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

IN THE MATTER OF:
John Sappington M.D.
License Number MD 09034
Case # C 81096, C181119, C181194, C181210, C181195

SUMMARY SUSPENSION

John Sappington M.D. (hereinafter "Respondent") is licensed as a physician in Rhode Island. Respondent was issued his license on October 5th, 1995. Respondent's current physician license was reinstated on June 14th, 2017 from a prior suspension involving facts related to case C96-014. The Board and the Director of Health make the following findings:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Respondent graduated from the University of Texas at Houston Medical School on June 30th, 1989.

B. Respondent is the attending physician for Patient A (alias) and Patient B (alias).

C. The Board received a complaint C181096 from a nurse who worked at Seven Hills group home regarding a patient at this group home. Complainant states *"...2 patients under the care of this doctor at seven hills group home made medication increases from 300 mg to 4000 mg daily. Despite the concerns of the pharmacist and the 2 nurses that work in the facility the doctor demanded they follow this order. These 2 patients present with increased lethargy, low blood pressures, difficulty ambulating and malaise...."*

D. Respondent sent an email to the Chief Administrative Officer of the Board on Saturday, September 22nd, 2018. Respondent states in this email, "…. *The Behavioral Director of 7 Hills requested that I see all of their clients after I covered a few of the 7 Hills clients for a provider in the clinic that they were not happy with. There was definitely a mix up in*

dosing of Gabapentin for two clients that were brought in for a crisis visits for harmful, assaultive and threatening behavior. If I was aware that their dose was 100 mg tid, I would have increased it to 300 mg tid. and (2) hs. NOT 800mg tid and (2) hs this is typically what I do if their dose is 600 mg tid. If the nursing staff would have pointed out the change in dose was from a baseline of 100 tid I would have never suggested they administer such a dose. Neither of those patients were admitted for hospitalization nor required ventilation assistance. I am looking into how this large dose increase could have happened. I am very reluctant to change or increase any group home client's medication unless absolutely indicated for assaultive threatening behavior. Additionally, all medication decisions are discussed with the Director. On the day these two clients were brought in the support staff had little knowledge of their history and the RN Director was not with them (I believe this is the first time she has not been present). Usually, the Director comes and she and I discuss thoroughly any and all changes that will be considered and ultimately prescribed during the session. This was not the case when these two clients were brought in for a crisis visit with staff that had minimal knowledge of their care....."

E. Respondent is the attending physician for Patient C (alias).

F. The Board received a complaint C181119 from the Behavioral Healthcare Developmental Disabilities and Hospitals Quality Assurance Unit. "... *(Patient C alias) became unresponsive in her recliner and was unable to speak/open her eyes. she was sent out 911 for her safety. Patient C appeared to be toxic and several tests done to determine the origin of her condition. She started her new dose of Gabapentin yesterday. This is a marked increase from her previous dose of 100mg TID, her new dose is 800mg TID and 1600mg qhs for a total of 4000mg from 300 mg. Agency advocated to prevent it from starting and Doctor Sappington insisted that he wanted this dose....)*

G. The Board received a complaint C181194 from a physician who is a subject matter expert in psychiatry regarding an allegation of dangerous prescribing by Respondent.

H. Complainant and Responding are both attending physicians who treat Patient D (alias).

I. Complainant states in his complaint, "*...I have been treating, or trying to treat, Patient D (alias) (2/28/87) since 7/16/18 for 2 conditions: Opioid Dependence with buprenorphine*

and Sedative, Hypnotic, Anxiolytic Dependence by tapering Klonapin; he had been on both of these medications prior to 7/16/18. Recognizing the contraindication of using both benzodiazepine and opioid medications I recommended that he start tapering the Klonapin from 1 mg/d to 0.75 mg/d. At his next visit on 7/20/18 he stated that he had not decreased the Klonapin dose and was instructed, again, to do so. A urine toxicology analysis on that date showed that he had 10 times the normal range for benzodiazepine metabolites. A call was then placed to his pharmacy to cancel all Klonapin refills. (According to the Butler Hospital notes he had been admitted on 6/29/18 for a relapse on heroin. He was on Klonapin 0.5 mg bid.) At his next visit on 8/3/18 he still had not decreased to dose of Klonapin and a call was placed to the prescriber of Klonapin, Dr (Alias), for coordination of care. Dr (alias) agreed to relinquish the role of prescribing Klonapin to the undersigned. On 8/25/18 I received a courtesy fax from CVS Caremark alerting me to the fact that my patient is receiving alprazolam and buprenorphine, emphasizing that "concurrent use is not recommended" unless it was for "end-of-life opioid analgesia." On 8/26/18 I receive a Rl PMP Alert stating, "Suspected Prescriber/Pharmacy Shopper". Upon review of the PMP I see that Dr John Sappington prescribed potentially lethal doses of Klonapin on 8/16/18, and on 8/23/18 also prescribed another benzodiazepine, Xanax, without communicating with the prescriber of the opioid (the undersigned) or the benzodiazepine (Dr Alias). An alternative to filing this complaint was considered and would have been for me to call Dr Sappington directly for Coordination of Care and that <u>may have had</u> a positive effect in <u>this case</u> but my suspicion is that this case is a representation of a pattern of prescribing by this doctor that is clearly thoughtless and, worse, dangerous. It is my understanding that Dr Sappington also is a Substance Abuse specialist which is all-the-more alarming: his prescribing practices of controlled substances should be the model for the rest of the prescribing community and I am not sure that this is the case. His treatment of this patient does not appear to meet the minimum standard of care and his prescribing of excessive quantities and doses of controlled substances to patients should be reviewed."

J. The Board received complaint C181210 regarding prescribing of Respondent. Complainant in this matter is a physician who is a medical director of a well-respected opioid treatment program in Rhode Island.

11. Complainant states in her complaint "*.... As per our conversation this afternoon, I am filing a complaint against Dr. John Sappington on the basis of dangerous prescribing practices. In several instances, he has rapidly increased doses of benzodiazepines for patients on medication assisted treatment with either methadone or buprenorphine. He has prescribed benzodiazepines to patients who were concurrently on multiple other sedating medications and/or with hx of recent alcohol use disorder. He has prescribed exceedingly high doses of benzodiazepines (e.g., 8 mg daily of alprazolam) to a patient maintained on 220 mg daily of methadone, a hx of benzo abuse, and two recent hospitalizations for overdose. Thank you for your attention and prompt response to my concern for the safety and well-being of CODAC's patients....*" In a subsequent email, complainant specifically was concerned about the prescribing regarding Patient E (alias) and patient F)

12. The Board received a complaint C181195 regarding from a physician who specializes in pain management regarding the prescribing to Patient G (alias). Upon review of the PDMP the Board noted Patient G was being prescribed by Respondent Valium (diazepam), a benzodiazepine, oxazepam (a benzodiazepine) as well as Adderall (dextroamphetamine), a stimulant, ketamine (an anesthetic) and large dose of oxycodone (an opioid). Patient G is receiving oxycodone from multiple other prescribers.

ORDER

A. After considering the findings of the Board regarding John Sappington M.D., it is hereby determined that the continuation of the practice of medicine by John Sappington, MD constitutes an immediate danger to the public.

B. Accordingly, John Sappington, MD is suspended from practicing medicine until further Order of the Department of Health Board of Medical Licensure and Discipline.

C. Respondent is required to ensure appropriate continuity of care for his patients including ready access to medical records, appropriate referral to qualified health professions.

D. Respondent is required to ensure a safe transition of care of any patients taking a controlled substance. Respondent shall refer patients who are taking medication assisted treatment with buprenorphine to any state recognized opioid treatment program, such as CODAC East Bay on 850 Waterman Ave, East Providence, Rhode Island 02914.

Nicole Alexander-Scott, M.D., M.P.H.
Director of Health

Date 10/9/18

The Respondent may request, in writing, a hearing on this suspension

CERTIFICATION

I hereby certify that a copy of this **ORDER** was delivered to John Sappington M.D., via constable to Respondent:

on this _____ day of _____, 2018.

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