Final Order No. DOH-07-2565-FOI-MQA
FILED DATE - 12-19-07
Department of Health
By: Rachel Deen
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2004-37880
LICENSE NO.: ME0057877

JACK K. GRAY, JR., M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) on November 30, 2007, in Orlando, Florida, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED that Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED, and shall constitute discipline upon Respondent's license.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 18 day of DECEMBER, 2007.

BOARD OF MEDICINE

Larry McPherson, Jr., Executive Director
for H. FRANK FARMER, JR., M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to JACK K. GRAY, JR., M.D., 2612 Shady Grove Lane, Knoxville, Tennessee 37921; and by interoffice delivery to Ephraim Livingston, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3265 this 19 day of December, 2007.

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Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. DOH Case No. 2004-37880

JACK K. GRAY, Jr, M.D.,

Respondent.
_____/

VOLUNTARY RELINQUISHMENT OF LICENSE

Respondent Jack K. Gray, Jr., M.D., license No. ME57877, hereby voluntarily relinquishes Respondent's license to practice Medicine in the State of Florida and states as follows:

1. Respondent's purpose in executing this Voluntary Relinquishment is to avoid further administrative action with respect to this cause. Respondent understands that acceptance by the Board of Medicine (hereinafter the Board) of this Voluntary Relinquishment shall be construed as disciplinary action against Respondent's license pursuant to Section 456.072(1)(f), Florida Statutes.

2. Respondent agrees to never reapply for licensure as a Medical Doctor in the State of Florida.

3. Respondent agrees to voluntarily cease practicing Medicine immediately upon executing this Voluntary Relinquishment. Respondent further agrees to refrain from the practice of Medicine until such time as this Voluntary Relinquishment is presented to the Board and the Board issues a written final order in this matter.

4. In order to expedite consideration and resolution of this action by the Board in a public meeting, Respondent, being fully advised of the consequences of so doing, hereby waives the statutory privilege of confidentiality of Section 456.073(10), Florida Statutes, and waives a determination of probable cause, by the Probable Cause Panel, or the Department when appropriate, pursuant to Section 456.073(4), Florida Statutes, regarding the complaint, the investigative report of the Department of Health, and all other information obtained pursuant to the Department's investigation in the above-styled action. By signing this waiver, Respondent understands that the record and complaint become public record and remain public record and that information is immediately accessible to the public. Section 456.073(10) Florida Statutes.

5. Upon the Board's acceptance of this Voluntary Relinquishment, Respondent agrees to waive all rights to seek judicial review of, or to otherwise

challenge or contest the validity of, this Voluntary Relinquishment and of the Final Order of the Board incorporating this Voluntary Relinquishment.

6. Petitioner and Respondent hereby agree that upon the Board's acceptance of this Voluntary Relinquishment, each party shall bear its own attorney's fees and costs related to the prosecution or defense of this matter.

7. Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent in connection with the Board's consideration of this Voluntary Relinquishment. Respondent agrees that consideration of this Voluntary Relinquishment and other related materials by the Board shall not prejudice or preclude the Board, or any of its members, from further participation, consideration, or resolution of these proceedings if the terms of this Voluntary Relinquishment are not accepted by the Board.

DATED this 25 day of October, 2007.

Jack K. Gray Jr.
Jack K. Gray, Jr., M.D.

STATE OF TN :
COUNTY OF Knox :
Before me, personally appeared Jack K. Gray Jr M.D, whose identity is known to me by TN DL 059103792 (type of identification) and who, under oath, acknowledges that his signature appears above. Sworn to and subscribed before me this 25 day of October, 2007.

Carrie Brown Merschat
NOTARY PUBLIC

My Commission Expires: 12/7/2010

Carrie Brown Merschat NOTARY PUBLIC LARGE

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2004-37880**

JACK K. GRAY, Jr., M.D.,

RESPONDENT.

_____/

10/11/04

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against the Respondent, Jack K. Gray, Jr., M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent's address of record is 2612 Shady Grove Lane, Knoxville, Tennessee 37921.

3. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida having been issued license number 57877.

4. From in or about 1997 through on or about August 27, 2004, Respondent provided treatment for Patient S.L., a fifty-five (55) year old male.

5. Patient S.L. had a history of a work related accident in 1987 resulting in four crushed vertebrae, chronic back pain, and an adjustment disorder with depressive mood. Patient S.L. was then treated for depression with Prozac and later started on Oxycontin to manage his low back pain.

6. The Respondent's medical records for Patient S.L. do not contain a record of an initial evaluation or examination or any notes that would indicate a reason why Respondent chose the treatment he did. The history in those records appears to have been directly provided by Patient S.L. in the patient's self-report questionnaire.

7. Respondent treated Patient S.L. for management of chronic pain as well as psychiatric complications, such as mood disorder secondary to chronic pain, and a chronic adjustment disorder. In the course of the treatment, Patient S.L. was initially seen monthly until the beginning of 2002 when the frequency was changed to every three to four months.

8. Respondent provided Patient S.L. with various psychotropic medications including therapeutic doses of the antidepressant medications,

Effexor and Prozac, as well as a benzodiazepine agent, Valium, for management of spasms associated with his painful condition. Respondent provided prescriptions for Soma, as well as Ambien, a sleep-inducing medication.

9. However, the core of the treatment and the only medication taken throughout the entire course was the opioid agonist, Oxycodone in the long-acting form Oxycontin. The patient's dose was escalated from an initial 80 mg BID (twice daily) to 480 mg BID and maintained at this level for a period of several years prior to his death. The patient was also receiving treatment with an antipsychotic medication, Seroquel, which was given to him for the purpose of treatment of his insomnia, as well as "agitation".

10. Patient S.L was not asked to provide a signed controlled substances agreement authorizing Respondent to be the only treating physician prescribing antidepressant and pain medications. There is no documentation of urine toxicology screens, pill counts, or pharmacy surveillance having been performed. On several occasions, Respondent postdated schedule II medication prescriptions for Patient S.L.

11. Respondent noted in his medical records that there was no family history of addiction even though in the questionnaire Patient S.L.

reported that both of his parents were alcoholics. The patient was known to be a smoker but there was no noted history of past substance abuse problems. There was no record of treatment by any other physicians included in the medical records. There was a copy of a release signed by the patient as well as a letter from Respondent requesting review of x-rays but no documentation suggesting that such records were ever obtained, reviewed or considered.

12. Respondent re-evaluated Patient S.L. every three months and documented a history and psychiatric evaluation.

13. Patient S.L.'s last visit with Respondent was on or about August 27, 2004, and he was scheduled for a follow-up appointment on January 7, 2005. However, on or about October 16, 2004, Patient S.L. was found deceased by paramedics. The coroner found excessively high levels of Oxycodone in Patient S.L.'s toxicology specimens.

14. Oxycontin is a semi-synthetic opiate that contains Oxycodone hydrochloride, a schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the relief of moderate to severe pain. Oxycontin has a high potential for abuse and has a currently accepted but limited medical use in treatment in the United States. Abuse of this substance may lead to severe physical and psychological dependence.

15. There was no documentation in Respondent's medical records for Patient S.L. of any physical examination including instances when the patient reported worsening or other change in the severity of his condition.

16. There is no other documentation in Respondent's medical records for Patient S.L. of psychiatric examination of the patient other than the note in the patient's records under the heading "Mental Status." There is no assessment form corresponding to these notes containing documentation that mental status examinations were performed. In the absence of a thorough examination of the patient, it is impossible to make an accurate diagnosis as well as differential diagnosis and formulate an appropriate treatment plan.

17. Respondent did not set reasonably frequent follow-up visits. According to the guidelines for opioid therapy in chronic nonmalignant patient as published in "Opioids in Pain Control, Basic and Clinical Aspects," Cambridge University Press, 1999, stating on page 3004:

> The patient should be seen monthly for the first 6 months and every 2 months thereafter. At each visit, the patient should be assessed for analgesia opioid-related side effects, compliance with functional goals and presence of aberrant drug-related

behavior. All of this documentation should be documented in the medical record..

18. Considering that Respondent was treating Patient S.L. with relatively high dose opioid therapy, (Patient S.L. weighed about 120 pounds and was taking over 900 mg of Oxycodone daily) a prudent physician should consider seeing such a patient at a minimum of every other month.

19. Respondent failed to assess the presence of aberrant drug taking behavior and/or opioid therapy-related side effects and complications that is expected of a prudent physician. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse and diversion. Opioid agonists delay gastric emptying and increase intestinal motility. Codeine continues to be prescribed for this anti-diarrhea side effect. Constipation is such a common side effect that it is expected to be present in varying degrees in all patients receiving opioids; certainly in the case of a patient taking such dose of opioid medication as did Patient S.L. Certainly, as a part of the monitoring of the patient, not only documentation of the steps undertaken to diligently ascertain that there was no such complication, an effort was needed to monitor the patient's compliance with some verifiable methods, such as periodic drug testing.

20. Respondent did not sufficiently document the process of obtaining informed consent. The issue is not as much as to whether he obtained a consent form for treatment with controlled substances but that he did not adequately document what discussion, if any, took place with the patient in regard to the risk/benefit analysis. The Florida Guidelines in Rule 64B8-9.013, Florida Administrative Code, require that such informed consent be documented in the clinical records.

COUNT ONE

21. Petitioner realleges and incorporates paragraphs one (1) through twenty (20) as if fully set forth herein.

22. Section 458.331(1)(t), Florida Statutes (1997-2003), provides that failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances constitutes grounds for disciplinary action by the Board of Medicine.

23. Rule 64B8-9.013, Florida Administrative Code, establishes the Board's standards and guidelines for the use of controlled substances for the treatment of pain.

24. Respondent failed to practice medicine with that level of care, skill, and treatment of Patient S.L. which is recognized by a reasonably

prudent similar physician as being acceptable under similar conditions and circumstances in one or more of the following ways:

a) By failing to record an initial evaluation or examination or make adequate notes that would indicate the reason why Respondent chose the treatment he did;

b) By failing to obtain a signed controlled substances agreement authorizing Respondent to be the only treating physician prescribing antidepressant and pain medications;

c) By failing to document urine toxicology screens, pill counts, or pharmacy surveillance;

d) By postdating one or more schedule II medication prescriptions;

e) By noting in the medical records that there was no family history of addiction even though in the questionnaire Patient S.L. reported that both of his parents were alcoholics;

f) By failing to record treatment by any other physicians and failing to document that such records were ever obtained, reviewed or considered;

g) By failing to document in the medical records any physical examination including for instances when the patient reported worsening or other change in the severity of his condition;

h) By failing to document in the medical records psychiatric examination of the patient and not preparing an assessment form corresponding to his notes headed "Mental Status" indicating that mental status examinations were performed;

i) By Respondent failing to set reasonably frequent follow-up visits;

j) By failing to assess the presence of aberrant drug taking behavior and/or opioid therapy-related side effects and complications;

k) By failing to sufficiently document the process of obtaining informed consent in that he did not adequately document what discussion, if any, took place with the patient in regard to the risk/benefit analysis in compliance with Rule 64B8-9.013, Florida Administrative Code, that requires informed consent be documented in the clinical records;

l) By failing to adequately evaluate, diagnose or treat Patient S.L.

25. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (1997-2003), by failing to practice medicine within the standard of care which would be recognized by a reasonably prudent medical professional under similar conditions and circumstances.

COUNT TWO

26. Petitioner realleges and incorporates paragraphs one (1) through twenty (20) as if fully set forth herein.

27. Section 458.331(1)(q), Florida Statutes (1997-2003), provides that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice is grounds for disciplinary action by the Board of Medicine. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to his or her intent.

28. Respondent prescribed legend drugs, including a controlled substance, inappropriately or in excessive or inappropriate quantities, without medical justification, endangering the patient's health, not in the

best interest of Patient S.L. and not in the course of the physician's professional practice, in one or more of the following ways:

a) By failing to obtain a signed controlled substances agreement authorizing Respondent to be the only treating physician prescribing antidepressant and pain medications;

b) By failing to document urine toxicology screens, pill counts, or pharmacy surveillance;

c) By postdating one or more schedule II medication prescriptions;

d) By failing to assess the presence of aberrant drug taking behavior and/or opioid therapy-related side effects and complications;

e) By failing to sufficiently document the process of obtaining informed consent in that he did not adequately document what discussion, if any, took place with the patient in regard to the risk/benefit analysis in compliance with Rule 64B8-9.013, Florida Administrative Code, that requires informed consent be documented in the clinical records;

f) By failing to adequately evaluate, diagnose or treat Patient S.L.

29. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (1997-2003), by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to his or her intent.

COUNT THREE

30 Petitioner realleges and incorporates paragraphs one (1) through twenty (20) as if fully set forth herein.

31. Section 458.331(1)(m), Florida Statutes (1997-2003), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, constitutes grounds for disciplinary action by the Board of Medicine.

32. Respondent failed to keep legible medical records justifying the course of treatment in one or more of the following ways:

a) By failing to record an initial evaluation or examination or make adequate notes that would indicate the reason why Respondent chose the treatment he did;

b) By failing to obtain a signed controlled substances agreement authorizing Respondent to be the only treating physician prescribing antidepressant and pain medications;

c) By failing to document urine toxicology screens, pill counts, or pharmacy surveillance;

d) By postdating one or more schedule II medication prescriptions;

e) By noting in the medical records that there was no family history of addiction even though in the questionnaire Patient S.L. reported that both of his parents were alcoholics;

f) By failing to record treatment by any other physicians and failing to document that such records were ever obtained, reviewed or considered;

g) By failing to document in the medical records any physical examination including for instances when the patient reported worsening or other change in the severity of his condition;

h) By failing to document in the medical records psychiatric examination of the patient and not preparing an assessment form corresponding to his notes headed "Mental Status" indicating that mental status examinations were performed;

i) By failing to sufficiently document the process of obtaining informed consent in that he did not adequately document what discussion, if any, took place with the patient in regard to the risk/benefit analysis in compliance with Rule 64B8-9.013, Florida Administrative Code, that requires informed consent be documented in the clinical records.

33. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (1997-2003), by failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 16th **day of** April, **2007.**

Ana M. Viamonte Ros, M.D., M.P.H.
Secretary, Department of Health

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Lilli Mumhard
DATE 4/10/07

By: Irving Levine
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DOH-Prosecution Services Unit
4052 Bald Cypress Way-Bin C-65
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Florida Bar # 0822957
(850) 245-4640 X8128
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PCP: April 13, 2007

PCP Members: Ashkar, Bearison, Beebe

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.