BEFORE THE NEW MEXICO MEDICAL BOARD

IN THE MATTER OF

KENNETH BULL, M.D. No. 2010-026

Respondent.

AMENDED DECISION AND ORDER

The Board amends its earlier-issued Decision and Order to make a minor clarification, which Dr. Bull has requested, to paragraph 3 of its Order. In all other respects, its Decision and Order as set forth below remains unchanged from the original. The issuance of this Amended Decision and Order does not serve to extend the deadline for seeking judicial review, which deadline has expired.

FINDINGS OF FACT

1. Respondent Dr. Kenneth Bull is a medical doctor who held a New Mexico medical license from 1973 until October 1, 2010, when the Board entered an order summarily suspending his license. Dr. Bull timely appealed the Board's suspension and Notice of Contemplated Action (NCA). The NCA charges, with respect to five patients, injudicious prescribing and improper management of medical records, not conforming to the Board's rules and standards.

2. Dr. Bull completed his medical training at the University of British Columbia. He completed his residency at Stanford University in Paolo Alto, California and has held academic positions at the University of Connecticut and University of New Mexico. Dr. Bull also held the position of chief of the psychiatric section at almost every Albuquerque hospital, including Presbyterian hospital on and off for twenty years.

3. Before the Board suspended Dr. Bull's medical license and beginning in 1974, Dr.

Bull was engaged in private practice treating primarily psychiatric patients. Dr. Bull was president of the New Mexico Psychiatric Association and a fellow of the American Psychiatric Association.

4. Dr. Bull treated the five patients at issue in the NCA. Dr. Bull treated each patient primarily for psychiatric conditions and in two cases with suboxone for opiate treatment. Dr. Bull has a reputation in the community for taking on the more difficult psychiatric cases. Dr. Bull's practice includes patients suffering from difficult and complex psychiatric conditions.

5. Dr. Mirin, a psychiatrist who has been covering many of Dr. Bull's patients during Dr. Bull's license suspension, testified that many of Dr. Bull's patients have a greater need than most patients for complex psychopharmacology medication to stabilize them.

6. Dr. Mirin was "uncomfortable" with some of the medications that Dr. Bull had been prescribing. Dr. Mirin saw 35-40 patients on the days he saw Dr. Bull's patients. Some of Dr. Bull's patients had been kept on medications for over 20 years.

7. Many of Dr. Bull's patients have been in treatment with him for years, including some he has treated for over twenty years.

8. Approximately 65% of psychiatric patients exhibit pain. Many psychiatric patients complain of generalized pain.

9. The Board's expert witness, Dr. Miriam Komaromy, is not a psychiatrist. She is an addictionologist and the medical director at Turquoise Lodge Hospital, the state hospital for substance abuse and addiction.

10. Dr. Komaromy is qualified to testify about the treatments of patients with medications.

11. Patient Number One was under Dr. Bull's treatment for approximately one year. Dr.

Carl Ray treated Patient Number One after Dr. Bull treated her. Dr. Ray testified that Patient Number One suffered from serious psychiatric illnesses.

12. Dr. Ray found that he could not tell from Dr. Bull's records whether he was diligent in his evaluation of Patient Number One. He found there was no notation of a specific diagnosis of a painful condition and no notation of a referral for evaluation of pain complaints.

13. Dr. Komaromy erred when she testified that Dr. Bull had prescribed oxycontin to Patient Number One. She acknowledged that she was confused because the records of Patients Numbers One and Two were commingled. Patient Number Two had oxycontin for fibromyalgia.

14. Dr. Bull prescribed hydrocodone to Patient Number One because she was already taking hydrocodone when she began her treatment with Dr. Bull. Dr. Bull also treated Patient Number One for anxiety and adult Attention Deficient Hyperactivity Disorder (ADHD). To treat Patient Number One's ADHD, Dr. Bull prescribed stimulants.

15. Dr. Bull explained in his testimony that he treated Patient Number One primarily for her psychiatric conditions, including anxiety and bipolar disorder. Dr. Bull explained that he saw the patient's past alcohol use as "partly a response—a way of self-medication for her bipolar disease."

16. Dr. Komaromy admitted that she was speculating about Patient No. One's alcohol addiction based on the inadequate notes from Dr. Bull.

17. Dr. Bull treated Patient Number Two, who was Patient Number One's daughter, for several serious and complex psychiatric conditions, including Bipolar Disorder, Obsessive Compulsive Disorder (OCD) and ADHD.

18. Dr. Bull treated Patient Number Two for more than a year. Patient Number Two denied having any addiction or substance abuse problems.

19. When Dr. Bull began treating Patient Number Two, she indicated to him that she had been previously diagnosed and treated for fibromyalgia unsuccessfully with cymbalta, lyrica, and neurontin.

20. Dr. Bull started treating Patient Number Two with pain medications, but also attempted a second trial of cymbalta to minimize her use of pain medications.

21. Dr. Bull testified that opiate medications can be indicated in the treatment of fibromyalgia. Dr. Sutter and Dr. Komaromy disagree. Fibromyalgia is a syndrome that is still poorly understood by medical professionals.

22. Dr. Ruben Sutter treated Patient Number Two after Dr. Bull. He testified that he sometimes prescribes medications in dosages higher than approved by the Federal Drug Administration. Dr. Bull's medical charts show that he saw Patient Number Two over fifty times from March 27, 2008 until June, 2009, when he terminated his treatment of her.

23. When Dr. Sutter saw Patient Number Two, he reduced or eliminated the medications that had been prescribed by Dr. Bull. Dr. Sutter was concerned that the level of drugs being given by Dr. Bull to Patient No. Two was "getting to be dangerous" and was "going to kill her liver."

24. Dr. Bull's patients came to see Dr. Sutter with a full spectrum of psychiatric illnesses. They were on a curious combination of medications and in higher dosages than approved by the FDA.

25. Regarding Patient Number Two, part of her treatment by Dr. Sutter was to suggest that she significantly cut back on the opioid pain medication. She was also on high dosages

of dextroamphetamine, and he suggested that it be cut by 15%. The patient was also on seemingly high dosages of benzodiazepine.

26. The patient also had been on hydrocodone and oxycodone. The amount of hydrocodone (40 mg) was not necessarily high, but adding the oxycodone (50 mg) could potentially kill her liver.

27. Dr. Sutter changed the medications for this patient and recommended a transfer to suboxone, which is an opioid replacement treatment.

28. The records from Dr. Bull regarding Patient Number Two were incredibly sparse in terms of documenting visits. He found no treatment plan. The closest thing was a March 26, 2009 letter outlining a diagnosis and alluding to medications she was getting and discussing some psychosocial challenges.

29. Dr. Bull's records did not facilitate an understanding of the treatment plan that resulted in the medication combinations, nor assist Dr. Sutter in continuing any sort of plan.

30. Dr. Sutter does not believe that the drugs that Dr. Bull prescribed and the quantities of those drugs were appropriate.

31. Generally, a doctor would not want patients to remain on narcotic pain medications because they are addictive and lose effectiveness.

32. Based on Dr. Bull's prescribing, Patient Number Two was getting in one month other drugs on top of the narcotics and amphetamines, which was a dangerous combination that could potentially kill someone.

33. Dr. Bull's medical records for Patient Number Two include five pages of medication charts with diagnoses and notes, Dr. Bull's handwritten progress notes from when he saw the patient, an extensive letter Dr. Bull wrote to Patient Number Two's school

detailing her diagnosis and progress in treatment, a symptom checklist and an extensive personal history.

34. Dr. Bull's medical charts for Patient Number Two are largely illegible.

35. Dr. Bull's intake notes of "no sleep" and "anger" are so broad that they could be evidence of anything. There is no specific diagnosis of depression or BAD. The symptom check list is done by the patient.

36. Dr. Bull fired Patient Number Two for stealing from his office. Dr. Sutter later fired Patient Number Two from his clinic for dishonest and non-compliant behavior, including seeking medication from multiple physicians.

37. Patient Number Three saw Dr. Bull in an effort to avoid becoming re-addicted to pain medications.

38. Dr. Bull treated Patient Number Three with buprenorphine, a synthetic opiate used for the treatment of opiate addiction, which is sold as subutex or suboxone.

39. Dr. Bull also treated Patient Number Three for chronic migraines.

40. The records from Patient Number Three's former primary care physician indicate that Patient Number Three suffered from migraine headaches long before he began treatment with Dr. Bull.

41. Patient Number Three's previous physician treated his migraines with topomax, verapamil, propanalol, and imitrex, non-opiate medications prescribed for migraines.

42. Patient Number Three's primary care physician previously treated the patient's pain issues (including migraines) with vicodin, demoral, and percocet, all opioids.

43. Dr. Bull also treated Patient Number Three for anxiety, as had Patient Number Three's primary physician.

44. Patient Number Three's wife complained to the Board but failed to tell the Board that she and her husband were separated. In her complaint, Patient Number Three's wife claimed Patient Number Three had gone into a full relapse into opiate addiction.

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46. Debbie Dieterich, the Board's investigator in this matter, acknowledged that Patient Number Three wanted his wife's complaint withdrawn.

47. Migraines can cause acute pain.

48. Patient Number Three was prescribed subutex, suboxone, and oxycontin. They may not have been taken simultaneously. The patient may have taken the opiate medication in the morning only on the days when he had a migraine and on non-migraine days suboxone.

49. Dr. Komaromy's testimony was that Dr. Bull was overprescribing pain medication.

50. Regarding Patient Number One, Dr. Komaromy was concerned that Dr. Bull had prescribed a number of highly addictive medications in very high doses and in dangerous combination. Patient Number One had been prescribed hydrocodone and a barbiturate, which is a sedative.

51. Overall, Dr. Komaromy was concerned about the quantity and addictive potential, as well as the sedative potential, leading to a risk of overdose death when combined and in high doses.

52. Dr. Bull's records for Patient Number One are not adequate to understand why he was prescribing the treatments he was prescribing.

53. Dr. Komaromy's conclusion regarding Dr. Bull's prescribing for Patient Number

One is: "The prescribing for this patient showed a pattern of reckless and excessive overprescribing of multiple sedating and addictive medication, with generally poor documentation of any rationale for why these medications were needed."

54. In addition, the escalations in dosages and early refills were signs that the patient was likely developing addiction problems. Another problem was Dr. Bull's adding additional medications in the same class on top of already prescribed medications, without justification in the medication record.

55. Regarding Patient Number Two, Dr. Bull prescribed high dosages of hydrocodone and oxycodone, in combination with acetaminophen. The quantities prescribed far exceed acceptable limits and lead to a tremendous risk of liver toxicity.

56. Dr. Komaromy's conclusions regarding Patient Number Two are the same as for Patient Number One. Dr. Bull was prescribing multiple medications with potential for addiction and oversedating, possibly inducing overdose death, with poor documentation of the rationale. Also, other concerns are the allowance of early refills and no documentation to support adding other medications of the same class.

57. Patient Number Three had been receiving pain medication management and had been using oxycontin, percocet and methadone.

58. Dr. Bull started the patient on suboxone, a treatment for opiate addition.

59. For Patient Number Three, Dr. Bull prescribed suboxone and at the same time prescribed high dosages of benzodiazepines, which is considered a risky combination because the risk of overdose death increases.

60. In addition, Dr. Bull prescribed oxycontin, which does not make sense, because the suboxone blocks the effects of other opiates. Therefore, prescribing the two is

contraindicated from the standpoint of treating addition. Also, oxycontin should not be prescribed to a person with a history of opiate addiction.

61. Dr. Bull also prescribed for Patient Number Three multiple different benzodiazepines, which increases the risk of opiate overdose death.

62. Dr. Bull's prescribing pattern for Patient Number Three led to an increased risk of addiction and was dangerous to the patient, including risk of death.

63. Regarding Patient Number Four, the parent of this patient complained, alleging that Dr. Bull's prescribing for this patient, a son, was abusive and negligent and resulted in the patient's medication overdose in May of 2010.

64. Patient Number Four had a history of alcohol and marijuana use and had been using oxycontin and heroin.

65. Dr. Bull initiated suboxone therapy, but also prescribed benzodiazepines, which is irrational and dangerous.

66. The patient was hospitalized for overdose, but the month following, Dr. Bull resumed the same addictive medications the patient had been taking before hospitalization.

67. Benzodiazepines, in combination with opiates, has a potential for overdose and overdose death.

68. Regarding Patient Number Five, this patient died from a suspected drug overdose. A large number of bottles of benzodiazepines and opiates prescribed by Dr. Bull were found in the patient's medicine cabinet when he died.

69. On the first visit with this patient, Dr. Bull had prescribed benzodiazepines and high doses of multiple opiates.

70. Dr. Bull's behavior with respect to Patient Number Five was irresponsible and

reckless and substantially increased the patient's risk of overdose death.

71. Regarding Patient Number Five, this patient was also getting substantial amounts of opiate drugs from another doctor, which overlapped Dr. Bull's prescribing.

72. Pharmacy records for Patient Number Three show that Dr. Bull prescribed 10 milligram oxycontin on October 3, 2008; the ten pills lasted Patient Number Three for twenty days, or approximately one pill every other day. On October 22, 2008, Patient Number Three received another prescription for ten more 10 milligram pills that lasted for eight days. The patient was then prescribed just six tablets of 10 milligram oxycontin on October 30, 2008. That prescription lasted the patient for nearly one hundred days.

73. Patient Number Four saw Dr. Bull for suboxone treatment, as well as serious psychiatric illnesses including anxiety and Post-Traumatic Stress Disorder (PTSD). Dr. Bull's charts for Patient Number Four reflect his diagnoses of opiate addiction, PTSD, and OCD.

74. Patient Number Four's mother complained to the Board about Dr. Bull. Patient Number Four had a difficult relationship with his mother, in part because she behaved in an erratic manner and is a difficult person. Patient Number Four told Dr. Bull that he saw his mother try to hang herself.

75. Dr. Bull also treated Patient Number Four with benzodiazepines for his anxiety and PTSD. Dr. Komaromy admitted that there are some circumstances under which it is appropriate to prescribe both benzodiazepines and suboxone at the same time.

76. Dr. Bull was attempting to closely monitor Patient Number Four, but Patient Number Four was not entirely compliant.

77. Dr. Bull later learned that Patient Number Four was not being honest with him.

Patient Number Four was a particularly difficult patient to treat because of his noncompliance and dishonesty issues.

78. Patient Number Four was on xanax when he first saw Dr. Bull. Dr. Bull was attempting to transition Patient Number Four from xanax to klonopin because of the addictive nature of xanax. While there was some overlap of the two medications, xanax and klonopin have different indications. One is more short-acting and one is more long-acting.

79. Dr. Komaromy testified that it does not violate acceptable practice to prescribe both xanax and klonopin at the same time. Dr. Komaromy's concern was not due just to the prescribing of the two drugs but the addition of suboxone in spite of a chart note and treatment contract that benzodiazepines in combination with suboxone can cause death.

80. It is unclear from the hospital records whether Patient Number Four actually overdosed on medication or simply stopped taking medication, leading to a seizure. There is no toxicology report in the Presbyterian Kaseman medical records.

81. Patient Number Five saw Dr. Bull for the treatment of anxiety and for depression. Dr. Bull prescribed benzodiazepines for Patient Number Five's situational anxiety, as indicated in the medical charts. A month later, Patient Number Five reported feelings of social anxiety and decreased confidence, which Dr. Bull also charted. Dr. Bull also prescribed Patient Number Five pain medication, as well as an anti-inflammatory (naproxen), for the pain in his arm associated with a motor vehicle accident.

82. Patient Number Five was dishonest with Dr. Bull about having past substance abuse problems. Patient Number Five was also dishonest because he failed to tell Dr. Bull that he was seeing another physician, Dr. Barry Maron, who was also prescribing Patient Number Five substantial amounts of pain medication. Dr. Komaromy's report was based on

Dr. Bull's prescribing.

83. Dr. Komaromy states that Dr. Bull should have known that Patient Number Five was abusing drugs because he was "fired" from the UNM Pain Clinic.

84. Patients may be "fired" by clinics for many different reasons, including noncompliance, personality issues, lack of trust issues, and disagreements over treatment plans.

85. Dr. Komaromy's report states that at the first visit, Patient Number Five was given three prescriptions for slow-release opiates and one for immediate-acting opiates (oxycodone). The medical charts and pharmacy records show that, at the first visit, Dr. Bull prescribed the patient 36, 20-milligrams tablets of short-acting oxycodone based on the patient's statement of the medication he was currently taking (oxycodone 5 milligrams, 3-4 every 4 hours). The pharmacy, however, did not have 20 milligram tablets. It substituted 144, 5-miligram tablets.

86. Dr. Bull prescribed 255 tablets of opiates to Patient Number Five, because, it appears from the charts, the patient told Dr. Bull that the patient's cousin stole his pain medication. Dr. Bull wrote a progress note that states "Meds. stolen by cousin."

87. The toxicology screen performed during Patient Number Five's autopsy shows that Patient Number Five consumed numerous powerful medications that Dr. Bull had not prescribed to him, including morphine, tramadol, codeine and phenobarbital. Of the six substances found in Patient Number Five's toxicology report, Dr. Bull prescribed only two.

88. Dr. Bull has acknowledged his charting needs improvement. He has developed a new charting system that he will implement with the Board's approval if his license is restored.

89. Dr. Bull realizes that his records are a major shortcoming and that he has to shape-up.

90. Dr. Bull has also recognized that he needs to be more aggressive in referring patients who need chronic pain management.

91. Dr. Bull was not aware of the Medical Board's regulations concerning the management of medical records.

92. Dr. Bull was not aware of the Medical Board's regulations about the management of chronic pain, which, among other things, require a physical examination and evaluations.

93. Dr. Bull did not develop a written treatment plan for the patients or record DSM-IV axis classifications.

94. About twenty of Dr. Bull's patients required treatment for addiction at Turquoise Lodge in the past five years.

95. Dr. Bull testified that he is not familiar with the New Mexico Pain Relief Act but would become familiar with it.

96. With respect to Patient Numbers One through Five, Dr. Bull has engaged in injudicious prescribing.

97. With respect to Patient Numbers One and Two and Patient Numbers Four and Five, Dr. Bull has failed to maintain timely, accurate, legible and complete medical records.

98. With respect to Patient Numbers Three, Four and Five, Dr. Bull has failed to treat and manage patients with chronic pain in the manner required by Title 16, Chapter 10, Part 15 of the Board's regulations entitled "Management of Chronic Pain with Controlled Substances."

CONCLUSIONS OF LAW

Dr. Bull has engaged in unprofessional or dishonorable conduct contrary to NMSA 1978, Section 61-6-15(D)(26) (injudicious prescribing of drugs) and Section 61-6-15(D)(33) (improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records).

ORDER

Dr. Bull is hereby placed upon probation subject to the following terms and conditions:

1. Dr. Bull's term of probation extends until further order of the Board.

2. Dr. Bull may continue to practice medicine in psychiatry but with the following conditions and restrictions described below.

3. Dr. Bull may not prescribe narcotics, including but not limited to, all opioid analgesics, including buprenorphine and all synthetic opioid analgesics, as defined by the Controlled Substance Act NMSA §30-31-2.

4. Dr. Bull is prohibited from treating patients with chronic pain.

5. Dr. Bull must alter his medical record-keeping practice in accordance with accepted practices and must appear before the Board on a quarterly basis.

6. Dr. Bull shall submit quarterly reports to the Board attesting to his compliance with this Order. Such quarterly reports shall be on a form provided by Board staff and sent to Dr. Bull.

7. Dr. Bull shall not delegate or direct the prescribing, administering or dispensing of opioid analgesics to any subordinate or other healthcare provider with whom he practices.

8. Dr. Bull must provide a copy of this Order to any healthcare provider with whom he practices.

If the Board has reasonable cause to believe that Dr. Bull has violated any of the terms and conditions of this Order, the Board may immediately and summarily suspend his license to practice as a physician in New Mexico. A breach of any term or condition of this Order shall constitute conduct unbecoming in a person licensed to practice medicine as set forth in NMSA 1978, Section 61-6-15(D)(29). The Board shall within 10 days of a summary suspension, issue a Notice of Contemplated Act, and Dr. Bull will be entitled to a formal hearing in accordance with the Uniform Licensing Act, NMSA 1978, Sections 61-1-1 through -33.

RIGHT TO JUDICIAL REVIEW

Dr. Bull may seek judicial review of this Decision and Order pursuant to NMSA 1978, § 61-1-17 and NMSA 1978, § 39-3-1.1. The time within which to do so is thirty days from the date of filing of the Board's Decision and Order.

Date: August 15, 2011

STEVEN WEINER, M.D., Chair
New Mexico Medical Board

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61. Dr. Bull also prescribed for Patient Number Three multiple different benzodiazepines, which increases the risk of opiate overdose death.

62. Dr. Bull's prescribing pattern for Patient Number Three led to an increased risk of addiction and was dangerous to the patient, including risk of death.

63. Regarding Patient Number Four, the parent of this patient complained, alleging that Dr. Bull's prescribing for this patient, a son, was abusive and negligent and resulted in the patient's medication overdose in May of 2010.

64. Patient Number Four had a history of alcohol and marijuana use and had been using oxycontin and heroin.

65. Dr. Bull initiated suboxone therapy, but also prescribed benzodiazepines, which is irrational and dangerous.

66. The patient was hospitalized for overdose, but the month following, Dr. Bull resumed the same addictive medications the patient had been taking before hospitalization.

67. Benzodiazepines, in combination with opiates, has a potential for overdose and overdose death.

68. Regarding Patient Number Five, this patient died from a suspected drug overdose. A large number of bottles of benzodiazepines and opiates prescribed by Dr. Bull were found in the patient's medicine cabinet when he died.

69. On the first visit with this patient, Dr. Bull had prescribed benzodiazepines and high doses of multiple opiates.

70. Dr. Bull's behavior with respect to Patient Number Five was irresponsible and reckless and substantially increased the patient's risk of overdose death.

71. Regarding Patient Number Five, this patient was also getting substantial amounts of opiate drugs from another doctor, which overlapped Dr. Bull's prescribing.

72. Pharmacy records for Patient Number Three show that Dr. Bull prescribed 10 milligram oxycontin on October 3, 2008; the ten pills lasted Patient Number Three for twenty days, or approximately one pill every other day. On October 22, 2008, Patient Number Three received another prescription for ten more 10 milligram pills that lasted for eight days. The patient was then prescribed just six tablets of 10 milligram oxycontin on October 30, 2008. That prescription lasted the patient for nearly one hundred days.

73. Patient Number Four saw Dr. Bull for suboxone treatment, as well as serious psychiatric illnesses including anxiety and Post-Traumatic Stress Disorder (PTSD).

Dr. Bull's charts for Patient Number Four reflect his diagnoses of opiate addiction, PTSD, and OCD.

74. Patient Number Four's mother complained to the Board about Dr. Bull. Patient Number Four had a difficult relationship with his mother, in part because she behaved in an erratic manner and is a difficult person. Patient Number Four told Dr. Bull that he saw his mother try to hang herself.

75. Dr. Bull also treated Patient Number Four with benzodiazepines for his anxiety and PTSD. Dr. Komaromy admitted that there are some circumstances under which it is appropriate to prescribe both benzodiazepines and suboxone at the same time.

76. Dr. Bull was attempting to closely monitor Patient Number Four, but Patient Number Four was not entirely compliant.

77. Dr. Bull later learned that Patient Number Four was not being honest with him. Patient Number Four was a particularly difficult patient to treat because of his noncompliance and dishonesty issues.

78. Patient Number Four was on xanax when he first saw Dr. Bull. Dr. Bull was attempting to transition Patient Number Four from xanax to klonopin because of the addictive nature of xanax. While there was some overlap of the two medications, xanax and klonopin have different indications. One is more short-acting and one is more long-acting.

79. Dr. Komaromy testified that it does not violate acceptable practice to prescribe both xanax and klonopin at the same time. Dr. Komaromy's concern was not due just to the prescribing of the two drugs but the addition of suboxone in spite of a chart note and treatment contract that benzodiazepines in combination with suboxone can cause death.

80. It is unclear from the hospital records whether Patient Number Four actually

overdosed on medication or simply stopped taking medication, leading to a seizure. There is no toxicology report in the Presbyterian Kaseman medical records.

81. Patient Number Five saw Dr. Bull for the treatment of anxiety and for depression. Dr. Bull prescribed benzodiazepines for Patient Number Five's situational anxiety, as indicated in the medical charts. A month later, Patient Number Five reported feelings of social anxiety and decreased confidence, which Dr. Bull also charted. Dr. Bull also prescribed Patient Number Five pain medication, as well as an anti-inflammatory (naproxen), for the pain in his arm associated with a motor vehicle accident.

82. Patient Number Five was dishonest with Dr. Bull about having past substance abuse problems. Patient Number Five was also dishonest because he failed to tell Dr. Bull that he was seeing another physician, Dr. Barry Maron, who was also prescribing Patient Number Five substantial amounts of pain medication. Dr. Komaromy's report was based on Dr. Bull's prescribing.

83. Dr. Komaromy states that Dr. Bull should have known that Patient Number Five was abusing drugs because he was "fired" from the UNM Pain Clinic.

84. Patients may be "fired" by clinics for many different reasons, including noncompliance, personality issues, lack of trust issues, and disagreements over treatment plans.

85. Dr. Komaromy's report states that at the first visit, Patient Number Five was given three prescriptions for slow-release opiates and one for immediate-acting opiates (oxycodone). The medical charts and pharmacy records show that, at the first visit, Dr. Bull prescribed the patient 36, 20-milligrams tablets of short-acting oxycodone based on the patient's statement of the medication he was currently taking (oxycodone 5 milligrams, 3-4 every 4 hours). The pharmacy, however, did not have 20 milligram tablets. It substituted 144, 5-miligram tablets.

86. Dr. Bull prescribed 255 tablets of opiates to Patient Number Five, because, it appears from the charts, the patient told Dr. Bull that the patient's cousin stole his pain medication. Dr. Bull wrote a progress note that states "Meds. stolen by cousin."

87. The toxicology screen performed during Patient Number Five's autopsy shows that Patient Number Five consumed numerous powerful medications that Dr. Bull had not prescribed to him, including morphine, tramadol, codeine and phenobarbital. Of the six substances found in Patient Number Five's toxicology report, Dr. Bull prescribed only two.

88. Dr. Bull has acknowledged his charting needs improvement. He has developed a new charting system that he will implement with the Board's approval if his license is restored.

89. Dr. Bull realizes that his records are a major shortcoming and that he has to shape-up.

90. Dr. Bull has also recognized that he needs to be more aggressive in referring patients who need chronic pain management.

91. Dr. Bull was not aware of the Medical Board's regulations concerning the management of medical records.

92. Dr. Bull was not aware of the Medical Board's regulations about the management of chronic pain, which, among other things, require a physical examination and evaluations.

93. Dr. Bull did not develop a written treatment plan for the patients or record DSM-IV axis classifications.

94. About twenty of Dr. Bull's patients required treatment for addiction at Turquoise Lodge in the past five years.

95. Dr. Bull testified that he is not familiar with the New Mexico Pain Relief Act but would become familiar with it.

96. With respect to Patient Numbers One through Five, Dr. Bull has engaged in injudicious prescribing.

97. With respect to Patient Numbers One and Two and Patient Numbers Four and Five, Dr. Bull has failed to maintain timely, accurate, legible and complete medical records.

98. With respect to Patient Numbers Three, Four and Five, Dr. Bull has failed to treat and manage patients with chronic pain in the manner required by Title 16, Chapter 10, Part 15 of the Board's regulations entitled "Management of Chronic Pain with Controlled Substances."

CONCLUSIONS OF LAW

Dr. Bull has engaged in unprofessional or dishonorable conduct contrary to NMSA 1978, Section 61-6-15(D)(26) (injudicious prescribing of drugs) and Section 61-6-15(D)(33) (improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records).

ORDER

Dr. Bull is hereby placed upon probation subject to the following terms and conditions:

1. Dr. Bull's term of probation extends until further order of the Board.

2. Dr. Bull may continue to practice medicine in psychiatry but with the following conditions and restrictions described below.

3. Dr. Bull may not prescribe narcotics, including but not limited to, all opioid analgesics, including buprenorphine and all synthetic opioid analgesics.

4. Dr. Bull is prohibited from treating patients with chronic pain.

5. Dr. Bull must alter his medical record-keeping practice in accordance with accepted practices and must appear before the Board on a quarterly basis.

6. Dr. Bull shall submit quarterly reports to the Board attesting to his compliance with this Order. Such quarterly reports shall be on a form provided by Board staff and sent to Dr. Bull.

7. Dr. Bull shall not delegate or direct the prescribing, administering or dispensing of opioid analgesics to any subordinate or other healthcare provider with whom he practices.

8. Dr. Bull must provide a copy of this Order to any healthcare provider with whom he practices.

If the Board has reasonable cause to believe that Dr. Bull has violated any of the terms and conditions of this Order, the Board may immediately and summarily suspend his license to practice as a physician in New Mexico. A breach of any term or condition of this Order shall constitute conduct unbecoming in a person licensed to practice medicine as set forth in NMSA 1978, Section 61-6-15(D)(29). The Board shall within 10 days of a summary suspension, issue a Notice of Contemplated Action, and Dr. Bull will be entitled to a formal hearing in accordance with the Uniform Licensing Act, NMSA 1978, Sections 61-1-1 through -33.

RIGHT TO JUDICIAL REVIEW

Dr. Bull may seek judicial review of this Decision and Order pursuant to NMSA 1978, § 61-1-17 and NMSA 1978, § 39-3-1.1. The time within which to do so is thirty days from the date of filing of the Board's Decision and Order.

Dated: May 9, 2011

STEVEN WEINER, M.D., Chair
New Mexico Medical Board

BEFORE THE NEW MEXICO MEDICAL BOARD

IN THE MATTER OF	)	
	)	
Kenneth Bull, MD	)	
License No. 73-99	)	**No. 2010-26**
	)	
Respondent.	)	

SUMMARY SUSPENSION ORDER

WHEREAS the New Mexico Medical Board ("Board") having received complaints against Respondent and investigations having been initiated; and

WHEREAS the Board having reviewed such investigations, reports and evaluations issued a Notice of Contemplated Action on August 9, 2010; and

WHEREAS the Board having received additional complaints, and having reviewed the additional investigations, reports and evaluations; and

WHEREAS pursuant to §61-6-15.1 NMSA 1978, the Board may summarily suspend a license issued by the board, and has simultaneously issued an Amended Notice of Contemplated Action on October 1, 2010; and

WHEREAS the Board pursuant to §61-6-15.1(A) has reason to believe that Respondent poses a clear and immediate danger to the public health and safety if the licensee continues to practice; AND GOOD CAUSE APPEARING; and

WHEREAS the Respondent is entitled to a hearing on this Order by the Board within fifteen days from the date the Respondent requests a hearing.

IT IS HEREBY ORDERED that Respondent's New Mexico license to practice medicine is hereby SUSPENDED until further Order of the Board.

Dated this 1st day of October, 2010.

Steven Weiner, M.D., Chair
New Mexico Medical Board

BEFORE THE NEW MEXICO MEDICAL BOARD

IN THE MATTER OF	)	
	)	
Kenneth Bull, MD	)	
License No. 73-99	)	**No. 2010-026**
	)	
Respondent.	)	

AMENDED NOTICE OF CONTEMPLATED ACTION

YOU ARE HEREBY NOTIFIED that pursuant to provisions of §61-1-4 NMSA 1978 of the Uniform Licensing Act (ULA), the New Mexico Medical Board ("Board") has before it sufficient evidence that, if not rebutted or explained, will justify the Medical Board imposing sanctions that could include restricting, revoking or suspending your license to practice medicine in the State of New Mexico.

1. Respondent is subject to action by the Board pursuant to §61-1-1 et seq. NMSA 1978 and §61-6-1 NMSA 1978 et seq.

2. This contemplated action is based on the following allegations:

A. From on or about June 10, 2008 to on or about June 2, 2009, Respondent injudiciously prescribed to Patient #1 including but not limited to: Respondent prescribed opiates to Patient #1 without medically indicating rationale; Respondent prescribed benzodiazepines to Patient #1, a patient with history of alcohol addiction; and Respondent prescribed a combination of opiates, benzodiazepines, barbiturates and sedating antidepressants to Patient #1 who was drinking heavily. During the time of Respondent's treatment of Patient #1, Respondent failed to chart patient visits, failed to chart diagnosis or rational for ongoing treatment, and failed to chart notes on medical record of Patient #1 as to why prescribing medications and/or changing doses of prescriptions.

These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing; and §61-6-15(D) (33) improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records.

B. From on or about June 10, 2008 to on or about June 2, 2009, Respondent injudiciously prescribed to Patient #2 including but not limited to: Respondent overprescribed combinations of drugs to Patient #2 that if all taken by Patient #2 would have been toxic. During the time of Respondent's treatment of Patient #2, Respondent noted diagnosis without any or little documentation as to symptoms supporting the diagnosis; Respondent failed to chart notes in the medical record of Patient #2 as to why prescribing medications and/or changing doses of prescriptions; and Respondent sent a letter regarding Patient #2 to the school of Patient #2 indicating particular diagnosis that was not documented in Patient #2's medical record.

These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing; and §61-6-15(D) (33) improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records.

C. From on or about June 2008 to on or about February 2009, Respondent injudiciously prescribed to Patient #3 including but not limited to: Respondent prescribed multiple high-dose benzodiazepines during the same period that he prescribed Suboxone, Subutex and Oxycodone in high doses to Patient #3; Respondent prescribed Suboxone and Subutex both to Patient #3; Respondent with the knowledge that Patient #3 had an addiction to opiate analgesics, prescribed them to Patient #3 in high doses; and Respondent prescribed buprenorphine-containing medication with Oxycodone to treat acute pain.

These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing and of 16.10.14 NMAC.

D. From on or about September 2008 to on or about May 2010, Respondent injudiciously prescribed to Patient #4 including but not limited to: Respondent prescribed multiple high-dose benzodiazepines during the same period that he prescribed Suboxone; Respondent prescribed number and combinations of benzodiazepines without medical justification; Respondent continued prescribing same medications to Patient #4 without adjustment even after noting Patient #4 had been hospitalized for an overdose; and Respondent failed to chart notes in the medical record of Patient #4 as to why prescribing medications and/or changing doses of prescriptions.

These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing and of 16.10.14 NMAC, and §61-6-15(D) (33) improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records.

E. From on or about February 2010 to on or about June 2010, Respondent injudiciously prescribed to Patient #5 including but not limited to: Respondent prescribed large amounts of benzodiazepines without indicating rationale for such prescribing; Respondent prescribed high-doses of opiates simultaneously with high-strength benzodiazepines without indicating rationale for such prescribing and with reason to know patient had addiction problems.

These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing and of 16.10.14 NMAC, and §61-6-15(D) (33) improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records.

3. Please take notice that pursuant to §61-1-4, you may secure a hearing before the Board by depositing in the mail within twenty (20) days after service of this notice a certified return receipt requested letter addressed to the Board and containing a request for a hearing. If

you do not request a hearing within twenty (20) days after service of this notice as described above, the Board will take the contemplated action, i.e., imposing sanctions that could include the revocation or suspension of your license to practice medicine in the State of New Mexico, and there will be no judicial review of their decision.

4. Pursuant to §61-1-8 NMSA 1978, you have the right to be represented by counsel or by a licensed member of your profession or both, and to present all relevant evidence by means of witnesses, books, papers, documents and other evidence; to examine all opposing witnesses who may appear on any matter relevant to the issues and have subpoenas duces tecum issued as of right prior to the commencement of the hearing, to compel the attendance of witnesses and the production of relevant books, papers, documents and other evidence upon making a written request therefore to the Board. The issuance of such subpoenas after commencement of the hearing rests with the discretion of the Board or Hearing Officer.

Dated this 1st day of October, 2010.

NEW MEXICO MEDICAL BOARD

Lynn Hart

Lynn Hart, Executive Director
NM Medical Board
2055 S. Pacheco, #400
Santa Fe, New Mexico 87505
(505) 476-7220

BEFORE THE NEW MEXICO MEDICAL BOARD

IN THE MATTER OF	)	
	)	
Kenneth Bull, MD	)	
License No. 73-99	)	**No. 2010-026**
	)	
Respondent.	)	

NOTICE OF CONTEMPLATED ACTION

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including failure to maintain timely, accurate, legible and complete medical records.

B. From on or about June 10, 2008 to on or about June 2, 2009, Respondent injudiciously prescribed to Patient #2 including but not limited to: Respondent overprescribed combinations of drugs to Patient #2 that if all taken by Patient #2 would have been toxic. During the time of Respondent's treatment of Patient #2, Respondent noted diagnosis without any or little documentation as to symptoms supporting the diagnosis; Respondent failed to chart notes in the medical record of Patient #2 as to why prescribing medications and/or changing doses of prescriptions; and Respondent sent a letter regarding Patient #2 to the school of Patient #2 indicating particular diagnosis that was not documented in Patient #2's medical record.

These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing; and §61-6-15(D) (33) improper management of medical records, including failure to maintain timely, accurate, legible and complete medical records.

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These allegations, if proven, would be a violation of §61-6-15(D) (26) NMSA 1978, injudicious prescribing and of 16.10.14 NMAC.

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Dated this 9th day of August, 2010.

NEW MEXICO MEDICAL BOARD

Lynn Hart, Executive Director
NM Medical Board
2055 S. Pacheco, #400
Santa Fe, New Mexico 87505
(505) 476-7220

NEW MEXICO BOARD OF MEDICAL EXAMINERS
491 Old Santa Fe Trail
Second Floor, Lamy Building
Santa Fe New Mexico 87501

Gary E. Johnson
GOVERNOR

Livingston Parsons, Jr., M.D.
PRESIDENT

August 23, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kenneth J. Bull, M.D.
2403 San Mateo Blvd, NE, Ste.#S-10
Albuquerque, New Mexico 87110

REF: LETTER OF REPRIMAND

Dear Dr. Bull,

I am writing on behalf of the New Mexico Board of Medical Examiners in this matter. This letter constitutes a formal public reprimand for your action related to doctor-patient relationships: asking a patient for a loan of $25,000.00.

In your response to the allegations on November 5 1995, you admitted making an offer of a short-term business loan from the patient to your business venture. Your letter of March 10, 1996 indicated that you would accept a letter of reprimand.

While the Board of Medical Examiners does not expect this type of behavior to occur again, if it does, the Board will respond with a Notice of Contemplative Action and proceed to take action against your license to practice medicine in New Mexico. This action of reprimand is a reportable action to the National Practioners Data Bank.

Sincerely,

Livingston Parsons Jr. M.D.

Livingston Parsons, Jr., M.D.
President

ADMINISTRATION
(505) 827-5022
(505) 827-7377 FACSIMILE

FINANCIAL
(505) 827-0750

INVESTIGATIONS
(505) 827-7302
(505) 827-8401

LICENSING
(505) 827-0033 APPLICATIONS
(505) 827-7317 PHYSICIAN ASSISTANT
(505) 827-0784 VERIFICATIONS