

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



**IN THE MATTER OF:**  
**Alvin Bacon, DO**  
**License No.: DO 00461**  
**Case No.: C200136**

### **CONSENT ORDER**

Alvin Bacon, DO (“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 Dr. Alvin Bacon (“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 April 30, 1996.
2. Respondent’s office is located at 598 Great Road, North Smithfield, Rhode Island. His specialty is Internal Medicine. He graduated from the University of Health Sciences College of Osteopathic Medicine in 1991.
3. The Board received an anonymous complaint against Respondent alleging that he was inappropriately prescribing controlled substances. The Board asked the Rhode Island Department of Health (“RIDOH”) Board of Pharmacy inspector (“Inspector”) to review Respondent’s PDMP for evidence of any aberrant prescribing. The Inspector identified 11 of Respondent’s patients—Patients A-K (aliases)—for further review based on Respondent’s

concerning prescribing to these patients.

4. Respondent was the attending Physician for Patients A-K.

5. The Investigative Committee reviewed Respondent's medical records for Patient's A-K.

6. Respondent appeared before the Investigative Committee on July 29, 2020, pursuant to which Respondent answered questions relative to his clinical care and prescribing for Patients A-K.

7. The Investigative Committee found that the medical records for seven of the eleven patients—Patients A, C-G, and I—lacked sufficient detail to justify the course of treatment. It was often difficult to discern from the medical record why these patients were treated with various controlled substances, including opioids and benzodiazepines.

8. The Investigative Committee determined that ten of the eleven patients—Patients A-J—were prescribed opioids of various potencies, including, among others, oxycodone, hydrocodone, and fentanyl, for prolonged periods of time. Although Respondent routinely checked the patient PDMP, he did not perform urine drug screens or pill counts or employ other measures to assure the prescribed controlled substances were not being diverted.

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

10. Patient D was on long term opioids, including oxycodone, which was prescribed for gout. Gout is an inflammatory condition, and oxycodone is not clinically indicated for gout. The medical record did not contain justification for this treatment.

11. Patient F was initially treated by Respondent for pain caused by post-operative complications from a laminectomy. Patient F was referred to and then went to a pain specialist who reduced the dose of his opioids. Thereafter, Respondent resumed care of Patient F—because Patient F asked him to—and substantially increased Patient F’s opioid doses without sufficient clinical justification.

12. Patient K had alcohol use disorder, a chronic health problem, which led him to check himself into a rehab facility. At admission to the rehab facility, Patient K was taking clonazepam—a long acting benzodiazepine—but this drug was stopped at the rehab facility. Patient K returned to Respondent’s care after discharge from the rehab facility, however, and Respondent restarted Patient K on clonazepam. The clinical justification for restarting the drug was not recorded in the medical record.

13. Patient E was being treated by Respondent for spinal stenosis, cervical pain, and chronic pain. Respondent’s care for Respondent included prescribing multiple high-dose opioids. The medical records for Patient E show a urine drug screen on February 28, 2020, with a positive finding of cannabinoids, but without any documentation of whether the positive screen for cannabinoids was addressed with Patient E or whether Respondent made any alterations in his clinical management of Patient E.

14. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent’s July 29, 2020 appearance, and Respondent’s response to the Board, that Respondent’s care of Patients A-K failed to conform to the applicable, minimal standards of acceptable and prevailing medical practice and that, therefore, Respondent 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.”*

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

16. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent’s July 29, 2020 appearance, and Respondent’s response to the Board, that the medical records did not sufficiently document the treatment plan required pursuant to Section 4.4(B) of the rules and regulations pertaining to Pain Management, Opioid Use, and the Registration of Distributors of Controlled Substances in Rhode Island (216-RICR-20-20-4) (“Regulations”), which 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;”* and that the medical records did not sufficiently document the education required pursuant to Section 4.4(D) of the 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(D) of the Regulations 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."*

18. The Investigative Committee determined that there was no pain agreement in the medical record for Patient A. Patients B-J did have pain agreements in their medical records, but they lacked sufficient detail and were not periodically updated.

19. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's July 29, 2020 appearance, and Respondent's response to the Board, that Respondent failed to satisfy the requirements of Section 4.4(F) of the Regulations, which provides, "*1. Chronic pain patients who receive opioid medication(s) shall have a written patient treatment agreement which shall become part of their medical record. This written agreement may be started at any point, at the practitioner's discretion, based on individual patient history and risk; however, no later than after ninety (90) days of treatment with an opioid medication. The written agreement shall be signed between, at a minimum, the practitioner and the patient (or their proxy). This written patient agreement for treatment may include, at the practitioner's discretion:*

- a. The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;*
- b. Reasons for which medication therapy may be discontinued, including but not limited to, violation of the written treatment agreement or lack of effectiveness;*
- c. The requirement that all chronic pain management prescriptions are provided by a single practitioner or a limited agreed upon group of practitioners;*
- d. The patient's agreement to not abuse alcohol or use other medically unauthorized substances or medications;*
- e. Acknowledgment that a violation of the agreement may result in action as deemed appropriate by the prescribing practitioner such as a change in the*

*treatment plan or referral to a substance use disorder treatment program; and*  
*f. A request that toxicology screens be performed at random intervals at the practitioner's discretion.*

*2. At their discretion, practitioners may have a written patient treatment agreement with any patient who receives opioid medication for any duration, based on individual patient history and risk.”*

20. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's July 29, 2020 appearance, and Respondent's response to the Board, that 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. The Investigative Committee concluded 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 Regulations, which 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."*

21. According to their medical records, Respondent prescribed Patients A-J opioids at various doses greater than ninety (90) morphine milligram equivalents per day (MME/day). Patient A was prescribed 120 MME/day. Patient B was prescribed 450 MME/day. Patient C was prescribed 180 MME/day. Patient D was prescribed 300 MME/day. Patient E was prescribed 135 MME/day. Patient F was prescribed 700 MME/day. Patient G was prescribed 180 MME/day. Patient H was prescribed 180 MME/day. Patient I was prescribed 135 MME/day. Patient J was prescribed 520 MME/day.

22. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's July 29, 2020 appearance, and Respondent's response to the Board, that the medical record did not reflect documentation that Respondent considered referring these patients to pain management, as required by Section 4.4(I) of the Regulations, which provides, "*1. Medication is only one aspect of treating chronic pain. Chronic pain often requires a multidisciplinary approach and the patient will often benefit from appropriate consultation not just with pain management specialists, but other professionals who offer treatment for pain. Other professionals such as chiropractors, acupuncturists, behavioral health providers, occupational therapists, and physical therapists are examples of providers who*

*can use their skills to help alleviate patient's chronic pain.*

*2. Practitioners shall consider referral to other professionals as clinically indicated, some indications would include, patients self-escalating their doses, early refills, inadequate pain relief, co-existing morbidities such as requirement for dialysis, chronic liver disease, prior history of a substance disorder or prior over-dose.*

*3. The consideration, and documentation of consideration, for consultation threshold for adults is ninety (90) MMEs per day (orally). In the event a practitioner prescribes a dosage amount that meets or exceeds the consultation threshold of ninety (90) MME per day (orally), a consideration of consultation with a pain medicine physician is required, and must be documented in the medical record.*

*a. If consultation is not obtained, the practitioner shall document in the patient's medical record that a consultation was considered and the rationale for not obtaining such consultation;*

*b. Consultation may include:*

*(1) An office visit with the patient and the pain medicine physician;*

*(2) A telephone consultation between the pain medicine physician and the practitioner;*

*(3) An electronic consultation between the pain medicine physician and the practitioner; or*

*(4) An audio-visual evaluation conducted by the pain medicine physician remotely, where the patient is present with either the practitioner or a licensed health care practitioner designated by the practitioner or the pain medicine physician.”*

23. According to their medical records, Respondent prescribed Patients A-J opioids at various doses greater than fifty (50) MME/day. Patients D, E, and J were prescribed one or more benzodiazepines in addition to the opioids. None of these patients was co-prescribed naloxone, despite the regulatory requirement to do so.

24. Respondent did document that some of these patients declined the naloxone prescription. However, at his July 29, 2020 appearance before the Investigative Committee, Respondent could not explain why no patients accepted the prescription for naloxone.

25. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's July 29, 2020 appearance, and Respondent's response to the Board, that Respondent violated Section 4.4(M) of the Regulations, which 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.*

*2. Prescribing any dose of an opioid when a benzodiazepine has been prescribed in the past thirty (30) days, or will be prescribed at the visit. Prescribers shall note medical necessity of the co-prescription of the opioid and the benzodiazepine and explain why the benefit outweighs the risk given the U.S. FDA black box warning.*

*3. Prescribing any dose of an opioid to a patient with a prior history of opioid use disorder or overdose. Prescribers must note medical necessity of prescribing of the opioid and explain why the benefit outweighs the risk given the patient's previous history."*

26. According to his medical records, Respondent prescribed Patient J fentanyl, which is a

long acting opioid.

27. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's July 29, 2020 appearance, and Respondent's response to the Board, that Respondent's documentation in Patient J's medical record failed to satisfy the relevant requirements of Section 4.4(N) of the Regulations, which provides, "*1. All practitioners prescribing long-acting and extended-release opioids shall have completed an educational program compliant with the Extended Release/Long Acting Opioid Analgesic Risk Evaluation and Mitigation Strategy Educational requirements issued by the U.S. FDA. This may be from a continuing education program or from an accredited professional preparation education program including approved residency training programs.*

*2. For patients on long-acting and extended-release opioids, including methadone, practitioners shall monitor use closely, especially upon initiation and following any dose increases. Practitioners shall also document in the medical record that the following education has been given to the patient and the patient has had the opportunity to ask questions and understands the following risks:*

- a. Serious life-threatening or even fatal respiratory depression may occur;*
- b. Methadone treatment may initially not provide immediate pain relief, and patient needs to be aware of overdose potential if taken in excess of dose, as prescribed;*
- c. Accidental consumption of long-acting and extended-release opioids especially in children, can result in fatal overdose;*
- d. Long-term opioid use can result in physical dependence on opiates and abrupt stopping of medication may cause withdrawal symptoms including, but not limited*

*to: runny eyes, runny nose, insomnia, diarrhea, vomiting, restlessness, nausea, weakness, muscle aches, leg cramps and hot flushes; and*

*e. Substance use disorder.*

*3. Patients who receive long-acting and extended-release opioid medication(s) on a long-term basis (ninety (90) days or greater) shall have a written patient treatment agreement, which shall become part of their medical record. This written agreement may be started at any point at the practitioner's discretion, based on individual patient history and risk; however, no later than after ninety (90) days of treatment with an opioid medication. The written agreement shall be signed between, at a minimum, the practitioner and the patient (or their proxy). This written patient agreement for treatment may include, at the practitioner's discretion:*

*a. The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;*

*b. Reasons for which medication therapy may be discontinued, including but not limited to, violation of the written treatment agreement or lack of effectiveness;*

*c. The requirement that all chronic pain management prescriptions are provided by a single practitioner, or a limited agreed upon group of practitioners;*

*d. The patient's agreement to not abuse alcohol, misuse other prescribed medications or use other medically unauthorized substances or medications;*

*e. Acknowledgment that a violation of the agreement may result in action as deemed appropriate by the prescribing practitioner such as a change in the treatment plan or referral to a substance use disorder treatment program; and*

*f. A request that toxicology screens be performed at random intervals at the*

*practitioner's discretion.”*

28. The Investigative Committee concluded, based on the foregoing, including its review of the relevant medical records, Respondent's July 29, 2020 appearance, and Respondent's response to the Board, that Respondent violated regulations of the Board/Director and, thereby, 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.”

**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 60 days of the ratification of this Consent Order, an administrative fee of \$2000.00 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: Lauren Lasso. Respondent will send notice of compliance with this condition to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@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 180 days of the ratification of this Consent Order, Respondent shall, at his own expense, complete the Case Western Reserve University Intensive Course in Medical Documentation: Clinical, Legal and Economic Implications for Healthcare Providers, or comparable Board-approved CME course in medical records including but not limited to an online course on medical documentation. Respondent will send notice of completion to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@health.ri.gov) within 30 days of satisfaction of this requirement.

7. Within 180 days of the ratification of this Consent Order, Respondent shall, at his own expense, complete the Vanderbilt University Medical Center Prescribing Controlled Drugs course, or comparable Board-approved CME course in prescribing of controlled substances including but not limited to an online course in prescribing of controlled substances. Respondent will send notice of completion to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@health.ri.gov) within 30 days of satisfaction of this requirement.

8. Within 30 days of the ratification of this Consent Order, Respondent shall, at his own expense, engage a Board-approved monitor who shall review no fewer than ten medical records per month to ensure Respondent’s appropriate prescribing of controlled substances and overall

compliance with applicable laws and regulations. Such monitoring shall continue for a period of 3 years, however Respondent may petition the Board for relief this condition after 2 years without further modification of this order, if monitoring is deemed acceptable.

9. Respondent's license shall be on probation for 12 months.

10. 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 20 days of the suspension and/or further discipline to request 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 24th day of September, 2020.

Alvin C. Bacon, DO  
Alvin Bacon, DO

Ratified by the Board of Medical Licensure and Discipline on the 4th day of October, 2020.

Nicole Alexander-Scott, MD, MPH  
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Rhode Island Department of Health  
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