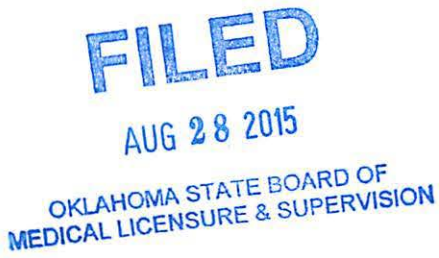
IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA, *ex rel.* THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 12-05-4543**
GEORGE B. HOWELL, SR., M.D., LICENSE NO. 27533,	)	
Defendant.	)	

ORDER OF REVOCATION OF LICENSE

This matter came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (herein referred to as "State" or "Board") on July 23, 2015, 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, the Oklahoma Administrative Procedures Act, 75 O.S. §§ 250-323 and the Oklahoma Open Meetings Act, 25 O.S. §§ 301-314.

George B. Howell, Sr., M.D. ("Defendant"), appeared in person. Mrs. Howell, wife of Dr. George B. Howell, appeared in support of Defendant.

Jason T. Seay and Joseph L. Ashbaker, Assistant Attorneys General, appeared on behalf of the State of Oklahoma, *ex rel.* the Oklahoma State Board of Medical Licensure and Supervision.

The Board *en banc*, after hearing the parties' arguments, hearing the sworn testimony of witnesses, reviewing the exhibits admitted 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:

Jurisdiction, Findings of Fact and Conclusions of Law

1. The Defendant holds Oklahoma Medical License No. 27533. At the time of the events in question, the Defendant practiced pain management at the Wellness Clinic of Roland, located in Roland, Oklahoma. The acts and omissions discussed herein occurred while the Defendant was acting as a physician pursuant to his medical license conferred upon him by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma. The Board possesses jurisdiction and authority over the Defendant and subject matter herein pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act ("Act") and its applicable regulations, 59 O.S. 2011 § 480, *et seq.* The Board is

authorized to enforce the Act as necessary to protect the public health, safety and welfare. Notice was given in all respects in accordance with law and the rules of the Board.

SUMMARY OF THE PERTINENT EVIDENCE

2. On August 1, 2014 the Board filed a Complaint against the Defendant for violations related to the Defendant's prescribing of controlled and dangerous substances ("CDS") from the Wellness Clinic, located in Roland, Oklahoma, near the Arkansas border. The Wellness Clinic was known as a "pill mill" for CDS.

3. The Defendant was a salaried employee of the Wellness Clinic ("Clinic"), owned by Bernard Tougas, P.A. ("P.A. Tougas"). P.A. Tougas also functioned as the clinic's principal agent and managing partner. P.A. Tougas was the Defendant's employer. P.A. Tougas, under the Defendant's supervision, sought to continually increase the number of patients seeking addictive pain killing drugs at the Clinic.

4. The following exhibits were introduced and admitted at the hearing on July 23, 2015, and reviewed and considered by the Board in rendering its decision:

a. State Exhibit 1: Medical Records of Patient M.T. (redacted) (Bates Nos. HOWELL, G. 000005-000315);

b. State Exhibit 2: Medical Records of Patient C.M. (redacted) (Bates Nos. HOWELL, G. 000319-000669);

c. State Exhibit 3: Medical Records of Patient B.B. (redacted) (Bates Nos. HOWELL, G. 000673-000881);

d. State Exhibit 4: Medical Records of Patient T.C. (redacted) (Bates Nos. HOWELL, G. 000885-001048);

e. State Exhibit 5: Medical Records of Patient G.T. (redacted) (Bates Nos. HOWELL, G. 001052-001159);

f. State Exhibit 6: Medical Records of Patient S.T. (redacted) (Bates Nos. HOWELL, G. 001163-001487);

g. State Exhibit 7: Voluntary Surrender of Controlled Substances Privileges (U.S. Department of Justice, Drug Enforcement Administration), executed by Dr. George Howell, MD, on February 21, 2014 (Bates No. MYERS001174);

h. State Exhibit 8: Voluntary Surrender of Controlled Dangerous Substances Privileges (Oklahoma Bureau of Narcotics and Dangerous Drugs Control), executed by Dr. George Howell, MD, on February 21, 2014 (Bates No. MYERS001175);

i. State Exhibit 9: Sixty-one (61) pages of copies of multi-scripts from National Family Pharmacy in Ft. Smith, Arkansas, with patient identifiers redacted (Bates Nos. HOWELL, G. 001488-001548); and

j. State Exhibit 10: CD of National Family Pharmacy in Ft. Smith, Arkansas, record of 32,160 prescriptions for CDS written by the Defendant filled at the National Family Pharmacy, with patient identifiers redacted (Bates Nos. HOWELL, G. 001553-002395).

TESTIMONY OF ROBERT DUVALL

5. Robert Duvall, the Board's Chief Investigator, was called as a witness for the State. He testified regarding the Board investigation in the instant case. In particular, he testified as to the complaints received by the Board about the practitioners of the Wellness Clinic in Roland. These complaints were from family members concerning the possibility of overprescribing by the practitioners at the Roland Clinic to the complainants' respective family members. The Board also received complaints from medical professionals, pharmacies and physicians, about the prescribing practices. The Board's investigation of the practitioners at the Wellness Clinic began in 2013. Duvall verified that State Exhibit Nos. 1 through 6 are true and accurate copies of six medical records obtained by the Board by way of administrative subpoena issued to the Wellness Clinic, with patient identifiers redacted.

TESTIMONY OF CHRIS SMITH

6. Chris Smith is the Agent in Charge of Diversion for the Oklahoma Bureau of Narcotics and Dangerous Drugs ("AIC Smith"). He is in charge of the diversion of CDS investigations conducted by the OBNDD. AIC Smith investigated the Defendant and his prescribing practices. AIC Smith testified to certain "red flags" he looks for in investigations as *indicia* of CDS violations:

> [T]he first things, you know, as a narcotic agent, we're always listening to what the information is, as you might, if you will, on the street, what informants might tell you, what other law enforcement professionals might tell you about certain things going on. That's one thing. Other things in diversion, we'll look at – we'll analyze data and prescription data of patients and doctors to see how much is being prescribed, what quantities are being prescribed, and what types of drugs are being prescribed. That's another thing. Then we will look at the history or backgrounds of the professional, our registrants. Then we'll look at probably the background and history of some of the patients. Then we'll look at – one of the big red flags is how far are these patients willing to travel to a certain doctor's office to obtain their controlled substances.

Hearing Trans. at 30:17-31:13.

7. AIC Smith testified that local law enforcement in the Northeastern Oklahoma area reported to him that a lot of prescription medications found "on the street" were coming from the Wellness Clinic. He made inquiry with the Board agents as to whether any complaints were filed against the practitioners of the Wellness Clinic, and confirmed with one of his agents that

many medications found "on the street" were being prescribed by the practitioners at the Wellness Clinic. AIC Smith then contacted Fort Smith Police Officer Paul Smith, who advised AIC Smith that the city was undergoing a "severe prescription drug problem" and many of the prescription drugs found "on the street" were prescribed by practitioners at the Wellness Clinic.

8. AIC Smith then contacted the Oklahoma Pharmacy Board concerning any complaints made regarding the Wellness Clinic. The Pharmacy Board advised him that it

> had received some complaints from some of the pharmacies in the area, particularly that there were a lot of opiates being prescribed from the Wellness Clinic to the point that many of the pharmacies were being warned by their distributors, their wholesalers, that they were selling too much of their allotment per month and that they were going to be cut off by their wholesaler and reported to DEA for selling so many opiates.

Hearing Trans. at 34:2-12.

9. As part of this investigation, AIC Smith interviewed the Defendant on January 30, 2014, along with Board Investigator S.W. AIC Smith explained the reason for the interview to the Defendant and stated it appeared the Defendant prescribed a high number of opiates. In response, the Defendant stated to AIC Smith that many people build up an opiate tolerance so drug strength and dosage units must be increased for patients. When asked about the fact that some patients of the Wellness Clinic had died from drug overdoses, the Defendant responded that he was aware of them "'and it concerned him a little,' and that was a quote." *Id.* at 36:14-15. The Defendant never discussed reduction of CDS dosages for his patients with AIC Smith.

10. AIC Smith affirmed that State Exhibit Nos. 7 and 8 are respectively copies of the voluntary surrender of DEA and OBNDD licenses executed by the Defendant.

11. AIC Smith affirmed that State Exhibit No. 9 consists of true and accurate copies of prescriptions, with patient identifiers redacted, that the OBNDD obtained from the DEA, who in turn obtained the prescriptions from the National Family Pharmacy in Ft. Smith Arkansas. All the prescriptions bear the Defendant's signature and DEA number. AIC Smith pointed to a prescription for Patient M.A. contained in Exhibit 9, which, on the same prescription form, listed seven prescriptions, including the following CDS: Oxycontin 80 mg., 112 count; Oxycontin 60 mg, 112 count; Oxycodone 30 mg., 168 count; Valium 10 mg, 168 count; Ambien 10 mg., 28 count; and Ambien 5 mg., 28 count. This prescription was for a twenty-eight day supply of drugs. AIC Smith confirmed that every single prescription form in Exhibit 9 combined prescriptions for multiple CDS and other substances on to a single prescription form, which is a violation of OBNDD prescribing regulations regarding CDS. AIC Smith counted 332 such prescription forms executed by the Defendant in violation of OBNDD prescribing regulations regarding CDS.

12. AIC Smith verified that State Exhibit No. 10 is a true and accurate copy of the printout received by OBNDD of the Defendant's patients that obtained CDS from the Nation Family Pharmacy in Ft. Smith, Arkansas, from January 2011 through January 2014. Exhibit 10 is 847 pages long and shows 32,160 prescriptions for CDS written by the Defendant and filled at

this single pharmacy in Arkansas. Exhibit 10 shows that 3,511,053 CDS dosage units were prescribed by the Defendant and filled at this Pharmacy alone between January 2011 and January 2014. AIC Smith testified that the quantum and quality of CDS illustrated by this prescribing record from a single pharmacy, along with the unlawful multiple prescriptions demonstrated by State Exhibit No. 9, raises serious "red flags" from an investigator's standpoint that CDS diversion was occurring and the Defendant was participating in the diversion of CDS.

TESTIMONY OF LARRY CARTER

13. Board investigator Larry Carter explained he has been an investigator for the Board for about one year. Prior to serving in that capacity, Carter was an Agent in Charge of the prescription drug diversion unit for the Oklahoma City area for the OBNDD. He has 20 years of experience investigating prescription drug diversion. Carter testified that he interviewed the Defendant at the Board's offices on December 11, 2014, for a couple of hours. During the interview, the Defendant told Carter:

> [The Defendant] learned about pain management working for Dr. Brackman in Arkansas back in around 2000 and that he learned everything he knew about pain management from him, "him" being Brackman; that Dr. Brackman died about 12 years ago. Since then, he's gone into family practice and back into pain management, but he [the Defendant] always – he seems to like pain management. He enjoys that practice, and he has kind of taken to it because he feels that that's an underserved area of the medical community.
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> [The Defendant] said that it was common practice for PA Tougas to bring prescriptions in for patients of the clinic and have Dr. Howell sign off on them specifically for Schedule II prescriptions because PAs cannot prescribe Schedule II drugs, and so this happened with – it was fairly routine, apparently. We asked him if he was – if he saw these patients before he actually signed the prescriptions or reviewed any of the notes, and he told us no, he did not; that Dr. Howell trusted PA Tougas to judge the medical condition of patients appropriately, and he believed that his medical assessment was appropriate to the prescriptions that were being issued.

Hearing Trans. at 52:10-20; 53:3-17. Carter also testified that the Defendant stated that he did not supervise P.A. Tougas.

14. Carter testified that a number of statements made by the Defendant during his interview raised several "red flags" from an investigator's point of view as it relates to the frequency which the Defendant prescribed CDS, the dosage amounts, the number of dosages, the types of drugs, and the large volume of patients seen by the Defendant, which was between 50 and 60 patients per day; the Defendant claimed he saw each patient for 10 to 15 minutes. Carter testified that the amount of time the Defendant claimed to have seen patients appeared incredulous, as such would require the Defendant to work nonstop 8 to 10 hours per day just

seeing patients. The Defendant told Carter that the Wellness Clinic only accepted cash from patients and did not take insurance.

TESTIMONY OF DR. RICHARD BRITTINGHAM

15. Dr. Richard Brittingham testified on behalf of the State as an expert witness. He received his bachelor's degree in psychology from the University of California at Santa Barbara and received his Doctor of Medicine from the University of Oklahoma in 1990. Dr. Brittingham became board certified in internal medicine in 1994 and was recertified in 2004. He became board certified in hospice and palliative medicine in 2010. He is employed by the Comanche County Hospital and also maintains a private medical practice. Before medical school, Dr. Brittingham enlisted in the U.S. Marine Corps. He served in the Vietnam War from 1967 to 1968. He left active duty in 1970. In 1990, Dr. Brittingham became a commissioned medical officer. He served as the Oklahoma National Guard's Medical Officer from 1990 to 2009. He retired at the rank of Colonel.

16. Dr. Brittingham testified that his primary practice area is internal medicine and palliative medicine. He routinely sees chronic pain patients, and he is familiar with the standard of care regarding pain management with chronic pain patients. Dr. Brittingham was asked to serve as an expert witness by the State and is paid per the terms of contract for his testimony. He is not a competitor of the Defendant. Dr. Brittingham is qualified to render an expert opinion in this matter regarding the standard of care rendered by the Defendant to the patients identified in State Exhibit Nos. 1 through 6.

17. Dr. Brittingham reviewed six patient charts, State Exhibit Nos. 1 through 6, at the request of the State and he rendered a professional opinion at the hearing as to the practice of medicine reflected in those charts.

18. With respect to the State Exhibit Nos. 1-6, Dr. Brittingham's opinion can be summed up with by his following testimony:

> [T]he chart[s], in my opinion, failed to even meet minimum standards of care. . . . First, as to evaluation of the patient, it was my opinion that the evaluation was minimal. There was no evidence, in some cases, where an examination had even been performed. For a period of time, the notes in the chart were handwritten notes, which were very difficult to read, and for the most part, illegible. There was no evidence, in my opinion, that the evaluation of the patient was thorough. For example, patients that had chronic pain – and all of them did – there could have been many, many reasons other than just chronic pain, *per se*, as to what was going on with that patient. Some of them might have had low back pain from a slipped disc, but it might have been from cancer as well, and the radiographic – there was very little by way of radiographic studies or blood studies to rule out various disease processes. I considered all of that part of the evaluation standard. In terms of a treatment plan, it seemed to me, in evaluating this case, that the treatment was narcotics and benzodiazepines. There was no other treatment given, and that, I think, is inappropriate. The informed consent and agreement, I have to say that in practically every chart that I reviewed, I saw a written –

basically, a standardized contract that was signed by the patient, and in some cases, there were three or four contracts signed at various different times.

As far as periodic review, if we are going to prescribe high doses of narcotics and benzodiazepines and dangerous substances to patients, we have an obligation to provide clinical surveillance to make sure that the patient is, number one, taking the medicine that they are supposed to be taking, and number two, that they are not diverting the medications that are being prescribed for them. So that periodic review, to me, means that you're evaluating the patient, are you taking the medication appropriately, is it working and so forth, and I didn't find much evidence in that regard either.

Hearing Trans. at 73:7-75:14.

19. Dr. Brittingham also observed in Exhibits 1 through 6, that no attempts were made to mitigate pain through alternative means. Treatment was by CDS alone. He observed no attempt to decrease CDS dosages by the Defendant. Each chart reflected the Defendant continually increased CDS dosages without medical necessity. Dr. Brittingham also observed that several charts evidenced prescription drug and pain management contract non-compliance by patients, which were never addressed by the Defendant.

20. Overall, Dr. Brittingham testified that the prescribing evidenced by State Exhibit Nos. 1 through 6 was excessive, unsafe and reflected a danger to the patients and the public. He testified that none of the Board's standards for chronic pain management, stated in Okla. Admin. Code § 435:10-7-11, were adhered to by the Defendant in rendering care to the patients as reflected in State Exhibit Nos. 1 through 6.

21. Dr. Brittingham's testimony, and the charting reflected in State Exhibit Nos. 1 through 6, establishes that CM, the Defendant's patient, died of combined opioid toxicity. BB, the Defendant's patient, died of combined acute drug toxicity. TC, the Defendant's patient, died of unknown causes. GT, the Defendant's patient, died of acute combined drug toxicity. This evidence further establishes that the Defendant rendered unprofessional care to each of these patients by, among other things, prescribing CDS with little or no examination or evidence of examination being performed, ignoring warning signs of abuse of CDS and noncompliant, and failing to adhere to the minimum standard of care in rendered chronic pain treatments to these patients.

22. Dr. Brittingham also reviewed State Exhibit 9 and opined that such prescriptions were illegal and reflected dangerous combinations of CDS. Dr. Brittingham's testimony and opinions are reliable and helpful in determining whether the Defendant appropriately prescribed CDS to the patients identified in State Exhibits Nos. 1 through 6 and as to whether the drug combinations reflected in the prescriptions in State Exhibit 9 are medically appropriate.

TESTIMONY OF THE DEFENDANT

23. The Defendant testified that he had many patients from out-of-state – from "all the different states." *Hearing Trans.* at 99:4-5. He knew the patients very well. The Defendant admitted to signing off on prescriptions written by P.A. Tougas without seeing patients,

reviewing patient charts, or questioning P.A. Tougas about the prescriptions. The Defendant concluded his testimony with the following: "[a] few years back, if I had heard someone was prescribing like I prescribed, I would have thought that he was a wild man, but that's not the case, and I don't believe that anymore." *Id.* at 100:3-6.

VIOLATIONS

24. Based on the evidence introduced at the hearing, the Board *en banc* found the Defendant guilty by clear and convincing evidence of unprofessional conduct as follows:

a. Prescribing or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship, in violation of 59 O.S. 2011, § 509(12);

b. Engaging in dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public, in violation of 59 O.S. 2011, § 509(8) and Okla. Admin. Code § 435:10-7-4(11);

d. Prescribing, dispensing or administering of controlled substances or narcotic drugs in excess of the amount considered good medical practice, or prescribing, dispensing or administering controlled substances or narcotic drugs without medical need in accordance with published standards, in violation of 59 O.S. 2011, § 509(16) and Okla. Admin. Code §§ 435:10-7-4(2), (6), (24);

e. Failing 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. 2011, § 509(18);

g. Failing to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act and maintaining adequate medical records to support diagnosis, procedure, treatment or prescribed medications, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

h. Engaging in the indiscriminate or excessive prescribing, dispensing or administering of Controlled or Narcotic drugs, in violation of Okla. Admin. Code § 435:10-7-4(1);

j. Engaging in gross or repeated negligence in the practice of medicine and surgery, in violation of Okla. Admin. Code § 435:10-7-4(15);

n. Violating OBN rules and regulations regarding CDS on at least 62 different occasions, in violation of Okla. Admin. Code § 435:10-7-4(27); and

o. Failing to properly supervise P.A. Tougas, impermissibly permitting P.A. Tougas to issue prescriptions or orders for drugs the Defendant is not

permitted to prescribe, and knowingly allowing or participating with P.A. Tougas in the negligence of P.A. Tougas' practice as a physician assistant, in violation of Okla. Admin. Code §§ 435:10-7-4(27), 435:15-5-1(b)(1)-(5), (7), 435:15-5-10(e), 435:15-5-11(a)(4), (b).

Orders

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

1. The medical license of Defendant, George B. Howell, Sr., M.D., Oklahoma license no. 27533, is hereby **REVOKED** as of the date of the hearing, July 23, 2015.

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; and

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

Dated this 28th day of August, 2015.

Billy H. Stout, M.D., Board Secretary
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

Certificate of Mailing

This is to certify that the foregoing Order of Revocation of License was sent by U.S. first-class mail, postage prepaid, on August 28th, 2015, to the following:

George B. Howell, Sr.
7015 East 14th Street N.
Wichita, Kansas 67206

Defendant Pro Se

Nancy Thiemann, Legal Secretary