COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1492

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY JOHN R. BAIRD, M.D., LICENSE NO. 36869, 9204 TAYLORSVILLE ROAD, SUITE 206, LOUISVILLE, KENTUCKY 40299

# SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Panel A, and John R. Baird, M.D. (hereafter "the licensee"), and, based upon their mutual desire to fully and finally resolve this matter without an evidentiary hearing, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER**:

## STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Second Amended Agreed Order:

1. At all relevant times, John R. Baird, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Physical Medicine and Rehabilitation.
3. At its November 18, 2010 meeting, Inquiry Panel A reviewed an investigation into allegations that the licensee was inappropriately prescribing controlled substances. While the Panel failed to find a violation at that time, it issued a Letter of Concern to the licensee, recommending that he comply with the Board's Opinion Regarding the Use of Controlled Substances in Pain Treatment.
4. On September 7, 2011, the Board received a grievance from a pharmacist, who alleged that the licensee was prescribing large amounts of controlled substances and

combinations of several controlled substances. The pharmacist also noted that patients were getting early refills of these prescriptions.

5. On February 21, 2012, the Board received a toxicology report regarding the death of Patient A, from the Clay County Coroner. The Coroner stated, in part,

   ...The blood serum levels indicate Alprazolam/Xanax in significant quantities, over 6 X maximum therapeutic range and Fentanyl/Duragesic at nearly 6X maximum therapeutic range as well as Oxycodone at 1.85 X therapeutic range...Further morphine is present in the urine screen as well. My opinion is this patient was consuming prescriptions medications in large quantities on a regular basis...Death will be ruled accidental and due to Acute Combined Narcotic Drug Toxicity, (Alprazolam, Oxycodone, Fentanyl, and Morphine).
   Providers are ... and Dr. John R. Baird, Healing Options, in Louisville, KY (Fentanyl, Oxycodone) ....

6. The Board requested a review of the licensee's prescribing patterns. In a report dated January 12, 2010 (sic – 2012), the reviewer identified the following issues:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances;
   - Long-term use of a controlled substance for which short-term use is generally indicated, and
   - Family members obtaining the same or similar controlled substances; and,
   - Dr. Baird is also prescribing amphetamines for the majority of his patients which may or may not be in accordance with the diagnosis/purpose outlined in 201 KAR 9:016.

   The reviewer selected 25 patient records for review by a Board consultant.

7. In a report dated March 30, 2012, one Board consultant concluded, in part, regarding his review of the four patients identified by the pharmacist initially,

   Medical record keeping, especially with reference to initial evaluation. Dr. Baird took over the management of the four patients I reviewed on the understanding that he was a qualified expert who was taking over the care of the patient who failed with treatment elsewhere, so he is a qualified consultant. In his evaluation which should have been comprehensive, I think he did not meet the quality expected. On more than one occasion in the four charts that I reviewed the history was not complete and did not meet quality as I have indicated in the appropriate spot in the review. There was no detailed dosing or duration of the patient's previous drug history in any of the records,

how many mg, how often a day or week or month or for how long. In cases where there had been mention that there was a problem with hepatic function, there was no real documentation how poor the hepatic functions were or how significant it was. In the case of the patient with a history of alcoholism, there was no real history of how it impacted the patient's current status and future. There were a lot of things mentioned in a casual format and these were usually not supported by real evidence. It is one thing to state that the patient had been exposed to prior drugs without stating what the dose was and what the duration of treatment was and what was the failure of or side effects. In situations where the KASPER was available, there was no mention what the review of the KASPER indicated. The KASPER report was there for sure, but there was no mention of what the review showed. The problem I have is that Dr. Baird took over the management of the patient without detailed assessment of the previous treatment and if Dr. Baird did assess the situation it was not noted in the medical record for none of the patients which I have reviewed. But there was an attempt to properly review the records, but it was not reflected in the medical records. Maybe Dr. Baird had reviewed all of these things in his mind and in his calculations, but it did not reflect in his medical records.

Medical records. It is commendable that Dr. Baird's records were all typed and neatly kept, but the information contained therein was not completely useful. Some of the information contained in these medical records was not even believable. Say for example, this has been mentioned in at least two or three patient that I reviewed out of the four. The patient had the same vital signs during each visit, at least the majority of the visits the vital signs were exactly the same irrespective of the level of pain or their disease. That would make someone like me very uncomfortable, so I do not know how to believe this. I have seen this remark made by another reviewer of the medical records stating the same. I do not know how this can happen. So least in two situations there were eight or more occasions where the patient's vital signs were exactly the same during the monthly visits, but the patient's illness level or intensity levels were much different. I also note that when the nurse practitioner or another associate was involved in keeping the medical records the vital signs were entirely different than the ones which Dr. Baird himself has signed. I do not know how this gels. Obviously when he kept the records on a few occasions with the clinical associate like a nurse practitioner the vital signs were entirely different than the practitioner did himself. I have no idea how this can be interpreted. I am not going to second guess anyone.

In some of Dr. Baird's dealings with the patients, there is a reflection of either gross ignorance or gross negligence or gross incompetence or a combination of all three. I have cited this in the various patients reviewed and I will go ahead and recount this in one specific instance. That is the case of the patient who had the diagnosis of hepatitis C, neuropathy and pancreatitis. The instance I refer to is that on 09/14/2009 there is a diagnosis of acute pancreatitis made with the patient having vital signs of blood pressure 120/70, pulse rate 80, respirations 15, with no record of body temperature. The abdomen was diffusely tender. There were hypoactive bowel sounds, but the patient was treated as an outpatient. No investigations were done. All that was done for this patient was that the patient was given a prescription for Dilaudid 4-8 mg q. 4-

6 h., Valium 10 mg t.i.d., Percocet 10 mg in the form of Roxicodone and Phenergan suppositories. Here I have to state that I was completely surprised and flabbergasted how a physician can diagnose acute pancreatitis and the patient have normal vital signs and the patient was treated with mega doses of depressive medication and pain medication with no laboratory investigations, no referral, not even a mention of the patient's hydration levels or ability to tolerate fluids or food, etc. The surprising thing was that the patient with this diagnosis and this prescription was not even seen for a month. The patient was seen on 09/14/2009 with acute pancreatitis diagnosed and was seen again only on 10/13/2009. There was not even a suggestion that the patient was going to be followed up earlier than the one-month followup. There are more details about this in the patient's individual review, but I quoted this to indication the level of the patients I have reviewed in this case.

In addition, I will quote some more examples when Dr. Baird, who seems to believe in the power of opioid medication in treating pain which all pain management physician probably do believe; when he changes dose of medications he does do in an arbitrary fashion. I have cited more than one example where the pain level has no relationship to the degree of medication increase he prescribed. Even when patients were not reporting more pain he seems to have increased the amount of pain medication prescribed. In none of the records which I have reviewed there does not appear to be any indication that Dr. Baird had calculated to assess the total amount of pain medication the patient was taking on a given day, such as the morphine equivalent of the total daily intake of pain medication per day, per month or whatever. He just seems to keep prescribing fairly large doses of pain medication and I have cited examples for this in the cases which I reviewed. There has to be some relationship with the pain level, function level and the response to the medications prescribed.

In addition to the above, even though I understand that Dr. Baird is dealing with people who are narcotic tolerant, even though Dr. Baird has not mentioned that word anywhere and has not documented the prior history of narcotic use in dosage form, he seems to start with extended release or sustained release for medication instead of trying the immediate release medication to adjust the patient's level of tolerance to a particular medication. He seems to start instantly to use the extended release medication instead of immediate release. At least most people do not start with the extended release medication without trying at least a few days or few weeks of the immediate release to determine the patient's tolerance level of that particular medication. This allows one to estimate the requirement of extended release medication per day before a patient can be stabilized on extended release medication. It may be possible to do that thing when a patient is opioid tolerant, but it would be most realistic to start the way the drug manufacturer is recommending how to start on extended release medication. In addition to the above, Dr. Baird is dealing with patients who have significant know how of opioid medication, his prescription for breakthrough medication usually reflects as following, for example, he prescribed Percocet 10/325 mg either 120 or 180 with the stipulation signature one to two of these q.4-6 h. That means the patient can take a mega dose of medication for breakthrough medication when the patient is already taking a mega dose in morphine equivalent in sustained release format. So, the dose of

the breakthrough pain medication is equal to or sometimes more than the dose of the sustained release form of the medication. One wonders what the rationale of the determination of the dose of opioid medication is in a patient. One can give Dr. Baird the benefit of the doubt that he is already dealing with a patients who are opioid tolerant and allow his discretion to start with higher does when raising the doses or changing from medication to the other, he needs to establish some parameters of why and how he is doing that. Maybe he has that thought in his mind, but he had not put that down in practice, so the reviewer is very basically blinded. So a reviewer like me wonder whether it is due to ignorance, negligence or incompetence and that may be the same reason why the pharmacist also got concerned with the prescription practice of the same physician and that is my guess.

There are other situations which also are worthwhile mentioning. For example, one of the patients' significant other person mentioned that the patient was over sedated and it does not appear that Dr. Baird thought this was a significant remark and I thought Dr. Baird just kept on increasing pain medication and adding stimulants. There seems to be a pattern of adding stimulants to opioid medications in Dr. Baird's practice, at least on more than one occasion, which I saw in review, even though it is a well-known practice from what I know about adding stimulants to chronic opioid medication would be to decrease sedation in patients who are in palliation and allow better pain control and sometimes adding stimulants may even reduce the amount of pain medication that the patient would need and they are functionally able to get somewhere around that. In any case, Dr. Baird seems to have a high incidence of attention deficient diagnoses in his patients and he seems to be adding more stimulant drugs to his patients. This may not be significant or may be significant and I will not be able to make an assessment from the review of four patients, but the overall review of the other material which I read through indicates that Dr. Baird has a higher incidence of attention deficit disorder diagnosed among his patients. In addition, another point that Dr. Baird seems to pay very give attention to hormone balance such as thyroid function, especially the sex hormones such as estrogen and testosterone in patients. It is very well known that patients who are victims of chronic pain do suffer from low levels of testosterone in the male population and in Dr. Baird's practice he seems to treat menopausal symptoms in women also very actively. I will not be able to make any adverse remark in this matter. This may be a complementary in my opinion to Dr. Baird's practice. But, none of the patients seem to have had an endocrinology consult as far as I have been able to see. Maybe that would be the best way to do it to be sure all bases are covered. But, if Dr. Baird is qualified to do endocrine evaluation all the credit to him.

Another point which needs mention here is Dr. Baird's unwillingness to get a second opinion or additional help. At least in the four patients I reviewed there was one patient where he could have gotten additional help and it would have been a advantageous to the patient and him rather than just desperately increase the pain medication dosing and get no significant improvement in the patient's condition. Sometimes when one believes in one's treatment so thoroughly, one may get blindsided and may not think of possibilities other than what one can do. That may have been the case here, at least in one case.

There was one situation which this reviewer got very concerned about. That is the case of the patient named [Patient B]. The patient had the diagnosis of hepatitis C, neuropathy and pancreatitis. This is the lady who had the morphine pump implanted and then it was explanted. The chart indicated that the pump was explanted because of pancreatitis. I could not understand that. When I have implanted quite a few morphine pumps in patients who are suffering from intractable pain with pancreatitis, so I do not know how this patient got pancreatitis from the implanted morphine pump. Dr. Baird had not indicated why this pump was explanted. There was no indication that he investigated why the pump was put in and why it was explanted and what was in the morphine pump. Morphine pump does not mean that the medication which goes given in the pump was morphine itself. At least that is the way I understand it. There are other medications which can be put in the morphine pump. A morphine pump means that it is a pump which infuses intrathecal opioids and other drugs. At least that is the way I understand it. Dr. Baird I believe did not investigate why the pump was explanted and what was in the pump, except to state that it was explanted because of pancreatitis. The surprising thing here is that the patient originally was stated to have allergy to penicillin and sulfa. When the patient was seen a second time on 01/21/2009 the patient's allergy list was added to with morphine. This is typed in bold letters in the medical record. The final allergies at the time were penicillin, sulfa, latex and morphine. I have searched the entire paper and the patient's hospital records from St. Mary's did not indicate the patient was allergic to morphine. To compound the issue, it indicates that the patient was prescribed morphine on 05/22/2009. On that date it is mentioned that the patient has allergy to Duragesic adhesive and then it states that we will have to try something else. The something else was morphine. She was prescribed MS Contin 100 mg three times a day. Here I could not find the allergy to morphine which was previously established on this patient. That is the reason why I came to the conclusion that there was something lacking in the coordination of the care and keeping of the medical records and the accuracy of the medical records. Once again, I have to apologize for the remark. I did go through the chart and I did not find anywhere that the morphine allergy entrance was a mistake or a slip of the pen. It is my contention that this is a serious medical error which obviously nobody noticed and if somebody noticed they did not think it was anything serious since nothing happened to the patient in that particular matter. But, when one documents in the record that the patient is allergic to the tape material of the Duragesic and the patient does have allergies, one would be inclined to check what other things the patient has allergy to before a prescription change is made. At least that is the way I look at it.

My final conclusion, and I will address this conclusion quoting from Dr. Baird's letter dated 05/25/2009, and this letter explains that fibromyalgia is Dr. Baird's passion. Dr. Baird also in this letter is trying to explain that he is trying to educate other physicians how to treat and manage patients with fibromyalgia. He also makes claims that his treatment method of using opioids in fairly large doses along with drugs such as gabapentin, Lyrica, Cymbalta, Savella, Valium, soma, amphetamine, zolpidem, Klonopin, Elavil, etc., is superior. He claims that he has data to support his claim. He has not produced any and as far as I know he has not published any. He says that he

has done some research, worked with Lily Pharmaceutical and Pfizer Pharmaceutical and I have not seen that data either. He also claims that others in Louisville do not treat fibromyalgia and I do not think that statement is true. Dr. Baird also claims that his practice is based on research, but he has not produced any of his research findings. Dr. Baird also thinks he is an asset to the community and the people suffering from fibromyalgia. In my opinion the jury is out on this particular statement. So far my review of the cases, the letters and the literature which Dr. Baird provided does not indicate that he has any qualification which makes him a specialist in the treatment of fibromyalgia. I do not know where he got specialist training from. That is not indicated.

In his background, I am kind of forced to answer the Board's question whether Dr. Baird's practice is dangerous to the community. So far, in the cases I have reviewed nothing dangerous has happened to his patients, which is good news; but in every aspect of his practice which I reviewed, namely in the keeping of medical records, in the assessment of patients, in the prescription pattern of opioid drugs and controlled drugs and in the management of patients in general, he has demonstrated a certain degree of excessive faith in himself, that his methodology of treatment is superior to others and that the sky is the limit in where he wants to go with the use of opioid medications. He is the ultimate authority in deciding what the dose he is going to prescribe. This philosophy is again a defense of practice which the Board has stated in the Board's letter to Dr. Baird in its communication to Dr. Baird on 12/29/2010. If one were to ask me the question is there one point which is outstanding as a deficiency in Dr. Baird's practice, the answer is no. Almost every aspect which I reviewed is lacking in some respect, but none outstanding, as I have stated before. I cannot without doubt state that his practice is dangerous to the community, but at the same time I can state that it is filled with multiple problems...

8. A second Board consultant reviewed 22 of the licensee's patient records. This reviewer concluded, in part,

...My observation from the records supplied would suggest adequate documentation with the exception of physical exam. The physical exam is marginal and clearly below the capacity for a board certified PM&R physician.
...There is little documentation of functional status but there is extensive patient reported perception of function. Like the previous reviewer it is at this point that I believe that Dr. Baird moves beyond the standard of care. While he is practicing medicine and attempting to relieve suffering I strongly disagree with his approach on three fronts; 1) the rather liberal use of high dose opioids; 2) combinations of three and in some cases four opioids (short and long acting) with other addictive substances such as Soma and benzodiazapines and 3) the use of opioids for fibromyalgia at all.
From a medical literature standpoint the following excerpt from a comprehensive dissertation review of opioids and fibromyalgia suggest caution.

Opioid use in chronic nonmalignant pain is a divisive subject in the current literature. Current guidelines suggest guarded use of opioids chronically in nonmalignant pain and these recommendations are based on moderate quality evidence at best. The use of opioids chronically in fibromyalgia patients deserves extra scrutiny for several reasons. First, the use of opioids in fibromyalgia patients ignores the complicated presentation of the disorder discussed above. Although opioids may temporarily control the pain experienced in the disorder, their use ignores the other aspects of the disorder including non-restorative sleep, fatigue, and irritable bowel.

Patients suffering from fibromyalgia may also have altered endogenous opioid activity. A study utilizing position emission tomography found that patients suffering from fibromyalgia syndrome exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing. There are two possible explanations for the demonstrated reduced availability. First, endogenous enkephalins levels are elevated in patients with fibromyalgia, even when compared to patients suffering from chronic low back pain. Elevated endogenous ligands in these patients may explain the reduced availability of receptors to opioids, decreasing their effectiveness in fibromyalgia patients. Another possible explanation is the increased presence of endogenous ligands may lead to down regulation of opioid receptors.

Not only is the failure rate of opioid use a greater concern in patients with fibromyalgia, there is also an increased concern of misuse or abuse among this population due to characteristics commonly seen in these patients. Risk factors commonly associated with nonmedical use of opioids include anxiety and mood disorders, each a common comorbidity seen in patients with fibromyalgia. In addition low self-rated health status, commonly seen in fibromyalgia, increases the propensity toward misuse or abuse of opioids.

Beyond these reasons there is also increased concern of adverse effect presentation in patients with fibromyalgia for several reasons. Fibromyalgia patients report adverse effects and intolerance to treatment at elevated rates. In addition to the increased reporting of adverse effects in general there are also concerns with the way certain specific adverse effects seen with opioid use may affect fibromyalgia patients. Constipation is a hallmark effect seen with opioid use and may be of increased concern with patients suffering from the irritable bowel symptoms commonly associated with fibromyalgia. Other adverse effects such as sedation and mental clouding are also of particular concern in patients with fibromyalgia due to the possible pre-existing mental dysfunction already present due to the disease itself.

While this consultant consistently marked "within minimum standards" on the Expert Review Worksheets for Records and Diagnosis, he made the following finding or similar finding in 19 of the 20 cases reviewed,

There is minimal documentation of physical exam which is required under the KBML regulations....A physical exam must be documented with each visit and his documentation though adequate in most respects does not meet the professional standards for Pain medicine in this regard.

This consultant also made the following specific findings in individual Expert Review Worksheets,

....
...Sudden cessation of opioids of this dose without attention to taper validates the patients complaints regardless of the appropriateness of initial therapy.
...It is a gray area of Pain Medicine practice to treat fibromyalgia with opioids....The dismissal of the patient on high dose opioids without taper breaches ethics.
....
I see no legitimate medical reason for prescribing 2 different short acting opioids and a long acting opioid in large doses in a patient with OSA. This is the extreme limit of or past the standard of care per ASIPP or APS guidelines. Dr. Baird provides no intensive monitoring of function and minimal physical exam....This combination of medications is non-standard and risky in a patient with obstructive sleep apnea....Though this patient was ultimately dismissed for non-compliance the original combination of medications is questionable.
....Use of 2 short acting opioids in an alternating fashion is not standard care but Dr. Baird monitors outcomes and appears to be evaluating the patient's response.
...."Tender all over" does not constitute a physical exam.
....Opioids have been titrated on this patient with little documented benefit. The patient complains of fatigue and stress exacerbating pain. Each dose escalation seems to result in little improvement.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. On 7/15/11 it is noted that the patient would have an inappropriate UDS because of taking her fathers Xannax. This is a clear harbinger for substance misuse/abuse....High doses of opioids and aberrant behavior would suggest to the average practitioner risk that would not justify continuing opioid treatment or at the minimum reevaluation of dosage and diversion ....Though this patient was ultimately dismissed for non-compliance the original medication is questionable.
....The use of several addictive agents in combination with little therapeutic benefit (VAS 7-8/10) is questionable. The decision to move to high dose opioid therapy with and combinations of psychostimulants and depressants is very risky and at the fringe of Pain Medicine standards...."Tender all over" does not constitute a physical exam. There are several interactions with other providers who raise red flags that should suggest to Dr. Baird that his patient likely has a personality DO....It is generally accepted that combinations of opioids and benzodiazapines plus Soma is high risk for addiction and adverse outcomes.... I believe that perhaps less addictive combinations could be prescribed and as such a reeducation process for Dr. Baird may be helpful.
....The daily acetaminophen dose exceeds new FDA recommendations if the patient is taking 10x/da. I am unsure of any rationale that supports this Rxn practice.
....Opioids for fibromyalgia are again controversial though this patient reports reasonable results. There was an aberrant behavior in that the patient took her child's adderall and no action was taken.

....High dose opioid therapy is maintained though hypogonadism a clear complication of high dose opioid therapy is diagnosed. Again a stimulant is prescribed for fatigue and somnolence rather than...
....I see no legitimate medical reason for prescribing 3 different short acting opioids and a long acting opioid. This is not the standard of care even with a wide benefit of the doubt which I have extended to Dr. Baird as his documentation and intent seem legitimate. He is practicing outside of acceptable standards in this case....This combination of medications is non-standard and dangerous.
....The doses of medication prescribed with minimal physical exam and functional evaluation is questionable. There are suggestions in literature that high dose opioid therapy in younger age groups is difficult to justify. Given the minimal pathology demonstrated better justification is warranted.

9. The licensee makes the following observations about the consultants' reviews,

   The Board's first consultant reviewed a total of 4 patient charts. The Board's second consultant reviewed the same 4 patient charts. The second consultant found that the licensee met the standard of care relating to 3 of the 4 patient charts for all categories of review included in the Expert Review Worksheets, including "diagnosis," "treatment," "records" and "overall" medical management. In addition, the second consultant found that the licensee met the standard of care relating to the remaining patient chart for diagnosis, treatment and records. However, the consultant found his overall medical care for this patient to be borderline.
   The second consultant reviewed an additional 18 patient charts, including the chart for Patient A. In a narrative report, the consultant did not find the licensee's medical management of the patient to be the cause of the patient's death. The consultant completed Expert Review Worksheets for 20 of the remaining patient charts. The consultant found that the licensee met the standard of care for "diagnosis" and "records" for all 20 patient charts reviewed and that he met the standard of care for "treatment" for 14 of the patient charts. The consultant made the following findings regarding the licensee's overall medical management of the 20 patients that were the subjects of Expert Review Worksheets: 8 clearly within the standard of care, 11 borderline, and 1 below standard of care. The reviewer did not find the licensee to be a danger to his patients or the public.

10. Following its review of this information at its May 16, 2013 meeting, the Board's Inquiry Panel B issued this Complaint and an Emergency Order of Restriction on May 28, 2013, prohibiting him "from prescribing, dispensing, or otherwise utilizing controlled substances until the resolution of the Complaint."

11. Immediately after the Panel issued its Emergency Order of Restriction, the licensee shifted his practice to southern Indiana, just across the Ohio River from Kentucky. He

encouraged his Kentucky patients to travel to Indiana so that he could prescribe controlled substances to them, in spite of the Emergency Order's prohibition. The licensee's stated purpose in doing so was to assist the patients in safely weaning off their existing prescriptions. The licensee did not have a valid DEA permit for southern Indiana at the time he issued these controlled substance prescriptions, so used his Kentucky DEA permit. The licensee stated that he was not aware that he was lawfully required to have a separate DEA permit to prescribe controlled substances in southern Indiana.

12. In or around October 2013, the licensee resolved the Complaint and Emergency Order of Restriction by entering into an Agreed Order of Indefinite Restriction, pursuant to which he is indefinitely restricted from utilizing opiates for the treatment of fibromyalgia; required to obtain and fully document an appropriate history of present illness for each patient encounter and to prescribe controlled substances appropriate only for a validly diagnosed medical condition; indefinitely restricted from prescribing, dispensing or administering more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner; required to maintain a "controlled substances log" for all controlled substances prescribed, subject to Board review, at the licensee's expense; and required to reimburse the Board's costs and pay a fine within four (4) years.
13. On or about October 16, 2017, the licensee paid the assigned fine and reimbursed the Board's costs.
14. In or around July 2018, the licensee became indicted on and pled guilty to charges pertaining to a scheme in which he accepted approximately $567,609.36 in kickbacks

from a clinical drug testing and drug screening laboratory in return for referring his patients' lab work (including that of Medicare and Medicaid beneficiaries) between May 2012 and July 2013.

15. On or about October 26, 2018, the licensee entered into an Amended Agreed Order which included, in part, terms and conditions prohibiting him from utilizing opiates for treatment of fibromyalgia, restricting him to prescribing no more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition without consultation with a Board-certified physician and required him to maintain a controlled substances log.

16. After entering into the Amended Agreed Order, the licensee shifted the focus of his practice to hormone replacement therapy, including the prescribing of testosterone, a controlled substance.

17. In or around Spring 2022, a Board consultant reviewed sixteen (16) of the licensee's patient charts and found that he departed from or failed to conform to acceptable and prevailing medical practices in regard to diagnoses in twelve (12) cases, in regard to treatment in twelve (12) cases, and in regard to recordkeeping in thirteen (13) cases. The consultant also opined that the licensee demonstrated gross ignorance ten (10) cases and gross incompetence in one (1) case. The consultant was unable to form an opinion in regard to three (3) cases due to limited data.

18. On or about May 30, 2022, the licensee responded to the consultant's report and provided additional explanation for his practice.

19. On or about November 21, 2022, the consultant reviewed the licensee's response and information and found that it did not change her opinion.

20. On or about February 16, 2023, the licensee chose to enter into this Second Amended Agreed Order in lieu of the issuance of a Complaint and Emergency Order of Restriction.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Second Amended Agreed Order:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, the licensee has engaged in conduct which violates the provisions of KRS 311.595(4), (9) - as illustrated by KRS 311.597(1)(a) and (d), (3) and (4) – and KRS 311.595(13). Accordingly, the licensee agrees that there are legal grounds for the parties to enter into this Second Amended Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve this matter without an evidentiary hearing by entering into an informal resolution such as this Second Amended Agreed Order.

**SECOND AMENDED AGREED ORDER**

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve this matter without an evidentiary hearing, the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

1. The license to practice medicine in the Commonwealth of Kentucky held by John R. Baird, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF

TIME, effective immediately upon the filing of this Second Amended Agreed Order;

2. During the effective period of this Second Amended Agreed Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION for an indefinite term, or until further order of the Board:

    a. Beginning immediately, the licensee SHALL NOT prescribe, dispense, or otherwise professionally utilize controlled substances unless and until approved to do so by the Panel;

    b. The Panel SHALL NOT consider a request by the licensee to resume the professional utilization of controlled substances unless and until:

        i. The Board has received an assessment report (and educational or remediation plan, if recommended) following the licensee's completion of a clinical skills assessment in endocrinology at *either* Center for Personalized Education for Professionals ("CPEP"), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, or LifeGuard, 400 Winding Creek Boulevard, Mechanicsburg, Pennsylvania, 17050, Tel. (717) 909-2590; and
        ii. The licensee has reimbursed the Board's costs in the amount of $1,750.00; and

    c. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee understands and agrees that if the Panel should grant the licensee's request to resume the professional utilization of controlled substances in the future, it will do so contingent upon the licensee entering into a Third Amended Agreed Order, which shall include at least the following terms and conditions:

    a. The licensee shall not utilize opiates for the treatment of fibromyalgia. The licensee understands and agrees that a decision whether to modify or terminate this condition in the future lies within the sole discretion of the Panel and that, in considering any such request for modification or termination, the Panel may consider that this condition was imposed based upon the recommendation of one of the Board consultants, who also

recommended that the restriction remain in place for the duration of the licensee's practice;

b. The licensee shall maintain a "controlled substances log" for all controlled substances prescribed, dispensed or otherwise utilized and shall provide for periodic review of the log and relevant records by Board agents upon request, along with any other conditions deemed necessary by the Panel at that time;

c. The licensee shall obtain and fully document an appropriate history of present illness for each patient encounter;

d. The licensee shall only prescribe controlled substances that are appropriate for a validly diagnosed medical condition;

e. The licensee shall not prescribe, dispense or administer more than 40 Morphine Equivalent Doses (MED) on a daily basis for any medical condition, unless he has appropriately consulted with a Board-approved practitioner, in a manner that meets the following requirements, prior to prescribing, dispensing or administering an amount of controlled substance that exceeds that dosage level for a specific diagnosed condition for a specific patient:
    i. The Board has previously approved the Board-certified physician to consult with the licensee in such cases;
    ii. The licensee has provided all relevant information regarding the specific patient and the specific condition, and any other conditions that bear on treatment decisions, to the approved physician;
    iii. The licensee has clearly advised the approved physician of the following information regarding the proposed professional utilization of an excess amount of controlled substances to the specific patient: the condition being treated; the controlled substance(s) being used to treat the condition; the strength of the controlled substance(s); the dosage units and dosage instruction for each controlled substance(s); and, the medical justification for using excess dosing for the specific patient and the specific condition(s);
    iv. Following adequate review, the approved physician has approved the use of controlled substance(s) in amounts that exceed 40 MED/day for the specific patient for the specific condition(s), in writing;
    v. The licensee has incorporated the written approval in the patient record;
    vi. The licensee reduces the controlled substance(s) used to 40 MED/day or less as soon as medically appropriate and safe; and

f. Any other terms/conditions deemed appropriate by the Panel at the time.

4. The licensee expressly agrees that if he should violate any term or condition of this Second Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Second Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Second Amended Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Second Amended Agreed Order.

5. The licensee understands and agrees that any violation of the terms of this Second Amended Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13), and may provide a legal basis for criminal prosecution.

SO AGREED on this 28th day of February 2023.

FOR THE LICENSEE:

JOHN R. BAIRD, M.D.

BRIAN R. GOOD
COUNSEL FOR THE LICENSEE

FOR THE BOARD:

WAQAR A. SALEEM, M.D.
CHAIR, PANEL A

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