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

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	FILED JAN 27 2012 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
Plaintiff,	)	
v.	)	**Case No. 10-08-4063**
LAWRENCE CHARLES GREEN, M.D., LICENSE NO. 9260,	)	
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, Lawrence Charles Green, M.D., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.*

2. Defendant, Lawrence Charles Green, M.D., holds Oklahoma license no. 9260 and practices family medicine in Tahlequah, Oklahoma.

PRIOR DISCIPLINARY ACTION

3. On or about January 7, 1997, the Board accepted a Voluntary Submittal to Jurisdiction and Agreed Order whereby Defendant's medical license was placed on a **FIVE (5) YEAR PROBATION.** The disciplinary action was based upon Defendant's admission that he allowed his spouse to dispense controlled dangerous substances for weight loss to patients at his clinic without the patients ever being examined by him. Under Defendant's probation, he was ordered to be physically present during all weight loss examinations and patient evaluations. It was further ordered that he must personally prescribe and devise all treatment plans for the weight loss patients.

CURRENT UNPROFESSIONAL CONDUCT ALLEGATIONS

IMPROPER PRESCRIBING OF CONTROLLED DANGEROUS SUBSTANCES FOR WEIGHT LOSS

4. **Patient CCD.**

A. From August 14, 2002 until March 14, 2011, Defendant treated Patient CCD for weight loss. The patient chart, which is illegible, reflects only **one examination** during this 8 ½ year period of time which occurred on the first visit on August 14, 2002. Thereafter, the chart contains a patient log with a list of ninety-three (93) weight loss visits containing only the date, weight, blood pressure, heart rate, and payment amount for the visit. Although it is illegible, it appears that the patient was prescribed Phentermine or Phendimetrazine by Defendant.

B. On Patient CCD's initial weight loss visit on August 14, 2002, she weighed 134 pounds. However, after being treated by Defendant for 8 ½ years with Phentermine and Phendimetrazine, she **gained 24 pounds** and now weighs 158 pounds.

C. Pharmacy records reflect that from March 17, 2008 until February 15, 2011, Patient CCD received twenty-five (25) prescriptions for #168 Phendimetrazine 35 mg with the dosage instruction to "Take 2 tablets by mouth three times a day."

D. A review of Defendant's chart on Patient CCD reveals that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not document an adequate physical examination with the only limited and illegible examination being at the beginning of the 8 ½ years of treatment, that he did not obtain a patient history, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with weight loss medications for over 8 ½ years.

5. **Patient CFD.**

A. From February 6, 2007 until February 25, 2011, Defendant treated Patient CFD for weight loss. The patient chart, which is illegible, reflects only **one examination** during the four (4) year period of time which occurred on the first visit on February 6, 2007. Thereafter, the chart contains a patient log with a list of sixty-four (64) weight loss visits containing the date, weight, blood pressure, heart rate, and payment amount for each visit. Although it is illegible, it appears that the patient was prescribed Phentermine or Phendimetrazine by Defendant.

B. Pharmacy records reflect that from February 14, 2008 until January 31, 2011, Patient CFD received forty-one (41) prescriptions for #168 Phendimetrazine 35 mg. In this approximate three (3) year period of time, Patient CFD received 6888 dosage units of

Phendimetrazine, at a rate of **6.36 dosage units per day.** During this three (3) year period of time, the patient **lost only 3 ½ pounds.**

C. When interviewed by Board investigators, Defendant was asked if he had a blood pressure reading over which he would not prescribe weight loss medications. He stated that it was around "140/90". However, a review of Patient CFD's chart reflects that during a thirteen (13) month period of time, Patient CFD's blood pressure was over this limit, and at one time, was as high as 171/99, yet Defendant nevertheless continued to prescribe controlled weight loss medications. Defendant even noted on the patient log at one point that the patient was on blood pressure medications, yet he continued to prescribe weight loss medications to him.

D. A review of Defendant's chart on Patient CFD reveals that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not document an adequate physical examination, with the only limited and illegible examination being at the beginning of the four (4) years of treatment, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with weight loss medications for 4 years.

6. **Patient BGD.**

A. From at least March 26, 2008 until January 7, 2011, Defendant treated Patient BGD for weight loss. The patient charts contains **no physical examination** of any kind during this approximate three (3) year period of time. The patient chart contains only one (1) notation on January 7, 2011 where the patient's weight, blood pressure, heart rate and payment amount for the visit are noted.

B. Pharmacy records reflect that from March 26, 2008 until January 7, 2011, Patient BGD received thirty-four (34) prescriptions for #168 Phendimetrazine 35 mg. and one (1) prescription for #28 Phentermine 37.5 mg. In this approximate three (3) year period of time, Patient BGD received 5740 dosage units of Phendimetrazine and Phentermine, at a rate of **5.64 dosage units per day.**

C. Since the chart reflects only one (1) recorded weight, it is unknown whether or not the medications prescribed were medically necessary or effective.

D. A review of Defendant's chart on Patient BGD reveals that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not document any physical examination or obtain any patient history during the entire three (3) years that he treated this patient, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with weight loss medications for 3 years.

7. **Patient JGD.**

A. From at least February 11, 2008 until February 15, 2011, Defendant treated Patient JGD for weight loss. The patient charts contains **no physical examination** of any kind during this approximate three (3) year period of time. The patient chart contains only a patient log for one (1) year between March 11, 2010 and March 18, 2011 where the patient's weight, blood pressure, heart rate and payment amount for the visit are noted. There is no documentation in the patient record of any of the prescriptions given from February 2008 until March 11, 2010.

B. Pharmacy records reflect that from February 11, 2008 until February 15, 2011, Patient JGD received seventy-nine (79) prescriptions for #84 Phendimetrazine 35 mg. In this approximate three (3) year period of time, Patient JGD received 6636 dosage units of Phendimetrazine at a rate of **6.03 dosage units per day.**

C. On Patient JGD's first recorded weight loss visit on March 11, 2010, she weighed 159 pounds. However, after being treated by Defendant for one (1) year with Phentermine, she weighed 179 and actually **gained 20 pounds**.

D. A review of Defendant's chart on Patient JGD reveals that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not document any physical examination or obtain any patient history during the entire three (3) years that he treated this patient, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with weight loss medications for 3 years.

8. **Patient PGD.**

A. From March 20, 2003 until January 31, 2011, Defendant treated Patient PGD for weight loss. The patient chart, which is illegible, reflects only **one examination** during the eight (8) year period of time which occurred on the first visit on March 20, 2003. Thereafter, the chart contains a patient log showing a list of one-hundred one (101) weight loss visits containing only the date, weight, blood pressure, heart rate, and payment amount for each visit. Although it is illegible, it appears that the patient was prescribed Phentermine or Phendimetrazine by Defendant.

B. Pharmacy records reflect that from February 12, 2008 until January 31, 2011, Patient PGD received thirty-eight (38) prescriptions for #168 Phendimetrazine 35 mg., four (4) prescriptions for #84 Phendimetrazine 35 mg. and thirty-seven (37) prescriptions for #28 Phentermine 30 mg. In this approximate three (3) year period of time, Patient PGD received 7756 dosage units of Phendimetrazine and Phentermine, at a rate of **7.15 dosage units per day.**

C. On Patient PGD's first recorded weight loss visit on March 2, 2003, she weighed only **126 pounds.** However, after being treated by Defendant for eight (8) years with

Phendimetrazine and Phentermine, she weighed 149 pounds on January 31, 2011, and actually **gained 23 pounds**.

D. A review of Defendant's chart on Patient PGD reveals that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not conduct a sufficient physical examination with the only limited and illegible examination being at the beginning of the 8 years of treatment, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with weight loss medications for 8 years.

E. When questioned by Board investigators as to why he would continue to prescribe weight loss medications for 8 years while the patient **gained** weight, Defendant responded that this patient "**insisted she has to have that to stay on track".** When further questioned about the long term use of Phendimetrazine and Phentermine, Defendant admitted that he couldn't imagine that it would do any good.

9. **Patient STD.**

A. From April 18, 2007 until March 18, 2011, Defendant treated Patient STD for weight loss. The patient chart, which is illegible, reflects only **one examination** during the four (4) year period of time which occurred on the first visit on April 18, 2007. Thereafter, the chart contains a patient log showing a list of forty-eight (48) weight loss visits containing only the date, weight, blood pressure, heart rate, and payment amount for each visit. Although it is illegible, it appears that the patient was prescribed Phendimetrazine by Defendant.

B. Pharmacy records reflect that from February 21, 2008 until February 16, 2011, Patient STD received thirty-nine (39) prescriptions for #168 Phendimetrazine 35 mg. In this approximate three (3) year period of time, Patient STD received 6553 dosage units of Phendimetrazine at a rate of **6.00 dosage units per day.**

C. On Patient STD's first recorded weight loss visit on April 18, 2007, she weighed 152 pounds. However, after being treated by Defendant for four (4) years with Phendimetrazine, she lost only eleven (11)pounds and weighed 141 pounds on March 18, 2011.

D. A review of Defendant's chart on Patient PGD reveals that he did not establish a legitimate need for the medications, that he did not document the type and amount of controlled dangerous substances being prescribed at each visit as required by narcotics laws, that he did not conduct a sufficient physical examination with the only limited and illegible examination being at the beginning of the 4 years of treatment, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient with weight loss medications for 4 years.

10. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. § 509 (8) and OAC 435:10-7-4 (11).

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

C. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509 (13) and OAC 435:10-7-4(39).

D. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509 (18) and OAC 435:10-7-4(41).

E. Failed to establish a physician/patient relationship prior to providing patient-specific medical services, care or treatment in violation of OAC 435:10-7-4(49).

F. Prescribed or administered a drug or treatment without sufficient examination and the establishment of a valid physician patient relationship in violation of 59 O.S. §509 (12).

G. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16).

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

I. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered

controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

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

K. Confessed to a crime involving violation of the antinarcotic laws and the laws of this state in violation of 59 O.S. §509(7).

L. 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).

M. Engaged in gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15).

Conclusion

WHEREFORE, the Plaintiff respectfully requests that the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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