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,	)	FILED NOV 19 2010 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
Plaintiff,	)	
v.	)	**Case No. 09-09-3836**
DAVID WARREN DAWSON, M.D., LICENSE NO. 17752,	)	
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 Warren Dawson, M.D., 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 Warren Dawson, M.D., holds Oklahoma license no. 17752 and practices family medicine in Midwest City, Oklahoma

OVERPRESCRIBING CONTROLLED DANGEROUS DRUGS

3. **Patient JBL-16 years old**

A. On or about March 9, 2006, Defendant began treating Patient JBL, a **sixteen (16) year old** female. Patient JBL's records do not contain any parental consent for her treatment.

B. On her first visit, Patient JBL complained of a sore throat and Defendant prescribed Darvocet to her. From January 8, 2009 until August 25, 2009, Defendant wrote or authorized seventeen (17) prescriptions for **2,040 dosage units** of controlled dangerous drugs to this patient. These prescriptions include eight (8) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of **960 dosage units,**

and nine (9) prescriptions for Carisoprodol and Xanax, Schedule IV controlled dangerous drugs, for a total of **1,080 dosage units**, for an **average of 8.91 dosage units per day** of controlled dangerous drugs.

C. A review of 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 order appropriate tests, that he did not obtain any PMPs or drug screens, that he did not have the patient execute a pain management contract, 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 with chronic pain medications.

D. When asked by Board investigators why he gave a sixteen (16) year old patient Darvocet without parental consent, Defendant admitted he did not realize she was only sixteen (16). He admitted he gave her the controlled dangerous drugs because she claimed to be hurting and was asking him for "stuff". He admitted that when a patient is in the room with him and asks for drugs, he gives in and gives them the medications they request.

4. **Patient KBL-17 years old**

A. On or about June 5, 2008, Defendant began treating Patient KBL, a **seventeen (17) year old** male, for alleged back pain. From June 8, 2008 until June 29, 2009, Defendant wrote or authorized twelve (12) prescriptions for **1,300 dosage units** of controlled dangerous drugs to Patient KBL. These prescriptions include eleven (11) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of **1,180 dosage units,** and one (1) prescription for Carisoprodol, Schedule IV controlled dangerous drugs, for a total of **120 dosage units**, for an **average of 3.37 dosage units per day** of controlled dangerous drugs.

B. A review of 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 obtain appropriate tests, that he did not obtain any PMPs, drug screens or prior medical records, that he did not have the patient execute a pain management contract, 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 with chronic pain medications.

C. Defendant admitted that he knew this patient was a minor at the time he began treating him and prescribing controlled dangerous substances to him. The chart does not contain any parental consent for treatment of this minor.

D. Oklahoma County Court records reflect that on or about June 11, 2009, Patient KBL was arrested for Felony Distribution of a Controlled Dangerous Substance:

Lortab and Oxycontin. Two (2) weeks after this arrest, Defendant again prescribed 120 Lortab to Patient KBL.

5. **Patient GDL-16 years old**

A. On or about November 15, 2007, Defendant began treating Patient GDL, a **sixteen (16) year old** male, for alleged back pain. On the first visit, Defendant prescribed sixty (60) Lortab to the patient. From January 15, 2008 through August 14, 2009, Defendant wrote or authorized forty-two (42) prescriptions for **4,950 dosage units** of controlled dangerous drugs to Patient GDL. These prescriptions include nineteen (19) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug for a total of **2,430 dosage units,** and twenty-three (23) prescription for Soma and Xanax, Schedule IV controlled dangerous drugs, for a total of **2,520 dosage units**, for an **average of 8.58 dosage units per day** of controlled dangerous drugs.

B. The patient chart contains no parental consent for the treatment of this minor.

C. Defendant's chart contains one (1) drug test which was negative. This test should have been positive since Defendant was prescribing Hydrocodone, Soma and Xanax to the patient.

D. A review of 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 obtain any PMPs and ignored the drug screen he did obtain, 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 with chronic pain medications.

6. **Patient CJL-14 years old**

A. On or about January 2, 2007, Defendant began treating Patient CJL, a **fourteen (14) year old** male, for alleged headaches and knee pain. This patient also suffered from severe epilepsy. On his first visit, Defendant prescribed the patient thirty (30) Lortab for his headaches. Six (6) weeks later, Defendant prescribed sixty (60) Lortab to the patient. Three (3) months later, while the patient was still **fourteen (14) years old**, Defendant prescribed one-hundred twenty (120) Lortab to him. Five (5) months later, the patient was fifteen (15) years old and Defendant prescribed one-hundred twenty (120) Lortab and one-hundred twenty (120) Soma to him.

B. Pharmacy records reflect that from January 2, 2007 through April 2, 2009, Defendant wrote or authorized forty-four (44) prescriptions for **4,752 dosage units** of controlled dangerous drugs to Patient CJL. These prescriptions include twenty-seven (27) prescriptions for Hydrocodone and Phenergan with Codeine, Schedule III controlled dangerous drugs for a total of **2,802 dosage units,** sixteen (16) prescriptions for Soma, a

Schedule IV controlled dangerous drug, for a total of **1,920 dosage units**, and one (1) prescription for Lonox, a Schedule V controlled dangerous drug, for an **average of 5.79 dosage units per day** of controlled dangerous drugs.

C. The patient chart contains three (3) drug screens, two (2) of which are negative for the drugs prescribed by Defendant. The chart additionally reflects that the patient was warned in advance by Defendant when drug tests would take place. Only after the third drug test where prescribed drugs were not detected was the patient discharged.

D. A review of 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 obtain any PMPs and ignored the first drug screen he did obtain, 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 with chronic pain medications.

7. **Patient SJL**

A. On or about November 28, 2006, Defendant began treating Patient SJL, the **mother of Patient CJL in paragraph 6** above, for alleged back pain. From September 25, 2007 through July 17, 2009, Defendant wrote or authorized forty-nine (49) prescriptions for a total of **7,020 dosage units** of controlled dangerous drugs to Patient SJL. These prescriptions include twenty-one (21) prescriptions for Hydrocodone, a Schedule III controlled dangerous drugs, for a total of **3,840 dosage units**, and twenty-eight (28) prescriptions for Valium, Xanax and Soma, Schedule IV controlled dangerous drugs, for a total of **3,180 dosage units**, for an **average of 10.62 dosage units per day** of controlled dangerous drugs.

B. On many visits, the patient received 240 Lortab, 120 Soma and 120 Xanax. The patient's chart contains no medical records from other providers.

C. The patient chart additionally contains multiple high blood pressure readings which Defendant never addressed. When interviewed by Board investigators, Defendant admitted that he did not address her high blood pressure because he thought it was because of her pain. He also admitted that he gave the patient too much medication.

D. A review of 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 obtain any PMPs, 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 with chronic pain medications.

8. **Patient SHL-18 years old**

A. On or about April 12, 2007, Defendant began treating Patient SHL, an **eighteen (18) year old** male, for alleged back pain. On the first visit, Defendant prescribed sixty (60) Lortab and sixty (60) Soma. The patient returned to Defendant thirteen (13) days later claiming that his medication had been stolen, so Defendant prescribed sixty (60) more Lortab to the patient.

B. The patient did not return to Defendant for eleven (11) months. When he saw Defendant on April 18, 2008, Defendant prescribed one-hundred twenty (120) Lortab, one-hundred twenty (120) Soma, and thirty (30) Ambien. One (1) month later, Defendant additionally prescribed thirty (30) Xanax, then increased it the next month to one-hundred twenty (120) for no documented reason.

C. The patient's chart contains no medical records from other providers. Defendant had no explanation as to why he significantly increased the quantities of controlled dangerous drugs prescribed to this patient.

D. From April 1, 2008 through July 10, 2009, Defendant wrote or authorized thirty-seven (37) prescriptions for a total of **4,290 dosage units** of controlled dangerous drugs and other dangerous drugs to Patient SHL. These prescriptions include twelve (12) prescriptions for Lortab, a Schedule III controlled dangerous drug, for a total of **1,440 dosage units,** and twenty-five (25) prescriptions for Xanax and Soma, Schedule IV controlled dangerous drugs, for a total of **2,850 dosage units**, for an **average of 9.23 dosage units per day** of controlled dangerous drugs.

E. A review of 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 obtain any PMPs, 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 with chronic pain medications.

9. **Patient LWL**

A. On or about April 24, 2007, Defendant began treating Patient LWL for alleged back pain, anxiety and depression. On the first visit, the patient advised Defendant that she was currently getting one-hundred twenty (120) Lortab, one-hundred twenty (120) Xanax and Cymbalta from a previous doctor. Defendant did not obtain the patient's prior medical records, nor did he confirm what medications she was receiving. Instead, he took her word for what medications she was taking and he then prescribed one-hundred twenty (120) Lortab, one-hundred twenty (120) Xanax and Cymbalta.

B. When questioned by Board investigators, Defendant admitted that merely taking the patient's word on what prescriptions she was getting when deciding what to prescribe to her was not good medical practice.

C. From April 24, 2007 through July 23, 2009, Defendant wrote or authorized eighty-four (84) prescriptions for **9,750 dosage units** of controlled dangerous drugs to Patient LWL. These prescriptions include twenty-six (26) prescriptions for Lortab, a Schedule III controlled dangerous drug, for a total of **3,600 dosage units**, and fifty-eight (58) prescriptions for Xanax, Ambien and Soma, Schedule IV controlled dangerous drugs, for a total of **6,150 dosage units**, for an **average of 11.88 dosage units per day** of controlled dangerous drugs.

D. A review of 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 obtain any PMPs, 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 with chronic pain medications.

OKLAHOMA HEALTH CARE AUTHORITY ISSUES

10. On or about January 30, 2009, Defendant was issued an Initial Notice of Quality Issues from the Oklahoma Health Care Authority ("OHCA"). Specifically, the OHCA found that with respect to controlled dangerous substances, Defendant prescribed without documented medical need, his physical examinations were inadequate, and his progress notes were not signed. OHCA found that Defendant's services did not meet medically acceptable standards of service and were not medically necessary.

11. On or about September 16, 2009, Defendant was issued a Notice of Medical Intervention and Education Team letter from the OHCA. According to the OHCA, the reviewers found that moderate or significant deviations from accepted standards of medical practice had occurred. Defendant was advised that these findings would be presented to OHCA. Defendant was invited to attend this meeting.

12. On or about October 9, 2009, Defendant met with representatives of the OHCA regarding the deficiencies in his charts and practice pattern. Based upon this meeting, Defendant executed a Corrective Action Plan on or about November 5, 2009. Under this Corrective Action Plan, Defendant agreed to correct the deficiencies regarding his prescribing of controlled dangerous substances and charting of the same.

13. Defendant failed to correct the deficiencies noted by the OHCA and on January 8, 2010, he was terminated by his employer, Midway Medical Clinic.

14. 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. Failed to maintain adequate medical records to support diagnosis, procedure, treatment or prescribed medications in violation of 59 O.S. §509 (20).

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. Issued prescriptions for narcotic or controlled drugs to minors in violation of 63 O.S. § 2601-2606 in violation of OAC 435:10-7-4(4).

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).

J. Failed to obtain informed consent, based upon full and accurate disclosure of risks, before prescribing, dispensing, or administering medical treatment for the therapeutic purpose of relieving pain in accordance with Oklahoma Administrative Code 435:10-7-11 where use may substantially increases the risk of death in violation of OAC 435:10-7-4(48).

Conclusion

WHEREFORE, the Plaintiff respectfully 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 and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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