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

IN THE MATTER OF:
Warren Purvis, MD
License No.: MD 06645
Case No.: C210649

CONSENT ORDER

Warren Purvis, 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 complaint 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 June 19, 1985. Respondent graduated from the University of Mississippi Medical School in 1977. Respondent's specialty is Psychiatry.

2. The Board opened a complaint relevant to Respondent's care of, as attending physician for, Patient A (alias), who has been under Respondent's care since 2006. The Board's main concerns prompting the complaint were Respondent's prescribing mixed amphetamine salts, as well as methylphenidate, at high doses to Patient A, who was ultimately determined to have bipolar disorder, for a prolonged period of time. The Board was also concerned about the quality of Respondent's medical records. Dr. Purvis contends that the use of medications in this case

in this fashion was appropriate and in fact supported by medical literature by leadings experts in the field. Dr. Purvis also contends that Patient A does not qualify for the diagnosis of bipolar disorder as determined by the criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

3. Methylphenidate and mixed amphetamine salts are both stimulants and Schedule II controlled substances.

4. Respondent provided a written response to the Board, along with relevant medical records, and appeared before the Investigative Committee on August 25, 2021.

5. The Investigative Committee determined, pursuant to Respondent's appearance and response, that Respondent treated Patient A for Attention Deficit Hyperactivity Disorder, which Patient A claimed to have had since his youth. Patient A claimed to have been treated with pemoline and, at times, Methylphenidate. Respondent did not verify Patient A's diagnosis, however, or document receipt of medical records from other of Patient A's health care providers. On the other hand, Respondent's original progress intake note for Patient A from July 2006 reflects that Patient A's spouse was concerned about mania, which is a recurrent them in Patient A's progress notes. Dr. Purvis contends that the patient was referred by a prior provider, and he spoke with that provider about the referral. The diagnosis was confirmed by this discussion as well as by Dr. Purvis's own assessment and his communication with others familiar with Patient A.

6. Respondent admitted that, in the course of his care of Patient A, spanning 15 years, he has never required Patient A to submit urine drug screens, even though there were concerns Patient A was using cocaine and Respondent many times confirmed use of marijuana. A September 14, 2006 progress note, among other things, reflects that Patient A's spouse was

concerned that Patient A was using cocaine, which Patient A denied, but there was no urine drug screen or conversation about drug testing. The Investigative Committee was concerned about the high doses of mixed amphetamine salts and methylphenidate prescribed to Patient A and that there was no documentation that Respondent did any assessment to see whether these medications were being diverted. Dr. Purvis contends that over the many years he treated patient A, there was only the one reference to alleged fear of cocaine use by patient A's spouse. Dr. Purvis did not suspect any illicit drug use aside from marijuana. As for the marijuana use, Patient A admitted to marijuana use, thereby obviating the need to test for it. Dr. Purvis feared a breakdown in the physician patient relationship if he had pressed for testing in this setting. Dr. Purvis requires drug screens for his patients when he deems it appropriate and necessary.

7. The Investigative Committee was concerned about the prolonged lengths of time between visits, often months, when Respondent himself recommended just weeks between appointments. Respondent acknowledged during his appearance that Patient A was busy and often had a hard time fitting in scheduled appointments, but there is no documentation that Respondent addressed this as a problem with Patient A. Dr. Purvis noted that he tried very hard to accommodate patient A's schedule, often seeing him at night well after regular business hours. On numerous occasions he advised Patient A that he would not provide medication refills if the patient failed to schedule and keep regular appointments.

8. In his response, as well as in Patient A's medical records, Respondent notes that Patient A had a long history of marijuana use, specifically smoking marijuana, but Respondent did not inquire how Patient A's frequent marijuana use affected his job performance, which lack of questioning concerned the Investigative Committee. The Investigative Committee noted that Patient A had a job that required constant use of sound judgement and technical proficiency,

which affected safety of self and others, yet, based on review of the medical records, Respondent did not consider the possibility of professional impairment. Respondent's records include correspondence from University Orthopedics, dated December 14, 2020, indicating that the department chair referred Patient A to the Rhode Island Physicians Health Program due to episodes of Patient A losing his temper, using foul language, being late for procedures, and, in one instance, commencing a procedure prior to allowing the anesthesia to take effect. The correspondence further notes, "*there are a number of bizarre behaviors*." The Investigative Committee concluded that the minimum standard of care was not met and that Respondent would need to assess the impact of Patient A's prolonged and frequent marijuana use on his ability to safely conduct his job for himself and his clients as well as its impact on his intermittent mania. Dr. Purvis disputes the board's characterization of Patient A's marijuana use, as he smoked marijuana one to two times per month, and Dr. Purvis never suspected any issue with impairment at work.

9. The Investigative Committee noted one particular encounter from September 2008, when Patient A's spouse contacted Respondent emergently, voicing concerns that Patient A's mood was spiraling, that Patient A was using marijuana excessively, and that Patient A was not sleeping for days, was moody and irritable, and was spending money. The Investigative Committee was concerned that this situation, which appeared emergent, was not treated as such according to the medical records. Neither was the diagnosis of bipolar disorder considered, nor any intervention other than routine follow up in November. The Investigative Committee concluded that the minimum standard of care for that visit would have been to address Patient A's underlying marijuana use and understand the cause of Patient A's insomnia prior to starting another drug, as Respondent did, Halcion, which is a Schedule IV controlled substances—

specifically, a habit-forming benzodiazepine. Dr. Purvis contends that he did address this issue with Patient A although it was not well documented.

10. Upon review Respondent's medical records for Patient A, the Investigative Committee was concerned that Respondent's progress notes did not include evidence of medication reconciliation. In fact, Patient A's medications are rarely named in the medical records apart from the initial encounter. There is a medication list, which includes dose and quantity, that indicates Patient A was taking varying dosages of stimulants and other medications. This list indicates that Patient A was prescribed 80 mg of methylphenidate daily, including a dose in the afternoon, which can cause insomnia, and 80 mg a day of Adderall (mixed amphetamine salts), which can also cause insomnia.

11. It is apparent from Respondent's medical record for Patient A that Patient A was self-dosing these stimulant medications and managing the doses based on how he felt the stimulants were helping him. The medical record did not contain documentation of what target symptoms were being addressed, whether they were improved or worse, or whether Patient A was adherent to a treatment plan. The progress notes were ambiguous and often contained the phrase, "*continue medications unchanged.*" Respondent's progress note for January 4, 2012 reflects Patient A's concern about medication, but the progress notes contains no documentation relative to the medications Patient A was taking or how they were affecting his insomnia. The progress notes merely observes that Patient A had "*some real problems sleeping.*" Stimulants are known to cause insomnia, which was not addressed by Respondent with Patient A. Rather, Respondent prescribed Patient A more Halcion. In addition, Respondent's progress note for June 13, 2013 reflects that Patient A was on "*80 mg mixture of Adderall and Ritalin in the morning. He also takes 70 mg in the afternoon. He is aware of the high dosage. He has been on it for a very long*

time. He has no side effects from it." Notably, however, the medical record contains no assessment of Respondent's side effects or vital signs, or assessment of the interaction of marijuana with Patient A's prescribed medications. The package insert from the Food and Drug Administration for Ritalin states that the maximum daily dose is 60 mg. The package insert for Adderall states, "*Only in rare cases will it be necessary to exceed a total of 40 mg per day.*" The Investigative Committee concluded that the medication management and documentation does not meet the minimum standard of care. Dr. Purvis contends that he spoke frequently with the patient about medications and verified he was experiencing no side effects.

12. Upon review of Respondent's medical record for Patient A, the Investigative Committee concluded that documentation was deficient in many respects and therefore the standard of care was not met on other bases as well.

13. Respondent violated R.I. Gen. Laws § 5-37-5.1(19).

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 agrees to pay, within 5 days of the ratification of this Consent Order, an administrative fee of $1100.00 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to "**Rhode Island General Treasurer,**" and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Jessica DeSanto. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of submitting the above-referenced payment.

5. Respondent hereby agrees to this reprimand on his physician license.

6. Within six months of ratification of this Consent Order, Respondent at his own expense shall complete the CPEP Prescribing Controlled Substances Course and send evidence of completion within 30 days of doing so to DOH.PRCompliance@health.ri.gov.

7. Effective upon ratification of this Consent Order, Respondent's license is on probation for 1 year.

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 9th day of December, 2021.

MD

Warren Purvis, MD

Ratified by the Board of Medical Licensure and Discipline on the 12th day of January, 2021.

MPH

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, RI 02908

JVMcDonald MD MPH

3/23/22 Corrected, consent order Ratified 1/22/22 MD