

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PREPARDNESS AND SYSTEMS ADMINISTRATION**



IN THE MATTER OF:

REGINALD WILLS, M.D.

Respondent.

NOTICE OF SUMMARY ACTION TO SUSPEND LICENSE

To: Reginald Wills, MD
4440 Willard Ave.
Chevy Chase, MD 20815

In accordance with the provisions of the District of Columbia Administrative Procedure Act, D.C. Code § 2-509; the District of Columbia Health Occupations Revision Act of 1985, D.C. Code § 3-1205.15(a); and 17 DCMR § 4118, the District of Columbia Department of Health (DC Health) gives you notice of the summary suspension of your medical license, MD8436, under D.C. Code § 3-1205.15(a).

Your license is **summarily suspended** effective immediately upon receipt of this notice. If you wish to appeal this summary suspension of your license, you must file a request for a hearing within 72 hours after service of this notice. Should you request a hearing, one will be held within 72 hours of a timely request, and a decision will be rendered within 72 hours after the close of the hearing. The request for a hearing must be submitted in writing to Suzanne Fenzel, Senior Assistant General Counsel, DC Health. The request may be submitted by email to Suzanne.Fenzel3@dc.gov or by mail to 2201 Shannon Place, SE, 4th Floor, Washington, DC 20020. Ms. Fenzel can be reached at (202) 724-8915.

The District of Columbia (the District) is represented by the Office of the Attorney General for the District of Columbia. A copy of your hearing request and any pleading or other written communication addressed to DC Health must also be delivered to Anthony Celo, Assistant Attorney General (AAG), Office of the Attorney General for the District of Columbia, Civil Enforcement Section, 400 6th Street, NW, Washington, DC 20001. AAG Celo can be reached at (202) 735-7559 or by email at Anthony.Celo@dc.gov.

You may appear personally at the hearing, and you may be represented by legal counsel. You have the right to produce witnesses and evidence, to cross-examine witnesses against you, to examine evidence produced, and to have subpoenas issued to require the production of witnesses and evidence.

All hearings are conducted in the English language. If you or any witnesses to be called are deaf, have a hearing impediment, or cannot readily understand or communicate the spoken English language, an application may be made to the Administrative Law Judge for the appointment of a qualified interpreter.

A request for a hearing will not stay the suspension of your license.

The summary suspension is based upon the following charge as set forth below.

Charge: Your conduct presents an imminent danger to the health and safety of the public, for which DC Health can summarily suspend your license under D.C. Code § 3-1205.15(a)(1)(D).

On February 12, 2025, DC Health received a notification from Walgreens Corporation that it has discontinued dispensing controlled substances prescribed by Reginald Wills, MD. DC Health immediately began an investigation of your prescribing practices.

DC Health has determined that your practice of medicine poses an imminent danger to the health and safety of the public. You failed to query the District's prescription drug monitoring database before initiating a new course of treatment that includes prescribing an opioid or benzodiazepine to be taken for more than 7 consecutive days and/or failed to query the database every 90 days while the course of treatment continued for eleven patients in violation of D.C. Code § 48-853.03c(a), which is grounds for suspension under D.C. Code § 48-853.03c(d).

You violated several District of Columbia laws and regulations related to the practice of a health profession and drugs in violation of D.C. Code § 3-1205.14(a)(25) when you prescribed controlled substances for pain to nine patients and:

- failed to keep adequate medical records in violation of D.C. Code § 3-1205.14(a)(37);
- failed to include clear documentation of unrelieved pain in patients' medical records in violation of 17 DCMR § 4616.1;
- failed to take patients' complete medical history and perform physical examinations in violation of 17 DCMR § 4616.3;
- failed to describe the nature and intensity of pain in patients' medical records in violation of 17 DCMR § 4616.3(a);
- failed to describe current and past treatments for pain in patients' medical records in violation of 17 DCMR § 4616.3(b);

- failed to include an accurate and complete medical history and physical examination, including history of drug abuse or dependence, in patients' medical records in violation of 17 DCMR § 4616.14(a);
- failed to include the treatment objective in patients' medical records in violation of 17 DCMR § 4616.14(c);
- failed to include the discussion of risks and benefits of treatments in patients' medical records in violation of 17 DCMR § 4616.14(d);
- failed to maintain an accurate record of each prescription date, type, dosage, and quantity in patients' medical records in violation of 17 DCMR § 4616.14(f);
- failed to include instructions and agreements in patients' medical records in violation of 17 DCMR § 4616.14(g);
- failed to maintain current records in an accessible manner that is readily available for review in violation of 17 DCMR § 4616.15.

D.C. Health's Investigative Factual Findings

Walgreens Prescriber Block

On July 23, 2024; August 6, 2024; August 27, 2024; September 18, 2024; October 28, 2024; and October 30, 2024, Walgreens Corporation reportedly sent you notice that they were reviewing your prescribing practices and a questionnaire for you to complete. All attempts to deliver these notices were reported as unsuccessful.

On December 13, 2024, Walgreens reportedly attempted to notify you about a Prescriber Block based on your failure to respond to earlier efforts to gather information about your prescribing practices. Walgreens noted that attempts to deliver this notice by FedEx and fax were unsuccessful.

Prescription Drug Management System

D.C. Health's investigator's review of the District of Columbia Prescription Drug Monitoring Program (DC PDMP) data shows that you wrote 80 prescriptions for opioids and benzodiazepines for 22 patients that were dispensed in the District between January 1, 2024, and February 14, 2025. The Virginia Prescription Drug Monitoring Program (VA PDMP) data shows that you wrote 201 prescriptions for opioids for 51 patients that were dispensed in Virginia over the same period. However, DC PDMP query records show that you did not submit any patient queries over the same period before initiating a new course of treatment or therapy for these patients in violation of D.C. Code §48-853.03(c).

Interview

On May 14, 2025, you submitted to an in-person interview with Investigators Emilia Moran and Mark Donatelli. You described your practice as a solo practitioner with no support staff and limited office hours, but that you were available for “telehealth” by telephone call. You stated that in March 2023, you began providing pain management and stopped accepting medical insurance. You stated that in 2023 approximately 60% of your patients were for pain management and in 2024 approximately 75% of your patients were for pain management.

You explained that you queried DC PDMP before prescribing opioids when you were utilizing an e-prescription system, but you stopped checking when you started using paper prescription pads in November 2024. When the investigators told you that DC PDMP has no record of queries in 2024, you had no answer or explanation.

When Investigators Moran and Donatelli asked you about your rationale for prescribing controlled substances based only on physical exams or patient’s self-reported histories, you simply responded that it was because you were not providing long term care. You said, “I was seeing them monthly, so I could see what I did. What I did accomplished [*sic*], that was the first thing. Secondly, by the second month or the second time, I was getting to know the patient a little better, you know.” You then explained that you “didn’t really want to be involved in sending people back and forth for medical records and x-rays; because many of them had had that,” and lacked insurance or “just wanted to show up and get a physical exam and see what was going on.” You stated, “my rationale was trying to help people to see what’s going on. But at the same time not create a problem for myself.” You explained that you did not ask patients for more clinical information because you were “dealing with the urgency of the person saying ‘I’m in pain.’”

When asked what processes you use to evaluate treatment effectiveness and tapering, you stated that you repeat the physical exam. You acknowledged that “history would be the most reliable,” but your patients are unwilling to report improvement in symptoms because they are “afraid you’re gonna cut them back, which you try to do. I try to do.” You stated that you attempt to taper patients off opioids by trying to “give them three months” or adding muscle relaxants and getting patients to exercise.

You admitted that you prescribe both opioids and muscle relaxants because patients “come for the pain relief” and will not “accept” that “the opioids are temporary and they’re not doing anything to cure you” and “the muscle relaxant ... is taking that muscle out of spasm and allow it to rest and rebuild some fibers.” When Investigators Moran and Donatelli asked why you did not transition patients to more conservative pain management plan, you said “they didn’t want it.” When they said, “shouldn’t that tell you something,” you responded “No. I mean you are not a practitioner. I am not saying that in an arrogant way. If a patient comes to my office and I say we are gonna start you on Tylenol #3 or #4, ‘I don’t want that I had it

already.” You explained that 95 out of 100 patients would not accept “Tylenol #3” because they have already had it.

You admitted that you did not have patients sign pain management contracts but explained that when patients “are Jonny on the spot when is time to get their refills, then I will suspect that they are not getting them from anywhere else.” Nonetheless, you agreed that you “should’ve really have them sign a contract.”

You suggested that you prescribed opioids out of concern that if patients can’t get pain medications, “they’re gonna buy much more dangerous products, like Fentanyl,” or “possibly they would get methadone suboxone.” You stated that you “wouldn’t dare put it in the notes” if a person came to you because they couldn’t get pain medications elsewhere. When asked if you were running a “pill mill,” you said “I don’t think it’s a pill mill, I think it’s more like an urgent care, or sub-urgent care type of thing. Because people don’t come in and say, ‘I want Dilaudid or I want Oxycodone 20 or I want this or that.’”

When Investigators Moran and Donatelli asked you about the prescriber block issued by Walgreens, you said “Well, I think it’s difficult for black people to get pain medicine...I think what happens, just being candid with you, I know you are not gonna hold this against me because I am talking about race. If a person got a prescription filled, they’re gonna tell their friends. I always tell them, go to your local family-owned pharmacy that’s your best bet....They will tell their friends, we can get this over here we can get this over there.” You denied receiving any official notifications from Walgreens Pharmacy about the prescriber block. You admitted that you knew about a prescriber block issued by CVS but were adamant that it was racially motivated.

Patient Records¹

On March 28, 2025, DC Health Investigators Moran and Donatelli served you a subpoena for the immediate production of the records of fifteen patients selected from the DC PDMP and VA PDMP data. You stated that all patient records had been relocated to a storage facility and that you would need more time to produce them. You requested and were granted an extension to produce the records no later than April 4, 2025. On April 4, 2025, you requested and were granted another extension to April 7, 2025. You provided Investigator Moran with pages of handwritten notes—several portions of which were illegible.

On April 7, 2025, you emailed Investigator Moran to report that you could not locate two of the fifteen requested patient records—Patient JA and Patient KD. According to PDMP data, you prescribed JA a total of 480 oxycodone pills over a period of 140 days and you prescribed KD a total of 960 codeine pills which were dispensed over a one-month period, 1,193 alprazolam pills which were dispensed over a total period

¹ All quotes from patient medical records are taken verbatim with no corrective language added.

of 141 days, and 270 oxycodone pills which were dispensed over a period of 56 days.

During your interview, you indicated that the medical records provided were a true and exact copy of each patient's full medical record. However, you later admitted that at least one patient's records were a "summary." You told Investigators Moran and Donatelli that you did not know if your patient records were "up to somebody else's standard." When the investigators explained to you that pain management has specific regulatory requirements for patient records, you claimed you were not practicing pain management despite earlier representations that approximately 75% of your patients are seen for pain management.

Patient AS

Patient AS presented on July 7, 2024, as a 34 year old male, and you recorded complaints of left shoulder pain from a motor vehicle accident that was not relieved by over-the-counter pain medications. You did not record the date of the accident, any physical examination, or imaging results. You recorded one controlled substance prescription in the patient's medical record, "Oxycodone 10 mg 3x a day," but wrote a total of five prescriptions for oxycodone between July 2024 and November 2024. Patient AS presented for a follow-up on an unknown date and you recorded that his shoulder felt normal and returned to premorbid state.

A review of AS's prescribing history shows that you prescribed a total of 210 Oxycodone HCL 10 mg tablets and 30 Oxycodone-Acetaminophen 10-325 tablets over a five month span.

Investigators Moran and Donatelli asked you why AS's records do not have the date of the accident or imaging of the injuries. You explained that AS "had gone to a lawyer who sent him to a doctor and he had some imaging which was not ... wasn't positive. He didn't have any dislocations, broken bones... So, I didn't think it was worth to repeat that." Yet, you admitted that you did not review the prior imaging or any prior reports yourself.

Patient AT

Patient AT presented on August 22, 2024, as a 68 year old male, by telemedicine and you noted that he "has not been my patient in a consistent manner for several years" but "he is suffering from metastatic prostate [cancer]" and was seeking pain, blood pressure, and COPD medications. You did not conduct a physical examination but noted he "is emaciated" but you were "not able to get vital signs & reluctantly agree to write his prescriptions until he can reconnect his cancer physician." You wrote a treatment plan, including codeine and oxycodone—for which you noted "limit supply."

You recorded undated telemedicine appointments in the months of September, October, November, and December 2024, and noted no changes.

You recorded additional telemedicine appointments in the months of January, February, and March 2025. In February 2025, you wrote “[n]o contact prescription given to grandson.” In March 2025, you wrote “patient abused his last renew prescription by me.”

A review of AT’s prescribing history shows that you continuously prescribed AT codeine and oxycodone between January 2024 and August 2024, and again in December 2024. Every month, you prescribed 120 Oxycodone HCL 10 mg tablets and between 600 and 1200 quantities of Promethazine-Codeine solution.

When Investigators Moran and Donatelli asked you about AT, you admitted that you only spoke with him over the telephone and never saw him in person or on video. You admitted that you continued to prescribe to AT without a physical assessment because his grandson was asking you to continue the prescriptions, which was “not good practice on my part.” You claimed that you were unable to contact AT’s oncologist, however, the provided records do not have the name or any record of attempts to contact the oncologist.

You explained that AT’s records are missing exact dates because they are summaries of what you were able to recall based on looking at the prescribing history. Investigators Moran and Donatelli then asked you if the records are real, you explained “I don’t have any records of when I talked to him on the phone. So, I tried to put down accurately what had happened.”

Patient AB

Patient AB presented on August 1, 2024, as a 24 year old female, with complaints of right shoulder and lower back pain from a motor vehicle accident that was not relieved by over-the-counter pain medications. You recorded vital records and a decreased range of motion, and listed a treatment plan including Percocet. On August 12, you prescribed 30 Oxycodone HCL 10 mg tablets.

On August 20, 2024, you noted improvement and a plan to “continue narcotics PRN” with a follow-up in two weeks “perhaps to DC narcotic.” On August 22, you prescribed 30 Oxycodone-Acetaminophen 10-325 tablets.

On August 31, 2024, you noted that you approved AB’s request for more oxycodone for “increased pain” and noted that her “exam unchanged” without record of vital records or physical examination. You prescribed 45 Oxycodone-Acetaminophen 10-325 tablets.

On September 18, 2024, you noted that patient reported issues with lifting and “nagging discomfort” in back. You recorded equal range of motion in shoulders and

no lower back spasms. You noted “final prescription Percocet PRN patient can wean self.” On September 25, you prescribed 60 Oxycodone-Acetaminophen 10-325 tablets.

A review of AB’s prescribing history shows that you prescribed a total of 30 Oxycodone HCL (IR) 10 mg tablets and 135 Oxycodone-Acetaminophen 10-325 tablets over two months.

Patient AM

Patient AM presented on February 24, 2024, as a 51 year old female, for medication refills. You noted a history of thyrotoxicosis, depression, episodic wheezing, recurrent sinusitis, and lower back pain. You recorded vital signs, weight, and observations from a physical examination. You noted that AM reported pain in extremities that “right knee chronically makes her unable to bare weight.” You wrote a treatment plan but did not specify which medications were refilled or how you determined proper dosage for refilled medications.

On April 4, 2024, AM presented for a follow-up to report “acute low back pain.” You noted her vitals and that “forward bending 60° with pain stans at 45°.” You recorded “Percocet tabs +2/4 . . . Add Flexeril 3x 1 day. Oxycodone 10 mg PRN Q8H.”

On April 26, 2024, AM presented for a follow-up and indicated she was feeling better with the medications but her “back still easy to start hurting.” You wrote that AM will continue Oxycodone.

On June 12, 2024, AM reported that her “back still an issue” and that you refilled her medications. You also prescribed AM 90 Alprazolam 1 mg tablets but did not note this change in her record.

On July 19, 2024, AM reported continued back pain and you noted discussing sleep postures, Epsom salt bath, and physical therapy. You did not indicate if any medications were refilled.

On August 19, 2024, AM presented for a follow-up and you noted refill of prescriptions “for chronic problems.”

On September 20, 2024, AM presented for a follow-up and reported that her back is “doing better.” You noted that AM was advised to only use meds for pain, to “make efforts to wean herself off Oxycodone,” and to switch to NSAIDs. You did not indicate if any medications were refilled.

On October 3, 2024, AM presented for a follow-up with no acute problems. You noted her condition is improving and you “will allow refills of pain prescriptions.”

A review of AM's prescribing history shows that between March 2024 and January 2025, you prescribed AM 90 Oxycodone HCL (IR) 10 mg tablets monthly. In December 2024 and January 2025, you prescribed AM a total of 210 Acetaminophen-Codeine #4 tablets.

Patient BG

Patient BG presented on April 16, 2024, as a 37 year old male, with complaints of right shoulder and upper back pain from a motor vehicle accident earlier in the year. BG stated pain came from lengthy or repetitive arm movements and that over-the-counter medications are not helping. You noted his weight and blood pressure and that a physical examination showed "somewhat guarding able to move arm all planes." You wrote "should/back contusion aggravated by use / might benefit from NSAID with change." You recorded a treatment plan of orthopedic referral, that you explained "RICE", and that you will prescribe 20mg of Oxycodone for a week.

On August 31, 2024, BG presented with complaints of unresolved shoulder pain. You noted that you reduced Oxycodone to 10 mg and prescribed Flexeril to use in place of over-the-counter medications.

On September 20, 2024, BG presented with reported improvement stating that "change to Flexeril really worked." You noted no changes to "current prescriptions."

On October 11, 2024, BG presented with reported improvements. You recorded that shoulders were "bilaterally the same." You wrote that treatment will "continue with no change. Make med PRN."

On December 17, 2024, BG presented and stated that after "8 weeks using some meds not everyday. Able to do most activities." You recorded that "right shoulder essentially the same as left shoulder." You noted the treatment plan as "Prescription 1 month."

On January 14, 2025, BG presented "requesting Oxycodone" for shoulder pain. You recorded that range of motion of right shoulder "not completely equal" to left shoulder. You noted "chronic pain syndrome" and your treatment plan included muscle relaxant, "refill oxycodone if what he has runs out," and a referral to "ortho MD."

A review of BG's prescribing history shows that in January and February 2024, you prescribed BG 240 quantities of Promethazine-Codeine solution per month. In August and September 2024, you prescribed BG 30 Oxycodone HCL (IR) 10mg tablets per month. In November 2024, you prescribed BG 60 Alprazolam 1 mg tablets and 120 Alprazolam 2 mg tablets. In February 2025, you prescribed BG 60 Alprazolam 1 mg tablets.

Patient CC

Patient CC presented on April 3, 2024, for an initial consultation for lower back pain. She noted no injuries to her lower back and stated that she used to work “as a meat locker employee at a supermarket,” and was currently assisting physically disabled students on and off the school bus. After physical examination, you assessed her as “probably nerve root irritation in lower thoracic and lumbar vertebrae.” You noted that she had no health insurance and was not able to “afford to pay out of pocket for consultation and neurological imaging.”

On July 29, 2024, CC presented for a follow-up. You noted that she was “walking much better,” but also noted that she “asked that I not lower meds as sometimes she feels like stay bet. Will allow same dose of analgesic.” Your plan was to “continue meds as last month. Add muscle relaxants-Flexeril.”

On August 19, 2024, CC presented for a follow-up. You noted that she reported, “Flexeril causing her feel unsteady on bus. Ok only take when not working.” You described her gait as more relaxed and noted you would discontinue Flexeril. The plan noted, “Pt advised to take muscle relaxant especially at bedtime. Continue Oxycodone.”

On August 31, 2024, CC presented for a follow-up. You noted that she “still needs MRI and health provider/neuro assessment.” Your plan was to continue Oxycodone and Flexeril.

On September 24, 2024, CC presented to “refill meds.” Your objective exam noted her forward bending of 60°. You recommended gentle stretches to help and renewed Oxycodone and Flexeril.

On October 9, 2024, CC presented for follow-up. The note did not denote any physical exam and you renewed the prescriptions for Oxycodone and Flexeril.

A review of CC’s prescribing history shows that you prescribed 300 Oxycodone-Acetaminophen 10-325 pills between January and March 2024. After her April 2024 visit, you prescribed her a total of 892 Oxycodone HCL 10 mg tablets over nine months and twenty days. On average, you prescribed CC more than 94 pills or tablets per month for over a year.

Patient LT

Patient LT presented on March 6, 2024, as a 30 year old female with complaints of “menstrual and post-menstrual pain 8/10. She also notes sever low back pain with multiple joints with arthritis dx.” You did not perform a pelvic exam because she presented with menses. Your assessment noted, “patient has significant [illegible] ~~menopausal~~ menstrual pain. Overusing NAIDs, Tylenol with Codeine not effective.”

Your plan noted, "Oxycodone 10 mg 3x3 day for 7 days. Cyclobenzaprine 10 mg 3x as needed for muscle spasm."

On March 25, 2024, LT presented for a follow-up and reported "positive results from meds." You did not conduct an exam. Your assessment reads, "Improved," and your plan was to "Refill Oxy Cyclobenzaprine."

On April 17, 2024, you noted that LT was, "only able to get 1 week of meds (pharmacy ran out of Oxycodone). Rewrite prescription for 2 weeks."

On April 23, 2024, you note that LT reported "75%" relief of symptoms. You recommended she consult with a gynecologist to rule out diagnosis of endometriosis. You noted, "Rx given to patient."

A review of LT's prescribing history shows you prescribed 201 Oxycodone HCL 10 mg tablets over the course of six weeks.

When Investigators Moran and Donatelli asked you about the clinical rationale for the prescriptions, you responded "history. I thought she had endometriosis but we didn't have a way to get her to a gynecologist who would see her."

Patient MD

Patient MD presented on June 19, 2024, as a 43 year old female, with complaints of "chronic pain OTC rx 'not working.' Patient her pain low lumbar & sacral" radiating to buttocks right more than left. Pain was described as "intermittent, sharp & aching." She did not report previous surgeries or heavy lifting but reported being her husband's caretaker. You noted that "patient has maculopapular rash on torso and upper extremities. Has been using peroxide with minimal refilled. Some itching." Your physical exam findings read "forward bending to @ 60 degrees some paravertebral muscle spasm 2+/4." Your assessment noted "maculopapular rash-looks allergic. Chronic low back pain with pass. Radiating to leg L>R." Your plan noted "trial with mild steroid cream - do not put on face. Oxycodone 10 mg, Flexeril 10 mg - try not overload back assisting husband."

On June 26, 2024, MD presented for a follow-up and you noted she "looks more relaxed" and that the skin rash resolved with the use of steroid cream. She reported that the medications helped and you noted that her condition had improved. Your plan was to continue medications without change.

On July 19, 2024, MD presented for a follow-up and reported improved effect and effective pain medications. A physical exam of her back noted "unchanged." Your assessment reads, "doing better," and your plan was to continue "present regimen."

On August 17, 2024, MD presented “for refill of Oxycodone and Flexeril.” Your objective assessment noted “straight legs raising today-negative-bilateral hung clear.” Your plan was to “Reduce Oxy frequency on return session.”

On August 30, 2024, you and MD “discuss need for lower Oxycodone use. Patient believe she is getting better need more time on meds.” Your plan was to “Reduce Oxy frequency on return session.”

A note dated September 16, 2024 reads, “Pt agrees to lower Oxy frequency still has meds, try 2 tabs every other day.”

On September 25, 2024, MD reported that she was concerned regarding her husband and reported that she was “maybe moving back to NY state.” Your plan was to “Allow refill.”

A note dated October 7, 2024 reads, “Pt cannot stop meds she thinks as her husband is moving much better. She is not [illegible] herself.” Your plan notes to change visits to as-needed. You provided two week “supply meds for emergency.”

A review of MD’s prescribing history shows that you prescribed 240 Oxycodone HCL 10 mg tablets and 120 Cyclobenzaprine 10 mg tablets over less than three months.

Patient JD

Patient JD presented on June 28, 2024, as a 52 year old male, accompanied by his wife, MD, “who was referred to my office by another patient.” You described him as not being a good historian and noted that “the source of the issue appears to be early onset of dementia.” He complained of “severe back pain” radiating “into both legs” and weakness in both legs for the previous five years. Your objective examination noted “forward bending 45°, not able to arch his back. Legs are only able to be lifted 6-8 inches,” and a shuffling gait. Your assessment noted “probable herniated disc disease.” JD reported doing “better when he as pain medication.” Your plan included Oxycodone 10 mg and Cyclobenzaprine 10 mg with reevaluation after medication, and you noted he, “Does not want PT or neuro referral.”

On August 30, 2024, JD presented for a follow-up and you noted his symptoms were “markedly improved.” The record also noted that JD was more verbal and indicated his condition had improved with the prescribed medications, but that he did not “want neuro eval & notes MRI done multiple times does not want another.” Your objective assessment noted that he was still unable to stand straight and reported, “I am in pain,” that he displayed forward bending of 45°, and that he is improved but, “he thinks he will be better at higher doses of meds.” You provided medication refills.

On September 13, 2024, JD's wife informed you that the "pharmacy only gave 1/2 of q/30 Rx as that was all they had. Allow 2 weeks of meds." You noted that JD needed to return in two weeks with discussion of referral and prescription for Suboxone.

On September 25, 2024, JD presented for a follow-up and you noted he "probably needs referral to neuro/discussed in detail." You also note "Exam of back only marginal improvement," and refilled medication for "1/2 meds (2-week supply)."

On October 7, 2024, JD and he wife returned for a follow-up and reported that "they are planning to NY. Discussed in detail need for objective info (MRI, neuro MD)...[A]lso I raised issue of dependence this was not the issue but needs to be addressed. Allow 2-weeks refill for patient's return to N.Y. Prognosis guarded."

A review of JD's prescribing history shows that you prescribed 314 Oxycodone HCL 10 mg tablets over less than four months. In total, you prescribed JD and his wife MD a total of 914 Oxycodone HCL 10 mg tablets and 120 Cyclobenzaprine 10 mg tablets over less than four months.

When Investigators Moran and Donatelli asked you about MD and JD, you admitted that "I really didn't question them that hard. Because they were... They looked dysfunctional. She had a terrible rash all over her body and he was out of it. And he wasn't out of it because he was drunk (excuse my language) or intoxicated; he just seemed very poverty of thought. You know, and I asked her what's going on with him. And she said, he needs his medicine, he hasn't had any medicine [pain medicine] for a while." Investigators Moran and Donatelli asked you if that was a "red flag," and you explained that it is not uncommon for people on pain medication to not function without it and stated that "[t]hey can't even put thoughts together." When asked if that was indicative of dependency, you answered "It is . . . but he was off of it so that's why he had the deficit." You then volunteered that you saw MD and JD more frequently because you had concerns about them misusing the medications.

Conclusion

Based on the above, your practice of medicine poses an imminent danger to the health and safety of the public and your license is hereby summarily suspended.

Please note that your request for a hearing does not stay this summary suspension. In addition, under 1 DCMR § 2818, your failure to appear at the time and place set for the hearing, either in person or through counsel, or both, will not preclude DC Health proceeding in this matter.

07/16/2025
DATE

J. Sam Hurley
J. SAM HURLEY, MPH, EMPS
Senior Deputy Director

**District of Columbia Department of Health
Health Systems and Preparedness Administration**