

BEFORE THE INDIANA MEDICAL
LICENSING BOARD
CAUSE NO. 2009 MLB 0031

IN THE MATTER OF THE LICENSE OF)
)
PHILLIP DELANO FOLEY, M.D.,)
)
LICENSE NO. 01019413A.)



PETITION FOR SUMMARY SUSPENSION

The Office of the Indiana Attorney General, by counsel, Deputy Attorney General Michael A. Minglin, on behalf of the State of Indiana (“Petitioner”), moves the Indiana Medical Licensing Board (“Board”) to suspend the license of Phillip Delano Foley, M.D. (“Respondent”) for ninety (90) days and in support of its petition states:

1. Respondent is a licensed physician in the State of Indiana holding license number 01019413A.

2. This Board has jurisdiction to suspend Respondent’s license in accordance with the provisions of Indiana Code §4-21.5-4 *et seq.* and Indiana Code §25-1-9-10.

3. Respondent’s address on file with the Board is 613 N. 10th Street, Middletown, Indiana, 47356, where he operates a solo practice as a general family physician.

4. Petitioner had a qualified medical expert review ten of Respondent’s patient files involving drug overdoses. The expert’s review of each of these cases is set forth below in a non-exhaustive summary:

(a) Patient E.D. (died June 12, 2004): Patient was initially seen by Respondent on May 29, 1998 complaining of stress and need for weight control. The patient never had a physical exam to document the physical findings or condition. Respondent prescribed hydrocodone on E.D.’s second visit on June 29, 1998 without

documentation/examination or objective studies. This was the same protocol for the following visits:

08-11-98	09-04-98	10-23-98	11-16-98	12-7-98
08-12-98	09-15-98	10-30-98	11-23-98	
08-21-98	09-23-98		11-30-98	

Respondent ignored E.D.'s signs of depression and merely prescribed more narcotics, depressants and/or muscle relaxants. On the following visits, Respondent performed no physical examination, drug testing or listed any rationale for the prescription of narcotics:

12-29-99	01-21-00	09-13-00
01-13-99	02-21-00	10-13-00
02-12-99	03-17-00	11-13-00
07-16-99	04-17-00	12-15-00
10-15-99	05-17-00	01-17-01
10-18-99	06-14-00	02-16-01
11-23-99	06-28-00	03-14-01
11-24-99	07-12-00	03-16-01
12-22-99	08-16-00	04-13-01

All of the following visits occurred without any physician/RN evaluation/examination.

E.D. was merely given refills for Vicodin, Soma, and Xanax.

05-09-01	01-07-02	09-25-02
06-29-01	01-28-02	10-02-02
07-02-01	02-08-02	11-11-02
07-18-01	03-08-02	11-13-02
07-20-01	04-24-02	12-11-02
08-23-01	05-29-02	12-23-02
09-19-01	06-28-02	01-08-03
10-15-01	07-22-02	02-04-03
11-12-01	07-29-02	03-28-03
11-30-01	08-28-02	
12-10-01	09-04-02	

Identical prescription abuses were done by Respondent continually for all subsequent visits in 2003 and 2004. Respondent continued to this prescribing pattern despite Respondent's knowledge of four drug overdose occurrences on 10-30-01, 08-14-03, 01-

13-04 and 04-01-04. Respondent's continued prescribing, after notice of the drug overdoses, directly contributed to E.D.'s death which was due primarily to an overdose of carisoprodol.

(b) Patient J.A.Y. (died June 25, 2004): Patient was a 21 year old male who initially saw Respondent on August 23, 2002, with a self-diagnosis of "two broken bones in my foot" and a "fracture" of the third vertebra (intake form). The spinal fracture was from 9/3/95 and was only an inferior endplate fracture that heals 99.9% of the time in 8 to 12 weeks and is not painful. Repeat films on 11-12-96 are completely normal and show no fracture. Patient states he was skateboarding, hardly a sport for someone who "stays in bed" due to chronic pain. There is no logical medical reason for this Patient to have short term narcotics. The note written by office assistant D. Forster, states Patient is being treated for lumbar spine (LS) disease and panic attacks. Using Vicodin ES and Soma do not constitute appropriate long-term medical care for either condition. There was a thoracic MRI done on 05-17-04, which reveals "NO PATHOLOGY" that would cause chronic pain. When Patient was seen in Saint John Hospital ER from hammer trauma to his head, his blood alcohol was 280mg/dl. This should have alerted Respondent about concomitant use of narcotics/depressants with life threatening amounts of alcohol being consumed.

In all chronicled visits, August 23, 2002, September 30, 2002, November 1, 2002, November 25, 2002, December 13, 2002, December 20, 2002, January 6, 2003, April 5, 2004, May 3, 2004, May 12, 2004, June 4, 2004, and June 23, 2004, Respondent never performed a physical exam. Respondent made no referral for psychiatric or mental health consultation despite a claim by J.A.Y. of "panic attacks." There is nothing in the records

to medically support the prescription of narcotics and muscle relaxants for “panic attacks.” The patient’s death due to drug overdose was directly the result of Respondent’s prescriptions issued to J.A.Y.

(c) Patient M.N. (died 10-22-04): Patient M.N. was seen by Respondent on August 23, 2000. Respondent performed no physical examination, yet prescribed oxycodone. Respondent’s records indicate that M.N. was tested by another pain physician and the results were normal, yet you continued to prescribe narcotics. The records indicate that M.N. was depressed, but depression was never addressed. Communications from M.N., other providers, and other health care facilities regarding drug overdose episodes did not deter Respondent for continuing to prescribe narcotics and benzodiazepams to this patient. The frequency, escalation of the dosages, lack of medical attention, and signs of M.N.’s drug abuse resulted in M.N. dying from a drug overdose.

(d) Patient G.T. (died April 3, 2005): G.T. was a 37 year old male glazier who first saw Respondent on July 2, 2002. Patient complained of headaches and underwent a CAT scan of his brain that was normal, yet Respondent prescribed narcotics. On August 29, 2002, Patient underwent an MRI for left knee pain that revealed a torn cartilage. Patient fell at work in December 2002, but a cervical MRI was normal. Subsequently, G.T. was evaluated by another physician who diagnosed musculoskeletal strain and treated him with physical therapy and returned him to work. However, Respondent continued to prescribe large doses of narcotics up until the Patient’s death.

On the following visits Respondent never performed a physical exam, provided refills without seeing the Patient, many refills were given early, there were never any

drug screens to validate Patient's compliance with their medical regimen, and Patient's depression was never addressed all of which were detrimental to G.T.:

07-17-02	05-16-03	10-20-04
08-02-02	07-14-03	10-29-04
08-13-02	09-08-03	11-22-04
08-26-02	01-09-04	12-10-04
08-29-02	02-16-04	01-14-05
09-27-02	04-02-04	02-16-05
11-15-02	05-07-04	02-18-05
01-06-03	07-16-04	03-14-05
02-28-03	08-02-04	03-16-05
04-07-03	08-18-04	03-28-05
05-09-03	09-24-04	

This egregious lack of medical care, "directly caused the death of [G.T.] by [Respondent's] prescriptive malfeasance."

(e) Patient A.M. (died June 12, 2005): A.M. saw Respondent after a shoulder injury where Respondent started A.M. on the usual combination of Xanax, Lortab, and Soma on December 31, 1998. She attempted suicide and had an alcohol overdose in January 1999. Her son committed suicide in 2004 and this incident exacerbated her depression and anxiety issues. Respondent never addressed the psychiatric issues and his continued prescription of controlled substances worsened her depression. A.M.'s death was attributable to bronchopneumonia and drug intoxication based on benzodiazepines, opiates, and sedatives prescribed by Respondent.

A.M.'s medications were refilled as follows:

01-11-99	05-07-99	10-22-99
03-10-99	06-08-99	11-22-99
03-17-99	07-01-99	12-22-99
04-05-99	07-15-99	01-21-00
04-09-99	08-25-99	02-04-00
04-14-99	09-24-99	02-18-00

03-15-00	03-28-01	04-01-02	05-09-03
04-14-00	04-25-01	05-01-02	06-06-03
06-13-00	06-18-01	05-31-02	07-02-03
07-11-00	07-16-01	06-28-02	08-01-03
07-12-00	08-13-01	07-29-02	09-03-03
08-08-00	09-10-01	10-28-02	10-16-03
09-05-00	10-03-01	11-25-02	11-12-03
10-04-00	11-05-01	12-20-02	12-12-03
11-03-00	12-05-01	01-15-03	01-09-04
12-20-00	01-04-02	02-13-03	02-06-04
01-17-01	02-04-02	03-12-03	03-03-04
02-28-01	03-04-02	04-12-03	04-20-04
05-28-04	10-18-04	04-06-05	
06-23-04	11-15-04	05-06-05	
06-23-04	12-13-04	06-01-05	
07-19-04	01-15-05		
08-18-04	02-09-05		
09-23-04 (son's suicide)	03-09-05		

(f) Patient J.Y. (died April 16, 2006): J.Y. first presented to Respondent on July 7, 2004 with anxiety, stress, depression, and shortness of breath. Without examining the Patient, Respondent prescribed benzodiazepines, then on August 2, 2004, narcotics were added without addressing her medical complaints. On August 16, 2004, again, without a physical exam or objective findings, Respondent added carisoprodol. On September 10, 2004, Respondent refilled J.Y.'s prescriptions for excessive amounts of narcotics, sedatives, and muscle relaxants without a physical exam or clinical evidence of injury.

This regime of prescriptions were repeated exactly the same on:

10-11-04	08-24-05
11-12-04	09-21-05
03-05-05	10-19-05
03-21-05	11-07-05
05-11-05	12-12-05
06-24-05	01-11-06
07-20-05	02-10-06
07-22-05	03-31-06

In addition, J.Y. was arrested on December 31, 2005 for an OWI and Respondent continued to prescribe the controlled substances for her. Respondent knew on November 7, 2005 that J.Y. was seven months pregnant, yet continued to prescribe opiates. The controlled substances prescriptions that Respondent issued to J.Y. caused her to become addicted and caused her fatal drug overdose on April 16, 2006.

(g) Patient G.P. (died 11-16-07): Respondent treated this Patient for coronary artery disease and diabetes in 1972, but started prescribing the standard “concoction” of controlled substances, alprazolam, carisoprodol, and hydrocodone in 2002 for “pressure” in his sinuses. The continued monthly return visits are stereotypical of Respondent to obtain repeat prescriptions for unknown maladies. Over the next five years, Respondent continued to prescribe in increasing strength and dosages with no drug screens, no physical examinations and no narcotic contract. G.P. was arrested for driving under the influence of drugs on October 26, 2006, but Respondent continued to prescribe the “concoction” until his death. While G.P.’s comorbidities made him more susceptible to physiologic derangements, the primary cause of G.P.’s death was due to Respondent’s negligent prescriptive practices.

(h) Patient T.P. (died 03-09-08): T.P. was seen by Respondent on June 11, 2004 and evaluated for an abnormal liver and gallbladder. Results were consistent with diabetic fatty liver. Without physical or objective findings, Respondent prescribed his concoction of hydrocodone, alprazolam and carisoprodol in January 2004. This concoction consisted of Lortab 10/500 mg #120, Soma 350 mg #120, and Xanax 1 mg #120. This “repertoire” continued on:

01-16-04	11-08-04
01-28-04	12-22-04

02-13-04	01-03-05
03-12-04	02-02-05
04-09-04	03-04-05
05-05-04	04-01-05
06-11-04	04-29-05
07-09-04	05-25-05
08-06-04	
09-08-04	

In early 2005, Respondent added Fioricet, which has acetaminophen, a drug that would be contraindicated due to T.P.'s liver problems. The trend continues on with no physical exam and office visits were only for the refilling of narcotics and controlled substance prescriptions as follows:

06-24-05
07-22-05
08-24-05
09-21-05 (morphine added; nothing withdrawn)
10-12-05
10-14-05
11-18-05
12-16-05
12-19-05
01-13-06
02-10-06
03-10-06
04-07-06
05-05-06
05-31-06
06-23-06
07-26-06
08-04-06
08-23-06
09-27-06

10-25-06	on these dates #120 Lortab 10/500 mg.;
11-20-06	#120 Xanax 1 mg., #120 Soma 350 mg.
12-20-06	#30 Kadian 100 mg, #120 Fioricet

01-17-07 (added Restoril-sleeping pill)
02-21-07
03-21-07
04-18-07 (Note in chart, "patient out of it for three days")

Even though there was no medical reason for T.P. to receive all of these prescriptions, and despite the April 18, 2007 patient file comment (“patient out of it for three days”), Respondent continued to prescribe on a monthly basis hydrocodone, alprazolam, carisoprodol, Firoicet and morphine. T.P. was arrested for driving under the influence due to drugs on June 4 and June 5, 2007. After these arrests, Respondent continued to prescribe the same “concoction” of drugs on June 11, 2007. He returned on August 8, 2007, September 7, 2007, October 5, 2007, and November 2, 2007 and received multiple refills of all medications. T.P. did not show up for an MRI and was still given refills of all medications. There was never a physical examination, drug screening, or narcotics agreement that is the required standard of care.

In November 2007, T.P. was treated at a hospital emergency room for a drug overdose, and Respondent’s office was sent these records. Thereafter, Respondent continued to prescribe full refills for the concoction to T.P. on November 28, 2007, December 28, 2007, January 23, 2008 and February 18, 2008 until the patient died on March 9, 2008 from a drug overdose. The care rendered by Respondent resulted in the demise of T.P. due to a drug overdose.

(i) Patient B.H. (died 03-01-09): Patient B.H. died of a drug overdose that was directly as a result of same negligent prescriptive practices as that engaged in by Respondent in all of the other records that the expert reviewed. The prescribing of carisoprodol, hydrocodone and alprazolam on a chronic basis to B.H. was without a legitimate medical necessity. Respondent’s patient file merely states alprazolam was for “anxiety” yet Respondent never does psychometric testing or refer B.H. for psychiatric assistance. There were no drug screens, and as a result of Respondent’s prescribing, B.H.

became addicted/habituated to these medications. The medications prescribed by Respondent were directly responsible for B.H.'s death.

(j) Patient S.P.: Patient S.P. has had multiple previous overdoses including an episode when she shared her fentanyl, prescribed by Respondent, with her father Patient T.P. on March 9, 2008. (Patient T.P. is the patient referred to above in paragraph 4(h).) S.P. did not die from the fentanyl overdose, but she resumed receiving controlled substances from Respondent about two months later. Respondent's "cookbook" use of alprazolam, hydrocodone, oxycodone and carisoprodol were without legitimate medical indications. Respondent was grossly negligent because he did not perform drug screens or perform physical examinations on Patient S.P. Respondent continued to prescribe controlled substances to S.P. without addressing her psychiatric medical condition or seeking an appropriate consultation. Respondent has continued to prescribe controlled substances, including alprazolam, to S.P. until at least August 17, 2009, without realizing or ignoring the fact that she was receiving medical treatment from a psychiatrist who prescribed her clonazepam, a controlled substance benzodiazepine. Respondent's continued prescribing for S.P. reveals a direct reckless and wanton abandonment for her personal safety and well-being and puts this patient at risk for a fatal drug overdose.

5. The Drug Enforcement Administration ("DEA") provided the National Drug Intelligence Center ("NDIC") with Respondent's INSPECT report for the period from January 2005 to May 2008 for analysis. This NDIC analysis revealed among other things, the following:

(a) Respondent wrote approximately 96, 131 original prescriptions for the period from January 1, 2005 through May 31, 2008 as follows:

2005	26,901 scripts
2006	22,752 scripts
2007	32,829 scripts
2008*	13,219 scripts
No date	430 scripts
Total	96,131 scripts

*The 2008 date only goes to May 31, 2008, not a full year.

(b) The NDIC analysis of the data reveals that Respondent works primarily on Mondays, Wednesdays and Fridays although he writes original prescriptions every day of the week as follows:

Sunday	581 scripts
Monday	23,597 scripts
Tuesday	3,677 scripts
Wednesday	30,440 scripts
Thursday	5,013 scripts
Friday	28,523 scripts
Saturday	3,870 scripts

During this time period, there were five days on which Respondent wrote over 400 prescriptions per day. There were 25 days that he wrote over 300 prescriptions per day and there were 181 days that he wrote over 200 prescriptions per day. (Note that re-fill prescriptions were not included in these counts.)

(c) The NDIC analysis reveals that on 45 days, Respondent saw over 100 patients, including 8 days on which he treated 130 or more patients. For example, on

April 27, 2007, Respondent treated 141 patients and wrote 424 prescriptions. Assuming that Respondent worked a non-stop, ten hour workday, Respondent would have spent approximately 4 minutes per patient and would have written 1.4 prescriptions every minute. The following table lists 25 days on which Respondent wrote 300 or more prescriptions per day and the number of patients per day:

<u>Date:</u>	<u>#Patients:</u>	<u>#RXs:</u>
04-27-07	141	424
09-26-07	139	424
07-25-07	151	423
12-08-07	145	413
08-22-07	140	404
10-24-07	143	394
01-04-08	126	385
06-29-07	138	377
06-27-07	129	376
09-28-07	135	357
05-30-07	127	357
05-03-07	119	341
10-26-07	126	340
03-28-07	111	329
08-31-07	117	322
03-21-07	111	319
12-07-07	109	318

04-23-08	100	312
03-07-08	113	310
08-24-07	109	306
04-14-08	111	305
01-17-07	107	304
11-26-07	105	303
10-15-07	112	302
12-21-07	123	300

(d) The NDIC analysis of the data indicated that 98.8 percent of the prescriptions written by Respondent belong to one of the following categories used in a “cocktail”: narcotic, depressant, muscle relaxant, or stimulant. Only 1.2 percent of prescriptions written by Respondent were from the category of Other. (The following table does not include refills.)

<u>Drug Category:</u>	<u>#RXs:</u>	<u>% of Total RXs:</u>
Narcotic	38,413	40.0%
Depressant	26,081	27.1%
Muscle Relaxant	18,851	19.6%
Stimulant	11,608	12.1%
Other	1,178	1.2%
Totals:	96,131	100.0%

(e) Hydrocodone, oxycodone and morphine accounted for 96.2 percent of the 38,413 prescriptions written for narcotics. Specifically, 27,301 prescriptions were written

for hydrocodone; 6,279 were written for oxycodone; and, 3,367 were written for morphine.

(f) Alprazolam, diazepam and zolpidem accounted for 93.3 percent of the 26,081 prescriptions written for depressants. Specifically, 18,646 prescriptions were written for alprazolam; 4,312 were written for diazepam; and, 1,308 were written for zolpidem.

(g) Carisoprodol accounted for 100 percent of the prescriptions written for muscle relaxants with a total of 18,851 prescriptions written.

(h) Benzphetamine and phentermine accounted for 90.5 percent of the 11,608 prescriptions written for stimulants. A total of 6,112 prescriptions were written for benzphetamine and 4,395 prescriptions were written for phentermine.

(i) 72.6 percent of Respondent's patients received prescriptions for two or more medications used in a cocktail. Specifically, 384 patients (23.2 percent) received at least one prescription from all four categories: narcotics, depressants, muscle relaxants, and stimulants. Approximately 483 patients (29.1 percent) received at least one prescription from three of the drug categories, and 337 patients (20.3 percent) received prescriptions for two of the drug categories. Only 5.1 percent of Respondent's patients received prescriptions for the category of Other.

(j) The NDIC analysis revealed that there were 48 patients who received 200 or more prescriptions from Respondent during the period from January 1, 2005 through May 31, 2008. The top recipient was Patient S.P. who received 373 prescriptions and who is referred to above in paragraph 4(j).

6. Based upon the above stated facts, the Respondent represents a clear and immediate danger to the public health and safety if allowed to continue to practice as a physician in the State of Indiana.

WHEREFORE, the State of Indiana requests that the Indiana Medical Licensing Board set a hearing on this petition for summary suspension and suspend Respondent's medical license for a period of ninety (90) days and for all other proper relief.

Respectfully submitted,

GREGORY F. ZOELLER
Attorney General of Indiana

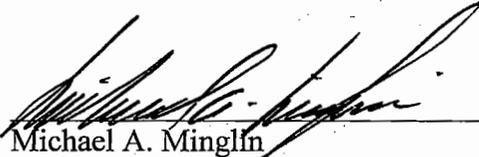
By: 

Michael A. Minglin
Deputy Attorney General
Attorney No. 10029-49

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing "Petition for Summary Suspension" has been served upon the Respondent at the address listed below, by UPS overnight mail, first class postage prepaid, on this 15th day of October, 2009:

Phillip Delano Foley, M.D.
613 N. 10th Street
Middletown, Indiana, 47356



Michael A. Minglin
Deputy Attorney General
Attorney Number: 10029-49

Deputy Attorney General, Michael A. Minglin
Office of the Attorney General
Indiana Government Center South
302 West Washington Street, Fifth Floor
Indianapolis, IN 46204-2770
(317) 232-6256