DOCKET NO. 503-01-2134

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
	§	
THE COMPLAINT AGAINST	§	OF
	§	
DAVID LYMAN BRYSON, M.D.	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

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I. Introduction

The Staff of the Texas State Board of Medical Examiners (Staff) brought this action to revoke the medical license of David L. Bryson, M.D., alleging that between January 1999 and March 2001 Dr. Bryson prescribed scheduled drugs and other medications to patients based solely on internet questionnaires or short telephone consultations. Staff alleges that Dr. Bryson's actions amounted to a failure to practice medicine in an acceptable manner consistent with the public health and welfare. Staff also alleges that Dr. Bryson failed to keep proper patient records and that he paid the Pill Box Pharmacy of San Antonio for referral of patients.

Dr. Bryson admits that he prescribed medications based on telephone interviews, but denies that this was an unacceptable manner of practicing medicine. Dr. Bryson also denies Staff's other allegations, and he contends that Staff's request for permanent revocation of his license is too severe because Staff failed to offer any evidence of patient harm.

The Administrative Law Judge (ALJ) finds that Dr. Bryson prescribed scheduled drugs and controlled substances in a manner that created a substantial risk of harm to his patients and in a manner inconsistent with public health and welfare. Therefore, the ALJ recommends that the Texas State Board of Medical Examiners revoke Dr. Bryson's medical license.

II. Procedural History

February 23, 2001	Staff served a formal complaint on Dr. Bryson, filed the complaint with the State Office of Administrative Hearings (SOAH), and requested a hearing and assignment of an administrative law judge. ALJ Casey Church assigned.
March 7, 2001	Staff filed and served its First Amended Complaint.
April 19, 2001	ALJ Church issued Order No. 2, establishing a prehearing schedule and setting the case for hearing on June 26, 2001.
June 12, 2001	U.S. Drug Enforcement Administration seized Dr. Bryson's medical records.
June 15, 2001	ALJ Church continued hearing on the merits and abated all prehearing deadlines due to seizure of Dr. Bryson's records.
July 30, 2001	Case reassigned to ALJ Thomas H. Walston.
September 26, 2001	ALJ Walston issued Order No. 13, modifying the prehearing

	schedule and setting the case for hearing on January 29, 2002.
October 8, 2001	Hearing rescheduled to February 12, 2002, at the request of Staff.
February 12-13, 2002	Hearing on the merits. Attorney Jean M. DeLoach represented the State Board of Medical Examiners. Dr. Bryson appeared *pro se*.
April 1, 2002	Staff and Dr. Bryson filed written closing arguments.
April 15, 2002	Staff and Dr. Bryson filed responses to closing arguments and the hearing record closed.
May 17, 2002	Proposal for Decision issued.

III. DISCUSSION

A. Overview

(1) Background:

Dr. David Bryson resides in Kerrville, Texas, and currently holds Texas Medical License No. E7013. Beginning in January 1987, Dr. Bryson worked as a staff physician at the State MHMR hospital in Kerrville, but that employment terminated in July 1998. In January 1999, Dr. Bryson began working with the Pill Box Pharmacy in San Antonio. At first, Dr. Bryson issued prescriptions (to be filled by the Pill Box) based on customer answers to questionnaires submitted over the internet. Most of these prescriptions were for unscheduled drugs such as Viagra, Propecia, and Claratin.

As 1999 progressed, Dr. Bryson gradually began to handle customers by telephone interviews rather than by internet questionnaire. This enabled him to prescribe a wider variety of drugs to be filled by the Pill Box, including scheduled drugs. In December 1999, the Texas Board of Medical Examiners issued a policy that prohibited physicians from prescribing drugs based solely on internet questionnaires, and thereafter Dr. Bryson conducted all of his consultations by telephone. Using these internet and telephone procedures, Dr. Bryson handled more than 10,000 patients during both 1999 and 2000, for a grand total of more than 20,000 patients.

During 1999, patients who received a prescription from Dr. Bryson paid (via their credit card) an $85.00 consultation fee in addition to the charges for drugs and shipping. The Pill Box handled all billings and disbursements because Dr. Bryson did not have the ability to process credit card transactions. For internet-only consultations, Dr. Bryson received $25.00 and the Pill Box kept $60.00; for telephone consultations, Dr. Bryson received $50.00 and the Pill Box kept $35.00. Beginning in 2000, the Pill Box increased the consultation fee to $100.00 because Dr. Bryson then consulted with all patients by telephone. Of this amount, Dr. Bryson received $50.00 and the Pill Box kept $50.00. During the time Dr. Bryson worked with the Pill Box, he received total compensation as follows: 1999 - $284,700.00; 2000 - $565,740.00; and 2001 - $87,450.00.

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On January 22, 2001, the Board convened a three-member disciplinary panel to consider Staff's Application for the Temporary Suspension of Dr. Bryson's medical license based on the same issues involved in this case. The panel found that Dr. Bryson's continued practice of medicine presented a continuing threat to the public welfare and ordered his license suspended immediately. Shortly thereafter, Dr. Bryson obtained temporary restraining orders from two different courts to prevent the Board from suspending his license, but the courts later dissolved both temporary restraining orders and Dr. Bryson has not practiced medicine since late February 2001.

(2) First Amended Complaint:

On March 7, 2001, Staff filed a First Amended Complaint, alleging three Counts on which Staff went to hearing. Count One alleges that during 1999 Dr. Bryson prescribed scheduled drugs and other medications, to be filled by the Pill Box Pharmacy, based on internet questionnaires and without ever speaking to the patient or performing any type of physical assessment.

Count Two alleges that after December 1999 and through February 1, 2001, patients contacted a representative of the Pill Box via the internet. The Pill Box would refer the patient to a scheduler, who then set a ten-minute appointment for the patient to call Dr. Bryson for a telephone consultation. Count Two also alleges that Dr. Bryson received patient referrals from internet chat rooms and other sources, and that he handled an average of fifty consultations per day. Finally, Count Two alleges that the Pill Box collected the consultation fees, forwarded $50.00 per telephone consultation to Dr. Bryson, and kept the balance for administrative costs and other expenses. However, patients paid a consultation fee only if Dr. Bryson wrote them a prescription.

Count Three alleges that Dr. Bryson prescribed controlled substances and dangerous drugs to hundreds of patients in Texas (via the internet and by telephone interviews) without establishing a proper physician-patient relationship. Staff alleges that Dr. Bryson prescribed medications without obtaining a thorough patient history, without obtaining patient medical records from treating physicians, without performing a mental and physical exam, without using appropriate diagnostic or laboratory testing, and without providing a means to monitor medication response to determine either adverse or beneficial outcomes.

Based on these three counts, Staff alleged that Dr. Bryson violated various statutes, Board rules, and published Board policies as follows:

- Failing to practice medicine in an acceptable manner consistent with the public health and welfare (TEX. OCC. CODE § 164.051(a)(6));
- Engaging in unprofessional conduct that is likely to deceive or defraud the public or injure the public (TEX. OCC. CODE §§ 164.051(a)(1) & 164.052(a)(5));
- Prescribing drugs that are nontherapeutic in nature or nontherapeutic in the manner the drug is prescribed (TEX. OCC. CODE §§ 164.052(a)(5) & 164.053(a)(5));
- Prescribing dangerous drugs and controlled substances in a manner inconsistent with the public health and welfare (TEX. OCC. CODE § 164.053(a)(6));
- Prescribing dangerous drugs and controlled substances without establishing a proper

physician-patient relationship (BME Internet Prescribing Policy);

- Paying the Pill Box Pharmacy for securing patients (TEX. OCC. CODE § 165.155(a)) ;
- Receiving payments from the Pill Box Pharmacy for securing customers for the pharmacy (TEX. OCC. CODE § 102.001) ;
- Failing to maintain adequate patient records (22 TEX. ADMIN. CODE (TAC) § 165.1); and
- Failing to follow Board guidelines for treatment of intractable pain (22 TAC § 170.3).

B. Witnesses and Documentary Evidence

(1) Ms. Becky Nichols, R.N.

Ms. Becky Nichols has been a Registered Nurse since 1977 and she has worked as an investigator for the Board of Medical Examiners (BME) for the past 15 years.[1] For this case, Ms. Nichols studied and prepared a summary of prescriptions issued by Dr. Bryson for the period February 2, 2001, through February 27, 2001.[2] During this one-month period, Dr. Bryson issued 4,709 prescriptions (1,150 new prescriptions; 3,559 refills) involving 63 different drugs and a total of 388,372 units (pills). All of the prescribed medications were either Schedule III, IV, or unscheduled drugs.[3] Hydrocodone was the most frequently prescribed drug, accounting for 2,920 prescriptions (62% of the total) and 273,780 units. Hydrocodone is a Schedule III narcotic for pain relief. The other most frequently prescribed drugs were diazepam (Valium, anti-anxiety) – 767 prescriptions (16%) and 42,060 units; alprazolam (Xanax, anti-anxiety) – 265 prescriptions (6%) and 18,470 units; and carisprodol (Soma, muscle relaxant) – 183 prescriptions (4%) and 15,360 units. These four drugs comprised 88% of the prescriptions issued by Dr. Bryson during February 2001.

On cross-examination, Ms. Nichols stated that she only knew that Dr. Bryson prescribed these drugs. She could not state whether these drugs were prescribed based on internet questionnaires or telephone consultations, or whether any drugs were improperly prescribed.[4]

(2) David Lyman Bryson, M.D.

Staff called Dr. Bryson as an adverse witness. He is a 64-year old physician who lives in Kerrville, Texas.[5] Dr. Bryson graduated from Yale Medical School in 1963 and completed an

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[1] Tr. 29.

[2] Tr. 30. The actual records reviewed by Ms. Nichols total 686 pages, contained in Ex. BME-37. Ms. Nichols summary is Ex. BME-36.

[3] Generally speaking, Schedule I and II drugs are considered the most dangerous; Schedule III and IV drugs are less dangerous; and unscheduled drugs are the least dangerous.

[4] Tr. 42-43.

[5] Tr. 45.

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internship at Lincoln Hospital in Bronx, New York, during 1971-72. He has not participated in residency or fellowship training and is not board certified in any field.[6] During 1995 Dr. Bryson was treated for alcohol dependency, but he has never been diagnosed with mental illness or depression. BME issued Texas Medical License No. E7013 to Dr. Bryson on December 8, 1976, through endorsement with New Mexico. BME suspended Dr. Bryson's license on January 22, 2001, in connection with the issues involved in this case.[7]

Between 1963 and 1982, Dr. Bryson worked at a variety of jobs, most frequently in Albuquerque, New Mexico, but also in New York City; Washington, D.C.; Bethesda, Maryland; Longmont and Crestone, Colorado; and other locations. Dr. Bryson's longest period of employment was for the Texas Department of Mental Health and Mental Retardation (MHMR). He worked as a staff physician at the MHMR hospital in Mexia, from February 1982 through December 1986. This facility provides long term care to severely mentally retarded patients. From January 1987 through July 1998, Dr. Bryson worked as a staff physician at the MHMR hospital in Kerrville. This facility primarily treats patients with psychiatric problems. Dr. Bryson also worked as a visiting physician at the Kerr County Jail from June 1991 through May 1995.[8]

At the MHMR hospital in Mexia, Dr. Bryson was the sole doctor for 250 female mentally retarded patients. He made rounds, had conferences, performed physical exams, and generally saw patients as their personal physician. He treated these patients for a wide variety of problems and it was not uncommon to prescribe controlled substances. When examining a patient at Mexia, Dr. Bryson would typically look into the patient's eyes, ears, nose, and mouth; feel glands in the neck; listen to their heart and lungs; feel the abdomen and palpate the liver; and check peripheral pulses, reflexes, and range of motion. But he did not have verbal interaction with these patients due to their mental retardation.[9]

In late 1998, after his employment terminated at the Kerrville State Hospital, Dr. Bryson read an article in a San Antonio newspaper about Mr. William Stallknecht, the owner of Pill Box Pharmacy. In the article Mr. Stallknecht described his internet prescription procedures for a few drugs such as Viagra and Claratin,[10] and he expressed a "Libertarian philosophy" that adults should be able to obtain whatever medications or drugs they desired. Dr. Bryson agreed with this philosophy,[11] so he called Mr. Stallknecht to discuss working with the Pill Box Pharmacy.

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[6] Tr. 50; Ex. BME-40.

[7] Tr. 47.

[8] Ex. BME-40.

[9] Tr. 52-58.

[10] It is not clear whether these drugs were dispensed with or without a doctor consultation.

[11] Ex. BME-33 (Dr. Bryson's 9/30/99 deposition at p. 66, attached to Ex. BME-33 as Ex. Board-6).

Mr. Stallknecht was interested in having Dr. Bryson conduct patient consultations in order to provide a larger variety of medications over the internet, and they struck a deal. Initially, Dr. Bryson reviewed internet consultation questionnaires and took telephone calls in San Antonio at the Pill Box Pharmacy. This lasted about six weeks until Dr. Bryson set up an office in his home in Kerrville.[12]

Dr. Bryson estimated that he wrote prescriptions for over 10,000 patients during both 1999 and 2000, for a total of more than 20,000 patients.[13] During 1999, each patient paid an $85.00 consultation fee by credit card for an internet questionnaire consultation. In theory, the patient paid this consultation fee to Dr. Bryson, but it was actually collected by the Pill Box Pharmacy. The Pill Box kept $60.00 and paid the $25.00 balance to Dr. Bryson. Each patient also paid an additional amount to the Pill Box for the prescribed drugs and for shipping. Dr. Bryson also began telephone consultations during 1999, and as the year progressed he had more telephone consultations and fewer internet-questionnaire consultations. For telephone consultations, Dr. Bryson received $50.00 of the $85.00. Beginning January 2000, Dr. Bryson ceased internet-questionnaire consultations and all patients had telephone consultations. The total consultation fee was increased to $100.00, although Dr. Bryson continued to receive only $50.00. For all cases – internet questionnaires and telephone consultations – Dr. Bryson did not receive any compensation if he did not write a prescription.[14] An IRS Form 1099 from shows that Dr. Bryson received $284,700.00 from the Pill Box during 1999.[15]

Dr. Bryson conceded that he never performed physical examinations on patients he handled through the internet or by telephone.[16] He also never ordered X-rays, CT scans, MRIs, or any other type of diagnostic imaging; nor did he order urinalyses, CBCs, or blood chemistries, although he may have suggested these to a few patients.[17] In addition, Dr. Bryson never obtained medical records from a patient's prior or current doctor,[18] never called a patient's doctor,[19] and never sent his

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[12] Dr. Bryson usually worked at his home office from 9:00 a.m. - 1:30 p.m., Monday through Friday, and 9:00 a.m. - 1:00 p.m. on Saturday. Other doctors worked for Pill Box during evening hours. Tr. 88-89.

[13] Tr. 73-74.

[14] Dr. Bryson also handled about 50 "charity patients" for whom he waived his fee. Tr. 81.

[15] Tr. 70.

[16] Tr. 75. Dr. Bryson did meet face-to-face with about 10 patients during 1999-2001, but none of these received a complete physical examination. Although the testimony was not entirely clear, it appears that these patients were not telephone or internet patients, but were acquaintances in Kerrville and one patient that Dr. Bryson met at the Pill Box Pharmacy in San Antonio.

[17] Tr. 98-100.

[18] However, about 24 patients did mail or fax copies of their records to Dr. Bryson.

[19] Dr. Bryson did recall that doctors for two AIDs patients called him.

records to a patient's doctor (although Dr. Bryson added that no doctor ever requested his records).[20] Dr. Bryson testified that he received two or three calls per month from patient family members stating that the patient was abusing drugs. When he received this type of information from a reputable source, he immediately canceled the patient's prescriptions.[21]

Dr. Bryson denies that the twelve sets of medical records introduced into evidence by BME Staff provide an accurate sample of his patients or his record keeping. He states that his record keeping improved during 2000 when he started using a form with a checklist for previous illness, allergies, etc.[22] He estimates that he treated 50% of his patients for chronic pain, primarily with hydrocodone, and that he treated about 25% of his patients for anxiety, primarily with Valium and Xanax.[23]

After Staff initiated disciplinary action against Dr. Bryson, some of his patients established a legal defense fund. Several thousand dollars from this fund were used to pay a portion of Dr. Bryson's legal expenses. In addition, Dr. Bryson's prior attorney was on a retainer with Mr. William Stallknecht and worked for Dr. Bryson at Mr. Stallknecht's direction.[24]

Finally, Dr. Bryson maintains that Staff has shown no harm to any patient. Although patient JA died from a drug overdose, Dr. Bryson states that a toxicology report showed positive for two benzodiazepines and oxycodone but not for hydrocodone, which is the drug Dr. Bryson prescribed. Therefore, Dr. Bryson contends that JA did not die from any prescription issued by him.[25] On cross examination, however, Dr. Bryson agreed that hydrocodone is an opioid and that the toxicology report also showed "indicative" for "common opioids."[26]

(3) Patient Records

BME Staff introduced twelve sets of Dr. Bryson's patient records into evidence and questioned him about these records. Most contain only one page of sparse notes by Dr. Bryson. A few also have a summary of prescriptions prepared by the Pill Box.

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[20] Tr. 93-94.

[21] Tr. 266.

[22] Tr. 260.

[23] Tr. 261-262.

[24] Tr. 267-268.

[25] Tr. 279-281.

[26] Tr. 285-286.

JA: The record for patient JA shows a diagnosis of "pharyngitis & hacking cough" but contains no other medical information. On the date of the consultation (November 4, 1999), JA was a 41-year-old male from Kennesaw, Georgia. Dr. Bryson diagnosed pharyngitis and prescribed Tussionex based on the sound of JA's voice.[27] Tussionex is a controlled substance that contains hydrocodone.

On November 21, 1999, JA died from a drug overdose. The drug screen contained in JA's autopsy showed positive for oxycodone, which Dr. Bryson stated is a different drug than hydrocodone. In addition, the autopsy report stated that police found an envelope of drugs from a Mexican pharmacy near JA's body.[28] In Dr. Bryson's opinion, this information showed that JA died from an overdose of drugs obtained from sources other than himself or the Pill Box Pharmacy.

JB: The record on JB merely shows "MVA —> LBP / GAD."[29] These notes stand for motor vehicle accident, low back pain, generalized anxiety disorder.[30] Dr. Bryson made this entry based on his telephone conversation with JB, a 21-year-old male from Mobile, Alabama. Dr. Bryson prescribed hydrocodone and alprazolam (Xanax). Between July 28, 2000, and October 19, 2000, the prescriptions and refills amounted to 400 Xanax and 360 hydrocodone.

LB: The totality of medical information contained in LB's record is "TMJ, pain meds, Al-codeine."[31] TMJ stands for temporal-mandibular joint, and these notes were based on a telephone consultation with LB, a 28-year-old female from Childersburg, Alabama. On August 17, 1999, Dr. Bryson prescribed "ES Hydrocodone/Apap and Cyclobenzaprine." Pharmacy records show that between August 17, 1999, and February 16, 2000, LB obtained 740 hydrocodone and 240 Cyclobenzaprine.

VB: VB, a 46-year-old female from Monmouth Junction, New Jersey, was an internet-only patient. She indicated on her questionnaire that she was taking Coumadin for clogged arteries.[32] Based on VB's request, Dr. Bryson prescribed 30 Xenecal, 120 mg. Xenecal is a fat blocker, but the Physician's Desk Reference (PDR) states that it can be contraindicated for Coumadin, which VB was

[27] Tr. 106. JA's record is Ex. BME-13.

[28] The autopsy report is Ex. BME-41.

[29] JB's record is Ex. BME-14.

[30] Tr. 108.

[31] LB's record is Ex. BME-15.

[32] VB's record is Ex. BME-16.

also taking. Dr. Bryson stated that he did not believe his prescription posed a risk because he only prescribed 30 pills with no refills.[33]

RC: The diagnosis in RC's record merely states "back pain." It does not indicate what level of the back was painful, i.e., the cervical, thoracic, or lumbar spine.[34] Dr. Bryson agreed that this description was inadequate and was an oversight on his part.[35] RC, a 39-year-old male from Elmira, New York, first contacted Dr. Bryson on January 17, 2000. Dr. Bryson prescribed hydrocodone (pain medication), diazepam (Valium - anti anxiety), and Carisoprodol (Soma - muscle relaxant). Dr. Bryson agreed that these drugs potentiate each other, but stated that he prescribed low-level doses because of this. Between January 17, 2000, and September 6, 2000, RL received 850 hydrocodone, 330 Valium, and 500 Soma.[36]

DF: DF was a 29-year-old female from San Antonio, Texas. Her record did not state any diagnosis,[37] although at hearing Dr. Bryson said DF was moderately obese because the record shows a height of 5'1" and a weight of 141 lbs.[38] Dr. Bryson prescribed 30 phentermine (amphetamine-type drug) with five refills. The prescription called for DF to take one pill per day, so the prescription and refills should have lasted four months. Dr. Bryson had no knowledge of whether DF lost weight or whether the drug was effective.[39]

EH: The one-page record for EH gives only her birth date, sex, height, weight, and a notation of no known allergies. No complaints or diagnoses are stated on DH's record.[40] She was a 39-year-old female from Roslindale, Massachusetts, and on August 6, 1999, Dr. Bryson prescribed her 90 Vicodin (hydrocodone) with three refills.

PH: PH was a 43-year-old male from Powder Springs, Georgia. His record dated August 3, 1999, includes only his birth date, sex, height, and weight. On that date Dr. Bryson diagnosed PH with "GAD" (general anxiety disorder) and prescribed 30 alprazolam (Xanax), with three refills.[41]

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[33] Tr. 114.

[34] RL's record is located at Ex. BME-17.

[35] Tr. 115.

[36] Ex. BME-17.

[37] DF's record is located at Ex. BME-18.

[38] Tr. 123.

[39] Tr. 124.

[40] EH's record is located at Ex. BME-19.

[41] PH's record is located at EX. BME-20.

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Concerning the GAD diagnosis, Dr. Bryson testified that "it's a diagnosis that I used rather freely for stress in life, the bumps . . . in the road of life. . . . It's stress. Another word for it is stress."[42]

Dr. Bryson wrote a second note in PH's record on August 26, 1999. It does not contain any information except PH's name, phone number, and a notation of an additional prescription for 60 hydrocodone and 30 alprazolam, both with three refills. The record contains no diagnosis to explain the hydrocodone prescription and Dr. Bryson had no independent recollection of it.[43]

A third note from the record dated January 14, 2000, also contains no information except for another prescription; this time for 100 hydrocodone and 60 alprazolam, both with three refills, and a notation to cancel the prior prescriptions of August 26, 1999. The record contains no information on why the doses were increased and Dr. Bryson had no independent recollection.[44]

Finally, PH's record contains a summary of prescriptions from the Pill Box Pharmacy, which shows that between August 4, 1999, and March 7, 2000, PH received 600 alprazolam and 380 hydrocodone. Dr. Bryson agreed that alprazolam can be an addictive drug.[45]

WH: WH was a 47-year-old male from Orange, California. His one-page medical record dated August 6, 1999, shows only his birth date, sex, height, weight, and the drug prescribed by Dr. Bryson.[46] This record contains no information about symptoms, complaints, or diagnosis. Dr. Bryson prescribed 90 diazepam (Valium), 5 mg, with three refills. The pharmacy record shows two refills of 90 diazepam, *10* mg, but there is nothing in the record to explain this increase in strength.

CK: CK was a 48-year-old male from Chicago Heights, Illinois. For CK, Dr. Bryson had four notes dated July 28, August 2, and September 1, 1999, and January 10, 2000.[47] On July 28, Dr. Bryson noted that CK complained of "MS pain," which stands for musculoskeletal pain, but the record does not state where the pain occurred. There is no other medical information on this record. Dr. Bryson prescribed 60 Vicodin (hydrocodone), 7.5 mg, with three refills.

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[42] Tr. 134-35.

[43] Tr. 144.

[44] Tr. 145.

[45] Tr. 135.

[46] WH's record is located at Ex. BME-21.

[47] CK's records are located at Ex. BME-22.

The August 2 note shows only that Dr. Bryson issued a prescription for 30 Ambien (for insomnia), 10 mg, with two refills. This note contains no medical information except: "recently ordered Vicodin."

The September 1 note contains no medical information but states that CK was getting an early refill of hydrocodone, this time for 90 tablets with three refills. The record contains no information about CK's complaints at that time or why the early refill was requested. The record also does not show a cancellation of the prior hydrocodone prescription, although Dr. Bryson testified that by changing the prescription "there was an implication to the pharmacy" to cancel the earlier prescription.[48] But pharmacy records show that CK actually continued to obtain refills for both the original July 28 hydrocodone prescription and the September 1 prescription.[49]

On January 10, 2000, Dr. Bryson noted: "renewal for back pain & insomnia." But this time the quantity was increased to 100 tablets with three refills, and a prescription was added for 30 diazepam (Valium), 10 mg, with three refills. Dr. Bryson conceded at hearing that "there's nothing in the record that indicates a rationale for prescribing diazepam."[50]

Pharmacy records show that between August 12, 1999, and March 2, 2000, CK filled 18 prescriptions for 1,060 hydrocodone, 60 Ambien, and 120 diazepam. Dr. Bryson agreed that the prescription history for CK is highly suspicious for drug abuse.[51]

DL: DL was a 29-year-old male from Winchester, Virginia. A one-page medical record dated February 19, 2000, simply states: "anxiety – wants to resume Alprazolam." No other medical information is included in the record.[52] Based on this request, Dr. Bryson prescribed 60 alprazolam (Xanax), 2 mg, with three refills. The records also contain a note by Dr. Bryson which states:

> On 23 Feb 2000 Mr. L—'s sister called me & said he had taken about 15 of his rx very shortly after receiving it. I immediately called the Pill Box & canceled his refills as I always do if there is credible evidence of misuse of the meds.

DR: DR was a 42-year-old female from Anaheim, California. Her one-page medical record lists her birth date, sex, height, and weight, but it contains no medical information – in

[48] Tr. 241.

[49] Ex. BME-22.

[50] Tr. 239.

[51] Tr. 255.

[52] DL's record is located at Ex. BME-23.

particular, no record of symptoms, complaints, or diagnosis.[53] On June 30, 1999, Dr. Bryson prescribed DR 90 Tylenol with codeine, with three refills. Pharmacy records show that between June 30, 1999, and February 14, 2000, DR obtained 560 Tylenol with codeine.

(4) William A. Stallnecht

Mr. William Stallnecht is the owner of the Pill Box Pharmacy. Staff called Mr. Stallnecht as a witness, but he asserted his Fifth Amendment privilege against self-incrimination and refused to answer any questions or provide any testimony.[54]

However, on May 24, 2001, Staff took Mr. Stallnecht's deposition, and the deposition was admitted into evidence.[55] In the deposition, Mr. Stallnecht testified that he is a licensed Texas pharmacist who owns two pharmacies called The Pill Box located next to each other on Fredericksburg Road in San Antonio. One of the pharmacies is a retail location and the other is a mail-order location. Mr. Stallnecht also owns a company called Physician Referral 2000, which he described as a physician referral group. Prior to December 1999, he also worked with Medicalcenter.net, by which the Pill Box pharmacy dispensed drugs based on a physician's review of a patient's answers to an internet questionnaire.[56]

Mr. Stallnecht recalled that he began his association with Dr. Bryson around January 1999, but they never entered a written agreement. Other doctors also worked as consultants for the Pill Box.[57] The Pill Box did not refer patients directly to Dr. Bryson. Instead, calls or internet inquiries were referred to a Mr. Brian Hildebrand, who worked as a scheduler. Mr. Hildebrand would then refer the customer to either Dr. Bryson or another consulting doctor, and the doctor would issue a prescription to be filled by the Pill Box. Mr. Stallnecht estimated that Dr. Bryson issued 30-50% of all Pill Box internet- and telephone-consultation prescriptions.[58]

Mr. Stallnecht testified that Dr. Bryson usually sent his prescriptions to the Pill Box by fax.[59] All payments were made by credit card to the Pill Box, which divided the payments between the Pill

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[53] DR's record is located at Ex. BME-24.

[54] Tr. 184-186.

[55] Ex. BME-35.

[56] Ex. BME-35, at 7-9. Mr. Stallnecht's brother-in-law owned and operated Medicalcenter.net.

[57] Ex. BME-35, at 10-11.

[58] Ex. BME-35, at 64.

[59] Ex. BME-35, at 33.

Box, the consulting doctor, Medicalcenter.net, and Mr. Hildebrand.[60] Mr. Stallnecht paid all expenses in connection with credit card processing and bank fees.[61] He considered this simply to be a service he provided to Dr. Bryson.[62] Mr. Stallnecht did not consider Dr. Bryson as his employee at anytime.[63] In his view, Dr. Bryson worked as an independent contractor. During 1999, 2000, and 2001, Mr. Stallnecht paid Dr. Bryson $284,700.00, $565,740.00, and $87,450.00 respectively.[64] Finally, Mr. Stallnecht testified that attorney Charles King was on a retainer for the Pill Box, and Mr. King assisted Dr. Bryson at Mr. Stallnecht's direction.

(5) Jerry Michael Stanton, D.O.

Staff called Dr. Michael Stanton as an expert witness. Dr. Stanton is an anesthesiologist who is Board Certified in anesthesiology and in the sub-specialty of pain management. He graduated in 1977 from the University of Health Sciences in Kansas City, Missouri, and has practiced medicine in the Dallas-Ft. Worth mid-cities area since 1983. Dr. Stanton estimates that 90% of his practice has been pain management for the past fifteen years. He has been a consultant for BME for about six years and has testified in other disciplinary proceedings.[65]

Dr. Stanton accepts patients only by referral from other doctors. In order to establish a proper physician-patient relationship, he obtains all medical records from the referring physician, including radiology and lab reports; obtains a complete history, including symptoms, social history, and psychological history; and performs a complete physical exam, emphasizing the area of complaint. And in order to properly diagnose and treat a patient, Dr. Stanton usually orders additional diagnostic testing.[66] He also discusses treatment options with the patient and explains risks associated with the proposed course of treatment.

Dr. Stanton also testified that it is important to follow patients by physically seeing and evaluating them after medication and treatment have begun. His follow-up evaluation for patients taking pain medication uses the "Four-A" system: Assess the patient, check for Addiction, Activities

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[60] Ex. BME-35, at 21-23.

[61] Ex. BME-35, at 28-29.

[62] Ex. BME-35, at 34.

[63] Ex. BME-35, at 42.

[64] Ex. BME-35, at 44-45 & 48. Also see Board Ex. 6 attached to Ex. BME-35. At some point (when is not clear from the record) Dr. Bryson went through personal bankruptcy. Therefore, during the years 2000 and 2001, most of the payments for Dr. Bryson actually went to the trustee of his bankruptcy estate.

[65] Tr. 148-150.

[66] Tr. 152.

of daily living, and Adverse effects of medications. Dr. Stanton generally requires patients who take controlled-substance pain medications to return at one- to two-week intervals until they are regulated on their medications. Then they return every three months. Dr. Stanton also stated that he sends copies of his reports to the patient's primary treating physician to advise of the treatment and status of the patient.[67]

Dr. Stanton reviewed the records of Dr. Bryson that were entered into evidence (Exhibits BME-13 – BME-24). He criticized the records for lacking appropriate patient histories and medical records from other doctors. Dr. Stanton also stated that it is important for a doctor to see a patient face-to-face in order to perform an adequate physical examination.[68]

Concerning Dr. Bryson's record on patient JB, which merely showed "MVA —> LBP / GAD,"[69] Dr. Stanton said that he would not prescribe pain medication without more information. In his opinion, "low back pain" is merely a symptom, not a diagnosis, and he noted that low back pain can have many causes, including metastatic bone disease. Dr. Stanton also said he would not prescribe medications based solely on a patient's statement that she had TMJ, as Dr. Bryson did with patient LB.[70] Likewise, Dr. Stanton reviewed records for patients VB, RC, DF, EH, PH, WH, CK, and DL,[71] and in his opinion, Dr. Bryson lacked adequate information in all of these cases to formulate a diagnosis and treatment plan or to prescribe scheduled drugs.[72]

Dr. Stanton also testified that a physician should never prescribe Viagra to a patient that he had not even talked to, as Dr. Bryson did with many internet-questionnaire customers. He also criticized Dr. Bryson for not having any clinical follow-up with his patients, not obtaining other medical records, not ordering a CBC or blood chemistries, not ordering tests for hepatic or renal function, and not ordering any radiological diagnostic imaging, especially since Dr. Bryson had no relationship with the patients' primary care physicians who may have ordered these tests.[73]

Based on the records he reviewed, Dr. Stanton stated his opinion that Dr. Bryson failed to practice medicine within the standard of care established by the BME and by the Texas Medical Practice Act, TEX. OCC. CODE §§ 164.051(a)(6) and 164.052(a)(5). Dr. Stanton also testified that

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[67] Tr. 153-154.

[68] Tr. 155-156; Ex. BME-15.

[69] Ex. BME-14.

[70] Tr. 156.

[71] Exs. BME-16 – BME-23.

[72] Tr. 157-165.

[73] Tr. 164-167.

Dr. Bryson committed prohibited acts by prescribing drugs that were not therapeutic as prescribed; by prescribing dangerous drugs and controlled substances in a manner inconsistent with the public health and welfare; by prescribing dangerous drugs and controlled substances to internet-questionnaire customers without establishing a proper physician/patient relationship; by failing to maintain adequate medical records for his patients; by failing to follow BME guidelines for the treatment of intractable pain; by failing to exercise sound medical judgment; and by splitting his consultation fee with the Pill Box Pharmacy.[74]

On cross-examination, Dr. Stanton stated that he had no knowledge whether Dr. Bryson had been sued for malpractice. And he agreed that he had no knowledge of patient harm caused by Dr. Bryson, and that there is no evidence on whether Dr. Bryson's patients were merely seeking drugs. Dr. Stanton also testified that the drug OxyContin has caused the most deaths in connection with treatment of chronic pain, even though those patients had face-to-face consultations with a physician. He added, however, that OxyContin deaths usually resulted from abuse of the drug and that face-to-face consultations prevent many additional deaths.

Finally, Dr. Stanton agreed that a doctor is not always required to obtain medical records from a patient's primary treating physician, such as when a patient goes to a walk-in clinic for temporary treatment of acute pain. But Dr. Stanton distinguished that situation from Dr. Bryson's practice of prescribing drugs to patients for chronic pain for several months.[75]

(6) Judy Forgason, M.D.

Staff also called Dr. Judy Forgason as an expert witness. Dr. Forgason practices outpatient psychiatry in Austin, Texas. She received her medical degree in 1982 from the University of Texas Medical Branch in Houston, and she has been Board Certified in Psychiatry and Neurology since 1988. Dr. Forgason has worked as a consultant for BME for eight years and has testified for BME in other enforcement proceedings.

In her practice, Dr. Forgason schedules a new patient for a one-hour interview. Before the first visit, the patient fills out a form with background information and a symptom checklist. Then during the initial interview Dr. Forgason obtains a current history, past medical and psychiatric history, social history, and family history; she formulates an assessment and a treatment plan; and she discusses follow-up care with the patient. Also, Dr. Forgason frequently obtains a patient's medical records and lab reports, contacts the patient's primary treating physician, and orders lab tests when a medication that she prescribes may cause serious adverse side effects.[76]

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[74] Tr. 167-172.

[75] Tr. 173-182.

[76] Tr. 200-202.

Prior to the hearing, Dr. Forgason reviewed Dr. Bryson's patient records that were admitted into evidence.[77] In her opinion, the records show that Dr. Bryson did not formulate any treatment plan other than a drug prescription, and they show that Dr. Bryson did not make any arrangements for clinical follow-up or assessment of treatment.[78]

As a psychiatrist, Dr. Forgason frequently prescribes benzodiazepine drugs such as Valium and Xanax. She stated that dangers associated with long-term administration of these drugs include habituation, addiction, and possible grand mal seizures during acute withdrawal. Depending on the patient, psychological dependency on these drugs can occur after only four months of continuous use. The prescribing physician needs to monitor this risk and gradually taper a patient off the medication when dependency occurs. Dr. Forgason stated that it can be very difficult to wean a patient off Xanax. Therefore, she tries to prescribe non-benzodiazepine antidepressant drugs for ongoing treatment of general daily stresses. Occasionally, however, some patients will need ongoing treatment with a benzodiazepine drug for acute panic disorders.[79]

Dr. Forgason testified that she would never prescribe a drug such as Valium or Xanax based solely on a telephone conversation with a patient, and especially not a prescription that would last four months. She stated that Dr. Bryson's records show that he did not obtain sufficient patient information and did not perform physical exams in order to formulate a diagnosis or treatment plan. Dr. Forgason also stated that Dr. Bryson did not demonstrate any plan for clinical follow-up for his patients.[80]

Dr. Forgason stated that in a physician-patient relationship, the physician is responsible for conducting a proper assessment, making a diagnosis, assessing for undiagnosed medical conditions, selecting medications, selecting dosage, and monitoring for possible drug abuse. In her opinion, Dr. Bryson failed to properly meet his responsibilities and she believes that Dr. Bryson's continuation in the practice of medicine creates a danger or threat to the general public.[81]

Based on Dr. Bryson's statements that he prescribed drugs for more than 20,000 patients during 1999 and 2000, and based on Staff's summary of drugs prescribed by Dr. Bryson during February 2001,[82] Dr. Forgason rendered an opinion that Dr. Bryson's medical practice did not meet

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[77] These patient records are Exs. BME-13 – BME-24.

[78] Tr. 203-204.

[79] Tr. 205-206.

[80] Tr. 208-210.

[81] Tr. 210-212.

[82] Ex. BME-36.

acceptable standards of care. She added that she has never seen such a large quantity of drugs prescribed by a single doctor, and that Dr. Bryson's actions sully all physicians and are an embarrassment to the profession.[83]

Dr. Forgason further testified that Dr. Bryson committed unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure the public; prescribed drugs that were non-therapeutic in the manner the drug was prescribed; prescribed dangerous drugs and controlled substances in a manner inconsistent with the public health and welfare; prescribed drugs without establishing a proper physician/patient relationship; failed to maintain adequate medical records for each patient; failed to exercise sound medical judgment in treating pain and related symptoms with dangerous drugs and controlled substances; and improperly paid the Pill Box Pharmacy for securing or soliciting patients.[84]

On cross-examination, Dr. Forgason stated that she had no knowledge of any patients harmed by Dr. Bryson, except that one family member complained that a patient was misusing drugs. However, she did not find the lack of complaints surprising because, in her opinion, patients who are abusing drugs will not complain when they get the drugs they want.[85]

Dr. Forgason also agreed that e-mail could be a valid method for patients and a physician to communicate, but only when a valid physician/patient relationship has already been established. She also agreed that a physician who is "on call" over a weekend can prescribe medications after only a telephone conversation with another doctor's patient. But she emphasized that in those circumstances the on-call doctor has a professional relationship with the doctor for whom she is on call, the patient has an established relationship with the other physician, and the on-call doctor will usually prescribe only a small amount of medicine to cover the patient until he can see his regular treating physician.[86]

(7) Letters of Recommendation:

Exhibit BME-33 is the transcript and exhibits from Dr. Bryson's Temporary Suspension hearing held on January 22, 2001. Board Exhibit 27 from that hearing (contained in Exhibit BME-33 for this hearing) contains 14 supportive letters (via e-mail) dated August through December 2000 from patients of Dr. Bryson. Most describe Dr. Bryson as a kind and caring physician, state that his consultations and treatment with medication greatly improved their condition, and state that his

[83] Tr. 213-215.

[84] Tr. 217-221.

[85] Tr. 222-223.

[86] Tr. 224-226.

method of practice was convenient. Several also report that their prior doctors provided inadequate treatment for pain and they had difficulty arranging convenient appointments.

C. Arguments of the Parties

(1) Staff:

Staff divided its argument into three parts: (1) allegations concerning failure to practice medicine in an acceptable professional manner and committing unprofessional conduct likely to deceive or injure the public; (2) allegations concerning failure to maintain adequate patient records; and (3) allegations concerning improper payments for securing patients.

Unprofessional Conduct: Concerning the unprofessional-conduct and unacceptable-practice-of-medicine allegations, Staff argues that Dr. Bryson prescribed massive amounts of controlled substances and dangerous drugs without first establishing a proper physician-patient relationship. Staff emphasizes that Dr. Bryson did not establish a proper medical diagnosis because he did not obtain a complete medical history, did not perform a mental status exam or physical exam, and did not order appropriate diagnostic testing. Indeed, Staff states, Dr. Bryson did not perform the most basic assessment of weighing patients or taking blood pressure, even though some of the drugs he prescribed were contraindicated for high blood pressure and heart disease. Staff also contrasts Dr. Bryson's practices with those of Dr. Stanton and Dr. Forgason and notes that both Dr. Stanton and Dr. Forgason testified that Dr. Bryson's practices fell below acceptable standards of care and endangered his patients. In Staff's view, Dr. Bryson offered no evidence to rebut Dr. Stanton's and Dr. Forgason's opinions.

Staff also criticizes Dr. Bryson for not taking responsibility for his actions and disagrees with his claim that he caused no patient harm. Staff cites Dr. Forgason's opinion that providing controlled substances to drug abusers was patient harm. And Staff argues that the very nature of Dr. Bryson's practice and poor record-keeping make it difficult, if not impossible, to determine what drugs he prescribed for more than 20,000 patients, much less the treatment outcomes. Further, Staff argues that the Medical Practices Act does not require a showing of actual harm to patients – rather, it only requires a showing of risk and possibility of danger.

Staff succinctly summarized its standard-of-care arguments as follows:

> Dr. Bryson's practice of medicine was something just above "drug dealing," only because he gave the truly needful patients the illusion that they were receiving quality medical care from a physician. In reality, he provided absolutely nothing to the long-term needs and comprehensive medical care that the "real" patients required.

For the drug seekers and drug abusers, it provided very easy access to their drugs of choice.[87]

Record Keeping: Concerning allegations that Dr. Bryson failed to maintain adequate patient medical records, Staff argues that Dr. Bryson repeatedly failed to document a medically based diagnosis, a medical necessity, or an indication for the drugs prescribed. Instead, Staff states, Dr. Bryson generally listed only a symptom such as "back pain" or "low back pain," or he did not chart any symptom or diagnosis. Further, for internet patients, Dr. Bryson made no medical record at all. Staff also points out that none of Dr. Bryson's records document any further communication or follow up with his patients, and that both Dr. Stanton and Dr. Forgason testified that Dr. Bryson violated Board Rule 165.1 by failing to maintain adequate patient records.

Payments for securing patients: Staff argues that Dr. Bryson had an improper financial arrangement with the Pill Box Pharmacy and Mr. Stallknecht. Staff notes that all of Dr. Bryson's consultation fees were received by some entity owned or controlled by Mr. Stallknecht, which then split and distributed the fee to Dr. Bryson, the Pill Box, and either Medicalcenter.net or PhysicianReferral2000 (both owned or controlled by Mr. Stallknecht). Staff contends that this arrangement amounted to a payment by Dr. Bryson to the Stallknecht entities in exchange for securing or soliciting patients. In Staff's view, Mr. Stallnecht's explanation that the monies paid to him were for expenses he incurred in handling the credit card transactions, scheduling, etc. is untrue. Staff suggests that the expenses actually incurred by Mr. Stallnecht were minuscule when compared to the amount of fees paid to him, which Staff calculates at $628,244.00 for the year 2000.

(2) Dr. Bryson:

Dr. Bryson divided his argument into three parts related to the three counts in Staff's First Amended Petition. He also argues that Staff and the Board have not properly applied Board disciplinary procedures to his case.

Count One - Internet consultation questionnaires: Dr. Bryson argues that this count is irrelevant and moot because he stopped writing prescriptions based on internet consultation questionnaires on December 24, 1999, as soon as he learned that BME issued a policy statement that such a practice was inappropriate.[88] He notes that he stopped this practice a full year before he

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[87] Staff Written Argument, at 29.

[88] Ex. BME-7. Internet Prescribing Policy

At the December 8-11, 1999, Board meeting the Board established the following policy regarding internet prescribing:

Section 164.053 [of the Texas Occupation Code] authorizes the Board to discipline a licensed

attended an Informal Settlement Conference with BME on December 15, 2000. Dr. Bryson also contends that Count One is inaccurate in its statement that he prescribed "scheduled drugs" based on consultation questionnaires. Dr. Bryson states that he never prescribed scheduled drugs based solely on questionnaires, and that 100% of his patients who were prescribed scheduled drugs received them only after a telephone consultation.

Count Two - Consultation Fees: Dr. Bryson disagrees with Count Two's implication that it was wrong for his patients to pay a consultation fee only when prescriptions were issued. In Dr. Bryson's view, he was practicing medicine "in a new and innovative way," and he wanted "patients to have the freedom of choice to speak by phone with a physician they had never met in person and not be charged a fee if they were not satisfied with my advice and recommended therapy, or if I decided that a prescription was not appropriate for the person with whom I was speaking."

Count Three - Physician / Patient Relationship: Dr. Bryson contends that his telephone consultations were comparable to the common practice for an "on call" physician who is covering for another physician (typically nights and weekends) to prescribe drugs for a patient based entirely on a telephone call. In those circumstances, it is a generally accepted practice for the on-call doctor

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Texas physician for unprofessional conduct that is likely to deceive or defraud the public or injure the public. Section 3.08(4)(E) defines unprofessional or dishonorable conduct to include "prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed." Section 164.053(a)(6)(A) defines unprofessional or dishonorable conduct to include prescribing, administering or dispensing in a manner not consistent with public health and welfare dangerous drugs as defined by Chapter 483, Health & Safety Code.

Section 3.08(18) authorizes the board to discipline a licensed Texas physician for professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

It is unprofessional conduct for a physician to initially prescribe any dangerous drugs or controlled substances without first establishing a proper physician-patient relationship. A proper relationship, at a minimum, requires:

(1) verifying that the person requesting the medication is in fact who they claim to be;

(2) establishing a diagnosis through the use of accepted medical practices such as a patient history, mental status exam, physical examination and appropriate diagnostic and laboratory testing;

(3) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options; and

(4) insuring availability of the physician or coverage for the patient for appropriate follow-up care.

An online or telephonic evaluation by questionnaire is inadequate.

to write a prescription without ever performing a physical examination or seeing the patient. Dr. Bryson also argues that he obtained an adequate patient history by questioning patients about their significant medical problems.

Board Procedures: Dr. Bryson complains that the Board did not follow its own rules when he appeared at an Informal Settlement Conference on December 15, 1999. In his view, the Board's rules required it to offer him an Agreed Order, perhaps with a stipulation that he would actually see patients before issuing any prescriptions. Instead, the Board did not offer an Agreed Order but proceeded directly to a Temporary Suspension Hearing. Dr. Bryson also complains that at the Informal Settlement Conference he was accused of not complying with a Board policy on the treatment of pain that was published just a few days before he was notified of the Conference. Dr. Bryson emphasizes that he had been practicing medicine via internet/telephone consultations for a lengthy period, and that he had been cooperating with the Board's ongoing investigation during 1999, but then the Board "called him in" and accused him of violating a new policy that he had no knowledge of before the December 1999 Conference.

IV. ALJ's Analysis and Recommendation

The ALJ concludes that Dr. Bryson's procedures for prescribing drugs based on internet questionnaires and telephone consultations during the period January 1999 through March 1, 2001, fell below acceptable standards of medical care. And although the ALJ does not find that Staff proved physical harm to any specific patient, the ALJ does find that Dr. Bryson's actions created a substantial risk of harm to his patients and endangered the public health and welfare. The ALJ also finds that Dr. Bryson failed to keep adequate medical records on his patients but does not find that Dr. Bryson made improper payments to others in exchange for securing or soliciting patients. Based on the large number of patients involved, the long duration of Dr. Bryson's substandard practice, and the likelihood that Dr. Bryson would continue a substandard practice in the future, the ALJ recommends that the Board revoke Dr. Bryson's medical license.

Standard of Care: The basic facts of this case are undisputed. Between January 1999 and March 2001, Dr. Bryson issued prescriptions for over 20,000 patients based on either patient answers to an internet questionnaire or on a short telephone consultation. At hearing, Dr. Bryson was very forthright and candidly admitted the nature of his practice and how he handled these patients. But Dr. Bryson denies that his practice fell below acceptable standards of medical care or created a substantial risk of harm or danger to his patients. In Dr. Bryson's view, he provided a convenient and innovative way for patients to obtain needed medications, especially for relief from chronic pain, and he argues that Staff failed to prove harm to any patient. The ALJ disagrees with Dr. Bryson and finds that his method of practice fell below acceptable standards of care, created a serious risk of harm to his patients, and endangered the public health and welfare.

Under Chapter 164 of the TEX. OCC. CODE, the Board is authorized to discipline physicians. Chapter 164 provides in relevant part:

§ 164.051. **Grounds for Denial or Disciplinary Action**

(a) The board may . . . take disciplinary action against a person if the person:

(1) commits an act prohibited under Section 164.052;

. . .

(3) commits . . . a direct or indirect violation of a rule adopted under this subtitle, . . . ;

. . .

(6) fails to practice medicine in an acceptable professional manner consistent with the public health and welfare;

. . .

§ 164.052. **Prohibited Practices by Physician or License Applicant**

(a) A physician . . . commits a prohibited practice if that person:

. . .

(5) commits unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public;

. . .

§ 164.053. **Unprofessional or Dishonorable Conduct**

(a) For purposes of Section 164.052(a)(5), unprofessional or dishonorable conduct likely to deceive or defraud the public includes conduct in which a physician:

. . .

(5) prescribes or administers a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed;

(6) prescribes, administers, or dispenses in a manner inconsistent with the public health and welfare:

(A) dangerous drugs as defined by Chapter 483, Health and Safety Code, or

(B) controlled substances scheduled in Chapter 481, Health and Safety Code, or the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Section 801 et seq.);

. . .

The evidence established that Dr. Bryson prescribed scheduled drugs and controlled substances to over 20,000 patients without doing any of the following: seeing the patients; obtaining complete medical histories; performing even basic physical examinations such as weighing patients and checking temperature, pulses, blood pressure, and reflexes; ordering X-rays, CT scans, MRIs, or other diagnostic imaging; or ordering urinalyses, CBCs, or blood chemistries. In addition Dr. Bryson never obtained medical records from patients' prior or current doctors, never called

patients' doctors, and never sent his records to patients' doctors. In other words, Dr. Bryson performed no independent evaluation of any patient but relied totally on whatever a patient told him either through a telephone conversation or through an internet questionnaire.

Dr. Bryson's procedures clearly created a substantial risk of harm to his patients and endangered the public health and welfare. First, he provided easy access to narcotics for drug addicts, drug abusers, and anyone else who wanted them. Indeed, Dr. Bryson testified in his deposition that he shared Mr. Stallnecht's philosophy that adults should be able to obtain whatever drugs they desire. And he testified in this proceeding that patients generally should be allowed to self prescribe their medications. It is unfortunate, but the ALJ takes official notice that an enormous number of people in this country abuse and are addicted to drugs and narcotics, including the prescription pain killers and anti-anxiety drugs prescribed by Dr. Bryson. Indeed, Dr. Bryson testified at hearing that he received two or three calls per month from patient family members stating that the patient was abusing drugs. Common sense suggests that these calls likely reflected only a small percentage of the total number of patients who were seeking drugs for recreational purposes or to support addictions. And of the twelve patient records offered into evidence by Staff, one involved drug-abusing patient JA, who died from a drug overdose, and another involved a family member calling Dr. Bryson to inform him that patient DL was a drug abuser. Although the patient JA appears to have died from an overdose of drugs obtained from another source, it also appears clear that JA obtained a hydrocodone prescription from Dr. Bryson to support his drug addiction.

At hearing Dr. Bryson argued that drug-seeking patients can mislead doctors and obtain drugs even when they meet face-to-face and the doctor performs an examination. While this may be true, it is also true that an in-person consultation will increase the doctor's ability to determine whether a legitimate medical problem exists, and the requirement for an in-person consultation is likely to discourage many drug-seeking patients. In contrast, Dr. Bryson's practice imposed no barriers and provided drug-seeking patients with unrestrained access to scheduled drugs and controlled substances.

Dr. Bryson also compared his practice to on-call physicians who prescribe drugs based solely on a telephone call. But as Dr. Forgason explained, in those circumstances the on-call doctor has a professional relationship with the doctor for whom she is on call, the patient has an established relationship with the other physician, and the on-call doctor will usually prescribe only a small amount of medicine for the patient until he can see his regular treating physician. In contrast, Dr. Bryson received cold calls from unknown persons and prescribed drugs for lengthy periods based solely on a telephone call and without any planned follow-up care.

Finally, Dr. Bryson suggested at hearing that chronic pain is frequently under-treated, and that his method of practice helped many patients with chronic pain who could not get adequate care from their regular treating physician. The Board has recognized that treating chronic pain can be difficult and has adopted specific rules to protect physicians who treat pain with dangerous drugs and controlled substances. *See*, 22 TAC Chapter 170. But the Board's rules impose various requirements in order for a physician to receive protection from discipline based on prescribing

drugs for pain. First, 22 TAC § 170.1 states that "these drugs may be prescribed for the treatment of pain and other related symptoms *after a reasonably based medical diagnosis has been made . . .*" In the present case, however, Dr. Bryson did not have a "reasonably based medical diagnosis." Instead, he merely accepted whatever a patient told him or prescribed whatever drugs the patient requested.

In addition, § 170.3(A) requires a documented medical history and

> . . . *physical examination by the physician providing the medication* including an assessment and consideration of the pain, physical and psychological function, any history and potential for substance abuse, coexisting diseases and conditions, and the presence of a recognized medical indication for the use of a dangerous drug or controlled substance.

But as discussed previously, Dr. Bryson never performed a physical examination on his patients, nor did he assess his patients for coexisting diseases and conditions. Similarly, § 170.3(B) provides that a physician should prepare an individually tailored written treatment plan by which treatment progress and success can be evaluated. But Dr. Bryson did not comply with any of these requirements.

Another danger of Dr. Bryson's practice is that many patients with significant, real medical problems would likely defer seeking proper medical care after receiving a prescription from Dr. Bryson. For example, Dr. Stanton testified that back pain can have many causes, including metastatic bone disease. A patient with a serious underlying condition who masked pain with drugs from Dr. Bryson and who failed to receive follow-up evaluation and care could be put at a greater risk of harm. In addition, some drugs are contraindicated for patients with high blood pressure or other conditions that a physician can detect with an examination and basic tests, but Dr. Bryson could not make these evaluations over the internet or by telephone.

In short, the ALJ concludes that Dr. Bryson's internet and telephone practice, which freely prescribed scheduled drugs and controlled substances to whomever asked for them, fell below acceptable standards of medical care, posed a substantial risk of harm to his patients, and endangered the public health and welfare. The testimony of both Dr. Stanton and Dr. Forgason supports this conclusion.

Medical Records: The ALJ also concludes that Dr. Bryson failed to keep adequate patient medical records. 22 TAC § 165.1 provides:

Medical Records.

> (a) Each licensed physician of the Board shall maintain an adequate medical record for each patient. For purposes of this section, "adequate medical record" shall mean any records documenting or memorializing the history, diagnosis, and treatment of any patient.

The majority of Dr. Bryson's patient records merely contain personal information (sex, birth-date, height, and weight), the patient's complaint, the drugs prescribed, and a credit card number. They did not contain an adequate medical history, a valid diagnosis, or a treatment plan (other than a drug prescription). For example, RC's record merely states "back pain." It does not indicate what level of the back was painful, i.e., the cervical, thoracic, or lumbar spine, and Dr. Bryson agreed that this description was inadequate. And records for DF, EH, WH, and DR did not contain any symptoms or diagnoses at all. The ALJ agrees with both Dr. Stanton and Dr. Forgason that these records failed to meet minimum standards of record keeping by a physician.

Payments for soliciting patients: The ALJ does not find that Staff proved by a preponderance of the evidence that Dr. Bryson made payments to the Pill Box Pharmacy in exchange for soliciting or securing patients. It is undisputed that the Pill Box processed and split Dr. Bryson's "consultation fees." But both Mr. Stallnecht and Dr. Bryson testified that these payments were for processing credit card transactions and for other services and expenses. Staff disputes these contentions and argues that the costs to the Pill Box were much less than the amount it received from Dr. Bryson's fees. But Staff offered no evidence concerning the expenses incurred by the Pill Box and, in any event, there was no requirement for the Pill Box to provide its services "at cost."

In addition, Dr. Bryson testified that the Pill Box did not refer all of the patients to him. He explained that initially the Pill Box referred most of the patients, but as time passed more and more patients contacted him directly after learning about his practice by word-of-mouth or through internet chat rooms. Dr. Bryson referred all of these contacts to Mr. Hildebrand for scheduling, and the Pill Box still received a share of the consultation fees even though these patients were not referred by the Pill Box. Dr. Bryson argues that this confirms that the payments to the Pill Box were for credit card processing and other expenses and not for the referral of patients.

The evidence raised suspicions that Dr. Bryson paid the Pill Box for referring patients, or alternatively that the Pill Box paid Dr. Bryson for writing prescriptions, but neither of these contentions was established by a preponderance of the evidence. Therefore, the ALJ recommends that the Board impose no discipline on Dr. Bryson based on these allegations.

Recommended Discipline: Staff requests that the Board permanently revoke Dr. Bryson's medical license. Staff argues that Dr. Bryson's practice deceived or defrauded the public, that he prescribed dangerous drugs in manner inconsistent with the public health and welfare, and that his actions caused a serious risk of danger to his patients. Staff also states that Dr. Bryson caused patient harm by prescribing controlled substances to drug abusers.

Dr. Bryson requests that, if the Board imposes discipline, it should be less severe than revocation of his license. Dr. Bryson notes that he has no history of prior disciplinary action, he states that he terminated the internet-questionnaire practice as soon as the Board issued its policy against such a practice, and he argues that the Board has shown no harm to any specific patient. Thus, if discipline is imposed, Dr. Bryson requests that it be less than permanent revocation.

The ALJ has carefully considered this case and recommends that the Board revoke Dr. Bryson's license. This recommendation is not made lightly. Dr. Bryson is an intelligent, articulate, and likeable person. He candidly admitted the nature of his practice, he testified honestly at hearing, and he has no prior disciplinary history.

On the other hand, Dr. Bryson refuses to acknowledge that his telephonic-drug-prescribing practice is inappropriate or that it endangers the public. Instead, he argues that his practice provided needed medications to many patients who could not get help elsewhere. While Dr. Bryson may have provided a service to some patients, he also provided easy access to drugs for drug-seeking customers and he likely endangered many others who actually needed medical care. In the ALJ's view, Dr. Bryson's actions were not driven by a desire to provide appropriate medical care. Rather, he was motivated by financial gain and by ideology – that adults should be able to obtain whatever drugs they desire.

While the ALJ does not pass on the philosophical merit of Dr. Bryson's position, it is clear that such a practice is inimical to appropriate medical care. As discussed previously, Dr. Bryson provided unfettered access to drugs to anyone who called him. This had the potential to injure patients two ways – providing drugs to abusers and addicts and diverting patients with significant, real medical problems away from appropriate medical care. The overarching problem with Dr. Bryson's practice was the inability to properly assess a patient's true condition and to formulate an appropriate treatment plan. Yet Dr. Bryson seems unwilling to recognize this problem. Instead, he persists in urging that patients can self-diagnose their condition, self-prescribe their medications, or otherwise request whatever drugs they desire. While a few patients may be able to self-diagnose and self-prescribe, the overwhelming majority cannot reliably do so. Thus, while Dr. Bryson likely helped some patients, he also likely endangered many more. And since Dr. Bryson continues to advocate for his method of practice, the ALJ concludes that his continued practice presents a danger to the general public. For this reason, the ALJ recommends that the Board revoke Dr. Bryson's medical license.

V. Findings of Fact

1. David L. Bryson, M.D., holds Texas Medical License E-7013.

3. The Texas State Board of Medical Examiners (Board) issued License E-7013 to Dr. Bryson on December 8, 1976.

4. Dr. Bryson's license has been temporarily suspended by the Board since January 22, 2001. At all other times relevant to this case, Dr. Bryson's license was in full force and effect.

5. In January 1999, Dr. Bryson entered into a business and financial relationship with Mr. William Stallnecht and the Pill Box Pharmacy, of San Antonio, Texas. Mr. William Stallnecht is a licensed Texas pharmacist.

6. Dr. Bryson' business and financial relationship with Mr. Stallnecht and the Pill Box Pharmacy (Pill Box) continued until March 1, 2001.

7. During 1999, Dr. Bryson consulted with over 10,000 patients through either internet questionnaires or telephone conversations. As the year progressed, Dr. Bryson consulted with fewer patients by internet questionnaire and consulted with more patients by telephone. Dr. Bryson prescribed only unscheduled drugs based on the internet questionnaire. He also prescribed scheduled drugs and controlled substances based on the telephone conversations.

8. After December 24, 1999, Dr. Bryson ceased consulting with any patients solely through internet questionnaires. After that date, he conducted all of his consultations by telephone.

9. From January 2000 through March 1, 2001, Dr. Bryson consulted with over 10,000 patients through telephone conversations. Dr. Bryson prescribed scheduled drugs and controlled substances to these patients based on the telephone conversations.

10. Between January 1999 and March 1, 2001, more than 50% of the prescriptions written by Dr. Bryson were for the pain medication hydrocodone.

11. Between January 1999 and March 1, 2001, more than 25% of the prescriptions written by Dr. Bryson were for anti-anxiety drugs, such as Xanax and Valium.

12. Between January 1999 and March 1, 2001, Dr. Bryson had no medical office or other facilities to examine patients.

13. Between January 1999 and March 1, 2001, Dr. Bryson never saw his patients or performed physical examinations, nor did he order urinalyses, CBCs, blood chemistries, X-rays, CT scans, MRIs, or any other type of diagnostic testing for any of the more than 20,000 patients that he consulted with by telephone or internet questionnaire.

14. Between January 1999 and March 1, 2001, Dr. Bryson did not consult with the treating physicians for any of his 20,000 patients.

15. Between January 1999 and March 1, 2001, Dr. Bryson failed to establish a proper medical diagnosis on his patients by not obtaining complete medical histories, not performing mental

status exams, not performing physical examinations, and not ordering appropriate diagnostic testing.

16. Between January 1999 and March 1, 2001, Dr. Bryson prescribed scheduled substances and dangerous drugs without establishing a proper physician / patient relationship.

17. Between January 1999 and March 1, 2001, Dr. Bryson ordered three refills for approximately 90% of the prescriptions he issued.

18. Between January 1999 and March 1, 2001, Dr. Bryson never requested or obtained any of his patients' relevant medical records directly from their prior or current treating physicians.

19. Between January 1999 and March 1, 2001, Dr. Bryson never provided a report or a medical or clinical record to any of his patients' then current or subsequent treating physicians.

20. Between January 1999 and March 1, 2001, Dr. Bryson prescribed dangerous drugs or controlled substances for pain without conducting any physical examinations of patients that included an assessment and consideration of the pain, physical and psychological function, history of substance abuse, coexisting diseases and conditions, or the presence of a recognized medical indication for the use of a dangerous drug or controlled substance.

21. Between January 1999 and March 1, 2001, Dr. Bryson failed to make any arrangements for clinical follow-up or assessment of treatment for any of his patients.

22. Between January 1999 and March 1, 2001, Dr. Bryson received two or three calls per month from patient family members stating that the patient was abusing drugs.

23. Between January 1999 and March 1, 2001, Dr. Bryson failed to exercise sound medical judgment in treating pain and related symptoms with scheduled drugs and controlled substances.

24. Between January 1999 and March 1, 2001, Dr. Bryson prescribed scheduled drugs and controlled substances in a manner that created a substantial risk of harm to his patients.

25. Between January 1999 and March 1, 2001, Dr. Bryson prescribed scheduled drugs and controlled substances in a manner inconsistent with public health and welfare.

26. Dr. Bryson's prescription of Tussionex (with hydrocodone) to patient JA on November 4, 1999, caused harm to JA in that it supported JA's addiction to pain medications.

27. During 1999, an $85.00 physician consultation fee was charged to each patient who received a prescription from Dr. Bryson. For internet-questionnaire patients, Dr. Bryson received $25.00 of the consultation fee and the Pill Box Pharmacy received $60.00 of the fee. For

telephone consultation patients, Dr. Bryson received $35.00 and the Pill Box Pharmacy received $50.00.

28. Between January 2000 and March 1, 2001, a $100.00 physician consultation fee was charged to each telephone-consultation patient who received a prescription from Dr. Bryson. Dr. Bryson received $50.00 of the consultation fee and the Pill Box Pharmacy received $50.00 of the fee. After January 1, 2000, Dr. Bryson consulted with all patients by telephone.

29. All patients paid their fees by credit card to the Pill Box Pharmacy, which then paid Dr. Bryson his share.

30. If Dr. Bryson did not write a prescription for a patient, the patient did not pay the consultation fee and Dr. Bryson received no compensation.

31. Dr. Bryson's patient records lacked adequate information to document a diagnosis or to formulate a treatment plan for the following patients: JB, LB, VB, RC, DF, EH, PH, WH, CK, and DL.

32. Dr. Bryson's medical practice between January 1999 and March 1, 2001, was unprofessional and likely deceived, defrauded, and injured the public.

33. Dr. Bryson's continuation in the practice of medicine creates a danger or threat to the general public.

VI. Conclusions of Law

1. The Board of Medical Examiners (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE ANN. § 164.151.

2. The State Office of Administrative Hearings has jurisdiction to conduct the administrative hearing in this matter and to issue a proposal for decision pursuant to TEX. OCC. CODE ANN. § 164.007 and TEX. GOV'T CODE ANN., Ch. 2003.

3. Notice of hearing was provided as required by the Administrative Procedure Act, Tex. Gov't Code Ann. §§ 2001.051 and 2001.052.

4. The hearing was conducted according to the requirements of the Administrative Procedure Act, the Rules of the State Office of Administrative Hearings, and the rules of the Texas State Board of Medical Examiners.

5. Based on Findings of Fact No. 30, Dr. Bryson violated 22 TEX. ADMIN. CODE (TAC) § 165.1 by failing to maintain adequate medical records.

6. Based on Findings of Fact Nos. 6-24, Dr. Bryson violated TEX. OCC. CODE § 164.051(a)(6) by failing to practice medicine in an acceptable manner consistent with the public health and welfare.

7. Based on Findings of Fact Nos. 6-24, Dr. Bryson violated TEX. OCC. CODE §§ 164.051(a)(1) and 164.052(a)(5) by engaging in unprofessional conduct that is likely to deceive or defraud the public or injure the public.

8. Based on Findings of Fact Nos. 6-24, Dr. Bryson violated TEX. OCC. CODE § 164.053(a)(6) by prescribing dangerous drugs and controlled substances in a manner inconsistent with the public health and welfare.

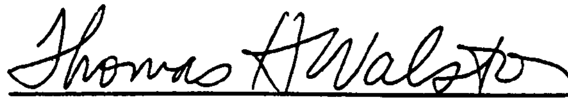
9. Based on Findings of Fact Nos. 6-24, Dr. Bryson violated the BME Internet Prescribing Policy by prescribing dangerous drugs and controlled substances without establishing a proper physician-patient relationship.

10. Based on Findings of Fact Nos. 6-24, Dr. Bryson violated 22 TAC § 170.3 by failing to follow Board guidelines for treatment of intractable pain.

11. Based on Conclusions of Law Nos. 5-10, the Texas State Board of Medical Examiners should revoke Dr. Bryson's medical license No. E-7013.

Signed May 17, 2002.

STATE OFFICE OF ADMINISTRATIVE HEARINGS



THOMAS H. WALSTON
ADMINISTRATIVE LAW JUDGE

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