IN THE MATTER OF	*	BEFORE THE MARYLAND
DAVID L. WALTOS, M.D.	*	BOARD OF
Respondent	*	PHYSICIANS
License Number: D23801	*	Case Number: 2003-217

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CONSENT ORDER

On December 13, 2005, the Maryland State Board of Physicians (the "Board"), charged David L. Waltos, M.D. (the "Respondent") (D.O.B. 05/13/1952), License Number D23801, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("Health Occ.") § 14-404(a) (2000). Specifically, the Board charged the Respondent with the following provisions of the Act under Health Occ. § 14-404(a):

The pertinent provisions of the Act provide the following:

(a) Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;

(40) Fails to keep adequate medical records as determined by appropriate peer review.

FINDINGS OF FACT

I. BACKGROUND

The Board finds the following:

1. At all times relevant to these charges, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. He was initially licensed in Maryland on or about August 16, 1979, and his license is presently active.

2. At the time of the acts described herein, the Respondent was a physician engaged in the practice of psychiatry at 28 Allegheny Avenue, #1208, Towson, Maryland 21204.

3. On or about April 16, 2003, the Board opened a full investigation based on its receipt of a complaint filed by the father of two minor daughters (hereinafter, the "complainant") alleging that the Respondent had been inappropriately filling prescriptions for the complainant's children for psychotropic medications and controlled dangerous substances ("CDS"). According to the complaint, the Respondent prescribed for the children at the request of the children's mother (who was the Respondent's patient). The complainant further alleged the children were not the Respondent's "patients," and that he had failed to maintain a medical record on either child.

4. As part of its investigation, the Board requested that the Maryland Psychiatric Society's Peer Review Committee conduct a peer review focusing on the complaint. Two Board-certified psychiatrists reviewed records[1] and interviewed the Respondent as well as the

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[1] The records reviewed included the children's school and medical records from other providers and the mother's redacted medical records.

children's mother. The reviewers concurred that the Respondent failed to meet the standard of quality medical care for either child (hereinafter, "Child A and B" respectively)[2] and that the Respondent's documentation was inadequate.

5. Based on its investigation, the Board charged the Respondent with violating Health Occ. § 14-404(a)(22) and (40).

II. PATIENT RELATED FINDINGS OF FACT

6. The Respondent began professional mental health care for Children A and B's mother in December 1989.

7. Child A was a seven year-old female, when the Respondent began prescribing for her in March 1999. She had a long history of anxiety, irritable and depressed mood, sleep disturbance, over-activity, inattentiveness and vocal tics, and had been given diagnoses including Attention Deficit Hyperactivity Disorder ("ADHD"), Anxiety Disorder NOS (Not otherwise specified), Obsessive Compulsive Disorder, Depression and Tic Disorder. Child A had been treated with psychotherapy and medication management by a number of health care providers, and had been prescribed several medications including stimulant and non-stimulant medications for ADHD, as well as Benadryl,[3] Klonopin,[4]

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[2] For purposes of confidentiality, neither the identity of the children, nor the mother will be revealed in this document, but are known to the Respondent.

[3] Benadryl is an antihistamine that can be used as a nighttime sleep aid.

[4] Klonopin (Clonazepam) is a benzodiazapine (Schedule IV controlled dangerous substance).

Luvox[5] and Prozac.[6] According to Child A's mental health records, she had been very sensitive to medication; the medications for her ADHD symptoms worsened her difficulties with anxiety and *vice versa*.

8. Child B was a five year-old female when the Respondent began prescribing for her in March 1999. Child B initially presented for psychiatric treatment at age four for difficulties with irritability, aggression, oppositional behavior, hyperactivity and difficulty attending to tasks in school. Child B was hospitalized as an in-patient at Shepard Pratt Hospital in February 2000, and for two brief hospitalizations in the day-hospital during March and May 2000. Child B's diagnoses included ADHD, Mood Disorder and Bipolar Disorder. Beginning at age four, Child B was treated with psychotherapy and a number of psychotropic medications including stimulant and non-stimulant medications for ADHD, mood stabilizers, antidepressants and antipsychotics.

9. The Respondent stated during his interview with the peer reviewers that he began "refilling" prescriptions for [Children A and B] dating back to March 1999. He indicated that his role consisted of prescribing refills of medications when the children's mother was unable to obtain appointments for the children or had difficulty

[5] Luvox is an antidepressant used in the treatment of OCD.
[6] Prozac is an antidepressant used in the treatment of depression and OCD.

reaching one of the treating psychiatrists for refills of the medications.

10. The Respondent stated that he reviewed copies of "past medical records" pertaining to [Child A] and [Child B] prior to prescribing medications, and that he had "face-to-face" contact with each child.

11. The Respondent in a written response to the Board dated October 4, 2002 conceded that: "I did not set up an individual medical record for either [Child A] or [Child B], although I did make notations in [the mother's] chart and kept supporting documentation about the children in that record..."

12. The medical records provided by the Respondent in response to a subpoena by the Board consisted of eight pages from the children's mother's mental health record with information related to her treatment redacted or blacked out. The primary documentation relating to Children A and B consisted of notations of medications prescribed over two periods: March 18, 1999 through August 26, 1999 and September 2001 (no day documented) through June 10, 2002.

13. On the following dates, the Respondent failed to specify in the children's mother's records for whom the medication was prescribed: March 18, 1999 (Dexedrine), July 29, 1999 (Adderal), August 5, 1999 (Adderal) and March 7, 2001 (Concerta).

14. The Respondent's sole documentation regarding the children's response to treatment was noted as follows in the mother's records:

   a. On March 23, 1999, the Respondent documented "Dexedrine not helpful." He failed to specify whether this applied to Child A or Child B; and

   b. On August 26, 1999, with regard to Child B, the Respondent noted," feels Add[7] helpful [with] focusing, maintaining attention [and] getting things done."[8]

15. On the following dates, the Respondent modified the dosage of Luvox for Child A without any documented reason:

   a. On June 10, 1999, the Respondent documented the following: ↑to 25 t.i.d. (three times daily);[9]

   b. On July 16, 1999, the Respondent modified the dosage to: Luvox 25, 100 t.i.d. (three times daily); and

   c. On October 25, 2001, the Respondent prescribed Luvox 25, #60, 2 QD (every day) x 2.[10]

16. According to pharmacy records from Charlesmeade Pharmacy, the Respondent prescribed Luvox to Child A without any documentation (in the mother's chart) on May 31, 2001 and November 28, 2001.[11]

17. According to pharmacy records from Charlesmeade Pharmacy, the Respondent prescribed Neurontin to Child B without any documentation (in the mother's chart) on August 17, 2002.

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[7] Adderall (an amphetamine that is a Schedule II controlled dangerous substance used in the treatment of ADD)
[8] The Respondent also documented a notation that [Child B] "has appt." with Dr. L. on the "14th" "along [with]" [Child A] on the "21st".
[9] On May 27, 1999, the Respondent prescribed Luvox 25, 60, 2 b.i.d. (60 tablets total (25 mg.); two tablets to be taken twice daily)
[10] The prescription reflects "Luvox 25, #60, 1 p.o. b.i.d". (one tablet twice daily).
[11] With two refills.

18. According to the Respondent's notes in the mother's chart, he prescribed several different medications for Child B over the course of several months including Concerta,[12] Neurontin,[13] Ritalin[14] and Tenex[15]:

May 2001	**Sept. 2001**	**Oct. 2001**	**Dec. 2001**	**Jan. 2002**	**Feb. 2002**	**March 2002**	**April 2002**	**May 2002**	**June 2002**
Concerta	Concerta		Concerta	Concerta	Concerta	Concerta	Concerta	Concerta	
		Neurontin (with 2 refills)		Neurontin (with 3 refills)			Neurontin (with 3 refills)		
			Ritalin	Ritalin		Ritalin			
			Tenex (with 2 refills)						Tenex

19. Additionally, during the same approximate time period, according to pharmacy records from Charlesmeade Pharmacy, the Respondent prescribed the following medications for Child B without any documentation (in the mother's chart):

a. On September 19, 2001, Tenex;

b. On November 8, 2001, Concerta; and

c. On August 17, 2002, Neurontin.

20. The standard of quality medical care for the psychiatric evaluation of a child requires assessment of current and past symptoms in major areas of functioning, information about past psychiatric

[12] Concerta (methylphenidate) is a Schedule II CDS used in the treatment of ADHD.
[13] Neurontin is an anticonvulsant used in the treatment of partial seizures.
[14] Ritalin (methylphenidate) is a Schedule II CDS used in the treatment of ADD.
[15] Tenex is an antihypertensive medication used in the treatment of ADHD.

treatment, developmental history and past medical history. The Respondent failed to document a psychiatric evaluation to determine a diagnostic formulation or treatment plan for either Child A or Child B.

21. The standard of quality medical (psychiatric) care for medication management visits requires that these visits occur at regular intervals and include face-to-face contact with the patient, documentation of response of symptoms to treatment, the development of additional symptoms, documentation of target symptoms for medication treatment, documentation of side effects to medications (or absence thereof), documentation of reasons for changing medications, documentation of mental status observed at each visit and documentation of treatment performed.

22. With regard to Child A and Child B, the Respondent:

    a. failed to conduct and/or document a psychiatric evaluation;

    b. failed to determine and/or document a diagnostic formulation or treatment plan;

    c. failed to document any face-to-face contact when prescribing or refilling medications;

    d. failed to document a mental status exam;

    e. insufficiently documented the children's response of symptoms to treatment;

    f. failed to document target symptoms for medication treatment;

g. failed to document side effects to medication treatment or absence thereof; and/or

h. failed to document the reasons for changing medications.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions as outlined above constitute violations of Md. Health Occ. Code Ann. § 14-404(a)(22) and (40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 22nd day of March, 2006, by a quorum of the Board considering this case:

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

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum period of **TWO (2) YEARS** from the effective date of this Consent Order; that date being the date the Board executes this Consent Order; subject to the following terms and conditions:

1. Within six months from the effective date of this Consent Order, at his own cost, the Respondent shall successfully complete a Board-approved comprehensive course in medical records documentation. The Respondent shall submit the course description/syllabus to the Board prior to enrolling in the course, for approval. The Board reserves the right to

reject the course submitted for fulfillment of this condition, and may request additional information regarding the course. The Respondent shall submit written verification of successful completion of the course to the Probation Unit of the Board no later than thirty (30) days from the completion of the course. This course shall be in addition to the Continuing Medical Education requirements for licensure;

2. Within six months from the effective date of this Consent Order, at his own cost, the Respondent shall enroll in and successfully complete a Board-approved individual educational tutorial in medical ethics, focused on boundary violations. The tutor shall be authorized to submit periodic reports to and communicate with the Board while the Respondent is enrolled in the educational tutorial, if in the discretion of the tutor such communication is indicated. At the completion of the tutorial, the Respondent shall be responsible for assuring that the tutor shall submit to the Board an assessment including a report of attendance, participation and completion of any assignments, including a copy of any essay or other written assignments that the Respondent was required to write and verification of successful completion of the tutorial. This tutorial shall be in addition to the Continuing Medical Education requirements for licensure;

3. The Board shall conduct a chart review and/or a peer review focusing on documentation/medical recordkeeping one year after the effective date of this Order;

4. The Respondent's probation may not be terminated while he is being investigated as a result of a subsequent complaint or if he has been charged by the Board with a violation of the Medical Practice Act based upon a subsequent complaint;

5. The Respondent shall comply with all laws governing the practice of medicine under the Maryland Medical Practice Act and all rules and regulations promulgated thereunder; and it is further

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

ORDERED that after the conclusion of the entire two (2) year period of **PROBATION**, the Respondent may file a written petition for termination of his probationary status without further conditions or restrictions, but only if the Respondent has satisfactorily complied with all conditions of this Consent Order, including all terms and conditions of probation, including the expiration of the two (2) year period of probation, and if there are no pending complaints regarding the Respondent before the Board; and it is further

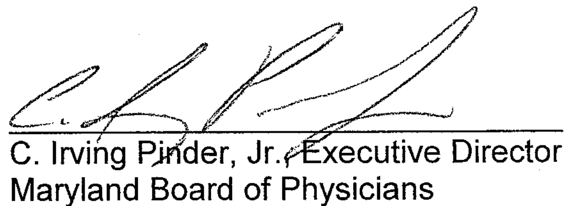
ORDERED that the Respondent shall not petition the Board for early termination of his probationary period or the terms of this Consent Order; and it is further

ORDERED that any violation of the terms and/or conditions of this Order shall be deemed a violation of probation and/or this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of probation and/or this Consent Order, the Board, in its discretion, may after a show cause hearing before the Board, impose any sanction that the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including a reprimand, probation, suspension, revocation and/or a monetary fine, said violation of probation being proved by a preponderance of the evidence; and be it further

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 et seq. (2004).

3/22/06
Date



C. Irving Pinder, Jr., Executive Director
Maryland Board of Physicians

CONSENT ORDER

I, David L. Waltos, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to

issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

March 6, 2006
Date

David L. Waltos, M.D.

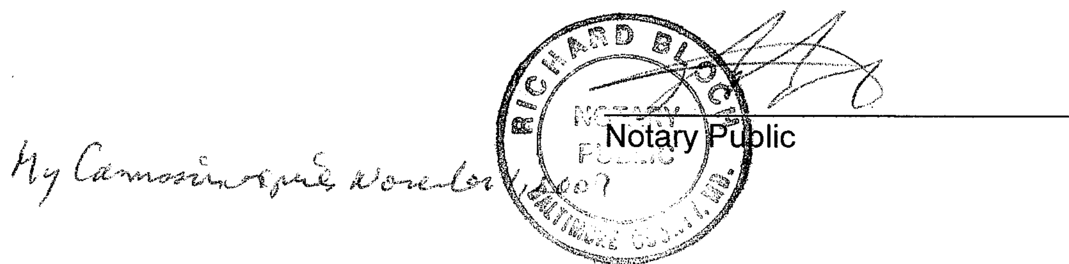
Reviewed and Approved by:

Richard Bloch, Esquire

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 6th day of March, 2006, before me, a Notary Public of the foregoing State and City/County personally appeared David L. Waltos, M.D., License Number D23801, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.



Notary Public