IN THE MATTER OF	*	**BEFORE THE**
ALAN S. WEISS, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D46462	*	**Case Number: 2221-0109**

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

CONSENT ORDER

On July 7, 2022, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") charged **ALAN S. WEISS, M.D.** (the "Respondent"), License Number D46462, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2021 Repl. Vol.). Panel A charged the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

> (a) *In general.* -- 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 license if the licensee:
>
> (3) Is guilty of:
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> (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; [and]
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

One form of unprofessional conduct in the practice of medicine is providing self-treatment or treatment to family members. The American Medical Association has addressed this in a series of ethics opinions:[1]

> **Opinion 8.19 (2012) – Self-Treatment or Treatment of Immediate Family Members**
>
> Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medial history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
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> Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.
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> It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians

[1] The Board and the disciplinary panels may consider the Principles of Ethics of the American Medical Association, but those principles are not binding on the Board or the disciplinary panels. *See* COMAR 10.32.02.16.

should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

Opinion 1.2.1 (2016) – Treating Self or Family

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried

over into the family member's personal relationship with the physician.

(e) Avoiding providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

On November 2, 2022, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, Order, and Consent.

FINDINGS OF FACT

Disciplinary Panel A finds:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on October 10, 1994, under License Number D46462. The Respondent's license is current through September 30, 2023.

2. The Respondent is board-certified in internal medicine and practices medicine at an office located in Annapolis, Maryland.

3. On or about March 9, 2021, the Board received a complaint from a family member (the "Complainant")[2] of one of the Respondent's patients ("Patient 1") alleging that the Respondent overprescribed butalbital to Patient 1 and alleging that Patient 1 overdosed on the drug. The Complainant stated that Patient 1 was found by the local police at the parking lot of a local pharmacy in a "psychotic trance."

4. Based on the complaint, the Board initiated an investigation of the Respondent's prescribing practices.

II. BOARD INVESTIGATON

Prescribing to Family Members

5. As part of its investigation, the Board contacted the Prescription Drug Monitoring Program ("PDMP") and received information that between January 1, 2020, and March 11, 2021, the Respondent prescribed controlled dangerous substances ("CDS") on multiple occasions to his family members from approximately late 2012 to mid 2019.

6. After receiving this information, the Board confirmed the PDMP information by obtaining copies of the issued prescriptions from various pharmacies.

7. A review of the prescriptions the Respondent issued to his Family Members revealed that between January 2, 2020, and February 17, 2021, the Respondent prescribed CDS and prescription-only medications to one family member on six (6) occasions and a second family member on two (2) occasions.

[2] For confidentiality reasons, the identity of any family member referenced herein will not be identified in this Consent Order.

8. In his under-oath interview with Board staff on June 7, 2021, the Respondent admitted to prescribing CDS and prescription-only medications to two family members, some of which occurred under non-emergent circumstances.

Peer Review

9. As part of its investigation, the Board also issued a subpoena to the Respondent for ten patient records and supporting materials and ordered a practice review on standards of care issues. The review was performed by two physicians who are board-certified in internal medicine. The reviewers independently concluded that in all ten cases reviewed, the Respondent failed to meet appropriate standards for the delivery of quality medical care ("Patients 1 through 10") and in nine of ten cases the Respondent failed to keep adequate medical records.

Patient-Specific Summaries

Patient 1

10. Patient 1, a female born in the 1980s, initially saw the Respondent on or about September 28, 2011, for chronic migraine, iron deficiency, anemia and vitamin D deficiency. Patient 1 was previously treated with Fioricet with codeine for her migraine but became addicted to codeine. At this initial visit, the Respondent prescribed to Patient 1 a thirty-day supply of Fiorinal, one to two tablets every four to six hours as needed, but without the codeine.

11. From 2011 on, with the exception of 2012 and 2014, Patient 1 generally saw the Respondent once to twice a year when she received blood work. The Respondent

maintained Patient 1 on Firoinal or Fioricet, one to two tablets every four to six hours as needed.

12. Beginning in 2019, Patient 1 began to receive large doses of Fioricet from the Respondent. During the approximately 13 months between on or about January 13, 2020, and February 27, 2021, Patient 1 received 21 separate prescriptions from the Respondent for Fiorinal (#240) for an average of a prescription every 20 days.

13. On or about February 28, 2021, Patient 1 was admitted to a hospital emergency department for acute psychosis after being found slumped over the steering wheel of her vehicle for over an hour. Patient 1's hospital urine drug screening was positive for Butalbital and Marijuana. The Respondent did not properly follow and manage this patient's controlled dangerous substance ("CDS") use.

14. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 1 for reasons including, but not limited to:

a. Over-prescribing CDS to Patient 1;

b. Failing to monitor how frequently Patient 1 was receiving prescribed CDS from the Respondent;

c. Failing to keep accurate documentation of the frequency and quantity of narcotic medication refills given.

Patient 2

15. Patient 2, a female born in the 1960s, initially saw the Respondent on or about September 7, 2016, with complaints of bloating, fatigue and irregular bowel movements. Patient 2 had a history of traumatic brain injury, pancreatitis, anxiety, drug and alcohol abuse, and post-traumatic stress disorder.

16. Throughout Patient 2's treatment period from September 2016 to the end of the review period in April 2021, the Respondent prescribed a monthly regimen of medications that included, but was not limited to: alprazolam 1 mg at bedtime as needed, Adderall 10 to 15 mg twice daily (discontinued as of April 21, 2021), Abilify 2 mg at bedtime, Focalin 25 mg daily (discontinued as of April 21, 2021), meloxicam 7.5 mg one to two tablets daily, omeprazole 40 mg daily, prazosin 1 mg two to four capsules at bedtime, and Zolpidem ER 12.5 mg at bedtime as need.

17. From her initial visit in September 2016 until 2019, Patient 2 generally saw the Respondent at least twice a year. Beginning in 2019, Patient 1 saw the Respondent generally once a year.

18. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 2 for reasons including, but not limited to:

a. Increasing Patient 2's CDS dosage or switching to different CDS without documented medical justification;

b. Abruptly discontinuing Adderall without tapering of doses;

c. Medications lists were not properly maintained;

d. Failing to accurately document refill of CDS; and

e. Failing to document follow up with Patient 2 after her critical visit to the hospital on January 24, 2020.

Patient 3

19. Patient 3, a male born in the 1970s, initially saw the Respondent on or about September 4, 2012, with complaints of chronic pain issues. Patient 3 had a history of testicular hypofunction, chronic pain, opiate dependence and fibromyalgia.

20. During Patient 3's treatment period from September 2012 to end of the review period in April 2021, he generally saw the Respondent two to three times a year and was prescribed a medications regimen that included, but was not limited to: Adderall XR 30 mg daily, Adderall 10 mg three times daily, Soma 350 mg three times daily as needed, Valium 5 mg twice daily as needed, Lunesta 3 mg at bedtime, Lidoderm patch 5% three times daily, testosterone transdermal gel 20/25 mg two pumps daily, and human chorionic gonadotropin injections.

21. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 3 for reasons including, but not limited to:

a. Increasing Adderall frequency without documented rationale;

b. Failing to monitor Patient 3's CDS use through PDMP/CRISP;

c. Prescribing multiple muscle relaxants (Soma, Valium and Zanaflex) without documented need for all three medications;

d. Failing to maintain an accurate medication list with correct doses; and

e. Failing to maintain proper medical records and write legible notes.

Patient 4

22. Patient 4, a female born in the 1950s, initially saw the Respondent on or about June 20, 2014, for weight loss. Patient 4 had a history of hypothyroidism, vitamin D deficiency, attention deficit disorder ("ADD"), narcolepsy, hyperlipidemia and non-scarring hair loss. After a series of visits until July 29, 2014 for weight loss, Patient 4 did not return to see the Respondent until on or about April 25, 2017, when she re-established care and complained of feeling like she "hit rock bottom."

23. During Patient 4's treatment period from June of 2014 to the end of the review period in April of 2021, the Respondent prescribed a medication regimen that included, but was not limited: Adderall 10 mg every six hours, Finasteride 5 mg daily, glycopyrrolate 1 gram twice daily, modafinil 100 mg one to two tablets daily, progesterone 100 mg at bedtime, natural thyroid 30 mg 3 tablets daily, and minoxidil 2.5 mg one to two tablets daily.

24. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 4 for reasons including, but not limited to:

a. Writing early scripts for Patient 4 to accommodate her needs without canceling the previous scripts;

b. Increasing Patient 4's Adderall dosage without documented justification;

c. Failing to maintain an accurate medication list with correct doses; and

d. Failing to maintain proper medical documentation and write legible notes.

Patient 5

25. Patient 5, a female born in the 1980s, initially saw the Respondent on or about April 25, 2019, with complaints of pain, anxiety and sleep disorder. The Respondent diagnosed Patient 5 with attention-deficit/hyperactivity disorder ("ADHD") and possible Ehlers-Danlos Syndrome ("EDS").

26. During Patient 5's treatment period from April of 2019 to the end of the review period in April of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Adderall XR 25 mg daily, Adderall 10 mg daily,

cyclobenzaprine 5 mg one to two tablets at bedtime, Escitalopram 20 mg daily, and Mydayis 37.5 mg daily.

27. The Respondent failed to meet quality medical standards in his treatment of Patient 5 for reasons including, but not limited to:

a. Prescribing both long-acting and short-acting Adderall without indicating inadequate response to a single therapy and the justification for the use of both; and

b. Prescribing both Adderall XR 25 mg and Mydayis 37.5 mg without canceling one prescription as transitioning to the other.

Patient 6

28. Patient 6, a female born in the 1980s, initially saw the Respondent on or about September 29, 2011, with a history of ADHD, metabolic syndrome, obstructive sleep apnea, hypothyroidism and obesity. Patient 6 did not follow up with the Respondent after the initial visit but resumed care on or about February 18, 2016. Since then, Patient 6 generally saw the Respondent once to twice per year for routine blood work.

29. During Patient 6's treatment period from September of 2019 to the end of the review period in March of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Adderall 30 mg one to two tablets daily, clonazepam 1 mg three times daily, duloxetine 90 mg daily, metformin ER 500 mg daily, and NP Thyroid 120 mg daily.

30. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 6 for reasons including, but not limited to:

a. Failing to monitor Patient 6's CDS use through PDMP/CRISP or medication contract;

b. Failing to discuss or document discussing abnormal bloodwork (elevated cholesterol and triglycerides) with Patient 6;

c. Failing to maintain an accurate medication list with correct doses; and

d. Failing to maintain proper medical records and write legible notes.

Patient 7

31. Patient 7, a female born in the 1960s, initially saw the Respondent in mid-2007 with a history of fibromyalgia, chronic pain syndrome, chronic fatigue syndrome, chronic obstructive pulmonary disease, chronic urinary incontinence, hypothyroidism and hyperlipidemia. The Respondent generally saw Patient 7 for follow up on an annual basis.

32. During Patient 7's treatment period from mid-2007 to the end of the review period in February of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: tramadol 50 mg, one to two tablets every six hours as needed, and clonazepam 0.5 mg one to two tablets three times daily as needed for chronic pain syndrome, Crestor for hyperlipidemia; gabapentin 300 mg three times daily for pain, amitriptyline 50 to 100 mg at bedtime, and Duloxetine 60 mg daily.

33. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 7 for reasons including, but not limited to:

a. Failing to monitor Patient 7's CDS use through PDMP/CRISP;

b. Failing to order more frequent follow up visits to assess the effectiveness of treatment or to attempt a reduction in medications;

c. Failing to refer Patient 7 for physical therapy, acupuncture, or other non-medication modalities to control pain;

d. Failing to maintain an accurate medication list with correct doses; and

e. Failing to maintain adequate medical records and write legible notes.

Patient 8

34. Patient 8, a female born in the 1960s, initially saw the Respondent in January of 2019 with a history of chronic depression/anxiety, irritable bowel syndrome, obstructive sleep apnea, hyperlipidemia, hypertension and cervical spinal degeneration.

35. During Patient 8's treatment period from January of 2019 to the end of the review period in March of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Alprazolam 1 mg three times daily, Bupropion ER 300 mg daily, clonidine 0.1 mg three times daily, doxepin 25 mg two tablets at bedtime, Lunesta 2 mg at bedtime, Olmesartan/hydrochlorothiazide 20 to 25 mg daily, Ondansetron 4 mg every eight hours as needed, potassium chloride 20 milliequivalents daily, progesterone 200 mg at bedtime, sertraline 150 mg daily, and quetiapine 50 mg at bedtime.

36. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 8 for reasons including, but not limited to:

a. Authorizing new prescriptions of alprazolam before refills were used;

b. Authorizing an increase in frequency of alprazolam without adequately documenting the indication;

c. Failing to monitor Patient 8's CDS use through PDMP/CRISP; and

d. Failing to maintain an accurate medication list with correct doses.

Patient 9

37. Patient 9, a male born in the 1960s, initially saw the Respondent in November of 2013 with a history of hypogonadism, ADD, hyperlipidemia, chronic anxiety and chronic insomnia.

38. During Patient 9's treatment period from November 2013 to March 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Adderall 12.5 mg twice daily for ADD, lorazepam as needed for anxiety, zolpidem for insomnia, and testosterone for hypogonadism.

39. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 9 for reasons including, but not limited to:

a. Increasing Patient 9's Adderall dosage to 12.5 mg twice daily on June 24, 2019, without documented medical rationale;

b. Failing to provide Patient 9's pharmacy with accurate prescription for Adderall;

c. Changing Patient 9's lorazepam dose on April 6, 2020, without documented indication;

d. Changing Lunesta to Zolpidem without documented reason;

e. Failing to monitor Patient 9's CDS use through PDMP/CRSIP; and

f. Failing to maintain an accurate medication list with correct doses.

Patient 10

40. Patient 10, a female born in the 1950s, initially saw the Respondent in October of 2009 with a history of chronic back pain, fibromyalgia, recurrent lumbar disc herniation and menopausal symptoms. Patient 10's MRI revealed lumbar 3/lumbar 4 disc herniation, which resulted in surgical correction by another provider. Patient 10 continued to complain of pain and was under another provider's care for pain management since December of 2017.

41. During Patient 10's treatment period from October 2009 to March 2021, the Respondent prescribed a medication regimen that included, but was not limited to, diazepam and cyclobenzaprine for muscle relaxation.

42. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 10 for reasons including, but not limited to:

a. Failing to maintain an accurate medication list with correct doses; and

b. Failing to maintain proper medical records and to write legible notes.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, Disciplinary Panel A concludes as a matter of law that the Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); failing 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, in violation of Health Occ. § 14-404(a)(22); and failing to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

ORDER

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

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

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **ONE YEAR.**[3] During probation, the Respondent shall comply with the following terms and conditions of probation:

(1) Within **SIX (6) MONTHS** of the effective date of this Consent Order, the Respondent is required to take and successfully complete **three** courses: (1) a course in Ethics; (2) a course in CDS prescribing; and (3) a course in medical documentation/recordkeeping. The following terms apply:

(a) It is the Respondent's responsibility to locate, enroll in and obtain the disciplinary panel's approval of the courses before the courses begin;

(b) The Respondent must provide documentation to the disciplinary panel that he has successfully completed the courses;

(c) the courses may not be used to fulfill the continuing medical education credits required for license renewal;

(d) The Respondent is responsible for the cost of the courses.

[3] If the Respondent's license expires during the period of probation, the probation and any conditions will be tolled.

(2) Within **SIX (6) MONTHS** of the effective date of this Consent Order, the Respondent shall pay a civil fine of **FIVE THOUSAND DOLLARS ($5,000.00).** The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physicians and mailed to P.O. Box 37217, Baltimore, Maryland 21297. The Board will not renew or reinstate the Respondent's license if the Respondent fails to timely pay the fine to the Board; and it is further

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

ORDERED that after the Respondent has fully and satisfactorily complied with all terms and conditions of probation and the minimum period of probation imposed by the Consent Order has passed, the Respondent may submit a written petition for termination of probation. After consideration of the petition, the probation may be terminated through an order of the disciplinary panel. The Respondent may be required to appear before the disciplinary panel to discuss his petition for termination. The disciplinary panel may grant the petition to terminate the probation through an order of the disciplinary panel if there are no pending complaints relating to the charges; and it is further

ORDERED that if the Respondent allegedly fails to comply with any term or condition imposed by 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 followed by an exceptions process before a disciplinary panel; and if there is no genuine

dispute as to a material fact, the Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, if the disciplinary panel determines that the Respondent has failed to comply with any term or condition imposed by this Consent Order, the 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 disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine on the Respondent; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board or her designee. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

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

11/29/2022
Date

Signature On File

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

CONSENT

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

By the 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 this right 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 my 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 understand the language and meaning of its terms.

Signature On File

19-November-22

Date

Alan S. Weiss, M.D.
Respondent

NOTARY

STATE OF MD

CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 19 day of November 2022, before me, a Notary Public of the foregoing State and City/County, personally appeared Alan S. Weiss, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Maia A Sarwer

Notary Public

My Commission expires: 01/22/2024

MAIA A SARWER
NOTARY PUBLIC
ANNE ARUNDEL COUNTY
MARYLAND
MY COMMISSION EXPIRES JAN. 22, 2024

IN THE MATTER OF	*	**BEFORE THE**
ALAN S. WEISS, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D46462	*	**Case Number: 2221-0109**

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CHARGES UNDER THE MARYLAND MEDICAL PRACTICE ACT

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby charges **ALAN S. WEISS, M.D.** (the "Respondent"), License Number D46462, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §§ 14-101 *et seq.* (2021 Repl. Vol.).

Panel A charges the Respondent with violating the following provisions of the Act under Health Occ. § 14-404:

> (a) *In general.* -- 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 license if the licensee:
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> (3) Is guilty of:
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> (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; [and]
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> Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medial history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
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> Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.
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> It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician

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becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

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When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried

over into the family member's personal relationship with the physician.

(e) Avoiding providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

ALLEGATIONS OF FACT[2]

Panel A bases its charges on the following facts that it has cause to believe are true:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on October 10, 1994, under License Number D46462. The Respondent's license is current through September 30, 2023.

2. The Respondent is board-certified in internal medicine and practices medicine at an office located in Annapolis, Maryland.

3. On or about March 9, 2021, the Board received a complaint from a family member (the "Complainant")[3] of one of the Respondent's patients ("Patient 1") alleging that the Respondent overprescribed butalbital to Patient 1 causing Patient 1 to overdose on

[2] The allegations set forth in this document are intended to provide the Respondent with reasonable notice of the asserted facts. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with these charges.

[3] For confidentiality reasons, the identity of any family member referenced herein will not be identified by name. The Respondent may obtain the identity of any family member referenced herein by contacting the Administrative Prosecutor.

the drug. The Complainant stated that Patient 1 was found by the local police at the parking lot of a local pharmacy in a "psychotic trance" after overdosing on butalbital.

4. Based on the complaint, the Board initiated an investigation of the Respondent's prescribing practices.

II. BOARD INVESTIGATON

Prescribing to Family Members

5. As part of its investigation, the Board contacted the Prescription Drug Monitoring Program ("PDMP") and received information that between January 1, 2020, and March 11, 2021, the Respondent prescribed controlled dangerous substances ("CDS") on multiple occasions to his family members from approximately late 2012 to mid 2019.

6. After receiving this information, the Board confirmed the PDMP information by obtaining copies of the issued prescriptions from various pharmacies.

7. A review of the prescriptions the Respondent issued to his Family Members revealed that between January 2, 2020, and February 17, 2021, the Respondent prescribed CDS and prescription-only medications to one family member on six (6) occasions and a second family member on two (2) occasions.

8. In his under-oath interview with Board staff on June 7, 2021, the Respondent admitted to prescribing CDS and prescription-only medications to two family members under non-emergent circumstances.

Peer Review

9. As part of its investigation, the Board also issued a subpoena to the Respondent for ten patient records and supporting materials and ordered a practice review

on standards of care issues. The review was performed by two physicians who are board-certified in internal medicine. The reviewers independently concluded that in all ten cases reviewed, the Respondent failed to meet appropriate standards for the delivery of quality medical care ("Patients 1 through 10") and in nine of ten cases the Respondent failed to keep adequate medical records.

Patient-Specific Summaries[4]

Patient 1

10. Patient 1, a female born in the 1980s, initially saw the Respondent on or about September 28, 2011, for chronic migraine, iron deficiency, anemia and vitamin D deficiency. Patient 1 was previously treated with Fioricet with codeine for her migraine but became addicted to codeine. At this initial visit, the Respondent prescribed to Patient 1 a thirty-day supply of Fiorinal, one to two tablets every four to six hours as needed, but without the codeine.

11. From 2011 on, with the exception of 2012 and 2014, Patient 1 generally saw the Respondent once to twice a year when she received blood work. The Respondent maintained Patient 1 on Firoinal or Fioricet, one to two tablets every four to six hours as needed.

12. Beginning in 2019, Patient 1 began to receive large doses of Fioricet from the Respondent. During the approximately 13 months between on or about January 13,

[4] More details regarding the Respondent's failure to meet standards of quality medical care and to keep adequate medical records are included in the peer review reports, which will be provided to the Respondent during discovery.

2020, and February 27, 2021, Patient 1 received 21 separate prescriptions from the Respondent for Fiorinal (#240) for an average of a prescription every 20 days.

13. On or about February 28, 2021, Patient 1 was admitted to a hospital emergency department for acute psychosis after being found slumped over the steering wheel of her vehicle for over an hour. Patient 1's hospital urine drug screening was positive for Butalbital and Marijuana, indicating medication misuse and barbiturate dependence.

14. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 1 for reasons including, but not limited to:

a. Over-prescribing controlled dangerous substance ("CDS") to Patient 1;

b. Failing to monitor how frequent Patient 1 was receiving prescribed CDS from the Respondent;

c. Failing to monitor Patient 1's CDS use through PDMP/CRISP;

d. Failing to respond to Drug Utilization Review Forms from pharmacy regarding the safety of the Respondent's prescribing practices; and

e. Failing to keep accurate documentation of the frequency and quantity of narcotic medication refills given.

Patient 2

15. Patient 2, a female born in the 1960s, initially saw the Respondent on or about September 7, 2016, with complaints of bloating, fatigue and irregular bowel movements. Patient 2 had a history of traumatic brain injury, pancreatitis, anxiety, drug and alcohol abuse, and post-traumatic stress disorder.

16. Throughout Patient 2's treatment period from September 2016 to the end of the review period in April 2021, the Respondent prescribed a monthly regimen of

medications that included, but was not limited to: alprazolam 1 mg at bedtime as needed, Adderall 10 to 15 mg twice daily (discontinued as of April 21, 2021), Abilify 2 mg at bedtime, Focalin 25 mg daily (discontinued as of April 21, 2021), meloxicam 7.5 mg one to two tablets daily, omeprazole 40 mg daily, prazosin 1 mg two to four capsules at bedtime, and Zolpidem ER 12.5 mg at bedtime as need.

17. From her initial visit in September 2016 until 2019, Patient 2 generally saw the Respondent at least twice a year. Beginning in 2019, Patient 1 saw the Respondent generally once a year.

18. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 2 for reasons including, but not limited to:

a. Frequently refilling Patient 2's CDS prescriptions too early;

b. Increasing Patient 2's CDS dosage or switching to different CDS without documented medical justification;

c. Failing to monitor Patient 2's CDS use through PDMP/CRISP;

d. Continuing to prescribe CDS despite Patient 2's verified and acknowledged use of illicit substances;

e. Abruptly discontinuing Adderall and Focalin without tapering of doses;

f. Prescribing Abilify 2 mg without documented medical justification;

g. Medications were listed without indicated use;

h. Failing to accurately document refill of CDS; and

i. Failing to document follow up with Patient 2 after her critical visit to the hospital on January 24, 2020.

Patient 3

19. Patient 3, a male born in the 1970s, initially saw the Respondent on or about September 4, 2012, with complaints of chronic pain issues. Patient 3 had a history of testicular hypofunction, chronic pain, opiate dependence and fibromyalgia.

20. During Patient 3's treatment period from September 2012 to end of the review period in April 2021, he generally saw the Respondent two to three times a year and was prescribed a medications regimen that included, but was not limited to: Adderall XR 30 mg daily, Adderall 10 mg three times daily, Soma 350 mg three times daily as needed, Valium 5 mg twice daily as needed, Lunesta 3 mg at bedtime, Lidoderm patch 5% three times daily, testosterone transdermal gel 20/25 mg two pumps daily, and human chorionic gonadotropin injections.

21. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 3 for reasons including, but not limited to:

a. Increasing Adderall frequency without documented rationale;

b. Failing to monitor Patient 3's CDS use through PDMP/CRISP;

c. Prescribing multiple muscle relaxants (Soma, Valim and Zanaflex) without documented need for all three medications;

d. Prescribing human chorionic gonadotropin without confirming a diagnosis of primary hypogonadism;

e. Prescribing Adderall without confirming a clinical diagnosis of attention-deficit/hyperactivity disorder ("ADHD");

f. Prescribing Lunesta 3 mg daily at bedtime without indication;

g. Failing to maintain an accurate medication list with correct doses and indications; and

h. Failing to write legible notes.

Patient 4

22. Patient 4, a female born in the 1950s, initially saw the Respondent on or about June 20, 2014, for weight loss. Patient 4 had a history of hypothyroidism, vitamin D deficiency, attention deficit disorder ("ADD"), narcolepsy, hyperlipidemia and non-scarring hair loss. After a series of visits until July 29, 2014 for weight loss, Patient 4 did not return to see the Respondent until on or about April 25, 2017, when she re-established care and complained of feeling like she "hit rock bottom."

23. During Patient 4's treatment period from June of 2014 to the end of the review period in April of 2021, the Respondent prescribed a medication regimen that included, but was not limited: Adderall 10 mg every six hours, Finasteride 5 mg daily, glycopyrrolate 1 gram twice daily, modafinil 100 mg one to two tablets daily, progesterone 100 mg at bedtime, natural thyroid 30 mg 3 tablets daily, and minoxidil 2.5 mg one to two tablets daily.

24. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 4 for reasons including, but not limited to:

a. Prescribing Adderall without confirming an indicated diagnosis;

b. Failing to adjust thyroid medication based on laboratory results;

c. Refilling Patient 4's Adderall prescriptions too early;

d. Increasing Patient 4's Adderall dosage without documented justification;

e. Failing to properly titrate Patient 4's thyroid medication according to her triiodothyronine level;

f. Failing to maintain an accurate medication list with correct doses and indications; and

g. Failing to write legible notes.

Patient 5

25. Patient 5, a female born in the 1980s, initially saw the Respondent on or about April 25, 2019, with complaints of pain, anxiety and sleep disorder. The Respondent diagnosed Patient 5 with attention-deficit/hyperactivity disorder ("ADHD") and possible Ehlers-Danlos Syndrome ("EDS").

26. During Patient 5's treatment period from April of 2019 to the end of the review period in April of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Adderall XR 25 mg daily, Adderall 10 mg daily, cyclobenzaprine 5 mg one to two tablets at bedtime, Escitalopram 20 mg daily, and Mydayis 37.5 mg daily.

27. The Respondent failed to meet quality medical standards in his treatment of Patient 5 for reasons including, but not limited to:

a. Prescribing both long-acting and short-acting Adderall without indicating inadequate response to a single therapy and the justification for the use of both;

b. Prescribing both Adderall XR 25 mg and Mydayis 37.5 mg; and

c. Diagnosing Patient 5 with ADHD and EDS without indicating the criteria used.

Patient 6

28. Patient 6, a female born in the 1980s, initially saw the Respondent on or about September 29, 2011, with a history of ADHD, metabolic syndrome, obstructive sleep apnea, hypothyroidism and obesity. Patient 6 did not follow up with the Respondent after the initial visit but resumed care on or about February 18, 2016. Since then, Patient 6 generally saw the Respondent once to twice per year for routine blood work.

29. During Patient 6's treatment period from September of 2019 to the end of the review period in March of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Adderall 30 mg one to two tablets daily, clonazepam 1 mg three times daily, duloxetine 90 mg daily, metformin ER 500 mg daily, and NP Thyroid 120 mg daily.

30. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 6 for reasons including, but not limited to:

a. Prescribing Adderall 30 mg to Patient 6 for off-label use without documented indication;

b. Failing to monitor Patient 6's CDS use through PDMP/CRISP or medication contract;

c. Increasing Cymbalta dosages without documented medical justification;

d. Failing to discuss or document discussing abnormal bloodwork (elevated cholesterol and triglycerides) with Patient 6;

e. Failing to maintain an accurate medication list with correct doses and indications; and

f. Failing to write legible notes.

Patient 7

31. Patient 7, a female born in the 1960s, initially saw the Respondent in mid 2007 with a history of fibromyalgia, chronic pain syndrome, chronic fatigue syndrome, chronic obstructive pulmonary disease, chronic urinary incontinence, hypothyroidism and hyperlipidemia. The Respondent generally saw Patient 7 for follow up on an annual basis.

32. During Patient 7's treatment period from mid 2007 to the end of the review period in February of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: tramadol 50 mg, one to two tablets every six hours as needed, and clonazepam 0.5 mg one to two tablets three times daily as needed for chronic pain syndrome, Crestor for hyperlipidemia; gabapentin 300 mg three times daily for pain, amitriptyline 50 to 100 mg at bedtime, and Duloxetine 60 mg daily.

33. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 7 for reasons including, but not limited to:

a. Prescribing large quantities of CDS (clonazepam and tramadol) without closer monitoring and more frequent patient visits;

b. Failing to monitor Patient 7's CDS use through PDMP/CRISP;

c. Failing to order more frequent follow up visits to assess the effectiveness of treatment or to attempt a reduction in medications;

d. Failing to take the precaution of dosing Patient 7's medications renally given that Patient 7 had evidence of stage 3 chronic kidney disease;

e. Failing to refer Patient 7 for physical therapy, acupuncture, or other non-medication modalities to control pain;

f. Failing to maintain an accurate medication list with correct doses and indications; and

g. Failing to write legible notes.

Patient 8

34. Patient 8, a female born in the 1960s, initially saw the Respondent in January of 2019 with a history of chronic depression/anxiety, irritable bowel syndrome, obstructive sleep apnea, hyperlipidemia, hypertension and cervical spinal degeneration.

35. During Patient 8's treatment period from January of 2019 to the end of the review period in March of 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Alprazolam 1 mg three times daily, bupropion ER 300 mg daily, clonidine 0.1 mg three times daily, doxepin 25 mg two tablets at bedtime, Lunesta 2 mg at bedtime, Olmesartan/hydrochlorothiazide 20 to 25 mg daily, Ondansetron 4 mg every eight hours as needed, potassium chloride 20 milliequivalents daily, progesterone 200 mg at bedtime, sertraline 150 mg daily, and quetiapine 50 mg at bedtime.

36. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 8 for reasons including, but not limited to:

a. Failing to refer Patient 8 to an endocrinologist or gynecologist for symptoms related to possible post-menopausal syndrome;

b. Authorizing new prescriptions of alprazolam before refills were used;

c. Authorizing an increase in frequency of alprazolam without indication;

d. Failing to monitor Patient 8's CDS use through PDMP/CRISP; and

e. Failing to maintain an accurate medication list with correct doses and indications.

Patient 9

37. Patient 9, a male born in the 1960s, initially saw the Respondent in November of 2013 with a history of hypogonadism, ADD, hyperlipidemia, chronic anxiety and chronic insomnia.

38. During Patient 9's treatment period from November 2013 to March 2021, the Respondent prescribed a medication regimen that included, but was not limited to: Adderall 12.5 mg twice daily for ADD, lorazepam as needed for anxiety, zolpidem for insomnia, and testosterone for hypogonadism.

39. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 9 for reasons including, but not limited to:

a. Diagnosing Patient 9 with ADD without proper documentary support;

b. Increasing Patient 9's Adderall dosage to 12.5 mg twice daily on June 24, 2019, without documented medical rationale;

c. Failing to adjust Patient 9's Adderall dosage after Patient 9 complained of heart palpitations;

d. Failing to provide Patient 9's pharmacy with accurate prescription for Adderall;

e. Changing Patient 9's lorazepam dose on April 6, 2020, without documented indication;

f. Changing Lunesta to Zolpidem without documented reason;

g. Failing to monitor Patient 9's CDS use through PDMP/CRSIP; and

h. Failing to maintain an accurate medication list with correct doses and indications.

Patient 10

40. Patient 10, a female born in the 1950s, initially saw the Respondent in October of 2009 with a history of chronic back pain, fibromyalgia, recurrent lumbar disc herniation and menopausal symptoms. Patient 10's MRI revealed lumbar 3/lumbar 4 disc herniation, which resulted in surgical correction by another provider. Patient 10 continued to complain of pain and was under another provider's care for pain management since December of 2017.

41. During Patient 10's treatment period from October 2009 to March 2021, the Respondent prescribed a medication regimen that included, but was not limited to, diazepam and cyclobenzaprine for muscle relaxation.

42. The Respondent failed to meet quality medical and record keeping standards in his treatment of Patient 10 for reasons including, but not limited to:

a. Failing to document his rationale for transitioning Patient 10 from diazepam to cyclobenzaprine;

b. Refilling Patient 10's medications without documented direction or quantity authorized;

c. Incorrectly documenting injection form of diazepam instead of oral form;

d. Failing to maintain an accurate medication list with correct doses and indications; and

e. Failing to write legible notes.

GROUNDS FOR DISCIPLINE

The Respondent's actions, as described above, constitute: being guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); failing 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, in violation of Health Occ. § 14-404(a)(22); and failing to keep adequate medical records as determined by appropriate peer review, in violation of Health Occ. § 14-404(a)(40).

NOTICE OF POSSIBLE SANCTIONS

If, after a hearing, Disciplinary Panel B of the Board finds that there are grounds for action under Health Occ. § 14-404(a)(3)(ii), (22) and/or (40), Disciplinary Panel B may impose disciplinary sanctions against the Respondent's license in accordance with the Board's regulations under COMAR 10.32.02.09 and 10.32.02.10, including revocation, suspension, reprimand, and/or probation, and may impose a fine.

NOTICE OF CASE RESOLUTION CONFERENCE

A conference before Panel A, sitting as the Disciplinary Committee for Case Resolution ("DCCR") in this matter, is scheduled for **WEDNESDAY, SEPTEMBER 14, 2022, at 9:00 A.M.** at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215. The Respondent must confirm in writing his intention to attend the DCCR. The Respondent should send written confirmation of his intention to participate in the DCCR to: Christine A. Farrelly, Executive Director, Maryland State Board of Physicians, 4201

Patterson Avenue, 4th Floor, Baltimore, Maryland 21215. The nature and purpose of the DCCR is described in the attached letter to the Respondent.

If the case cannot be resolved at the DCCR, a pre-hearing conference and a hearing in this matter will be scheduled at the Office of Administrative Hearings, 11101 Gilroy Road, Hunt Valley, Maryland 21031. The hearing will be conducted in accordance with Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq.* (2021 Repl. Vol.).

BRIAN E. FROSH
ATTORNEY GENERAL

7/7/22
Date

K. F. Michael Kao
Assistant Attorney General
Office of the Attorney General
Health Occ. Prosecution & Litigation
300 West Preston Street, Suite 201
Baltimore, Maryland 21201