) prescriptions for Hydrocodone and Histinex HC Syrup, Schedule III controlled dangerous drugs, for 480 dosage units, and four (4) prescriptions for Soma, a Schedule IV controlled dangerous drug, for 210 dosage units, for an average of **6.62 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not record any vital signs in the patient's chart, that he failed to obtain a full history of the patient, 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 multiple visits and a diagnosis of vague pain without any physical findings. Additionally, on February 7, 2007, Defendant was notified by Exchange Pharmacy in Oklahoma City, Oklahoma that the prescription Defendant had written to Patient THL on February 7, 2007 for Oxycodone had been altered from 20 mg. to 80 mg. Defendant advised the pharmacy not to honor the prescription, but he continued to prescribe Oxycodone to the patient on March 7, 2007 and April 3, 2007.

11. From December 19, 2006 until March 13, 2007, Defendant wrote or authorized seven (7) prescriptions for controlled dangerous drugs to Patient IUL for alleged severe anxiety and depression. These prescriptions include three (3) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 250 dosage units, and four (4) prescriptions for Xanax, a Schedule IV controlled dangerous drug, for 200 dosage units, for an average of **5.36 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he recorded minimal vital signs on only one (1) visit in the patient's chart, that he failed to obtain a full history of the patient, 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 multiple visits and a diagnosis of vague anxiety without any physical findings. **Patient IUL died on March 14, 2007.**

TREATMENT OF BOARD INVESTIGATOR

12. On or about March 6, 2007, Board Investigator Jana Lane, posing as Patient "Jana Rhodes", sought medical care from Defendant. Investigator Lane posed as a patient at the joint request of the DEA, the OBN and the Board. On her first visit to Defendant, Investigator Lane advised Defendant that she had previously had ankle pain and that while her ankle no longer hurt, she needed pain medication. Defendant did not obtain any vital signs, nor did he perform any

physical examination on Investigator Lane. During this office visit, Defendant did not touch Investigator Lane as part of any examination. At the conclusion of the office visit, Defendant gave Investigator Lane a prescription for sixty (60) Percocet 10 mg.

13. On or about March 30, 2007, Investigator Lane returned to Defendant's office for a follow-up visit, at which time she provided fictitious medical records. Defendant did not look at the fictitious medical records at this time. During this visit, Defendant did not perform any physical examination, did not obtain any vital signs, nor did he touch Investigator Lane as part of any examination. At the conclusion of the office visit, Defendant gave Investigator Lane a prescription for sixty (60) Percocet 10 mg. and one-hundred (100) Ultram.

14. During the March 30, 2007 office visit, Investigator Lane additionally requested Phentermine. Defendant advised her that she must weigh herself first, which she did. Investigator Lane advised Defendant that she was 5'5" and weighed 153 pounds. Defendant advised her that she was not heavy, but then he agreed to give her a prescription for 60 Phentermine 37.5 mg., with four (4) refills. Defendant did not record nor take any vital signs pursuant to Investigator Lane's request for Phentermine.

OTHER CHARTS SUBPOENAED

15. As part of its investigation of Defendant, Board investigators randomly subpoenaed charts from Defendant for Patients AAL, RAL, JBL, HDL, MFL, JGL, CHL, WHL, BKL, GLL, RML, CML, JPL, DPL and TZL. A review of these randomly selected charts reveals that in each instance, the patients received prescriptions for controlled dangerous drugs on each and every visit. Drugs prescribed to these patients include Hydrocodone, Soma, Valium, Xanax, Phenergan w/codeine, Percocet, Volteren, Ambien, Adipex and Oxycontin. Of these fifteen (15) charts, only one (1) has a height and weight recorded, and only one (1) has a temperature recorded. The remaining charts contain no evidence of any physical exam or recording of any vital signs prior to prescribing the controlled dangerous substances to the patients. Defendant's charts reflect numerous visits with no documentation other than a listing of drugs prescribed. Defendant's charts additionally reflect multiple visits and a diagnosis of vague pain without any physical findings.

16. 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 practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18).

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

F. 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).

G. 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).

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

I. 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).

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 26th day of June, 2007 at 11:20 a.m.

Respectfully submitted,

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