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. 03-12-2750**
PATRICK JOSEPH FAHEY, M.D., LICENSE NO. 20515	)	
Defendant.	)	

FINAL ORDER OF PERMANENT REVOCATION

This cause came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (the "Board") on May 11, 2006, at the office of the Board, 5104 N. Francis, Suite C, Oklahoma City, Oklahoma, pursuant to notice given as required by law and the rules of the Board.

Elizabeth A. Scott, Assistant Attorney General, appeared for the plaintiff and defendant appeared not.

The Board *en banc* after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

Findings of Fact

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.* The Board has jurisdiction over this matter, and notice has been given in all respects in accordance with law and the rules of the Board.

2. Defendant, Patrick Joseph Fahey, M.D., holds Oklahoma license no. 20515.

SEXUAL MISCONDUCT-PATIENT DCW

3. Beginning on or around September 14, 2000 and continuing through at least July 2004, Patient DCW was a patient of Defendant. Beginning in or around mid-2001, Defendant engaged in physical conduct with Patient DCW which was sexual in nature, including sexual intercourse. At the time Defendant began his sexual relationship with Patient DCW in mid-2001, she was eighteen (18) years old. Defendant engaged in the sexual conduct in his office, at his home, at apartments he leased on behalf of Patient DCW, and at a motel in Idabel, Oklahoma. Defendant engaged in these sexual acts at the same time that he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances and other dangerous drugs to this patient.

4. During the time that Defendant was treating Patient DCW and was engaging in a sexual relationship with Patient DCW, Defendant purchased two (2) automobiles for Patient DCW: a Toyota Forerunner and a 2003 Nissan Exterra. With respect to the Exterra, Defendant gave Patient DCW a check for approximately $30,000.00, which she gave to the car dealer to purchase the car. Defendant additionally paid for the insurance on the cars he bought Patient DCW. Defendant admits that he purchased the Exterra for Patient DCW. Defendant engaged in these acts at the same time that he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances to this patient.

5. During the time that Defendant was treating Patient DCW and was engaging in a sexual relationship with her, Defendant signed the lease for at least three (3) apartments for Patient DCW and purchased two (2) cellular telephones for Patient DCW's use.

6. Defendant claims that on or about September 17, 2001, he released Patient DCW as a patient. However, pharmacy records reveal that beginning December 31, 2001 and continuing through July 25, 2004, Defendant continued to prescribe controlled dangerous substances to Patient DCW. Prescriptions written by Defendant to Patient DCW after September 17, 2001 include seven (7) prescriptions for Adderall, Endocet, Percocet and Oxycodone APAP, Schedule II controlled dangerous drugs, for 360 dosage units, and seven (7) prescriptions for Diazepam and Alprazolam, Schedule IV controlled dangerous drugs, for 305 dosage units. Defendant additionally continued to prescribe or provide samples of numerous non-controlled dangerous drugs. 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 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 DCW from December 31, 2001 through July 25, 2004.

SEXUAL MISCONDUCT-PATIENT KCW

7. Beginning on or around January 14, 2003 and continuing through September 8, 2003, Patient KCW was a patient of Defendant. Patient KCW was being treated for back pain

and headaches. Beginning on or around July 24, 2003 and continuing through September 2003, Defendant engaged in physical conduct with Patient KCW which was sexual in nature, including sexual intercourse. Defendant engaged in the sexual conduct in his office, at his home, and at a conference he attended in Denver, Colorado on or about August 16-17, 2003. Defendant admits that he and Patient KCW stayed in the same hotel room at the Denver Marriott on August 16-17, 2003. Defendant engaged in these sexual acts at the same time that he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances and other dangerous drugs to this patient.

8. Prescriptions for controlled dangerous drugs written by Defendant to Patient KCW include fifteen (15) prescriptions for Mepergan Fortis, Oxycontin, Meperidine, and Endocet, Schedule II controlled dangerous drugs, for 870 dosage units, ten (10) prescriptions for Vicoprofen and Hydrocodone, Schedule III controlled dangerous drugs, for 755 dosage units, and four (4) prescriptions for Soma, Valium and Xanax, Schedule IV controlled dangerous drugs, for 210 dosage units. A review of Defendant's records reveals that he did not establish a legitimate medical need for the medications.

9. A review of Patient KCW's medical chart includes a "Follow-up Medical Evaluation" dated August 14, 2003 wherein Defendant accused Patient KCW of "inappropriate physical conduct" towards him. However, two (2) days later, on August 16-17, 2003, Defendant admits that he and Patient KCW stayed in the same hotel room at the Denver Marriott at a conference.

10. On September 15, 2003, Patient KCW broke off her relationship with Defendant. On this same date, Patient KCW's attorney hand-delivered a letter to Defendant setting forth allegations of professional misconduct.

11. Board investigators subsequently subpoenaed computer records from Defendant's office and discovered that the August 14, 2003 "Follow-up Medical Evaluation" found in Patient KCW's chart accusing her of "inappropriate physical conduct" was not created until over one month later on September 16, 2003, which was a day after Patient KCW broke off her relationship with Defendant and Defendant was made aware of Patient KCW's claims against him.

12. A review of Patient KCW's medical chart includes a "Follow-up Medical Evaluation" dated September 15, 2003 which states that Defendant allegedly released Patient KCW from his clinic on September 8, 2003.

13. Computer records obtained by Board investigators from Defendant's office reveal that the September 15, 2003 "Follow-up Medical Evaluation" where Defendant states that he released Patient KCW on September 8, 2003 was not created until September 16, 2003, which was a day after Patient KCW broke off her relationship with Defendant and Defendant was made aware of Patient KCW's claims against him.

14. On or about March 24, 2003, Defendant signed a prescription for Viagra with one (1) refill to ACW, the husband of Patient KCW described above. A review of Defendant's records reveals that he failed to perform any physical examination on this patient prior to prescribing the 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 that ACW was a patient. Defendant intended the Viagra for Patient KCW's personal use and wrote it in the name of her husband for insurance purposes.

SEXUAL MISCONDUCT-PATIENT CDW

15. Beginning on or around March 20, 2002 and continuing through at least December 2004, Patient CDW was a patient of Defendant. Beginning in or around June 2004 and continuing through September 2004, Defendant engaged in physical conduct with Patient CDW which was sexual in nature, including sexual intercourse. Defendant engaged in the sexual conduct with Patient CDW at his office. Defendant engaged in these sexual acts at the same time he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances and other dangerous drugs to this patient.

16. Prescriptions for controlled dangerous drugs written by Defendant to Patient CDW include forty-three (43) prescriptions for Roxicodone, a Schedule II controlled dangerous drug, for 4365 dosage units, eleven (11) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 590 dosage units, and forty-one (41) prescriptions for Soma, Valium, Alprazolam, Temazepam, Xanax and Migrin-A, Schedule IV controlled dangerous drugs, for 2345 dosage units.

17. Patient CDW last saw Defendant in his office in December 2004. However, on January 25, 2005, February 25, 2005, April 5, 2005 and May 25, 2005, Defendant created patient records in Patient CDW's chart to reflect that he had treated her on those dates when in fact he had not. During this time, Defendant continued to prescribe controlled dangerous drugs to Patient CDW by providing post-dated written prescriptions to her husband, who was also a patient of Defendant.

SEXUAL MISCONDUCT-PATIENT BBW

18. Beginning in or around June 2004 and continuing through November 2005, Patient BBW was a patient of Defendant. During this time, Defendant engaged in physical conduct with Patient BBW which was sexual in nature, including sexual intercourse. At the time Defendant began his sexual relationship with Patient BBW, she was nineteen (19) years old. Defendant engaged in the sexual conduct with Patient BBW at his office, at the apartment he

rented for her, and at various hotels where they stayed when traveling together. Defendant engaged in these sexual acts at the same time he was maintaining a doctor-patient relationship and prescribing controlled dangerous substances and other dangerous drugs to this patient.

19. Prescriptions for controlled dangerous drugs written by Defendant to Patient BBW between November 2004 and September 2005 include eight (8) prescriptions for Oxycodone 15 mg. and Dilaudid, Schedule II controlled dangerous drugs, for 880 dosage units, and three (3) prescriptions for Hydrocodone 10 mg., a Schedule III controlled dangerous drug, for 325 dosage units. Defendant additionally gave Patient BBW at least two (2) injections of Demerol in or around December 2004, once in an apartment he rented for her, and once during a trip he took with her to North Carolina. Defendant additionally gave Patient BBW prescriptions for other dangerous drugs, including Aviane, Maxalt and Promethazine. Defendant did not treat Patient BBW in his office, but gave her the prescriptions and injections "on the side". Defendant failed to perform any physical examination on Patient BBW prior to prescribing the controlled dangerous drugs and other dangerous drugs to her, he did not establish a legitimate medical need for the medications, and he did not establish a valid physician patient relationship prior to prescribing the medications.

20. During the time Defendant was treating Patient BBW and was engaging in a sexual relationship with her, specifically between January 13, 2005 and August 31, 2005, Defendant leased an apartment for him and Patient BBW. Defendant additionally purchased a 2005 Toyota GTF for Patient BBW.

PRESCRIBING VIOLATIONS-THE "G" FAMILY

A review of pharmacy records and patient charts reveals that Defendant wrote or authorized numerous prescriptions for controlled dangerous substances to at least **eight (8) members of the same family** during the relevant time period. As set forth below, **Patients BGW, EGW, JOGW, CGW, MGW and JEGW are brothers, AGW is the son of JOGW, and GGW is the wife of CGW.**

21. From June 19, 2001 until October 11, 2002, Defendant wrote or authorized one-hundred fifty-six (156) prescriptions for controlled dangerous drugs to Patient BGW for alleged back pain. These prescriptions include sixty (60) prescriptions for Meperidine, Tylox, Endocet, Oxycontin, Endodan, Adderall, Oxycodone and Roxicodone, Schedule II controlled dangerous drugs, for a total of 3067 dosage units, thirty-seven (37) prescriptions for Hydrocodone and Fioricet/Codeine, Schedule III controlled dangerous drugs, for a total of 2625 dosage units, and fifty-nine (59) prescription for Soma, Alprazolam, Diazepam, Xanax and Phentermine, Schedule IV controlled dangerous drugs, for a total of 3105 dosage units, for an average of **17.66 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 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 with no documentation other than the patient's intake form.

22. From August 23, 2001 until April 15, 2003, Defendant wrote or authorized one-hundred sixty-six (166) prescriptions for controlled dangerous drugs to Patient EGW for alleged chronic pain. These prescriptions include sixty-nine (69) prescriptions for Methadone, Oxycontin, Adderall and Roxicodone, Schedule II controlled dangerous drugs, for a total of 4606 dosage units, forty-three (43) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 3694 dosage units, and fifty-four (54) prescriptions for Soma, Xanax and Temazepam, Schedule IV controlled dangerous drugs, for 2406 dosage units, for an average of **17.07 dosage units per day of controlled dangerous drugs.** On or about July 2, 2002, Defendant was advised by another physician that Patient EGW had been released from his care due to obtaining pain medications from multiple physicians. Defendant nevertheless continued to prescribe controlled dangerous drugs to Patient EGW. 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 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 with no documentation other than the patient's intake form. **Patient EGW died on December 5, 2003 from Methadone Toxicity.**

23. From May 5, 2002 until October 14, 2004, Defendant wrote or authorized one-hundred fifty (150) prescriptions for controlled dangerous drugs to Patient AGW for alleged shoulder pain. These prescriptions include ninety-eight (98) prescriptions for Methadone, Roxicodone, Oxycontin, Oxycodone, Adderall and Duragesic Patch, Schedule II controlled dangerous drugs, for a total of 6630 dosage units, forty-eight (48) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 4710 dosage units, and four (4) prescriptions for Soma, Valium and Temazepam, Schedule IV controlled dangerous drugs, for 130 dosage units, for an average of **12.60 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 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 with no documentation other than the patient's intake form.

24. From January 8, 2003 until November 4, 2003, Defendant wrote or authorized sixty-one (61) prescriptions for controlled dangerous drugs to Patient JOGW for alleged shoulder pain. These prescriptions include thirty-four (34) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 2158 dosage units, and twenty-seven (27) prescriptions for Soma and Valium, Schedule IV controlled dangerous drugs, for 1200 dosage units, for an average of

10.87 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 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.

25. From March 5, 2002 until September 23, 2004, Defendant wrote or authorized one-hundred and one (101) prescriptions for controlled dangerous drugs to Patient CGW for alleged lower back pain. These prescriptions include nine (9) prescriptions for Morphine, Oxycontin and Roxicodone, Schedule II controlled dangerous drugs, for 405 dosage units, thirty-two (32) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 3337 dosage units, and sixty (60) prescriptions for Soma and Xanax, Schedule IV controlled dangerous drugs, for 4710 dosage units, for an average of **9.26 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 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 claims that he performed a facet injection, but he did not document the procedure in the patient's chart.

26. From January 30, 2003 until April 12, 2004, Defendant wrote or authorized fifty-two (52) prescriptions for controlled dangerous drugs to Patient MGW for alleged lower back pain. These prescriptions include four (4) prescriptions for Adderall, a Schedule II controlled dangerous drug, for 240 dosage units, twenty-three (23) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 1922 dosage units, and twenty-five (25) prescriptions for Valium, a Schedule IV controlled dangerous drug, for 1260 dosage units, for an average of **9.32 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals 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.

27. From April 14, 2004 until September 30, 2004, Defendant wrote or authorized thirteen (13) prescriptions for controlled dangerous drugs to Patient JEGW for alleged lower back pain. These prescriptions were for Roxicodone, Oxycontin, Oxycodone and Adderall, Schedule II controlled dangerous drugs, for 1345 dosage units, for an average of **7.69 dosage units per day of controlled dangerous drugs.** Defendant's chart contains no documentation of disease and includes a diagnosis of ADD without any substantiation. 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 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.

28. From November 14, 2002 until September 23, 2004, Defendant wrote or authorized thirty-seven (37) prescriptions for controlled dangerous drugs to Patient GGW for alleged chronic pain from old scars. These prescriptions include twenty-six (26) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 3132 dosage units, and eleven (11) prescriptions for Xanax and Restoril, Schedule IV controlled dangerous drugs, for 330 dosage units, for an average of **5.10 dosage units per day of controlled dangerous drugs**. Defendant's chart reflects that he made no physical or objective findings other than the patient's claim of "painful scars". 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 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.

PRESCRIBING VIOLATIONS-OTHER PATIENTS

29. From May 23, 2002 until July 18, 2002, Defendant wrote or authorized nine (9) prescriptions for controlled dangerous drugs to Patient MAW for alleged lower back pain. These prescriptions were for Hydrocodone, a Schedule III controlled dangerous drug, for 360 dosage units, and Soma and Xanax, Schedule IV controlled dangerous drugs, for 420 dosage units, for an average of **13.93 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 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. **Patient MAW died on July 20, 2002 due to Acute Hydrocodone Intoxication.**

30. From November 8, 2002 until January 31, 2003, Defendant wrote or authorized sixteen (16) prescriptions for controlled dangerous drugs to Patient RGW for alleged lower back pain. These prescriptions include one (1) prescription for Roxicodone, a Schedule II controlled dangerous drug, for 60 dosage units, five (5) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 510 dosage units, and ten (10) prescriptions for Soma and Valium, Schedule IV controlled dangerous drugs, for 540 dosage units, for an average of **13.21 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 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.

31. From November 12, 2002 until January 31, 2003, Defendant wrote or authorized thirteen (13) prescriptions for controlled dangerous drugs to Patient TGW, **the wife of Patient**

RGW described above, for alleged lower back pain and leg pain. These prescriptions include five (5) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 450 dosage units, and eight (8) prescriptions for Soma and Diazepam, Schedule IV controlled dangerous drugs, for 465 dosage units, for an average of **11.02 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 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 contains no documented physical findings.

32. From February 19, 2002 until April 27, 2004, Defendant wrote or authorized one-hundred thirty-three (133) prescriptions for controlled dangerous drugs to Patient SPW for alleged back pain. These prescriptions include seventy (70) prescriptions for Roxicodone, Oxycontin, Adderall and Oxycodone, Schedule II controlled dangerous drugs, for 5710 dosage units, nine (9) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 686 dosage units, and fifty-four (54) prescriptions for Ambien, Soma, Restoril, Xanax, Midrin, Valium, Phentermine, Ionamin and Migrin-A, Schedule IV controlled dangerous drugs, for 2315 dosage units, for an average of **10.92 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 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. Patient SPW was treated for over two (2) years with narcotic pain medications without a confirmed diagnosis.

33. On or about September 30, 2002, Defendant signed a prescription for Serafem to SHPW, **the wife of Patient SPW described above.** On or about January 27, 2003, Defendant signed a prescription for Xanax, a Schedule IV controlled dangerous drug, to SHPW, and on or about April 28, 2003, Defendant signed a prescription for Ambien, a Schedule IV controlled dangerous drug, to SHPW. A review of Defendant's records reveals that he failed to perform any physical examination on this patient prior to prescribing the 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 that SHPW was a patient.

34. From June 3, 2003 until July 31, 2003, Defendant wrote or authorized twenty-two (22) prescriptions for controlled dangerous drugs to Patient CWW for alleged back pain. These prescriptions include eight (8) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 384 dosage units, and fourteen (14) prescriptions for Carisoprodol and Clonazepam, Schedule IV controlled dangerous drugs, for 578 dosage units, for an average of **13.00 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 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. **Patient CWW died on August 23, 2003 from the Toxic Effects of Hydrocodone, Carisoprodol and Acetaminophen.**

35. From January 28, 2004 until February 24, 2004, Defendant wrote or authorized four (4) prescriptions for controlled dangerous drugs to Patient MSW for alleged lower back pain. These prescriptions include two (2) prescriptions for Methadone and Avinza, Schedule II controlled dangerous drugs, for 45 dosage units, and two (2) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 75 dosage units, for an average of **4.44 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 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. **Patient MSW died on February 28, 2004 from Methadone Toxicity.**

36. From June 20, 2001 through September 7, 2004, Defendant wrote or authorized two-hundred twenty-six (226) prescriptions for controlled dangerous drugs to Patient THW for alleged leg pain. These prescriptions include one-hundred sixty-four (164) prescriptions for Methadone, Oxycontin, Oxycodone, Duragesic Patch, and Endocet, Schedule II controlled dangerous drugs, for 6636 dosage units, four (4) prescriptions for Hydrocodone and Testosterone, Schedule III controlled dangerous drugs, for 225 dosage units, and fifty-eight (58) prescriptions for Ambien, Restoril, Midrin and Alprazolam, Schedule IV controlled dangerous drugs, for 889 dosage units, for an average of **6.60 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 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 frequently refilled prescriptions for Methadone and Oxycontin after four (4) to five (5) days.** Defendant also gave Patient THW testosterone injections with no documented diagnosis.

37. On or about April 23, 2002, Defendant signed a prescription for Xanax, a Schedule IV controlled dangerous drug, to SHW, **the wife of Patient THW described above.** On or about May 7, 2002, Defendant signed a prescription for Xanax, a Schedule IV controlled dangerous drug, to SHW. A review of Defendant's records reveals that he failed to perform any physical examination on this patient prior to prescribing the 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 that SHW was a patient.

38. From February 21, 2002 until November 25, 2003, Defendant wrote or authorized fifty-nine (59) prescriptions for controlled dangerous drugs to Patient DYW for a fractured wrist. These prescriptions include fifty-seven (57) prescriptions for Oxycontin and Roxicodone, Schedule II controlled dangerous drugs, for 4320 dosage units, and two (2) prescriptions for Xanax and Midrin, Schedule IV controlled dangerous drugs, for 90 dosage units, for an average of **6.87 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 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. On November 25, 2003, Defendant noted in his chart that Patient DYW had tested positive on a drug screen and admitted to cocaine use. Defendant did not refer Patient DYW for any treatment and he prescribed Roxicodone, a Schedule II controlled dangerous drug, to her on this date.

39. From January 9, 2003 until August 4, 2004, Defendant wrote or authorized thirty-eight (38) prescriptions for controlled dangerous drugs to Patient KWW for alleged fibromyalgia. These prescriptions include twenty-four (24) prescriptions for Oxycodone and Oxycontin, Schedule II controlled dangerous drugs, for 1865 dosage units, four (4) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for 120 dosage units, and ten (10) prescriptions for Alprazolam and Diazepam, Schedule IV controlled dangerous drugs, for 600 dosage units, for an average of **4.51 dosage units per day of controlled dangerous drugs.** On May 22, 2003, Defendant noted in the patient's chart that he was monitoring her for drug dependency. On June 12, 2003, Defendant released Patient KWW as a patient, offered to assist her in finding a narcotics detoxification program, and stated that he could no longer prescribe any controlled dangerous drugs to her. However, according to the patient's chart and pharmacy records, Defendant continued to prescribe controlled dangerous drugs to her for fourteen (14) months after he discharged her. 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 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.

MEDICAID FRAUD UNDERCOVER AGENT -PATIENT TAW

40. On February 10, 2004, the Federal Bureau of Investigation, the Drug Enforcement Agency, the Medicaid Fraud Control Unit of the Oklahoma Attorney General's Office and the Oklahoma State Board of Medical Licensure and Supervision conducted a joint undercover investigation of the Defendant. An Undercover Investigator from the Medicaid Fraud Control Unit of the Oklahoma Attorney General's Office posed as "Patient TAW" and sought medical treatment from Defendant. Patient TAW advised Defendant that her chief complaint was the need for a prescription and a new doctor. Patient TAW listed sleeplessness and headaches as

prior complaints, but indicated no current pain. She advised Defendant that she had been taking Lortab and Oxycontin obtained from a friend. Defendant conducted no physical exam at that time. Defendant gave Patient TAW prescriptions for Oxycontin 20 mg., a Schedule II controlled dangerous drug, for 30 dosage units, Midrin, a Schedule IV controlled dangerous drug, for 60 dosage units, and Flexeril, a non-controlled drug, for 30 dosage units. 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 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.

41. On March 3, 2004, Patient TAW returned to Defendant for a follow-up appointment. Patient TAW indicated no current pain, and indicated sleeplessness and headaches as her complaint on the patient questionnaire. Defendant conducted no physical exam at that time. Defendant then gave Patient TAW prescriptions for Oxycontin 20 mg., a Schedule II controlled dangerous drug, for 60 dosage units, and Restoril, a Schedule IV controlled dangerous drug, for 30 dosage units. 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 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.

42. On April 5, 2004, Patient TAW returned to Defendant for a follow-up appointment. Patient TAW indicated no current pain, and indicated sleeplessness and headaches as her complaint on the patient questionnaire. At this time, Patient TAW spoke with Defendant about Patient SCW, her alleged "sister-in-law" whom she had referred to Defendant for treatment after sharing her Oxycontin with her. Defendant left the exam room and returned with Patient SCW's patient chart. He showed Patient TAW portions of Patient SCW's patient chart and discussed confidential physician/patient conversations he had had with Patient SCW with Patient TAW. He also discussed Patient SCW's medical treatment with Patient TAW. Patient TAW advised Defendant that she had run out of her Oxycontin because she had shared it with her alleged sister-in-law. Defendant conducted no physical examination at that time. Defendant then gave Patient TAW prescriptions for Oxycontin 20 mg., a Schedule II controlled dangerous drug, for 90 dosage units, and Xanax, a Schedule IV controlled dangerous drug, for 60 dosage units. 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 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.

43. 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 physical conduct with a patient which is sexual in nature, or in any verbal behavior which is seductive or sexually demeaning to a patient in violation of 59 O.S. §509 (17).

C. Committed an act of sexual abuse, 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, manipulation or fraudulent representation 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) and OAC 435:10-7-4(41).

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

H. Engaged in predatory sexual behavior in violation of OAC 435:10-7-4(45).

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

J. 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).

K. 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).

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

M. 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).

N. Used 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).

O. Except as otherwise permitted by law, prescribed, sold, administered, distributed, ordered, or gave to a habitué or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug in violation of OAC 435:10-7-4(25).

P. Willfully betrayed a professional secret to the detriment of the patient in violation of 59 O.S. 509(3) and OAC 435:10-7-4(14).

Conclusions of Law

1. The Board has jurisdiction and authority over the Defendant and subject matter herein pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act") and its applicable regulations. The Board is authorized to enforce the Act as necessary to protect the public health, safety and welfare.

2. Defendant is guilty of unprofessional conduct as follows:

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, or in any verbal behavior which is seductive or sexually demeaning to a patient in violation of 59 O.S. §509 (17).

C. Committed an act of sexual abuse, 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, manipulation or fraudulent representation 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) and OAC 435:10-7-4(41).

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

H. Engaged in predatory sexual behavior in violation of OAC 435:10-7-4(45).

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

J. 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).

K. 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).

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

M. 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).

N. Used 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).

O. Except as otherwise permitted by law, prescribed, sold, administered, distributed, ordered, or gave to a habitué or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug in violation of OAC 435:10-7-4(25).

P. Willfully betrayed a professional secret to the detriment of the patient in violation of 59 O.S. 509(3) and OAC 435:10-7-4(14).

3. The Board further found that the Defendant's license should be permanently revoked without the right to reapply based upon any or all of the violations of the unprofessional conduct provisions of 59 O.S. §509 (3), (8), (11), (12), (13), (16), (17) and (18), and OAC 435:10-7-4 (1), (2), (6), (11), (14), (19), (23), (25), (27), (39), (41), (44) and (45).

Order

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

1. The license of Defendant, Patrick Joseph Fahey, M.D., Oklahoma license no. 20515, is hereby **PERMANENTLY REVOKED** without the right to reapply as of the date of this hearing, May 11, 2006.

2. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and costs, investigation costs, staff time, salary and travel expenses, witness fees and attorney's fees.

Dated this 12 day of May, 2006.

Gerald C. Zumwalt, M.D., Secretary
Oklahoma State Board of Medical
Licensure and Supervision

CERTIFICATE OF SERVICE

I certify that on the 15 day of May, 2006, I mailed, via first class mail, postage prepaid, a true and correct copy of this Order to Michael R. Green, 3739 E. 31st Street, Tulsa, OK 74135-1506, Linda G. Scoggins, Scoggins & Cross, 204 N. Robinson, Suite 3100, Oklahoma City, OK 73102 and to Patrick Fahey, P.O. Box 470385, Tulsa, OK 74147-0385.

Janet Swindle