State of Rhode Island
Department of Health
Board of Medical Licensure and Discipline

IN THE MATTER OF:
David Disanto, MD
License No.: MD 05417
Case Nos.: C200735, C201111, and C201178

CONSENT ORDER

David Disanto, MD ("Respondent") is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline ("Board") has reviewed and investigated the above-referenced complaints pertaining to Respondent through its Investigative Committee. The Board makes the following

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since October 18, 1978. Respondent's office is located at 2464 Pawtucket Avenue, East Providence, Rhode Island. His specialty is neurosurgery. He graduated from the University of Texas at Galveston Medical School in 1977.

2. The Board received a Complaint No. 200735 from Patient A (alias), in which complaint Patient A alleged that Respondent was inappropriately prescribing controlled substances, as his office staff—not he—was writing prescriptions. Additionally, the complaint alleged that diagnostic studies were not being ordered.

3. Pursuant to the complaint, the Board asked the Rhode Island Department of Health ("RIDOH") Board of Pharmacy inspector ("Inspector") to review Respondent's PDMP for

evidence of aberrant prescribing. Pursuant to such review, the Inspector identified several patients—Patients B-F (aliases)—for further review because of Respondent's irregular prescribing to these patients, and an additional complaint—Complaint No. 201111—was opened.

4. Thereafter, the Board received a third complaint—Complaint No. C201178—from a physician who stated, "*I have a patient*," identified herein as Patient G (alias), "*who has been seeing [Respondent] in East Providence. This provider has been over prescribing narcotics and should be investigated.*"

5. Respondent was the attending physician for Patients A-G.

6. The Investigative Committee reviewed Respondent's medical records for Patient's A-G.

7. Respondent appeared before the Investigative Committee on October 28, 2020, pursuant to which Respondent answered questions relative to his clinical care and prescribing for Patients A-G.

8. The Investigative Committee found that the medical records for Patients A-G lacked sufficient detail to justify the course of treatment. Patients were rarely examined and it was often difficult to discern from the medical record why these patients were treated with various controlled substances, including opioids and benzodiazepines.

9. The Investigative Committee determined that these patients were prescribed opioids of various potencies for prolonged periods of time, including, among others, oxycodone and hydrocodone. Although Respondent checked the patient PDMP, he did not consistently perform and interpret urine drug screens or pill counts or employ other measures to ensure that the prescribed controlled substances were not being diverted. For several patients—Patients B-D and F—when urine drug screens were negative for the prescribed medication, there was no follow-up from Respondent or documentation to explain the apparent evidence of diversion.

10. The Investigative Committee also noted that some patients—Patients C and E—were prescribed an opioid in combination with one or more than one benzodiazepine. The Investigative Committee determined that the medical record did not contain clinical justification for the combination of these medications, which can cause a potentially fatal overdose.

11. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's October 28, 2020 appearance, and Respondent's written response to the Board, that Respondent's care of Patients A-G violated R.I. Gen. Laws § 5-37-5.1(19), which defines "unprofessional conduct" as including, "*[i]ncompetent, negligent, or willful misconduct in the practice of medicine, which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board.*"

12. Section 4.4(B) of the Opioid Regulations, "Documentation of Treatment Plan," provides, "*Documentation in the medical record for chronic pain shall state the objectives that will be used to determine treatment success and shall include, at a minimum: (a) Any change in pain relief; (b) Any change in physical and psychosocial function; and (c) Additional diagnostic evaluations or other planned treatments.*"

13. According to their medical records, Respondent prescribed Patients A-G varying doses of opioids.

14. The Investigative Committee observed, however, that the medical records did not state the objectives that will be used to determine treatment success, any change in pain relief, any change in physical or psychosocial function, or additional diagnostic or other planned treatments. The Investigative Committee concluded, therefore, that Respondent had violated Section 4.4 (B)

of the Opioid Regulations.

15. Section 4.4(D) of the Opioid Regulations, "Patient Education/ Informed Consent," provides, "*If prescribing opioids, the practitioner will advise patients specifically about adverse risks of taking alcohol or other psychoactive medications (e.g., sedatives and benzodiazepines), tolerance, dependence, overdose or death if acute or long-term use. For those patients in recovery from substance use disorder, education shall be focused on relapse risk factors. This education, which must be documented in the medical record, will be communicated orally or in writing depending on patient preference and shall include as a minimum:*

1. Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

2. Educate patient regarding safe disposal options for unused portion of a controlled substance.

3. Requirement for Conversation: Prior to initiating a prescription for an opioid drug and, upon the second refill and/or upon the third prescription, specifically discuss with the patient who is eighteen (18) years of age or older, or the patient's parent or guardian if the patient is under eighteen (18) years of age:

a. The risks of developing a dependence or substance use disorder to the prescription opioid drug and potential of overdose or death;

b. The adverse risks of concurrent use of alcohol or other psychoactive medications;

c. The risk the medication(s) or underlying medical condition may impair an individual's ability to safely operate any motor vehicle;

d. The responsibility to safeguard all medications;

e. If the prescriber deems it appropriate, discuss such alternative treatments (including non-opioid medications, as well as nonpharmacologic treatments) as may be available; and

f. For patients in recovery from substance use disorder, education shall be focused on relapse risk factors. This discussion shall be noted in the patient's medical record at each applicable visit."

16. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's October 28, 2020 appearance, and Respondent's response to the Board, that the medical records did not sufficiently document the conversation required pursuant to Section 4.4(D) of the Opioid Regulations, including relative to adverse risks of taking alcohol or other psychoactive medications (e.g., sedatives and benzodiazepines), tolerance, dependence, overdose or death if acute or long-term use.

17. Section 4.4(G) of the Opioid Regulations, "Periodic Review," provides, "*Periodic reviews, including an in-person visit, shall take place at intervals not to exceed six (6) months.*

1. During the periodic review, the practitioner shall determine:

a. Patient's adherence with any medication treatment plan;

b. If pain, function, or quality of life have improved or diminished using objective evidence; and

c. If continuation or modification of medications for pain management treatment is necessary based on the practitioner's evaluation of progress towards treatment objectives.

2. The practitioner shall consider tapering, changing, or discontinuing treatment when:

a. Function or pain does not improve after a trial period; or

b. There is reason to believe there has been misuse, development of substance use disorder, or diversion.

3. For patients the practitioner is maintaining on continuous opioid therapy for pain for six (6) months or longer, the practitioner shall review information from the PDMP at least every twelve (12) months. Documentation of that review shall be noted in the patient's medical record."

18. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's October 28, 2020 appearance, and Respondent's response to the Board, that Respondent's medical records did not sufficiently document evidence of meaningful periodic review of each patient's clinical progress, which is required pursuant to Section 4.4(G) of the Opioid Regulations. There was not sufficient evidence that patients were adhering to a treatment plan, that there was improvement or worsening of patient's pain, or that function or quality of life have improved or diminished.

19. Section 4.4(M) of the Opioid Regulations, "Co-prescribing of Naloxone," provides, "*A prescriber must co-prescribe naloxone when:*

1. Prescribing an opioid which individually or in aggregate with other medications is more than or equal to fifty (50) MMEs per day, or document in the medical record why this is not appropriate for the patient."

20. According to the medical records, Respondent prescribed Patients B-F opioids more than 50 MMEs per day, but neither co-prescribed naloxone for these patients nor documented in the medical record why it is not appropriate for each patient.

21. The Investigative Committee concluded, based on the foregoing, that Respondent violated Section 4.4(M) of the Opioid Regulations.

22. Section 1.5.12(D) of the Physician Regulations provides, "Medical Records . . . must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and mediation [sic] lists; patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations."

23. The Investigative Committee concluded, based on the foregoing, including its review of

the relevant medical records, Respondent's October 28, 2020 appearance, and Respondent's response to the Board, that Respondent's medical records do not contain sufficient documentation to justify the clinical course of treatment.

24. Based on its determination that Respondent violated Sections 4.4(B), 4.4(D), 4.4(G), and 4.4(M) of the Opioid Regulations and Section 1.5.12(D) of the Physician Regulations, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37-5.1(24), which defines "unprofessional conduct" as including, "*[v]iolating any provision or provisions of this chapter or of an action, stipulation, or agreement of the board.*"

25. The Respondent has been diagnosed with a serious medical condition that will impair his ability to continue to practice medicine.

26. As a consequence of said medical condition, Respondent has decided to retire from the practice of medicine effective April 30, 2021 and he has chosen not to contest the allegations of charges in Count One and Count Two by the State of Rhode Island Department of Health Board of Medical Licensure and Discipline, of December 22,2020 and Respondent does not admit to any wrongdoing.

Based on the foregoing, the parties agree as follows:

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.

2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.

3. If ratified by the Board, Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence on his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for those specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and

h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the Rhode Island Department of Health ("RIDOH") public website.

4. Respondent has paid $2800 for costs associated with investigating the above-referenced complaints.

5. Respondent agrees to a reprimand on his physician license.

6. Respondent hereby agrees to this retire his physician license on April 30th, 2021, due to a medical condition.

7. Respondent agrees if he desires to reinstate his physician license he will successfully complete, at his own expense, the Vanderbilt University Medical Center Prescribing Controlled Drugs course, or comparable Board-approved CME course in prescribing of controlled substances. Respondent will send notice of completion to DOH.PRCompliance@health.ri.gov within 30 days of satisfaction of this requirement. If Respondent does reactivate his license, he will agree to a Board approved monitor for 12 months, who shall send monthly reports based on Respondents controlled substance prescribing.

8. If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of RIDOH ("Director") shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's medical license. If the Director imposes

further disciplinary action, Respondent shall be given notice and shall have the right to request within 20 days of the suspension and/or further discipline an administrative hearing. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 8th day of March, 2021.

David Disanto, MD

Ratified by the Board of Medical Licensure and Discipline on the 10th day of March, 2021.

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
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Providence, RI 02908