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. 07-05-3291**
NANCY ELLEN GRAYSON, M.D., LICENSE NO. 17590,	)	
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, Nancy Ellen Grayson, M.D., Oklahoma license no. 17590, 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, Nancy Ellen Grayson, M.D., holds Oklahoma license no. 17590 and practices as a psychiatrist in Tulsa, Oklahoma.

PATIENT AML-SEXUAL MISCONDUCT AND PRESCRIBING VIOLATIONS

3. A review of Defendant's records reveals that Defendant began treating Patient AML on or around June 26, 2000 for alleged back, shoulder and leg pain, as well as ADHD.

4. A review of Defendant's medical records on Patient AML reveals that the patient frequently contacted Defendant requesting certain specific controlled dangerous drugs in certain strengths and quantities for his own self-diagnosed ailments, to which the Defendant generally complied. Defendant additionally asked Patient AML to make a list of all lab tests, consultations and medications he wanted, to which she generally complied.

5. Throughout Defendant's treatment of Patient AML, the patient admitted he was stockpiling his prescriptions from Defendant. Defendant nevertheless continued to prescribe large quantities of controlled dangerous substances to him.

6. Defendant's records reflect that during 2001, she post-dated prescriptions for Patient AML for Schedule II controlled dangerous substances. She signed the prescriptions and wrote the drug name, strength and quantity, but allowed Patient AML to fill in the date on the prescriptions.

7. Defendant's treatment of Patient AML continued until approximately October 2001, at which time the patient kissed Defendant at the close of a counseling session.

8. At the next treatment session on approximately October 8, 2001, Defendant claims to have terminated her treatment of Patient AML.

9. Several weeks later, Patient AML contacted Defendant and asked her to come to his apartment, which she did. At the patient's apartment, Defendant and the patient engaged in "heavy kissing". Over the next several months, Defendant went to the patient's apartment on numerous occasions, where she spent the night with the patient, slept in the same bed with the patient, and continued sexual contact with the patient. This conduct continued for several months throughout 2002, after which time Defendant claims that she again terminated her relationship with the patient.

10. During the time that Defendant was sleeping at Patient AML's apartment and continuing her sexual contact with him, she maintained a doctor-patient relationship with him and continued to treat Patient AML by prescribing large amounts of controlled dangerous substances to the patient. Pharmacy records reflect that from October 24, 2001 through December 23, 2002, Defendant prescribed or authorized forty-seven (47) prescriptions to Patient AML for Desoxyn, Oxycontin 80 mg., Oxycontin 10 mg., Morphine, Methadone 10 mg., Methadone 40 mg., Methadone Oral Solution, Hydromorphone tablets and injections, Dilaudid, Focalin and Dextroamphetamine, all Schedule II controlled dangerous substances, for a total of **16,939 total dosage units**, for an **average of 39.86 dosage units per day** of Schedule II controlled dangerous drugs. Defendant's chart on this patient reveals that she failed to perform any physical examination on this patient during this time period, that she did not order appropriate tests, that she did not establish a legitimate medical need for the medications, and that she did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects no office visits during this entire period of time.

11. In late 2002 or early 2003, Patient AML again asked Defendant to treat him, to which she agreed. Defendant's records reflect that she treated Patient AML in her office on three (3) occasions during 2003. Pharmacy records reflect that from January 2, 2003 until November 28, 2003, Defendant prescribed or authorized forty-four (44) prescriptions to Patient AML for Oxycontin 80 mg., Oxycontin 10 mg., Roxicodone, Dextroamphetamine, Methadose, Morphine

Sulfate Injection, Numorphan Injection and Hydromorphone Injection, all Schedule II controlled dangerous substances, for a total of **18,630 total dosage units**, for an **average of 56.45 dosage units per day** of Schedule II controlled dangerous drugs. Defendant's chart on this patient reveals that she failed to perform any physical examination on this patient during this time period, that she did not order appropriate tests, that she did not establish a legitimate medical need for the medications, and that she did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

12. Defendant's records reflect that the last time she treated Patient AML in her office was on December 12, 2003. However, she nevertheless continued to prescribe controlled dangerous substances to him for almost three (3) years. Pharmacy records reveal that from January 7, 2004 through September 11, 2006, Defendant prescribed or authorized forty-five (45) prescriptions to Patient AML for Oxycontin 80 mg., Oxycontin 10 mg., Concerta, Ritalin, Oxycodone 80 mg., Oxycodone 30 mg., Percodan, Dextroamphetamine, Numorphone Injection, Hydromorphone Injection, Adderall, and Focalin, all Schedule II controlled dangerous substances, for a total of **15,063 total dosage units**, for an **average of 15.40 dosage units per day** of Schedule II controlled dangerous drugs. Defendant's chart on this patient reveals that she failed to perform any physical examination on this patient during this time period, that she did not order appropriate tests, that she did not establish a legitimate medical need for the medications, and that she did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart contains no record of any office visits during this period of time.

13. A review of Patient AML's previous medical records provided to Defendant reflects that the patient had previously overdosed on prescription medications. Additionally, a neurological consultation obtained in October 2000 reflects that there was no etiologic basis for the patient's complaints of leg pain. Further, an MRI obtained in 2000 reflected normal spine function. Defendant nevertheless continued to prescribe large amounts of controlled dangerous substances to the patient. A review of Defendant's records reveals that Defendant did not establish a legitimate medical need for the medical treatment, that she ignored test results, that she did not perform a sufficient examination prior to prescribing medications, and that she failed to maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

14. Defendant admits that throughout her treatment of Patient AML, she gave him undated prescriptions for Schedule II controlled dangerous substances so as to allow him to fill his prescriptions at any time.

PATIENT JML-PRESCRIBING VIOLATIONS

15. Beginning on or around September 20, 2001, Defendant began treating Patient JML, the mother of Patient AML in paragraphs 3-14 above. Defendant's chart reflects that she was treating the patient for alleged depression, anxiety and narcolepsy. Defendant's chart additionally reflects that the patient was treated in Defendant's office for these conditions on

three (3) occasions: September 20, 2001, November 26, 2002 and January 2, 2003. She was also treated via telephone on April 29, 2003 and on December 12, 2003, which was her last treatment by Defendant.

15. Pharmacy records reflect that from October 12, 2001 until November 28, 2003, Defendant prescribed or authorized forty-four (44) prescriptions to Patient JML for Oxycontin, Desoxyn, Dexedrine, Kadian, Roxicodone, Morphine 30 mg., Methylin, Dextroamphetamine, Hydromorphone, Morphine Injection, Hydromorphone Injection, Adderall and Focalin, all Schedule II controlled dangerous substances, for a total of **13, 251 total dosage units**, for an **average of 17.05 dosage units per day** of Schedule II controlled dangerous drugs. Defendant's chart on this patient reveals that she failed to perform a sufficient physical examination on this patient during this time period, that she did not order appropriate tests, that she did not establish a legitimate medical need for the medications, and that she did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

16. Despite the fact that Defendant ceased treating Patient JML on December 12, 2003, she continued to prescribe large quantities of controlled dangerous substances to her after this time. Pharmacy records reflect that from January 7, 2004 until April 30, 2005, Defendant prescribed or authorized twenty-three (23) prescriptions to Patient JML for Oxycontin 80 mg., Oxycontin 10 mg., Ritalin, Morphine, Concerta, Morphine Sulphate Injection, Dextroamphetamine, Hydromorphone Injection and Adderall, all Schedule II controlled dangerous substances, for a total of **7,460 total dosage units**, for an **average of 15.57 dosage units per day** of Schedule II controlled dangerous drugs. A review of Defendant's records reveals that she failed to perform a sufficient physical examination on this patient during this time period, that she did not order appropriate tests, that she did not establish a legitimate medical need for the medications, and that she did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart contains no record of any office or telephone visits during this period of time.

17. Defendant is guilty of unprofessional conduct in that she:

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 physical conduct with a patient which is sexual in nature, ... in violation of 59 O.S. §509 (17).

C. Committed an act of sexual ... misconduct or exploitation related or unrelated to the licensee's practice of medicine and surgery in violation of OAC 435:10-7-4 (23).

D. Abused the physician's position of trust by coercion [or] manipulation ... in the doctor-patient relationship in violation of OAC 435:10-7-4(44).

E. 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).

F. 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).

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

H. 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).

I. Confessed to a crime involving violation of the antinarcotics laws and regulations of the federal government and the laws of this state in violation of 59 O.S. §509(7).

J. 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 standards in violation of 59 O.S. §509(16) and OAC 435:10-7-4(2) and (6).

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

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

M. 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).

N. Aided or abetted the practice of medicine and surgery by an unlicensed, incompetent, or impaired person in violation of OAC 435:10-7-4(21).

O. Failed to provide a proper setting and assistive personnel in violation of OAC 435:10-7-4(41).

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 10th day of August, 2007 at 1:00 p.m.

Respectfully submitted,

Elizabeth A. Scott

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