

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH**

IN THE MATTER OF:)	
)	
ROBERT D. HUNT, M.D.)	BEFORE THE TENNESSEE
)	BOARD OF MEDICAL
RESPONDENT)	EXAMINERS
)	
NASHVILLE, TENNESSEE)	CASE NO. 2020008491
TENNESSEE LICENSE NO. 16999)	

CONSENT ORDER

The Division of Health Related Boards of the Tennessee Department of Health (“State”), by and through the Office of General Counsel, and Respondent, Robert D Hunt, M.D., (“Respondent”), by and through his attorney M. Todd Sandahl, respectfully move the Tennessee Board of Medical Examiners (“Board”) for approval of this Consent Order affecting Respondent’s medical license in the State of Tennessee.

The Board is responsible for the regulation and supervision of medical professionals licensed to practice in the State of Tennessee. *See Tennessee Medical Practice Act, Tennessee Code Annotated sections (“TENN. CODE ANN. §§”) 63-6-101, et seq.* It is the policy of the Board to require strict compliance with the laws of this State, and to apply the laws so as to preserve the quality of medical care provided in Tennessee. It is the duty and responsibility of the Board to enforce the Tennessee Medical Practice Act in such a manner as to promote and protect the public health, safety and welfare in every practicable way, including disciplining individuals who violate the provisions of TENN. CODE ANN. § 63-6-101, *et seq.* or the Rules and Regulations promulgated by the Board and recorded in the Official Compilation Rules and Regulations of the State of Tennessee (“TENN. COMP. R. & REGS.”)

Respondent, by signing this Consent Order, waives the right to a contested case hearing and any and all rights to judicial review in this matter. Respondent agrees that presentation to and consideration of this Consent Order by the Board for ratification and all matters divulged during

that process shall not constitute unfair disclosure such that the Board or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should this Order not be ratified. Likewise, all matters, admissions and statements disclosed or exchanged during the attempted ratification process shall not be used against Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

STIPULATIONS OF FACT

1. Respondent has been at all times pertinent hereto licensed by the Board as a medical doctor, having been granted license number 16999 on about April 21, 1986, which currently has an expiration date of November 30, 2020.
2. Respondent is certified by the American Board of Psychiatry and Neurology in psychiatry and child psychiatry.
3. Respondent operates a medical practice out of his home under various names, including “Center for Attention & Mood Disorders,” “Centers for Psychiatric Attention,” “Center for Attention, Mood & Wellness,” “Center for Attention, Learning, Mood & Addictions,” “Center for Attention and Hyperactivity Disorders,” and “Center for Attention.” Respondent’s practice includes caring for minors and adults with psychiatric problems such as attention disorders, and also addiction treatment.
4. In about February 2020, Respondent saw an approximately six-year-old patient (“Patient 1”) and her parents for the first time for an evaluation. During the encounter, Respondent exhibited impaired decision-making and possible cognitive impairment, including asking the same questions repeatedly, writing prescriptions for Adderall after agreeing with Patient 1’s parents that Patient 1 did not need such a prescription, making numerous errors in Patient 1’s medical record such as discussing Patient 1’s relationship with Patient 1’s children and success at work. At the end of Patient 1’s appointment, Respondent gave

Patient 1's parents several papers, including not just Adderall prescriptions for Patient 1, but also patient records containing a mix of information regarding Patient 1 and other patients, including HIPAA-protected information such as patient names, prescribed medications, and other information about those patients.

5. GS is a registered nurse and advanced nurse practitioner licensed to practice in Tennessee. GS was a patient of Respondent from about 2010 through about 2020. Respondent was also a patient of GS from about August 2018 through about March 2020. Respondent has exhibited evidence of cognitive impairment when interacting with GS, including reporting having difficulty in charting and printing prescriptions for patients and asking GS about medications to help with Respondent's memory. At the conclusion of GS's April 2020 appointment with Respondent, Respondent gave GS incorrect prescriptions. When GS mentioned this to Respondent, Respondent stated he would mail GS the correct prescriptions.
6. On about May 15, 2020, GS received a package from Respondent in the mail that included unsigned prescriptions Respondent wrote for GS, copies of other patients' medical records, Respondent's personal income tax and banking information, and other personal documents belonging to Respondent.
7. On about April 3, 2020, a Department of Health investigator contacted Respondent by phone. During the phone call, Respondent exhibited possible cognitive impairment, including having trouble following the conversation and becoming confused about whether Respondent had received a certified letter from the investigator.
8. In April 2020, after repeated requests from the Department of Health investigator, Respondent produced medical records for 7 patients in addition to Patient 1 to whom he had recently prescribed controlled substances. Each of these additional patient records was incomplete and had inconsistencies, such as:

- a. Despite Respondent prescribing the 7 patients controlled substances on a monthly basis throughout 2019 and up through at least April 2020, each patient had at most 2-3 visit notes per year. Many of these patients had no visits with Respondent documented in the six months before April 2020 - for one patient who had received monthly controlled substance prescriptions through April 2020, the most recent visit note was dated January 2019; another patient's most recent visit note was April 2019.
- b. Only two of the 7 records requested had visit notes from 2020. One of those 2020 visit notes is copied word-for-word from the patient's previous note dated April 2019. The only other 2020 visit note, for a different patient, included rambling and nonsensical sentences such as, "[Patient name] has been a historian of Russian history are student of Russian history particular ladies read a good deal of salts and that's who wrote some of the major biographies of Russia in the history of Russian one of his more accessible books is out of home adventures."
- c. Many of the medical records had sheets labeled "current meds" that were grossly out of date, reflecting that they were most recently updated more than a decade ago.
- d. Many visit notes incorrectly listed the dosages and medications Respondent prescribed to the patient on that visit and what medications the patient had been taking previously. For example, in one patient record Respondent repeatedly documented that the patient was taking "Adderall XR 750 mg + Wellbutrin 150 mg/d in AM," but elsewhere Respondent documents that the patient's Wellbutrin had been discontinued several years prior, and 750 mg is more than ten times the maximum recommended daily dosage of Adderall.

- e. Many visit notes among the 7 patient records are identical or nearly identical from visit to visit over a period of years.
9. From January 1, 2019 through at least May 22, 2020, Respondent never looked up a single patient in the CSMD and never successfully logged into the CSMD, despite writing patients prescriptions for opioids and/or benzodiazepines during that time period.
10. In the summer of 2020 Respondent was diagnosed with cognitive impairment and is not mentally safe to practice medicine at this time.
11. Respondent states that he was unaware of cognitive impairment prior his diagnosis in the summer of 2020.
12. Respondent states that he was unaware of a heart condition that required surgery in September of 2020, which further affected Respondent's cognitive impairment.
13. Respondent states that he exercised his best judgment in treating patients while unaware of his cognitive impairment.
14. Respondent states that he is unaware of any harm caused to his patients regarding his medical care and treatment.
15. Respondent states that he complied with the standard of care in treating patients while unaware of his cognitive impairment.

GROUND FOR DISCIPLINE

The preceding Stipulations of Fact are sufficient to establish that Respondent has violated the following statutes or rules which are part of the Act, TENN. CODE ANN. § 63-6-101, *et seq.* for which disciplinary action before and by the Board is authorized:

16. The facts in paragraphs one (1) through ten (10) constitute a violation of T.C.A § 63-6-214(b)(18) engaging in the practice of medicine when mentally or physically unable to safely do so.

POLICY STATEMENT

The Tennessee Board of Medical Examiners takes the following action in order to protect the health, safety and welfare of the people of the State of Tennessee and ensure that the public confidence in the integrity of the medical profession is preserved.

ORDER

NOW THEREFORE, Respondent, for the purpose of avoiding further administrative action with respect to this cause, agrees to the following:

17. The Tennessee medical license of Robert Hunt, M.D., license number 16999, is hereby **VOLUNTARILY SURRENDERED** as of the effective date of this order. Respondent acknowledges will have the same effect as a Revocation.
18. In order to be eligible to apply for a medical license in the future, Respondent must:
 - a. Undergo a comprehensive fitness to practice and neuropsychological evaluation through a program such as the Vanderbilt Comprehensive Assessment Program (“VCAP”) or an equivalent program pre-approved in writing by the Board’s medical director, cause the results of that evaluation and any updates or progress reports to be sent to the Board’s Disciplinary Coordinator, and comply with all recommendations from that evaluation.

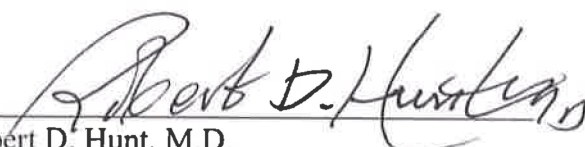
- b. Obtain the advocacy of the Tennessee Medical Foundation (“TMF”) and demonstrate 100% compliance with any follow-up treatment and/or monitoring recommendations. Respondent must cause TMF to submit quarterly reports of any recommended ongoing monitoring or treatment to the Board’s Disciplinary Coordinator. Respondent must also cause TMF to submit a recommendation to the Board’s disciplinary coordinator regarding whether Respondent is safe to resume the practice of medicine.
 - c. Submit documentation demonstrating Respondent’s compliance with the recommendations from the evaluation(s) Respondent underwent such as discharge summaries or progress reports from treating physicians.
 - d. Appear in person before the Board for an interview.
19. Respondent acknowledges that in order to apply for a new medical license Respondent may also be required to comply with the Board’s rules and policies regarding reinstatement and re-entry to practice, including and not limited to Rules 0880-02-.09 and 10.
20. Respondent further acknowledges when considering any future application for a medical license that he might submit, the Board will have authority to deny that application or offer Respondent a conditional license based on the facts of this order and any other relevant information.
21. Because the violations of the practice act in this case appear to be attributable to a mental condition that Respondent did not have control over, and Respondent is agreeing to surrender his license, no costs will be assessed.
22. Respondent understands that this is a formal disciplinary action and will be reported to the National Practitioners Data Bank (N.P.D.B.) and/or similar agency.

This **CONSENT ORDER** was approved by a majority of a quorum of the Tennessee Board of Medical Examiners at a public meeting of the Board and signed this 29th day of September, 2020. 30th

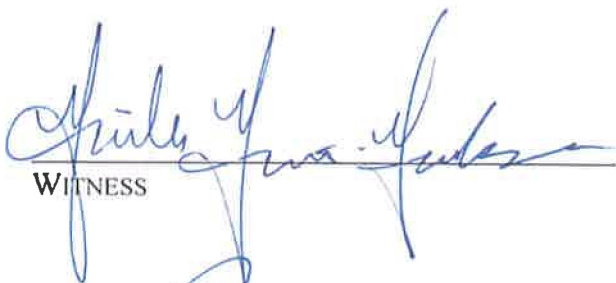


Chairperson
Tennessee Board of Medical Examiners

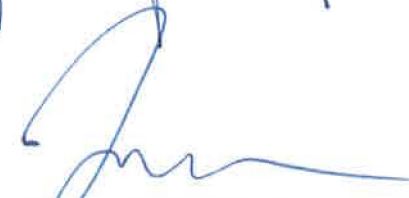
APPROVED FOR ENTRY:


Robert D. Hunt, M.D.
RESPONDENT

9.28.20
DATE


WITNESS

9/28/2020
DATE


M. Todd Sandahl, Attorney at Law
234 First Avenue South
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(615) 794-3450
Attorney for Respondent

9/28/2020
DATE



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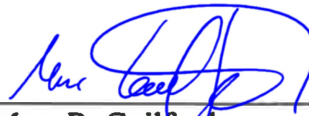
09/29/2020

DATE

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been served upon Respondent, Robert Hunt, M.D., through his attorney Todd Sandahl, 234 First Avenue South, Franklin, TN 37064 by delivering same in the United States Mail, Certified Number 7019 2970 0000 8587 6560, return receipt requested, and United States First Class Mail, with sufficient postage thereon to reach its destination.

This 7th day of October, 2020.



Marc R. Guilford
Senior Associate General Counsel