

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

In the Matter of:
Susan M. Hare, M.D.
No.: 11415
(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 Susan M. Hare, M.D. ("Dr. Hare" 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, 329:18 and 329:18-a, and New Hampshire Board of Medicine Administrative Rules ("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 October 3, 2001. Respondent holds license number 11415. Respondent is board certified in internal medicine and pediatric medicine, and practices at Riverfront Medical Group, 322 West Main Street, Suite 133, Tilton, NH 03276 ("Riverfront").
3. The Board received complaints relating to Respondent's pain management practice. The complaints related to Respondent's prescribing practice, patient treatment

records, and supervision of the licensed practical nurse who directly assisted Respondent in her practice and who was also a pain management patient under Respondent's care.

4. In response to this information, the Board conducted an informal investigation, obtaining information from various sources and conducting a review of patient treatment records pertaining to Respondent's pain management practice.
5. Respondent stipulates that if a disciplinary hearing were to take place, Hearing Counsel would prove that Respondent engaged in professional misconduct relating to her prescribing practices in the treatment of pain management patients and relating to her supervision of her licensed practical nurse, in violation of RSA 318-B:9, RSA 318-B:10, RSA 329:17, VI(c), and Med. 501.02(d), (e), (h) and (i), by the following facts pertaining to her practice at Riverfront:
 - A. The medical record documented that Respondent first treated M.V. on December 11, 2007 for pain due to back and neck problems. Respondent requested medical records from other medical providers, and received them on February 4, 2008. M.V. signed an *Agreement for Opioid Maintenance Therapy for Non-Cancer/Cancer Pain* ("Agreement") dated December 11, 2007. Two pharmacies were noted in the *Agreement*. The pharmacy originally listed on the *Agreement* was changed to Flowers on March 29, 2008.
 - (1) On February 14, 2008, Respondent prescribed M.V. OxyContin 80 mg #100 and OxyContin 20 mg #90. On February 27, 2008, M.V. attempted to obtain Percocet from the ER at LRG Healthcare after

reporting that he had slipped on some icy stairs. Respondent failed to adequately manage M.V.'s pain management treatment by responding or adjusting M.V.'s treatment as a result of his attempt to obtain additional medication.

(2) On March 21, March 28, and May 6, 2008, M.V. received or filled prescriptions that Respondent wrote for OxyContin 80 mg #100 with instructions for OxyContin to be taken "prn." There was no explanation or rationale to support these off-label instructions.

(3) Respondent wrote prescriptions for OxyContin on February 1, 2008 and for oxycodone February 14, 2008 that were written before the instructions on the prescription indicated that the medication should be finished. The medical record did not document a rationale or reason for prescribing the controlled while the patient continued to have medication from the prior prescription available. The early prescription written on February 14, 2008 was filled early, on the date it was written.

B. Respondent first treated D.M. on July 9, 2007, for chronic back pain originating from work-related back strain. D.M. reported that previous treatment had failed to provide relief. Respondent prescribed a trial of medication that included controlled substances for pain relief.

(1) Respondent failed to adequately document a complete physical evaluation of D.M.

(2) During the continued treatment of D.M., Respondent failed to adequately document in the medical record a rationale and treatment

plan for the medication to be prescribed and subsequent changes in the medications prescribed. Although the record does contain notes on August 9, 2007 and March 7, 2008, there are no notes explaining the dosage increase for oxycodone on September 20, 2007, or why the dosage was not decreased after December 24, 2007 when the treatment plan said to increase the dosage for one prescription and then reduce it back to the previous level, or why the dosage changed on April 22, 2008 from every four to six hours to every four hours.

- (3) Respondent failed to manage D.M.'s change in medication when she prescribed both Fentanyl patches and oxycodone for pain management.
- (4) Respondent failed to adequately manage D.M.'s pain management treatment by allowing prescriptions to be written before they were due on February 1, 2008 and April 29, 2008, though they were not filled early. Respondent also failed to address concerns brought to her attention relating to the D.M.'s reaction to the medication regime she was prescribed.

C. Respondent first treated D.G. on July 24, 2007 for worsening back pain originating from an injury in 2001. The medical record documented visits on July 30, August 20, August 28, September 5, September 26, October 17, November 23, and August 7, 2008. An *Agreement* was signed by D.G and Respondent's nurse, LPN N.M.K., on July 24, 2007.

- (1) Although office visits were scheduled for D.G., the documentation of the physical examinations conducted at those visits was inadequate. The

medical record documented a checklist sheet, with inadequate details of specific results of the examination to support Respondent's treatment.

- (2) Respondent failed to appropriately monitor and adjust D.G.'s treatment in response to his changes to and/or violations of the *Agreement*. Two pharmacies were listed on the *Agreement* with no documentation of when the change in pharmacy occurred. In January and February of 2008, Respondent was informed by the New Hampshire Drug Use Review Board that D.G. used four pharmacies to fill prescriptions in the preceding six months. At the time, the *Agreement* listed CVS as the original pharmacy and Osco as the new pharmacy. Respondent's medication sheet, however, listed Osco and Rite Aid for this time period. Respondent failed to document any response to this information in the medical record.
- (3) Respondent continued to prescribe controlled substances for D.G. after Respondent received the results of urine drug screens positive for Cocaine on or about October 17, 2007 and November 28, 2007.
- (4) The medical record does not adequately document Respondent's rationale behind changing or increasing the dosage of controlled substance prescriptions. On August 20, 2007, the medical record noted, "preparing to wean" D.G. from prescribed narcotics. Weaning was not initiated or accomplished through the next five visits and no rationale for the change in the plan to wean D.G. from use of controlled substances was documented.

- (5) The medical record and medication list documented that in January and February of 2008, Respondent prescribed Methadone, oxycodone and Klonopin for D.G. without having an office visit or conducting an examination.
- (6) Respondent provided Methadone prescriptions early to D.G. on November 25 and December 19, 2007, and January 17 and January 29, 2008. The November 25, 2007 prescription was filled the day it was written and the December 19, 2008 prescription was filled on December 20, 2007.

D. The medical record documented that Respondent first treated H.S.U. on April 14, 2008, for pelvic pain following a cesarean section that had been performed in November of 2007.

- (1) The medical record failed to document that Respondent conducted a pelvic examination during the first visit. Respondent represents that H.S.U. refused an exam, but admits failing to document that refusal. Respondent prescribed oxycodone 15 #50, ordered a CT scan, and noted that pain medication would be provided until CT scan results were obtained.
- (2) Additional prescriptions for oxycodone were written on April 21, 2008 and May 9, 2008, with no corresponding telephone or office note. H.S.U. was also prescribed Cipro and Ultram. The CT scan results came back negative, Respondent discussed doctor shopping with H.S.U. and declined to prescribe more narcotics, and H.S.U. did not return for

another visit. Respondent was the third in a series of doctors from whom H.S.U. sought narcotics.

E. The medical record documented that Respondent first treated J.C. on September 25, 2007, for worsening back pain. An *Agreement* was documented as signed by J.C. on that date. J.C. reported prior use of oxycodone and Methadone with good relief. Respondent prescribed oxycodone 30 mg t.i.d. prn, noting a plan to refer J.C. to an orthopedic group. The medical record specifically noted that J.C. did not wish to have Methadone prescribed. The medical record documented a follow-up visit on October 10, 2007, which noted that J.C. was doing better on the medication. J.C. also reported to Respondent that he took an "old" Methadone tablet. On October 17, 2007, Respondent received the results of a urine drug screen that was positive for oxycodone, Methadone and cocaine.

- (1) Respondent failed to adequately manage J.C.'s pain management treatment and continued to prescribe controlled substances after Respondent received a positive urine drug screen.
- (2) J.C. was next treated on November 9, 2007, when he reported that he had increased his dose of oxycodone contrary to the instructions written on the prescription. The medical record from November 9, 2007 documented his failure to follow instructions and the Respondent's denial of his request to increase the dose, but did not document a response to J.C.'s failure to follow Respondent's medication instructions.

- (3) On January 15, 2008, J.C. reported injuring his back while shoveling. The medical record noted that Respondent prescribed oxycodone 30 mg q.i.d. for one prescription, with a plan to reduce the amount of prescribed medication offered to J.C. Respondent prescribed two additional prescriptions for oxycodone 30 mg. q.i.d. with no reduction and no explanation or rationale for the failing to follow the plan.
- (4) On February 4, 2008, Respondent failed again to adequately respond to or adjust the treatment plan when J.C. reported that his wallet and prescription were stolen and he failed to file a police report of the incident. Respondent rewrote the prescription without verifying the reported theft. Respondent represents that she requested, and the patient said he would file, a police report, but admits she did not request a copy.

F. The medical record documented that Respondent first treated J.R. on July 16, 2008 for depression and anxiety.

- (1) The medical record failed to document a mental health evaluation or an adequate history to support the diagnosis on July 16, 2008. Respondent admits she did not document an adequate history at the first visit and prior to issuing a prescription with four refills, but the record shows she requested past treatment records on the date of the first visit and obtained them approximately two weeks later. These records confirmed her diagnosis.

- (2) Respondent failed to adequately manage J.R.'s treatment. On July 16, 2008, Respondent prescribed alprazolam 1 mg #90 with 4 refills. A new prescription was issued on October 9, 2008 without an office visit.
- (3) Respondent received the results of a urine drug screen positive for Cocaine and alprazolam on August 15, 2008. Respondent failed to adequately manage J.R.'s treatment in that she failed to document in the medical record an office visit, discussion with J.R., adjustment in treatment, or any response to the positive urine drug screen. Respondent continued to prescribe the controlled substance for J.R. despite the drug screen results.

G. The medical record documented that Respondent first began treating S.C. for persistent low back pain on April 23, 2007. The medical record documented an *Agreement* signed by S.C., dated April 23, 2007.

- (1) The medical record documents that S.C. had office visits on April 23, May 7, July 3, and August 28, 2007.
- (2) On May 7, 2007, the medical record documents that S.C. reported ingesting an increased dose of medication contrary to Respondent's instruction. The medical record documents no response or any follow-up plan to address S.C.'s misuse of the controlled substance, and fails to identify the medication in question.
- (3) The *Agreement* in the medical record failed to adequately document when S.C. changed the pharmacy used to fill controlled substance prescriptions on one of the two occasions when he changed pharmacies.

- H. The medical record documents that Respondent first treated S.D. for shoulder pain on December 21, 2006. The medical record documents an *Agreement* signed by S.D. and dated March 7, 2007.
- (1) The medical record documents office visits for S.D. on December 21 and December 26, 2006, and January 1, January 25, January 30, February 21 and 22, March 7, April 19, May 30, June 13, and September 17, 2007.
 - (2) On or between December 21, 2006 and August 9, 2007, S.D. used five different pharmacies to fill controlled substance prescriptions written by Respondent. The *Agreement* failed to adequately document when use of a particular pharmacy changed. Respondent offers a partial explanation by representing that one pharmacy was Flowers, which was closed on weekends, so a second pharmacy was allowed. Flowers then closed altogether, requiring a transfer to a third pharmacy. Respondent admits that the other changes in pharmacies were not adequately documented.
- I. The medical record documents that Respondent first treated J.D. for chronic hip pain on March 19, 2007. The medical record documents an *Agreement* signed by J.D. and dated April 9, 2007.
- (1) The medical record includes a record of J.D.'s medical care prior to March 19, 2007. The record of prior medical care documented that J.D. was previously discharged from a pain center on June 5, 2006 because he lied about having filled a prescription for a controlled substance early. The medical record of J.D.'s prior medical care also documented

J.D.'s subsequent discharge from another practice reportedly for attempting to fill a forged prescription on October 24, 2006.

- (2) The medical record documenting Respondent's care of J.D., and the *Agreement* in the Riverfront medical record include no documentation addressing the prior violations and/or J.D.'s discharge from the prior practices nor any plan for managing his treatment.

J. The medical record for J.H. includes one office note from treatment at Geromed dated August 28, 2006. The medical record documented Vicodin prescriptions and Respondent's prior care of J.H. at Geromed on May 18, August 3, August 28, September 26, and October 23, 2006, for chronic back pain and tooth pain.

- (1) The medical record documents that J.H. received phoned-in medications on June 6, 2007 and requested pain medication on June 12 and June 21, 2007. The Riverfront medical record documents one office visit for J.H. during this time period, on June 25, 2007. The record shows subsequent office visits on September 17, October 16, and November 23, 2007 and June 20, 2008.
- (2) The medical record failed to adequately document two prescriptions for hydrocodone with multiple refills written by Respondent for J.H. from January 16, 2007 through July 16, 2007. All subsequent prescriptions were adequately documented.

K. The medical record for H.K. documented that Respondent began treating H.K. for back pain on March 5, 2007. The medical record documents an

Agreement signed by H.K. and dated August 6, 2007, which identified use of one pharmacy. H.K. also suffered from Hodgkin's lymphoma that Respondent represents as terminal, Stage III, and metastatic.

(1) The medical record documents office visits on March 5, April 3, May 1, June 13, June 26, July 5, August 6, August 29, September 25, and September 26, 2007.

(2) The medical record documents that on or about June 6, 2007, Respondent was informed that H.K. was using multiple pharmacies to fill prescriptions for controlled substances, and not just the pharmacy listed in the *Agreement*. The medical record documented that Respondent was also informed that H.K. was treated by multiple physicians who wrote him prescriptions for controlled substances. The medical record documented no response or any follow-up plan offered by Respondent to address the violation of the *Agreement* and the risk of over prescribing of controlled substances by multiple physicians.

(3) Respondent filled a telephone request for OxyContin on July 24, 2007. A telephone note dated July 26, 2007 documented a call from H.K. indicating that H.K. lost his Vicodin prescription before it was filled. The medical record did not document any follow-up by Respondent to manage H.K.'s treatment by addressing concerns of misuse of controlled substances related to H.K.'s claim about the lost prescription.

L. The medical record for M.R. documented that Respondent first treated M.R. for chronic neck and shoulder pain on April 17, 2007. The medical record

includes an *Agreement* signed by M.R. and dated April 17, 2007. The medical record documents additional office visits on April 26, May 3, and September 27, 2007.

(1) Prescriptions signed by Respondent prescribing OxyContin for M.R. on October 3 and October 22, 2007 were incorrect, instructing administration on a “prn” (as needed) instead of “qid” (four times per day) basis. In addition, the prescription as written conflicted with information in the medical record, which indicated administration “qid.” The medical record failed to document a rationale or plan for this instruction for use of the medication.

(2) The medical record documented M.R. provided a sample for a urine screen, which was dated September 25, 2007 and reported on October 1, 2007 as positive for Methadone, Cannabinoid, oxazepam, and Benzodiazepines. The medical record documented no order for a follow-up test or follow-up plan to address the use of non-prescribed controlled substances. The record documented that Respondent continued to prescribe oxycodone and OxyContin for M.R. on October 3, October 8, October 11, October 15, October 18, October 22, and October 25, 2007.

M. The medical record for J.S. documented that Respondent first treated J.S. for heel and low back pain on June 13, 2007. The medical record documents an *Agreement* signed by J.S. dated July 5, 2007.

- (1) J.S. had been discharged from the care of a previous physician in May of 2007.
- (2) On the first visit, Respondent accepted the medical record of J.S.'s prior care that J.S. hand carried to Respondent's office at Riverfront. The medical record at Riverfront failed to document that a copy of the prior treating record for J.S. was also obtained from the previous physician's office.
- (3) The medical record at Riverfront documents office visits for J.S. on June 13, July 5, and August 9, 2007.
- (4) Respondent received the report of a urine drug screen for J.S. on July 5, 2007 that was negative for any medications prescribed by Respondent that J.S. should have been taking. The medical record documents no follow-up testing and no follow-up plan for J.S. as a result of this negative drug screen.

N. The medical record for B.S. documents that he was first treated by Respondent on January 15, 2007. The medical record documents office visits on January 15, February 26, May 23, May 30, and July 19, 2007.

- (1) The medical record documents an *Agreement* signed by B.S. and dated March 8, 2007. The *Agreement* was signed almost two months after Respondent commenced prescribing B.S. controlled substances for chronic pain management treatment.
- (2) The medical record documents a telephone note dated May 4, 2007 by LPN N.M. that B.S. had "broken drug contract 3 complaints." The

medical record documents no follow-up plan or explanation of this report. Respondent failed to document in the medical record any adjustment to treatment or response to this information and continued to prescribe roxicodone and Methadone for B.S. until July 30, 2007.

O. The medical record for T.H. documents an office visit on September 6, 2007 when Respondent treated T.H. for pain management. The medical record documents that T.H. signed an *Agreement* on September 28, 2007.

(1) The medical record documents office visits on September 6, September 28, December 20, December 27, and December 31, 2007, and January 23, February 19, and March 4, 2008.

(2) Shortly after the office visit with T.H. on September 28, 2007, T.H. reportedly suffered an overdose-type reaction while incarcerated and reported to the nurses at the county House of Corrections that she had ingested 8 oxycodone tablets. The county House of Corrections faxed Respondent's practice a request for T.H.'s medical record and a signed release on September 28, 2007. Despite several further requests, the medical record was not provided until a new request was made February 25, 2008.

P. The Medical record documented that Respondent first treated M.C. on August 21, 2007 for increasing back pain following an accident. There was an Agreement dated August 21, 2007 signed by M.C. Follow up visits were noted in the medical record on September 14 and October 4, 2007, and April 3, and July 1, 2008.

- (1) Respondent prescribed "Oxy 15 prn" initially. The dose was increased to oxycodone 30 mg q 6 on October 4, 2007 in response to M.C.'s complaint that the pain was worse. Oxycodone was also prescribed on November 2 and November 27, 2007.
- (2) On November 23, 2007, the record reflected that M.C. was treated in the emergency room for narcotic withdrawal. A urine drug screen taken on that date tested positive for Cocaine and Methadone.
- (3) The medical record did not document Respondent's response to this emergency room visit or the positive urine screen.
- (4) Additional prescriptions for oxycodone were filled on seven occasions on or between December 27, 2007 and March 24, 2008 without M.C. being examined at an office visit.
- (5) A second urine drug screen tested negative for oxycodone and positive for Methadone on May 21, 2008. The record documented a letter dated May 27, 2008, notifying M.C. that M.C. was in violation of M.C.'s *Agreement* and would no longer be prescribed opioids, benzodiazepene or barbiturates.
- (6) On or between May 27, 2008 and January 30, 2009, Respondent continued to prescribed oxycodone, Ambien, Xanax and Fiorinal for M.C.
- (7) In January of 2008, L.C., spouse of M.C., initiated care with Respondent for arthritis and back pain. Respondent prescribed L.C. Methadone and oxycodone.

- (8) On December 17, 2008, L.C. reported to Respondent an accidental overdose on medications that required emergency room treatment and intubation. As per the hospital note, M.C. agreed to keep L.C.'s prescription medicine.
- (9) Respondent failed to appropriately manage M.C.'s pain management treatment, in that she failed to adequately address two concerning urine drug screens and an emergency room visit for narcotic overdose.
- (10) Respondent failed to address concerns about M.C.'s abuse of Methadone when she was reported as keeping L.C.'s Methadone.

Q. The medical record documents that C.J. initiated treatment with Respondent on March 19, 2008. A urine drug screen from that date tested positive for oxycodone, cocaine and cannabinoid. Office visits were documented on March 19, May 6, July 3, September 8, and October 9, 2008. There is a signed *Agreement* dated May 6, 2008.

- (1) C.J. submitted to a second urine drug screen on April 17, 2008 that tested positive for Cannabinoid, Cocaine, Methadone and oxycodone.
- (2) C.J. submitted to a third urine drug screen on April 28, 2008, which tested positive for oxycodone, cocaine, methamphetamine, and benzodiazepine.
- (3) The record documented an office visit on July 3, 2008. C.J.'s record also documented a letter dated July 3, 2008, which notified C.J. that Respondent would no longer treat C.J. for pain management. Respondent prescribed oxycodone for C.J. at this visit.

- (4) Respondent continued to prescribe oxycodone for C.J. on April 21, May 6, and July 3, 2008. She also prescribed Effexor on March 19, 2008.
 - (5) A urine drug screen for C.J. dated July 20, 2008 tested positive for Cocaine.
 - (6) Respondent failed to adequately manage C.J.'s pain management treatment in that she failed to respond to urine drug screens positive for other medications not prescribed.
- R. The medical record documented that T.W. was first seen by Respondent on June 21, 2007. An *Agreement* was documented in the file dated July 3, 2007. T.W. submitted to a urine drug screen on July 3, 2007, which tested positive for Cocaine and Canabinoid.
- (1) A second urine drug screen was documented in the record on May 20, 2008, which was positive for Cannabis, Cocaine, opiates, Morphine, and Methadone. The record documented a telephone call to T.W., informing T.W. of the positive test for controlled substances not prescribed and indicating that T.W. would be terminated from opioid prescriptions on June 26, 2008.
 - (2) Respondent failed to adequately manage T.W.'s pain management treatment by failing to appropriately respond to urine drug screens positive for non-prescribed controlled substances.
- S. The medical record documented that M.S. initiated treatment on February 20, 2008 for jaw pain related to a fracture and for back pain. M.S. signed an

Agreement dated February 20, 2008 and Respondent prescribed Methadone 10 mg tid and Percocet q 4-6 prn.

- (1) Respondent treated M.S. on March 3, March 18, May 12, July 28, August 27, October 29, and December 17, 2008.
- (2) On May 17, 2008, Respondent received information from another medical care provider for M.S., that he had been seen for symptoms of withdrawal.
- (3) On August 27, 2008, M.S. submitted to a urine drug screen that tested positive for Cannabinoid, Methadone and oxycodone.
- (4) The *Agreement* listed two pharmacies without indicating the date on which the pharmacy changed.
- (5) The medical record documented a letter dated September 4, 2008 that notified M.S. that Respondent had discontinued the practice of chronic pain management. The patient was put on a 60-day notice of termination of this treatment. The letter was signed by M.S. on September 22, 2008.
- (6) The medical record documented positive urine drug screen on October 24, 2008.
- (7) On December 12, 2008, M.S. reported to LRGHealthcare that he needed to have his prescriptions filled. His medications were listed as oxycodone, Methadone, and Xanax. On December 17, 2008, Respondent prescribed clonazepam for M.S.

- (8) Respondent wrote a prescription for Klonopin on December 15, 2008 and oxycodone on December 17, 2008, after the sixty-day period was over.
- (9) Respondent failed to adequately monitor M.S.'s pain management treatment.
- T. Respondent failed to adequately manage treatment and care of LPN N.M. who was also a patient, in that on at least one occasion LPN N.M. called in a controlled substance prescription for her own use.
- U. Respondent signed prescriptions that were blank except for the patient names prior to the date of issuance that she kept in a locked box in her office for issuance at times when Respondent was not available to write prescriptions. In addition, Respondent failed to adequately monitor the practice of LPN N.M. in that Respondent provided LPN N.M. with the sole knowledge and possession of a key to the box containing these prescriptions.
- V. In February of 2008, Respondent failed to arrange for appropriate medical coverage for chronic pain management patients, resulting in confusion and interruption in patient care. Respondent represents that she was available by telephone.
- W. Respondent treated chronic pain patients after issuing discharge notices and also treated returning chronic pain patients after informing the Board on February 10, 2009 that she had stopped accepting new chronic pain patients and that all her chronic pain patients had been referred to other pain clinics.

- X. The review of the patient treatment files for patients treated for chronic pain and pain management revealed a pattern in Respondent's prescribing practice that was incompatible with the basic knowledge and competence expected of a physician.
6. The Board finds that Respondent committed the acts as described above and concludes that Respondent's conduct constitutes a pattern of inadequate records keeping and a pattern of inadequate management of pain management patients, and that, by engaging in such conduct, Respondent violated RSA 318-B:9, 318-B:10, RSA 329:17, VI(c); Med. 501.02(d), (e), (h) and (i).
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's license to practice medicine is **SUSPENDED FOR FIVE YEARS, OF WHICH TWO YEARS ARE IMPOSED** upon the effective date of this *Settlement Agreement* and **THREE YEARS ARE HELD IN ABEYANCE FOR FIVE YEARS** from the effective date of this *Settlement Agreement*, provided all other terms of this *Agreement* are met.
- B. Respondent is **INDEFINITELY RESTRICTED** from the effective date of this *Settlement Agreement* from prescribing Schedule II and III narcotics.

- (1) It is agreed that the DEA may amend Respondent's registration to include only Schedules IIN, IIIN, IV, and V.¹
- (2) Respondent may petition the Board no earlier than two years from the effective date of this *Settlement Agreement* to remove this restriction. It shall be Respondent's burden, at that time, to show cause to the Board why the restriction should be removed and satisfy any concerns by the Board that the removal of this restriction could result in a resumption of the treatment of chronic pain patients that is permanently restricted as set forth in paragraph B, below.

C. Respondent is PERMANENTLY RESTRICTED from treating chronic pain patients. Further, as long as Respondent owns or maintains her own practice and is the sole physician in that practice, she shall not employ a nurse practitioner or physician's assistant who prescribes Schedule II or III narcotics for chronic pain patients in Respondent's practice.

D. Respondent shall complete the UNIVERSITY OF CALIFORNIA, SAN DIEGO, SCHOOL OF MEDICINE PHYSICIAN ASSESSMENT AND CLINICAL EDUCATION (PACE) PROGRAM COURSE ON PHYSICIAN PRESCRIBING PRACTICES or the CASE WESTERN RESERVE SCHOOL OF MEDICINE CONTINUING EDUCATION COURSE ON CONTROLLED SUBSTANCE MANAGEMENT, or an equivalent that is pre-approved by the Board, within twelve months of the effective date of this *Settlement Agreement*.

¹ "IIN" is DEA registration terminology for Schedule II non-narcotic and "IIIN" is DEA terminology for Schedule III non-narcotic.

- E. Respondent shall meaningfully participate in a program of TWENTY-FOUR CONTINUING MEDICAL EDUCATION CREDITS (CMEs) in the areas of documentation of medical records, documentation of prescribing practices, and boundaries for professionals treating colleagues or office personnel.
- (1) These CMEs shall be obtained in addition to the credit hours required by the Board for renewal of licensure and shall be completed within twelve months from the effective date of this *Settlement Agreement*.
- (2) Within thirty days of completing these CMEs, Respondent shall notify the Board and provide written proof of completion.
- F. Respondent is assessed an ADMINISTRATIVE FINE in the amount of five thousand dollars (\$5,000.00). Respondent shall pay this fine in five installments of one thousand dollars (\$1,000.00) each. The first payment shall be due within thirty days of the effective date of this *Settlement Agreement*. The remaining payments shall be due within thirty days of the previous payment. All payments shall be made in the form of a money order or bank check made payable to "Treasurer, State of New Hampshire" and delivered to the Board's office at 2 Industrial Park Drive, Suite 8, Concord, NH 03301.
- G. Respondent shall bear all costs of the training, supervision and/or reporting required by this *Settlement Agreement*, but she may share such costs with third parties.
- H. Within ten days of Respondent's receipt of this *Settlement Agreement* after its effective date, 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.

I. For a continuing period of one year 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, in addition to the potential consequence set forth in Paragraph 8(C), above.

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.

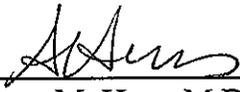
11. This *Settlement Agreement* shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.
12. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to her other than those 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 her 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 her 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 her right to a fair and impartial hearing in the future if the Board does not accept this *Settlement Agreement*.
17. Respondent is not under the influence of any drugs or alcohol at the time she signs this *Settlement Agreement*.
18. Respondent certifies that she has read this document titled *Settlement Agreement*. Respondent understands that she has the right to a formal adjudicatory hearing concerning this matter and that at said hearing she would possess the rights to

confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on her 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*, she 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.

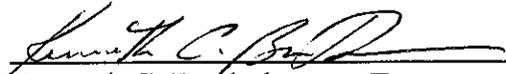
FOR RESPONDENT

Date: 8/25/10



Susan M. Hare, M.D.
Respondent

Date: 9/3/10

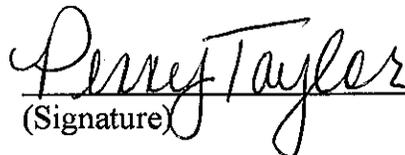


Kenneth C. Bartholomew, Esq.
Counsel for Respondent

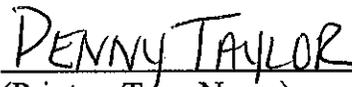
FOR THE BOARD/*

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

Date: 9/8/2010



(Signature)



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

/* Recused Board members: Amy Feitelson, MD;
James G. Sise, MD; Bruce Friedman, MD; and
Robert P. Cervenka, MD

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