

IN THE MATTER OF  
ARNOLD BRENNER, M.D.

Respondent

License Number: D00429

\* BEFORE THE  
\* MARYLAND STATE  
\* BOARD OF PHYSICIANS  
\* Case Number: 2013-0569

\* \* \* \* \*

### CONSENT ORDER

#### PROCEDURAL BACKGROUND

On November 25, 2013, the Maryland State Board of Physicians (the "Board") charged **ARNOLD BRENNER, M.D.** (the "Respondent"), License Number D00429, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.*

Specifically, the Board charged the Respondent with violating the following provisions of the Act under H.O. § 14-404(a):

- (3) Is guilty of: (ii) unprofessional conduct in the practice of medicine;
- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and
- (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On February 26, 2014, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring as a result of this DCCR, the Respondent agreed to enter into this Consent

Order, which consists of Procedural Background, Findings of Fact, Conclusions of Law, Order, Consent and Notary.

### **FINDINGS OF FACT**

Disciplinary Panel B makes the following Findings of Fact:

#### **I. Background/licensing information**

1. At all times relevant hereto, the Respondent was and is licensed to practice medicine in Maryland. The Respondent was issued License Number D00429 on or about April 11, 1969. The Respondent's license is active and current through September 30, 2014.

2. At all times relevant hereto, the Respondent was board-certified in pediatrics and maintained an office for the practice of medicine at 5400 Old Court Road, Suite 105, Randallstown, Maryland 21133 (the "Randallstown office").

#### **II. The Complaint**

3. The Board initiated an investigation of the Respondent after receiving a complaint, dated January 24, 2013, from an investigator (the "Complainant")<sup>1</sup> of a health insurance company (the "Company"). The Complainant reported that the Company investigated the Respondent, a pediatrician, after finding that he had prescribed large amounts of opiates and other medications to adult patients.

4. The Complainant cited one instance involving an adult patient ("Patient A") in which the Respondent prescribed large amounts of opiates (*i.e.*, hydrocodone, a Schedule III controlled dangerous substance, or "CDS") and benzodiazepines (*i.e.*, alprazolam, a Schedule IV CDS) for over a three-year time period. The Complainant

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<sup>1</sup> To ensure confidentiality, the names of complainants, patients or other individuals will not be disclosed in this Consent Order. The Respondent is aware of the identities of all individuals referenced herein.

stated that during one one-month time frame, the Respondent provided Patient A with as many as five separate prescriptions for hydrocodone and alprazolam. The Complainant also noted that the Respondent provided four other adult patients with prescriptions for smaller quantities of benzodiazepines such as clonazepam and alprazolam, and muscle relaxants, such as carisoprodol.

5. The Complainant stated that he/she interviewed the Respondent on December 5, 2012, at the Respondent's office, to address these prescribing issues. The Respondent acknowledged that he wrote the prescriptions for all five adult patients but at the time was unable to locate the medical records for four of them. The Complainant stated that the medical record the Respondent produced for Patient A was "incomplete and somewhat illegible . . . [with] . . . no indication of a pain contract, urinalysis, or referrals outside the office regarding pain treatment. Increases or changes in pain medication went without justification and there was no treatment plan . . . ."

6. During the December 5, 2012, site visit, the Complainant observed that the Respondent's office was "in great disarray," with "files, papers and other office items . . . stacked on counters and floors," and that the office was "very unkempt."

### **III. Board investigation/peer review findings**

#### **A. Site visit**

7. Board staff conducted an unannounced site inspection of the Respondent's Randallstown office on March 26, 2013. Board staff served the Respondent with a subpoena for original medical records for a series of adult and pediatric patients. During the site visit, Board staff inspected the Respondent's office and found that several non-patient areas of the office were in complete disarray. The

desk and surface areas of the non-patient areas were unclean, disorderly and covered with stacks of paper, boxes, computer equipment, an expired tube of a dermatologic product and other items. Board staff examined the Respondent's medication cabinet and a refrigerator adjacent to the Respondent's laboratory area and found expired medications, such as B-12 sublingual tablets, nasal sprays, dermatologic products, topical steroidal creams and solutions, and anti-fungal drugs. The Respondent displayed permits for the laboratory area that were expired. The Respondent's maintenance of his office, his office condition and possession of expired medications, as described above, constitute, in whole or in part, a violation of H.O. § 14-404(a)(3), Is guilty of: (ii) unprofessional conduct in the practice of medicine.

**B. Peer review findings**

8. The Board obtained eight medical records from the Respondent and submitted them for peer review. These charts involved four adult patients and four pediatric patients. The reviewers agreed that the Respondent failed to meet appropriate standards for the delivery of quality medical and surgical care with respect to three of the adult patients ("Patients A, B and C") and failed to keep adequate medical records with respect to all eight patients ("Patients A through H").

9. Examples of the above findings are set forth in the following patient summaries.

**Patient A**

10. The Respondent provided medical care to Patient A, a woman about 50 years old, for about six years. Patient A is reportedly the mother of a pediatric patient the Respondent treated. The Respondent initially began treating Patient A in or around

2006 for panic attacks and anxiety. The Respondent saw Patient A multiple times per year and managed her anxiety with medications.

11. The Respondent also treated Patient A for gastrointestinal symptoms and ordered metabolic laboratory work in 2011 that included a complete blood count and more detailed laboratory testing. The Respondent ordered amino acid profiles at least six different times, DNA studies on two separate occasions, and copper, lead, glutathione and urine porphyrin studies. The Respondent also performed Lyme disease and thyroid testing.

12. The Respondent also ordered other testing, such as hair analysis and urine organic acid profiles, that were performed by laboratories in other states. The Respondent's record for Patient A also states that he prescribed medications including Zithromax, an antibiotic, and an asthma inhaler (Albuterol).

13. Patient A complained of musculoskeletal pain in 2011 onward, for which the Respondent prescribed multiple hydrocodone and benzodiazepine prescriptions. The Respondent typically prescribed small amounts of these medications, often through prescriptions written for seven days' supply. The Respondent did not document all prescriptions for hydrocodone in Patient A's chart.

14. The prescription survey the Company provided indicated that the Respondent wrote Patient A 92 different prescriptions for pain medications totaling 3195 pills. The average number of pills prescribed per prescription was 35. The average number of prescriptions was 4.6 per month. The average number of pills was approximately 160 per month, or 5.325 per day. Of these prescriptions, 19 prescriptions, accounting for 626 pills, were written within a few days of another

prescription. The Respondent issued these prescriptions well before Patient A should have been due for more medication had she taken them as prescribed. The survey also indicated that the Respondent prescribed alprazolam 2 mg. over a 20-month period, constituting 1806 pills, or about three pills per day.

15. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient A, in violation of H.O. § 14-404(a)(22), in that the Respondent:

- (a) inappropriately treated an adult patient for an extended period of time for several chronic conditions;
- (b) inappropriately prescribed narcotic pain and benzodiazepine medications for extended periods of time;
- (c) inappropriately prescribed narcotic pain and benzodiazepine medications over an extended period of time without adequately addressing Patient A's possible dependency issues;
- (d) treated several conditions without a clear treatment plan;
- (e) provided treatment for conditions without a clear or adequate diagnosis; and
- (f) failed to obtain appropriate written informed consent for alternative treatments provided.

16. The Respondent failed to keep adequate medical records with respect to Patient A, in violation of H.O. § 14-404(a)(40), in that the Respondent's medical records:

- (a) were largely illegible, indecipherable and disorganized;
- (b) were not always in chronological order, making it difficult to follow his plan of care;
- (c) do not adequately state his plan of care regarding the conditions he treated;

- (d) do not adequately address his rationale regarding his treatment of Patient A's chronic pain issues and her possible narcotic/benzodiazepine use and dependency issues;
- (e) do not always contain entries corresponding to when narcotic pain medications were prescribed;
- (f) do not document an adequate rationale for prescribing medications including an antibiotic and an asthma inhaler; and
- (g) contain disorganized laboratory results.

**Patient B**

17. The Respondent began providing pediatric care to Patient B in or around 1989 when Patient B was about 12 years old. Patient B is now in his mid-30s and is related to a person whom the Respondent employs. The Respondent's medical record for Patient B indicates that he saw him for various conditions in the 1990s, including coughs. The chart indicates that the Respondent prescribed Adderall (amphetamine salts), a Schedule II CDS used to treat attention deficit disorder ("ADD"), in 2001. The Respondent continued to provide medical care to Patient B into 2012, during Patient B's adulthood.

18. The Respondent's chart for Patient B indicates that he saw him for various conditions in 2001, 2004 and 2012.

19. Patient B's chart indicates that the Respondent evaluated Patient B for migraines and headaches. Patient B's chart contains a brain MRI in 2004, although no corresponding note exists in Patient B's chart for that time. The Respondent also ordered MRI, CT and other diagnostic studies to evaluate Patient B's migraines in June 2008. According to these reports, the tests were done after Patient B was hospitalized for headaches and an inability to speak. The diagnostic tests were all normal. Patient

B's medical record does not contain a corresponding progress note for 2008 to support this testing.

20. The Respondent issued prescriptions for amphetamine salts for ADD on six occasions between September 2010 and September 2011, without corresponding progress notes in Patient B's chart.

21. The Respondent's medical record for Patient B contains an electronic medical record note for 2012, during which time the Respondent treated Patient B for gastritis. The progress note, dated December 7, 2012, also diagnoses Patient B with ADD but makes no note of Patient B's medication status, leaving it unclear if Patient B was still taking Adderall.

22. Patient B's medical record does not contain notes of annual physical examinations from 1989 through 2012.

23. Patient B's chart contains progress note entries that are out of chronological order, entries regarding at least three relatives of Patient B and test results for those family members.

24. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient B, in violation of H.O. § 14-404(a)(22), in that the Respondent:

- (a) inappropriately treated an adult patient for an extended period of time for chronic conditions;
- (b) failed to take a detailed history, perform physical examinations or otherwise failed to evaluate fully the conditions for which the Respondent treated Patient B, including ADD and migraines;
- (c) failed to record office notes when treating Patient B for chronic conditions including ADD and migraines;



- (d) failed to formulate treatment plans to address Patient B's chronic conditions;
- (e) failed to document or perform re-evaluations of the chronic conditions for which the Respondent was treating Patient B;
- (f) failed to refer or document referring Patient B to a neurologist for further evaluation of his migraines; and
- (g) co-mingled medical records of other patients.

25. The Respondent failed to keep adequate medical records with respect to Patient B, in violation of H.O. § 14-404(a)(40), in that the Respondent's medical records:

- (a) were largely illegible, indecipherable and disorganized;
- (b) were not always in chronological order, making it difficult to follow his plan of care;
- (c) do not adequately state his plan of care regarding the conditions he treated;
- (d) lacked progress/treatment notes or a treatment plan for conditions the Respondent treated, such as ADD and migraines;
- (e) do not contain annual physical examinations for many years;
- (f) contain co-mingled records with other family members; and
- (g) failed to record re-evaluations of chronic conditions for which the Respondent treated Patient B.

### **Patient C**

26. The Respondent began providing pediatric care to Patient C, a woman now about 30 years old, in 1998. Patient C is related to Patient B and is also related to an individual whom the Respondent employs. Patient C's medical record contains co-mingled medical record entries regarding Patient C's two children.

27. Patient C's progress notes start in 1998, and note a two year history of depression. The note states that Patient C is a daily smoker although no clear note of

this is made elsewhere in the chart. The next progress note appears to begin in 2006. The Respondent recorded three progress notes in 2006, three in 2008, one in 2011 and three in 2013.

28. Patient C's chart indicates that the Respondent treated Patient C for depression and various medical conditions. Patient C's chart lists that she is on medications including Wellbutrin, an anti-depressant, and Xanax, a benzodiazepine, but there is no indication of who was prescribing these medications. In 2008, the Respondent ordered tests for food allergies and celiac disease, for which there is no documented support in the record.

29. The Company's prescription drug survey indicates that the Respondent wrote prescriptions for Patient C for Xanax, Wellbutrin and Zithromax.

30. The Respondent failed to meet appropriate standards for the delivery of quality medical care with respect to Patient C, in violation of H.O. § 14-404(a)(22), in that the Respondent:

- (a) inappropriately treated an adult patient for an extended period of time for chronic conditions;
- (b) inappropriately treated an adult patient for mental health issues;
- (c) failed to appropriately treat Patient C's mental health issues;
- (d) failed to formulate a treatment plan to address Patient C's mental health issues;
- (e) failed to refer Patient C for mental health treatment; and
- (f) provided treatment for acute conditions without supporting treatment notes.

31. The Respondent failed to keep adequate medical records with respect to Patient C, in violation of H.O. § 14-404(a)(40), in that the Respondent's medical records:

- (a) were largely illegible, indecipherable and disorganized;
- (b) were not always in chronological order, making it difficult to follow his plan of care;
- (c) do not adequately state his plan of care regarding the conditions he treated;
- (d) do not contain progress notes to support the prescribing provided;
- (e) do not contain adequate documentation of an evaluation of Patient C's medical and mental health conditions; and
- (f) contain co-mingled laboratory test results and progress notes with other family members.

#### **Patients D through H**

32. The peer reviewers reviewed medical records involving one additional adult patient ("Patient D") and four pediatric patients ("Patients E through H"). The reviewers found that in these cases, as with the cases of Patients A through C, *supra*, the Respondent failed to keep adequate medical records, in violation of H.O. § 14-404(a)(40).

33. The reviewers found that with respect to Patients D through H, the Respondent's records were largely illegible, indecipherable and disorganized. The records were not always in chronological order, making it difficult to follow or discern the Respondent's plan of care. The Respondent's records contain test results that are scattered throughout the record, without order. The Respondent's medical records fail to contain written informed consent for most of the alternative treatments provided.

#### **CONCLUSIONS OF LAW**

Based on the foregoing Findings of Fact, Disciplinary Panel B concludes as a matter of law that the Respondent violated the following provisions of the Act: H.O. §

14-404(a)(3), Is guilty of: (ii) Unprofessional conduct in the practice of medicine; H.O. § 14-404(a)(22), Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and H.O. § 14-404(a)(40), Fails to keep adequate medical records as determined by appropriate peer review.

### **ORDER**

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby

**ORDERED** that the Respondent is **REPRIMANDED**; and it is further

**ORDERED** that the Respondent is placed on **PROBATION** for a minimum period of **TWO (2) YEARS**. The Respondent must fully and satisfactorily comply with the following probationary terms and conditions:

1. The Respondent shall not to provide treatment or otherwise provide any medical care to adult patients other than in a *bona fide* emergency. The Respondent shall not prescribe, administer, dispense or give away any prescription medications to adult patients.

2. The Respondent shall successfully complete a Disciplinary Panel B-approved course in medical recordkeeping. The Respondent shall submit written documentation to Disciplinary Panel B regarding the particular course he proposes to fulfill this condition. Disciplinary Panel B reserves the right to require the Respondent to provide further information regarding the course he proposes, and further reserves the right to reject his proposed course and require submission of an alternative proposal. Disciplinary Panel B will approve a course only if it deems the curriculum and the

duration of the course adequate to satisfy its concerns. The Respondent shall be responsible for submitting written documentation to Disciplinary Panel B of his successful completion of this course. The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing Disciplinary Panel B with adequate written verification that he has completed the course according to the terms set forth herein.

3. The Respondent shall maintain his office in a clean, orderly and safe condition, in compliance with the Act and all applicable State and federal laws and regulations. The Respondent shall forthwith dispose of all expired medications in compliance with all applicable State and federal laws and regulations, and thereafter shall ensure that his office does not maintain any expired medications.

4. Within six (6) months of the date Disciplinary Panel B executes this Consent Order, Disciplinary Panel B, its employees or agents may conduct an unannounced site visit of the Respondent's office to determine if it is being maintained in a clean, orderly and safe condition. The Respondent shall at all times cooperate with Disciplinary Panel B, its employees or agents in conducting the inspection. The Respondent understands and agrees that if Disciplinary Panel B's inspection determines that his office is not maintained in a clean, orderly and safe condition, such acts shall constitute a violation of this Consent Order.

5. The Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine.

6. Disciplinary Panel B reserves the right to conduct a peer review by an appropriate peer review entity, or a chart review by a Disciplinary Panel B designee, to be determined at the discretion of Disciplinary Panel B.

**AND IT IS FURTHER ORDERED** that after the conclusion of the entire **TWO (2) YEAR** period of **PROBATION**, the Respondent may file a written petition to Disciplinary Panel B requesting termination of his probation. After consideration of his petition, the probation may be terminated through an order of Disciplinary Panel B or designated Disciplinary Panel B committee. The Respondent may be required to appear before Disciplinary Panel B or designated Disciplinary Panel B committee. Disciplinary Panel B, or designated Disciplinary Panel B committee, shall grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions of this Consent Order, and if there are no outstanding complaints against him that are related to the charges before the Board or a Board panel; and it is further

**ORDERED** that if the Respondent violates any of the terms or conditions of this Consent Order or probation, Disciplinary Panel B, in its discretion, after notice and an opportunity for a hearing before an administrative law judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before Disciplinary Panel B, may impose any other sanctions that may have been imposed by a Board disciplinary panel, including a reprimand, probation, suspension, revocation and/or a monetary fine, said violation being proven by a preponderance of the evidence; and it is further

**ORDERED** that the Respondent shall not apply for early termination of probation; and it is further

**ORDERED** that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of the Consent Order; and it is further

**ORDERED** that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't § 10-611 *et seq.* (2009 Repl. Vol.).

3/10/2014  
Date

Christine A. Farrelly  
Christine A. Farrelly, Acting Executive Director  
Maryland State Board of Physicians

**CONSENT**

I, Arnold Brenner, M.D., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by this Consent Order and its conditions and restrictions. I waive any rights I may have had to contest the Findings of Fact and Conclusions of Law.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of Disciplinary Panel B to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of Disciplinary Panel A that might have followed any such hearing.

I sign this Consent Order after having had an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and

terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

3/5/14  
Date

Arnold Brenner  
Arnold Brenner, M.D.  
Respondent

Read and approved by:

Craig M. Kadish  
Craig M. Kadish, Esquire  
Counsel for Dr. Brenner

**NOTARY**

STATE OF Maryland

CITY/COUNTY OF: Baltimore City

I HEREBY CERTIFY that on this 5<sup>th</sup> day of March, 2014, before me, a Notary Public of the State and County aforesaid, personally appeared Arnold Brenner, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

[Signature]  
Notary Public

OLEG IV STOVSKIY  
NOTARY PUBLIC STATE OF MARYLAND  
My Commission Expires December 23, 2014

My commission expires: \_\_\_\_\_