State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline

IN THE MATTER OF:
John Sappington M.D.
License Number MD 09034
Case # 181211, 181096,181119,181463,181194,181210,181195, 181197

Surrender of License

John Sappington M.D. (hereinafter "Respondent") is licensed as a physician in Rhode Island. After review of the above referenced matters, the Board of Medical Licensure and Discipline (Board) makes the following findings of fact:

Findings of Fact

1. Respondent is a licensed physician in the State of Rhode Island. His license was issued on October 5th, 1995. The license was reinstated by a Consent Order on June 14th, 2017 based on resolution of a prior suspension of his license on March 12th, 1996 involving facts related to case C96-014.

2. Respondent's license was suspended on September 24th, 2018 due to a violation of the Consent Order, ratified on June 14th, 2017 and amended April 11th, 2018, which is the subject of Complaint 181211.

3. Respondent had prescribed various controlled substances to different patients over various dates and did not review the PDMP prior to prescribing these controlled substances, as required in the Consent Order ratified on June 14th, 2017. Respondent submitted a detailed response disputing the allegations.

4. Respondent's license, which was still suspended, was the subject of a Summary Suspension Order on October 9th, 2018, based on Complaints 181096, 181119, 181194, 181210 and 181195.

5. Complaint 181096 was filed by an emergency room nurse who treated two patients from a

group home. She alleged that Respondent improperly increased the dose of Gabapentin for these two group home patients from 300 mg to 4000 mg daily, despite the concerns of the pharmacist and the nurses that worked in the facility and that Respondent demanded that they follow this order. She alleged that these patients presented to the hospital with increased lethargy, low blood pressures, difficulty ambulating and malaise.

6. The Board noted a copy of a fax sent on a prescription refill request form from a pharmacist to Respondent questioning the dose increase. Respondent mistakenly thought it was a refill request and initialed it without reading it, and therefore did not change the dosage.

7. Respondent admitted this was a medication error and it was not his intent to increase the dose from 300 mg a day to 4,000 mg a day. Respondent pointed out that the hospital records for both patients noted that they were awake, alert and orientated. Respondent disputed that the patient was harmed and alleged that the residential facility negligently delayed filling the prescription, negligently administered the Gabapentin and negligently failed to communicate with Respondent about the Gabapentin and the patient's changed condition.

8. Complaint 181119 was filed by the Behavioral Healthcare Developmental Disabilities and Hospitals Quality Assurance Unit relating to a group home patient who was alleged to have been unresponsive and was sent out for her safety to the emergency room. The complaint alleged that the patient appeared to be toxic and several tests were done to determine the origin of her condition. She started her new dose of Gabapentin the day before. This was a marked increase from her previous dose of Gabapentin from 100 mg TID to her new dose of 800 mg TID and 1600 mg qhs for a total of 4000 mg from 300 mg, that the group home advocated to prevent it from starting and that Respondent insisted that he wanted this dose.

9. The Board noted a copy of a fax sent on a prescription refill request form from a pharmacist to Respondent questioning the dose increase. Respondent mistakenly thought it was a refill request and initialed it without reading it, and therefore did not change the dosage.

10. Respondent admitted this was a medication error and it was not his intent to increase the dose. Respondent pointed out that the hospital record for the patient noted that she was awake, alert and orientated on arrival to the hospital. Respondent disputed that the patient was harmed and alleged that the residential facility negligently delayed filling the

prescription, negligently administered the Gabapentin and negligently failed to communicate with Respondent about the Gabapentin and the patient's changed condition.

11. Complaint 181463 contains disputed hearsay allegations about Respondent's communications with a pharmacist involving whether Respondent read faxes from the pharmacist, the manner in which Respondent completed changed or discontinued prescriptions and about Respondent's response to a particular inquiry from the pharmacist. It is alleged Respondent just writes yes or no. The complaint alleges that when the pharmacist informed Respondent that when he started or changed a new prescription, Respondent needed to indicate the change or discontinue the medication, Respondent replied, "I don't have time for that" and "essentially hung up".

12. Complaint 181463 also attached a copy of a fax for a patient who was prescribed Lithium Carbonate 300 mg capsules, on which the pharmacist wrote "Pt. has previously been taking the Lithium E.R. 300 mg tab. Do you want to change to the plain capsules or continue with the previous E.R. tabs?" Respondent noted on the reply fax "as written". The pharmacist replied back, "so which do you want, 300 mg Reg 2 @ HS or 300 mg Reg bid, please pick one". Respondent wrote on a reply fax "300 Reg bid I don't care". Respondent informed the Board that he intended to convey to the pharmacist that either alternative was acceptable and that he intended no disrespect toward the pharmacist.

13. The Board received Complaint 181194 which relates to disputed allegations from a former treating physician of Respondent's patient who contended that Respondent prescribed excessive doses of benzodiazepines to a patient who was receiving an opiate medication. The Board contends that the complainant is a subject matter expert in psychiatry alleging dangerous prescribing by Respondent.

14. The Complainant and Respondent both treated the patient.

15. The Complainant alleged that he treated the patient who had Opioid Dependence, for which he received buprenorphine and Sedative, Hypnotic, Anxiolytic Dependence by tapering Klonopin. The Complainant states he had been on both of these medications prior to 7/16/18. Recognizing the contraindication of using both benzodiazepine and opioid medications the Complainant recommended that the patient start tapering the Klonopin from 1 mg/d to 0.75 mg/d and stated that a urine toxicology analysis on that date showed

that the patient had 10 times the normal range for benzodiazepine metabolites. A call was then placed to his pharmacy to cancel all Klonopin refills. (According to hospital records, the patient had been admitted on 6/29/18 for a relapse on heroin. He was on Klonopin 0.5 mg bid.) At his next visit on 8/3/18 he still had not decreased the dose of Klonopin and a call was placed to the prescriber of Klonopin, Dr (Alias), for coordination of care. Dr (alias) agreed to relinquish the role of prescribing Klonopin to the Complainant. Subsequently, the Complainant alleged that on 8/25/18 he received a courtesy fax from a pharmacy alerting him to the fact that the patient was receiving alprazolam and buprenorphine and stating the concurrent use was "not recommended" unless it was for "end-of-life opioid analgesia". On 8/26/18, the Complainant received a RI PMP Alert stating, "Suspected 'Prescriber/Pharmacy Shopper". Upon review of the PMP, the Complainant saw that Respondent prescribed potentially lethal doses of Klonopin on 8/16/18, and on 8/23/18 also prescribed another benzodiazepine, Xanax, without communicating with the Complainant or another provider. The Complainant noted that an alternative to filing this complaint by calling Respondent directly for Coordination of Care was considered and that may have had a positive effect in this case, but the Complainant suspected that this case was a representation of a pattern of prescribing by Respondent that was clearly thoughtless and, worse, dangerous. The Complainant noted his understanding that Respondent also is a Substance Abuse specialist which was deemed all-the-more alarming because his prescribing practices of controlled substances should be the model for the rest of the prescribing community and the Complainant was not sure that this was the case.

16. Respondent disputes the allegations. He pointed out the alleged "potentially lethal" dose of Klonopin was significantly below the maximum dose based on the manufacturer's recommendations, particularly for this opiate tolerant patient. The patient never demonstrated any side effects as a result of the concurrent use of the opiate and benzodiazepine medications. Respondent pointed out that the patient had terminated with the Complainant and chose to treat with Respondent so Respondent had no reason to communicate with the Complainant. The Complainant never attempted to communicate with Respondent.

17. The Board received Complaint 181210 which relates to disputed allegations from a physician who contended that Respondent prescribed excessive doses of benzodiazepines

to a patient who was receiving an opiate medication. The Complainant alleged in her complaint that Respondent rapidly increased doses of benzodiazepines for two patients on medication assisted treatment with either methadone or buprenorphine, prescribed benzodiazepines to patients who were concurrently on multiple other sedating medications and/or with a history of recent alcohol use disorder, and prescribed exceedingly high doses of benzodiazepines (e.g., 8 mg daily of alprazolam) to a patient maintained on 220 mg daily of methadone, with a history of benzo abuse, and two recent hospitalizations for overdose.

18. Respondent disputed these allegations, pointing out that one patient, who had severe panic disorder, already had been taking Xanax and Methadone when he first saw the patient. Respondent tried a course of Klonopin instead of Xanax, which was not effective. Respondent then switched the patient back to Xanax at a dose of 8 mg per day, which was less than the equivalent dose of Klonopin. Respondent pointed out that the manufacturer's instructions for Xanax state that for panic disorder, patients may require as much as 10 mg per day. The patient never demonstrated any side effects as a result of the concurrent use of the opiate and benzodiazepine medications. As to the second patient, Respondent pointed out that no Xanax was prescribed, that he did not rapidly increase the dose of Klonopin for this patient, who had panic disorder and who had been taking Klonopin before he treated with Respondent, that he received 4 mg per day, which is consistent with the manufacturer instructions and that the patient never demonstrated any side effects as a result of the concurrent use of the opiate and benzodiazepine medications.

19. The Board received Complaint 181195 which relates to disputed allegations from a physician who specializes in pain management regarding the prescribing by Respondent to a patient of Valium, oxazepam, Adderall, ketamine and an alleged large dose of oxycodone. The patient was receiving oxycodone from multiple other prescribers at the same time. The Complainant was very concerned about the apparent redundant prescribing of oxycodone in this patient with multiple other psychoactive medications and contended that Respondent improperly prescribed medications, including benzodiazepines, to a patient who was receiving an opiate medication. The Complainant alleged that Respondent did not check the PDMP and was unaware that the patient had oxycodone from another prescriber, Respondent did not document in the medical record why he provided the extra prescription of oxycodone, and Respondent did not attempt to contact the other physician who was

prescribing the oxycodone.

20. Respondent disputes the allegations pointing out that the patient had been on Oxycodone before treating with Respondent, that Respondent prescribed Oxycodone once, many other providers prescribed larger doses of Oxycodone than Respondent, Respondent successfully weaned the patient from Oxycodone to Suboxone, the doses of other medications were appropriate and the Complainant never communicated with Respondent, never treated the patient and never reviewed Respondent's medical records.

21. Complaint 181197 relates to a review by a Board of Pharmacy investigator who reviewed the PDMP and identified patients who the investigator contended improperly received Methadone, Testosterone and Ketamine. Respondent disputed in detail all of the allegations.

22. Respondent was the attending physician for a patient who was prescribed hydrocodone-acetaminophen and lorazepam. Respondent was also the attending physician for a patient who was prescribed methadone for a period greater than 90 days. There was no evidence in the medical record that Respondent had educated these patients about the risks of opioids, as well as requirements for safe storage and disposal of the opioid as required by the regulation section 4.4.D in *216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island.*

23. Respondent did not review the PDMP prior to prescribing the methadone, and did not document in the medical record a pain agreement. The Board contends that Respondent did not meet the requirements of the regulation 4.4 E or F.

24. Respondent is the attending physician for three patients to whom he prescribed methadone for pain management. Methadone is a long acting schedule 2 opioid. The Board contends that Respondent did not document in the medical record meeting the specific requirements of prescribing a long acting opioid as required by regulation 4.4 L.

25. Respondent was the attending physician for two patients who were prescribed testosterone, a schedule III-controlled substance. One of these patients had testosterone given without a testosterone level documented in the medical record, or physical exam of their testicles.

26. Respondent appeared before the Investigative Committee December 6th, 2018 relating to a

number of pending complaints.

27. Respondent stated that he was unaware of regulations promulgated by RIDOH, initially in March of 2015, then updated in 2017 as *216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island.*

28. On December 6, 2018, the Investigating Committee of the Board made a finding of "Unprofessional Conduct" by Respondent and found that Respondent has violated: § RIGL 5-37.5.1 (24) *Violating any provision or provisions of this chapter or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board; § RIGL 5-37.5.1 (19) Incompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subdivision;216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island section D. Patient Education/ Informed Consent;216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island section E. The Prescription Drug Monitoring Program (PDMP) shall be reviewed prior to starting any opioid. 216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island section F. Written Patient Treatment Agreement;216-RICR-20-20-4 Pain Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island section I. Multidisciplinary Approach to Treatment of Chronic Pain; and 216-RICR-20-20-4 Pain*

Management, Opioid Use and the Registration of Distribution of Controlled substances in Rhode Island section L. Long-acting Opioids, Including Methadone.

29. Respondent disputes these findings of fact and alleged violations.

Based on the foregoing, the parties agree as follows:

30. Respondent admits to and hereby agrees to remain under the jurisdiction of the Board.

31. Respondent agrees that in lieu of further contesting the alleged violations he will agree to this Surrender of License. Respondent's acceptance of this Surrender of License shall not be construed as an admission of liability and he expressly disputes and denies any such liability. He understands that it is a proposal and is subject to the final approval of the Director and is not binding until it is fully signed by Respondent and the Director.

32. Respondent hereby acknowledges and waives:

    a. The right to appear personally or by counsel or both before the Board;

    b. The right to produce witnesses and evidence in his behalf at a hearing;

    c. The right to cross examine witnesses;

    d. The right to have subpoenas issued by the Board;

    e. The right to further procedural steps except for specifically contained herein;

    f. Any and all rights of appeal of this surrender of license to practice medicine;

    g. Any objection to the fact that potential bias against the Respondent may occur as a result of any presentation of this surrender of license to practice medicine.

33. This Surrender of License shall become part of the public record of this proceeding once it is approved by the Director, and it shall be reported to the National Practitioner Data Bank, the Federation of State Medical Boards and posted on the Rhode Island Department of Health website.

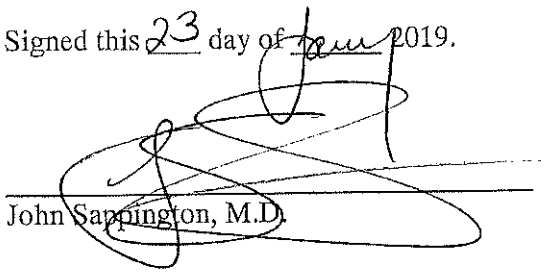
34. Failure to comply with this Surrender of License to practice medicine, when approved by the Director, shall subject Respondent to further disciplinary action.

35. The Board has imposed administrative fees related to investigating the above referenced matters in the total amount of $12,437.92. Respondent has communicated to the Board that he is having current financial difficulties and is not able to pay the required administrative fee at this time. Respondent agrees to make a "good faith" effort to pay the administrative fee and will annually submit to the Board a partial payment of 20% of the total fees, to the extent that he is financially able to do so. The fee payment as described above is payable within 30 days after each anniversary of the ratification of this order. The first payment is due 12 months after ratification of this order. In the event that Respondent is unable to pay the administrative fee next year or in any subsequent year, he will submit an affidavit that states and supports that he is having financial difficulties. The Board agrees to waive assessment and enforcement of any remaining administrative fees against Respondent after 5 years if Respondent submits an affidavit at that point stating he is unable to pay the administrative fees due to persistent financial difficulty.

36. The Board shall consider all pending complaints, other than those referenced above, administratively closed upon signature by the parties to this Surrender of License.

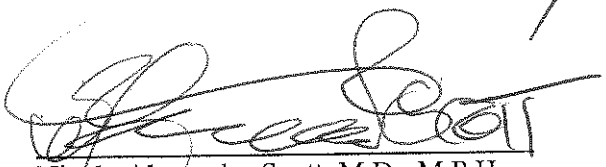
37. Respondent agrees to not seek licensure in Rhode Island in the future.

Signed this 23 day of Jan 2019.



John Sappington, M.D.

Approved this 13th day of February, 2019.



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