BEFORE THE WEST VIRGINIA BOARD OF OSTEOPATHY

WEST VIRGINIA BOARD OF OSTEOPATHY,

Complainant,

v. Complaint No. 10-05

ANITA T. DAWSON, D.O.,

Respondent.

COMPLAINT AND STATEMENT OF CHARGES

The West Virginia Board of Osteopathy (hereinafter identified as the "Board") has received information that ANITA T. DAWSON, D.O., (hereinafter identified as the "Respondent") has engaged in unprofessional and unethical conduct in the prescribing of Controlled Substances. Based upon this information and upon additional facts obtained following an investigation, the Board hereby initiates a Disciplinary Complaint against the Respondent.

As a result of the information obtained by the Board, including credible documentation from the state Vital Statistics Office and the state Board of Pharmacy, the Board finds there is **probable cause** to believe that the Respondent has engaged in conduct, practices and acts that constitute professional negligence, gross malpractice, and a willful departure from accepted standards of professional conduct.

The specific charges are as follows:

1. The Respondent, ANITA T. DAWSON, D.O., is a licensee of the Board and holds license number 918 to practice osteopathic medicine and surgery in the State of West Virginia.

2. At all times material to this case, the Respondent has practiced osteopathic medicine in Cabell County, West Virginia.

3. Under State and Federal law, a "Controlled Substance" is a drug, substance, or an immediate precursor of a drug or substance, that appears on a list or schedule of substances defined by statute, and that may only be possessed, created, manufactured or transferred under restricted conditions.

4. The schedules for Controlled Substances range from Schedule I to Schedule V, where the substances listed in Schedule I carry the highest potential for abuse and those in Schedule V are deemed to have the lowest potential for abuse.

COUNT I

5. In 2004, Patient A* sought treatment from the Respondent at least ten times. Over the course of these treatments, the Respondent prescribed Hydrocodone, a Schedule III Controlled Substance, and Alprazolam, a Schedule IV Controlled Substance, in increasing dosages and amounts.

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* To protect the confidentiality of patient information, patients are referenced by letters. The identities of each patient are listed in a Confidential Addendum to this Statement of Charges.

6. In July, 2004, the Respondent also began prescribing Temazepam, a Schedule IV Controlled Substance, to Patient A.

7. On or about July 21, 2004, the Respondent prescribed 150 tablets containing 10 milligrams of Hydrocodone, 120 tablets containing 2 milligrams of Alprazolam, and 30 tablets of Temazepam.

8. Eight days later, Patient A died as a result of his consumption of Alprazolam, combined with other drugs and alcohol.

9. In providing treatment to Patient A, the Respondent prescribed Controlled Substances without taking reasonable measures to determine whether abuse or diversion of these substances was occurring, or likely to occur, and prescribed Controlled Substances when she knew, and should have known, that these substances would be used for other than an accepted, therapeutic purpose, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.5.

COUNT II

10. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 5 through 8.

11. By prescribing Controlled Substances to Patient A, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the

osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT III

12. In her practice of osteopathic medicine, the Respondent provided medical services to Patient B, beginning in April, 2005. Over the course of these treatments, the Respondent prescribed Hydrocodone, a Schedule III Controlled Substance, and Diazepam, a Schedule IV Controlled Substance.

13. On August 10, 2005, Patient B had two prescriptions from the Respondent filled: one for 90 tablets of Hydrocodone in ten milligram strength and one for 120 tablets of Diazepam in 10 milligram strength.

14. On August 12, 2005, Patient B died from "combined Cocaine, Hydrocodone & Diazepam intoxication."

15. In providing treatment to Patient B, the Respondent prescribed Controlled Substances without taking reasonable measures to determine whether abuse or diversion of these substances was occurring, or likely to occur, and prescribed Controlled Substances when she knew, and should have known, that these substances would be used for other than an accepted, therapeutic purpose, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.5.

COUNT IV

16. In her practice of osteopathic medicine, the Respondent provided medical services to Patient C, between January, 2004 and November, 2005. During this period, the Respondent regularly prescribed large amounts of Oxycodone, a Schedule II Controlled Substance; Carisoprodol, a Schedule III Controlled Substance in West Virginia; and Alprazolam, a Schedule IV Controlled Substance. In addition, the Respondent also prescribed the following drugs on a regular basis: Butorphanol, a Schedule IV Controlled Substance; Fentanyl, a Schedule II Controlled Substance; and Zolpidem, a Schedule IV Controlled Substance.

17. On November 22, 2005, Patient C had four prescriptions from the Respondent filled: one for 210 tablets of Oxycodone in ten milligram strength, one for 120 tablets of Carisoprodol in 350 milligram strength, one for 180 tablets of Alprazolam in 2 milligram strength, and one for 30 tablets of Zolpidem tartrate in 2 milligram strength.

18. On November 23, 2005, Patient C died from over-ingestion of Alprazolam and a narcotic drug prescribed by another doctor.

19. In providing treatment to Patient C, the Respondent prescribed Controlled Substances without taking reasonable measures to determine whether abuse or diversion of these substances was occurring, or likely to occur, and prescribed Controlled Substances when she knew, and should have known, that these substances would be used for other than an accepted, therapeutic

purpose, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.5.

COUNT V

20. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 16 through 18.

21. By prescribing Controlled Substances to Patient C, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT VI

22. In her practice of osteopathic medicine, the Respondent provided medical services to Patient D, between 2004 and 2006. During this period of treatment, the Respondent prescribed Oxycodone, a Schedule II Controlled Substance, Carisoprodol, a Schedule III Controlled Substance in West Virginia, Clonazepam, a Schedule IV Controlled Substance, and Alprazolam, a Schedule IV Controlled Substance.

23. In December, 2005, and January, 2006, the Respondent increased the dosage level of the Oxycodone that she prescribed for Patient D from 10

milligrams per tablet, to 15 milligrams per tablet and then 30 milligrams per tablet.

24. On January 11, 2006, Patient D filled a prescription from the Respondent for 90 tablets of Oxycodone at the 30 milligram strength.

25. On January 12, 2006, Patient D died from Oxycodone intoxication.

26. In prescribing Controlled Substances to Patient D, without taking reasonable precautions to prevent the patient's accidental overdose of the medication, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT VII

27. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 22 through 25.

28. By prescribing Controlled Substances to Patient D, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT VIII

29. In her practice of osteopathic medicine, the Respondent provided medical services to Patient E, between 2004 and 2006. During this period of treatment, the Respondent regularly prescribed Hydrocodone, a Schedule III Controlled Substance, and Alprazolam, a Schedule IV Controlled Substance, to Patient E

30. In December, 2005, and January, 2006, the Respondent also prescribed Oxycodone, a Schedule II Controlled Substance, in addition to the other medications to Patient E.

31. On January 13, 2006, Patient E filled three prescriptions from the Respondent: 35 tablets of Oxycodone at 10 milligram strength, 175 tablets of Hydrocodone at 10 milligram strength, and 140 tablets of Alprazolam at 2 milligram strength.

32. On January 24, 2006, Patient E died from Oxycodone intoxication.

33. In prescribing Controlled Substances to Patient E, without taking reasonable precautions to prevent the patient's accidental overdose of the medication, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT IX

34. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 29 through 32.

35. By prescribing Controlled Substances to Patient E, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT X

36. In her practice of osteopathic medicine, the Respondent provided medical services to Patient F, between 2004 and 2006. During this period of treatment, the Respondent regularly prescribed Hydrocodone, a Schedule III Controlled Substance, and Alprazolam, a Schedule IV Controlled Substance, to Patient F.

37. On January 26, 2006, Patient F filled one prescription from the Respondent for 200 tablets of Hydrocodone at 10 milligram strength, and on January 27, 2006, Patient F filled another prescription from the Respondent for 200 tablets of Alprazolam at 2 milligram strength.

38. On March 9, 2006, Patient F died from respiratory failure resulting from taking a double dose of her prescribed medication.

39. In prescribing Controlled Substances to Patient F, without taking reasonable precautions to prevent the patient's accidental overdose of the medication, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XI

40. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 36 through 38.

41. By prescribing Controlled Substances to Patient F, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XII

42. In her practice of osteopathic medicine, the Respondent provided medical services to Patient G, between 2005 and 2007. During this period of treatment, the Respondent regularly prescribed Oxycodone, a Schedule II Controlled Substance, Hydrocodone, a Schedule III Controlled Substance, and Lorazepam, a Schedule IV Controlled Substance, to Patient G.

43. On November 30, 2007, Patient G filled three prescriptions from the Respondent: 150 tablets of Hydrocodone at 10 milligram strength, 100 tablets of Lorazepam at 2 milligram strength, and 90 tablets of Oxycodone at 10 milligram strength.

44. On December 23, 2007, Patient G died from the effects of combining her prescribed Oxycodone and Hydrocodone with other drugs.

45. In prescribing Controlled Substances to Patient G, without taking reasonable precautions to prevent the patient's accidental overdose of the medication, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XIII

46. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 42 through 44.

47. By prescribing Controlled Substances to Patient G, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XIV

48. In her practice of osteopathic medicine, the Respondent provided medical services to Patient H, between 2003 and 2009. During this period of treatment, the Respondent regularly prescribed Hydrocodone, a Schedule III Controlled Substance, and Diazepam, a Schedule IV Controlled Substance, to Patient H. From time to time, the Respondent also prescribed Carisoprodol, a Schedule III Controlled Substance in West Virginia, to Patient H.

49. During his course of treatment with the Respondent, Patient H also occasionally sought and obtained prescriptions for Controlled Substances from other physicians. The Respondent had the means and the knowledge to obtain this information as part of her treatment of Patient H.

50. On January 10, 2009, Patient H filled two prescriptions from the Respondent: 120 tablets of Hydrocodone at 10 milligram strength, and 60 tablets of Diazepam at 10 milligram strength.

51. On January 13, 2009, Patient H died from poisoning by combining his prescribed Hydrocodone and Diazepam with illicitly obtained Oxycodone.

52. In providing treatment to Patient H, the Respondent prescribed Controlled Substances without taking reasonable measures to determine whether abuse or diversion of these substances was occurring, or likely to occur, and prescribed Controlled Substances when she knew, and should have known, that these substances would be used for other than an accepted, therapeutic

purpose, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.5.

COUNT XV

53. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 48 through 51.

54. By prescribing Controlled Substances to Patient H, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XVI

55. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1-54.

56. By engaging in all of the acts alleged above, the Respondent has engaged in dishonorable, unethical and unprofessional conduct of a character likely to deceive and harm the public, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §24-1-18.1.5.

COUNT XVII

57. In her practice of osteopathic medicine, the Respondent provided medical services to Patient I, between 2005 and 2009. During this period of

treatment, the Respondent regularly prescribed Oxycodone, a Schedule II Controlled Substance, and Clonazepam, a Schedule IV Controlled Substance, to Patient I. From time to time, the Respondent also prescribed Carisoprodol, a Schedule III Controlled Substance in West Virginia, to Patient I.

58. On February 25, 2009, Patient I filled a prescription from the Respondent for 90 tablets of Clonazepam in a 2 milligram strength. Shortly thereafter, on March 6, 2009, Patient I filled a prescription from the Respondent for 180 tablets of Oxycodone in a 10 milligram strength, and on March 7, 2009, Patient I filled a prescription from the Respondent for 90 tablets of Oxycodone in a 15 milligram strength.

59. On April 2, 2009, while under the influence of the Clonazepam, Patient I drove a motor vehicle and collided with another vehicle, killing its occupants: Carole Crawford, Meaghan Crawford and Kelsey Kuhn.

60. On February 19, 2010, Patient pled "Guilty" in the Circuit Court of Cabell County, West Virginia, to three felony charges of Driving a Motor Vehicle while under the Influence of Controlled Substances and Drugs, Causing the Death of Another Person. In entering her plea, Patient I acknowledged that she had been addicted to her prescribed medication and had been abusing those drugs for a lengthy period.

61. In providing treatment to Patient I, the Respondent prescribed Controlled Substances without taking reasonable measures to determine whether abuse or diversion of these substances was occurring, or likely to occur, and prescribed Controlled Substances when she knew, and should have known,

that these substances would be used for other than an accepted, therapeutic purpose, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.5.

COUNT XVIII

62. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 57 through 60.

63. Following the vehicle crash, Patient I was hospitalized for a brief period of time and then sought treatment again from the Respondent. The Respondent continued to prescribe Controlled Substances to Patient I at weekly intervals, including the Clonazepam in amounts of 21 tablets per week and Oxycodone at 10 milligram strength in amounts of 56 tablets per week.

64. Seven weeks after the crash, the Respondent also prescribed 180 tablets of Hydrocodone, a Schedule III Controlled Substance, in a 10 milligram strength to Patient I.

65. By prescribing, and continuing to prescribe, Controlled Substances to Patient I under all of the attendant circumstances, the Respondent has engaged in dishonorable, unethical and unprofessional conduct of a character likely to harm the public, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §24-1-18.1.5.

COUNT XIX

66. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 57 through 60 and paragraphs 63 and 64.

67. By prescribing Controlled Substances to Patient I, in amounts, frequency, and duration that would be deleterious to the patient's health and safety, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XX

68. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1-67.

69. By engaging in all of the acts alleged above, the Respondent has committed a pattern of acts during the course of her medical practice that, under the attendant circumstances, constitute gross malpractice and gross negligence, all of which is a basis for disciplinary action pursuant to WEST VIRGINIA CODE §30-14-11(a)(5) and 24 CSR 1, §§ 24-1-18.1.5 and 24 -1-18.2.3.

COUNT XVII

70. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1-67.

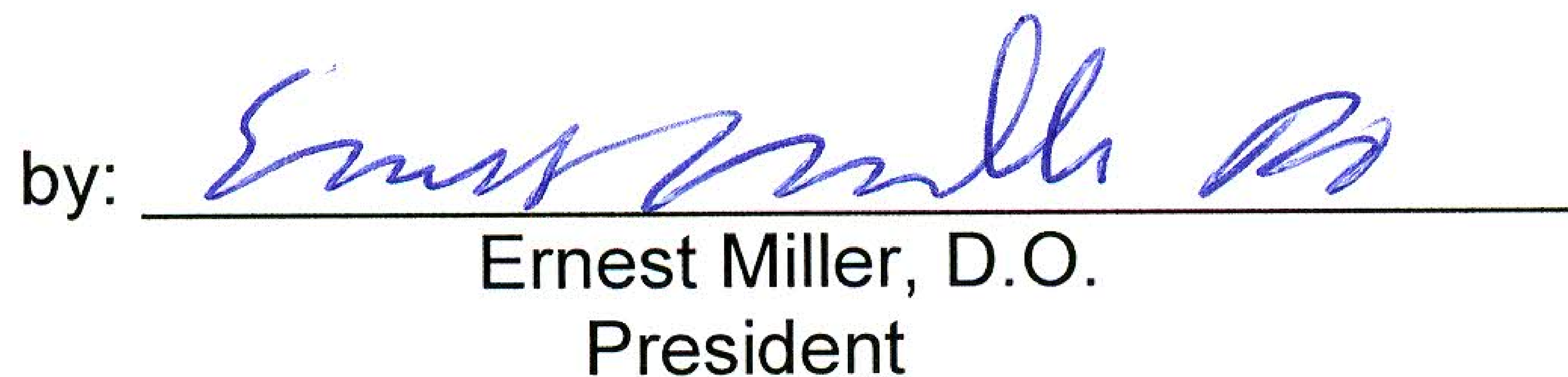
71. By engaging in all of the acts alleged above, the Respondent has demonstrated a lack of professional competence to practice osteopathic medicine with a reasonable degree of skill and safety for patients, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §§ 24-1-18.1.9.

CONCLUSION

Based upon all of the foregoing, the West Virginia Board of Osteopathy finds that there is **probable cause** to believe that the Respondent has engaged in unprofessional conduct and has engaged in conduct, practices and acts that constitute a departure from accepted standards of professional conduct in the practice of osteopathic medicine and surgery.

This matter shall, therefore, be set down for hearing, at a date and time to be arranged by counsel for the parties, to determine the truth of the allegations and to determine whether a final disciplinary sanction, if any, should be ordered by the Board.

WEST VIRGINIA BOARD OF OSTEOPATHY

by: 

Ernest Miller, D.O.
President

Date: 4/7/2010

BEFORE THE WEST VIRGINIA BOARD OF OSTEOPATHY

WEST VIRGINIA BOARD OF OSTEOPATHY,

Complainant,

v. **Complaint No. 10-05**

ANITA T. DAWSON, D.O.,

Respondent.

ORDER FOR SUMMARY SUSPENSION OF LICENSE

On the 6th day of April, 2010, the West Virginia Board of Osteopathy (hereinafter referenced as the "Board") met to review allegations that Anita T. Dawson, D.O., had engaged in unprofessional and unethical conduct. As a result of this review, the Board has issued formal charges and instituted disciplinary proceedings against this doctor, a licensee of the Board.

In addition to finding that there is probable cause to believe this licensee has engaged in unprofessional conduct, the West Virginia Board of Osteopathy makes the following findings:

1. The Statement of Charges filed in complaint number 10-05 alleges that the licensee's conduct and violations of the standards of care caused, or contributed to the deaths of eleven people;
2. Eight of those people were patients of the licensee;
3. Three of the people were not patients, but were members of the public killed by the actions of a patient who was then under the influence of controlled substances and drugs, prescribed by the licensee in

violation of the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession;

4. The Statement of Charges describes a repeated and continuing pattern of conduct occurring from the year 2004 through 2009; and

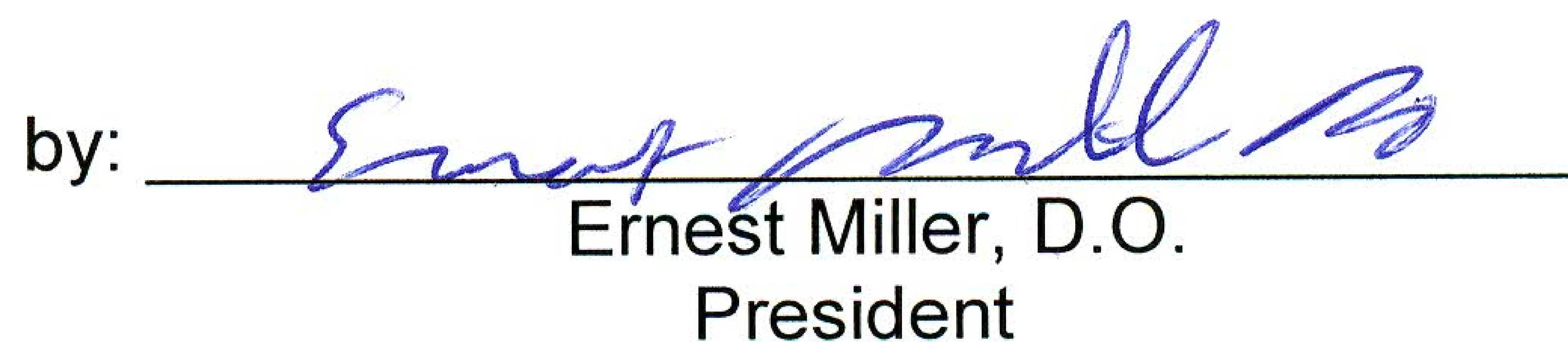
5. Despite these tragic outcomes, the Respondent continues in the same pattern of unsafe, unethical, and unprofessional conduct with gross indifference to the safety of her patients and the public.

For these reasons, the Board finds that Dr. Dawson's continuation in the practice of osteopathic medicine and surgery constitutes an **immediate danger to the public**, not only to her own patients, but also to the public at large.

Now, therefore, the West Virginia Board of Osteopathy ORDERS that the license of the Respondent, Anita T. Dawson, D.O., is **IMMEDIATELY** and **SUMMARILY SUSPENDED**. The Respondent shall not practice osteopathic medicine and surgery in the State of West Virginia until further order of this Board or of a court of law.

This matter shall be set down for a hearing on the necessity of this summary action for the 20th day of April, 2010, at the hour of 9:30 AM, at the office of the West Virginia Board of Osteopathy, 405 Capitol Street, Fourth Floor Conference Room, Charleston, West Virginia.

WEST VIRGINIA BOARD OF OSTEOPATHY

by: 

Ernest Miller, D.O.
President

Date: 4/7/2010