COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 959
ADMINISTRATIVE ACTION NO. 04-KBML-0331

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWALTH OF KENTUCKY HELD BY WRENDA B. GALLIEN, M.D., LICENSE NO. 35312, 974 BRECKENRIDGE LANE, #206, LOUISVILLE, KENTUCKY 40207

ORDER DISMISSING REMAINING CHARGES IN COMPLAINT, WITHOUT PREJUDICE

The Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, considered this matter at its April 17, 2008 meeting. The Panel considered that Complaint filed on July 30, 2004, the Order of Suspension filed on April 25, 2007, a March 24, 2008 memorandum by the Board's General Counsel, an Objection to Motion to "Dismiss Remaining Complaint" filed by the licensee, and an Objection filed by the licensee.

Having considered all of that information and being sufficiently advised, Inquiry Panel B **ORDERS**:

1. In light of the Panel's resolution of this matter by final Order of Suspension issued on April 25, 2007, which was not appealed, it is not presently necessary to resolve the remaining charges in the Complaint alleging violations of KRS 311.595(4) and (9), as illustrated by KRS 311.597(1) and (4). Accordingly, the Panel **ORDERS** that the remainder of Complaint No. 959, relating to the charged violations of KRS 311.595(4) and (9), as illustrated by KRS 311.597(1) and (4), is hereby **DIMISSED, WITHOUT PREJUDICE.** Accordingly, further administrative proceedings on Complaint No. 959 are terminated upon the filing of this Order;

2. While KRS 311.604(3) provides that the licensee shall be afforded the opportunity at reasonable intervals to demonstrate that she can resume the competent practice of medicine with reasonable skill and safety to patients, such a demonstration would require, at a minimum, the successful completion of the CPEP assessment previously ordered in sufficient time for the Panel to receive and review the written findings and conclusions of such evaluations prior to a regularly scheduled Panel meeting.

3. If the Panel should determine that it is appropriate to permit the licensee to resume the active practice of medicine, pursuant to KRS 311.604(3), the Panel will determine at that time whether it is necessary to address the charged violations of KRS 311.595(4) and (9), as illustrated by KRS 311.597(1) and (4) and, if so, the Panel will determine the appropriate manner of addressing the charged violation, along with any other alleged violations that may be within the Panel's knowledge at that time.

SO ORDERED on this 21st day of April, 2008.

Randel C. Gibson DO

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

Certificate of Service

I certify that the original of this Order was delivered to C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222 and copies were mailed to J. Fox DeMoisey, Esq., 905 Baxter Avenue, Louisville, Kentucky 40204 and to Susan S. Durant, Esq., Hearing Officer, Office of the Attorney General, 1024 Capitol Center Drive, Suite 200, Frankfort, Kentucky 40601-8204 on this 24th day of April, 2008.

C Lloyd Vest

C. Lloyd Vest II
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. 959
ADMINISTRATIVE ACTION NO. 04-KBML-0331

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWALTH OF KENTUCKY HELD BY WRENDA B. GALLIEN, M.D., LICENSE NO. 35312, 974 BRECKENRIDGE LANE, #206, LOUISVILLE, KENTUCKY 40207

ORDER OF SUSPENSION

At its April 19, 2007 meeting, the Board's Inquiry Panel B took up this case to consider the licensee's failure to submit to a clinical skills assessment ordered pursuant to KRS 311.604. The Panel reviewed a March 9, 2007 memorandum by the Board's General Counsel; the Complaint filed of record July 30, 2004; the proposed Interim Agreed Order; correspondence dated February 6, 2007 prepared by the licensee's counsel, J. Fox DeMoisey; the Order to Complete Clinical Skills Assessment filed of record February 9, 2007; and an e-mail from Cindy Usick, Center for Personalized Education for Physicians (CPEP) dated March 5, 2007.

Having considered all of the relevant information available to it and being sufficiently advised, the Panel makes the following Findings of Fact and Conclusions of Law,

FINDINGS OF FACT

1. On July 30, 2004, the Panel issued a Complaint and Emergency Order of Suspension against the licensee's Kentucky medical license, alleging violations of KRS 311.595. The Complaint alleged, in part, that the licensee had engaged in criminal conduct.

2. The original trial of the indictment pending against the licensee ended in a mistrial. Although the criminal trial was rescheduled for completion and resolution, the trial has been postponed repeatedly at the licensee's request.
3. The licensee's Kentucky medical license has remained suspended and she has not actively practiced medicine since July 30, 2004.
4. At its January 18, 2007 meeting, the Panel voted to issue an Order to Submit to CPEP Evaluation, to determine the licensee's current competence to practice medicine, pursuant to KRS 311.604. However, the Panel also voted to permit its counsel to negotiate an Interim Agreed Order, which would fully and fairly address each party's interests, if possible.
5. An Interim Agreed Order was forwarded to the licensee's counsel for execution. However, on February 6, 2007, the Board received written notice from the licensee's counsel notifying the Board that she declined to enter into such an Interim Agreed Order.
6. On February 9, 2007, the Panel issued its Order to Complete Clinical Skills Assessment. The licensee received actual notice of this Order.
7. The licensee failed to comply with the Order to Complete Clinical Skills Assessment. Furthermore, the licensee has failed to demonstrate that her failure to do so was due to circumstances beyond her control.

CONCLUSIONS OF LAW

1. KRS 311.604 provides, in part,

> (1) When a hearing or inquiry panel receives information that a physician has not been engaged in the active practice of medicine for at least two (2) years, the panel may order the physician to successfully complete a board-approved clinical

competency examination or a board-approved clinical skills assessment program at the expense of the physician. The Panel shall review the results of the examination or assessment and determine whether the physician may resume the practice of medicine without undue risk or danger to the patients or the public.

(2) Failure of a physician to successfully complete the clinical competency examination or the clinical skills assessment when directed shall constitute an admission that the physician is unable to practice medicine according to accepted and prevailing standards, unless the failure was due to circumstances beyond the control of the physician. The failure shall constitute a default and a final order may be entered without presentation of additional evidence.

2. When the Panel issued the Order to Complete Clinical Skills Assessment on February 9, 2007, it made the requisite findings under KRS 311.604 that there was probable cause to believe that the licensee had not been engaged in the active practice of medicine for at least two (2) years.

3. The licensee received actual notice of the Order and was fully aware of the date by which to schedule the assessment.

4. The licensee's failure to schedule the assessment pursuant to the Order to Complete Clinical Skills Assessment was not due to circumstances beyond her control; rather, the licensee made a conscious choice not to schedule the assessment.

5. By failing to comply with the Order to Complete Clinical Skills Assessment, the licensee has admitted that she is unable to practice medicine according to accepted and prevailing standards of care by reason of an extended absence from the active practice of medicine, in violation of KRS 311.595(8).

6. Pursuant to KRS 311.604, the Panel may take the failure to complete the assessment as order as a default and may issue a Final Order without the taking of testimony or presentation of evidence.

ORDER OF SUSPENSION

Based upon the Findings of Fact and Conclusions of Law, and, after considering all available options, Inquiry Panel B hereby **ORDERS**:

1. The license to practice medicine in the Commonwealth of Kentucky held by Wrenda B. Gallien, M.D., is **SUSPENDED** indefinitely, with that period of suspension to commence immediately upon the filing of this Order of Suspension and continuing until further Order of the Panel.
2. During the effective period of suspension, the licensee SHALL NOT engage in any act which would constitute 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 – unless and until approved to do so by the Panel.
3. The licensee shall be afforded the opportunity at reasonable intervals to demonstrate that she can resume the competent practice of medicine with reasonable skill and safety to patients; the burden of persuasion on that issue rests solely upon the licensee. The Panel shall not consider any request by the licensee to resume the active practice of medicine unless she has completed a clinical skills assessment by the Center for Personalized Education For Physicians (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, Colorado 80230, (303)577-

3232 and the Board has received the written Clinical Skills Assessment report from CPEP. The decision whether to grant such a request lies solely within the Board's discretion.

SO ORDERED this 25th day of April, 2007.

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

CERTIFICATE OF SERVICE

I certify that the original of this Order of Suspension was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return receipt requested to J. Fox DeMoisey, Esq., 905 Baxter Avenue, Louisville, Kentucky 40204; and Wrenda B. Gallien, M.D., 974 Breckinridge Lane, #206, Louisville, Kentucky 40207 on this 25th day of April, 2007.

C. Lloyd Vest II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
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 Suspension is received by the licensee or the licensee's attorney, whichever shall occur first.

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. 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.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 959

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY WRENDA B. GALLIEN, M.D., LICENSE NO. 35312, 8521 OLD LAGRANGE ROAD, LOUISVILLE, KENTUCKY 40242

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, considered this matter at its July 15, 2004 meeting. At that meeting, Inquiry Panel B considered memoranda from Betty Prater, Medical Investigator; a newspaper article from The Courier-Journal; an Indictment from Jefferson Circuit Court against the licensee; Arrest Citations and the licensee's Voluntary Statement dated September 25, 2003; reports from Board consultants dated April 1, 2004 and October 24, 2002; Grievance Form dated July 10, 2002 with Addendum; the licensee's response dated September 12, 2002; the Letter of Warning/Notice of Continuing Investigation dated January 23, 2003 addressed to the licensee; and correspondence dated August 4, 2003 and December 5, 2003 from Vanderbilt University Medical Center. Having considered all of this information and being sufficiently advised, Inquiry Panel B ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

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

1. At all relevant times, Wrenda B. Gallien, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On September 25, 2003, the licensee was arrested and charged with illegally prescribing controlled substances - including OxyContin, wrongfully filling prescriptions for controlled substances, and tampering with physical evidence.
4. Sergeant William Stivers, Metro Narcotics, reported that a pharmacist had contacted Metro Narcotics regarding an OxyContin prescription authorized by the licensee. Metro Narcotics determined that the licensee had signed her name to multiple blank prescriptions before leaving the state for three days, allowing the nurse practitioners to illegally prescribe the controlled substances. Upon learning of the police investigation, the licensee instructed office staff to destroy any of the remaining presigned blank prescriptions. The police investigation revealed controlled substances were prescribed to friends, without patients being examined. The licensee wrote a statement admitting to many of the charges and surrendered her DEA following her arrest.
5. On September 25, 2003 the licensee was arrested by the Metro Narcotics. The licensee provided the following written statement:

> I, Wrenda B. Gallien, M.D., have been involved in leaving signed scripts @ my practice for prescriptions to be written in my absence if need be. On 9-23 prescriptions were written for Patient B and given to Patient A. There have been several scripts written to patients/persons including OxyContin; Percocet, Xanax that were given one time or another to Patient A. I did have suspicions that he was selling the prescriptions despite that he did have legitimate pain @ times. I have approximately 5 patients on pain medications (2) who definitely take their pain medication. I know & should have understood the seriousness of my behavior. I have known Patient A since 1997 and have considered him to be just like a son.

I initially began prescribing prescriptions to him specifically and he later referred several friends for medication/treatment. I have written prescriptions for Patient B & Patient C for OxyContin, Percocet & Xanax without them being in the office and were given to Patient A.

6. Cheryl Denzik, ARNP began working for the licensee working in January 2003. Ms. Denzik states that September 23, 2003 was the first occasion that the licensee was not physically present at the office while the licensee was seeing patients. Before leaving town, the licensee had given a verbal order to Ms. Denzik that if a patient was on Xanax or a controlled substance and needed a refill with no changes, prescription blanks had been signed and left with the office manager for Ms. Denzik to use. Ms. Denzik believed she had handed out four of these prescriptions, pre-signed and left blank by the licensee. She admitted that this was wrong, but it was done with the verbal order of the licensee. Ms. Denzik was not aware that the licensee treated any patients for pain management.

7. In November 2003, the licensee was indicted by the Jefferson County Grand Jury, along with Patient A and two nurse practitioners, on thirteen (13) counts of Prohibited Activities Relating to Controlled Substances (Class D Felony); fifteen (15) counts of Obtaining or Attempting to Obtain Controlled Substances by Fraud or Deceit (Class D Felony); one (1) count of Tampering with Physical Evidence (Class D Felony); and Wrongfully Filling Prescription nine (9) counts (Class A Misdemeanor). The licensee is awaiting trial in Jefferson Circuit Court.

8. A Board Consultant reviewed nine (9) patient records for whom the licensee had prescribed pain medication. The Consultant found a number of these

cases to be below minimum standards in the areas of diagnosis, treatment, and records. Specifically as to three patients of the same family, Patients A, B and D, the Consultant concluded that there was a serious and potentially dangerous lapse of clinical judgment. The Panel has considered the Consultant's report and incorporates it by reference into the findings of fact.

9. The licensee was interviewed at the office of her attorney, Jason Segeleon, on February 11, 2004, and she stated substantially as follows:

> She prescribed pain medication to long-time psychiatric patients, whom she had no reason to believe were abusing the medication or doctor shopping. She stayed in contact with the patients' other treating physicians and researched information regarding the nature of the medication and possible drug interactions. She frequently consulted with the nurse practitioner employed by J. Patrick Murphy, M.D. If there was ever an incidence when she felt she was "out of her comfort zone" she researched the drug and sought advice form other medical professionals. She never prescribed outside the scope of her knowledge.
>
> Patient E and Patient F were long time patients with MS. Roy J. Meckler, M.D., was aware of the medications Dr. Gallien prescribed for Patient E, because Dr. Gallien saw Patient E more frequently. Patient F had difficulty getting around so Dr. Gallien provided the pain prescriptions and also provided Patient F's neurologist with lists of medications she was prescribing. Patient G was prescribed pain medication for her headaches when she was between doctors due to changing insurance policies. Patient H had been dismissed from the practice as soon as Dr. Gallien learned she was getting Xanax from another clinic. Patient I suffered from severe cellulites and had no insurance. Dr. Gallien tried unsuccessfully to refer her to a pain management specialist. Patient C was a patient she treated for ADHD and pain from lung cancer surgery, which continued to cause numbness and discomfort. Patient C was started on OxyContin for fixed pain dosage and also prescribed Percocet for rescue pain. Patient C's primary care physician had retired and Dr. Gallien saw her as a patient on five occasions. She had absolutely no suspicion of any abuse of drugs Patient C may have been of concern to the police because Patient A was Patient C's friend and had picked up a prescription for her on one occasion.
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> ...
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> She has known ... [Patient A, B and D] since 1977 and was close to them, but had no relationship other than friendship with the family members. Patient D was under the care of Dr. Meckler and David A.

Petruska, M.D. Because of Patient D's schedule and frequent travel out of state, Dr. Gallien wrote the prescriptions he needed. She went with Patient D to many of his appointments with other doctors and all were aware of the fact that she was prescribing the medications he needed. She tried to record every prescription written but she admitted she was not treating him as a patient and he did not have a standard well-documented patient file. Her prescribing for Patient D was solely as a matter of convenience for him.

Patient B, Patient D's daughter, also did not have a typical patient chart. Patient B lived in Ohio and Dr. Gallien saw her on weekends when she came home to visit her family. Dr. Gallien maintained, at her home, some notes on the prescriptions she provided to Patient B since 1999 for severe depression and anxiety, Fibromyalgia, endometriosis and migraine headaches. Patient B intermittently received pain medication from another doctor in Ohio, but Dr. Gallien did not prescribe pain medication for Patient B, until after a motor vehicle accident in July 2003. Following that accident, Dr. Gallien wrote two prescriptions for pain medication starting her on OxyContin initially, because she had previously taken hydrocodone. In July, Dr. Gallien was present when Patient B handed her insurance card to her brother Patient A and asked him to pick up the prescription for her. In September 2003, Patient A was going to Ohio to visit his sister and offered to pick up the prescription medication Patient B needed. Dr. Gallien believes this incident triggered suspicions from the pharmacist and led to the police investigation. The police questioned Patient B and because she was frightened she denied that Dr. Gallien had ever provided prescriptions to her. Fifteen of the police charges relate to medication Dr. Gallien prescribed for Patient B.

Dr. Gallien had followed Patient A, Patient D's son, in treatment since 1999. Eric had suffered a tragic accident at age 15 and his toe and heel had been amputated. Doctors Kutz & Kleinert had created a heel from the ball of his foot in one significant surgery and two follow up surgeries. Patient A had a limp, difficulty with his spinal alignment and chronic pain. No other physicians, other than the surgeon and a chiropractor, have ever treated Patient A. Dr. Gallien initially treated him for ADHD. Subsequently she prescribed medications for anxiety, sleep disorder, and the chronic pain. She did not suspect that he was abusing or diverting medications, which she prescribed for him. In September 2003, someone suggested to her that Patient A was possibly diverting medication. She questioned him and he emphatically denied it. She had seen him in pain and believed with the amount of medication she was prescribing for him that he shouldn't have had this continuing amount of pain. In July or August 2003, she referred him to a pain management specialist.

Dr. Gallien believes some of Patient A's records may have been misfiled in another folder for a different patient with the same name. Dr. Gallien was served with a subpoena from the Board in August 2003,

requesting records for Patient A. At that time, Dr. Gallien discovered that his medical records were missing and attempted to recreate a patient file for him. Patient A was seen at her office for an occasional appointment and also stopped by on occasion to pick up a prescription Dr. Gallien had written for him.

In retrospect, Dr. Gallien would not have prescribed any pain medication to the ... family [of Patients A, B, and D].

Prior to leaving town in October 2003, Dr. Gallien left specific instructions to the nurse practitioners for them to take care of the medication needs of scheduled patients. They were told to provide patients with refills and with no medication changes. Generally the nurse practitioners worked along side her and she signed each narcotic prescription needed for the patients they were seeing in therapy. She frequently prescribed Ritalin, Xanax, and Ambien to patients being seen by the nurse practitioners. She only prescribed pain medications to a very few long time patients she was seeing and to members of the ... family [of Patients A, B, and D].

10. In July 2002, the Board received a grievance from a patient alleging that the licensee provided inappropriate psychiatric care. The patient specifically alleged the licensee inappropriately prescribed combinations of medications that caused him emotional harm and financial loss. He further alleged the licensee ignored all his complaints of serious side effects, i.e., hallucinations, blackouts, and terrorist threats.

11. A Board Consultant reviewed the records relevant to the initial grievance and concluded that there is evidence of substandard documentation of clinical decision-making. The Consultant recommended that the licensee improve medical record documentation, with an additional recommendation of less rapid titration of medications that can cause significant side effects or evidence that she has discussed these with the patient, particularly when prescribing at the upper limits of the medication range.

12. The Panel is the single body charged by statute, KRS 311.592 and 13B.125, to determine whether there is probable cause to believe that the physician's practice constitutes an immediate danger to the public health, welfare and safety. If so, the Panel may issue an interim Emergency Order to protect the public pending final resolution of the Complaint.

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

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal 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(4) and (9) as illustrated by KRS 311.597(1) and (4).
4. The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of her patients or the general public.
5. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general.

Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's medical practice.

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

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

EMERGENCY ORDER OF SUSPENSION

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

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

SO ORDERED this 30th day of July, 2004.

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

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and a copy was mailed via certified mail return-receipt requested to Wrenda B. Gallien, M.D., 453 Mallard Creek Road, Louisville, Kentucky 40207 and to Hon. Jason Segeleon, 125 South Seventh Street, Louisville, Kentucky 40202 on this 30th day of July, 2004.

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

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 957

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY WRENDA B. GALLIEN, M.D., LICENSE NO. 35312, 8521 OLD LAGRANGE ROAD, LOUISVILLE, KENTUCKY 40242

COMPLAINT

Comes now the Complainant, Preston P. Nunnelley, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on July 15, 2004, states for its Complaint against the licensee, Wrenda B. Gallien, M.D., as follows:

1. At all relevant times, Wrenda B. Gallien, M.D., was licensed by the Board to practice medicine in the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On September 25, 2003, the licensee was arrested and charged with illegally prescribing controlled substances - including OxyContin, wrongfully filling prescriptions for controlled substances, and tampering with physical evidence.
4. Sergeant William Stivers, Metro Narcotics, reported that a pharmacist had contacted Metro Narcotics regarding an OxyContin prescription authorized by the licensee. Metro Narcotics determined that the licensee had signed her name to multiple blank prescriptions before leaving the state for three days, allowing the nurse practitioners to illegally prescribe the controlled substances. Upon learning of the police investigation, the licensee instructed office staff to destroy any of the remaining presigned blank prescriptions. The police investigation revealed controlled substances were prescribed to friends,

without patients being examined. The licensee wrote a statement admitting to many of the charges and surrendered her DEA following her arrest.

5. On September 25, 2003 the licensee was arrested by the Metro Narcotics. The licensee provided the following written statement:

> I, Wrenda B. Gallien, M.D., have been involved in leaving signed scripts @ my practice for prescriptions to be written in my absence if need be. On 9-23 prescriptions were written for Patient B and given to Patient A. There have been several scripts written to patients/persons including OxyContin; Percocet, Xanax that were given one time or another to Patient A. I did have suspicions that he was selling the prescriptions despite that he did have legitimate pain @ times. I have approximately 5 patients on pain medications (2) who definitely take their pain medication. I know & should have understood the seriousness of my behavior. I have known Patient A since 1997 and have considered him to be just like a son. I initially began prescribing prescriptions to him specifically and he later referred several friends for medication/treatment. I have written prescriptions for Patient B & Patient C for OxyContin, Percocet & Xanax without them being in the office and were given to Patient A.

6. Cheryl Denzik, ARNP began working for the licensee working in January 2003. Ms. Denzik states that September 23, 2003 was the first occasion that the licensee was not physically present at the office while the licensee was seeing patients. Before leaving town, the licensee had given a verbal order to Ms. Denzik that if a patient was on Xanax or a controlled substance and needed a refill with no changes, prescription blanks had been signed and left with the office manager for Ms. Denzik to use. Ms. Denzik believed she had handed out four of these prescriptions, pre-signed and left blank by the licensee. She admitted that this was wrong, but it was done with the verbal order of the licensee. Ms. Denzik was not aware that the licensee treated any patients for pain management.

7. In November 2003, the licensee was indicted by the Jefferson County Grand Jury, along with Patient A and two nurse practitioners, on thirteen (13) counts of Prohibited Activities Relating to Controlled Substances (Class D Felony); fifteen (15) counts of Obtaining or Attempting to Obtain Controlled Substances by Fraud or Deceit (Class D Felony); one (1) count of Tampering with Physical Evidence (Class D Felony); and Wrongfully Filling Prescription nine (9) counts (Class A Misdemeanor). The licensee is awaiting trial in Jefferson Circuit Court.

8. A Board Consultant reviewed nine (9) patient records for whom the licensee had prescribed pain medication. The Consultant found a number of these cases to be below minimum standards in the areas of diagnosis, treatment, and records. Specifically as to three patients of the same family, Patients A, B and D, the Consultant concluded that there was a serious and potentially dangerous lapse of clinical judgment. The Panel has considered the Consultant's report and incorporates it by reference into the findings of fact.

9. The licensee was interviewed at the office of her attorney, Jason Segeleon, on February 11, 2004, and she stated substantially as follows:

> She prescribed pain medication to long-time psychiatric patients, whom she had no reason to believe were abusing the medication or doctor shopping. She stayed in contact with the patients' other treating physicians and researched information regarding the nature of the medication and possible drug interactions. She frequently consulted with the nurse practitioner employed by J. Patrick Murphy, M.D. If there was ever an incidence when she felt she was "out of her comfort zone" she researched the drug and sought advice form other medical professionals. She never prescribed outside the scope of her knowledge.
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> Patient E and Patient F were long time patients with MS. Roy J. Meckler, M.D., was aware of the medications Dr. Gallien prescribed for Patient E, because Dr. Gallien saw Patient E more frequently. Patient F

had difficulty getting around so Dr. Gallien provided the pain prescriptions and also provided Patient F's neurologist with lists of medications she was prescribing. Patient G was prescribed pain medication for her headaches when she was between doctors due to changing insurance policies. Patient H had been dismissed from the practice as soon as Dr. Gallien learned she was getting Xanax from another clinic. Patient I suffered from severe cellulites and had no insurance. Dr. Gallien tried unsuccessfully to refer her to a pain management specialist. Patient C was a patient she treated for ADHD and pain from lung cancer surgery, which continued to cause numbness and discomfort. Patient C was started on OxyContin for fixed pain dosage and also prescribed Percocet for rescue pain. Patient C's primary care physician had retired and Dr. Gallien saw her as a patient on five occasions. She had absolutely no suspicion of any abuse of drugs Patient C may have been of concern to the police because Patient A was Patient C's friend and had picked up a prescription for her on one occasion.

...

She has known ... [Patient A, B and D] since 1977 and was close to them, but had no relationship other than friendship with the family members. Patient D was under the care of Dr. Meckler and David A. Petruska, M.D. Because of Patient D's schedule and frequent travel out of state, Dr. Gallien wrote the prescriptions he needed. She went with Patient D to many of his appointments with other doctors and all were aware of the fact that she was prescribing the medications he needed. She tried to record every prescription written but she admitted she was not treating him as a patient and he did not have a standard well-documented patient file. Her prescribing for Patient D was solely as a matter of convenience for him.

Patient B, Patient D's daughter, also did not have a typical patient chart. Patient B lived in Ohio and Dr. Gallien saw her on weekends when she came home to visit her family. Dr. Gallien maintained, at her home, some notes on the prescriptions she provided to Patient B since 1999 for severe depression and anxiety, Fibromyalgia, endometriosis and migraine headaches. Patient B intermittently received pain medication from another doctor in Ohio, but Dr. Gallien did not prescribe pain medication for Patient B, until after a motor vehicle accident in July 2003. Following that accident, Dr. Gallien wrote two prescriptions for pain medication starting her on OxyContin initially, because she had previously taken hydrocodone. In July, Dr. Gallien was present when Patient B handed her insurance card to her brother Patient A and asked him to pick up the prescription for her. In September 2003, Patient A was going to Ohio to visit his sister and offered to pick up the prescription medication Patient B needed. Dr. Gallien believes this incident triggered suspicions from the pharmacist and led to the police investigation. The police questioned Patient B and because she was frightened she denied that Dr. Gallien had

ever provided prescriptions to her. Fifteen of the police charges relate to medication Dr. Gallien prescribed for Patient B.

Dr. Gallien had followed Patient A, Patient D's son, in treatment since 1999. Eric had suffered a tragic accident at age 15 and his toe and heel had been amputated. Doctors Kutz & Kleinert had created a heel from the ball of his foot in one significant surgery and two follow up surgeries. Patient A had a limp, difficulty with his spinal alignment and chronic pain. No other physicians, other than the surgeon and a chiropractor, have ever treated Patient A. Dr. Gallien initially treated him for ADHD. Subsequently she prescribed medications for anxiety, sleep disorder, and the chronic pain. She did not suspect that he was abusing or diverting medications, which she prescribed for him. In September 2003, someone suggested to her that Patient A was possibly diverting medication. She questioned him and he emphatically denied it. She had seen him in pain and believed with the amount of medication she was prescribing for him that he shouldn't have had this continuing amount of pain. In July or August 2003, she referred him to a pain management specialist.

Dr. Gallien believes some of Patient A's records may have been misfiled in another folder for a different patient with the same name. Dr. Gallien was served with a subpoena from the Board in August 2003, requesting records for Patient A. At that time, Dr. Gallien discovered that his medical records were missing and attempted to recreate a patient file for him. Patient A was seen at her office for an occasional appointment and also stopped by on occasion to pick up a prescription Dr. Gallien had written for him.

In retrospect, Dr. Gallien would not have prescribed any pain medication to the ... family [of Patients A, B, and D].

Prior to leaving town in October 2003, Dr. Gallien left specific instructions to the nurse practitioners for them to take care of the medication needs of scheduled patients. They were told to provide patients with refills and with no medication changes. Generally the nurse practitioners worked along side her and she signed each narcotic prescription needed for the patients they were seeing in therapy. She frequently prescribed Ritalin, Xanax, and Ambien to patients being seen by the nurse practitioners. She only prescribed pain medications to a very few long time patients she was seeing and to members of the ... family [of Patients A, B, and D].

10. In July 2002, the Board received a grievance from a patient alleging that the licensee provided inappropriate psychiatric care. The patient specifically alleged the licensee inappropriately prescribed combinations of medications that caused him emotional harm and financial loss. He further alleged the

licensee ignored all his complaints of serious side effects, i.e., hallucinations, blackouts, and terrorist threats.

11. A Board Consultant reviewed the records relevant to the initial grievance and concluded that there is evidence of substandard documentation of clinical decision-making. The Consultant recommended that the licensee improve medical record documentation, with an additional recommendation of less rapid titration of medications that can cause significant side effects or evidence that she has discussed these with the patient, particularly when prescribing at the upper limits of the medication range.

12. By her conduct, the licensee has violated KRS 311.595(4) and (9) as illustrated by KRS 311.597(1) and (4). Accordingly, legal grounds exist for disciplinary action against her Kentucky medical license.

13. 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. Her failure to respond may be taken as an admission of the charges;

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

14. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for January 11-13, 2005 at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure. This hearing shall proceed as scheduled and the hearing date shall

only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by Wrenda B. Gallien, M.D.

This 30th day of July, 2004.

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

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. C. William Schmidt, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, and a copy was mailed to Division of Administrative Hearings, 1024 Capital Center Drive, Frankfort, Kentucky 40601-8204 and copies were sent via certified mail, return-receipt requested to Wrenda B. Gallien, M.D., 453 Mallard Creek Road, Louisville, Kentucky 40207 and to Hon. Jason Segeleon, 125 South Seventh Street, Louisville, Kentucky 40202 on this 30th day of July, 2004.

L. CHAD ELDER
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