BOARD OF MEDICAL PRACTICE

In re: Judith H. Tietz, M.D.	)	Docket No. MPN 022-0217

STIPULATION AND CONSENT ORDER

NOW COME Judith H. Tietz, M.D., and the State of Vermont, by and through Vermont Attorney General Thomas J. Donovan, Jr., and hereby stipulate and agree to the following in the above-captioned matter:

1. Judith H. Tietz, M.D. ("Respondent") holds Vermont medical license number 042.0009132 originally issued by the Vermont Board of Medical Practice on June 30, 1995. Respondent is a physician.
2. Jurisdiction in this matter rests with the Vermont Board of Medical Practice ("the Board"), pursuant to 26 V.S.A. §§ 1353-1357, 3 V.S.A. §§ 809-814, and other authority.

FINDINGS OF FACT

3. The Board opened this matter in February of 2017 upon receipt of a complaint concerning Respondent's prescribing practices. The matter was assigned to the North Investigative Committee of the Board ("the Committee").
4. Respondent is a psychiatrist who treats patients at her private practice in Townsend, Vermont.
5. The Committee's investigation revealed that Respondent was prescribing opioids for chronic pain to some of her psychiatric patients. The investigation led to the identification of five patients to whom Respondent was prescribing

Office of the ATTORNEY GENERAL
109 State Street
Montpelier, VT
05609

opioids for chronic pain that were of particular concern. The Committee analyzed in detail the records of Respondent's treatment and management of the five patients.

6. The Committee determined that Respondent's treatment of the five patients was not in conformance with the essential standards of acceptable and prevailing practice and constituted the performance of unsafe patient care.

7. The specific instances of treatment that constituted unacceptable and unsafe patient care and failure to conform to the essential standards of acceptable and prevailing practice for the five identified patients are as follows:

   a. Patient #1:

      i. Respondent began prescribing opioids (fentanyl and oxycodone) to Patient #1 in May of 2012 without documentation of an evaluation or rationale for the prescribing. Despite Respondent's ongoing treatment of the patient into 2017, she failed to document adequate evaluations of the patient's medical condition(s) that justified the continued prescribing of opioids for chronic pain. She also did not consistently perform annual functional assessments or conduct documented risk benefit assessments for the continued prescribing of opioids.

      ii. Respondent continued to prescribe opioids to the patient despite evidence of aberrant behavior including incarceration for "possession and sale" and drug diversion, and being on parole for

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

issues involving marijuana and cocaine. She also failed to document a sufficient evaluation of such aberrant behavior.

iii. Respondent did not conduct the required annual reviews of the Controlled Substance Treatment Agreement that was implemented in 2015. Respondent failed to obtain a signed written Informed Consent to treatment from the patient.

iv. Respondent failed to conduct the required annual querying of the Vermont Prescription Monitoring System ("VPMS") during her ongoing treatment of the patient in 2015 and 2016.

b. Patient #2:

i. Respondent began prescribing fentanyl and oxycodone to Patient #2 in 2012. Respondent's medical records include notes from a specialist treating the patient indicating that the patient did not need to be prescribed more opioids as enough time had passed since the patient's operation which necessitated the opioid prescribing. Yet, Respondent continued to prescribe opioids to the patient documenting a justification of chronic pain.

ii. Respondent continued prescribing opioids to the patient despite evidence of the patient engaging in aberrant behaviors and red flags for potential diversion. Respondent failed to properly address and evaluate the aberrant behaviors and red flags with increased monitoring, such as urine drug screens and checking VPMS.

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

iii. The patient's medical record did not contain a signed written Informed Consent for Respondent's treatment.

iv. Respondent's clinical monitoring for diversion was substandard. She did not perform any urine drug screening, queried VPMS annually only two out of the four years that annual querying was required, did not consistently perform an annual review of the Controlled Substance Treatment Agreement, did not consistently perform annual functional assessments, and failed to conduct any documented risk benefit assessments for the continued prescribing of opioids.

c. Patient #3.

i. Respondent prescribed opioids for the treatment of Patient #3's chronic pain from 2012 through 2017, documenting that the patient's chronic pain was caused by multiple sclerosis. However, in December of 2014, the neurologist who was treating the patient's multiple sclerosis opined that the patient's chronic pain was not caused by multiple sclerosis but rather by back pain that needed to be further evaluated. Respondent did not perform other evaluation(s) to determine the underlying cause of the patient's back pain or whether treatment of opioids was indicated, and documented continued prescribing of opioids to treat the patient's chronic pain caused by multiple sclerosis.

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

ii. Respondent's records do not contain a Controlled Substance Treatment Agreement or signed written Informed Consent to treatment.

iii. Respondent failed to perform urine drug screens and did not perform the required VPMS queries until 2017. She also did not conduct any documented risk benefit assessments for the continued prescribing of opioids.

d. Patient #4:

i. Respondent began treating Patient #4 with opioids for chronic pain in 2013. Despite the patient's history of opioid abuse and attending Narcotics Anonymous, Respondent prescribed short-acting rather than long-acting opioids to control the patient's pain and did not document that she considered other non-opiate forms of pain control.

ii. Respondent failed to document the performance of evaluations of the patient's medical condition(s) that were causing the chronic pain and justifying ongoing treatment with opioids.

iii. There is no written Controlled Substance Treatment Agreement or signed written Informed Consent to treatment in Respondent's medical record for the patient.

iv. Respondent's clinical monitoring for diversion was grossly inadequate as she failed to do the following: perform any urine drug screenings, query VPMS until 2017, perform annual

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

functional assessments, or conduct documented risk benefit assessments for the continued prescribing of opioids.

e. Patient #5:

i. Respondent began prescribing opioids to treat Patient #5's chronic pain in 2011.

ii. Respondent's medical records for the patient note potential red flags for diversion and aberrant behaviors, such as: a 2013 visit to an emergency department documenting heroin abuse, request for replacement prescription for oxycodone, unclear notes referencing the patient's "addiction," and a note that the patient's girlfriend was in rehab for addiction treatment. Yet, Respondent continued to prescribe opioids to treat the patient's chronic pain, and provided a replacement prescription for oxycodone the same day without an evaluation to determine the true reason for the need for a replacement.

iii. In 2012 Respondent started a taper of the patient's opioids without a clearly documented justification or plan, and then abruptly stopped the taper and increased the patient's opioid dose without documented rationale or justification.

iv. Throughout the seven years that she treated the patient, Respondent did not obtain a signed Controlled Substance Treatment Agreement or a signed written Informed Consent to treatment.

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

v. Respondent's clinical monitoring for potential diversion was grossly inadequate. She failed to address and evaluate aberrant behavior when warranted, did not query VPMS until 2017 and did not perform annual urine drug screens.

vi. Respondent failed to document the performance of evaluations of the patient's condition that was causing chronic pain, performed only one annual functional examination, and did not conduct any documented risk benefit assessments of the patient for the continued prescribing of opioids.

8. The Vermont Prescription Monitoring System Rule ("VPMS Rule") 6.2.4[1] provides that a Vermont licensed prescriber and/or their delegates must query the VPMS system "At least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance." 18 V.S.A. § 4289(d)(1).

9. Respondent did not query VPMS yearly starting in 2015 for any of the five patients discussed in Paragraph 7. Despite starting to prescribe opioids (which were Schedule II, III, or IV controlled substances) for chronic pain for all five patients in 2011 or 2012, Respondent did not query VPMS for Patients #1, 2 and 3 until 2017.

10. VPMS Rule 6.2.3 provides that a Vermont licensed prescriber and/or their delegates must query the VPMS system "Prior to writing a replacement

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

[1] The VPMS Rule referenced in this Stipulation and Consent Order refer to the VPMS Rule with an effective date of August 1, 2015.

prescription for a Schedule II, III, or IV controlled substance." 18 V.S.A. § 4289(d)(4).

11. Respondent provided a replacement prescription to Patient #5 for oxycodone, a Schedule II controlled substance, without querying VPMS.

12. Rule 4.1 of the Vermont Rule Governing the Prescribing of Opioids for Chronic Pain[2] provides "The prescriber shall conduct and document a thorough medical evaluation and physical examination as part of the patient's medical record when prescribing opioids for chronic pain."

13. Respondent did not conduct and/or document an evaluation as required in Rule 4.1 for four of the five patients referenced in Paragraph 7.

14. Rule 4.3 of the Vermont Rule Governing the Prescribing of Opioids for Chronic Pain provides "The prescriber shall evaluate and document benefits and relative risks, including the risk for misuse, abuse, diversion, addiction, or overdose, for the individual patient of the use of opioids prior to writing an opioid prescription for chronic pain. The evaluation should include but not be limited to a Risk Assessment as defined in Section 3.11 of this rule."

15. Respondent did not perform and document an evaluation of the benefits and relative risks for using opioids for four of the five patients referenced in Paragraph 7.

16. Rule 5.3.1 of the Vermont Rule Governing the Prescribing of Opioids for Chronic Pain provides "[f]or patients prescribed opioids for 90 days or more for chronic pain, the prescriber shall: Receive, and include in the patient's

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

[2] The Vermont Rule Governing the Prescribing of Opioids for Chronic Pain referenced in this Stipulation and Consent Order are the Rules with the effective date of August 1, 2015.

medical record, a signed Informed Consent from the patient…that shall include information regarding the drug's potential for misuse, abuse, diversion, and addiction; the risks associated with the drug for life-threatening respiratory depression; potentially fatal overdose as a result of accidental exposure…and potential fatal overdose when combining with alcohol and/or other psychoactive medication including but not limited to benzodiazepines and barbiturates."

17. Respondent did not receive signed Informed Consents from any of the five patients referenced in paragraph 7.

18. Rule 5.3.2 of the Vermont Rule Governing the Prescribing of Opioids for Chronic Pain provides "[f]or patients prescribed opioids for 90 days or more for chronic pain, the prescriber shall: Receive, and include in the patient's medical record, a signed Controlled Substance Treatment Agreement from the patient…This agreement must include functional goals for treatment, dispensing pharmacy choice, and safe storage and disposal of medication. It shall include other requirements as determined by the prescriber, such as directly observed urine drug testing and pill counts to reasonably and timely inform the prescriber if the patient is missing the prescribed substance."

19. Respondent did not receive signed Controlled Substance Treatment Agreements from two of the five patients referenced in paragraph 7. She did not receive such an agreement from Patient #5 until 2017.

Office of the ATTORNEY GENERAL 109 State Street Montpelier, VT 05609

CONCLUSIONS OF LAW

20. The Board may find, "that failure to practice competently by reason of any cause on...multiple occasions constitutes unprofessional conduct." 26 V.S.A. § 1354(b). And "[f]ailure to practice competently includes, as determined by the board... (1) performance of unsafe or unacceptable patient care; or (2) failure to conform to the essential standard of acceptable and prevailing practice." 26 V.S.A. § 1354(b)(1) and (2).

21. Respondent's unacceptable treatment of all five patients as described in paragraph seven above was not in conformance with the applicable standard of care for opioids prescribing.

22. The Board may find that "failure to comply with provisions of ...state statutes or rules governing the practice of medicine" constitutes unprofessional conduct. 26 V.S.A. § 1354(a)(27).

23. Respondent's failure to comply with Rule 6.2.3 and 6.2.4 of the Vermont Prescription Monitoring System Rule constitutes unprofessional conduct.

24. Respondent's failure to comply with Rule 4.1, 4.3, 5.3.1 and 5.3.2 of the Vermont Rule Governing the Prescribing of Opioids for Chronic Pain constitutes unprofessional conduct.

25. Respondent agrees that the Board may enter as its facts and/or conclusions paragraphs one through twenty-four above, and further agrees that this is an adequate basis for the Board's actions set forth herein. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

Office of the ATTORNEY GENERAL 109 State Street Montpelier, VT 05609

26. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, she has determined that she shall enter into this instant agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; she has concluded that this agreement is acceptable and in the best interest of the parties.

27. Respondent acknowledges that she is knowingly and voluntarily entering into this agreement with the Board. She acknowledges and agrees that at all times and in all communications and proceedings related to this matter before the Board she has had the right to be represented by counsel. Respondent has carefully reviewed and considered this Stipulation and Consent Order.

28. Respondent agrees and understands that by executing this document she is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of her own to contest any allegations by the State.

29. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be administratively closed by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

30. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, she shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this agreement, none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall be kept in strict confidence, and it shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

31. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in her permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities either directly or through medical licensing information sharing centers, including but not limited to: The Federation of State Medical Boards Board Action Databank and the National Practitioner Data Bank. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

32. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

ORDER

WHEREFORE, based on the foregoing, and the consent of Respondent, it is hereby ORDERED that:

1. Respondent shall be reprimanded for the conduct set forth above.
2. Respondent shall pay an administrative penalty of $5,000.00 consistent with 26 V.S.A. § 1361(b). Payment shall be made to the "State of Vermont Board of Medical Practice," and shall be sent to the Vermont Board of Medical Practice office, at the following address: David Herlihy, Executive Director, Vermont Board of Medical Practice, P.O. Box 70, Burlington VT 05402-0070. The payment shall be due no later than three months after this Stipulation and Consent Order is approved by the Board.
3. No later than one year from the date that this Stipulation and Consent Order is approved by the Board, Respondent shall have successfully completed an AMA PRA Category 1 continuing medical education ("CME") course on the topic of medical record keeping. Respondent shall seek prior approval, in writing, from the Committee for the CME course. Upon successful completion of the CME course, she shall provide the Committee with proof of attendance. Respondent shall also provide the Committee with a brief written narrative of the CME course which will document what she learned from the course, and how she will apply that knowledge to her practice. Respondent shall provide proof of attendance and the written narrative to the Committee within 30 days of

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

completion of the course. Respondent shall be solely responsible for all costs associated with the CME course.

4. Within 45 days of the date that this this Stipulation and Consent Order is approved by the Board, Respondent shall cease and be prohibited from prescribing opioids to her patients for any reason under any circumstances. Respondent may petition the Committee for relief of this condition no sooner than five years from the date that this Stipulation and Consent Order is approved by the Board. Respondent may not petition the Committee for relief of this condition until she completed no less than 10 credits of AMA PRA Category 1 live, in-person training on the prescribing of opioids, at least five of which must have been completed within 120 days of the submission of her petition. Prior to submitting her petition for relief, Respondent must provide the Committee with proof of attendance and a brief written narrative of the CME course(s) which will document what she learned from the course(s), and how she will apply that knowledge to her practice. If Respondent's petition is granted, the Committee retains the right to require that Respondent enter into a Practice Monitoring Agreement which would provide for Respondent's opioid prescribing to be monitored by a Committee-approved practice monitor for a length of time that the Committee deems appropriate.

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609

SIGNATURES

DATED at Montpelier, Vermont, this 23rd day of July, 2018.

STATE OF VERMONT

THOMAS J. DONOVAN, JR.
ATTORNEY GENERAL

By: Kassandra P. Diederich

Kassandra P. Diederich
Assistant Attorney General
Office of the Attorney General
109 State Street
Montpelier, VT 05609-1001

DATED at Townshend, Vermont, this 27th day of July, 2018.

Judith H. Tietz, M.D.
Respondent

Office of the ATTORNEY GENERAL 109 State Street Montpelier, VT 05609

AS TO JUDITH H. TIETZ, M.D.
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

W. Heaz

MD

Brent Burger MD

MD

Office of the ATTORNEY GENERAL
109 State Street
Montpelier, VT 05609

DATED: September 5th, 2018

ENTERED AND EFFECTIVE: September 6th, 2018