

**State of New Hampshire
Board of Medicine
Concord, New Hampshire 03301**

In the Matter of:
Robert H. Richardson, M.D.
No.: 7206
(Misconduct Allegations)

SETTLEMENT AGREEMENT

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine (“Board”) and Robert H. Richardson, M.D. (“Dr. Richardson” or “Respondent”), a physician licensed by the Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a; and Medical Administrative Rule (“Med”) 206 and 210, the Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.
2. The Board first granted Respondent a license to practice medicine in the State of New Hampshire on September 10, 1985. Respondent holds license number 7206. Respondent's license to practice medicine lapsed on June 30, 2007.
3. In December of 2008, the Board received information that Dr. Richardson continued to practice medicine after his license lapsed on June 30, 2007. The Board also received information from a patient who said that Dr. Richardson failed to return the

phone calls of a patient diagnosed with depression. (BOM # 2008-314, 2009-67 and 2009-262).

4. In response to this, the Board conducted an investigation and obtained information from various sources pertaining to Respondent's practice without a license and the quality of care provided to patients while he was licensed. A random selection of thirteen patient files was reviewed to assess the quality of care provided to Respondent's patients.
5. Respondent stipulates that if a disciplinary hearing were to take place, Hearing Counsel would prove that Respondent engaged in professional misconduct, in violation of RSA 329:17, VI (c) (engaged in a pattern of conduct which is incompatible with basic knowledge and competence which is expected of persons licensed to practice medicine or any particular specialty thereof); RSA 329:17, VI (d) (conduct which is repeatedly negligent in practicing medicine); RSA 329:17, VI (k) (failed to maintain adequate medical record documentation on diagnostic and therapeutic treatment); RSA 329:24 (Unauthorized practice); Med. 501.01(a); Med. 501.02 (d); Med. 501.02 (e) (1) and (2); Med 501.02 (h); Med 501.02 (i); Med 501.02 (j); and the *American Medical Association, Code of Medical Ethics, Standard 8.19*, (relating to self-treatment of physicians) by the following facts:
 - A. Dr. Richardson was licensed to practice medicine in the State of New Hampshire from September 10, 1985 through June 30, 2007. Dr. Richardson practiced psychiatry at Mental Health Associates, P.O. Box 549, Jackson, NH 03846-0549.

- B. On or between July 1, 2007 and December 30, 2008 Dr. Richardson treated patients and prescribed controlled substances and other medication for patients after his New Hampshire Medical license had lapsed.
- C. On or between January 11, 2002 and December 9, 2008, Dr. Richardson treated Sandra S.
- (1) The medical record for Sandra S. does not document an adequate or complete mental status examination or evaluation.
 - (2) The medical record for Sandra S. does not accurately and completely document each patient encounter.
 - (3) The medical record for Sandra S. documented that Dr. Richardson prescribed Zoloft, Wellbutrin, Paxil, Effexor, Baclofen and Ambien for Sandra S.
 - (4) The medical record for Sandra S. does not document a discussion about the risks, benefits or side effects of any of the medications.
 - (5) The medical record documented that Dr. Richardson continued to treat Sandra S. after his New Hampshire medical license lapsed on June 30, 2007.
- D. On or between December 12, 2002 and October 10, 2008, Respondent treated Jim D.
- (1) The medical record does not accurately and completely document each patient encounter and does not document an evaluation of Jim

- D. The medical record fails to clearly document a treatment plan appropriate for Dr. Richardson's specialty.
- (2) The medical record fails to completely document medications prescribed for Jim D. The medical record documented appropriate medication, dosage and direction, but failed to document the number of pills prescribed. The medical record failed to document a discussion about the risks, benefits or side effects of any of the medications.
 - (3) The medical record documented that Dr. Richardson continued to treat Jim D. after Dr. Richardson's New Hampshire medical license had lapsed.
- E. On or between July 7, 2001 and September 8, 2006, Dr. Richardson treated Judie J.
- (1) The medical record documents treatment records from multiple providers. The medical record does not accurately and completely document each patient encounter and does not document an evaluation, diagnosis or treatment plan for Judie J. appropriate for Dr. Richardson's specialty.
 - (2) The medical record fails to completely document medications prescribed for Judie J. The medical record documented appropriate medication, dosage and direction, but failed to document the number of pills prescribed. The medical record failed to document

a discussion about the risks, benefits or side effects of any of the medications.

- (3) The medical record stops on May 8, 2006. Correspondence in the medical record discusses home visits to occur every other Friday evening beginning on September 8, 2006. The medical record fails to document the home visits.

F. On or between September 22, 2008 and December 22, 2008, Respondent treated Thomas T.

- (1) The medical record does not accurately and completely document each patient encounter. The medical record failed to adequately document follow-up treatment provided at each visit.
- (2) Dr. Richardson prescribed Risperdal, and prescribed Methadone to Thomas T. for detoxification and pain management.
- (3) The medical record did not include either a pain management contract or urine drug screens to assess Thomas T.'s compliance with the Methadone treatment.
- (4) The medical record failed to document a discussion about the risks, benefits or side effects of any of the medications.
- (5) Respondent failed to accurately and completely document each patient encounter with Thomas T. Respondent failed to document in the medical record sufficient detail and information necessary to document his assessment or evaluation of Thomas T.'s progress.

- (6) Dr. Richardson treated Thomas T. after Dr. Richardson's New Hampshire medical license lapsed.
- G. On or between June 9, 1992 and October 24, 2008, Respondent treated Patricia B.
- (1) The medical record does not accurately and completely document each patient encounter and does not document an evaluation, diagnosis or treatment plan for Patricia B. appropriate for Dr. Richardson's specialty. Dr. Richardson failed to document a complete and accurate patient history and mental status examination. Respondent failed to clearly separate individual and/or couple's therapy.
 - (2) The medical record documented that Dr. Richardson prescribed Serzone, Seroquel and Zyprexa, Celexa and Geodon. Respondent failed to document the rationale for continuing or changing Patricia B.'s medication regime. The medical record failed to document a discussion about the risks, benefits or side effects of any of the medications. Respondent prescribed Klonopin and Ativan, Namenda, Gabitril and Lexapro for Patricia B., in doses and in a manner that was appropriate.
 - (3) Respondent continued to treat Patricia B. after his New Hampshire medical license lapsed.

H. On or between February 1998 and March 6, 2007, Respondent treated Cornelia D.

- (1) Respondent prescribed Wellbutrin for Cornelia D. but the start date of this medication was not documented in the file. The dosage prescribed appears to be within an appropriate range.
- (2) The medical record did not document the rationale for initiating Wellbutrin therapy. The medical record did not document a discussion of the risks, benefits or side effects of the medication.
- (3) Respondent failed to accurately and completely document each patient encounter with Cornelia D.
- (4) The medical record failed to adequately document follow-up treatment provided at each visit.

I. On or between November 5, 2003 and December 29, 2008 Respondent provided pain management treatment for Richard M.

- (1) The medical record documents treatment records from multiple providers. The medical record does not accurately and completely document each patient encounter and does not document an evaluation for Richard M. which was appropriate for Dr. Richardson's specialty.
- (2) Respondent failed to accurately and completely document each patient encounter with Richard M.

- (3) The medical record documents that Dr. Richardson prescribed Oxycodone as part of Richard M's treatment.
 - (4) The medical record did not document a discussion of the risks, benefits or side effects of the medication.
 - (5) Dr. Richardson continued to treat Richard M. after Dr. Richardson's New Hampshire medical license had lapsed.
- J. On or between May 1, 2004 and December 2, 2008, treated Kim C.
- (1) Respondent failed to accurately and completely document each patient encounter with Kim C.
 - (2) Respondent diagnosed Kim C. with ADHD. The medical record fails to adequately document an initial evaluation of Kim C. which supported this diagnosis.
 - (3) The medical record documented that Dr. Richardson prescribed Dexadrine, Oxycodone and Methadone for Kim C.
 - (4) The medical record did not document a discussion of the risks, benefits or side effects of the medication.
 - (5) The medical record failed to adequately document the progress and treatment plan in Kim C.'s follow-up treatment.
 - (6) Dr. Richardson continued to treat Kim C. after his New Hampshire medical license had lapsed.
- K. On or between November 12, 1996 and November 6, 2008 respondent provided medical care for his colleague in the medical practice, Richard A.

- (1) The medical record documented multiple dates where "blood letting sessions" transpired.
 - (2) Respondent failed to accurately and completely document each patient encounter with Richard A. The medical record failed to document an evaluation or treatment plan for Richard A. appropriate for Dr. Richardson's specialty.
 - (3) On June 23, 2001, Respondent prescribed Wellbutrin for Richard A. The medical record failed to document the rationale for this treatment and documented no discussion of the risks, benefits or side effects of this medication.
 - (4) Dr. Richardson continued to treat Richard A. after Dr. Richardson's New Hampshire medical license had lapsed.
- L. On or between February 25, 2004 and June 12, 2007, Dr. Richardson treated Bruce F.
- (1) The medical record failed adequately document each patient encounter in a legible and organized manner.
 - (2) The notes are signed and dated, but include no history, diagnosis or treatment plan appropriate to Dr. Richardson's specialty.
- M. On or between July 1, 2008 and December 22, 2008, Respondent treated James T.
- (1) The medical record failed to accurately and completely document all patient encounters with James T.

- (2) The medical record failed to document a treatment plan for James T. which was appropriate for Dr. Richardson's specialty.
- (3) The medical documented that Respondent prescribed Effexor, Namenda, Gabitril and/or Lexapro for James T.
- (4) The medical record failed to document a discussion of the risks, benefits and side effects of using the medication.
- (5) Dr. Richardson treated James T. after Dr. Richardson's New Hampshire medical license had lapsed.

N. Dr. Richardson treated Peter B from October 12, 2008 through December 7, 2008.

- (1) Respondent failed to accurately and completely document each patient encounter with Peter B.
- (2) The medical record failed to document a patient history, exam, diagnosis and treatment plan appropriate to Dr. Richardson's specialty.

O. On or between July 15, 200 and July 1, 2008 Respondent treated Barbara H.

- (1) Dr. Richardson failed to accurately and completely document each patient encounter with Barbara H.
- (2) The medical record failed to document a diagnosis, and failed to document rationale for the treatment provided.
- (3) The follow-up notes do not adequately document outside treatment or a treatment plan appropriate to Dr. Richardson's specialty.

(4) The medical record documented that on June 25, 2007, Dr. Richardson prescribed Effexor for Barbara H. The medical record did not document a discussion of the risks, benefits or side effects of this medication. Respondent prescribed Zoloft and Cymbalta without an explanation of the rationale for commencing or phasing out this drug therapy.

(5) Dr. Richardson continued to treat Barbara H. after his New Hampshire medical license had lapsed.

P. On or between November 6, 2007 and January 15, 2008 Respondent treated Ann L. Respondent failed to provide adequate follow-up care to Ann L. in that he failed repeatedly to return telephone and written messages to schedule her follow-up treatment.

Q. On March 25, 2009, Respondent underwent an evaluation which revealed that Respondent used samples of Venlafaxin, for his personal use.

6. The Board finds that Respondent committed the acts as described above and concludes that, by engaging in such conduct, Respondent violated RSA 329:17, VI (c), (d), (k); RSA 329:24; Med. 501.01(a); Med. 501.02 (d); Med. 501.02 (e) (1) and (2); Med 501.02 (h); Med 501.02 (i); Med 501.02 (j), and the *American Medical Association Code of Medical Ethics, Standard 8.19*.

7. Respondent acknowledges that this conduct constitutes grounds for the Board to impose disciplinary sanctions against Respondent's license to practice as a physician in the State of New Hampshire.

8. Respondent consents to the Board imposing the following discipline pursuant to RSA 329:17, VII:
 - A. Respondent is REPRIMANDED.
 - B. Respondent is required to participate, at his own expense, in a COMPETENCE ASSESSMENT performed by the Center for Personalized Education for Physicians ("CPEP") in Denver, Colorado, or an equivalent comprehensive evaluation of his clinical skills and his mental and physical ability to practice medicine. The name, address and description of an equivalent alternative evaluation shall be pre-approved by the Board.
 - C. The CPEP assessment, or its equivalent, shall be completed within one (1) year from the effective date of this *Settlement Agreement*. Within fifteen (15) days of completing the assessment program, Respondent shall notify the Board and provide written proof of completion.
 - D. Within 60 days of completion of the assessment program, Respondent shall provide a copy of any written report, assessment, evaluation or recommendations made as part of the assessment program. Respondent shall sign all releases necessary to allow agents of the New Hampshire Board of Medicine to receive copies of the CPEP or equivalent assessment and/or to discuss the assessment with representatives of the assessment program.
 - E. Respondent shall follow all recommendations made for treatment and/or follow up measures made by the assessment program or evaluation.

- F. Respondent shall sign any releases necessary and arrange for the Board to receive a copy of all evaluations or assessments completed as part of the follow-up recommendations made by the CPEP program or its equivalent. Respondent shall provide the Board with an initial assessment by the provider of any follow-up treatment or training or remedial measures recommended by CPEP or its equivalent within 60 days of the commencement of the follow-up treatment or training. Respondent shall continue to provide quarterly reports to the Board of the follow-up treatment or training through the duration of the treatment or training.
- G. For the purposes of reporting follow-up treatment and training a quarter shall begin on the first day of the month following the date of an initial assessment or evaluation, and shall end on the last day of the third month following that month.
- H. Respondent shall bear all costs of complying with the terms of this *Settlement Agreement*, but he shall be permitted to share such costs with third parties.
- I. The Board may consider Respondent's compliance with the terms and conditions herein and with the recommendations of any treating mental health professional in any subsequent proceeding before the Board regarding Respondent's license. Respondent shall sign any releases necessary to enable the Board to receive progress reports from any provider of mental health counseling. Progress reports should be provided to the Board on a quarterly

basis, commencing with an initial treatment evaluation provided within thirty days of the commencement of any such treatment.

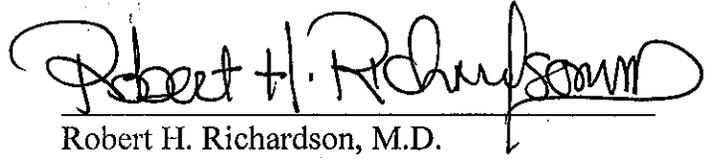
- J. Any application or petition for reinstatement of Respondent's lapsed license shall not be considered by the Board until he has fulfilled all follow-up recommendations of the CPEP program or its equivalent and has received notice from the Board that he is in compliance with all of the terms and conditions of this Settlement Agreement.
- K. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the *Settlement Agreement* to any current employer for whom Respondent performs services as a physician or work which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority which licenses, certifies or credentials physicians, with which Respondent is presently affiliated.
- L. For a continuing period of three (3) years from the effective date of this agreement, Respondent shall furnish a copy of this *Settlement Agreement* to any employer to which Respondent may apply for work as a physician or for work in any capacity which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority that licenses, certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

9. Respondent's breach of any terms or conditions of this *Settlement Agreement* shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the Board.
10. Except as provided herein, this *Settlement Agreement* shall bar the commencement of further disciplinary action by the Board based upon the misconduct described above. However, the Board may consider this misconduct as evidence of a pattern of conduct in the event that similar misconduct is proven against Respondent in the future. Additionally, the Board may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.
11. This *Settlement Agreement* shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.
12. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to him other than those terms and conditions expressly stated herein.
13. The Board agrees that in return for Respondent executing this *Settlement Agreement*, the Board will not proceed with the formal adjudicatory process based upon the facts described herein.
14. Respondent understands that his action in entering into this *Settlement Agreement* is a final act and not subject to reconsideration or judicial review or appeal.
15. Respondent has had the opportunity to seek and obtain the advice of an attorney of his choosing in connection with his decision to enter into this agreement.

16. Respondent understands that the Board must review and accept the terms of this *Settlement Agreement*. If the Board rejects any portion, the entire *Settlement Agreement* shall be null and void. Respondent specifically waives any claims that any disclosures made to the Board during its review of this *Settlement Agreement* have prejudiced his right to a fair and impartial hearing in the future if this *Settlement Agreement* is not accepted by the Board.
17. Respondent is not under the influence of any drugs or alcohol at the time he signs this *Settlement Agreement*.
18. Respondent certifies that he has read this document titled *Settlement Agreement*. Respondent understands that he has the right to a formal adjudicatory hearing concerning this matter and that at said hearing he would possess the rights to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on his own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Settlement Agreement*, he waives these rights as they pertain to the misconduct described herein.
19. This *Settlement Agreement* shall take effect as an Order of the Board on the date it is signed by an authorized representative of the Board.

FOR RESPONDENT

Date: 6-21-10


Robert H. Richardson, M.D.
Respondent

FOR THE BOARD/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: July 12, 2010


(Signature)

PENNY TAYLOR
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

/* Board members, recused:
Amy Feitelson, MD