IN THE MATTER OF * BEFORE THE

PHILIP F. SHERMAK, P.D. * MARYLAND STATE BOARD

LICENSE #6431 * OF PHARMACY

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FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

After an investigation of the pharmacy practice of Philip F. Shermak, P.D., ("the Respondent"), the Maryland State Board of Pharmacy ("the Board") issued a charging document on July 17, 1991 against the Respondent alleging that he was professionally incompetent in violation of Health Occupations Article §12-313(b)(20). On November 21 and December 11, 1991, a hearing was held before the Board.[1] Present at the hearing were the Respondent and his attorney, Anton Keating, Esq., the Administrative Prosecutor, Roberta Gill, Assistant Attorney General, Roslyn Scheer, Executive Director for the Board, Brenda Askew, Board staff and the Counsel to the Board, Nancy P. Tennis, Assistant Attorney General.

Findings of Fact

1. At all times relevant to these charges, Respondent was licensed and is now licensed to practice pharmacy in the State of Maryland.

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[1] Board member William Adams was unable to attend the December session of the hearing but read the December transcript of the hearing before participating in deliberations.

2. During the years 1988-91, Respondent was an owner of and the dispensing pharmacist at Winn's Pharmacy located at 2540 East Fayette Street in Baltimore, Maryland.

3. As a pharmacist, the Respondent has a corresponding responsibility to determine that a controlled dangerous substance is prescribed and dispensed only for a legitimate medical purpose.

DR. CORAL GORDON AND PATIENTS A, B AND C

1. Over a period of nine months, from January 13, 1988 through September 11, 1988 Respondent dispensed 2,724 tablets of dolophine to three patients based on prescriptions signed by Coral Gordon, M.D. Dolophine is a brand name for methadone, a schedule II controlled dangerous substance.

2. Dr. Gordon, a general practitioner was not authorized to operate a substance abuse or methadone treatment center. Moreover, the evidence does not demonstrate that she was engaged in the practice of a specialty that typically uses massive doses of painkillers.

3. As stated in Dr. Gordon's medical records, Patient A, who received 1,054 tablets of dolophine over a period of four months, was a heroin user who "wants to get off everything..." and was "[r]eferred by Dr. Shermak, a pharmacist."

4. As stated in Dr. Gordon's medical records, a second patient, Patient B, had used methadone and seconal for the previous eleven years and wanted to get off drugs. Her records

state "Dr. Shermak says he's like [Patient A] - a wild one - not able to stick to any kind of treatment."

5. Dr. Gordon's medical notes also refer to Patient C, who received 1,370 tablets of dolophine over a six-month period, as a person in need of a substance abuse program.

6. Respondent acknowleged that Dr. Gordon, a ninety-two year-old practitioner, was "so old her secretary used to drive her around, she wouldn't drive herself." December 11, T48. Dr. Gordon subsequently surrendered her license to the Board of Physician Quality Assurance as the result of an investigation of her practice. State's Exhibit 15.

Patient A

7. Respondent acknowledged that, over a period of one year, Respondent dispensed percoset to Patient A based on prescriptions from thirteen different doctors. Respondent admitted that he became suspicious of Patient A, and claimed that, after talking to one of the doctors, he (Respondent) "threw [Patient A] out and never filled a prescription for him again." December 11, 1992, T-43. Respondent subsequently admitted under cross-examination that he had indeed filled other prescriptions for Patient A. In fact, Respondent referred Patient A to Dr. Gordon, informing her that the patient was a heroin user, and subsequently dispensed large amounts of methadone and nembutal to Patient A based on prescriptions signed by Dr. Gordon.

8. As shown by State's Exhibit 12, on April 5, 1988, Respondent dispensed 100 tablets of dolophine (methadone) to

Patient A with instructions to take one tablet every four hours. This prescription should have lasted for at least 16 days, yet Respondent filled another dolophine prescription written by Dr. Gordon for the same patient only five days later on April 11, 1988. Also on April 5, Respondent dispensed thirty capsules of seconal, with instructions to take one capsule at bedtime. Although this prescription should have lasted thirty days, Respondent dispensed nembutal to Patient A on April 15, 1988 which was only ten days later.

9. On April 15, 1988, Respondent again dispensed a hundred tablets of methadone to Patient A with instructions for the patient to take a tablet every four hours. Although this prescription should have lasted at least sixteen days, Respondent again dispensed methadone based on a new prescription signed by Dr. Gordon on April 18, 1988, only three days later. Also on April 15, Respondent dispensed fifteen capsules of nembutal to the same patient with instruction to take one capsule at bedtime. Only seven days later, on April 22, 1988, Respondent filled two separate prescriptions, one for thirty capsules and the other for one hundred capsules of nembutal. Both prescriptions were signed by Dr. Gordon. The patient was instructed to take one nembutal capsule at bedtime; therefore, these two prescriptions should have lasted a hundred and thirty days. Only three days later however, on April 25, 1988, Respondent filled another prescription for Patient A for nembutal signed by Dr. Gordon.

10. On April 22, 1988, Respondent dispensed one hundred tablets of dolophine to Patient A to be taken at the rate of two

tablets every four hours. This prescription should have lasted at least eight days; however, on April 25, 1988, only three days later, Respondent filled another prescription for one hundred tablets of dolophine signed by Dr. Gordon for Patient A.

11. Respondent dispensed the hundred tablets of dolophine to Patient A on April 25 with instructions to take two tablets every four hours. This prescription should have lasted at least eight days. Only four days later, however, on April 29, 1988, Respondent filled another prescription for one hundred tablets of dolophine signed by Dr. Gordon. Respondent also dispensed ten capsules of nembutal to Patient A on April 25. Although this prescription should have lasted at least ten days, Respondent filled Dr. Gordon's prescription dated two days later on April 27, 1988 for Patient A in the amount of fifty nembutal capsules. Because that prescription instructed the patient to take four capsules a day it should have lasted at least twelve days. Only two days later, however, on April 29, 1988, Respondent dispensed another thirty capsules of nembutal to Patient A pursuant to another prescription signed by Dr. Gordon.

12. Respondent dispensed the one hundred tablets of dolophine to Patient A on April 29 with instructions to take two tablets every four hours. The dosage should have lasted at least eight days. Only five days later, however, on May 4, Respondent filled another dolophine prescription issued by Dr. Gordon to Patient A. That prescription for a hundred tablets to be taken 1 tablet every four to six hours should have lasted at least sixteen days. Only three days later, however, on May 7,

Respondent dispensed ninety tablets of dolophine to Patient A based on a prescription signed by Dr. Gordon. As that prescription instructed the patient to take three tablets every four hours, it should have lasted at least five days. Only two days later, however, on May 9, Respondent dispensed a hundred and eighty tablets of dolophine to Patient A based on a prescription signed by Dr. Gordon.

13. The May 9, 1988 prescription was labelled by Dr. Gordon as "final Rx-patient has appointment with hospital for continuing treatment." In addition, because the one hundred and eighty tablets of dolophine were to be taken by Patient A at a rate of 3 tablets every 4 hours, the prescription should have lasted 10 days. Fifteen days later, on May 24, 1988, the Respondent dispensed another twenty-four tablets of dolophine to Patient A as prescribed by Dr. Gordon.

14. The thirty capsules of nembutal dispensed to Patient A on April 29, 1988 by the Respondent should have lasted thirty days. Only three days later, however, Respondent dispensed fifty capsules of nembutal to Patient A based on a prescription written by Dr. Gordon and dated May 2, 1988. The latter prescription should have lasted fifty days; however, only two days later, Respondent dispensed fifty additional capsules of nembutal to Patient A on May 4, 1988 based on a prescription signed by Dr. Gordon.

15. The fifty capsules of nembutal dispensed on May 4, 1988, by the Respondent should have lasted Patient A fifty days.

Yet on May 9, 1988, Respondent dispensed another forty-eight capsules of nembutal as prescribed by Dr. Gordon.

16. On May 31, 1988, the Respondent dispensed forty tablets of dolophine to Patient A as prescribed by Dr. Gordon. Because the patient was instructed to take two and a half tablets a day, that prescription should have lasted at least sixteen days. Only four days later, however, on June 4, 1988, Respondent dispensed another thirty tablets of dolophine to Patient A as prescribed by Dr. Gordon. That prescription should have lasted at least twelve days. Only four days later, however, on June 8, 1988, Respondent dispensed an additional twenty-four capsules of dolophine to Patient A as prescribed by Dr. Gordon.

17. On June 8, 1988, Respondent also dispensed twelve capsules of nembutal to Patient A. Dr. Gordon had prescribed that the patient take one capsule at bedtime and, therefore, this amount should have lasted for twelve days. Yet on June 10, 1988, Respondent dispensed an additional eighteen capsules of nembutal to Patient A as prescribed by Dr. Gordon. Again, this dosage should have lasted eighteen days. Yet four days later, on June 14, 1988, Respondent dispensed additional nembutal to Patient A as prescribed by Dr. Gordon.

18. On June 20, 1988, Respondent dispensed seventy-six tablets of dolophine to Patient A. Because Dr. Gordon instructed that the patient should take only two tablets four times a day, this supply should have lasted at least nine days. Only four days later, however, on June 24, 1988, Respondent dispensed twenty-four tablets of dolophine to Patient A. Because Dr.

had an obligation "to report the physician to the appropriate authority, to the Division of Drug Control or [United States Drug Enforcement Agency]," and that he should not have continued to fill the patient's prescriptions. November 21, 1991, T.190-91.

22. The Board finds the Respondent's testimony with respect to Patient A to lack credibility. Respondent attempted to justify dispensing large amounts of methadone to Patient A because Patient A was jaundiced and in pain. Respondent admits, however, that from his experience, he knew that methadone was not a treatment for jaundice. He also admits that Patient A was able to walk in and pick up his own prescription. He also acknowledged that jaundice relates to liver failure, and that the liver metabolizes toxic substances like drugs for the body yet he did not challenge the excessive use of nembutal and methadone (dolophine) for a patient with jaundice. December 11, 1991, T.50-51 and 57. Instead, based on Patient A's medical record, the Board finds that Respondent told Dr. Gordon that Patient A was a heroin user and that Patient B was "like [Patient A] - a wild one - not able to stick to any kind of treatment."

23. Respondent did not present expert testimony that would support his pattern of dispensing.

24. The circumstances surrounding the prescriptions for Patient A provided more than suffient notice for Respondent that Dr. Gordon was, for whatever reason, engaged in a practice of overprescribing without adequate medical justification. The Board finds that Respondent knew that Patient A was a drug abuser

Gordon instructed with respect to this prescription that Patient A take two tablets only three times a day, the supply should have lasted four days. Three days later, however, Respondent dispensed another sixty tablets of dolophine as prescribed by Dr. Gordon.

19. On June 24, 1988, Respondent dispensed ten capsules of nembutal to Patient A. As instructed by Dr. Gordon the dosage of one or two capsules at bedtime should have lasted at least five days. Only three days later, however, on June 27, 1987, Respondent dispensed additional nembutal to Patient A as prescribed by Dr. Gordon.

20. On July 7, 1988, Respondent dispensed sixty tablets of dolophine with instructions from Dr. Gordon to Patient A to take one tablet every four hours. This dosage should have lasted at least fifteen days. Only four days later, however, on July 11, 1988, Respondent dispensed an additional forty-eight tablets of dolophine to Patient A with instructions to take one tablet every four hours. This supply should have lasted at least twelve days. Only eight days later, however, on July 19, 1988, Respondent dispensed an additional one hundred tablets of dolophine to Patient A as prescribed by Dr. Gordon.

21. As indicated by the State's expert, Dr. Eileen Zuckerman, a pharmacist is responsible to judge whether a prescription is written for a legitimate medical purpose. November 21, 1991, T.180. The Board accepts the opinion of Dr. Eileen Zuckerman that, based on the prescribing practice exhibited by Dr. Gordon with respect to Patient A, the Respondent

yet continued to dispense Schedule II drugs to him without a legitimate medical reason.

25. Despite these continuing patterns of overprescribing, the Respondent did not refuse to fill any of these prescriptions nor did he report Dr. Gordon's conduct to responsible authorities such as the Maryland Division of Drug Control during that agency's inspections of his pharmacy or to the United States Drug Enforcement Agency.

DR. RAYMOND BAYERLE

Michael Williard

26. Over a four-month period from May 5, 1988 through September 8, 1988, Respondent filled prescriptions signed by Dr. Raymond Bayerle that provided eight hundred (800) tablets of dilaudid to Michael Williard. Dilaudid is a schedule II controlled dangerous substance.

27. Over a period of seven months from February 5, 1988 to September 21, 1988, Respondent dispensed four thousand three hundred and ninety (4,390) tablets of dilaudid to fill prescriptions signed by Dr. Raymond Bayerle for fictitious patients. These prescriptions were picked up at Winn's Pharmacy by Michael Williard's wife, brother and friends.

28. Michael Williard subsequently pleaded guilty to a felony count of conspiracy to distribute dilaudid and dolophine in violation of 21 U.S.C. §846 in the United States District Court for the District of Maryland [in connection with prescriptions dispensed by Respondent].

29. The fact that Dr. Raymond Bayerle was not in a specialty, such as cancer treatment, that would call for the amount of the dilaudid obtained by the fictitious prescriptions signed by Bayerle and presented by Williard, his wife, brother and friends should have placed Respondent on notice that Dr. Bayerle, who also subsequently pleaded guilty to conspiracy to distribute dilaudid, was not prescribing for a legitimate medical purpose. The Board does not believe that the Respondent reported Dr. Bayerle to drug enforcement authorities. At the very least, Respondent could have declined to fill Dr. Bayerle's prescriptions. During the same time period, however, Respondent offered Dr. Bayerle a rental unit in Respondent's building so that Dr. Bayerle could open an office above Respondent's pharmacy.

Donald Zorbach

30. Over a six-month period including December 10, 1987 through June 23, 1988, Respondent filled prescriptions signed by Dr. Raymond Bayerle that provided five hundred (500) tablets of dilaudid and two hundred (200) tablets of dolophine (i.e., methadone) to Donald Zorbach.

31. Donald Zorbach subsequently pleaded guilty to a felony count of conspiracy to distribute dilaudid and dolophine in violation of 21 U.S.C. §846 in the United States District Court for the District of Maryland [in connection with prescriptions filled by Respondent].

32. Respondent enabled Donald Zorbach and Michael Williard to obtain large amounts of dolophine or methadone despite

circumstances that should have raised his suspicions. Respondent admits that on one occasion, after describing Dr. Bayerle's prescribing practices to Dr. Bayerle's supervisor, Respondent complied with the supervisor's request not to fill a particular prescription. December 11, T-34. Dr. Raymond Bayerle's practice was not registered as an authorized methadone treatment center and, in any case, would not have been authorized to use prescriptions to treat addicts. Moreover, as indicated above, Dr. Bayerle did not practice a specialty that would call for large amounts of dilaudid and dolophine. Yet, Respondent continued to fill prescriptions for large amounts of dilaudid and dolophine, in contravention of his corresponding responsibility to fill only those prescriptions that serve a legitimate medical purpose.

33. The Board is skeptical that a Howard County police officer, if told an accurate account of Dr. Bayerle's prescribing practices, would have advised Respondent to continue filling Dr. Bayerle's prescriptions. In any event, the Board finds, as acknowledged by Respondent, that a police officer does not have the expertise of a pharmacist to determine whether there is a legitimate medical basis for a prescription. In addition, the Board finds that the circumstances described in detail above warranted a refusal by the Respondent to fill Dr. Bayerle's prescriptions.

SUMMARY

34. Although Patients A, B and C saw Dr. Gordon in Timonium, Maryland and Donald Zorbach and Michael Williard obtained their prescriptions from Dr. Bayerle, who practiced in Howard County, all six patients took these numerous prescriptions to the Respondent at Winn's Pharmacy. Respondent was unable to give a coherent explanation of why all these patients would come "from all over the city" to Respondent's pharmacy in Highlandtown. December 11, 1991, T.60-64.

35. During the period January to July 1988, the Respondent also dispensed excessive amounts of dilaudid, a schedule II controlled dangerous substance. During that period, Winn's Pharmacy distributed 314 prescriptions that included a total of 28,580 tablets of dilaudid. [Its closest competitorin Maryland was Giant Pharmacy No 1155, which dispensed only eighteen prescriptions totalling 820 tablets]. Eighty per cent of those 28,580 tablets were dispensed by the Respondent to patients of Dr. Bayerle. In contrast, the average pharmacy in Maryland purchases approximately 500-1000 tablets of dilaudid for dispensing per year.

36. The Board believes the testimony of the State's expert witness, Dr. Eileen Zuckerman, who testified that, with respect to prescriptions written by Drs. Gordon and Bayerle, the pattern of dispensing by the Respondent constitutes incompetence in the practice of pharmacy. November 21, 1991, T.194.

37. By dispensing methadone, nembutal and dilaudid in excessive amounts and under highly suspicious circumstances, by continuing to dispense schedule II controlled dangerous

substances despite circumstances that should have alerted him that the prescriptions were not for a legitimate medical purpose, by failing to challenge repeated overprescribing by doctors who were not operating drug treatment facilities (and if they were, would not be authorized in any event to administer such drugs by way of prescription) and who were not practicing oncology or a similar specialty demanding massive amounts of painkilling treatments, and by failing to report suspicious prescribing practices in any meaningful way to the appropriate authorities, the Respondent demonstrated incompetence in the practice of pharmacy.

CONCLUSIONS OF LAW

Based on the aforegoing Findings of Fact, the Board hereby concludes as a matter of law that the Respondent is professionally incompetent in violation of Maryland Health Occupations Article §12-313(b)(20).

ORDER

On this 16 day of September 1992, it is

ORDERED by a vote of a two-thirds majority of the Board members now serving that Respondent's license to practice pharmacy is hereby **REVOKED**, and be it further

ORDERED that upon receipt of this the Respondent, Philip F. Shermak, P.D., shall immediately deliver the following items to the Board's Executive Director or her designated representative:

(1) his diploma-sized Certificate of Licensure by the Maryland Board of Pharmacy.

(2) his current Department of Health and Mental Hygiene License Renewal Certificate, and

(3) his current wallet-sized renewal card.

9/16/92
Date

Steven Cohen, P.D.
Chairman
Maryland Board of Pharmacy