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,	)	FILED MAY 25 2012 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
v.	)	Case No. 10-08-4063
LAWRENCE CHARLES GREEN, M.D., LICENSE NO. 9260, Defendant.	)	

ORDER ACCEPTING
VOLUNTARY SUBMITTAL TO JURISDICTION

Plaintiff, the State of Oklahoma, ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Kimberly Heaton, Assistant Attorney General for the State of Oklahoma, and the staff of the Board, as represented by the Secretary of the Board, Gerald C. Zumwalt, M.D., and the Executive Director of the Board, Lyle Kelsey, and the Defendant, Lawrence Charles Green, M.D., Oklahoma license no. 9260, who appears in person and through counsel, Nick E. Slaymaker, proffer this Agreement for acceptance by the Board *en banc* pursuant to Section 435:5-1-5.1 of the Oklahoma Administrative Code ("OAC").

AGREEMENT AND ACKNOWLEDGMENT BY DEFENDANT

By voluntarily submitting to jurisdiction and entering into this Order, Defendant pleads guilty to the allegations in the Complaint and Citation filed herein on January 27, 2012 and acknowledges that hearing before the Board would result in some sanction under the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act").

Defendant, Lawrence Charles Green, M.D., states that he is of sound mind and is not under the influence of, or impaired by, any medication or drug and that he fully recognizes his right to appear before the Board for evidentiary hearing on the allegations made against him. Defendant hereby voluntarily waives his right to a full hearing, submits to the jurisdiction of the Board and agrees to abide by the terms and conditions of this Order. Defendant acknowledges that he has read and understands the terms and conditions stated herein.

PARTIES' AGREEMENT AND STIPULATIONS

Plaintiff, Defendant and the Board staff stipulate and agree as follows:

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, 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 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 having been 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. Defendant successfully completed the Probation.

IMPROPER PRESCRIBING OF CONTROLLED DANGEROUS SUBSTANCES FOR WEIGHT LOSS

1ST PATIENT-PATIENT CCD

4. 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.

5. 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.

6. 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."

7. 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.

2ND PATIENT-PATIENT CFD

8. 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.

9. 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.

10. 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 notes 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.

11. 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.

3RD PATIENT-PATIENT BGD

12. From at least March 26, 2008 until January 7, 2011, Defendant treated Patient BGD for weight loss. The patient chart contains no physical examination of any kind during this approximately 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 visit are noted.

13. 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.

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

15. 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.

4TH PATIENT-PATIENT JGD

16. From at least February 11, 2008 until February 15, 2011, Defendant treated Patient JGD for weight loss. The Patient Chart 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 13, 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.

17. 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.

18. 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 weight 179 and actually gained 20 pounds.

19. 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.

5th PATIENT-PATIENT PGD

20. 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.

21. 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.

22. 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.

23. A review of Defendant's chart on Patient PGD reveals that Defendant 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.

24. 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. Defendant asserts that his comment was in relation to the reduced effect of the medication due to the patient's tolerance.

6TH PATIENT-PATIENT STD

25. 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.

26. 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.

27. 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.

28. A review of Defendant's chart on Patient STD 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.

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

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

B. 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).

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. 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).

E. 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).

F. 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).

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

H. 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 OAC 435:10-7-4(2) and (6).

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

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, Lawrence Charles Green, M.D., Oklahoma medical license 9260, is guilty of unprofessional conduct set forth below based on the foregoing facts:

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

B. 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).

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. 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).

E. 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).

F. 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).

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

H. 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 OAC 435:10-7-4(2) and (6).

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

Order

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

1. The Board *en banc* hereby adopts the agreement of the parties in this Voluntary Submittal to Jurisdiction.

2. The license of Defendant, Lawrence Charles Green, M.D., Oklahoma license no. 9260, is hereby **SUSPENDED,** beginning May 17, 2012, and continuing for **90 DAYS** until August 15, 2012.

3. At the conclusion of the period of suspension, Defendant shall be placed on **PROBATION** for a period of **FIVE (5) YEARS** under the following terms and conditions:

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

Licensure and Supervision.

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

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

D. Defendant will execute such releases of medical and psychiatric records during the entire term of probation as necessary for use by the Compliance Consultant or other Board designee to obtain copies of medical records and authorize the Compliance Consultant or other Board designee to discuss Defendant's case with Defendant's treating physicians and/or physicians holding Defendant's records.

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

F. Defendant will take no medication except that which is authorized by a physician treating him for a legitimate medical need and only during that time in which he is being treated by the physician for that specific medical need. Defendant has the affirmative duty to inform any and every doctor treating him of the Board Order immediately upon initiation, or continuation of treatment.

G. During the period of suspension, Defendant shall complete a Prescribing Class covering prescribing and required record-keeping at a facility approved in advance in writing by the Board Secretary. Defendant shall provide to the Board Secretary proof of successful completion of said class. If an approvable class cannot be identified within Oklahoma and completed within the period of suspension, Defendant will advise the Secretary before the end of the period of suspension in order to identify and complete an approvable class as soon thereafter as practicable.

H. After the period of suspension, Defendant shall submit to the Board a written protocol to be followed by Defendant when treating weight loss patients. The protocol must be approved in advance in writing by the Board Secretary.

I. Defendant shall allow the Board's Compliance Consultant or his designee to periodically review his charts to determine his compliance with this Order.

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

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

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

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

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

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

4. Defendant shall pay an **ADMINISTRATIVE FINE** in the amount of **$5,000.00** on or before May 17, 2013.

5. Defendant's suspended license shall not be reinstated unless Defendant has reimbursed the Board for all taxed costs and expenses incurred by the State of Oklahoma.

6. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and investigation costs.

Dated this 17 day of May, 2012.

Gerald Zumwalt, MD, Board Secretary
Oklahoma State Board of
Medical Licensure and Supervision

AGREED AND APPROVED

Lawrence Charles Green, M.D.
License No. 9260

Nick E. Slaymaker, Attorney
For Lawrence Charles Green, M.D.

Elizabeth Scott #12470
Assistant Attorney General
State of Oklahoma
101 N.E. 51st Street
Oklahoma City, OK 73105

Attorney for the Oklahoma State
Board of Medical Licensure and
Supervision

CERTIFICATE OF MAILING

I certify that on the 25 day of May, 2012, a mailed a true and correct copy of the Order Accepting Voluntary Submittal to Jurisdiction to Lawrence Charles Green, M.D., 1325 E. Boone Street, #203, Tahlequah, Oklahoma 74464; and to Nick Slaymaker, counsel for Lawrence Charles Green, M.D., at Scoggins & Cross, PLLC., 201 Robert S. Kerr, Suite 710, Oklahoma City, OK 73102, and faxed a copy of the foregoing Order to Nick Slaymaker at (405) 239-4305.

Janet Swindle