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

IN THE MATTER OF THE APPLICATION OF	)	
DAVID WARREN DAWSON, M.D.,	)	
FOR REINSTATEMENT OF OKLAHOMA MEDICAL LICENSE NO. 17752	)	**Case No. 09-09-3836**

ORDER GRANTING REINSTATEMENT OF LICENSE UNDER TERMS OF PROBATION

This matter came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision on July 12, 2012, at the Board office, 101 N.E. 51st Street, Oklahoma City, Oklahoma 73105, pursuant to notice given as required by law and rules of the Board.

Defendant, David Warren Dawson, M.D., appeared in person and pro se.

Elizabeth A. Scott, Assistant Attorney General, appeared on behalf of the State of Oklahoma, ex rel. the Oklahoma State Board of Medical Licensure and Supervision.

The Board *en banc* heard testimony, reviewed the exhibits presented, and being fully apprised of the premises, entered the following Findings of Fact, Conclusions of Law, and Orders:

Findings of Fact

1. The Board *en banc* has jurisdiction over the subject matter herein, and notice has been given in all respects as required by law and the rules of the Board.

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 eighteen (18) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug for a total of **2,310 dosage units,** and twenty-four (24) prescription for Soma and Xanax, Schedule IV controlled dangerous drugs, for a total of **2,640 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. Midway Medical Clinic believed that Defendant failed to correct the deficiencies noted by the OHCA and on January 8, 2010, Defendant was terminated.

14. On or about December 1, 2010, the State filed its Complaint against Defendant based upon numerous narcotics laws violations.

15. On or about September 15, 2011, after hearing before the full Board, the Board issued a Final Order of Suspension whereby Defendant's license was suspended for six (6) months, during which time he was required to complete training and education on prescribing, pay all costs and fees and prior to reinstatement, he was required to personally appear before the Board to report on his training and education on prescribing.

16. Defendant is now seeking reinstatement of his Oklahoma medical license no. 17752.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to reinstate the license of a physician pursuant to 59 O.S. §508.1.

2. The Board may impose practice parameters and other restrictions as necessary to protect the health, safety and welfare of the public under 59 O.S. §480 *et seq.*

ORDER

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

1. Defendant's medical license shall be reinstated on PROBATION for a term of **THREE (3) YEARS** under the following terms and conditions:

> A. Defendant will conduct his practice in compliance with the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act as interpreted by the Oklahoma State Board of Medical Licensure and Supervision. Any question of interpretation regarding said Act shall be submitted in writing to the Board and no action based on the subject of the question will be taken by Defendant until clarification of interpretation is received by

Defendant from the Oklahoma State Board of Medical Licensure and Supervision.

B. Upon request of the Board Secretary, Defendant will request all hospitals in which he anticipates practicing to furnish to the Board Secretary of the Oklahoma State Board of Medical Licensure and Supervision a written statement regarding monitoring of his practice while performing services in or to that hospital.

C. Defendant will furnish to each and every state in which he holds licensure or applies for licensure and hospitals, clinics or other institutions in which he holds or anticipates holding any form of staff privilege or employment, a copy of the Board Order stipulating sanctions imposed by the Oklahoma State Board of Medical Licensure and Supervision.

D. Defendant will not supervise allied health professionals that require surveillance of a licensed physician.

E. Defendant shall obtain counseling for behavioral issues and communication skills at a counselor approved in advance in writing by the Board Secretary. Defendant will authorize in writing the release of any and all records of that treatment to the Board. Defendant shall continue said treatment until released by the Board and shall provide quarterly reports from his therapist to the Board Secretary for his review.

F. Defendant shall allow the Compliance Consultant or his designee to periodically review his charts to determine his prescribing practices and his compliance with this Order.

G. Defendant will not prescribe, administer or dispense any medications for personal use or for that of any family member.

H. Defendant shall attend courses on appropriate prescribing and documentation for a minimum of five (5) hours each year during the term of his probation.

I. Defendant shall obtain a primary care physician for his primary care health needs to be approved in advance in writing by the Board Secretary.

J. Defendant will keep the Oklahoma State Board of Medical Licensure and Supervision informed of his current address.

K. Defendant will keep current payment of all assessments by the Oklahoma State Board of Medical Licensure and Supervision for prosecution, investigation and monitoring of his case, which shall include but is not limited to a one hundred fifty dollar ($150.00) per month fee during the term of probation.

L. Defendant shall additionally pay the Board four hundred twenty-five dollars ($425.00) per month pursuant to his payment plan with the Board to pay off the costs and fees owed to the Board for the investigation and prosecution of this case. Defendant shall continue to pay this amount each month to the Board until all investigation and prosecution fees have been paid in full.

M. If Defendant fails to timely pay both the probation monitoring fee of $150.00 per month and the assessment for the investigation and prosecution of his case in the amount of $425.00 per month, this violation shall be considered a material breach of his probation sufficient to authorize the Executive Director to immediately suspend his license pursuant to 59 O.S. §506(B) pending full hearing on the matter.

N. Defendant's obligation to begin paying the $425.00 per month assessment for the investigation and prosecution of his case shall begin six (6) months after he is reinstated or one (1) month after he obtains employment, whichever occurs last. Defendant's obligation to pay the $150.00 per month probation monitoring fee begins immediately upon reinstatement.

O. Until such time as all indebtedness to the Oklahoma State Board of Medial Licensure and Supervision has been satisfied, Defendant will reaffirm said indebtedness in any and all bankruptcy proceedings.

P. Defendant shall make himself available for one or more personal appearances before the Board or its designee upon request.

Q. Defendant shall submit any required reports and forms on a timely, accurate and prompt basis to the Compliance Coordinator or designee.

R. Failure to meet any of the terms of this Board Order will constitute cause for the Board to initiate additional proceedings to suspend, revoke or modify Defendant's license after due notice and hearing.

S. Defendant shall not prescribe, order, administer or dispense any controlled dangerous substances.

2. A copy of this written order shall be sent to Defendant as soon as it is processed.

Dated this 12 day of July, 2012.

J Andy Sullivan, MD

Deborah Huff, M.D., President
Oklahoma State Board of Medical
Licensure and Supervision

Certificate of Service

On the 13 day of July, 2012, a true and correct copy of this order was mailed, postage prepaid, to David Dawson, 1900 Renaissance Drive, #306, Norman, OK 73071.

Shelley Crowder

Shelley Crowder