COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 918

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY DAVID H. THURMAN, M.D., LICENSE NO. 14526, 801 BARRETT AVENUE, LOUISVILLE, KENTUCKY 40204

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B considered this matter at its October 16, 2003 meeting. At that meeting, Inquiry Panel B considered a Memorandum from George Stewart, Medical Investigator, dated October 1, 2003; a grievance dated August 7, 2002; a Final Diagnosis for an autopsy report performed on April 29, 2002; correspondence from Danna Droz, Branch Manager, Drug Enforcement & Professional Practices Branch, Cabinet for Health Services dated May 15, 2002; Dawn Medical Examiner Episodes for 2001; correspondence from Howard R. Udell, Executive Vice President, General Counsel, Purdue Phama L.P. dated August 29, 2002; Law Department Memorandum from Robin E. Abrams dated August 13, 2002; correspondence from Kathleen Harter, M.D. dated July 21, 2003; the licensee's response dated November 27, 2002; and a Board consultant report dated July 11, 2003 with Expert Review Worksheet and Guidelines adopted by the Board attached. Having considered all of this information and being sufficiently advised, Inquiry Panel B ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel B concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Suspension:

1. At all relevant times, David H. Thurman, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Physical Medicine and Rehabilitation.
3. On August 9, 2002, the Board received a grievance alleging that the licensee provided inappropriate care to grievant's son, Patient A. The allegations include that the licensee inappropriately prescribed Methadone to Patient A, which caused the patient's death by drug overdose.
4. Donna M. Hunsaker, M.D., Office of the Chief Medical Examiner, performed the autopsy on Patient A on April 29, 2002. Dr. Hunsaker concluded that Shawn had died of combined Methadone and Nordiazepam intoxication.
5. Danna Droz, RPh, JD, Cabinet for Health Services, Drug Control and Professional Services, Manager was requested to examine the licensee's prescribing patterns and identify patients with whom inappropriate prescribing may have occurred. Ms. Droz listed 24 patients whose records should be reviewed by a Board Consultant. Ms. Droz's review of the licensee's KASPER records raised the following concerns:

    1. Long-term use of one or more controlled substances, sometimes in unusual combinations;
    2. Combinations of controlled substances favored by persons who abuse or divert controlled substances;
    3. Patients using multiple pharmacies;

4. Patients driving long distances (Prestonsburg, Salyersville, Monticello, Bowling Green & Georgetown) to see this physician;
5. Long term use of acetaminophen-containing compounds at near toxic levels, especially in a patient who is 70 years old; and
6. Patients getting refills from 2 prescriptions at the same time which could indicate inadequate record keeping by the physician;

Ms. Droz reported that these conclusions were reached and patient names selected after review of only one-third of the KASPER records. (July 1, 2001 through August 31, 2002)

6. Pat Sowers, Investigator with the Drug Enforcement Administration (DEA), stated that his agency and the Louisville Metro Narcotics Unit investigated the licensee with special attention to his prescribing and billing practices. Mr. Sowers described one incident in which an undercover officer, posing as a patient, was sent to see the licensee in September 2002. After what was described as a cursory examination for a stiff back, the undercover officer was given a prescription for 60 Methadone tablets, 10mg. The receptionist told the officer that he had to pay $170 in cash for the office visit because they did not accept checks. On the second visit, 30 days later, the licensee apologized to the officer for not giving him 120 tablets the first time and told him he should have come back for more. At that point, the licensee asked him how he felt and he said fine; he had no pain. The licensee gave him another prescription for Methadone, 120 tablets, 10mg., and charged him $60 in cash for the office visit. In addition to listening to this conversation (the officer was wearing a recording device), Mr. Sowers tape recorded the conversations.

7. On August 29, 2002, Howard R. Udell, Executive Vice President and General Counsel for Purdue Pharma L.P., (manufacturers of Oxycontin) notified the Board by letter, of their concerns regarding potentially inappropriate prescribing of Oxycontin by the licensee.

8. Robin E. Abrams, Attorney for Purdue Pharma, outlined in her memorandum to the Board that a Purdue Pharma sales representative and her District Manager, had both expressed concerns regarding the licensee's prescribing of Oxycontin. Ms. Abrams stated that the sales representative initially reported to them in February of 2001 that a number of physicians were arrested in Louisville, KY for misprescribing and diverting Oxycontin. Shortly afterwards, the licensee's prescribing of Oxycontin was "reduced dramatically." However, after about a year, he started back and his prescribing of the drug constantly increased.

   Being concerned about his prescribing habits, the sales representative would often talk to the licensee about patient abuse, the importance of urine screening, pill counts, and KASPER reports. At first, he would listen to her and adopt her recommendations. Unfortunately, this would only last a little while and he would revert back to his old ways. The sales representative also reported that some of the office staff told her that the licensee had stopped urine screenings and he told all of his patients that were prescribed Oxycontin to take at least one tablet "before going to bed." The sales representative was also told of patients driving in groups from large distances to see him and paying cash for their prescriptions.

   The District Manager reported that he had recently attended a meeting with Louisville Metro Narcotics and they were apparently investigating the licensee.

He also stated that he and the sales representative had spoken to the licensee on several occasions about precautionary measures regarding his prescribing, but apparently to no avail. The District Manager suggested that Purdue no longer call on the licensee.

Ms. Abrams' stated that based on the information they had received from both the sales representative and her District Manager, Purdue Pharma has decided to no longer call on the licensee and to turn over all the information they had to the Kentucky Board of Medical Licensure for follow-up.

9. During the course of the investigation, the Purdue Pharma sales representative was interviewed. The sales representative stated that she has been a sales representative in the Louisville area for Purdue Pharma for over two years. In that time she established a good relationship with the licensee and his staff. Although she feels he runs a "sloppy business" she does not think he is doing anything malicious or unethical and that he thinks, as he often told her, that people come to him because they have no place else to go. The sales representative generally called on the licensee about twice a month and because of her concerns and those of his staff she made a point of trying to convince him of the importance of patient screening, doing pill counts, urine testing, and running KASPER reports. It appeared for a little while that the licensee would take her advice, but then he would eventually drift back to his old habits, which was very frustrating to her.

The office staff often told her stories about patients driving great distances to Louisville to get prescriptions for Methadone, Oxycontin, and other drugs and

about how they would pay cash even though they were unemployed. They also told about anonymous telephone calls to the office, informing the licensee that patient so and so was selling their Oxycontin. When told about the calls, the licensee would brush it off saying it was just patients telling on each other.

Another time the staff told the licensee they were concerned about a husband and wife team that drove up from Monticello, KY about three hours from Louisville, to get a prescription for large amounts of Oxycontin, Lortab, and Vicodin. The couple always paid cash and also paid in cash to have the prescriptions filled, usually amounting to thousands of dollars. The next day, the couple's son would show up and get the same amount. The licensee told them not to worry, there was a lot of scum "out there" and if they did something bad with their "meds" it was their problem.

The sales representative recalled that she had also asked the licensee why he would give "meds" to patients, knowing they might be abusing them and he told her, "I really don't give a fu*k. There are a bunch of idiots out there and if one of them dies off, it's just one less scum on the street." The sales representative, under orders from Purdue Pharma, no longer has contact with the licensee or his staff.

10. The District Manager for Perdue Pharma, reported that he had noticed for sometime a lack of consistency in the licensee's practice and what he described was his "failure to follow State Medical Board guidelines and those of the DEA." It also became apparent to him that the sales representative was wasting her time in trying to get the licensee to conform. So, in light of the investigation being

conducted by Louisville Metro Narcotics, he felt it prudent for Purdue Pharma to quit calling on the licensee altogether.

11. Patient B was interviewed during the course of the investigation and reported that she has been undergoing Methadone treatment by the licensee. Patient B has seen him at least five times. Patient B drives three hours from Albany, KY, to see him because they do not have a Methadone Clinic in her area and added that even if they did, she could not afford what they would charge her. The main issue she had with the licensee is that in addition to charging $150 in cash for each office visit, he also charges another $50 or $60 in cash for shots that she feels are unnecessary. She thinks he gives them just to make extra money and if you refuse he won't give you a prescription.

    Patient B recalled on one occasion that the licensee wanted to give her a shot in her back and she told him "no." She was afraid he would paralyze her. Instead, he gave her the shot in the knee. In closing, Patient B says she knows for a fact that a lot of people in her area drive to Louisville to see the licensee because of his reputation for giving people what they want.

12. During the course of the investigation, the Board received a letter dated July 21, 2003 from Kathleen Hunter, M.D.. Dr. Hunter expressed her concerns regarding the dispensing of Methadone by the licensee to a patient at the plant where she worked. She was especially "concerned" and "somewhat perplexed" that the patient had been prescribed a course of "Methadone 10mgs #180, with instructions to take two every eight hours for low back pain, stiffness of the neck, and numbness and tingling of the hands. At this same visit he was given

prescriptions for Cyclobenzaprine 10 mgs #90 to take three at night as needed for insomnia and muscle spasms and Imipramine 10 mgs #30 to take four at night as needed. Dr. Hunter was concerned with the dispensing of methadone and the quantity of it by the licensee.

13. The licensee was interviewed regarding the grievance filed by Patient A's mother. The licensee reported that he saw Patient A for the first time on January 28, 2002. He presented with lower back pain and told him that he had been in an automobile accident that resulted in an "L1 fracture that required internal fixation." He initially prescribed Methadone and Cyclobenzaprine and later changed the Cyclobenzaprine to Soma because of Patient A 's "continued nocturnal muscle cramps to the left calf." On April 24, 2002, Patient A was placed on Paxil CR 12.5, because of increased nervousness over his father having been diagnosed with "metastatic cancer." At no time was he ever placed on Valium. The licensee also provided a letter dated November 27, 2002 providing the same details of his treatment of Patient A.

14. As to his overall prescribing practices and pain management practice, the licensee reported that his patient load is about 700 to 800 a month and he usually adds about 30 a month to that figure. On the other hand he will drop just as many because they fail to pass a drug test or he feels they might be doctor shopping. Most of his patients are described as being on the low end of the per capita scale and are usually people who have been injured on the job, been involved in car accidents, and so on. They come from all over the state and because they call and make appointments no inquiry is made as to where they live. He tries to do

background checks, but is not always successful and therefore has to rely on what the patients tell him.

The licensee was asked about a family that travels from Monticello to see him and then obtains prescriptions for large amounts of Oxycontin. He responded that it was probably Patients C and D, and he agrees he might be giving them too much medication and will look into the matter. The husband, Patient C, he thinks, was getting 600 tablets a month and his wife, Patient D, 300. The husband had apparently suffered a back injury while working on a roof and the wife had been hurt in an automobile accident.

In response to his record keeping and certain charts selected for review, the licensee stated he takes a history and does a physical examination on every patient with the focus being on pain. Once he has established "an anatomic and physiologic basis for the pain," he starts the patient on the appropriate treatment program, which generally consists of pain medications, exercise, and injections (prolotherapy) in the affected area. In addition, his office uses KASPER and drug screening tests to detect doctor shopping and/or duplication of medications. The licensee feels the medical records will speak for themselves.

The licensee provided a written response dated November 27, 2002 providing the same details of his pain management practice discussed in his interview. In his written response the licensee acknowledged problems highlighted by Danna Droz's review of the licensee's KASPER and stated that steps have been taken to prevent such errors from occurring again.

15. A Board consultant reviewed 26 patient files and other information from the Board's investigation. The Panel has considered the Consultant's report and incorporates it by reference into the findings of fact. Specifically, the Consultant concluded, in part,

> In summary as regards narcotics, there is a point at which the strength and the quantity of a narcotic prescribed is clearly excessive for the diagnosis. These cases [reviewed] demonstrate a clear pattern of such practice. It is apparent that a patient need only present to Dr. Thurman's office with a complaint of pain and no supporting documentation, and that patient can leave the office with a prescription for a large quantity of a schedule III or II narcotic.
>
> It is my opinion Dr. Thurman's practice in prescribing controlled substances departs from the boundaries of acceptable practice within the Commonwealth of Kentucky as outlined in this report. It is my opinion that this physician has established a pattern of such acts, which would be gross incompetence, ignorance, negligence, or malpractice. This pattern of acts is outlined earlier in this report. Given these findings it is my opinion this physician's practice of inappropriately prescribing controlled substances does constitute a danger to the health and safety of these patients and to the general public.

16. In his review of patient records, the Board Consultant noted deficiencies in the following areas:

- Lack of detail regarding past treatment of the patient
- Inadequate information as to past medications tried and failed
- Failure to obtain past medical records, MRIs and X-rays
- Inadequate initial psychiatric assessment
- Psychiatric diagnosis rarely stated despite prescribing psychotropic medication
- Failure to inquire about substance abuse history
- Pain listed as diagnosis (Pain is symptom not diagnosis)
- Treatment plans inadequate
- Initial KASPER was rare
- Failure to use drug contract (Patients not advised of addictive potential of narcotics)
- Inadequate documentation to support prescribing of addictive muscle relaxants
- Chronic use of benozdiazepines

- Too high of a dosage of too strong a narcotic for too weak of a diagnosis

The Board Consultant highlighted several patients that illustrated the problems noted above. Specifically, the Consultant addressed the treatment of Patient E as follows:

> Patient E was a 46 y.o. male who seven days prior to his initial office visit with Dr. Thurman developed a spontaneous onset of pain in the medial right scapula while lying in bed. A scan and x-ray were ordered and the patient was given a Rx for 200 Oxycodone 5mg. He was seen in follow-up eight days later. The bone scan was negative. The x-rays had been done the before the follow-up visit but not read. The patient was given another Rx for 200 of the 5mg Oxycodone. This means the patient was going through 25 per day of the Oxycodone 5mg for a working diagnosis of thoracic strain. On subsequent follow-up visits an MRI of the thoracic spine was basically negative.
>
> A KASPER was obtained two months after Dr. Thurman started treatment. The KASPER showed the patient had received multiple narcotic prescriptions including both pain pills and cough syrups from two different doctors in the year leading up to his first visit with Dr. Thurman. Despite the benign diagnosis and evident prior high narcotic consumption, these narcotics were continued. Eventually the patient was moved up to Morphine Sulfate and finally to a combination of OxyContin 120 mg per day and Oxycodone 60 mg per day. For a diagnosis of thoracic strain, this prescribing begs description.

17. As to Patient A, subject of the original grievance, the Board Consultant concluded,

> [i]n my opinion, it is grossly negligent to take a patient with a seven-year - old injury such as this with no prior medical records, no history of prior drug treatment, and who was reportedly on no medications at that time and to start them out on 60mg per day of Methadone. Even worse is to increase that dose by 50% one month later and then increase that dose by another 33% in another month.

18. The Panel finds there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.

19. The Panel finds and concludes that controlled substances are controlled and regulated by the General Assembly because they are, by their very nature, dangerous to the public if not handled appropriately. They present a danger to the health, welfare and safety of patients if they are not prescribed or are not taken in an appropriate manner. To that end, the Board has promulgated guidelines which set out the appropriate and safe manner in which to provide such substances to patients. (Guidelines for Prescribing Controlled Substances; *adopted* 6/20/1996 and Model Guidelines for the Use of Controlled Substances in Pain Treatment; *adopted* 3/22/2001 and Considerations for Prescribing Benzodiazepines; *adopted* 6/18/98) Controlled substances create a danger to the health, welfare and safety of the public if they are diverted for illegal sale and/or use. The Panel specifically finds and concludes that the prescribing of controlled substances to patients creates a danger to the public health, safety and/or welfare if a physician prescribes such substances in a manner inconsistent with the Board's guidelines

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal basis for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms

of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.

3. There is probable cause to believe that the licensee has violated KRS 311.595(9), as illustrated by 311.597(1)(a), (b), (d), (3) and (4) [standard of care: (Guidelines for Prescribing Controlled Substances; *adopted* 6/20/1996 and Model Guidelines for the Use of Controlled Substances in Pain Treatment; *adopted* 3/22/2001 and Considerations for Prescribing Benzodiazepines; *adopted* 6/18/98)].

4. The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.

5. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general. Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.

6. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

   KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel B hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by David H. Thurman, M.D., is SUSPENDED and Dr. Thurman is prohibited from practicing medicine in the Commonwealth of Kentucky until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

Inquiry Panel B further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 16th day of October, 2003.

PRESTON P. NUNNELLEY, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed via certified mail return-receipt requested David H. Thurman, M.D., 801 Barrett Avenue, #108, Louisville, Kentucky 40204 on this 16th day of October, 2003.

L. Chad Elder by C William

L. CHAD ELDER
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
502/429-8046

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COMPLAINT

Comes now the Complainant Preston P. Nunnelley, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on October 16, 2003, states for its Complaint against the licensee, David H. Thurman, M.D., as follows:

1. At all relevant times, David H. Thurman, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Physical Medicine and Rehabilitation.
3. On August 9, 2002, the Board received a grievance alleging that the licensee provided inappropriate care to grievant's son, Patient A. The allegations include that the licensee inappropriately prescribed Methadone to Patient A, which caused the patient's death by drug overdose.
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13. The licensee was interviewed regarding the grievance filed by Patient A's mother. The licensee reported that he saw Patient A for the first time on January 28, 2002. He presented with lower back pain and told him that he had been in an automobile accident that resulted in an "L1 fracture that required internal fixation." He initially prescribed Methadone and Cyclobenzaprine and later changed the Cyclobenzaprine to Soma because of Patient A 's "continued nocturnal muscle cramps to the left calf." On April 24, 2002, Patient A was placed on Paxil CR 12.5, because of increased nervousness over his father having been diagnosed with "metastatic cancer." At no time was he ever placed on Valium. The licensee also provided a letter dated November 27, 2002 providing the same details of his treatment of Patient A.

14. As to his overall prescribing practices and pain management practice, the licensee reported that his patient load is about 700 to 800 a month and he usually adds about 30 a month to that figure. On the other hand he will drop just as many

because they fail to pass a drug test or he feels they might be doctor shopping. Most of his patients are described as being on the low end of the per capita scale and are usually people who have been injured on the job, been involved in car accidents, and so on. They come from all over the state and because they call and make appointments no inquiry is made as to where they live. He tries to do background checks, but is not always successful and therefore has to rely on what the patients tell him.

The licensee was asked about a family that travels from Monticello to see him and then obtains prescriptions for large amounts of Oxycontin. He responded that it was probably Patients C and D, and he agrees he might be giving them too much medication and will look into the matter. The husband, Patient C, he thinks, was getting 600 tablets a month and his wife, Patient D, 300. The husband had apparently suffered a back injury while working on a roof and the wife had been hurt in an automobile accident.

In response to his record keeping and certain charts selected for review, the licensee stated he takes a history and does a physical examination on every patient with the focus being on pain. Once he has established "an anatomic and physiologic basis for the pain," he starts the patient on the appropriate treatment program, which generally consists of pain medications, exercise, and injections (prolotherapy) in the affected area. In addition, his office uses KASPER and drug screening tests to detect doctor shopping and/or duplication of medications. The licensee feels the medical records will speak for themselves.

The licensee provided a written response dated November 27, 2002 providing the same details of his pain management practice discussed in his interview. In his written response the licensee acknowledged problems highlighted by Danna Droz's review of the licensee's KASPER and stated that steps have been taken to prevent such errors from occurring again.

15. A Board consultant reviewed 26 patient files and other information from the Board's investigation. The Panel has considered the Consultant's report and incorporates it by reference into the findings of fact. Specifically, the Consultant concluded, in part,

> In summary as regards narcotics, there is a point at which the strength and the quantity of a narcotic prescribed is clearly excessive for the diagnosis. These cases [reviewed] demonstrate a clear pattern of such practice. It is apparent that a patient need only present to Dr. Thurman's office with a complaint of pain and no supporting documentation, and that patient can leave the office with a prescription for a large quantity of a schedule III or II narcotic.
>
> It is my opinion Dr. Thurman's practice in prescribing controlled substances departs from the boundaries of acceptable practice within the Commonwealth of Kentucky as outlined in this report. It is my opinion that this physician has established a pattern of such acts, which would be gross incompetence, ignorance, negligence, or malpractice. This pattern of acts is outlined earlier in this report. Given these findings it is my opinion this physician's practice of inappropriately prescribing controlled substances does constitute a danger to the health and safety of these patients and to the general public.

16. In his review of patient records, the Board Consultant noted deficiencies in the following areas:

- Lack of detail regarding past treatment of the patient
- Inadequate information as to past medications tried and failed
- Failure to obtain past medical records, MRIs and X-rays
- Inadequate initial psychiatric assessment
- Psychiatric diagnosis rarely stated despite prescribing psychotropic medication

- Failure to inquire about substance abuse history
- Pain listed as diagnosis (Pain is symptom not diagnosis)
- Treatment plans inadequate
- Initial KASPER was rare
- Failure to use drug contract (Patients not advised of addictive potential of narcotics)
- Inadequate documentation to support prescribing of addictive muscle relaxants
- Chronic use of benozdiazepines
- Too high of a dosage of too strong a narcotic for too weak of a diagnosis

The Board Consultant highlighted several patients that illustrated the problems noted above. Specifically, the Consultant addressed the treatment of Patient E as follows:

> Patient E was a 46 y.o. male who seven days prior to his initial office visit with Dr. Thurman developed a spontaneous onset of pain in the medial right scapula while lying in bed. A scan and x-ray were ordered and the patient was given a Rx for 200 Oxycodone 5mg. He was seen in follow-up eight days later. The bone scan was negative. The x-rays had been done the before the follow-up visit but not read. The patient was given another Rx for 200 of the 5mg Oxycodone. This means the patient was going through 25 per day of the Oxycodone 5mg for a working diagnosis of thoracic strain. On subsequent follow-up visits an MRI of the thoracic spine was basically negative.
>
> A KASPER was obtained two months after Dr. Thurman started treatment. The KASPER showed the patient had received multiple narcotic prescriptions including both pain pills and cough syrups from two different doctors in the year leading up to his first visit with Dr. Thurman. Despite the benign diagnosis and evident prior high narcotic consumption, these narcotics were continued. Eventually the patient was moved up to Morphine Sulfate and finally to a combination of OxyContin 120 mg per day and Oxycodone 60 mg per day. For a diagnosis of thoracic strain, this prescribing begs description.

17. As to Patient A, subject of the original grievance, the Board Consultant concluded,

> [i]n my opinion, it is grossly negligent to take a patient with a seven-year - old injury such as this with no prior medical records, no history of prior drug treatment, and who was reportedly on no medications at that time and

to start them out on 60mg per day of Methadone. Even worse is to increase that dose by 50% one month later and then increase that dose by another 33% in another month.

18. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by 311.597(1)(a), (b), (d), (3) and (4). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.

19. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) His failure to respond may be taken as an admission of the charges;

    (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

20. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for May 26 and 27, 2004 at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by David H. Thurman, M.D.

This 16th day of October, 2003.

PRESTON P. NUNNELLEY, M.D.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed to Division of Administrative Hearings, 1024 Capital Center Drive, Frankfort, Kentucky 40601-8204; and a copy was mailed via certified mail return-receipt requested David H. Thurman, M.D., 801 Barrett Avenue, #108, Louisville, Kentucky 40204 on this 16th day of October, 2003.

L Chad Elder by C Wyl Usp

L. CHAD ELDER
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