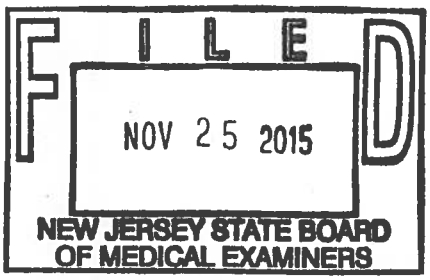


STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

**EFFECTIVE DATE: DECEMBER 4, 2015**

In the matter of:

ERIC THOMAS, M.D.
License No. 25MA08851700

ORDER OF TEMPORARY
LICENSURE SUSPENSION

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") on October 1, 2015, upon the filing of a Verified Administrative Complaint and Order to Show Cause, seeking the entry of an Order temporarily suspending the license of respondent Eric M. Thomas, M.D., to practice medicine and surgery in the State of New Jersey. The seven count administrative complaint focuses upon care provided by respondent to seven individual patients. In each of the seven counts, the Attorney General alleges, among other items, that respondent engaged in gross negligence and indiscriminately prescribed Controlled Dangerous Substances ("CDS").

A hearing on the application for the temporary suspension of Dr. Thomas' license commenced before the Board on October 14, 2015, and ultimately concluded on November 4, 2015. Upon consideration of all evidence and testimony presented, we find, for the reasons set forth more fully below, that the State has met its



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statutory burden to palpably demonstrate that Dr. Thomas' continued practice of medicine would present clear and imminent danger to the public health, safety and welfare, and Order the temporary suspension of Dr. Thomas' license pending the completion of plenary proceedings.

At its core, our decision is predicated upon our review of six patient records which evidence that Dr. Thomas -- over and over again -- prescribed opiates indiscriminately. Dr. Thomas consistently elected to ignore "red flags" and instead continued to prescribe opiates to patients who repeatedly tested positive for illegal drugs, including cocaine and heroin; to patients who repeatedly tested positive for CDS that Dr. Thomas did not prescribe; and to patients who repeatedly tested negative for the drugs that Dr. Thomas did prescribe. In one extreme instance, Dr. Thomas shockingly continued to prescribe Oxycodone to patient G.P., without any modification of dosage, after she tested positive for cocaine, heroin, morphine and codeine, and negative for prescribed Oxycodone, in an initial urine screen conducted in August 2013; was then found to be positive for heroin, morphine and codeine, and negative for Oxycodone, in a second urine screen performed in September 2013; and remained negative for Oxycodone in a third screen in October 2013.

Dr. Thomas also consistently continued to prescribe opiates after he querying the New Jersey Prescription Monitoring

and Reporting System (hereinafter the "PMRS") and reviewing information disclosing that his patients were "doctor shopping." In several instances, Dr. Thomas continued unabated prescribing of opiates to patients who were identified on the PMRS as securing prescriptions from as many as ten other physicians, to include prescriptions for the very same opiates that Dr. Thomas was prescribing. In another instance, Dr. Thomas continued to prescribe after learning that his patient was not only securing prescriptions from multiple providers, but also had two different names and two different birthdays in the PMRS system. In yet another case, he continued to prescribe after being told by a pharmacist that his patient was filling prescriptions using three different names.

In the case of patient L.K., the evidence before us shows that, on December 30, 2014 (the day after L.K.'s first office visit), Dr. Thomas doubled the dose of Oxycodone which L.K. had been receiving from her prior treating physician, without making any effort to contact that physician to obtain records or determine whether L.K. had been discharged from that practice. There is nothing in Dr. Thomas' records that documents why he determined that the dose should be so markedly increased, and he did so notwithstanding that he first secured a PMRS printout that should have caused him to question whether she may have been discharged by her prior treating physician for abuse or diversion. He then

continued to prescribe Oxycodone at the doubled dose, along with Klonopin (Tramadol was also added in March 2015), at visits that occurred at no greater than three week intervals for a total period of five months, even though every single visit L.K. "slipped out" of his office without providing requested urine screens, and even though he did not have a scintilla of objective evidence, such as diagnostic testing or imaging studies, to substantiate L.K.'s pain complaints.

While we find the evidence before us regarding Dr. Thomas' indiscriminate prescribing of CDS to be sufficient, standing alone, to support a conclusion that his continued practice of medicine presents clear and imminent danger, in this case our findings are buttressed by evidence suggesting that respondent failed to competently diagnose and/or manage his patients' pain syndromes and comorbid conditions such as hypertension and diabetes, even though he served as each patient's primary care provider. Taken in its totality, the evidence before us shows that Dr. Thomas repeatedly abrogated his core responsibility as a physician to exercise sound judgment, and that repeated abrogation of judgment compels this Board to presently order the temporary suspension of his medical license pending the completion of plenary proceedings in this matter. We set forth below a summary of the procedural history of this matter, and thereafter detail the

specific findings made and concerns identified which support our unanimous decision to temporarily suspend Dr. Thomas' license.

*Procedural History*

As noted above, the Attorney General commenced an action seeking, inter alia, the temporary suspension of the medical license of respondent Eric Thomas, M.D., on October 1, 2015, upon the filing of a seven Count Verified Administrative Complaint, an Order to Show Cause, a certification of Deputy Attorney General Jillian Sauchelli dated September 25, 2015 and a supporting brief. The Order to Show Cause required respondent to appear before the Board on October 14, 2015 for a hearing on the State's application. On October 9, 2015, respondent filed a written reply brief in opposition to the State's application.

On October 14, 2015, respondent appeared, represented by Michael Keating, Esq. Deputy Attorney General Jillian Sauchelli appeared for the complainant Attorney General. The hearing commenced with opening arguments of counsel, after which D.A.G. Sauchelli presented her case in support of the application for temporary suspension. The State's case rests on documents alone, specifically Dr. Thomas' patient records for each of the seven patients identified in the complaint, a prescription profile for patient K.G., an expert report authored by Roger Thompson, M.D., and a copy of a Consent Order of Temporary Suspension of Dr.

Thomas' New Jersey CDS Registration which had been previously filed on May 21, 2015.

The defense then started to present its case, by calling Respondent to testify about the care he provided to each of the seven patients. Early during Dr. Thomas' testimony concerning his care and treatment of patient K.G., however, it became apparent that the patient records which were then in evidence were likely incomplete. In order to be fair to Dr. Thomas, and to ensure that any action we might take would be based on review of the entirety of Dr. Thomas' records, we then decided to adjourn the hearing to afford the parties time to attempt to jointly settle the record.[1]

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[1] On October 14, 2015, the Board authorized a hearing Committee to convene on October 22, 2015 to continue the temporary suspension hearing, and fully authorized the Committee to decide the application and to enter any relief that might be found necessary. Determinations made and/or actions taken by the Committee were to be subject to review by the full Board. The Board also specifically ordered that the parties should meet and attempt to jointly settle the record before October 22, 2015.

On October 22, 2015, the hearing Committee again adjourned the matter, subject to two express conditions: 1) the parties were to continue to seek to mutually agree upon the precise contours of Dr. Thomas' patient record for each of the seven patients, and to fully redact those records to allow the records to then be introduced into the public evidentiary record in this matter; and 2) Dr. Thomas was to be afforded an opportunity to submit, in writing, his proposal for an interim resolution of this matter, with the Attorney General to have an opportunity to then respond in writing. See Letter from Hearing Committee Chair George Scott, D.O., to counsel, dated October 22, 2015.

On October 30, 2015, Respondent proposed a monitoring arrangement with a "carve out" of any prohibition on prescribing of CDS to allow him to prescribe Adderall. Respondent's proposal was opposed by D.A.G. Sauchelli. Prior to the continuation of the temporary suspension hearing on November 4, 2015, we convened in Executive Session to consider respondent's proposal, however we decided not to accept the proposal, and instead continued the temporary suspension hearing.

The hearing was ultimately continued, and heard to conclusion before the full Board on November 4, 2015.[2] Respondent then completed his testimony concerning his treatment of patient K.G., and proceeded to testify regarding care provided to patients J.W., M.G., R.H., G.P. and L.K.[3] Respondent also moved into evidence a defense expert report dated November 2, 2015, prepared by Angelo Scotti, M.D.[4] Following Dr. Thomas' testimony, the parties presented closing arguments of counsel.[5]

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Prior to the resumption of the hearing, the parties were able to reach agreement upon the contours of the records maintained by Dr. Thomas for each patient. Fully redacted, Bates stamped copies of each patient record were marked and entered into evidence on November 4, 2015. In order to avoid any confusion going forward, we then ordered that only the patient records marked and introduced on November 4, 2015 are to continue to be maintained in evidence. Accordingly, all copies of patient records marked or introduced at either the October 14 or October 22 hearings are no longer considered to be part of the public evidentiary record in this matter, as those exhibits have been superseded by the documents marked into evidence on November 4, 2015.

[2] The hearing reconvened on November 4, 2015 at 11:00 a.m. and concluded at 8:30 p.m. Deputy Attorney General Steven Flanzman served as counsel to the Board.

[3] With the agreement of both parties, we conducted the hearing on a "patient by patient" basis. Specifically, Dr. Thomas first offered direct testimony concerning his care of an individual patient, the Attorney General cross-examined Dr. Thomas regarding that patient, and Board members were then afforded an opportunity to question Dr. Thomas about his care of the patient.

[4] The evidentiary record in this matter consists of the following documents, all of which (with the exception of R-3, which is not in evidence, see below) were moved into evidence without objection:

<u>Attorney General's Exhibits</u>:

P-1 Patient record for J.B. (Count 5)
P-2 Patient record for K.G. (Count 3)
P-3 Patient record for M.G. (Count 1)
P-4 Patient record for R.H. (Count 4)

*Preliminary Findings of Fact and Conclusions of Law*

Upon review of the records in evidence and testimony offered by Dr. Thomas, we conclude that the Attorney General has made a palpable demonstration that Dr. Thomas' continued practice would present clear and imminent danger to the public health, safety and welfare. The evidence before us demonstrates that Dr. Thomas has, time and time again, exercised extraordinarily poor

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P-5 Patient record for L.K. (Count 6)
P-6 Patient record for G.P. (Count 2)
P-7 Expert report of Roger Thompson, M.D., dated August 27, 2015 with addendum dated September 22, 2015 and curriculum vitae of Dr. Thompson.
P-8 Prescription profile for prescriptions written by Dr. Thomas for patient K.G.
P-9 Patient record for J.W. (Count 7)
P-10 Consent Order of Temporary Suspension of NJ CDS Registration, filed May 21, 2015.
P-11 Addendum to expert report of Dr. Thompson, dated November 2, 2015.

Respondent's Exhibits

R-1: Expert report of Angelo Scotti, M.D., dated November 2, 2015.
R-2 Curriculum vitae of Dr. Scotti.

Also marked, for identification as R-3, were certain additional excerpts from records Dr. Thomas maintained for patients who were not named in the complaint, which Respondent's counsel proffered would be offered to show Respondent's general practice in caring for diabetic patients. Those records, however, were thereafter not further referenced in the hearing, and Respondent did not seek to move those records into evidence.

[5] Dr. Thomas concluded his testimony concerning patient L.K. at approximately 8:00 p.m. While Mr. Keating had proffered that Dr. Thomas would testify regarding all seven patients, we then determined that there was ample evidence in the record at that time to allow us to fully decide the temporary suspension application, and we thus found it unnecessary to consider (for purposes of the temporary suspension application alone) any allegations or evidence regarding respondent's care of patient J.B. (Count 5). All determinations and actions herein are thus based only on consideration of evidence presented regarding Counts 1-4 and 6-7 of the Verified Complaint.

judgment, and thereby abrogated his basic responsibilities as a licensee, when prescribing opiates. In so doing, he has clearly facilitated the abuse or diversion of drugs. Specifically, review of Dr. Thomas' records supports the following preliminary findings focused upon the prescribing of CDS[6]:

1) Dr. Thomas repeatedly initiated opiate therapy on a patient's first office visit, without simultaneously ordering diagnostic or imaging studies and without securing prior treatment records: Patient records reflect that Dr. Thomas prescribed Oxycodone to patients J.W., R.H., G.P and L.K., and Methadone to patient M.G., on the patient's first office visit, based on the patient's subjective pain complaint(s) and limited physical examination findings alone. In each case, Dr. Thomas commenced opiate therapy without simultaneously ordering imaging studies, or other diagnostic tests, to seek to objectively confirm a patient's presenting pain complaint(s). He also, in each case, commenced opiate therapy without making any effort to attempt to determine why any of the five identified patients -- all of whom had been obtaining prescriptions for opiates written by other physicians (in M.G.'s case, in a methadone treatment program) -- decided to transfer care and have prescribing done by a new physician. Dr. Thomas thus did not secure any patient's prior treatment records,

[6] Findings herein are referred to as "preliminary," given that all findings are necessarily based on the limited record before us at this time.

nor did he contact any patient's prior treating physician. By failing to do so, respondent missed an opportunity to determine whether any patient had been discharged or terminated by a prior prescribing physician(s) for abusing or diverting prescribed opiates.

2) Dr. Thomas twice commenced opiate therapy without addressing significant contraindications in self-completed patient histories: In two instances, we found significant self-reported information about substance abuse included in a patient's initial intake form which was seemingly ignored or disregarded by Dr. Thomas. M.G. wrote on his intake form that he was currently using heroin "every day." (MG10). The "medical assessment" section of M.G.'s patient record, for M.G.'s first visit on February 26, 2014, includes consistent information, specifically a notation that M.G. "presents with Heroin addiction; uses 10-15 bags heroine." R.H. self-reported on his intake form that he drank a gallon of Barcardi a week (RH14). There is nothing within Dr. Thomas' medical record that memorializes his having had any conversation(s) with either patient about the risks of the self-reported substance use, or concerning the possible dangers that use of heroin or alcohol might present when taken simultaneously with Oxycodone. Simply put, it appears that Dr. Thomas either failed to read either patient's intake form or, even worse, read the forms but chose to ignore the

critical information thereon.[7] In the case of patient M.G., that failure could well have had life-threatening consequences.[8]

3) Dr. Thomas repeatedly continued to treat his patients for complaints of pain with long term opiate prescribing, without documenting any periodic (or often times any) review to evaluate whether his continued long term prescribing of opiates was efficacious or otherwise improving a patient's functionality, without ordering diagnostic tests or imaging studies to substantiate pain syndromes, and without making reasonable efforts to pursue non-narcotic treatment modalities: Dr. Thomas' records simply do not memorialize his making any meaningful attempts to evaluate the continued efficacy of prescribing of opiates.[9] For

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[7] Dr. Thomas testified that he had conversations with both patients regarding their drug or alcohol use, and maintains that the history he ascertained from M.G. was that he had previously used heroin but was not using at the time of his initial visit. No such information is documented in Dr. Thomas' patient records.

Throughout the course of the temporary suspension hearing, Dr. Thomas repeatedly testified that he had conversations with patients that were not documented in his records, to include conversations regarding unexpected urine testing results and regarding information gleaned from PMRS queries revealing that a patient was obtaining narcotics from multiple providers (see infra). There is nothing, however, in evidence that corroborates his claims, and the absence of any documentation of such conversations in the patient records necessarily supports an inference that no such conversation(s) occurred.

[8] While a urine screen conducted at the time of M.G.'s first visit was negative for heroin, we also note that heroin is a drug that can be particularly difficult to detect and is often missed on urine screens.

[9] Board regulations require that physicians prescribing controlled dangerous substances for management of pain for three months or more review, no less than every three months, the course of treatment, new information about the etiology of the pain and the patient's progress

example, in K.G.'s case, despite prescribing Oxycodone for a period of over two and one-half years, there is nothing in K.G.'s records which documents any review to assess whether Oxycodone was having a positive effect on K.G.'s functionality (such as documentation whether K.G. was able to perform more activities as a result of pain medications). Many of Dr. Thomas' charts only sporadically include pain scores. M.G.'s record includes only one documented pain score for a visit on March 17, 2015 (MG58), even though M.G. was prescribed methadone for back pain and abdominal pain for a period which spanned fifteen months.[10]

Dr. Thomas also consistently failed to order, or secure, diagnostic testing or imaging studies. Specifically, it does not appear that he ordered any diagnostic or imaging tests to evaluate pain syndromes for patients M.G. (back and abdominal pain), G.P. (lumbar sciatica and hip pain)[11] or L.K. (lumbar radiculopathy and

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toward treatment objectives, and periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs such as nonsteroidal anti-inflammatories, or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence. See N.J.A.C. 13:35-7.6, generally; N.J.A.C. 13:35-7.6(d). Dr. Thomas' patient records are devoid of any entries suggesting that he made any effort to comply with the Board's regulatory requirements.

[10] It is not clear why Dr. Thomas elected to prescribe Methadone for M.G.'s back and abdominal pain. In response to questioning by Board members at the temporary suspension hearing, Dr. Thomas conceded that methadone was not the drug of choice for treating M.G.'s diagnosed pain syndromes.

[11] While there does appear to be a notation, in the "plan" section for G.P.'s December 10, 2014 visit stating "f/u MRI! Pt needs one", there is

hip pain). While Dr. Thomas did order an MRI for R.H. after eleven months of opiate therapy, (RH166, visit of 5/9/14), he continued to prescribe Oxycodone even though R.H. never went for the M.R.I.[12]

4) Dr. Thomas failed to enter written controlled substance agreements with five of the six patients: Applying our collective expertise, we fully concur with the observation made within Dr. Thompson's expert report that "the controlled substance agreement is the essential backbone of the physician-patient relationship in the prescribing of chronic controlled substances." (P-7). Despite the fact that Dr. Thomas engaged in long term opiate prescribing for each of the six patients, he routinely eschewed entering written controlled substance agreements, thereby deviating markedly from acceptable standards of practice. Even if Dr. Thomas' failure to enter such agreements upon the initiation of prescribing could be excused, his failure to do so in the face of "red flags" suggestive of abuse (see points 5 and 6 below) simply facilitated patient abuse or diversion of prescribed CDS. Additionally, while Dr. Thomas did ultimately enter a written

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nothing in the record that memorializes that Dr. Thomas in fact ordered the "needed" study (GP72).

[12] In K.G.'s case, respondent began opiate therapy approximately four months after initially attempting to manage KG's pain with Tramadol, but did not order any diagnostic studies seeking to identify the source of K.G.'s pain until over 2 years after treatment was initiated (September 2014 MRI ordered; see KG 305-06). In J.W.'s case, an MRI was obtained October 16, 2013; ten months into treatment (JW87).

agreement with patient R.H., he only did so eight months after initiating treatment, after R.H. had multiple urine screens with unexpected results and notwithstanding the fact that Dr. Thomas was aware (from PMRS queries) that R.H. had been obtaining narcotic prescriptions, including prescriptions for Oxycodone, from numerous other providers.[13]

Even R.H.'s controlled substance agreement, however, proved to be illusory. The agreement, executed on February 20, 2014, included a predicate clause that Dr. Thomas was to be the only physician prescribing opioid pain medications for R.H. On March 12, 2014, Dr. Thomas learned (upon querying the PMRS) that R.H. violated the agreement four days after it was entered by filling a prescription, written on February 24, 2014, by another provider for Endocet. While breach of any condition of a written controlled substance agreement is cause for immediate dismissal from practice (see Thompson report, P-7 in evidence), Dr. Thomas simply ignored the written agreement and continued to write R.H. prescriptions for Oxycodone.[14]

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[13] Dr. Thomas repeatedly testified that he entered "verbal" contracts with patients. His claims are belied, however, not only by the absence of any documentation of such "contracts," but also by his consistent failure to discontinue opiate prescribing or discharge patients when confronted with information that would typically be considered to constitute a violation of a controlled substance agreement.

[14] While Dr. Thomas' records reflect that he did then refer R.H. to "pain management," his actions were once again rendered meaningless when he continued to prescribe Oxycodone after R.H. failed to go to a pain management specialist.

5) Dr. Thomas routinely continued to prescribe opiates after securing information from the PMRS that revealed his patients were obtaining prescriptions from multiple providers, to include prescriptions for the same opiates Dr. Thomas prescribed: While Dr. Thomas often queried the PMRS, he repeatedly exhibited extraordinarily poor and suspect judgment by continuing to prescribe opiates to patients who he learned were obtaining multiple prescriptions for Schedule II opiates from other prescribing physicians. In the case of patient J.W., for example, Dr. Thomas' patient records include a series of print-outs from the PMRS that show that J.W. was receiving prescriptions simultaneously from as many as nine or ten concurrent prescribers (JW42, 4/22/13; JW51, 5/23/13; JW56, 7/15/13; JW063 8/12/13; and JW 112, 2/7/14)[15]. Those print-outs also show that J.W. obtained prescriptions for Oxycodone - the very opiate that Dr. Thomas was prescribing - from multiple providers. Dr. Thomas' records fail to include any information suggesting that Dr. Thomas confronted J.W. about the information gleaned from the PMRS, and clearly reflect that his prescribing of Oxycodone continued unabated throughout the entire course of J.W.'s treatment.

In the case of patient R.H., Dr. Thomas secured information when querying the PMRS in August 2013 (8/15/13, 8/16/13

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[15] No additional PMRS print-out reports appear in J.W.'s records subsequent to the 2/7/14 report.

and 8/27/13) that R.H. was obtaining and filling Oxycodone prescriptions not only from respondent, but also from other providers, and that he was obtaining prescriptions from eight other physicians (RH48-55, 58-60). Subsequent queries revealed that R.H. continued to receive prescriptions, to include additional prescriptions for Oxycodone 30 mg, from multiple providers, and Dr. Thomas even learned that R.H. had two names and two birthdates in the PMRS (see RH 94, query 12/9/13; RH111, query 2/20/14). As with patient J.W., however, any benefit that Dr. Thomas could have derived from querying the PMRS was eviscerated by his election to simply ignore the evident "red flags" and continue unabated prescribing.

6) Dr. Thomas routinely continued to prescribe opiates after conducting urine screens that returned "positives" for illegal drugs, "positives" for drugs not prescribed by Dr. Thomas and/or "negatives" for the opiates Dr. Thomas prescribed: While Dr. Thomas frequently conducted urine screens on patients prescribed CDS (with the sole exception of patient L.K., who never provided a urine for testing; see discussion of findings made regarding patient L.K. below), time and time again he reduced that testing to a meaningless and hollow exercise. In virtually every instance, Dr. Thomas' records fail to memorialize any discussions with patients regarding unexpected urine screen results and, even

more alarmingly, his records show that unexpected testing results did not cause him to discontinue his prescribing.

Patient G.P.'s case includes the most flagrant example of Dr. Thomas' poor judgment and reckless failure to react to aberrant urine screens. On August 27, 2013, G.P.'s urine tested positive for cocaine, heroin, codeine and morphine and negative for Oxycodone (GP41). Three weeks later (on G.P.'s next office visit), her urine test was positive for heroin, morphine and codeine, and negative for Oxycodone prescribed by Dr. Thomas (GP45). G.P.'s next urine screen (GP96, 10/17/13) continued to show negative findings for prescribed Oxycodone (GP49). Notwithstanding those results, Dr. Thomas prescribed Oxycodone, 30mg, #75 on all three office visits. Focusing on the office visit of October 17, 2013, we find it shocking that Dr. Thomas would then have written a prescription for Oxycodone, given that he had two consecutive reports showing that his patient was using illegal drugs and that she was not using Oxycodone. When appearing before the Board, Dr. Thomas suggested that the prescription he wrote on October 17, 2013 was to serve as a "bridge" until G.P. could be seen by a pain management specialist. His explanation, however, is nonsensical, for Dr. Thomas clearly then knew that G.P. had not been taking Oxycodone and thus could not have possibly needed any "bridge" prescription. Dr. Thomas' explanation is also belied by the fact that he continued to prescribe Oxycodone to G.P. even after she did

not go to a pain management specialist following the October 17, 2013 referral. Indeed, Dr. Thomas continued to prescribe Oxycodone for G.P. on each and every office visit until he surrendered his CDS privileges (G.P.'s last visit prior thereto was on May 11, 2015), and even added Oxycontin starting on a visit on December 15, 2013.[16]

While Dr. Thomas' decision-making and actions regarding patient G.P. are profoundly disturbing, the evidence demonstrates that his decision-making and prescribing behavior also deviated from any reasonable norm with all six patients. We thus find that the records routinely show that Dr. Thomas ignored aberrant urine screening results, and continued uninterrupted prescribing of opiates in the face of blatant "red flags."[17] Focusing solely on

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[16] On December 5, 2013, Dr. Thomas recorded that he had referred G.P. for pain management, and wrote that he told the patient "I could no longer prescribe short acting Oxycodone." (GP56). Later, his chart includes a handwritten note on a PMRS printout dated January 2, 2014 stating: "I called pharmacy and confirmed they filled it even though G gave me the script back! Owner of Pharmacy found that she has three names and owner said he would be looking at his cameras." (GP81).

There is nothing in Dr. Thomas' records suggesting any further communication with the referenced pharmacy owner. Nevertheless, even though G.P. ignored multiple instances where Dr. Thomas documented referring her to pain management, and even though he had abundant evidence suggesting that G.P. was either abusing or diverting prescribed drugs, Dr. Thomas continued to prescribe Oxycodone to G.P. on every visit, ultimately escalating quantities prescribed to amounts (#90) that exceeded the quantity he prescribed (#75) before G.P.'s first "dirty" urine screen in August 2013.

[17] During the hearing before the Board, Dr. Thomas often testified that, when confronted with positive urine screen findings, adverse PMP information or with patients who failed to go to pain management after referral, he would continue to prescribe opiates for his patients but

screens that were positive for unexpected substances or negative for prescribed drugs,[18] we note that Dr. Thomas failed to meaningfully address the following aberrant screening results:

-- Patient M.G.: M.G. tested positive for morphine and cocaine on one occasion (MG038, collection date 4/17/14), positive for cocaine alone on three occasions (MG53, 1/21/15; MG57, 2/17/15; and MG61, 3/17/15) and positive for morphine on three occasions (MG21, 3/5/14; MG29, 3/12/14; MG69, 4/15/15).

-- Patient R.H.: R.H. tested positive for Suboxone on 4/29/14 (RH158). He also tested negative for Oxycodone four times in a span of approximately six weeks (RH131, 3/13/14; RH141, 4/1/14; RH144, 4/3/14; and RH153, 4/22/14).

-- Patient K.G.: Patient K.G.'s records include multiple urine screens positive for illegal drugs and/or for medication not prescribed by Dr. Thomas, to include a screen positive for cocaine (KG198, 12/10/13), a screen positive for morphine (KG210, 1/6/14), and multiple screens positive for

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"taper" amounts. While we have not conducted a comprehensive analysis of Dr. Thomas' prescribing to determine whether he in fact decreased or tapered his prescribing in all such circumstances, it is beyond dispute that Dr. Thomas simply did not discontinue prescribing to any patient in any of the above circumstances. Further, even if he may have tapered prescribed quantities at one office visit, "tapering" was often short term only, and Dr. Thomas routinely would decrease or increase quantities prescribed without documenting his rationale for doing so in the patient record.

[18] For purposes of this analysis alone, we are not focusing on diluted screens, although we point out that Dr. Thomas' apparent failure to address diluted screens is yet an additional point of concern supporting our findings.

barbiturates (KKG320, 11/6/14; KG325, 11/20/14; KG329, 12/4/14; KG336, 12/19/14; KG347, 12/31/14; KG355, 1/16/15; KG362, 1/30/15; and KG370, 2/13/15).

Patient JW: Dr. Thomas prescribed Oxycodone on every visit throughout the twenty-eight month period that he treated J.W. (until his CDS registration was suspended), notwithstanding repeated negative screens for Oxycodone (JW19, initial visit 1/9/13; JW24, 2/8/13; JW78, 9/18/13; JW85, 10/25/13; JW90, 11/23/13; JW100, 1/110/14; JW105, 1/28/14), and notwithstanding multiple positive screens for THC (marijuana) and in some instances morphine [JW59, 7/6/13; JW64, 8/12/13; JW68, 8/26/13; JW78, 9/18/13; JW164, 5/2/14; JW167, 5/23/14; JW180, 6/12/14; JW 192, 7/3/14 (morphine); JW212, 8/11/14 (marijuana and morphine); JW226 10/16/14 (marijuana and morphine)].

7) Dr. Thomas consistently continued to prescribe opiates after patients ignored or failed to comply with referrals that he would make to pain management, and when patients failed to secure ordered imaging studies: When testifying before the Board, Dr. Thomas suggested that his ordinary practice (when he would obtain information showing that patients were abusing or diverting drugs) was to refer non-compliant patients to pain management and discontinue treatment. If that was his standard practice, however, it was a practice followed solely in its breach in the six cases before us. By way of example, Dr. Thomas referred J.W. to pain

management after just two months of treatment, and thereafter documented several additional referrals to pain management (JW34, 3/25/13; JW86, 10/25/13; JW94, 1/10/14). Each and every time, J.W. failed to secure the referral, yet each and every time, his failure to do so was without consequence as Dr. Thomas continued to prescribe Oxycodone unabated. In a similar fashion, Dr. Thomas referred R.H. to pain management on 12/9/13 (RH93) and 1/22/13 (RH102-103), but continued to prescribe opiates after R.H. failed to see a pain management specialist.[19]

8) Dr. Thomas' conduct regarding patient L.K. -- to include doubling her dose of Oxycodone on initiation of treatment without recording any basis to have done so; failing to secure prior treatment records and/or contact prior treating physicians; failing to order any imaging studies or to ensure that L.K. provided a claimed prior MRI, and continuing to prescribe even when L.K. consistently failed to provide requested urine screens -- manifestly demonstrates the clear and imminent danger of his continued practice: While we have not, given the stage of the application, sought to review in detail Dr. Thomas' care of each

[19] Dr. Thomas repeatedly suggested that he continued to prescribe for patients after referring them to pain management because they would come back to his office stating that they could not afford to be seen by pain management specialists. While Dr. Thomas' compassion may be understandable, his decision to continue to prescribe when his patients failed to go for referrals facilitated abuse or diversion of narcotics. Further, we note that these very same patients were typically "self-pay", uninsured patients, who were able to afford not only Dr. Thomas' fees but also to pay (presumably without reimbursement from insurance) to fill expensive opiate and other drug prescriptions.

individual patient, we find it appropriate to analyze and discuss L.K.'s case separately as, although spanning only five months, it vividly illustrates the magnitude of the danger of Dr. Thomas' practices. L.K. was a 29 year-old woman who first came to see Dr. Thomas on December 29, 2014. Dr. Thomas' record states (in the medical assessment portion) "needed primary doctor/check-up." (LK15). Dr. Thomas testified that L.K. told him she had congenital disc disease, and he then asked her to bring in a "pending" MRI. Her chart reveals that she thereafter did not provide Dr. Thomas any prior imaging studies, and it is clear and undisputed that Dr. Thomas never ordered an imaging study to corroborate the patient's otherwise subjective pain complaints.

Dr. Thomas accessed the PMRS on December 29, 2014, and his records include a print-out from that query which documents that L.K. had been filling prescriptions for Oxycodone, 15 mg tablets, (along with Tramadol, 50 mg tablets and certain other drugs) written by another physician in the months before she presented to Dr. Thomas (LK21, 22). Had Dr. Thomas carefully reviewed that print out, he would have seen that L.K.'s prior treating physician had been writing prescriptions for #120 Oxycodone, 15 mg every 28-30 days (thereby prescribing L.K. 60 mg of Oxycodone, or four pills daily) from May 2014 through November 2014, but then suddenly cut the prescribed quantity in half when writing for a 15 day supply (Oxycodone, 15mg, #60) on December 10,

2014. That information is suspicious alone; when coupled with L.K.'s presentation "need[ing] a primary doctor," it was clearly information which should have caused Dr. Thomas to question whether L.K.'s arrival at his office could have been occasioned because she was discharged by her prior treating doctor (or could no longer get the quantity of drugs she was seeking from that physician).[20]

Dr. Thomas wrote L.K. a prescription for Oxycodone, 15mg, #12, on December 29, 2014 (LK38) and drew blood for laboratory analysis (LK39,40). The very next day (December 30, 2014), Dr. Thomas wrote L.K. a prescription for a total of Oxycodone, 15mg., #120, but issued the prescription to be taken 2 tablets every 6 to 8 hours. He then wrote for a total quantity of 180 pills when L.K. next returned to his office two weeks later (LK37), and thereafter continuously wrote prescriptions for Oxycodone, 15 mg, #180 on every office visit (intervals between visits ranged from seventeen days to twenty-one days).[21] It thus appears that Dr. Thomas

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[20] We do not know, on the record before us, why L.K. sought Dr. Thomas' care on December 29, 2014, nor do we know whether her prior treating physician in fact discharged her or whether the physician's decision to cut the prescribed quantity of Oxycodone was in any way related to concerns regarding possible abuse or diversion. Rather, we raise the above points only to suggest that there was more than enough information available to Dr. Thomas to have caused him to explore those issues, and to underscore the gravity of Dr. Thomas' failure to have sought to contact L.K.'s prior treating physician or to secure her prior treatment records.

[21] On each visit from January 12, 2015 through the end of treatment, Dr. Thomas would issue two prescriptions to L.K. -- one for 120 Oxycodone on the date of the visit and one for 60 Oxycodone which would be written the date of the visit but include instructions that it was not to be

immediately **doubled** L.K.'s Oxycodone dose from that which he knew -- or should have known - had been prescribed by her prior treating physician (assuming the PMRS information is accurate), did so without making any notation in his patient records why such an extraordinary dosage increase was indicated or needed, and then continued to maintain L.K. on the doubled dose until he could no longer prescribe CDS. During the course of the five month period that Dr. Thomas treated L.K., Dr. Thomas never had L.K. execute a controlled substance agreement, never conducted a single urine screen, never secured her prior imaging studies and never ordered that she obtain new imaging studies. When appearing before the Board, Dr. Thomas testified that he wanted to obtain urine screens from L.K. and that he had a phlebotomist on premises, but that L.K. somehow managed to "slip out" of the office, time and time again, without submitting a urine sample. Once again, we find Dr. Thomas' testimony to be senseless, as it is clear that if he wanted to ensure that L.K. gave a urine sample while in his office, he could have simply refused to provide her with prescriptions until confirming that the sample was left. At a minimum, Dr. Thomas' conduct in L.K.s' case demonstrates a laxity of practice that

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filled until two weeks from the date of the visit. By doing so, on each visit, Dr. Thomas provided L.K. with prescriptions for a total of 180 Oxycodone 15mg, with the intent that the prescriptions were to provide a three week supply.

enabled a drug-seeking patient (whether an abuser or diverter) to facilely secure CDS.[22]

*Findings specific to Medical Care*

We are unanimously of the opinion that the findings set forth above regarding Dr. Thomas' prescribing of CDS, and the repeated and profound lapses of judgment evident therein, form a compelling and more than adequate predicate - standing alone -- to support a conclusion that his continued practice presents clear and imminent danger and to impose a temporary suspension of license. Nonetheless, we point out herein that our concerns regarding Dr. Thomas' medical practice are not solely limited to prescribing, but also sweep in concerns regarding his ability to competently provide general internal medical care.

Most significantly, Dr. Thomas' myopic focus on managing patient pain complaints with narcotics only -- without seeking to delve further and secure imaging studies or other diagnostic tests -- evidences a gaping inability to accurately diagnose, treat and

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[22] While Dr. Thomas testified on direct examination that his relationship with L.K. ended when he "terminated" her as a patient, there is nothing in his record to support that claim. We note, instead, that the record suggests that Dr. Thomas continued to prescribe for L.K. through and including an office visit on May 8, 2015 (LK65-71), and only stopped prescribing on May 28, 2015 after he had lost his CDS privileges. We also note that the medical assessment portion of the record for L.K.'s May 28, 2015 visit lists "follow-up, refills on meds," further supporting an inference that Dr. Thomas would have continued prescribing Oxycodone, Klonopin and Tramadol for L.K. had he been able to do so. In a similar ilk, his testimony on direct that he sought to cut her from four Oxycodone daily to three daily is simply belied by the record which shows that he never reduced the quantity of CDS prescribed at any visit.

manage pain syndromes. The records of all six patients are replete with evidence demonstrating that Dr. Thomas repeatedly failed to document his taking of adequate medical histories and his performance of thorough physical examinations to sufficiently explore the etiology of his patient's pain complaints. Repeatedly, there simply was no objective corroboration for recorded diagnoses. For reasons discussed at length during Board member questioning and colloquy during the hearing, we found Dr. Thomas' initial diagnosis of K.G.'s back and knee pain, and his subsequent treatment of those symptoms, to be superficial and wholly insufficient. Similarly, Dr. Thomas' diagnosis of "abdominal pain" for patient M.G. lacks any credible support in his patient record.

In addition to diagnosis, treatment and management of pain syndromes, the following issues have been identified as concerns that should be more fully explored in the plenary hearings:

-- Dr. Thomas' ability to diagnose and treat hypertension, and/or to address significantly elevated blood pressure readings: We note that there are many instances where patients presented to Dr. Thomas' office and were recorded to have profoundly elevated blood pressure recordings, however typically there is no information at all in Dr. Thomas' medical chart which memorializes how he evaluated or addressed those readings. By way of example, Dr. Thomas' chart note for R.H.'s office visit of

November 11, 2013 consists of nothing beyond a recorded pulse of 86 and a recorded blood pressure reading of 166/145 (RH87-88). Similarly, Dr. Thomas recorded a blood pressure of 184/85 for patient M.G. on April 14, 2015 (MG67-68), but again his records are devoid of anything suggesting that he sought to explore why the blood pressure would be so markedly elevated.

In the case of patient J.W., our concerns focus not on a single reading but rather upon consistently elevated pressure readings during the course of treatment. By way of example, Dr. Thomas' patient records reflect that J.W. presented with elevated systolic ($\geq$140) and/or diastolic ($\geq$90) pressures on each of his first six visits (JW16, 1/9/13, 150/82, JW 021, 2/8/13, 145/79; JW26, 3/1/13, 139/93, JW31, 3/25/13, 143/91, JW36, 4/22/13 140/89; JW48, 5/28/13, 152/92), and thereafter continued to present with elevated pressure readings on numerous visits. Notwithstanding that evidence, it appears that Dr. Thomas never diagnosed J.W. with hypertension, and failed to even secure testing that would ordinarily be indicated such as an EKG, a stress test or cardiac enzymes.

-- Dr. Thomas' ability to adequately manage and treat diabetes: On three separate occasions, R.H.'s hemoglobin A1c was found to be markedly elevated (RH31, 6/13/13, HbA1c of 11.0; RH115, 2/20/14, hbA1c of 12.4; RH165; 5/9/14; HbA1c of 11.4), and, in each case (particularly after the second and third laboratory tests),

Dr. Thomas' records do not suggest that he did anything beyond making slight adjustments in R.H.'s Levemir insulin administration. Those adjustments appear to have been insufficient to control R.H.'s diabetes, in turn raising concerns regarding Dr. Thomas' ability to manage and treat diabetes.[23]

-- Dr. Thomas' ability to manage and monitor the use of Coumadin, a blood-thinning agent: Respondent began prescribing Coumadin to K.G. in January 2014 after K.G. was hospitalized for ascites, bilateral pleural effusions and congestive heart failure. While Dr. Thomas did monitor K.G.'s PT/INR levels, it appears that K.G.'s recorded PT/INR levels failed to be in a therapeutic range for anticoagulation for an eight month period from May 22, 2014 through December 31, 2014. That failure, in turn, raises questions regarding Dr. Thomas' competency to effectively manage and monitor the use of Coumadin.[24]

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[23] Dr. Thomas maintained in his testimony that R.H. was a non-compliant patient, who he ultimately discharged for failing to take prescribed medicine and for misrepresenting information regarding fasting blood sugars. Obviously, if true, that information may militate against the findings made above, but in any case Dr. Thomas' records fail to adequately document and support those contentions. We leave further development of the facts concerning R.H's care and his overall compliance with taking prescribed medications for the plenary proceeding.

[24] Finally, we point out that Dr. Thomas' record keeping clearly falls far below minimum acceptable standards. Simply put, it appears that on many office visits, Dr. Thomas did nothing beyond recording vital signs and refilling narcotic prescriptions. His records are thus repeatedly skeletal, and provide a reader (which would include any subsequent treating physician) little or no idea what Dr. Thomas did, beyond refilling prescriptions, on many office visits.

*Conclusion and Order*

Based on the findings set forth above, we unanimously conclude that the Attorney General has met the statutory burden of palpably demonstrating that Dr. Thomas' continued practice would present clear and imminent danger. Simply put, Dr. Thomas' approach to prescribing of CDS exposed his patients to grave risks associated with abuse or addiction to CDS, or facilitated diversion. Dr. Thomas repeatedly obtained, but then blindly ignored, evidence that his patients were using illegal drugs, doctor shopping and/or not using the drugs he prescribed. His patients were thus able to obtain a steady stream of opiates regardless of aberrant urine testing results (or, in L.K.'s case, even without having to submit urine samples), regardless whether they were known to be obtaining prescriptions for CDS from multiple sources, and regardless whether they ever followed-up on referrals Dr. Thomas made. Dr. Thomas' lax practices, to include his repeated failure to secure prior records or contact prior treating physicians, to order or secure imaging studies, to periodically evaluate the efficacy of treatment, and to enter and/or enforce controlled substance agreements also enabled patients to facilely obtain opioid prescriptions whether they had any real or legitimate need for those opiates. In a very real way, Dr. Thomas acted as a drug supplier for his patients, and became an "easy mark" for drug-seeking patients. All of the above practices ultimately evidence a

fundamental and profound absence of good judgment, and all form a compelling predicate for a conclusion that Respondent's continued practice of medicine presently would present clear and imminent danger to public health, safety and welfare.

In our deliberations, we sought to consider whether restraints short of a full temporary suspension of license would be adequate to protect the public. Ultimately, though, we have concluded that the repeated dereliction of judgment manifest in the record before us admits of no remedy short of a full temporary suspension of license. We have found gaping lapses in Dr. Thomas' approach to the practice of internal medicine, prescribing of CDS and, most fundamentally, in his ability to exercise good judgment, and we conclude that those lapses are so pronounced that there would simply be no way to adequately protect the public interest at this time while allowing Dr. Thomas to continue to practice.

In order to allow for an orderly transition of care for Dr. Thomas' current patients, however, our Order is to be effective thirty days from its pronouncement on the record -- specifically, at the close of business on Friday, December 4, 2015. In the interim period, Dr. Thomas shall be precluded from providing care for any new patients, and shall make appropriate arrangement for the transfer of care and medical records for all existing patients.

WHEREFORE, it is on this 25 day of November, 2015

ORDERED:

1. The license of respondent Eric Thomas, M.D., to practice medicine and surgery in the State of New Jersey is ordered temporarily suspended, commencing at 5:00 p.m. on Friday, December 4, 2015. The temporary suspension shall thereafter continue until the conclusion of all plenary hearings in this matter, or until further Order may be entered by the Board.

2. Between November 4, 2015 (the date on which this decision was placed on the record following the hearing) and December 4, 2015, respondent shall neither accept in his practice, nor provide any form of treatment to, any "new" patients. Respondent shall, during that time period, make appropriate arrangements for the transfer of records and care of his current patients to other licensed physician(s).

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: _____
Stewart A. Berkowitz, M.D.
Board President