IN THE MATTER OF	*	**BEFORE THE MARYLAND**
ALAN R. VINITSKY, M.D.	*	**STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
LICENSE NO.: D22180	*	**CASE NO.: 2016-1026 B**

* * * * * * * * * * * *

CONSENT ORDER

On April 30, 2018, Disciplinary Panel B ("Panel B") of the Maryland State Board of Physicians (the "Board") charged **Alan R. Vinitsky, M.D.** (the "Respondent"), License No. D22180, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §14-401 *et seq*. (2014 Repl. Vol. & 2017 Supp.)

The pertinent provision of Health Occ. §14-404(a) under which Panel B voted to charge Respondent provides the following:

> (a) Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a licensee if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State[.]

On September 26, 2018, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of the DCCR, Respondent agreed to enter this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel B makes the following findings of fact:

I. License and Medical Background

1. At all times relevant hereto, Respondent was, and is, licensed to practice medicine in Maryland. Respondent was originally licensed to practice medicine in Maryland on July 20, 1978 under license number D22180. Respondent last renewed his license in or about September 2017, which will expire on September 30, 2019.

2. On June 22, 1977, Respondent was granted lifetime certification in Internal Medicine by the American Board of Internal Medicine.

3. On November 7, 1980, Respondent was granted lifetime certification in Pediatrics by the American Board of Pediatrics.

4. Since 2001, Respondent has maintained an office under the name of "Enlightened Medicine" in Montgomery County, Maryland for the solo practice of medicine and pediatrics. Respondent has a special interest in environmental medicine and treating chronic illnesses such as chronic fatigue, autonomic nervous system dysfunction, Lyme disease, and diseases caused by mold, chemicals, and metal toxins.

5. Respondent is authorized to prescribe buprenorphine for up to 30 patients.

II. Complaint

6. On or about June 17, 2016, the Board received a complaint from a physician at unnamed urgent care center regarding a patient, Patient 1, who he had seen

at the urgent care center.[1] The physician/complainant had reviewed a CRISP (Chesapeake Regional Information System for our Patients) report on Patient 1 and learned that a "local MD" had been prescribing Patient 1 Oxycodone 180 tablets monthly. Upon request, the physician/complainant provided the name of Patient 1 and Respondent's name as the prescribing physician.

III. Board Investigation

7. On August 25, 2016, in response to a subpoena, Respondent submitted the complete medical record of Patient 1. At the request of the Board, Respondent submitted a written response to the complaint and a detailed narrative of the care he provided Patient 1.

8. The Board issued a subpoena to the Prescription Drug Monitoring Program ("PDMP") to obtain a computer-generated printout of all prescriptions written by Respondent from September 1, 2015 to September 29, 2016.

9. On January 13, 2017, the Board issued a subpoena to Respondent for a complete copy of the medical records of nine additional patients, who were selected by Board staff from the PDMP printouts; and, requested that Respondent provide a summary of care for each patient listed in the subpoena.

10. On February 3, 2017, the Board received the nine subpoenaed medical records and summaries of care.

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[1] Patient names are confidential and are not used in the Consent Order. Respondent has been provided a Confidential Patient Identification List containing the names of each of the individuals referenced in the Consent Order.

11. On April 6, 2017, Board staff interviewed Respondent under oath who stated the following:

a. Patients in his practice who are on pain medicines were on pain medicines when they initially came to see him. He did not initiate these patients on pain medicines;

b. Respondent has approximately 20 to 30 patients who are on pain medicines, including 6 patients who he is treating with buprenorphine, out of approximately several thousand patients in his practice; and

c. He "dislikes" having to confront patients with inconsistencies between what they have told him and information in a CRISP report because he "is not a confrontational person and rather have things be smooth and evened out."

12. On May 25, 2017, the Board referred the case to an independent peer review agency, requesting a peer review of Respondent's prescribing of controlled dangerous substances ("CDS"), by two physicians who are board-certified in pain medicine.

13. On August 16, 2017, the Board received the peer review reports. The reviewers concurred that regarding nine of the ten patients reviewed (Patients 1, 2, 3, 4, 6, 7, 8, 9, and 10[2]), Respondent failed to meet the appropriate standards for the delivery of quality medical care.

14. On August 16, 2017, the Board sent copies of the peer review reports to Respondent with the names of the reviewers redacted requesting Respondent to provide a Supplemental Response.

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[2] One of the reviewers stated he/she did not feel qualified to comment on the care of Patient 5, a psychiatric patient. The other reviewer opined that Respondent met the standard of quality care.

15. On September 5, 2017, the Board received Respondent's Supplemental Response, which was subsequently reviewed by the two reviewers, prior to the issuance of Charges. Respondent, among other points, stated that:

a. He has asked his patients not to refer other patients to him for pain management;

b. On April 26, 2017, he signed up for CRISP to be able to use PDMP;

c. He has initiated written doctor-patient agreements with patients; and

d. He has successfully weaned Patient 9 off all opioids.

IV. Summary of "Fails to Meet Standards of Quality Medical Care"

16. In nine of the ten cases reviewed, the reviewers concurred that Respondent fails to meet standards for quality medical care in prescribing CDS, in that Respondent:

a. Fails to perform an adequate work-up of the underlying source of the pain prior to prescribing opioids;

b. Incorrectly treats the pain associated with diseases such as migraine headaches, chronic fatigue, and infections (chronic Lyme disease, Bartonellosis, and mold) with opioids instead of using standard treatments for these diseases;

c. Inappropriate manages pain with escalating and frequently high dosing of opioids;

d. Misrepresents the dosing of opioids and other CDS in that he documents a thirty-day supply but frequently renews prescriptions before their refill dates;

e. Inappropriately prescribes benzodiazepine and opioids concomitantly;

f. Fails to document a risk/benefits assessment and assess goals for opioid therapy prior to prescribing opioids;

g. Fails to obtain informed consent or document an opioid agreement;

h. Fails to consistently utilize urine drugs screens ("UDS") or perform pill counts to verify compliance or to test for signs of diversion or taking illicit substances, particularly on high risk patients; and

i. Fails to consider the results of UDS for subsequent prescribing.

V. Patient Specific Standard of Care Findings[3]

Patient 1[4]

17. On or about November 13, 2015, Patient 1, a male in his mid-30s, consulted Respondent because his "pain physician closed (sic) practice and I need to find a new one." Patient 1 reported that he has "retractable migraines with aura, post-herpetic neuralgia, and degenerative disc disease." Patient 1 reported that his medications were oxycodone 30 mg four times a day.[5] Respondent assessed "postherpetic neuroglia and variant of migraine, not elsewhere classified" and prescribed oxycodone 30 mg every 6 to 8 hours, 30 tablets and oxymorphone ER 40 mg every 12 hours, 30 tablets.

18. On November 16, 2015, Patient 1 returned the oxymorphone ER and requested Fentanyl patch. Respondent prescribed Fentanyl patch 25 mcg, five patches.

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[3] The Peer Review reports contain a synopsis of the care provided by Respondent to each patient as understood by each reviewer from a review of Respondent's medical records. Respondent has been provided a copy of the peer review reports.

[4] Patient 1 is the subject of the complaint.

[5] Records from Patient 1's prior treating physician that are contained in Respondent's records state that on September 14, 2015, Patient 1 was last prescribed oxymorphone 10 mg 4 times a day, PRN (as needed), 120 tablets, and was told to follow-up in 30 days. There are no further recorded visits with the prior treating physician.

19. On November 24, 2015, Respondent prescribed oxycodone 30 mg every 6 to 8 hours, 60 tablets, for migraine.

20. On December 7, 2015, Respondent prescribed oxycodone 30 mg three times daily and 2 at bedtime, 150 tablets for migraine and continued to prescribe the same level and amount for several months.

21. On March 22, 2016, Respondent increased the prescription of oxycodone 30 mg to 180 tablets for migraine.

22. On August 22, 2016, the last day for which the Board has medical records, Respondent prescribed oxycodone 30 mg one tablet every 4 hours,180 tablets.

23. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 1, for reasons including but not limited to that he:

a. Prescribed oxymorphone 40 mg twice a day and oxycodone 30 mg every 6 to 8 hours, at the initial visit, even though Patient 1 came to him from a previous provider who was prescribing oxymorphone 40 to 60 mg a day;

b. Failed to confront Patient 1 with information from a baseline UDS which was positive for clonazepam and THC and continued to prescribe oxycodone;

c. Escalated Patient 1's opioid doses due to aggravation of pain following pesticide exposure in March 2016 or motor vehicle accident in May 2016; but, failed to taper Patient 1 back down after the flare-up subsided;

d. After a year of prescribing opioids, had escalated Patient 1 from 60 mg of oxymorphone a day to oxycodone 180 mg a day;

e. Prescribed well over 250 MME (morphine milligram equivalents) per day, even though Patient 1 continued to have ongoing pain and was an opioid failure[6]; and

f. Failed to consistently document a physical examination at follow-up visits.

Patient 2

24. On November 9, 2015, on an initial visit for "medication refill" Respondent noted that Patient 2's current medications were oxycodone 30 mg twice a day and Adderall 20 mg twice a day. Respondent was able to verify Adderall but unable to verify oxycodone. Responded prescribed oxycodone 30 mg every 6 to 8 hours, 30 tablets.

25. On November 30, 2015, Respondent increased oxycodone 30 mg to 120 tablets.

26. Respondent continued to see and treat Patient 2 monthly at the same dosage and amount, through February 2, 2017, Respondent last documented a visit with Patient 2.

27. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 2, for reasons including but not limited to that he:

a. Failed to perform a thorough initial work-up, including obtaining imaging, or review of prior work-up as part of a diagnostic work-up;

b. Doubled Patient 2's dose of oxycodone without a documented rationale or medical justification, and without confirmation of this being Patient 2's current dose; and

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[6]When a patient is a on high doses of opioids but has no pain relief and no functional improvement, the patient is an "opioid failure."

c. Failed to try non-opioid pain management modalities.

Patient 3

28. On July 15, 2013, Respondent initially saw Patient 3, then a 32-year-old male. Patient 3 reported that he has been treated by another physician with Suboxone, which was tapered from 3 films daily to one film daily. Patient 3 reported that two weeks ago he ran out of Adderall 20 mg in the am and 10 mg midday.

29. Respondent continued to see and treat Patient 3 monthly. Respondent treated Patient 3 with a wide range of opioids and other CDS at high doses, including oxycodone, Dilaudid, fentanyl lozenges, Opana, Opana ER, OxyContin, morphine sulfate ER, methadone, buprenorphine, Adderall, Adderall XR, Dexedrine, diazepam, and clonazepam.

30. On August 4, 2016, Respondent last saw Patient 3 and refilled prescriptions for Adderall, methadone and Roxicodone.

31. On August 30, 2016, Respondent was informed by another provider that Patient 3 was admitted to an inpatient addiction center for opioid addiction treatment.

32. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 3 for reasons including but not limited to that he:

a. Shifted from initially treating Patient 3 for medication assisted treatment for opioid addiction and maintenance of medication for ADHD; however, over time, treated Patient 3 with opioids for acute and chronic pain;

b. Failed to obtain psychiatric/mental health and pain management consults sooner over the three-years which Respondent treated Patient 3, a high-risk

patient due to his age, history of prescription opioid addiction, abuse history and psychiatric history;

c. Prescribed sufficient pills for thirty days but provided refills early with most refills being given between 7 to 20 days after the previous visit;

d. Prescribed doses of opioids that exceeded the recommended limit of 50 to 100 MME per day for chronic pain management by prescribing over 500 MME per day for most of the duration of Patient 3's treatment, even though Patient 3 continued to have ongoing pain and was an opioid failure;

e. Co-prescribed benzodiazepines with opioids despite there being a Federal Drug Administration ("FDA") warning against this;

f. Prescribed Roxicodone and Dilaudid while Patient 3 was also on a long acting opioid and then added Actiq which created an unnecessary high risk of respiratory depression and death for Patient 3;

g. Prescribed Suboxone while Patient 3 was still on opioids and then prescribed Actiq[7] to help with withdrawal symptoms that were caused by the addition of Suboxone;

h. Documented multiple fractures and increased opioid medications even though records from Patient 3's hand surgeon clearly stated no fracture;

i. Increased opioid medications even though records from Patient 3's hospitalization for low back pain indicated mild findings on a lumbar MRI;

j. Continued to prescribe Adderall even though Respondent was aware that another provider was prescribing Adderall;

k. Prescribed methadone without obtaining a baseline electrocardiogram (EKG); and

l. Failed to respond to aberrant behaviors, known as "red flags" such as requesting early refills, absence of opioids on UDS, report of lost or stolen

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[7] Actiq (Fentanyl Citrate) is indicated for the management of breakthrough pain in cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.

medications, claim of having flushed medications down the toilet but then coming back for requesting a refill.

Patient 4

33. On November 21, 2014, Patient 4, then a 38-year-old male, initially presented to Respondent for a prescription refill of oxycodone which he had been taking for four years. Patient 4 had herniated a disc in his lower back and did not want surgery. Patient 4 has smoked one pack of cigarettes per day for many years. Patient 4's medications were oxycodone 30 mg twice daily and Adderall 20 mg twice daily. Respondent refilled these medications.

34. Respondent saw Patient 4 monthly and continued the same medications.

35. On May 20, 2015, Patient 4 requested an increase in oxycodone due to difficulty sleeping. Respondent prescribed oxycodone 30 mg every 8 hours (three times a day) 90 tablets and continued Adderall.

36. By March 2016, Respondent had increased oxycodone 30 mg to six times a day (180 tablets), with refills at 4 weeks or less, which was more than 6 tablets a day.

37. Then, Respondent started Patient 4 on methadone with a goal to reduce his oxycodone use.

38. On November 21, 2016, Respondent was still prescribing oxycodone 30 mg, 180 (6 tablets a day) and Adderall. Respondent also prescribed methadone 5 mg, 60 tablets.

39. On December 21, 2016, Respondent decreased oxycodone to 30 mg, 170 tablets and increased Methadone to 5 mg, 60 tablets.

40. On January 17, 2017, the last visit for which the Board has records, Respondent maintained oxycodone 30 mg, 170 tablets, increased methadone to 10 mg, 60 tablets and continued Adderall. Respondent documented that his goal was to have Patient 4 on oxycodone to 140 - 150 tablets a month.[8]

41. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 4 for reasons including but not limited to that he:

a. Failed to perform any baseline diagnostic testing to determine the underlying source of Patient 4's chronic pain;

b. Failed to obtain and review records from previous prescriber;

c. Failed to perform a risk/benefit analysis for ongoing use of opioids in a young patient who is a smoker with a higher than average risk of addiction to prescription opioids;

d. Continued to escalate opioid does without any testing and without considering non-opioid alternatives;

e. Prescribed doses of opioids that exceeded the recommended limit of 50 to 100 MME per day for chronic pain management by prescribing over 200 MME per day for most of the duration of Patient 4's treatment, even though Patient 4 continued to have ongoing pain and was an opioid failure;

f. Inappropriately escalated Patient 4 from 60 mg of opioids a day to more than 180 mg a day without obtaining additional testing to explain increase in pain and to justify the ongoing use of higher and higher doses of opioids without any functional benefit;

g. Failed to wean Patient 4's dose of opioids; and

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[8] Patient initially presented to Respondent with a four -year history of taking oxycodone 30 mg, 60 tablets a month.

h. Prescribed sufficient pills for thirty days but provided early refills with most refills being given between 19 to 26 days after the previous visit.

Patient 5[9]

Patient 6

42. On June 9, 2015, Respondent initially saw Patient 6, then a female in her mid-forties with a history of a work injury in 2008 and subsequent surgeries in 2011 and 2015. Her then current medications were oxycodone 30 mg three to four times a day and Xanax 1 mg three times a day. Prior MRI of left knee noted "mild osteoarthritis".

43. On August 14, 2015, Respondent lowered Xanax to 0.5 mg, 90 tablets.

44. Thereafter, Respondent maintained Patient 6 on oxycodone 30 mg,120 tablets and Xanax 0.5 mg, 90 tablets.

45. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 6 for reasons including but not limited to that he:

a. Failed to perform a risk/benefit assessment at the time of initiation of prescriptions;

b. Prescribed doses of opioids that exceeded the recommended limit of 50 to 100 MME per day for chronic pain management, by prescribing over 150 MME per day for the duration of Patient 6's treatment, even though Patient 6 continued to have ongoing pain and was an opioid failure;

c. Failed to wean Patient 6's dose of opioids; and/or try nonopioid modalities for pain management;

d. Failed to maintain the orthopedic consult as part of his records and to justify treating Patient 6 with high levels of opioids when the 2015 MRI of

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[9] There are no charges pertaining to Patient 5.

the left knee had only revealed mild osteoarthritis and yet patient and determine other treatment options; and

e. Co-prescribed benzodiazepines (Xanax) with opioids despite there being an FDA warning against this; and failed to document discussion of the risk or attempt to wean Patient 6 off benzodiazepines or to try a non-benzodiazepine for treatment of anxiety.

Patient 7

46. On or about December 29, 2015, Respondent began treating Patient 7, a male in his early 50s, on referral from another physician for renewal of prescriptions for pain management. Patient 7 reported cervical, thoracic, and lumbar spine pain.

47. Respondent prescribed morphine sulphate 30 mg, 2 tablets every 4 hours, 240 tablets, Xanax 1 mg, 180 tablets, and Losartan.[10]

48. On January 27, 2016, Respondent prescribed Xanax 1 mg, 180 tablets, Seroquel[11] 100 mg, 180 tablets, Zolpidem[12] 12.5 mg, 60 tablets, and morphine sulphate 30 mg. 240 tablets

49. On April 4, 2016, Respondent added methadone 10 mg, 120 tablets.

50. Respondent continued these same medications through January 23, 2017, the date of the last visit for which the Board obtained records.

51. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 7, for reasons including but not limited to that he:

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[10] Losartan (Cozaar) is used to treat high blood pressure.
[11] Seroquel is used to treat certain mental/mood conditions such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder.
[12] Zolpidem (Ambien) is a sedative primarily used for the treatment of trouble sleeping.

a. Prescribed doses of opioids that exceeded the recommended limit of 50 to 100 MME per day for chronic pain management, by prescribing 240 MME per day for most of the duration of Patient 7's treatment, even though Patient 7 continued to have ongoing pain and was an opioid failure;

b. Added methadone when Patient 7 was already on high doses of opioids, but failed to taper the opioids; and when there was no functional improvement, failed to discontinue methadone;

c. Failed to obtain records of testing to establish underling pathology that supports the severe pain related symptoms as reported by Patient 7;

d. Failed to wean Patient 7's dose of opioids;

e. Co-prescribed benzodiazepines (Xanax) with opioids despite there being an FDA warning against this; and

f. Failed to consult with other specialties for consideration of non-opioid treatment options.

Patient 8

52. On September 28, 2011, Respondent initially saw Patient 8, a male in his late 20s, who presented with a complaint of getting "sick" often with fatigue and cough.

53. On November 24, 2014, Respondent documented that Patient 8 had been seen by a neurologist who diagnosed severe carpal tunnel and bi-radial nerve palsy. Respondent noted that Patient 8 had been on oxycodone 30 mg and Diazepam 10 mg having been diagnosed with PTSD (post-traumatic stress disorder) and GAS (generalized anxiety disorder).

54. On December 5, 2014, Respondent adjusted Patient 10's dose of Lyrica to 200 mg twice daily and oxycodone 15 mg three times a day, 90 tablets.

55. During 2015 and 2016, Respondent continued to prescribe oxycodone,

increasing it to oxycodone 20 mg, 180 tablets and oxycodone 30 mg 180 tablets.

56. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 8 for reasons including but not limited to that he:

a. Assumed prescribing pain medicine from previous pain management practice but failed to review records from prior practice;

b. Prescribed doses of opioids that exceeded the recommended limit of 50 to 100 MME per day for chronic pain management by prescribing 350 MME per day for most of Patient 8's treatment, even though Patient 8 continued to have ongoing pain and was an opioid failure;

c. Failed to wean Patient 8's dose of opioids;

d. Prescribed sufficient pills for 28 or 30 days but provided early refills with most refills being given between 20 to 23 days after the previous visit; and

e. Failed to counsel Patient 8 regarding a 2015 UDS which was positive for Soma and THC but failed to obtain any further UDS.

Patient 9

57. On September 3, 2015, Respondent initially saw Patient 9 for severe pain and Lyme's disease. Respondent noted a history of severe obsessive-compulsive disorder, anxiety, seizures, Lyme's disease, chronic pain all over and arthralgia, ankylosing spondylitis, and status/post liver transplant due to drug usage. Respondent prescribed Dilaudid 8 mg every four to 6 hours, oxycodone 30 mg. every four to six hours, Xanax 1 mg as needed, doxycycline, Plaquenil and Wellbutrin.

58. Respondent continued to treat Patient 9 with oxycodone and Dilaudid, and at times with fentanyl and methadone.

59. In September 2016, Patient 9 stated he wanted to get off opiates.

60. On January 26, 2017, Respondent refilled oxycodone 30 mg 180 tablets and methadone 10 mg 90 tablets.

61. Respondent failed to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 9 for reasons including but not limited to that he:

a. Failed to obtain diagnostic testing to evaluate Patient 9's low back pain, which would support ongoing use of high doses of opioids;

b. Diagnosed ankylosing spondylitis without adequate laboratory work or imaging;

c. Prescribed doses of opioids that exceeded the recommended limit of 50 to 100 MME per day for chronic pain management, by prescribing 1300 MME per day for some months and generally exceeding the recommended limit for most of the duration of Patient 9's treatment, even though Patient 9 continued to have ongoing pain and was an opioid failure;

d. Failed to wean Patient 9's dose of opioids;

e. Failed to refer Patient 9 to a psychiatrist;

f. Initiated methadone without a baseline EKG

g. Co-prescribed benzodiazepines (Xanax) with opioids despite there being an FDA warning against this;

h. Inappropriately prescribed two short-acting opioids at the same time without there being any adjustments in either levels; and

i. Prescribed sufficient pills for 28 or 30 days but provided refills early with most refills being given between 7 to 23 days after the previous visit.

Patient 10

62. On May 13, 2009, Respondent initially saw Patient 10 for evaluation of her chronic complaints of vertigo, headaches, balance problems, fatigue, depression, anxiety,

shortness of breath, eyelid drooping and cognitive problems.

63. In 2014, Respondent started prescribing opioids initially for complaints of back pain.

64. Throughout 2014, 2015, and 2016, Respondent continued to prescribe Vicodin, then fentanyl and oxycodone, for multiple complaints of back pain, then abdominal pain, and then more generalized pain, which Respondent assessed as "chronic pain syndrome."

65. Beginning in late 2016, Respondent began seeing Patient 10 through "Skype." The last entry, in January 2017, was with Patient 10's husband.

66. Respondent fails to meet appropriate standards for the delivery of quality medical care regarding his care and treatment of Patient 10 for reasons including but not limited to that he:

a. Failed to order testing, such as an MRI, to evaluate the source of the back pain for which he was prescribing escalating doses of opioids in a high-risk patient with significant psychiatric history;

b. Failed to prescribe a trial of anti-inflammatory, muscle relaxant, Gabapentin, Lyrica, or physical therapy;

c. Failed to consider tapering the doses of opioids when Patient 10 continued to feel worse despite increasing doses and was having significant constipation; and

d. Inappropriately prescribed naltrexone, an opioid antagonist, and Vicodin, an opioid agonist, which is clinically and pharmacologically contraindicated.

CONCLUSION OF LAW

Based on the Findings of Fact, Panel B concludes as a matter of law that Respondent failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed in this State, in violation of Health Occ. § 14-404(a)(22)).

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby:

ORDERED that Respondent is **REPRIMANDED;** and it is further

ORDERED that the Respondent is permanently prohibited from prescribing all Controlled Dangerous Substances ("CDS") and from issuing written certifications to patients for medical cannabis treatment; and it is further

ORDERED that the permanent prohibitions listed above shall go into effect **NINETY (90) DAYS** after the effective date of this Consent Order; and it is further

ORDERED that in emergency cases, the Respondent may issue no more than one prescription for a CDS medication for each patient per year, but the prescription may not exceed the lowest effective dose and quantity needed for a duration of **five (5) days.** The prescription may not be refilled, nor may it be renewed. The Respondent shall notify the Board within 24 hours of any prescription written under the authority of this paragraph; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum

period of **ONE (1) YEAR**[13], to begin upon the effective date of this Consent Order; and it is further

ORDERED that during the probationary period, the Panel may issue administrative subpoenas to the Maryland Prescription Drug Monitoring Program ("PDMP") on a quarterly basis for the Respondent's CDS prescriptions. The administrative subpoenas will request a review of the Respondent's CDS prescriptions from the beginning of each quarter; and it is further

ORDERED that, after a minimum period of **ONE (1) YEAR**, the Respondent may submit a written petition to the Board or Panel B requesting termination of probation. The Respondent may be required to appear before the panel to discuss his petition. After consideration of the petition, the probation may be terminated through an order of the Board or Panel B. The Board or Panel B will grant the petition to terminate the probation if the Respondent has complied with any probationary term and condition and if there are no pending complaints related to the charges; and it is further

ORDERED that the Respondent shall not apply for early termination of probation; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition of probation or this Consent Order, the Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings. If

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[13] If the Respondent's license expires while the Respondent is on probation, the probationary period and any probationary conditions will be tolled.

there is no genuine dispute as to a material fact, the Respondent shall be given a show cause hearing before the Board or Panel B; and it is further

ORDERED that, after the appropriate hearing, if the Board or a disciplinary panel determines that the Respondent has failed to comply with any term or condition of probation or this Consent Order, the Board or disciplinary panel may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, or suspend or revoke the Respondent's license to practice medicine in Maryland. The Board or disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon the Respondent; and it is further

ORDERED that Respondent is responsible for all costs incurred in fulfilling the terms and conditions of probation and this Consent Order; and it is further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §14-101 - §14-702, and all federal and state laws and regulations governing the practice of medicine in Maryland; and it is further

ORDERED that unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board's Executive Director, who signs on behalf of Panel B; and it is further

ORDERED that this Consent Order is a public document. *See* Md. Code Ann., Health Occ. §§ 1-607, 14-411.1(b)(2) and Gen. Prov. §§ 4–333(b)(6) (2014 & Supp. 2017).

October 18, 2018
date

Christine A. Farrelly
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

CONSENT

I, Alan R. Vinitsky, M.D. assert that I am aware of my right to consult with and be represented by counsel in considering this Consent Order and in any proceedings that would otherwise result from the charges currently pending.

I, Alan R. Vinitsky, M.D. acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq*. concerning the pending charges. I waive these rights and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on their behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I

acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understands the language and meaning of its terms.

Signature on File

10/12/2018
Date

Alan R. Vinitsky, M.D., Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF Carroll

I HEREBY CERTIFY that on this 12 day of October, 2018 before me, a Notary Public of the State and County aforesaid, personally appeared Alan R. Vinitsky, M.D., License number D22180, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires 4/27/19

10/12/18
Date

DONNA G MORTIMER
Notary Public-Maryland
Carroll County
My Commission Expires
4/27/19