SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS FOR SOUTH CAROLINA

IN THE MATTER OF: **RONALD PAUL HARGRAVE, M.D.** License No. MMD.12316 OIE # 2015-173 Respondent.	**FINAL ORDER** **(PUBLIC)**

This matter came before the State Board of Medical Examiners for South Carolina ("Board") for a hearing on August 7, 2017, to consider the Memorandum of Agreement and Stipulations ("MOA") signed by the above named respondent ("Respondent") on March 20, 2017.

In the MOA, Respondent acknowledged the State was prepared to file a Formal Complaint, and Respondent waived the authorization and filing of a Formal Complaint as well as formal hearing procedures and elected to dispose of the matter pursuant to S.C. Code Ann. § 1-23-320(f) (1976, as amended) in lieu of, *inter alia*, a Panel Report of the Medical Disciplinary Commission. Additionally, in the MOA Respondent waived the right to thirty days' notice of the hearing.

A quorum of the Board was present. The hearing was held pursuant to S.C. Code Ann. §§ 40-1-90, 40-47-116 and the provisions of the Administrative Procedures Act, S.C. Code Ann. § 1-23-10 *et seq*. (1976 as amended) to determine what sanctions, if any, were appropriate. After due consideration, the Board decided to impose the sanctions stated in this Order.

Rowland P. Alston, III, Esquire, Assistant Disciplinary Counsel, represented the State. Respondent appeared *pro se* and waived his right to counsel.

The Board considered the facts stipulated in MOA, the admissions of violations in the MOA, the testimony of Respondent, and an Affidavit of an Investigator with the Office of Investigations and Enforcement, South Carolina Department of Labor Licensing and Regulation, of a good faith estimate of investigative costs incurred in the investigation of this matter.

EXHIBITS

State's Exhibit #1: MOA
State's Exhibit #2: Affidavit of Costs

FINDINGS OF FACT

1. Respondent stipulated in the MOA to the facts stated below, which the Board adopts:

   a. Respondent graduated from the University of North Carolina School of Medicine in 1984 and is Board Certified in Emergency Medicine. Respondent was issued a South Carolina medical license on July 10, 1985. Respondent was employed

at Palmetto Flight Physicals, located at 2701 Tybee Pass, Mount Pleasant, South Carolina, 29466.

b. Respondent diagnosed patient ("patient") generally with Anxiety and Back Pain. Respondent prescribed patient controlled substances including Alprazolam, Clonazepam, Oxycodone, and Ambien.

c. Respondent admits patient attempted to refill an Alprazolam prescription written by him prior to the prescription end date. A pharmacist did not authorize an early prescription refill for patient at a pharmacy store. Respondent went to the pharmacy store to explain patient's Alprazolam request for early prescription refill. The pharmacist authorized patient's early refill and referred Respondent to the South Carolina Department of Health and Environmental Control.

d. Respondent avers that he prescribed patient Alprazolam. In April 2015, patient had a prescription for Alprazolam (three (3) times daily), but he verbally increased the dosage to four (4) times daily (as needed) due to patient's distress.

e. An expert reviewed patient's medical records and found to a reasonable degree of medical certain the Respondent's treatment as documented in the records did not meet the standard of care. Specifically, the expert found:

i. Alprazolam, Clonazepam, Oxycodone, and Ambien are controlled substances possessing substantive addictive potential. Respondent's prescribing patterns of high doses of opioids, including an estimate of one hundred and twenty milligram (120 mg) of Morphine combined with Alprazolam, Clonazepam, and Ambien situated patient at a very high risk of respiratory depression and suicide. Respondent's opioids prescription to patient of more than one hundred morphine milligram equivalents (100 MME) is extremely dangerous especially with concurrent Benzodiazepine use.

ii. Respondent failed to document suicidal or homicidal ideations on patient's medical record. Respondent noted a referral for possible steroid injections due to patient's back pain. Due to illegible documentation on patient's medical record, it was difficult to determine when patient was seen by a pain management physician. Respondent noted patient made an effort to see a physician on March 14, 2015, but it is not certain if patient was seen by the physician.

iii. On patient's medical record, there was incomplete assessment/treatment plan. On February 21, 2015, Respondent only documented "back pain and trouble sleeping" on patient's medical history. Furthermore, Respondent document "an MRI of LS spine stating MRI proven radiculopathy LS-S1" on the assessment form. The expert was unable to read patient's remaining study due to Respondent's illegible documentation. On patient's physical exam, Respondent failed to document any neurologic exam to assess patient's radiculopathy.

iv. Besides Respondent's prescriptions and a note of possible patient's referral for steroid injection, there were no adequate treatment plans and goals documented in patient's medical record. A patient's treatment plan and goals for pain treatment should include:

1. Reasonable attainable improvement in pain and activity;

2. Improvement in pain associated problems such as sleep disturbance, depression, and anxiety;

3. Avoidance of unnecessary or excessive use of medications;

4. Goals for improved physical, functional and psychosocial activity set to help guide treatment; and

5. Discussion of pharmacologic and non-pharmacologic treatment for pain control.

v. The history on almost each of Respondent's notes was insufficient and not very helpful in determining patient's treatment plans and goals. The only history documented for patient in most clinical appointments was "Back Pain/Trouble Sleeping and Anxiety/Back Pain." Respondent failed to document the specific location, the length of time, radiation of pain, intensity of pain, duration of pain, current and past treatment, underlying or coexisting disease conditions, the effects of pain in physical and psychological function, and history of substance abuse.

vi. The physical exam was not generally complete with respect to the symptoms described in patient's history. For instance, Respondent did not document any neurologic exam or straight leg exam to assess patient's radiculopathy. On each appointment with Respondent, patient's pulse rate was within 100 to 134, but Respondent failed to address these pulse rates in any of his notes.

vii. On May 11, 2015, Respondent was aware that patient was concerned about her opioid taper and her anxiety problems were exacerbated. Respondent documented a taper schedule of patient's opioid prescription over a thirty (30) day period. Respondent should have referred patient to a Psychologist/Psychiatrist or Addiction Specialist, but he continued to prescribe more Clonazepam and Alprazolam medications.

viii. According to the Generalized Principles on Standard of Care, "the registration and utilization of the South Carolina Prescription Monitoring Program/South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS), which provides both current and historical survey of Narcotic, Sedative and Controlled Substances Use, is considered mandatory for prescribers to provide safe, adequate pain treatment. Drug screening is strongly recommended." Respondent failed to document these guidelines on patient's

medical records.

ix. Respondent should have addressed the possibility of drug diversion by patient. During patient's appointment on April 17, 2015, Respondent documented patient's friend may have taken all of her Oxycodone #90 (20 mg). Respondent apparently did not document any police report, further investigation or conducting SCRIPTS search on patient's medical record.

x. On April 24, 2015, patient stated she increased her Oxycodone dosage to four (4) times daily, but only received a partial refill of the prescription. During this period, Respondent provided patient another prescription for Oxycodone #120 (20 mg). Within a two (2) week period, Respondent prescribed patient a total of three hundred (300) tablets of Oxycodone (20 mg). Respondent failed to conduct a SCRIPTS search on patient which is mandatory for all controlled substance prescriptions.

xi. Respondent should have considered the utilization of a multimodal approach for patient. For example, physical therapy, non-opioid medications, surgical options, cognitive and behavioral methods, rehabilitation approaches, and complementary treatment (Acupuncture and Chiropractors).

2. At the hearing, Respondent testified that he believed the patient had developed a large tolerance to the medications.

CONCLUSIONS OF LAW

1. Respondent admitted in the MOA that his conduct in this matter constitutes sufficient grounds for disciplinary or corrective action under South Carolina Code of Laws Ann. § 40-1-110 *et seq*. and South Carolina Code of Laws Ann. § 40-47-110 *et seq*. in the following particulars:

a. Respondent violated S.C. Code Ann. § 40-47-110(B)(9) in that Respondent engaged in dishonorable, unethical, or unprofessional conduct that is likely either to deceive, defraud, or harm the public; and

b. Respondent violated S.C. Code Ann. § 40-47-110(B)(17) in that Respondent has failed to prepare or maintain an adequate patient record of care provided.

2. The Board has jurisdiction in this matter and, upon finding that a licensee has violated any of the provisions of S.C. Code Ann. § 40-47-110 and 40-1-110 (2011), has the authority to cancel, fine, suspend, revoke, issue a public reprimand or private reprimand, or restrict, including probation or other reasonable action, such as requiring additional education or training or limitation on practice, the authorization to practice of a person who has engaged in misconduct. Additionally, the Board may require the licensee to pay a fine of up to twenty-five thousand dollars. S.C. Code Ann. § 40-47-120 (2011).

3. Additionally, the Board may require the licensee to pay the costs of the disciplinary action. S.C. Code Ann. §§ 40-1-170 and 40-47-170 (2011).

4. The Board concludes that Respondent's prescribing and record-keeping habits were inappropriate, as also concluded by the expert reviewer. The Board further concludes that it would be appropriate to publicly reprimand the Respondent for his conduct and to require him to complete Board-approved courses in record-keeping and prescribing within six (6) months of the date of this Order. The Board further concludes that it is appropriate to assess Respondent the costs of Four Hundred and 00/100 ($400.00) Dollars incurred in the investigation of this matter, also to be paid within six (6) months of the date of this Order.

5. The sanctions imposed are consistent with the purpose of these proceedings and have been made after weighing the public interest and the need for the continuing services of qualified medical doctors against the countervailing concern that society be protected from professional ineptitude and misconduct.

6. The sanctions imposed are designed not to punish the physician, but to protect the life, health, and welfare of the people at large.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED, AND DECREED that:

1. The MOA is accepted.

2. Respondent has violated the Medical Practice Act.

3. Respondent is hereby publicly reprimanded.

4. Respondent must complete Board-approved courses in record-keeping and prescribing within six (6) months of the date of this Order.

5. Respondent must pay the costs of Four Hundred and 00/100 ($400.00) Dollars incurred in the investigation of this matter within six (6) months of the date of this Order.

6. If Respondent fails to abide by any of the aforementioned terms and conditions, Respondent's license may be immediately temporarily suspended until further Order of the Board.

AND IT IS SO ORDERED.

STATE BOARD OF MEDICAL EXAMINERS
FOR SOUTH CAROLINA

Stephen R. Gardner MD

STEPHEN R. GARDNER, M.D.
President of the Board

September 6, 2017