IN THE MATTER OF	*	**BEFORE THE**
WILLIAM T. DANDO, M.D.	*	**MARYLAND STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License Number: D50835	*	**Case Number: 2005-0835**

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CONSENT ORDER

On September 18, 2009, the Maryland State Board of Physicians (the "Board") charged William T. Dando, M.D. (the "Respondent") (D.O.B. 07/19/1954), License Number D50835, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2005 Repl. Vol. & 2008 Supp.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follows:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review.

On March 3, 2010, a conference with regard to this matter was held before the Board's Case Resolution Conference ("CRC") Panel. As a result of the CRC, the Respondent agreed to enter into this Consent

Order, consisting of Findings of Fact, Conclusions of Law and Order.

GENERAL FINDINGS OF FACT

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine in Maryland on June 28, 1996, and is board-certified in family medicine. The Respondent maintains an office for the practice of family medicine located at 405 Frederick Avenue, #200, Catonsville, Maryland. He holds privileges at St. Agnes Healthcare and Frederick Villa Nursing Center.

2. On or about May 9, 2005, the Board received a complaint that the Respondent prescribed an excessive amount of Xanax, a benzodiazepine and Schedule IV Controlled Dangerous Substance ("CDS"), to a patient ("Patient A") while the Patient A was residing in Maryland and after she had moved to Texas. The complaint further alleged that the Respondent continued to prescribe "massive" amounts of Xanax to Patient A even after she displayed side effects including tremors, delayed reflexes and lethargy. Thereafter, the Board initiated an investigation and subpoenaed from the Respondent 12 patient records for peer review, the results of which review are set forth below.

Patient-Specific Findings of Fact

Patient A

3. Patient A, a female born in 1946, was the patient described in the complaint to the Board. She initially presented to the Respondent on

December 13, 2001, with an abscess on her right calf that was causing her pain. The Respondent incised and drained the abscess and prescribed antibiotics and Lortab #40, a Schedule III CDS, for pain.

4. Patient A returned several times in January 2002 for follow-up visits. On January 11, 2002, she complained that her leg continued to ache and that she was unable to sleep at night because of leg cramping. The Respondent noted that he was adding an "anxiolitic *(sic)* for sleep" and prescribed Xanax .5 mg, #20 (1 every 6 – 8 hours).

5. On February 27, 2002, Patient A returned complaining of, *inter alia,* increased fatigue, inability to concentrate and racing thoughts. The Respondent noted that Patient A had previously taken anti-depressants and mood stabilizers including: Prozac, Remeron, Zoloft, Paxil, Elavil and Lithium. He further noted that Patient A had advised that "Xanax has helped in the past." The Respondent prescribe Anafranil, an anti-obsessional medication, and increased Patient A's dosage of Xanax from .5 mg 1 tablet every 6 – 8 hours, to 2 mg 1 tablet every 6 – 8 hours.

6. On July 15, 2002, the Respondent documented that Patient A had called with "worsening anxiety." The Respondent prescribed Trazodone, an anti-depressant, and noted, "Appt with Psych ASAP ER if worse."

7. The next day, July 16, 2002, Patient A called the Respondent's office and left a message that she had had a "bad reaction to meds." Based on that telephone message, the Respondent doubled Patient A's dosage of Xanax 2mg from 1 tablet to 2 tablets every 6 to 8 hours.

8. Patient A next presented on August 6, 2002, stating that she was using Xanax, "2 pills 3 times a day." The Respondent documented, "[c]oncerns about high dosage of medication without evaluation expressed." Nonetheless, he refilled Patient A's Xanax prescription (2 mg, 2 tablets every 6 – 8 hours). The Respondent maintained Patient A's dosage of Xanax at this level for the remainder of the review period, through May 2005. The Respondent failed to decrease Patient A's Xanax dosage during this time, nor did he counsel her about decreasing the dosage.

9. On January 9, 2003, the Respondent, documented that Patient A had presented after being "rushed to the ER on Friday [J]an 3rd for seizures" after she had stopped taking Xanax on December 30, 2002. Patient A stated that the ER physician had told her that she had suffered from a grand mal seizure. The Respondent continued Patient A's Xanax at the same high dosage, noting "Monitor for seizure activity; Neuro consult for recurrence." Thereafter, the Respondent failed to document that Patient A was monitored for seizure activity, nor did he document that he had referred Patient A for a neurological consultation or that she otherwise had obtained the consultation.

10. On February 25, 2004, the Respondent noted that Patient A had "pos emotional outbursts, pos suicidal ideation." The Respondent failed to refer Patient A to a psychiatrist or other mental health care provider. The Respondent filled her Xanax prescription.

11. On August 18, 2004, the Respondent diagnosed Patient A with Diabetes Uncomplicated Type II and prescribed Avandamet.[1] The Respondent noted that, "lab results were reviewed with pt;" however, there are no laboratory results in Patient A's chart to support this diagnosis. In addition, the Respondent's notes of office visits prior to the August 18 visit do not reveal any concerns related to diabetes.

12. In or around August 2004, Patient A notified the Respondent that she had moved to Texas. The Respondent prescribed Xanax to Patient A based on her telephonic requests on at least 3 occasions through May 2005, the end of the review period.[2]

13. The Respondent failed to consider non-pharmacological treatment alternatives or substituting a longer-acting benzodiazepine or less addictive anxiolytic for Xanax. Moreover, the Respondent failed to reduce, taper and/or discontinue Xanax at any time during Patient A's course of treatment.

14. The Respondent maintained his records electronically. Several identically worded entries are repeated visit after visit for months at a time. For instance, the Respondent noted that cholesterol and cardiac CRP (C-reactive protein) lab results were pending for each visit from August 2003 through May 2005. The Respondent also frequently noted, "[c]oordinate care with consultants and other health care professionals as needed", however; there is no correspondence between the Respondent and

[1] Avandamet is an antidiabetic medication.
[2] Patient A's pharmacy run reveals that on June 27, 2005, she filled a prescription for Xanax (#180) that the Respondent had written.

consultants, nor is there any other documentation that indicates that the Respondent coordinated Patient A's care with other health care provider.

15. The only medication list in Patient A's chart is dated December 21, 2007, presumably the date it was printed out in response to the Board's subpoena. The Respondent failed to note the date that the listed medications were started, nor did he document previously prescribed medications.

Patient B

16. Patient B, a female born in 1959, initially presented on February 16, 2002 with complaints of left wrist pain and swelling over the previous year. The Respondent noted that Patient B had sores on her arms, abdomen and legs and that she picked at them. He diagnosed Patient B with "Anxiety r/o [rule out] underlying OCD [obsessive compulsive disorder]." The Respondent failed to document a history to referable to his diagnosis; the only objective date he recorded was "insight and judgment intact." The Respondent prescribed Luvox, an anti-depressant indicated for treatment of OCD, and refilled Patient B's diazepam (Valium), an anti-anxiety medication and Schedule IV CDS, which apparently had been prescribed by a prior physician.

17. Patient B returned to the Respondent on March 5, 2002, complaining that her left wrist still hurt. The Respondent documented that her thyroid stimulating hormone ("TSH") was low and diagnosed her with "mild thyroid

dysfunction." The Respondent failed to follow-up on that diagnosis or to conduct further testing.

18. Patient B next returned on November 2, 2004 for a gynecological examination. Patient B complained of bleeding, painful intercourse, abnormal odor and abdominal pain. The Respondent conducted a pelvic examination and documented that clue cells [3] were present. The Respondent inappropriately prescribed 3 different antibiotics and ordered an ultrasound to evaluate uterine bleeding.

19. Patient B underwent the ultrasound on January 5, 2005, the results of which revealed a prominent endometrial stripe measuring 1.5 cm (15 mm).[4] The Respondent failed to address this finding in later notes and prescribed a course of hormonal cycling therapy to control Patient B's abnormal bleeding. The Respondent failed to refer Patient B for an endometrial biopsy.

20. On March 15, 2005, Patient B presented with a "severe cough." The Respondent documented that her blood pressure was elevated at 160/102. On March 31, 2005, Patient B's blood pressure was 145/94. On March 31, 2005, the Respondent prescribed Clonidine (with 3 refills), a medication usually reserved for severe uncontrolled blood pressure, but otherwise failed to address or follow-up on Patient B's elevated blood pressure.

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[3] Clue cells are epithelial cells of the vagina whose stippled appearance is the result of being covered with bacteria.

[4] A thickened endometrial stripe (the thickness of the inner lining of the uterus) is an indication of possible endometrial cancer.

21. The Respondent documented that Patient B had a first degree family history of breast cancer and possible previous abnormal mammograms; however, he failed to refer Patient B for an annual mammogram during the 3 year period of review.

Patient C

22. On July 29, 2002, the Respondent authorized a prescription for a Schedule IV CDS, Darvocet-N 100,[5] #40 for Patient C, a female born in 1971, after receiving a telephonic request from a pharmacy, despite having never seen Patient C as a patient.

23. The Respondent failed to document his treatment rationale for prescribing Darvocet-N 100 to Patient C without first examining her. He also failed to document clearly his treatment rationale in subsequent visits; Patient C complained of headaches, but they were not a significant feature of her complaints. In correspondence with a consulting physician, the Respondent noted that Patient C "actually seems to benefit most from PRN[6] use of Darvocet [for depression] which of course is not approved for emotional disturbances"

24. The Respondent frequently authorized prescriptions for Darvocet and other medications for Patient C at her telephonic request and without seeing her for months at a time.

25. One month later, on August 29, 2002, Patient C presented to the Respondent with a rash on her face. The Respondent noted that she also

[5] Darvocet N 100 is a Schedule IV CDS.
[6] PRN is the abbreviation for "as needed."

complained of increased headaches and nervousness since stopping Prozac, an anti-depressant. His only psychiatric observations were: "good attention to grooming" and "insight and judgment intact." The Respondent prescribed Celexa, an anti-depressant. The Respondent failed to conduct an appropriate history of Patient C prior to prescribing Celexa; he failed to address her symptoms of depression and functional symptoms, nor did he assess her risk for suicide.

26. On April 15, 2003, Patient C presented complaining of mood swings and difficulty concentrating. The Respondent prescribed Focalin, a psycho-stimulant, based on these subjective complaints alone and in the absence of significant psychomotor slowing or a history of attention deficit disorder ("ADD"), and without screening or assessing Patient C for ADD.

27. The Respondent failed to conduct health maintenance care during the 5-year review period; he failed to conduct gynecological examinations or lipid screenings during this time.

Patient D

28. Patient D, a male born in 1965, initially presented on June 5, 2001 with complaints of right ear pain and impotence. The Respondent prescribed Viagra.

29. Patient D next presented on August 16, 2001, reporting that his leg and testicles had been injured when a refrigerator rolled on his leg. The Respondent prescribed Percocet, a Schedule II CDS, #40.

30. On August 24, 2001, Patient D called the Respondent's office seeking a refill of his pain medication and complaining of a cough. The Respondent prescribed Lortab, a Schedule III CDS, #40, and Tussionex, a CDS Schedule III cough syrup.

31. On November 9, 2001, the Respondent documented that Patient D admitted to "overusing meds." The Respondent noted that his plan was to discontinue all controlled substances. The Respondent referred Patient D for counseling and prescribed 2 antidepressants in the absence of an adequate psychiatric examination or history.

32. On July 12, 2002, the Respondent documented that Patient D's mother had advised him that Patient D was obtaining narcotics over the internet and was concerned that he might harm himself.

33. Patient D did not return to the Respondent until October 7, 2003, at which time he complained of severe back pain. The Respondent prescribed 240 tablets of Lortab without reference to Patient D's possible substance abuse. The Respondent failed to make provisions for Patient D's proper use of the medication, nor did he place Patient D on a pain contract.

34. Over the next several months, the Respondent authorized prescriptions for Lortab for Patient D, often over the telephone.

35. On February 21, 2005, the Respondent noted that Patient D presented with persistent abdomen pain and was scheduled for renal cell cancer surgery. The Respondent prescribed Percocet #180 for Patient D's pain and diazepam #90 for his anxiety.

36. On March 1, 2005, the Respondent began prescribing Seroquel, an anti-psychotic agent, for "mood stabilization." On September 8, 2005, the Respondent started Zyprexa, also an anti-psychotic agent, for "bipolar illness." On August 22, 2006, the Respondent started a trial of Risperdal and noted that he recommended that Patient D follow-up with a psychiatrist. The Respondent failed to conduct or document an adequate psychiatric examination or follow-up at any time during the course of treatment, nor did he document that Patient D was under the care of a psychiatrist or other mental health provider.

37. By consultation report dated March 7, 2005, a copy of which is in Patient D's chart, Patient D's oncologist noted that Patient D had been hospitalized in January 2005 "for acute psychiatric crisis ... which was reportedly felt most likely related to opiate intoxication." According to Patient D, he had not received a formal psychiatric evaluation except when hospitalized, and not been taking the anti-depressants prescribed by the Respondent.[7]

38. On May 5, 2005, Patient D returned with complaints of worsening back pain. The Respondent prescribed large amounts of Percocet #240, 1 – 2 tablets every 4 – 6 hours, and OxyContin #120, 1 – 2 tablets twice a day. The Respondent documented that he was going to refer Patient D to pain management for evaluation of alternative treatment; however, there is no indication in Patient D's chart that the Respondent made such a referral.

[7] Patient D underwent a left nephrectomy on March 29, 2005.

The Respondent failed to place Patient D on a pain contract, nor did he require Patient D to undergo periodic toxicology screens.

39. On June 22, 2005, Patient D told the Respondent that he had left all of his medications at a family member's house in West Virginia. Patient D stated that he was not suicidal, but "sometimes wishes that things would just end." The Respondent prescribed several anti-depressants, Xanax, OxyContin #60 and Percocet #240. The Respondent ordered a lumbar spine magnetic resonance imaging ("MRI") with contrast at this visit. The Respondent documented that the results of the MRI were pending, for over 2 years, through June 2007; however, there are no results of the MRI in Patient D's chart. The Respondent finally dropped this entry from Patient D's office notes in October 2007.

40. On September 18, 2006, after noting that Patient D was "doing generally well," the Respondent prescribed Strattera, a medication indicated for the treatment of Attention-Deficit/Hyperactivity Disorder ("ADHD") in the absence of documenting his treatment rationale or any symptoms or history to support the treatment.

41. On March 6, 2007, the Respondent noted that Patient D had requested a longer-acting pain medication so he would be able to sleep through the night. The Respondent prescribed OxyContin 10 mg #60, 1 tablet twice a day. The Respondent failed to consider, however, that Patient D had

been taking 80 mg of short-acting oxycodone (Percocet) a day and that the dose of OxyContin may be inadequate and cause withdrawal.[8]

42. On October 16, 2007, the Respondent prescribed 120 tablets of Percocet to Patient D. On October 30, 2007, Patient D reported that he had left his toiletry bag in West Virginia (for the second occasion) and that his Percocet was in the bag. The Respondent documented that he "refill[ed] medication for pain with precautions and instructions on proper use," but failed to place Patient D on a pain contract or any other type of monitoring.

43. On December 3, 2007, Patient D's last visit in the review period, the Respondent documented that Patient D advised that "longer acting oxycodone helped." The Respondent, however, had not documented that he had prescribed OxyContin to Patient D since March 6, 2007.

Patient E

44. Patient E, a female born in 1951, initially presented to the Respondent on April 2, 2002, with a history of Type 2 diabetes, hypertension and depression. The Respondent documented that Patient E's diabetes was "uncontrolled and significant risk for long term complications." The Respondent also documented that he recommended "routine care such as yearly eye exams, every 3 – 6 months monitoring of glycohemoglobin ["HbA1C"] and kidney functions;" however, during the review period (2002 through 2007), he failed to monitor appropriately and at recommended

[8] In subsequent notes, it appears that the Respondent switched Patient D back to Percocet, although he failed to document the reason why. At times, it is difficult to determine the medication, dosage and quantity that the Respondent prescribed as his notes often state only, "pain meds refilled."

intervals Patient E's diabetes, which was often uncontrolled. The Respondent ordered Hb1AC tests on only 3 occasions during the 5-year review period; he failed to obtain Patient E's Hb1AC levels at a minimum of every 6 months..

45. The Respondent ordered only 1 microalbumin test, a measure of kidney function, during the 5-year review period. He failed to order this test on an annual basis.

46. On January 16, 2007, Patient E complained of severe back pain and weakness for the previous 2 months. The Respondent documented that he ordered an MRI of Patient E's back. The electronic order form notes that the MRI was "abnormal – see report;" however, the report is not in Patient E's chart.

47. Starting in April 2007 and continuing through October 2007, the Respondent prescribed Percocet #90.[9] The Respondent added Restoril to Patient E's medication regimen in June 2007 to address her complaints of insomnia. Although there are several references from physicians other than the Respondent that Patient E had a history of alcohol abuse (for example, in a consultation report it is noted that Patient E was encouraged to *resume* Alcoholics Anonymous), the Respondent failed to document this history and prescribed CDS to her without addressing this potential issue.

[9] The Respondent prescribed 120 tablets of Percocet on 2 occasions in October 2007 after Patient E had burned herself.

48. The Respondent failed to order annual mammograms or Pap smears for Patient E.

Patient F

49. Patient F, a male born in 1967, initially presented to the Respondent on March 3, 2004 and was treated over the next several months for minor health complaints. On January 24, 2005, Patient F presented with complaints of fatigue over the previous 2 months. Patient F reported that his work schedule had changed and that he had lapsed into "unwanted sleep several times this past month." The Respondent noted that Patient F believed that his fatigue was related to narcolepsy.

50. The Respondent diagnosed Patient F with narcolepsy without cataplexy[10] in the absence of any documentation to support that diagnosis. The Respondent failed to document whether Patient F experienced hallucinations, sleep paralysis, automatic behavior or ocular disturbances. He also failed to order a Multiple Sleep Latency Test, a sleep disorder diagnostic tool. Based on the unsupported diagnosis of narcolepsy, the Respondent prescribed Ritalin 20 mg., a Schedule II CDS psycho-stimulant, to Patient R.

51. The Respondent refilled Patient F's prescription for Ritalin in February and April 2005.

52. On July 1, 2005, the Respondent documented that Patient F was presenting for a "follow-up exam from last visit for ADD, improved" The

[10] Cataplexy is the sudden and transient loss of muscle tone.

Respondent had not documented any history or symptoms pertaining to ADD in Patient F's previous note.

53. On January 24, 2005, the Respondent ordered a battery of laboratory studies including Chem-7 and lipid panels. The Respondent documented on 2 occasions, July 1, 2005 and January 26, 2006, that he reviewed "recent Labs with pt"; however, the results of the labs ordered by the Respondent in January 2005 remained pending through January 2006. The Respondent failed to follow-up on these studies.

Patient G

54. Patient G, a female born in 1979, initially presented on January 14, 2005, requesting refills of her medications. The Respondent diagnosed Patient G with ADD (non-hyperactive) in the absence of an adequate examination and documentation to support this diagnosis and prescribed Adderall XR 25 mg., a Schedule II psycho-stimulant. The Respondent failed to document Patient G's history relating to ADD including but not limited to: her functioning at home or work; how long she had been taking Adderall or her previous health care providers. The Respondent documented that he planned to obtain Patient G's past medical records; however, there are none in Patient G's chart.

55. From February 2005 through August 2005, the Respondent refilled Patient G's Adderall prescription by telephone and failed to monitor her usage of this CDS.

56. The Respondent failed to assess at regular intervals the efficacy of treating Patient G with Adderall.

57. The Respondent's conduct as set forth above with regard to Patients A through G, in whole or in part, constitutes the Respondent's failure to meet the standard of quality care, in violation of H.O. § 14-404(a)(22) and his failure to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22) and failed to keep adequate medical records as determined by appropriate peer review, in violation of H.O. § 14-404(a)(40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of April, 2010, by a majority of the quorum of the Board considering this case:

ORDERED that the Respondent is **REPRIMANDED**; and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum of **EIGHTEEN (18) MONTHS** and **UNTIL** all of the following terms and conditions are fully and satisfactorily completed:

a. Within six (6) months of the effective date of the Consent Order, the Respondent shall successfully complete at his own expense a Board-approved

intensive course in CDS prescribing. The course shall be in addition to the Continuing Medical Education ("CME") credits required for licensure;

b. Within six (6) months of the effective date of the Consent Order, the Respondent shall successfully complete at his own expense a Board-approved intensive course in medical record-keeping. The course shall be in addition to the CME credits required for licensure; and it is further

ORDERED that the Respondent is subject to chart and/or peer review at the discretion of the Board during the probationary period. A chart or peer review that is unsatisfactory in the opinion of the Board will be considered a violation of this Consent Order; and it is further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining to the practice of medicine; and it is further

ORDERED that the Respondent's failure to comply with any of the conditions of this Consent Order, shall be considered a violation of probation and a violation of this Consent Order; and it further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction for with the Board may have imposed, including a

reprimand, probation, suspension, revocation and/or monetary fine, said violation being proven by a preponderance of the evidence; and it is further

ORDERED that after eighteen (18) months from the effective date of this Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board or designated Board committee. The Board, or designated Board committee, will grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that the Respondent shall be responsible for all costs under this Consent Order; and it is further

ORDERED that this Consent Order shall be a public document pursuant to Md. State Gov't Code Ann. § 10-611 (2009 Repl. Vol.).

4/28/18
Date

John T. Papavasiliou
Deputy Director
Maryland Board of Physicians

CONSENT

I, William T. Dando, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this

Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

3/10/2010
Date

William T. Dando, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Harford

I HEREBY CERTIFY that on this 10th day of March 2010, before me, a Notary Public of the foregoing State and City/County personally

appeared William T. Dando, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Virginia M. Baier
Notary Public
My Commission Expires 12/3/13