

**BOARD OF MEDICAL PRACTICE**

In re: Robert Allen Penney, M.D.        )  
  )     Docket No. MPS 183-0813  
  )

**STIPULATION AND CONSENT ORDER**

NOW COME Robert Allen Penney, M.D., and the State of Vermont, by and through Vermont Attorney General William H. Sorrell, and hereby stipulate and agree to the following in the above-captioned matter:

1. Robert Allen Penny, M.D. (“Respondent”) holds Vermont medical license number 042.0007370 originally issued by the Vermont Board of Medical Practice on February 12, 1986.
2. Jurisdiction in this matter rests with the Vermont Board of Medical Practice (“the Board”), pursuant to 26 V.S.A. §§ 1353-1357, 3 V.S.A. §§ 809-814, and other authority.

**FINDINGS OF FACT**

3. The Board opened the Docket No. MPS 183-0813 matter in August of 2013 upon receipt of information concerning Respondent. The matter was assigned to the South Investigative Committee of the Board (“the Committee”).
4. The Committee’s investigation included, in part, the review of Respondent’s records regarding his treatment of several patients for opioid dependence and chronic non-malignant pain. Respondent’s treatment of these patients included the prescribing and management of buprenorphine and opioid medications.

**Office of the  
ATTORNEY  
GENERAL  
109 State Street  
Montpelier, VT  
05609**

5. Upon review of Respondent's records for Patients A, B, C, D, E and F, the Committee's investigation determined that his records failed to reflect that he interpreted and discussed urine drug screen results for all six patients. The Committee also determined that Respondent's patient charts did not consistently document quantities of the opioids that he was prescribing to his patients.
6. Patient A: The Board's investigation determined that Respondent's treatment of Patient A constituted a failure to practice competently, and a failure to practice within the standard of care. Respondent prescribed opioid medication to Patient A for the treatment of chronic pain. Respondent failed to document in Patient A's chart the results of all urine drug screen results that were negative for opioids. Respondent also failed to document having a detailed discussion with Patient A regarding the negative opiate confirmation results. Despite the negative opioid urine drug screen results, Respondent failed to make appropriate adjustments to Patient A's treatment plan. Additionally, Respondent did not document the quantities of the opioids that he was prescribing to Patient A in his office notes. It is Respondent's position that the documentation of the opioids that he prescribed to Patient A are contained in a separate section of the electronic medical records that could not be printed and provided to the Committee.
7. Patient B: The Board's investigation determined that Respondent's treatment of Patient B constituted a failure to practice competently, and a failure to practice within the standard of care. Respondent prescribed opioid medication

to Patient B for the treatment of chronic pain. Patient B had a history of cocaine use. Respondent failed to document in Patient B's chart the results of all urine drug screen results that were negative for opioids. Respondent also failed to document having a detailed discussion with Patient B regarding the negative opiate confirmation results. Despite the negative opioid urine drug screen results, Respondent failed to make appropriate adjustments to Patient B's treatment plan. Additionally, Respondent did not document the quantities of the opioids that he was prescribing to Patient B in his office notes. It is Respondent's position that the documentation of the opioids that he prescribed to Patient B are contained in a separate section of the electronic medical records that could not be printed and provided to the Committee.

8. Patient C: The Board's investigation determined that Respondent's treatment of Patient C constituted a failure to practice competently, and a failure to practice within the standard of care. Respondent prescribed opioid medication to Patient C for the treatment of chronic pain. Patient C's records show that he frequently requested larger quantities of opioid medications, and often ran out of such medications early. Patient C had multiple urine drug screen results that were negative for opioids. Respondent failed to document in Patient C's chart the results all urine drug screen results that were negative for opioids.

Respondent also failed to document having a detailed discussion with Patient C regarding the negative opiate confirmation results. Despite the negative opioid urine drug screen results and repeated request for early refills and larger quantities of opioid medications, Respondent failed to make appropriate

adjustments to Patient C's treatment plan. Additionally, Respondent did not document the quantities of the opioids that he was prescribing to Patient C in his office notes. It is Respondent's position that the documentation of the opioids that he prescribed to Patient C are contained in a separate section of the electronic medical records that could not be printed and provided to the Committee.

9. Patient D: The Board's investigation determined that Respondent's treatment of Patient D constituted a failure to practice competently, and a failure to practice within the standard of care. Respondent prescribed opioid medication to Patient D for the treatment of chronic pain. Patient D had a history of cocaine use. Patient D's records show that he frequently requested dose increases for his prescribed opioid medications, and often ran out of such medications early. Patient D had multiple urine drug screen results that were negative for opioids. Respondent failed to document in Patient D's chart the results of all urine drug screen results that were negative for opioids. Respondent also failed to document having a detailed discussion with Patient D regarding the negative opiate confirmation results. Despite the negative opioid urine drug screen results and frequent requests for increased doses of opioid medications, Respondent failed to make appropriate adjustments to Patient D's treatment plan. Additionally, Respondent did not document the quantities of the opioids that he was prescribing to Patient D in his office notes. It is Respondent's position that the documentation of the opioids that he

prescribed to Patient D are contained in a separate section of the electronic medical records that could not be printed and provided to the Committee.

10. Patient E: The Board's investigation determined that Respondent's treatment of Patient E constituted a failure to practice competently, and a failure to practice within the standard of care. Respondent prescribed buprenorphine to Patient E for the treatment of opioid addiction. Patient E had urine drug screen results that were positive for opiates, cocaine, morphine and benzodiazepines. During the course of Respondent's treatment of Patient E, she relapsed with Vicodin and Klonopin. At one point during the course of Respondent's treatment of Patient E, she was using up to 1-2 mg of Klonopin a day, which can pose a medical risk when taken with Suboxone. Patient E violated her drug treatment contract numerous times, yet Respondent still continued to prescribe buprenorphine and did not make appropriate modifications to her treatment plan.

11. Patient F: The Board's investigation determined that Respondent's treatment of Patient F constituted a failure to practice competently, and a failure to practice within the standard of care. Respondent prescribed buprenorphine and opioid medication to Patient F. Patient F relapsed on street drugs during the course of Respondent's treatment. On a few occasions Patient F reported that his medications were stolen, and Respondent provided him with replacement medications. From 2009 to 2013 Respondent obtained 81 urine drug screens from Patient F. Patient F had multiple urine drug screens that were negative for opioids, one urine drug screen that was negative for buprenorphine, and

two urine drug screens that contained hydromorphone which was not being prescribed. Respondent failed to document having a detailed discussion with Patient F regarding the results of any of the urine drug screens. Despite Patient F's numerous violations of his drug treatment contract, Respondent continued to prescribe buprenorphine and opioids without making appropriate modifications to his treatment plan or considering transition to a methadone clinic. Additionally, Respondent did not document the quantities of the opioids that he was prescribing to Patient F in his office notes. It is Respondent's position that the documentation of the opioids that he prescribed to Patient F are contained in a separate section of the electronic medical records that could not be printed and provided to the Committee.

#### **CONCLUSIONS OF LAW**

12. It is unacceptable medical practice for a licensee to inadequately document an interpretation and discussion of concerning, inconsistent urine drug screen results of patients to whom the licensee is prescribing opioids, or opioids and buprenorphine, and to continue to prescribe such medications without appropriately modifying the patient treatment plans. Such conduct may constitute the performance of unsafe or unacceptable patient care and the failure to conform to the essential standards of acceptable and prevailing practice in violation of 26 V.S.A. §§ 1354(b)(1) and (2). Such conduct may also constitute a gross failure to use and exercise on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the

ordinary, skillful, careful and prudent physician engaged in similar practice under the same or similar conditions in violation of 26 V.S.A. §§ 1354(a)(22).

13. It is unacceptable medical practice for a licensee to inadequately document the quantity of opioid medication prescribed to patients. Such conduct may constitute the performance of unsafe or unacceptable patient care and the failure to conform to the essential standards of acceptable and prevailing practice in violation of 26 V.S.A. §§ 1354(b)(1) and (2).
14. Respondent acknowledges that it is the Board's position that if the State were to file charges against him it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. § 1354(b)(2), based upon at least six acts that constitute unprofessional conduct violations.
15. Respondent agrees that the Board may enter as its facts and/or conclusions paragraphs 1 through 11 above, and further agrees that this is an adequate basis for the Board actions set forth herein. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.
16. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into the instant agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; he has concluded that this agreement is acceptable and in the best interest of the parties.

17. Respondent acknowledges that he is knowingly and voluntarily entering into this agreement with the Board. He acknowledges he has had the advice of counsel regarding this matter and in the review of this Stipulation and Consent Order. Respondent is fully satisfied with the legal representation he has received in this matter.
18. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of his own to contest any allegations by the State.
19. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be administratively closed by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.
20. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this agreement, none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall



be kept in strict confidence, and it shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

21. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to: the Federation of State Medical Boards Board Action Databank, the National Practitioner Data Bank, and the Healthcare Integrity and Protection Data Bank. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.
22. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

## ORDER

WHEREFORE, based on the foregoing, and the consent of Respondent, it is hereby

ORDERED that:

1. Respondent shall be reprimanded for the conduct set forth above.
2. No later than one (1) year from the date of approval of this Stipulation and Consent Order, Respondent shall attend and successfully complete one (1) in-person or online continuing medical education ("CME") course on safe and competent opioid prescribing practices, and one (1) in-person or online CME course on medical record keeping. Respondent shall seek the Committee's approval of each proposed CME course no later than sixty (60) days prior to the date of each course. Upon Respondent's successful completion of the CME courses, he shall provide the Committee with written proof of attendance for both courses. Respondent shall also provide a brief written narrative of each CME course to the Committee which will document what he learned from the courses, and how he will apply that knowledge to his practice. Respondent shall provide the proof of attendance and written narrative to the Committee within thirty (30) days of completion of each CME course. Respondent shall be solely responsible for all costs associated with the CME courses.
3. Respondent shall pay an administrative penalty of two thousand dollars (\$2,000.00) consistent with 26 V.S.A. § 1361(b). Payment shall be made to the "State of Vermont Board of Medical Practice," and shall be sent to

the Vermont Attorney General's Office at the following address:

Kassandra P. Diederich, Assistant Attorney General, Office of the

Attorney General, 109 State Street, Montpelier, VT 05609-1001. The

payment shall be due no later than 14 days after this Stipulation and

Consent Order is approved by the Board.

**Office of the  
ATTORNEY  
GENERAL  
109 State Street  
Montpelier, VT  
05609**

SIGNATURES

DATED at Montpelier, Vermont, this 29th day of July, 2015.

STATE OF VERMONT

WILLIAM H. SORRELL  
ATTORNEY GENERAL

By: Kassandra P. Diederich  
Kassandra P. Diederich  
Assistant Attorney General  
Office of the Attorney General  
109 State Street  
Montpelier, VT 05609-1001

2015. DATED at Burlington, Vermont, this 6<sup>th</sup> day of August,

Robert Allen Penney, M.D.  
Robert Allen Penney, M.D.  
Respondent

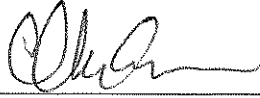
2015. DATED at Burlington, Vermont, this 13 day of August

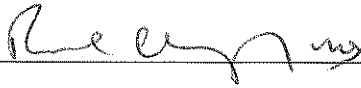
Ritchie Berger, Esquire  
Ritchie Berger, Esquire  
Dinse, Knapp & McAndrew, P.C.  
P.O. Box 988  
209 Battery Street  
Burlington, Vermont 05402-0988  
Counsel for Respondent

Office of the  
ATTORNEY  
GENERAL  
109 State Street  
Montpelier, VT  
05609

AS TO ROBERT ALLEN PENNEY, M.D.

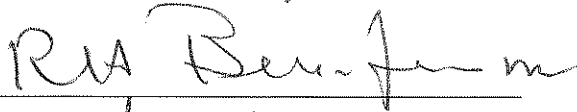
APPROVED AND ORDERED  
VERMONT BOARD OF MEDICAL PRACTICE

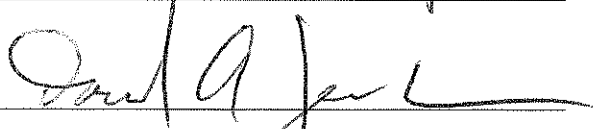


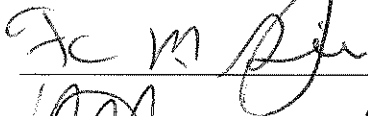


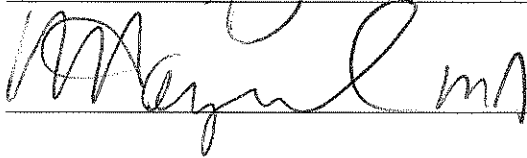












\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dated: September 2<sup>nd</sup>, 2015

ENTERED AND EFFECTIVE: September 2<sup>nd</sup>, 2015

Office of the  
ATTORNEY  
GENERAL  
109 State Street  
Montpelier, VT  
05609