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. 06-07-3135**
JERRY DAVID WHATLEY, M.D., LICENSE NO. 19096,	)	
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, Jerry David Whatley, M.D., Oklahoma license no. 19096, 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, Jerry David Whatley, M.D., holds Oklahoma license no. 19096, and is a pediatrician practicing in Ardmore, Oklahoma.

3. A review of prescription records reveals that Defendant began treating his wife, Patient JWW, on or around January 27, 2003 and continuing through at least November 11, 2005. Prescriptions written by Defendant to Patient JWW during this time include one (1) prescription for Histinex HC, a Schedule III controlled dangerous drug, and eleven (11) prescriptions for Alprazolam, Lunesta and Carisoprodol, Schedule IV controlled dangerous drugs, for 720 dosage units. Pharmacy records reflect that Defendant wrote these prescriptions in his wife's name, as well as her maiden name. A review of Defendant's records reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient

relationship prior to prescribing the medications, and that he failed to keep any record of the prescriptions written to Patient JWW.

4. Upon being questioned by the Board's investigator, Defendant admitted that he wrote some of the prescriptions to his wife in her maiden name, knowing that he could not prescribe controlled dangerous drugs to his wife. Defendant additionally admitted that some of the Alprazolam prescriptions he wrote to his wife were for his personal use.

5. A review of prescription records reveals that on September 2, 2004, Defendant wrote a prescription to Patient JCW, his brother-in-law. The prescription was for Hydrocodone, a Schedule III controlled dangerous drug. A review of Defendant's records reveals that he failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medication, that he did not establish a valid physician patient relationship prior to prescribing the medication, and that he failed to keep any record of the prescription written to Patient JCW.

6. Upon questioning by the Board's investigator, Defendant admitted that Patient JCW may have returned some of the Hydrocodone to Defendant for his personal use.

7. A review of prescription records reveals that Defendant prescribed controlled dangerous substances to himself by writing the prescriptions to "David Coffman", a fake name. Prescriptions written by Defendant to himself include two (2) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 100 dosage units. A review of Defendant's records reveals that he failed to perform any physical examination prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient relationship prior to prescribing the medications to himself, and that he failed to keep any record of the prescriptions written to himself.

8. From August 2004 until August 2006, Defendant ordered drugs from Quest Pharmaceuticals, Inc. to be dispensed by him at his office. Drugs ordered include Alprazolam 2 mg. (4,500 dosage units), Phentermine 37.5 mg (1,400 dosage units), Nandrolone and Testosterone. Upon questioning by the Board's investigator and a DEA agent, Defendant admitted that he kept no dispensing log showing to whom these drugs were dispensed. A review of Defendant's patient charts showed no record of any dispensations of these drugs.

9. From August 2004 until August 2006, Defendant ordered Hydrocodone 10 mg. (2,500 dosage units). A review of Defendant's patient charts showed that 1,150 dosage units were unaccounted for.

10. Upon further questioning by the Board's investigator, Defendant admitted that he had taken some of the Alprazolam and Hydrocodone he had ordered from the pharmaceutical company for his personal use.

11. From March 7, 2005 until August 8, 2006, Defendant wrote or authorized thirty-three (33) prescriptions for controlled dangerous drugs to Patient MBW, one of Defendant's employees. These prescriptions include fifteen (15) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 1230 dosage units, and eighteen (18) prescriptions for Alprazolam, a Schedule IV controlled dangerous drug, for a total of 1620 dosage units. A review of Defendant's records reveals that he failed to perform any physical examination prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient relationship prior to prescribing the medications to Patient MBW, and that he failed to keep complete records of the prescriptions written. The patient chart reflects only one (1) office visit on May 30, 2006.

12. From October 31, 2005 until August 7, 2006, Defendant wrote or authorized twenty-five (25) prescriptions for controlled dangerous drugs to Patient JGW, the husband of Defendant's employee, Patient MBW. These prescriptions include one (1) prescription for Testosterone, a Schedule II controlled dangerous drug, eleven (11) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 990 dosage units, and thirteen (13) prescriptions for Alprazolam, a Schedule IV controlled dangerous drug, for a total of 1080 dosage units. A review of Defendant's records reveals that he failed to perform a complete physical examination prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient relationship prior to prescribing the medications to Patient JGW, and that he failed to keep complete records of the prescriptions written. The patient's chart reflects only one (1) office visit on June 2, 2006, which was after nineteen (19) of the prescriptions were written by Defendant to this patient.

13. From February 3, 2005 until August 1, 2006, Defendant wrote or authorized forty-nine (49) prescriptions for controlled dangerous drugs to Patient KPW, one of Defendant's employees. These prescriptions include one (1) prescription for Meperidine, a Schedule II controlled dangerous substance, for 30 dosage units, twenty-four (24) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 1080 dosage units, and twenty-four (24) prescriptions for Alprazolam and Chloral Hydrate, Schedule IV controlled dangerous drugs, for a total of 1,810 dosage units. A review of Defendant's records reveals that he failed to perform any physical examination prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient relationship prior to prescribing the medications to Patient KPW, and that he failed to keep any record of the prescriptions written to Patient KPW. Defendant kept no patient chart on Patient KPW.

14. From March 31, 2006 until July 17, 2007, Defendant wrote or authorized prescriptions for controlled dangerous drugs to Patient RGW, the boyfriend of Defendant's employee, Patient KPW. These prescriptions include four (4) prescriptions for Alprazolam, a Schedule IV controlled dangerous drug, for a total of 310 dosage units. A review of Defendant's records reveals that he failed to perform a complete physical examination prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient relationship prior to prescribing the medications to Patient RGW, and that he failed to keep complete records of the prescriptions written. The patient's chart reflects only one (1) office visit on May 16, 2006, where the patient allegedly complained of chronic knee pain and anxiety.

15. From July 14, 2005 until June 14, 2006, Defendant wrote or authorized sixteen (16) prescriptions for controlled dangerous drugs to Patient LHW, one of Defendant's employees. These prescriptions include four (4) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 270 dosage units, and twelve (12) prescriptions for Alprazolam and Diazepam, Schedule IV controlled dangerous drugs, for a total of 1,140 dosage units. A review of Defendant's records reveals that he failed to perform any physical examination prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient, that he did not establish a valid physician patient relationship prior to prescribing the medications to Patient LHW, and that he failed to keep any record of the prescriptions written to Patient LHW. Defendant admits he kept no patient chart on Patient LHW.

16. On or about February 5, 2004, Defendant wrote a prescription for Amphetamine 10 mg., a Schedule II controlled dangerous substance, to Patient MWW, his son, for a total of ninety (90) dosage units.

17. 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. 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).

C. 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).

D. Prescribed, sold, administered, distributed, ordered, or gave any drug legally classified as a controlled substance or recognized as an addictive dangerous drug to a family member or to himself or herself in violation of OAC 435:10-7-4(26).

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

G. 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).

H. Committed any act which is a violation of the criminal laws of any state when such act is connected with the physician's practice of medicine in violation of 59 O.S. § 509 (9).

I. Failed to keep complete and accurate records of the purchase and disposal of controlled drugs or of narcotic drugs in violation of 59 O.S. § 509 (10).

J. Wrote false or fictitious prescriptions for any drugs or narcotics declared by the laws of this state to be controlled or narcotic drugs in violation of 59 O.S. § 509 (11).

K. 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).

L. Purchased or prescribed any regulated substance in Schedule I through V, as defined by the Uniform Controlled Dangerous Substances Act, for the physician's personal use in violation of OAC 435:10-7-4(5).

M. Engaged in the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

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 12th day of April, 2007 at 8.00 a.m.

Respectfully submitted,

Elizabeth A. Scott

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