FILED OF RECORD

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K.B.M.L.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1726

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY GARY C. PATTON, M.D., LICENSE NO. 24639, 501 DARBY CREEK ROAD, SUITE 55, LEXINGTON, KENTUCKY 40509

ORDER OF REVOCATION

On July 21, 2016, the Kentucky Board of Medical Licensure (hereinafter "the Board"), acting by and through its Hearing Panel B, took up this case for final action. The members of Panel B reviewed the Complaint, filed April 22, 2016; the hearing officer's Recommended Order Finding Gary C. Patton, M.D., in Default, dated June 22, 2016; and a June 24, 2016 memorandum from the Board's counsel. The licensee, Gary C. Patton, M.D., did not file exceptions to the hearing officer's recommended order and did not appear before the Panel.

Having considered all the information available and being sufficiently advised, Hearing Panel B ACCEPTS the hearing officer's recommended findings and ADOPTS those findings and INCORPORATES them BY REFERENCE into this Order; Hearing Panel B FURTHER ACCEPTS AND ADOPTS the hearing officer's Recommended Order. (Attachment) Having considered all of the sanctions available under KRS 311.595 and the nature of the violations in this case, Hearing Panel B has determined that revocation is the appropriate sanction. Accordingly, Hearing Panel B **ORDERS**:

1. The license to practice medicine held by Gary C. Patton, M.D., is hereby REVOKED and he may not perform any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – in the Commonwealth of Kentucky;

2. The provisions of KRS 311.607 SHALL apply to any petition for reinstatement filed by the licensee; and

3. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the costs of these proceedings in the amount of $250.00, prior to filing any petition for reinstatement of his license to practice medicine in the Commonwealth of Kentucky.

SO ORDERED on this 22nd day of July, 2016.

Randel C Gibson DO

RANDEL C. GIBSON, D.O.
CHAIR, HEARING PANEL B

CERTIFICATE OF SERVICE

I certify that the original of the foregoing Order of Revocation was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601 and a copy was sent via certified mail return-receipt requested to the licensee, Gary C. Patton, M.D., License No. 24639, 501 Darby Creek Road, Suite 55, Lexington, Kentucky 40509-2610 on this 22nd day of July, 2016.

Sara Farmer

Sara Farmer
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, the effective date of this Order will be thirty (30) days after this Order of Revocation is received by the licensee.

The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel or Assistant General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested, along with a copy of this Order.

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RECOMMENDED ORDER FINDING GARY C. PATTON, M.D., IN DEFAULT AND CANCELING ADMINISTRATIVE HEARING

This action is before the hearing officer on the *Motion for Default Ruling* filed by the Kentucky Board of Medical Licensure. After reviewing the motion, the hearing officer finds it has substantial merit, and therefore, he recommends the Board find Dr. Patton in default and take any appropriate action against his license. In support of that recommendation, the hearing officer states the following:

On April 22, 2016, the Board issued the *Complaint* against Dr. Patton. The Board alleged he failed to comply with the terms of the *Second Amended Agreed Order* that required him to participate in a Personalized Implementation Program with the Center for Personalized Education for Physicians ("CPEP"). Dr. Patton had earlier entered into several agreed orders with the Board in response to reports from consultants who found deficiencies in Dr. Patton's prescribing practices for controlled substances. In this action the Board asserts Dr. Patton failed to provide CPEP with his second and third set of medical charts as part of CPEP's review, failed to communicate with CPEP after June 2015, and lied about that fact to the Board's investigator. *Complaint*, pages 7-8. Based upon that misconduct the Board has charged Dr. Patton with violating KRS 311.595(13), which subjects a licensee to sanction for violating an agreed order issued by the Board.

Attached to the Board's *Motion for Default Ruling* is a copy of the Board's certified mail receipt showing that the *Complaint* was delivered to Dr. Patton's address of record on April 25, 2016. Therefore, under the provisions of KRS 311.591(4), Dr. Patton was required to file a response to the Board's charges by May 25, 2016, and when Dr. Patton failed to file a response, the Board filed its motion for a default ruling.

Upon receipt of his copy of the motion, the hearing officer issued an order directing Dr. Patton to respond to the *Complaint* and to the *Motion for Default Ruling* within ten days of the date of the hearing officer' order. *Order Requiring Filing of Response*, dated June 1, 2016. As of the date of this recommendation, Dr. Patton has filed nothing in response to the hearing officer's order.

Under KRS 311.591(4), the "failure to submit a timely response or willful avoidance of service may be taken by the board as an admission of the charges." Dr. Patton is in default due to his failure to file a response to the *Complaint*, and pursuant to KRS 311.591(4), the Board may assume that Dr. Patton admits that the allegations in the *Complaint* are true. Based upon his admission of the factual allegations against him, Dr. Patton is in violation of KRS 311.595(13).

Because Dr. Patton is in default, the administrative hearing scheduled for July 26-27, 2016, is canceled.

RECOMMENDED ORDER

Based upon Dr. Gary C. Patton's failure to respond to the charges in the *Complaint*, the hearing officer recommends the Board find Dr. Patton in default, find that he has admitted to the charges in the *Complaint*, and find that he has violated the provisions of KRS 311.595(13). The

hearing officer further recommends the Board take any appropriate action against the license of Dr. Patton for his violation of the Board's statutes governing the practice of medicine.

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4) a party has the right to file exceptions to this recommended decision:

> A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the recommendations with the agency head.

A party also has a right to appeal the Final Order of the agency pursuant to KRS 13B.140(1) which states:

> All final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

Pursuant to KRS 23A.010(4), "Such review [by the circuit court] shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in circuit court.

SO RECOMMENDED this 22nd day of June, 2016.

THOMAS J. HELLMANN
HEARING OFFICER
810 HICKMAN HILL RD
FRANKFORT KY 40601
(502) 330-7338
thellmann@mac.com

CERTIFICATE OF SERVICE

I hereby certify that the original of this RECOMMENDATION was mailed this 22nd day of June, 2016, by first-class mail, postage prepaid, to:

JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

for filing; and a true copy was sent by first-class mail, postage prepaid, to:

GARY C PATTON MD
501 DARBY CREEK RD STE 55
LEXINGTON KY 40509

SARA FARMER
ASSISTANT GENERAL COUNSEL
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

THOMAS J. HELLMANN

1726FC

COMMONWEALTH OF KENTUCKY
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CASE NO. 1726

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COMPLAINT

Comes now the Complainant C. William Briscoe, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on April 21, 2016, states for its Complaint against the licensee, Gary C. Patton, M.D., as follows:

1. At all relevant times, Gary C. Patton, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On April 15, 2002, the licensee pled guilty to amended charges of two counts of Possession of Schedule IV Controlled Substances, based upon his accidental overdose of Ecstasy and GHB. The licensee was placed on probation and entered into a drug treatment program. The Board's Inquiry Panel B and the licensee entered into a 5-year Agreed Order of Probation in Board Case No. 840 on July 10, 2002, to address these issues. On November 10, 2005, the Panel granted the licensee's request to terminate the Agreed Order of Probation, upon his assurance that he would continue to take appropriate steps to address his substance abuse issues for an appropriate amount of time.
4. During the course of a pending Board investigation based upon two separate grievances, the Board obtained a review of the licensee's prescribing of controlled

substances for a one-year period. The reviewer recommended that the Board obtain specific patient records for review based upon the following concerns

- Combinations of controlled substances favored by persons who abuse or divert controlled substances
- Improper refills of controlled substance based on days' supply
- Patients prescribed Suboxone along with high doses of benzodiazapines, and/or tramadol which may or may not be appropriate.

5. A number of the licensee's patient records were obtained for review by a Board consultant. In a report dated April 16, 2013, the consultant concluded, in part,

...
It is clear that Dr. Patton is a caring and thorough psychiatrist. He spends time with his patients and uses several modalities of treatment, not just medication. However, there are some systemic problems with his care. Most obvious is the difficulty with documentation. Another problem is that many of the reports are dictated but apparently not proofread....

The chart of Patient A was reviewed...the urine drug screens of April 11, 2012 and May 14, 2012 are both positive for THC. This was not discussed with the patient or addressed. Also, there are not other urine drug screens in the chart. Urine drug screens should be more frequent.

The chart of Patient B was reviewed....no quantity or number of refills for medications was stated. Second, the urine drug screen of January 1, 2012 was positive for Diazepam (Valium) metabolites. This is not addressed. Third blood pressure, heart rate, and weight for this patient were not documented.

The chart of Patient C was reviewed....first, when the patient was started on Suboxone she only needed 8 mg to stabilize. On subsequent visits she was given 24 mg a day. The reason for this increase is not stated. Second, drug screens were done on March 12, 2011; October 25, 2011; March 12, 2011; and May 3, 2012. More frequent drug screens and some random screens and random pill counts are appropriate. Third, the patient was prescribed Adderall for attention deficit disorder. Since Adderall can affect heart rate, blood pressure, and weight, these should be checked periodically. This was not done.

The chart of Patient D was reviewed....prescribing for an employee except under emergency situations raises the issue of a dual relationship. As the situation did appear to be urgent and the patient lacked other resources, one time prescribing is acceptable. However, the frequency, quantity and number of refills, if any, is not stated. Nor is there any documentation of a discussion of the risks and benefits of the medicines.

The chart of Patient E was reviewed...First, the office visit of February 16, 2011 states that Klonopin 1mg TID was prescribed. The visit of May 18, 2011 does not state the current medicines. August 22, 2011 lists the Klonopin as 2mg TID. No mention is made as to when or why this increase was made. Nor is there any mention of the adverse effects that can come from increasing the dose. Second, the office visit of February 16, 2011 lists Tegretol 200 mg BID as one of the medications. However, nowhere is there a discussion of the risks and benefits of Tegretol, although this could have occurred prior to the patients transferring from the Behavioral Medicine Network to Dr. Patton's office. Also, I do not see that doctor Patton ordered a Tegretol level, necessary to determine the adequacy of the dose, or a CDC or ALT, necessary to ensure that Tegretol is not causing adverse medical effects. Third, on November 22, 2011 Dr. Patton prescribed prazosin 5mg HS. There is no documented discussion of the risks and benefits of this medicine. Nor are there any measurements of blood pressure, which can be lowered by this medicine.

The chart of Patient F was reviewed....when prescribing a stimulant such as Adderall one should routinely check blood pressure, heart rate, and weight as these can be adversely affected by the medicine.

The chart of Patient G was reviewed....as in previous cases the patient was prescribed Adderall without monitoring blood pressure, heart rate, and weight. Second, the number of refills of each medicine is not stated.

The chart of Patient H was reviewed....First, on January 10, 2012 the patient was started on Zoloft. While the indications for that this are apparent, there was no discussion as to how the medicine was started. Nor was there any discussion of the risks and benfits. Second, there is no record of the quantity and number of refills of medicines.

The chart of Patient I was reviewed...First, the note of June 19, 2011 states: "no current medicines." The note of July 26, 2011 notes current medicines as: Lamictal 25mg BID; Seroquel 25mg one BID; bupropion 75mg one BID. There is no mention as to when these medicines were started, what the indications for starting these medicines were, and whether or not the risks and benefits of these medicines were discussed with the patient.

The chart of Patient J was reviewed. Also, additional information from Dr. Patton was reviewed as was the death certificate, toxicology report, the report from Paula York, and Dr. Patton's response. The KASPER was also reviewed. First, on February 8, 2012 the patient received a prescription for Xanax 2mg BID with two refills. This prescription was not documented in the progress note. Second, on May 17, 2012 the patient received a prescription for Xanax 2mg BID number 60 with one refill. Again this was not documented in the progress note. On June 1, 2012 the patient received a prescription for Xanax 2 mg one BID and one half at

bedtime number 75 with no refills. While a dose increase may have been warranted as it was written at least six weeks before the patient would have run out, care should have been taken to void the remaining refill.

On June 20, 2012 a prescription for Xanax 2mg number 75 with one refill was written. There is no clinic note for that day. On the copy of the prescription sent to me it is written "who okayed this" and "No extension 101 exists." Presumably someone was questioning the validity of this prescription.

On July 16, 2012 a prescription was written for Xanax 2mg number 75 with one refill. There is no clinic note accompanying this. Patient J should not have needed more Xanax until October.

On August 13 2011 there was a clinic note. Patient J was prescribed Xanax 2mg number 75 with three refills. Again the script was weeks early given the previous prescriptions.

On October 15, 2013 the patient requested a 60 day supply of Xanax. He stated that he would be working out of town and would need a 60 day supply. Again, care should have been taken that the previous prescriptions have been voided prior to writing this.

6. In a report dated January 8, 2013, Paula York, Office of Inspector General, reported,

On January 2, 2013, this office received information from David Straub, a detective with Lexington Metro Narcotics. After reviewing a KASPER report for Patient J, who was found dead on December 14, 2012 of an alleged overdose, Det. Straub noted numerous prescriptions for alprazolam which had been prescribed by Dr. Gary Patton. Det. Straub was concerned Dr. Patton may have inappropriately prescribed alprazolam to Patient J.

...Det. Straub noted that Patient J had been receiving prescriptions for oxycodone 15mg, quantity of 180, and morphine sulfate ER 60mg, quantity of 60, on a monthly basis from prescribers located at The Pain Treatment Center of the Bluegrass. In addition to the pain medications, Det. Straub noted that Patient J was receiving prescriptions for alprazolam from Dr. Gary Patton, a psychiatrist practicing in Lexington, KY. Det. Straub observed numerous prescriptions for alprazolam issued for Patient J by Dr. Patton and was concerned Dr. Patton may have inappropriately prescribed alprazolam to patient Patient J.
...The prescriptions were filled at various pharmacies in Lexington.

Patient J had received prescriptions for alprazolam prior to 05/17/2012 on a monthly basis, for quantity of 60 per prescription. I contacted the pharmacies to verify if the prescriptions were written or telephoned in order to identify if new prescriptions had been issued along with active refills still remaining on older

prescriptions. After speaking with the pharmacies, a spreadsheet of all alprazolam prescriptions issued by Dr. Patton to Patient J since 05/17/2012...An analysis of the prescriptions revealed the following:

1. From 05/17/2012 through 12/07/2012, (approximately 7 months), Patient J obtained 14 prescriptions for alprazolam from six (6) different pharmacies, all prescribed by Dr. Patton
2. According to the instructions, if Patient J had taken the alprazolam prescriptions as prescribed, the amount of tablets should have lasted 14 months.
3. From 06/17/2012 through 12/07/2012, Patient J obtained 1140 tablets for alprazolam 2mg.
4. According to information provided by pharmacies, the instructions on the majority of prescriptions were for alprazolam 2mg twice daily and one-half at bedtime explaining the prescriptions for alprazolam 2mg, quantity of 75, for 30 days supply.

...

CONCLUSION: Dr. Gary Patton prescribed alprazolam 2 mg to Patient J on 14 occasions between 05/17/2012 through 12/07/2012, for what appears to be numerous overlapping prescriptions. These prescriptions resulted in Patient J obtaining 1140 tablets over approximately a seven month period.

7. The parties resolved all of the above allegations, without an evidentiary hearing, by entering into an Agreed Order of Indefinite Restriction on November 21, 2013.

8. During the course of the above investigation, the Board received a new grievance relating to the licensee, on March 19, 2013, from the parents of one of the licensee's patients. The patient's record was obtained and provided to a Board consultant for review. In a report dated September 15, 2013, the consultant concluded, in part,

Dr. Patton is thorough in his evaluation and diagnosis. He suggested treatments that are generally within the norm. However, there appears to be a difference between what the chart describes as the medication the patient was taking and what they are actually taking. For example, on July 30, 2012 he prescribed clonazepam 2 milligram. This medication change is not listed in subsequent current medication list. [The patient] is prescribed clonazepam 1mg #60 on August 29, and 2 mg #60 on September 12, 2012. The subsequent prescriptions are not reflected in the progress notes.

Another problem is that Dr. Patton does not indicate the quantity of each medicine and the number of refills prescribed. The result is that some refills are filled weeks or sometimes months after the original date. ....

Another area of concern is his family involvement. ....

The question then becomes: Did Dr. Patton know that [the patient] was impaired? Should he have known this? He certainly was aware that his treatments can cause impairment. He does note that there are no early refills (except towards the end of treatment). He does not note any evidence of impairment during his sessions with her. Urine drug screens that have been done have not shown any evidence of illicit opiate use. He repeatedly laments the lack of family involvement in [the patient's] care. The parents, in their complaint, state "we have repeatedly made phone calls and sent letters documenting her abuse of the drugs he prescribed, but to no avail." There is no mention in the medical record of these letters or phone calls. Absent any concrete evidence of these attempts to contact Dr. Patton, it is difficult to know the truth.

In summary, the problems in the treatment of [the patient] arise largely from inadequate documentation of the medication, quantity and number of refills prescribed. Regular use of KASPER would have also been helpful. Regular family involvement would have helped greatly. In previous communications, Dr. Patton indicated that he had begun changing the way he monitored prescriptions. Adequate attention to this would likely prevent these problems.

9. On or about March 18, 2014, the licensee resolved the investigation by entering into an Amended Agreed Order of Indefinite Restriction which included the following terms and conditions: the licensee could not prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel; the licensee was to complete the "Prescribing Controlled Drugs" course at Vanderbilt University Medical Center or the University of Florida; the licensee was to successfully completed the CPEP Documentation Seminar and enrolled in the PIP; the licensee was to reimburse the Board the costs of the investigation in the amount of $1,560.00, on or before May 21, 2014; and the licensee was not to violate any provision of KRS 311.595 and/or 311.597.

10. On or about May 15-17, 2014, the licensee attended the "Prescribing Controlled Drugs" course at the University of Florida.

11. In June 2014, the licensee attended the CPEP Documentation Seminar and enrolled in the PIP.

12. The licensee failed to reimburse the Board's costs by May 21, 2014. On August 12, 2014, he reimbursed a remaining balance of $399.60.

13. On or about October 16, 2014, the licensee requested and the Panel granted reinstatement of the licensee's prescribing privileges subject to terms and conditions set forth in a Second Amended Agreed Order filed on October 30, 2014.

14. The Second Amended Agreed Order required that the licensee maintain a "controlled substances log," successfully complete the Personalized Implementation Program ("PIP") offered by the Center for Personalized Education for Physicians ("CPEP"), and not violate any provision of KRS 311.595 and/or 311.597.

15. In a letter to the Board dated August 12, 2014, the licensee stated that he had enrolled in the PIP offered by CPEP.

16. In April 2015, CPEP notified the licensee that his second and third set of charts required for review in the PIP were overdue.

17. In February 2016, CPEP notified the Board that the last correspondence they had with the licensee was on June 16, 2015 when he reported that his home had caught fire and he was living in his garage. The licensee had still not provided the second and third set of charts for review.

18. During an interview with the Board investigator on February 25, 2016, the licensee stated that had notified CPEP of a fire at his home in June 2015, as well as the death of his dog. He stated he had worked something out with them.

19. The licensee was instructed by the Board investigator to submit a letter explaining why he was late in submitting charts and why he had failed to communicate with CPEP since June 2015. The letter was due March 4, 2016.

20. On March 10, 2016, the licensee sent the Board's investigator an email stating the following:

> As we discussed in our meeting, there was a mixup in the dates I submitted. My records were unfortunately destroyed in a house fire, and the information on these dates was subsequently miscommunicated to me. I apologize for the discrepancy. It was only later that I discovered the correct dates, and realized my mistake. I appreciate the opportunity to resubmit, and will be working with PIP to correct this.

21. The Board's investigator contacted Mary Minobe at CPEP, who stated that the last contact from the licensee was in June 2015. Ms. Minobe stated that CPEP sent an email to the licensee on February 23, 2016 but they had not received a response from him.

22. On or about April 21, 2016, the Board's Inquiry Panel A determined that the physician has violated the terms of an order and the licensee's practices place his patients and the public at risk and in danger. As a result, the licensee was suspended from the practice of medicine in the Commonwealth of Kentucky pending resolution of this Complaint.

23. By his conduct, the licensee has violated KRS 311.595(13).

24. Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.

25. 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.

26. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for July 26-27, 2016, 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 and pursuant to KRS Chapter 13B. 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 in the Commonwealth of Kentucky held by GARY C. PATTON, M.D.

This 22nd day of April, 2016.

C. William Briscoe MD

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellman, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601; and a copy was mailed via certified mail return-receipt requested to the licensee, Gary C. Patton, M.D., License No. 24639, 501 Darby Creek Road, Suite 55, Lexington, Kentucky 40509, on this 22nd day of April, 2016.

Sara Farmer

Sara Farmer
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

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EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel A, considered a Memorandum from Medical Investigator Kevin Payne, dated March 18, 2016; a Second Amended Agreed Order, filed of record on October 30, 2014; and an email from the licensee, dated March 10, 2016 and having considered this information and being sufficiently advised, Inquiry Panel A 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 A concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of Suspension:

1. At all relevant times, Gary C. Patton, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On April 15, 2002, the licensee pled guilty to amended charges of two counts of Possession of Schedule IV Controlled Substances, based upon his accidental overdose of Ecstasy and GHB. The licensee was placed on probation and entered into a drug treatment program. The Board's Inquiry Panel B and the licensee

entered into a 5-year Agreed Order of Probation in Board Case No. 840 on July 10, 2002, to address these issues. On November 10, 2005, the Panel granted the licensee's request to terminate the Agreed Order of Probation, upon his assurance that he would continue to take appropriate steps to address his substance abuse issues for an appropriate amount of time.

4. During the course of a pending Board investigation based upon two separate grievances, the Board obtained a review of the licensee's prescribing of controlled substances for a one-year period. The reviewer recommended that the Board obtain specific patient records for review based upon the following concerns

   - Combinations of controlled substances favored by persons who abuse or divert controlled substances
   - Improper refills of controlled substance based on days' supply
   - Patients prescribed Suboxone along with high doses of benzodiazapines, and/or tramadol which may or may not be appropriate.

5. A number of the licensee's patient records were obtained for review by a Board consultant. In a report dated April 16, 2013, the consultant concluded, in part,

   ...
   It is clear that Dr. Patton is a caring and thorough psychiatrist. He spends time with his patients and uses several modalities of treatment, not just medication. However, there are some systemic problems with his care. Most obvious is the difficulty with documentation. Another problem is that many of the reports are dictated but apparently not proofread....

   The chart of Patient A was reviewed...the urine drug screens of April 11, 2012 and May 14, 2012 are both positive for THC. This was not discussed with the patient or addressed. Also, there are not other urine drug screens in the chart. Urine drug screens should be more frequent.

   The chart of Patient B was reviewed....no quantity or number of refills for medications was stated. Second, the urine drug screen of January 1, 2012 was positive for Diazepam (Valium) metabolites. This is not addressed. Third blood pressure, heart rate, and weight for this patient were not documented.

The chart of Patient C was reviewed....first, when the patient was started on Suboxone she only needed 8 mg to stabilize. On subsequent visits she was given 24 mg a day. The reason for this increase is not stated. Second, drug screens were done on March 12, 2011; October 25, 2011; March 12, 2011; and May 3, 2012. More frequent drug screens and some random screens and random pill counts are appropriate. Third, the patient was prescribed Adderall for attention deficit disorder. Since Adderall can affect heart rate, blood pressure, and weight, these should be checked periodically. This was not done.

The chart of Patient D was reviewed....prescribing for an employee except under emergency situations raises the issue of a dual relationship. As the situation did appear to be urgent and the patient lacked other resources, one time prescribing is acceptable. However, the frequency, quantity and number of refills, if any, is not stated. Nor is there any documentation of a discussion of the risks and benefits of the medicines.

The chart of Patient E was reviewed...First, the office visit of February 16, 2011 states that Klonopin 1mg TID was prescribed. The visit of May 18, 2011 does not state the current medicines. August 22, 2011 lists the Klonopin as 2mg TID. No mention is made as to when or why this increase was made. Nor is there any mention of the adverse effects that can come from increasing the dose. Second, the office visit of February 16, 2011 lists Tegretol 200 mg BID as one of the medications. However, nowhere is there a discussion of the risks and benefits of Tegretol, although this could have occurred prior to the patients transferring from the Behavioral Medicine Network to Dr. Patton's office. Also, I do not see that doctor Patton ordered a Tegretol level, necessary to determine the adequacy of the dose, or a CDC or ALT, necessary to ensure that Tegretol is not causing adverse medical effects. Third, on November 22, 2011 Dr. Patton prescribed prazosin 5mg HS. There is no documented discussion of the risks and benefits of this medicine. Nor are there any measurements of blood pressure, which can be lowered by this medicine.

The chart of Patient F was reviewed....when prescribing a stimulant such as Adderall one should routinely check blood pressure, heart rate, and weight as these can be adversely affected by the medicine.

The chart of Patient G was reviewed....as in previous cases the patient was prescribed Adderall without monitoring blood pressure, heart rate, and weight. Second, the number of refills of each medicine is not stated.

The chart of Patient H was reviewed....First, on January 10, 2012 the patient was started on Zoloft. While the indications for that this are apparent, there was no discussion as to how the medicine was started. Nor was there any discussion of the risks and benfits. Second, there is no record of the quantity and number of refills of medicines.

The chart of Patient I was reviewed...First, the note of June 19, 2011 states: "no current medicines." The note of July 26, 2011 notes current medicines as: Lamictal 25mg BID; Seroquel 25mg one BID; bupropion 75mg one BID. There is no mention as to when these medicines were started, what the indications for starting these medicines were, and whether or not the risks and benefits of these medicines were discussed with the patient.

The chart of Patient J was reviewed. Also, additional information from Dr. Patton was reviewed as was the death certificate, toxicology report, the report from Paula York, and Dr. Patton's response. The KASPER was also reviewed. First, on February 8, 2012 the patient received a prescription for Xanax 2mg BID with two refills. This prescription was not documented in the progress note. Second, on May 17, 2012 the patient received a prescription for Xanax 2mg BID number 60 with one refill. Again this was not documented in the progress note. On June 1, 2012 the patient received a prescription for Xanax 2 mg one BID and one half at bedtime number 75 with no refills. While a dose increase may have been warranted as it was written at least six weeks before the patient would have run out, care should have been taken to void the remaining refill.

On June 20, 2012 a prescription for Xanax 2mg number 75 with one refill was written. There is no clinic note for that day. On the copy of the prescription sent to me it is written "who okayed this" and "No extension 101 exists." Presumably someone was questioning the validity of this prescription.

On July 16, 2012 a prescription was written for Xanax 2mg number 75 with one refill. There is no clinic note accompanying this. Patient J should not have needed more Xanax until October.

On August 13 2011 there was a clinic note. Patient J was prescribed Xanax 2mg number 75 with three refills. Again the script was weeks early given the previous prescriptions.

On October 15, 2013 the patient requested a 60 day supply of Xanax. He stated that he would be working out of town and would need a 60 day supply. Again, care should have been taken that the previous prescriptions have been voided prior to writing this.

6. In a report dated January 8, 2013, Paula York, Office of Inspector General, reported,

On January 2, 2013, this office received information from David Straub, a detective with Lexington Metro Narcotics. After reviewing a KASPER report for Patient J, who was found dead on December 14, 2012 of an alleged overdose, Det. Straub noted numerous prescriptions for alprazolam which had been prescribed by Dr. Gary Patton. Det. Straub was concerned Dr. Patton may have inappropriately prescribed alprazolam to Patient J.

...Det. Straub noted that Patient J had been receiving prescriptions for oxycodone 15mg, quantity of 180, and morphine sulfate ER 60mg, quantity of 60, on a monthly basis from prescribers located at The Pain Treatment Center of the Bluegrass. In addition to the pain medications, Det. Straub noted that Patient J was receiving prescriptions for alprazolam from Dr. Gary Patton, a psychiatrist practicing in Lexington, KY. Det. Straub observed numerous prescriptions for alprazolam issued for Patient J by Dr. Patton and was concerned Dr. Patton may have inappropriately prescribed alprazolam to patient Patient J.
...The prescriptions were filled at various pharmacies in Lexington.

Patient J had received prescriptions for alprazolam prior to 05/17/2012 on a monthly basis, for quantity of 60 per prescription. I contacted the pharmacies to verify if the prescriptions were written or telephoned in order to identify if new prescriptions had been issued along with active refills still remaining on older prescriptions. After speaking with the pharmacies, a spreadsheet of all alprazolam prescriptions issued by Dr. Patton to Patient J since 05/17/2012...An analysis of the prescriptions revealed the following:

1. From 05/17/2012 through 12/07/2012, (approximately 7 months), Patient J obtained 14 prescriptions for alprazolam from six (6) different pharmacies, all prescribed by Dr. Patton
2. According to the instructions, if Patient J had taken the alprazolam prescriptions as prescribed, the amount of tablets should have lasted 14 months.
3. From 06/17/2012 through 12/07/2012, Patient J obtained 1140 tablets for alprazolam 2mg.
4. According to information provided by pharmacies, the instructions on the majority of prescriptions were for alprazolam 2mg twice daily and one-half at bedtime explaining the prescriptions for alprazolam 2mg, quantity of 75, for 30 days supply.

...

CONCLUSION: Dr. Gary Patton prescribed alprazolam 2 mg to Patient J on 14 occasions between 05/17/2012 through 12/07/2012, for what appears to be numerous overlapping prescriptions. These prescriptions resulted in Patient J obtaining 1140 tablets over approximately a seven month period.

7. The parties resolved all of the above allegations, without an evidentiary hearing, by entering into an Agreed Order of Indefinite Restriction on November 21, 2013.

8. During the course of the above investigation, the Board received a new grievance relating to the licensee, on March 19, 2013, from the parents of one of the licensee's patients. The patient's record was obtained and provided to a Board

consultant for review. In a report dated September 15, 2013, the consultant concluded, in part,

> Dr. Patton is thorough in his evaluation and diagnosis. He suggested treatments that are generally within the norm. However, there appears to be a difference between what the chart describes as the medication the patient was taking and what they are actually taking. For example, on July 30, 2012 he prescribed clonazepam 2 milligram. This medication change is not listed in subsequent current medication list. [The patient] is prescribed clonazepam 1mg #60 on August 29, and 2 mg #60 on September 12, 2012. The subsequent prescriptions are not reflected in the progress notes.
>
> Another problem is that Dr. Patton does not indicate the quantity of each medicine and the number of refills prescribed. The result is that some refills are filled weeks or sometimes months after the original date. ....
>
> Another area of concern is his family involvement. ....
>
> The question then becomes: Did Dr. Patton know that [the patient] was impaired? Should he have known this? He certainly was aware that his treatments can cause impairment. He does note that there are no early refills (except towards the end of treatment). He does not note any evidence of impairment during his sessions with her. Urine drug screens that have been done have not shown any evidence of illicit opiate use. He repeatedly laments the lack of family involvement in [the patient's] care. The parents, in their complaint, state "we have repeatedly made phone calls and sent letters documenting her abuse of the drugs he prescribed, but to no avail." There is no mention in the medical record of these letters or phone calls. Absent any concrete evidence of these attempts to contact Dr. Patton, it is difficult to know the truth.
>
> In summary, the problems in the treatment of [the patient] arise largely from inadequate documentation of the medication, quantity and number of refills prescribed. Regular use of KASPER would have also been helpful. Regular family involvement would have helped greatly. In previous communications, Dr. Patton indicated that he had begun changing the way he monitored prescriptions. Adequate attention to this would likely prevent these problems.

9. On or about March 18, 2014, the licensee resolved the investigation by entering into an Amended Agreed Order of Indefinite Restriction which included the following terms and conditions: the licensee could not prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to

do so by the Panel; the licensee was to complete the "Prescribing Controlled Drugs" course at Vanderbilt University Medical Center or the University of Florida; the licensee was to successfully completed the CPEP Documentation Seminar and enrolled in the PIP; the licensee was to reimburse the Board the costs of the investigation in the amount of $1,560.00, on or before May 21, 2014; and the licensee was not to violate any provision of KRS 311.595 and/or 311.597.

10. On or about May 15-17, 2014, the licensee attended the "Prescribing Controlled Drugs" course at the University of Florida.

11. In June 2014, the licensee attended the CPEP Documentation Seminar and enrolled in the PIP.

12. The licensee failed to reimburse the Board's costs by May 21, 2014. On August 12, 2014, he reimbursed a remaining balance of $399.60.

13. On or about October 16, 2014, the licensee requested and the Panel granted reinstatement of the licensee's prescribing privileges subject to terms and conditions set forth in a Second Amended Agreed Order filed on October 30, 2014.

14. The Second Amended Agreed Order required that the licensee maintain a "controlled substances log," successfully complete the Personalized Implementation Program ("PIP") offered by the Center for Personalized Education for Physicians ("CPEP"), and not violate any provision of KRS 311.595 and/or 311.597.

15. In a letter to the Board dated August 12, 2014, the licensee stated that he had enrolled in the PIP offered by CPEP.

16. In April 2015, CPEP notified the licensee that his second and third set of charts required for review in the PIP were overdue.

17. In February 2016, CPEP notified the Board that the last correspondence they had with the licensee was on June 16, 2015 when he reported that his home had caught fire and he was living in his garage. The licensee had still not provided the second and third set of charts for review.

18. During an interview with the Board investigator on February 25, 2016, the licensee stated that had notified CPEP of a fire at his home in June 2015, as well as the death of his dog. He stated he had worked something out with them.

19. The licensee was instructed by the Board investigator to submit a letter explaining why he was late in submitting charts and why he had failed to communicate with CPEP since June 2015. The letter was due March 4, 2016.

20. On March 10, 2016, the licensee sent the Board's investigator an email stating the following:

> As we discussed in our meeting, there was a mixup in the dates I submitted. My records were unfortunately destroyed in a house fire, and the information on these dates was subsequently miscommunicated to me. I apologize for the discrepancy. It was only later that I discovered the correct dates, and realized my mistake. I appreciate the opportunity to resubmit, and will be working with PIP to correct this.

21. The Board's investigator contacted Mary Minobe at CPEP, who stated that the last contact from the licensee was in June 2015. Ms. Minobe stated that CPEP sent an email to the licensee on February 23, 2016 but they had not received a response from him.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to him, Inquiry Panel A finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases 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(13).
4. The Inquiry Panel concludes there is probable cause to believe that the physician has violated the terms of an order and that the licensee'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 licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the licensee 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 licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain violations in the

recent past presents probable cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee'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, 520 U.S. 924 (1997), 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 A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Gary C. Patton, M.D. is SUSPENDED and Dr. Patton is prohibited from performing any act which constitutes the "practice of medicine or osteopathy," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the Board's hearing panel has finally resolved the Complaint or until such further Order of the Board.

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

SO ORDERED this 22nd day of April, 2016.

C. William Briscoe MD

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. Michael S. Rodman, 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 to the licensee, Gary C. Patton, M.D., License No. 24639, 501 Darby Creek Road, Suite 55, Lexington, Kentucky 40509, on this 22nd day of April, 2016.

Sara Farmer

Sara Farmer
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1534

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY GARY C. PATTON, M.D., LICENSE NO. 24639, 2704 OLD ROSEBUD ROAD, SUITE 230, LEXINGTON, KENTUCKY 40509

SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Gary C. Patton, M.D. (hereafter "the licensee"), and, based upon their mutual desire to reinstate the licensee's prescribing privileges, subject to monitoring, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Second Amended Agreed Order:

1. At all relevant times, Gary C. Patton, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On April 15, 2002, the licensee plead guilty to amended charges of two counts of Possession of Schedule IV Controlled Substances, based upon his accidental overdose of Ecstasy and GHB. The licensee was placed on probation and entered into a drug treatment program. The Board's Inquiry Panel B and the licensee entered into a 5-year Agreed Order of Probation in Board Case No. 840 on July 10, 2002, to address these issues. On November 10, 2005, the Panel granted the licensee's request to terminate the Agreed Order of Probation, upon his assurance that he would continue to take appropriate steps to address his substance abuse issues for an appropriate amount of time.

4. During the course of a pending Board investigation based upon two separate grievances, the Board obtained a review of the licensee's prescribing of controlled substances for a one-year period. The reviewer recommended that the Board obtain specific patient records for review based upon the following concerns

   - Combinations of controlled substances favored by persons who abuse or divert controlled substances
   - Improper refills of controlled substance based on days' supply
   - Patients prescribed Suboxone along with high doses of benzodiazapines, and/or tramadol which may or may not be appropriate.

5. A number of the licensee's patient records were obtained for review by a Board consultant. In a report dated April 16, 2013, the consultant concluded, in part,

   ...
   It is clear that Dr. Patton is a caring and thorough psychiatrist. He spends time with his patients and uses several modalities of treatment, not just medication. However, there are some systemic problems with his care. Most obvious is the difficulty with documentation. Another problem is that many of the reports are dictated but apparently not proofread....

   The chart of Patient A was reviewed...the urine drug screens of April 11, 2012 and May 14, 2012 are both positive for THC. This was not discussed with the patient or addressed. Also, there are not other urine drug screens in the chart. Urine drug screens should be more frequent.

   The chart of Patient B was reviewed....no quantity or number of refills for medications was stated. Second, the urine drug screen of January 1, 2012 was positive for Diazepam (Valium) metabolites. This is not addressed. Third blood pressure, heart rate, and weight for this patient were not documented.

   The chart of Patient C was reviewed....first, when the patient was started on Suboxone she only needed 8 mg to stabilize. On subsequent visits she was given 24 mg a day. The reason for this increase is not stated. Second, drug screens were done on March 12, 2011; October 25, 2011; March 12, 2011; and May 3, 2012. More frequent drug screens and some random screens and random pill counts are appropriate. Third, the patient was prescribed Adderall for attention deficit disorder. Since Adderall can affect heart rate, blood pressure, and weight, these should be checked periodically. This was not done.

   The chart of Patient D was reviewed....prescribing for an employee except under emergency situations raises the issue of a dual relationship. As the situation did appear to be urgent and the patient lacked other resources, one time prescribing is acceptable.

However, the frequency, quantity and number of refills, if any, is not stated. Nor is there any documentation of a discussion of the risks and benefits of the medicines.

The chart of Patient E was reviewed...First, the office visit of February 16, 2011 states that Klonopin 1mg TID was prescribed. The visit of May 18, 2011 does not state the current medicines. August 22, 2011 lists the Klonopin as 2mg TID. No mention is made as to when or why this increase was made. Nor is there any mention of the adverse effects that can come from increasing the dose. Second, the office visit of February 16, 2011 lists Tegretol 200 mg BID as one of the medications. However, nowhere is there a discussion of the risks and benefits of Tegretol, although this could have occurred prior to the patients transferring from the Behavioral Medicine Network to Dr. Patton's office. Also, I do not see that doctor Patton ordered a Tegretol level, necessary to determine the adequacy of the dose, or a CDC or ALT, necessary to ensure that Tegretol is not causing adverse medical effects. Third, on November 22, 2011 Dr. Patton prescribed prazosin 5mg HS. There is no documented discussion of the risks and benefits of this medicine. Nor are there any measurements of blood pressure, which can be lowered by this medicine.

The chart of Patient F was reviewed....when prescribing a stimulant such as Adderall one should routinely check blood pressure, heart rate, and weight as these can be adversely affected by the medicine.

The chart of Patient G was reviewed....as in previous cases the patient was prescribed Adderall without monitoring blood pressure, heart rate, and weight. Second, the number of refills of each medicine is not stated.

The chart of Patient H was reviewed....First, on January 10, 2012 the patient was started on Zoloft. While the indications for that this are apparent, there was no discussion as to how the medicine was started. Nor was there any discussion of the risks and benfits. Second, there is no record of the quantity and number of refills of medicines.

The chart of Patient I was reviewed...First, the note of June 19, 2011 states: "no current medicines." The note of July 26, 2011 notes current medicines as: Lamictal 25mg BID; Seroquel 25mg one BID; bupropion 75mg one BID. There is no mention as to when these medicines were started, what the indications for starting these medicines were, and whether or not the risks and benefits of these medicines were discussed with the patient.

The chart of Patient J was reviewed. Also, additional information from Dr. Patton was reviewed as was the death certificate, toxicology report, the report from Paula York, and Dr. Patton's response. The KASPER was also reviewed. First, on February 8, 2012 the patient received a prescription for Xanax 2mg BID with two refills. This prescription was not documented in the progress note. Second, on May 17, 2012 the patient received a prescription for Xanax 2mg BID number 60 with one refill. Again this was not documented in the progress note. On June 1, 2012 the patient received a prescription for Xanax 2 mg one BID and one half at bedtime number 75 with no refills. While a dose

increase may have been warranted as it was written at least six weeks before the patient would have run out, care should have been taken to void the remaining refill.

On June 20, 2012 a prescription for Xanax 2mg number 75 with one refill was written. There is no clinic note for that day. On the copy of the prescription sent to me it is written "who okayed this" and "No extension 101 exists." Presumably someone was questioning the validity of this prescription.

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On August 13 2011 there was a clinic note. Patient J was prescribed Xanax 2mg number 75 with three refills. Again the script was weeks early given the previous prescriptions.

On October 15, 2013 the patient requested a 60 day supply of Xanax. He stated that he would be working out of town and would need a 60 day supply. Again, care should have been taken that the previous prescriptions have been voided prior to writing this.

6. In a report dated January 8, 2013, Paula York, Office of Inspector General, reported,

On January 2, 2013, this office received information from David Straub, a detective with Lexington Metro Narcotics. After reviewing a KASPER report for Patient J, who was found dead on December 14, 2012 of an alleged overdose, Det. Straub noted numerous prescriptions for alprazolam which had been prescribed by Dr. Gary Patton. Det. Straub was concerned Dr. Patton may have inappropriately prescribed alprazolam to Patient J.

...Dr. Straub noted that Patient J had been receiving prescriptions for oxycodone 15mg, quantity of 180, and morphine sulfate ER 60mg, quantity of 60, on a monthly basis from prescribers located at The Pain Treatment Center of the Bluegrass. In addition to the pain medications, Dr. Straub noted that Patient J was receiving prescriptions for alprazolam from Dr. Gary Patton, a psychiatrist practicing in Lexington, KY. Det. Straub observed numerous prescriptions for alprazolam issued for Patient J by Dr. Patton and was concerned Dr. Patton may have inappropriately prescribed alprazolam to patient Patient J. ...The prescriptions were filled at various pharmacies in Lexington.

Patient J had received prescriptions for alprazolam prior to 05/17/2012 on a monthly basis, for quantity of 60 per prescription. I contacted the pharmacies to verify if the prescriptions were written or telephoned in order to identify if new prescriptions had been issued along with active refills still remaining on older prescriptions. After speaking with the pharmacies, a spreadsheet of all alprazolam prescriptions issued by Dr. Patton to Patient J since 05/17/2012...An analysis of the prescriptions revealed the following:

1. From 05/17/2012 through 12/07/2012, (approximately 7 months), Patient J obtained 14 prescriptions for alprazolam from six (6) different pharmacies, all prescribed by Dr. Patton

2. According to the instructions, if Patient J had taken the alprazolam prescriptions as prescribed, the amount of tablets should have lasted 14 months.
3. From 06/17/2012 through 12/07/2012, Patient J obtained 1140 tablets for alprazolam 2mg.
4. According to information provided by pharmacies, the instructions on the majority of prescriptions were for alprazolam 2mg twice daily and one-half at bedtime explaining the prescriptions for alprazolam 2mg, quantity of 75, for 30 days supply.

...

CONCLUSION: Dr. Gary Patton prescribed alprazolam 2 mg to Patient J on 14 occasions between 05/17/2012 through 12/07/2012, for what appears to be numerous overlapping prescriptions. These prescriptions resulted in Patient J obtaining 1140 tablets over approximately a seven month period.

7. The parties resolved all of the above allegations, without an evidentiary hearing, by entering into an Agreed Order of Indefinite Restriction on November 21, 2013.

8. During the course of the above investigation, the Board received a new grievance relating to the licensee, on March 19, 2013, from the parents of one of the licensee's patients. The patient's record was obtained and provided to a Board consultant for review. In a report dated September 15, 2013, the consultant concluded, in part,

Dr. Patton is thorough in his evaluation and diagnosis. He suggested treatments that are generally within the norm. However, there appears to be a difference between what the chart describes as the medication the patient was taking and what they are actually taking. For example, on July 30, 2012 he prescribed clonazepam 2 milligram. This medication change is not listed in subsequent current medication list. [The patient] is prescribed clonazepam 1mg #60 on August 29, and 2 mg #60 on September 12, 2012. The subsequent prescriptions are not reflected in the progress notes.

Another problem is that Dr. Patton does not indicate the quantity of each medicine and the number of refills prescribed. The result is that some refills are filled weeks or sometimes months after the original date. ....

Another area of concern is his family involvement. ....

The question then becomes: Did Dr. Patton know that [the patient] was impaired? Should he have known this? He certainly was aware that his treatments can cause impairment. He does note that there are no early refills (except towards the end of treatment). He does not note any evidence of impairment during his sessions with her. Urine drug screens that have been done have not shown any evidence of illicit opiate use. He repeatedly laments the lack of family involvement in [the patient's] care. The parents, in their complaint, state "we have repeatedly made phone calls and sent letters

documenting her abuse of the drugs he prescribed, but to no avail." There is no mention in the medical record of these letters or phone calls. Absent any concrete evidence of these attempts to contact Dr. Patton, it is difficult to know the truth.

In summary, the problems in the treatment of [the patient] arise largely from inadequate documentation of the medication, quantity and number of refills prescribed. Regular use of KASPER would have also been helpful. Regular family involvement would have helped greatly. In previous communications, Dr. Patton indicated that he had begun changing the way he monitored prescriptions. Adequate attention to this would likely prevent these problems.

9. On or about March 18, 2014, the licensee resolved the investigation by entering into an Amended Agreed Order of Indefinite Restriction which included the following terms and conditions: the licensee could not prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel; the licensee was to complete the "Prescribing Controlled Drugs" course at Vanderbilt University Medical Center or the University of Florida; the licensee was to successfully completed the CPEP Documentation Seminar and enrolled in the PIP; the licensee was to reimburse the Board the costs of the investigations in the amount of $1,560.00, on or before May 21, 2014; and the licensee was not to violate any provision of KRS 311.595 and/or 311.597.
10. On or about May 15-17, 2014, the licensee attended the "Prescribing Controlled Drugs" course at the University of Florida.
11. In June 2014, the licensee attended the CPEP Documentation Seminar and enrolled in the PIP.
12. The licensee failed to reimburse the Board's costs by May 21, 2014. On August 12, 2014, he reimbursed a remaining balance of $399.60.
13. On or about October 16, 2014, the licensee requested and the Panel granted reinstatement of the licensee's prescribing privileges subject to terms and conditions set forth in this Second Amended Agreed Order.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Second Amended Agreed Order:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, there were legal grounds for the parties to enter into the Second Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the Board's investigation and reinstate the licensee's prescribing privileges, subject to monitoring, by entering into an informal resolution such as this Second Amended Agreed Order.

SECOND AMENDED AGREED ORDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to reinstate the licensee's prescribing privileges, subject to monitoring, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER ("Order"):**

1. The license to practice medicine in the Commonwealth of Kentucky held by Gary C. Patton, M.D., CONTINUES to be RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;

2. During the effective period of this Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:

   a. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed;

      i. The controlled substances log SHALL include date, patient name, patient complaint, medication prescribed, when it was last prescribed and how much on the last visit. Note: All log sheets will be consecutively numbered, legible i.e. printed or typed, and must reflect "call-in" and refill information. Prescriptions should be maintained in the following manner: 1) patient; 2) chart; and 3) log;
      ii. The licensee SHALL permit the Board's agents to inspect, copy and/or obtain the controlled substance log and other relevant records, upon request, for review by the Board's agents and/or consultants; and
      iii. The licensee SHALL reimburse the Board fully for the costs of each consultant review performed pursuant to this Order. Once the Board receives the invoice from the consultant(s) for each review, it will provide the licensee with a redacted copy of that invoice, omitting the consultant's identifying information. The licensee SHALL pay the costs noted on the invoice within thirty (30) days of the date on the Board's written notice. The licensee's failure to fully reimburse the Board within that time frame SHALL constitute a violation of this Order;

   b. The licensee SHALL successfully complete and pass the CPEP Personalized Implementation Program (PIP), at his expense and as directed by CPEP's staff;
      i. The licensee SHALL provide the Board's staff with written verification that he has successfully completed PIP promptly after completing that program; and
      ii. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the PIP to the Board's Legal Department promptly after their completion;
      iii. The licensee's failure to successfully complete and pass the PIP SHALL constitute a violation of this Order; and

   c. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee understands and agrees that at least two (2) favorable consultant reviews must be performed, on terms determined by the Panel or its staff, before the Panel will consider a request to terminate this Order.

4. The licensee expressly agrees that if he should violate any term or condition of this Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Order.

5. The licensee understands and agrees that any violation of the terms of this Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 30th day of October, 2014.

FOR THE LICENSEE:

GARY C. PATTON, M.D.

COUNSEL FOR THE LICENSEE
(If applicable)

FOR THE BOARD:

C. William Briscoe M.D.

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

Leanne K. Diakov

LEANNE K. DIAKOV
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1534

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY GARY C. PATTON, M.D., LICENSE NO. 24639, 2704 OLD ROSEBUD ROAD, SUITE 230, LEXINGTON, KENTUCKY 40509

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel A, and Gary C. Patton, M.D. (hereafter "the licensee"), and, based upon their mutual desire to fully and finally resolve a subsequent grievance similar to those addressed in the original Agreed Order of Indefinite Restriction without an evidentiary hearing, hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION**:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Amended Agreed Order of Indefinite Restriction:

1. At all relevant times, Gary C. Patton, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On April 15, 2002, the licensee plead guilty to amended charges of two counts of Possession of Schedule IV Controlled Substances, based upon his accidental overdose of Ecstasy and GHB. The licensee was placed on probation and entered into a drug treatment program. The Board's Inquiry Panel B and the licensee entered into a 5-year Agreed Order of Probation in Board Case No. 840 on July 10, 2002, to address these issues. On November 10, 2005, the Panel granted the licensee's request to terminate the

Agreed Order of Probation, upon his assurance that he would continue to take appropriate steps to address his substance abuse issues for an appropriate amount of time.

4. During the course of a pending Board investigation based upon two separate grievances, the Board obtained a review of the licensee's prescribing of controlled substances for a one-year period. The reviewer recommended that the Board obtain specific patient records for review based upon the following concerns

   - Combinations of controlled substances favored by persons who abuse or divert controlled substances
   - Improper refills of controlled substance based on days' supply
   - Patients prescribed Suboxone along with high doses of benzodiazapines, and/or tramadol which may or may not be appropriate.

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It is clear that Dr. Patton is a caring and thorough psychiatrist. He spends time with his patients and uses several modalities of treatment, not just medication. However, there are some systemic problems with his care. Most obvious is the difficulty with documentation. Another problem is that many of the reports are dictated but apparently not proofread....

The chart of Patient A was reviewed...the urine drug screens of April 11, 2012 and May 14, 2012 are both positive for THC. This was not discussed with the patient or addressed. Also, there are not other urine drug screens in the chart. Urine drug screens should be more frequent.

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The chart of Patient I was reviewed...First, the note of June 19, 2011 states: "no current medicines." The note of July 26, 2011 notes current medicines as: Lamictal 25mg BID; Seroquel 25mg one BID; bupropion 75mg one BID. There is no mention as to when these medicines were started, what the indications for starting these medicines were, and whether or not the risks and benefits of these medicines were discussed with the patient.

The chart of Patient J was reviewed. Also, additional information from Dr. Patton was reviewed as was the death certificate, toxicology report, the report from Paula York, and Dr. Patton's response. The KASPER was also reviewed. First, on February 8, 2012 the patient received a prescription for Xanax 2mg BID with two refills. This prescription was not documented in the progress note. Second, on May 17, 2012 the patient received

a prescription for Xanax 2mg BID number 60 with one refill. Again this was not documented in the progress note. On June 1, 2012 the patient received a prescription for Xanax 2 mg one BID and one half at bedtime number 75 with no refills. While a dose increase may have been warranted as it was written at least six weeks before the patient would have run out, care should have been taken to void the remaining refill.

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On August 13 2011 there was a clinic note. Patient J was prescribed Xanax 2mg number 75 with three refills. Again the script was weeks early given the previous prescriptions.

On October 15, 2013 the patient requested a 60 day supply of Xanax. He stated that he would be working out of town and would need a 60 day supply. Again, care should have been taken that the previous prescriptions have been voided prior to writing this.

6. In a report dated January 8, 2013, Paula York, Office of Inspector General, reported,

On January 2, 2013, this office received information from David Straub, a detective with Lexington Metro Narcotics. After reviewing a KASPER report for Patient J, who was found dead on December 14, 2012 of an alleged overdose, Det. Straub noted numerous prescriptions for alprazolam which had been prescribed by Dr. Gary Patton. Det. Straub was concerned Dr. Patton may have inappropriately prescribed alprazolam to Patient J.

...Dr. Straub noted that Patient J had been receiving prescriptions for oxycodone 15mg, quantity of 180, and morphine sulfate ER 60mg, quantity of 60, on a monthly basis from prescribers located at The Pain Treatment Center of the Bluegrass. In addition to the pain medications, Dr. Straub noted that Patient J was receiving prescriptions for alprazolam from Dr. Gary Patton, a psychiatrist practicing in Lexington, KY. Det. Straub observed numerous prescriptions for alprazolam issued for Patient J by Dr. Patton and was concerned Dr. Patton may have inappropriately prescribed alprazolam to patient Patient J. ...The prescriptions were filled at various pharmacies in Lexington.

Patient J had received prescriptions for alprazolam prior to 05/17/2012 on a monthly basis, for quantity of 60 per prescription. I contacted the pharmacies to verify if the prescriptions were written or telephoned in order to identify if new prescriptions had been issued along with active refills still remaining on older prescriptions. After speaking with the pharmacies, a spreadsheet of all alprazolam prescriptions issued by Dr. Patton to Patient J since 05/17/2012...An analysis of the prescriptions revealed the following:

1. From 05/17/2012 through 12/07/2012, (approximately 7 months), Patient J obtained 14 prescriptions for alprazolam from six (6) different pharmacies, all prescribed by Dr. Patton
2. According to the instructions, if Patient J had taken the alprazolam prescriptions as prescribed, the amount of tablets should have lasted 14 months.
3. From 06/17/2012 through 12/07/2012, Patient J obtained 1140 tablets for alprazolam 2mg.
4. According to information provided by pharmacies, the instructions on the majority of prescriptions were for alprazolam 2mg twice daily and one-half at bedtime explaining the prescriptions for alprazolam 2mg, quantity of 75, for 30 days supply.

...

CONCLUSION: Dr. Gary Patton prescribed alprazolam 2 mg to Patient J on 14 occasions between 05/17/2012 through 12/07/2012, for what appears to be numerous overlapping prescriptions. These prescriptions resulted in Patient J obtaining 1140 tablets over approximately a seven month period.

7. The parties resolved all of the above allegations, without an evidentiary hearing, by entering into an Agreed Order of Indefinite Restriction on November 21, 2013.

8. During the course of the above investigation, the Board received a new grievance relating to the licensee, on March 19, 2013, from the parents of one of the licensee's patients. The patient's record was obtained and provided to a Board consultant for review. In a report dated September 15, 2013, the consultant concluded, in part,

Dr. Patton is thorough in his evaluation and diagnosis. He suggested treatments that are generally within the norm. However, there appears to be a difference between what the chart describes as the medication the patient was taking and what they are actually taking. For example, on July 30, 2012 he prescribed clonazepam 2 milligram. This medication change is not listed in subsequent current medication list. [The patient] is prescribed clonazepam 1mg #60 on August 29, and 2 mg #60 on September 12, 2012. The subsequent prescriptions are not reflected in the progress notes.

Another problem is that Dr. Patton does not indicate the quantity of each medicine and the number of refills prescribed. The result is that some refills are filled weeks or sometimes months after the original date. ....

Another area of concern is his family involvement. ....

The question then becomes: Did Dr. Patton know that [the patient] was impaired? Should he have known this? He certainly was aware that his treatments can cause impairment. He does note that there are no early refills (except towards the end of treatment). He does not note any evidence of impairment during his sessions with her.

Urine drug screens that have been done have not shown any evidence of illicit opiate use. He repeatedly laments the lack of family involvement in [the patient's] care. The parents, in their complaint, state "we have repeatedly made phone calls and sent letters documenting her abuse of the drugs he prescribed, but to no avail." There is no mention in the medical record of these letters or phone calls. Absent any concrete evidence of these attempts to contact Dr. Patton, it is difficult to know the truth.

In summary, the problems in the treatment of [the patient] arise largely from inadequate documentation of the medication, quantity and number of refills prescribed. Regular use of KASPER would have also been helpful. Regular family involvement would have helped greatly. In previous communications, Dr. Patton indicated that he had begun changing the way he monitored prescriptions. Adequate attention to this would likely prevent these problems.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Amended Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, there were legal grounds for the parties to enter into the Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(7)(b), the Panel has determined that additional discipline is not necessary for this new grievance, in light of the parties' previous resolution of similar issues in the original Agreed Order of Indefinite Restriction.
4. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending investigation without an evidentiary hearing by entering into an informal resolution such as this Amended Agreed Order of Indefinite Restriction.

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally address a subsequent grievance similar to those addressed in the Agreed Order of Indefinite Restriction on November 21, 2013 without an evidentiary hearing, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Gary C. Patton, M.D., CONTINUES to be RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;
2. During the effective period of this Amended Agreed Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:
    a. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel;
    b. The Panel will not consider a request by the licensee to resume the professional utilization of controlled substances prior to May 21, 2014 and unless and until the following conditions have been satisfied – 1); the licensee has successfully completed the "Prescribing Controlled Drugs" course at The Center for Professional Health at Vanderbilt University Medical Center, Nashville, TN, (615) 936-0678 or the University of Florida, 8491 N.W. 39th Avenue, Gainesville, Florida 32606 (352) 265-5549, at his expense; and 2) the licensee has successfully completed the Patient Care Documentation Seminar offered by the

Center for Personalized Education for Physicians (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230 – 303/577-3232, at his expense;

c. Upon successful completion of the Documentation Seminar, the licensee SHALL immediately take all necessary steps to enroll in the CPEP Personalized Implementation Program. The licensee shall complete the Personalized Implementation Program, at his expense, as directed by CPEP's staff.

d. The licensee SHALL provide the Board's staff with written verification that he has successfully completed CPEP's Documentation Seminar, promptly after completing the Seminar, and that he has enrolled in the 6-month Personalized Implementation Program;

e. The licensee SHALL provide the Board's staff with written verification that he has successfully completed the 6-month Personalized Implementation Program promptly after completing that program.

f. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Documentation Seminar and Personalized Implementation Program to the Board's Legal Department promptly after their completion;

g. If the Panel should grant the licensee's request to resume the professional utilization of controlled substances, it will do so by an appropriate Amended Agreed Order, which shall set include each condition specified by the Panel, based upon the information available to it at that time, but SHALL include the following conditions, at a minimum:

i. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed;

ii. The licensee SHALL provide the log and relevant records, upon request, for review by Board agents, including consultants, at his expense;

iii. If not already completed, the licensee SHALL successfully completed the PIP, as directed by CPEP and at his expense;

h. The licensee SHALL pay the costs of the investigation in the amount of $1,560.00 on or before May 21, 2014;

i. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Amended Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Amended Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Amended Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the

licensee violated a term or condition of this Amended Agreed Order of Indefinite Restriction.

5. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order of Indefinite Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 18th day of March, 2014.

FOR THE LICENSEE:

GARY C. PATTON, M.D.

ROBERT F. DUNCAN, ESQ. / WILLIAM A HOSKINS
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

C. WILLIAM BRISCOE, M.D.
CHAIR, INQUIRY PANEL A

LEANNE K. DIAKOV
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COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1534

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AGREED ORDER OF INDEFINITE RESTRICTION

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The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Indefinite Restriction:

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2. The licensee's medical specialty is Psychiatry.
3. On April 15, 2002, the licensee plead guilty to amended charges of two counts of Possession of Schedule IV Controlled Substances, based upon his accidental overdose of Ecstasy and GHB. The licensee was placed on probation and entered into a drug treatment program. The Board's Inquiry Panel B and the licensee entered into a 5-year Agreed Order of Probation in Board Case No. 840 on July 10, 2002, to address these issues. On November 10, 2005, the Panel granted the licensee's request to terminate the

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4. According to information provided by pharmacies, the instructions on the majority of prescriptions were for alprazolam 2mg twice daily and one-half at bedtime explaining the prescriptions for alprazolam 2mg, quantity of 75, for 30 days supply.

...

CONCLUSION: Dr. Gary Patton prescribed alprazolam 2 mg to Patient J on 14 occasions between 05/17/2012 through 12/07/2012, for what appears to be numerous overlapping prescriptions. These prescriptions resulted in Patient J obtaining 1140 tablets over approximately a seven month period.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(9), as illustrated by KRS 311.597(1)(a) and (d), (3) and (4). Accordingly, there are legal grounds for the parties to enter into this Agreed Order of Indefinite Restriction.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this pending investigation without an evidentiary hearing by entering into an informal resolution such as this Agreed Order of Indefinite Restriction.

AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this pending investigation without an

evidentiary hearing, the parties hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Gary C. Patton, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, effective immediately upon the filing of this Order;
2. During the effective period of this Agreed Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:
    a. The licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel;
    b. The Panel will not consider a request by the licensee to resume the professional utilization of controlled substances unless and until the following conditions have been satisfied – 1) six (6) months have elapsed since the filing of this Agreed Order of Indefinite Restriction; 2) the licensee has successfully completed the "Prescribing Controlled Drugs" course at The Center for Professional Health at Vanderbilt University Medical Center, Nashville, TN, (615) 936-0678 or the University of Florida, 8491 N.W. 39th Avenue, Gainesville, Florida 32606 (352) 265-5549, at his expense; and 3) the licensee has successfully completed the Patient Care Documentation Seminar offered by the Center for Personalized Education for Physicians (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230 – 303/577-3232, at his expense;

c. Upon successful completion of the Documentation Seminar, the licensee SHALL immediately take all necessary steps to enroll in the CPEP Personalized Implementation Program. The licensee shall complete the Personalized Implementation Program, at his expense, as directed by CPEP's staff.

d. The licensee SHALL provide the Board's staff with written verification that he has successfully completed CPEP's Documentation Seminar, promptly after completing the Seminar, and that he has enrolled in the 6-month Personalized Implementation Program;

e. The licensee SHALL provide the Board's staff with written verification that he has successfully completed the 6-month Personalized Implementation Program promptly after completing that program.

f. The licensee SHALL take all steps necessary, including signing any waiver and/or consent forms required to ensure that CPEP will provide a copy of any evaluations from the Documentation Seminar and Personalized Implementation Program to the Board's Legal Department promptly after their completion;

g. If the Panel should grant the licensee's request to resume the professional utilization of controlled substances, it will do so by an appropriate Amended Agreed Order, which shall set include each condition specified by the Panel, based upon the information available to it at that time, but SHALL include the following conditions, at a minimum:

i. The licensee SHALL maintain a "controlled substances log" for all controlled substances prescribed, dispensed;

ii. The licensee SHALL provide the log and relevant records, upon request, for review by Board agents, including consultants, at his expense;

iii. If not already completed, the licensee SHALL successfully completed the PIP, as directed by CPEP and at his expense;

h. The licensee SHALL pay the costs of the investigation in the amount of $1,560.00 within six (6) months from entry of this Agreed Order of Indefinite Restriction;

i. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Indefinite Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 15 day of November 2013.

FOR THE LICENSEE:

GARY C. PATTON, M.D.

ROBERT F. DUNCAN, ESQ / WILLIAM A. HOSKINS
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

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CHAIR, INQUIRY PANEL A

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