COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2128

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY WILLIAM K. VINCENT, M.D., LICENSE NO. 36099, 222 PHILLIP STONE WAY, CENTRAL CITY, KENTUCKY 42330

COMPLAINT

Comes now the Complainant, Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel which met on October 19, 2023, states for its Complaint against the licensee, William K. Vincent, M.D., as follows:

1. At all relevant times, William K. Vincent, M.D. ("the licensee"), was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is addiction medicine.
3. On or about April 19, 2022, a Social Service Clinician with the Kentucky Department of Corrections contacted the Kentucky Board of Medical Licensure ("the Board") and expressed concern about the prescribing practices at a clinic named A New Start ("ANS") located in Central City, Kentucky. The grievant stated substantially as follows: the licensee is one of the primary prescribers at ANS; the grievant began to see an increase in clients with whom she counseled who were patients at ANS; clients shared with her about their addiction treatment at ANS and some reported being prescribed four to six different drugs from the clinic; one client stated that he was receiving suboxone as treatment for marijuana use; and although the grievant has subsequently been transferred to the Barren River Region, which includes Bowling Green, she still has some clients request to go to ANS in Central City instead of using the local clinics in Bowling Green.

4. The Board's investigator made a request to the Cabinet for Health and Family Services, Office of Inspector General ("OIG") for a review of the KASPER records for the licensee for the date range of May 3, 2021 through May 3, 2022.

5. On or around September 30, 2022, OIG Investigator, Laura Wells, PharmD., R.Ph., issued a report on the licensee's KASPER records she reviewed and analyzed. She noted several patterns of concern, including:

    - Multiple patients appear to be receiving high doses and/or large quantities of controlled substance(s);
    - A large portion of patients appear to be receiving buprenorphine products in combination with other controlled substances (such as: stimulants, benzodiazepines, gabapentin);
    - Multiple patients appear to be receiving buprenorphine mono-product, which may/may not be prescribed in accordance with 201 KAR 9:270;
    - Based on KASPER data and employee names provided on the practice website, it appears that Dr. Vincent may be prescribing buprenorphine products and/or other controlled substances to other providers and staff in the practice, which may/may not be appropriate.

6. The OIG Investigative Report included Medicaid/Billing Considerations for the licensee and Ms. Wells found:

    > [...] There were multiple dates when Dr. Vincent appeared to prescribe to more than 40 – 50 unique patients per day. Within the date range evaluated, he appeared to prescribe to the most unique patients on 02/02/2022, when he appeared to prescribe to approximately 69 unique patients. A referral will be made to the CHFS OIG MPI Branch for any necessary evaluation.

7. Ms. Wells identified eighteen (18) patients illustrative of some of the above noted concerns. The patient charts were subpoenaed from the licensee and provided to a Board Consultant for review.

8. In or around November 2022, the Board received correspondence from counsel for the licensee, "supplementing" the medical records that had been requested via subpoena, and stating substantially as follows: The licensee disagrees with the OIG

investigative report. He retained Roger Starner Jones, M.D., to review the subpoenaed records, and Dr. Jones disagrees with the OIG's findings. The licensee also provided numerous research articles and other literature to support his disagreement with the OIG Investigative Report.

9. A Board Consultant conducted a detailed review of each patient chart selected by the OIG, as well as reviewing the OIG Investigative Report and the licensee's letters and attachments dated November 11, 2022 and November 14, 2022. Of the eighteen (18) patient charts reviewed, the Board Consultant found that the licensee deviated from acceptable and prevailing medical practices in seventeen (17). In sum, the Board Consultant came to the following conclusions,

> Patients were admitted to treatment for the primary diagnosis of OUD. Intake did appear to include the elements of History (HPI, PMH, PPH, ROS), psychosocial history, physical exam, laboratory screens. It was not clear that all of these were obtained prior to first prescription. Proper consents and education were a part of the record. Lacking was a clear indication of past treatment episodes especially as it would necessitate differentiation of new patients, patients transitioning to a new prescriber, transfers, patients who have experienced past treatment with buprenorphine. Past medical records were not obtained or reviewed. Kasper reports did not regularly identify continued treatment without a break to justify initial higher doses of buprenorphine. Simply identifying familiarity with buprenorphine does not justify admission without induction and at higher doses.
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> Induction dosing was not seen. Patients were routinely admitted, treated with 16-24 mgs. buprenorphine on first day not meeting Kentucky standards. As well it was not clear that COWS [Clinical Opiate Withdrawal Scales] evaluation occurred for all patients and for some COWS did not show moderate to severe [withdrawal]. Dosing for a patient in transition from methadone treatment did not follow the standard guidance for a patient initiating MOUD from a long-acting opioid. Patients would then be at risk for precipitated withdrawal on first dose of buprenorphine. Patients were usually seen at intervals identified in the Kentucky Standards although this was inconsistent.
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> Dosing of buprenorphine included use of buprenorphine mono product without clear identification of requirements necessitating its use. Doses were typically greater than 16 mgs. without clear rationale. Patients

remained in extended treatment without efforts to adjust dose to more acceptable levels.

The medical record (EMR) was in general excessive, repetitive, conflictual and difficult to follow. Particularly in earlier years the EMR repeated much information gathered earlier in treatment but did not seem to change through a patient's course suggesting there was little attempt to update. Medication identification in each visit was incomplete as it did not regularly identify all medications a patient was taking. Problem lists were incomplete with an initial problem list not showing all identified problems and a later problem list (assessment of visit) not clearly matching even the incomplete list. Prescriptions written were not a part of the EMR (typically showed RX for buprenorphine but not for other medications provided by the practitioner).

Comments referring to tobacco use as 'under construction', to physical as 'was non focal', 'next anticipated taper', has not had two tapers', 'failed two consecutive tapers' were confusing and often inaccurate. Documentation of VS's [vital signs] created some questions as these reflected nursing notes which of their own showed limited variability and the question of not actually being measured at each visit. Information regarding the DS review process and results was excessive and unnecessary. Construction of a visit note varied from practitioner to practitioner and varied from note to note creating confusion.

Of considerable concern was the ability to discern from any patient visit the actual conclusion and plan of action particularly for struggling patients. As stated RX's provided were not clear, changes in prescribed medications (new or eliminated) were not clear, changes in dosing were not clear.

HPI provided by Dr. Vincent was typically present but was often incomplete as it did not reflect important patient information visit to visit (e.g. RX change, response to changes in treatment, other practitioner visits and interventions). ROS [review of symptoms] and physical exams, particularly during the earlier years showed a complete review, extensive physical, and assessment which suggests very extended visits. This changed in later years where this information was much more limited suggesting less lengthy visits.

Identification of alcohol use was deficient. Use was evident in several patients reviewed but was not addressed by Dr. Vincent.

Drug screens were obtained routinely, including POC screens and then definitive testing. DS results were often not added to the EMR (POC not reviewed) and frequently did not accurately reflect true results. Diluted specimens and DS's with abnormal pH were not addressed. DS's buprenorphine or norbuprenorphine absent required more serious intervention then was reflected in the EMR. DS's absent for prescribed medications often seen (BZD and gabapentin) and required more intensive intervention. DS's showing evidence of two BZD's or of a BZD different

from that prescribed required more intensive intervention. Reliance of 'levels' with drug screens has limited benefit and should not routinely be used to assess status of drug use.

Attention to comorbid medical issues was quite limited. Routine laboratory reviews occurred at least annually. However abnormal findings were not incorporated into treatment plans and basically ignored. Significant was lack of attending to HCV [Hepatitis C] positive. Patient's with various metabolic problems (hyperglycemia, hypokalemia, hypercalcemia, e.g.) were not addressed. Anemia may have been identified but not addressed. Other hematologic abnormalities were not addressed. RX's were written for unidentified problems and/or for problems not adequately evaluated either subjectively or objectively. It was difficult to discern routine attention to tobacco use. It appears that patients were regularly asked about their PCP visits but there was no attention to motivating patients to routine visits or even to more urgent visits to address these problems nor communication with other providers. Patients had procedures with associated needs for analgesia (surgery, e.g.) and these required a close collaboration between Dr. Vincent and other providers.

Several patients were prescribed anti-hypertensives, clonidine, and prazosin. The fact that this was done without close monitoring of BP's was dangerous.

Identification of sleep problems was insufficient and would have been better addressed with full sleep evaluations for accurate diagnosis and treatment. Use of then both sedative-hypnotics and stimulants was likely inappropriate and dangerous.

Similar issues occurred with MH treatment. It appears that referrals were made and some patients did see a MH APRN (it is suggested this APRN had some association with ANS). I could find minimal exchange of information from this APRN to Dr. Vincent. At times RX's for psychotropics were initiated by, or adopted by, or stopped by the APRN. Some were initiated by or then adopted by Dr. Vincent. Unfortunately, as I have concerns about the prescribing routines of Dr. Vincent, it appears that this APRN was inappropriate in his/her prescribing and these prescriptions were then continued by Dr. Vincent. Discussion re. approaches to patients did not occur between Dr. Vincent and APRN. Considering the significant MH issues that many of these patients faced (amongst them active hallucinosis), this communication would be necessary and consideration of referrals to other MH resources were to be considered. Evidence of polypharmacy existed with prescription of multiple medications with properties including sedation, mood-altering, and dependence existed and was dangerous. Lack of clarity in Medication Lists made it difficult to discern just what many patients were being prescribed. The multiple trials of psychotropics suggested much more serious problems and necessitated expert consultation.

[...]

Kasper reports were routinely obtained and it appears they were reviewed. Of concern is that in several cases RX's appeared on the Kasper report from practitioners outside of ANS that would directly impact patient treatment. Although these prescriptions may have been appropriate it was incumbent on Dr. Vincent to identify the RX's, address with patients, and discuss with the prescribers. I see no documentation that this process occurred.

Of critical concern were the prescribing habits and routines of Dr. Vincent. For patients with a diagnosis of Substance Use Disorder the use of any potentially addicting substance carries risk. Of course there may be co-morbid medical problems that would necessitate the use of such medications but this should be carefully and clearly investigated and then followed closely. If there is then evidence of a patient misusing prescribed medications, using other medications or substances with the prescribed medication and possible diversion of the prescribed medication, the continued prescription should be avoided. As well alternative approaches to using mood altering, potentially addicting medications exist and these should be exhausted before prescribing more dangerous medication.

[...]

Medications such as antiemetics (promethazine), antihistamines (hydroxyzine), and gabapentin are known to often be misused by patients with OUD. Use of these medications by Dr. Vincent in some patients did not show clear rationale and carried inherent dangers. In particular gabapentin, a controlled substance, is widely misused, dangerous with its sedative properties, and notably misused in patients with OUD. Its prescription by Dr. Vincent in his patients necessitated clear rationale for an FDA approved purpose to be acceptable. It would not be acceptable to use under the guise of pain management and alternative approaches including physical methods, safer medications, and pain management referral would have been preferable.

[...]

There is evidence that Dr. Vincent managed the care of several individuals who were employed at this practice. This raises some ethical questions as well as confidentiality issues in their treatment. As well there is some suggestion that some were not held to the same standard of treatment that would have been routine for other patients in this practice.

As a final conclusion I see Dr. Vincent's practice definitely outside the standards for treatment in the Commonwealth of Kentucky, dangerous to his patients, and dangerous to the community. Major concerns exist for accurate evaluation of patients, for identification of active diagnoses, for documentation in the medical record and in prescribing.

10. In reviewing the published articles submitted by the licensee under cover of letter dated November 11, 2022, the Board Consultant substantially stated,

> To conclude these studies looked for the most part at use of Methylphenidate, sustained release formulations, were limited studies, have not been replicated, and do not come close to showing any conclusive evidence for treating stimulant use disorders with stimulants. To the contrary of the conclusions of Dr. Vincent and [his counsel] "incorporation of ADHD medications into the treatment program for patients suffering from an addiction to stimulants such as cocaine and methamphetamine has proved successful" and that "the accepted treatment of patients experiencing a meth addiction includes prescribing of medications used for ADHD treatment" carries little support and is inaccurate. Treatment of Stimulant Use Disorder continues to be a purely behavioral approach albeit difficult and with limited success.
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> [...]
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> This practice is definitely not an accepted approach by leaders in the addiction field nor in this community. His use as well showed little to no success for his patients mostly evidenced by misuse of the medication and continued illicit stimulant use.

11. The Board Consultant's report, including review worksheets, is adopted and incorporated herewith in its entirety by reference.

12. On or about August 3, 2023, the licensee, through counsel, responded to the Board Consultant's report by letter. He provided more literature as well as reviews by Patrick Murphy, M.D., and Starner Jones, M.D. which he retained who support his practice of medicine. On or about August 9, 2023, August 11, 2023, August 24, 2023, and August 31, 2023, the licensee, through counsel, supplemented his response with additional materials.

13. The Board Consultant reviewed and considered the licensee's response of August 3, 2023 and subsequent supplementations and stated that the information provided did not change his findings about the licensee's practices.

14. On October 19, 2023, the licensee's counsel appeared before Panel A and acknowledged that the licensee is not the only provider at ANS.

15. Simultaneous with this Complaint and in accordance with KRS 311.592, the Chair of the Board's Inquiry Panel A authorized the issuance of an emergency order of restriction pursuant to which licensee will become prohibited from prescribing, dispensing, or otherwise professionally utilizing controlled substances in the Commonwealth of Kentucky pending resolution of this Complaint.

16. By his conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12). Accordingly, legal grounds exist for disciplinary action against his license to practice medicine in the Commonwealth of Kentucky.

17. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) His failure to respond may be taken as an admission of the charges; and

    (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

18. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for **June 10 - 14, 2024**, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine in the Commonwealth of Kentucky held by William K. Vincent, M.D.

This 24th day of October, 2023.

W. Saleem.

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

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., 810 Hickman Hill Road, Frankfort, Kentucky 40601; and copies were mailed via certified mail return-receipt requested to the licensee, William K. Vincent, M.D., License No. 36099, 222 Phillip Stone Way, Central City, Kentucky 42330 and via email to keljenvincent@gmail.com; and to counsel for the licensee, Lisa English Hinkle, Esq., McBrayer, PLLC, 201 East Main Street, Suite 900, Lexington, Kentucky 40507, and via email to lhinkle@mcbrayerfirm.com on this 24th day of October, 2023.

Nicole A. King

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