

RHODE ISLAND BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN THE MATTER OF:

David A. Kahn, MD

License No.: MD10341

Complaint No.: C24-0202

CONSENT ORDER

The Board of Medical Licensure and Discipline ("Board") makes the following:

FINDINGS OF FACT

1. David A. Kahn, MD ("Respondent") has been licensed to practice medicine in the state of Rhode Island since June 7, 2000.

2. This Complaint arises from psychiatric care provided by Respondent to a patient from October of 2018 through November of 2023. Respondent treated the patient in person on a regular basis, until March 2, 2020, at which time he began to see the patient via telehealth. At the initial visit, Respondent diagnosed the patient with both opioid and benzodiazepine dependence, as well as attention deficit/hyperactivity disorder ("ADHD"). Respondent

prescribed Dextroamphetamine-Amphetamine, Clonazepam, and Buprenorphine-Naloxone, adjusting doses based on the patient's reported effects. At a subsequent visit, the patient reported suffering from chronic atrial fibrillation and had been treated for two partial occlusions and elevated intracardiac pressure. Respondent subsequently provided one prescription of Gabapentin on December 14, 2020 when the patient reported experiencing a back sprain, without any in-person evaluation of the cause of the patient's pain or consultation with his other physicians. The patient reported using alcohol on several visits. On July 20, 2021, the Respondent increased the dose of clonazepam.

3. During a telehealth visit on May 31, 2022, the patient reported that he was living in an eldercare facility in the state of Nevada and had recently been diagnosed with Parkinson's

disease. Despite the patient no longer being physically present in the state of Rhode Island, Respondent continued to provide medical care to the patient, and also continued to prescribe medications, including controlled substances. Ongoing telemedicine visits occurred on August 25, October 20, and December 15 in 2022 and April 6, July 27, and November 15 in 2023. Respondent continued to provide this treatment to the patient by telehealth under the mistaken belief he was permitted to do so, and in the interest of providing the patient with continuity of care while the patient searched for a new provider in Nevada. Patient returned to Rhode Island in the Fall of 2023 and Respondent saw patient for an in-person appointment on September 21, 2023.

4. Respondent was interviewed by the Board's Investigative Committee on July 11, 2024. Respondent appeared for the interview with his legal counsel. Based upon its investigation and examination of the medical records, the Investigative Committee determined that Respondent prescribed controlled substances via telemedicine, in excess of one year, to a person physically present and living in the state of Nevada without having a license to practice medicine in the state of Nevada and without a Controlled Substance Registration ("CSR") issued by the state of Nevada. At the interview, the Respondent explained that he was under the mistaken belief that he was permitted to prescribe to this patient pursuant to revised federal laws for COVID-19 and in compliance with Nevada Revised Statute § 639.235.

5. The Investigative Committee further found that Respondent failed to adhere to the requirements set forth under the Board's regulation, *Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island*, 216-RICR-20-20-4. Respondent's medical records 216-RICR-20-20-4.4(C)(4). failed to document that Respondent conducted a conversation with the patient, prior to initiating and continuing the prescription for

an opioid drug, on the required subjects, including dependency risks. 216-RICR-20-20-4.4(D)(3). Respondent's medical records likewise failed to document any review of the Prescription Drug Monitoring Program (PDMP) prior to Respondent providing a prescription for an opioid drug, which Respondent understood was part of the patient's medication regime for a number of years, as well as documentation of periodic reviews of the PDMP, at least every three months. 216-RICR-20-20-4.4(E). The medical records failed to document that Respondent entered into a written Patient Treatment Agreement as required for all patients receiving opioid medication, which must be entered no later than 90 days from the beginning of treatments with opioid medication and signed by both Respondent and patient. 216-RICR-20-20-4.4(F). The medical records established that Respondent failed to conduct periodic in-person visits with the patient at intervals not to exceed six months. 216-RICR-20-20-4.4(G). The medical records failed to document periodic urine drug screens for controlled substances to ensure compliance with the medications prescribed and lack of use of non-prescribed drugs. The medical records also failed to document discussions with the patient of the danger of concurrent alcohol and benzodiazepine usage. The Investigative Committee also found that the medical records likewise violated the requirements of 216-RICR-40-05-1.5.12(D) and (E) in that they are not signed by the Respondent, refer to the patient by his initials and his various names/nicknames without a date of birth, and do not demonstrate medication reconciliation being performed with all of his prescribed drugs, and do not contain sufficient information to justify the course of treatment.

6. As a result of its review of the medical records and information gathered during its investigation, the Investigative Committee made a probable cause determination of unprofessional conduct, in violation of R.I. Gen. Laws § 5-37-5.1(19) and (26).

Based upon the foregoing, the Parties agree as follows:

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

2. Respondent agrees to this Consent Order and understands that it is subject to final approval by the Board and is not binding on Respondent until final ratification.

3. If ratified by the Board, 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 on 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 those specifically contained herein;
 - f) any and all rights of appeal of this Consent Order; and
 - g) any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the RI DOH public website.

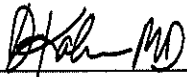
4. Respondent is hereby issued an order of reprimand by the Board and shall pay administrative fees in the amount of \$1,100.00. Said administrative fees must be paid within six (6) months from the ratification of this Consent Order and shall be made payable to the Rhode Island General Treasurer, and delivered to the Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn. Jessica DeSanto. Respondent will send notice of compliance of this condition to DOH.PRCCompliance@health.ri.gov within thirty (30) days of submitting the above-referenced payment.

5. Respondent, at his own expense, shall complete and successfully pass a course on prescribing controlled substances, and a course on medical record documentation. The courses can be offered by the Center for Personalized Education for Professionals (CPEP), Case Western Reserve University School of Medicine, or another educational institution approved by the Board

in advance. Respondent shall likewise submit evidence of attendance and completion of the 8-hour training program required by the Drug Enforcement Administration on the subjects of substance use disorders and addiction. Compliance with the education and training programs set forth herein must be completed within six (6) months from the ratification of this Consent Order.

6. In the event that any term of this Consent Order is violated, after ratification and approval, the Board or its Director shall have the discretion to impose further disciplinary action pursuant to R.I. Gen. Laws §§ 5-37-5.1 through 5-37-6.3. If the Board or its Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within twenty (20) days of further discipline. The Board or its Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. Any administrative hearings, whether initiated by the Board or the Respondent, shall be conducted in accordance with R.I. Gen. Laws §§ 5-37-5.1 through 5-37-6.3 or R.I. Gen. Laws §§ 5-37-8 and 42-35-14(c), the Rules and Regulations for the Licensure and Discipline of Physicians (216-RICR-40-05-1), the Rules and Regulations for Practices and Procedures Before the Rhode Island Department of Health (216-RICR-10-05-4), and applicable provisions of R.I. Gen. Laws Chapter 42-35-1 *et seq.*

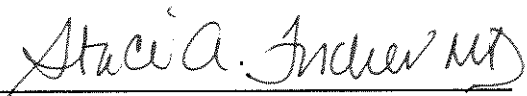
As Assented to and Signed this 19th day of August 2026.



David A. Kahn, MD

Ratified by the Medical Licensure and Discipline Board on the 9th day of _____

September, 2026.

A handwritten signature in dark ink, reading "Staci A. Fischer MD". The signature is fluid and cursive, with the "MD" at the end being more distinct. It is positioned above a horizontal line.

Staci A. Fischer, MD
Chief Administrative Officer
Rhode Island Board of Medical Licensure and Discipline