BEFORE THE WEST VIRGINIA BOARD OF MEDICINE

WEST VIRGINIA BOARD OF MEDICINE,

Petitioner,

V. **Complaint Nos. 19-101-W & 19-164-B**

WILLIAM ANDREW STEWART, M.D.,

Respondent.

WEST VIRGINIA BOARD OF MEDICINE'S FINAL DECISION AND ORDER

On November 14, 2022, the West Virginia Board of Medicine met and considered the "Hearing Examiner's Recommended Findings of Fact, Conclusions of Law and Recommended Decision" issued by Hearing Examiner Lewis G. Brewer, Esquire, on October 24, 2022 in this matter. After considering the recommended decision, and the underlying record adduced in this matter, the Board of Medicine voted to adopt and accept the recommended decision.

Wherefore, having adopted and accepted the recommended decision, its contents are hereby incorporated in their entirety by reference in this Final Decision and Order. A copy of the same is attached to this Final Decision and Order. It is hereby **ORDERED** that the "Hearing Examiner's Recommended Findings of Fact, Conclusions of Law and Recommended Decision" is hereby accepted and adopted.

Accordingly, Respondent's license to practice medicine and surgery in this State is hereby **REVOKED** effective upon entry of this Order. However, such revocation of Respondent's license is immediately **STAYED** through September 6, 2024, while Respondent remains in the West Virginia Medical Professionals Health Program ("WVMPHP"), in accordance with his current Continuing Recovery Care Agreement. At the expiration of

Respondent's agreement with the WVMPHP, he may petition the Board to have his license reinstated on a probationary basis for such period of time and subject to any practice restrictions that the Board deems necessary and appropriate.

Additionally, Respondent is hereby **PUBLICLY REPRIMANDED** for his professional misconduct in violation of the West Virginia Medical Practice Act.

It is further **ORDERED** that Respondent shall pay the costs and expenses of this proceeding, as permitted by 11 C.S.R. 1A § 12.3.g. (2017). The costs and expenses assessed to Respondent shall be paid to the Board within thirty (30) days of the issuance of an invoice by the Board.

Respondent has the right to appeal this Final Decision and Order to the Intermediate Court of Appeals of West Virginia. Notice of Appeal must be filed with the Intermediate Court of Appeals of West Virginia within thirty (30) days of issuance of this Final Decision and Order, with a copy served on the Board of Medicine.

11-22-22

ENTERED THIS 22 **DAY OF** November, **2022.**

ASHISH P. SETH, MD
PRESIDENT

QUARTEL-AYNE AMJAD, MD, MPH
SECRETARY

BEFORE THE WEST VIRGINIA BOARD OF MEDICINE HEARING EXAMINER

WEST VIRGINIA BOARD OF MEDICINE,

Petitioner,

v. **Complaint Nos. 19-101-W & 19-164-B**

WILLIAM ANDREW STEWART, M.D.

Respondent.

HEARING EXAMINER'S RECOMMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED DECISION

PROCEDURAL HISTORY

This matter came on for hearing on June 14, 15, 16, and 17, 2022, in the Hearing Room of the West Virginia Board of Medicine, 101 Dee Drive, Charleston, West Virginia, pursuant to the Order Rescheduling Hearing entered by the Hearing Examiner on October 5, 2021. At the hearing, the West Virginia Board of Medicine ("Board" or "Petitioner") was represented by counsel, Greg S. Foster, Esquire, and Jamie S. Alley, Esquire. The Board appeared through its Executive Director, Mark A. Spangler. The Respondent, Dr. William Andrew Stewart, M.D. ("Respondent" or "Dr. Stewart"), was present throughout the hearing while represented by counsel, Edward C. Martin, Esquire, and Shereen C. McDaniel, Esquire, with Flaherty Sensabaugh Bonasso, PLLC.

The Board issued the Complaint, Notice of Hearing, Pre-Hearing Deadlines and Protective Order ("CNOH") in this matter on July 27, 2021, setting forth five (5) counts of professional disciplinary charges against Dr. Stewart arising from two separate complaints, identified as Initiated Complaint No. 19-101-W and Complaint No. 19-164-B.

The CNOH originally scheduled the public hearing in this matter to convene on October 26, 27 and 28, 2021. By motion filed on September 3, 2021, Respondent moved to continue the hearing due to counsel's scheduling conflict. Respondent's motion was granted by the undersigned Hearing Examiner by Order entered September 9, 2021. Thereafter, by subsequent Order entered October 5, 2021, the hearing was rescheduled for June 14, 15, 16, and 17, 2022. Given the delay in proceeding to hearing, Respondent duly executed a written waiver of his right to challenge the statutory time frame for the Board to issue a final ruling in this matter.

During the hearing, the Board presented testimony from the following witnesses: the Respondent; Jeffrey Thaxton, MD; Lisa Strawn, RN; Robin Sylvester; Amy Moore; Penny Lesher; Patient A[1]; Michael A. Sucher, MD (expert witness); Patient D; and Peter D. Ray, MD (expert witness). The Respondent similarly presented testimony from these witnesses: John David Hayes, MD; Shelda Martin, MD; Richard Umstot, MD; Kari Hunter; Laura Gail Huffman; Fred Kerns, MD; Respondent; Donna Jean Slayton, MD; Phillip Bradley Hall, MD; Thomas McIlwain, MD; and Greg Skipper, MD (expert witness).

The public hearing was recorded and transcribed by a court reporter, and the parties were given an opportunity to obtain a copy of the transcript. Due to a delay in receiving the transcript from the court reporter, the deadline for submission of Proposed Findings of Fact, Conclusions of Law and Recommended Decision to the Hearing Examiner was extended to September 28, 2022, by agreement of the parties and

[1] To protect the privacy of witnesses who were patients of the Respondent, such witnesses will be identified solely as "Patient A" or "Patient D," and so forth. These witnesses are identified in the Confidential Patient Key. *See* Ex 39. Witness confidentiality is also required by the Protective Order issued in conjunction with the CNOH.

pursuant to an Order entered by the undersigned Hearing Examiner on August 10, 2022. The parties timely filed Proposed Findings of Fact and Conclusions of Law which have been carefully considered in the adjudication of this matter. The parties also filed pleadings requesting corrections to the hearing transcript which have been addressed in a separate Order dated October 18, 2022.

ISSUE

Whether or not the West Virginia Board of Medicine should discipline the Respondent's medical license through revocation, suspension, or other limitation pursuant to the West Virginia Medical Practice Act and/or the Board of Medicine's Legislative Rules.

MOTIONS

All decisions rendered at the hearing in this case on motions filed or otherwise made in this case are hereby affirmed. Further, all other motions filed or otherwise made in this case by either of the parties which were not previously ruled upon by the undersigned Hearing Examiner are hereby denied and rejected. After a review of the record and the exhibits admitted into evidence, any stipulations entered into by the parties, any matter of which the undersigned Hearing Examiner took administrative notice during the proceedings, assessing the credibility of the witnesses, and weighing the evidence in consideration of the same, the undersigned Hearing Examiner makes the following findings of fact and conclusions of law. To the extent that the testimony of any witness is not in accord with these findings and conclusions, such testimony is not credited. To the extent that these findings of fact and conclusions of law are consistent with any proposed findings of fact and conclusions of law submitted by the parties, the

same are adopted by the undersigned Hearing Examiner, and to the extent that the same are inconsistent with such proposed findings and conclusions, they are rejected. Any proposed finding of fact, conclusion of law, or argument proposed and submitted by a party but omitted herein is deemed irrelevant, or unnecessary to the determination of the material issues in this matter.

In accordance with 11 C.S.R. 3 §§ 14.1 & 14.3 (2010), the following Proposed Findings of Fact are made based upon the testimony taken and documentary evidence presented before the undersigned Hearing Examiner.

FINDINGS OF FACT

1. The West Virginia Board of Medicine ("the Board" or "Petitioner") is the "regulatory and disciplinary body for the practice of medicine and surgery" for physicians, podiatrists and physician assistants in West Virginia. W. Va. Code §§ 30-3-5 & 30-3-7(a).

2. The Board is responsible for regulating the practice of medicine to protect the public health. W. Va. Code § 30-3-1, *et seq*. *See Vest v. Cobb*, 138 W. Va. 660, 76 S.E.2d 885 (1953).

3. Dr. Stewart holds an active status West Virginia license, No. 15926, to practice medicine and surgery in the state of West Virginia. Dr. Stewart's West Virginia license was initially issued on September 11, 1989. *See* Ex 28.[2]

4. Dr. Stewart's self-identified medical area of specialty is plastic and reconstructive surgery. Tr., Vol I, at 28; Ex 28.

[2] The parties pre-marked their exhibits, the majority of which were jointly stipulated to by the parties as admissible. All admitted exhibits retained their pre-marked exhibit numbers, without being renumbered, to maintain consistency. Exhibits will be referenced as "Ex __" followed by a number. The hearing transcript, which consists of four volumes, one for each day of hearing, will be cited as "Tr. Vol __, at ___," with the volume number in Roman numerals followed by the pertinent page numbers, *e.g.*, "Tr, Vol IV, at 123."

5. Dr. Stewart graduated from medical school at West Virginia University in 1988. He completed a five-year general surgery residency at Charleston Area Medical Center ("CAMC") in Charleston, West Virginia, followed by a second residency in plastic and reconstructive surgery at the University of Missouri in Columbia from 1993 to 1995. Tr., Vol I, at 27-28.

6. Dr. Stewart returned to Charleston, West Virginia, in 1995, after completing his plastic surgery residency at the University of Missouri, and began to practice as a plastic surgeon. He assumed the medical practice of a retiring plastic surgeon, and renamed the practice as Mountain State Plastic Surgery. Tr., Vol I, at 29-30.

7. Another plastic surgeon, Jeffrey Thaxton, MD ("Dr. Thaxton"), joined Dr. Stewart at Mountain State Plastic Surgery in 2004. At that time, Mountain State Plastic Surgery was located in the Kanawha City section of Charleston, West Virginia. Tr., Vol I, at 30-31, 122-23.

8. Shortly after Dr. Thaxton joined the practice, the name of the practice was changed from Mountain State Plastic Surgery to Stewart & Thaxton Plastic Surgery ("STPS"). STPS was co-owned by Dr. Stewart and Dr. Thaxton. Tr., Vol I, at 30-32, 34, 122.

9. Sometime in 2017, STPS moved its offices from Kanawha City to 505 Capitol Street in downtown Charleston, West Virginia. Tr., Vol I, at 33-34, 122.

10. While operating at both locations, STPS maintained a small staff of eight or nine employees. Both office locations had an operating room for performing outpatient surgical procedures. Tr., Vol I, at 33-34.

11. Procedures not requiring general anesthesia or sedation would be performed in examination rooms while procedures requiring general anesthesia or sedation would be performed in STPS' on-site operating room. Procedures covered by insurance or involving patients with a concerning medical condition would be performed in a hospital setting. Tr., Vol I, at 34-35.

12. At all times relevant to Complaint Nos. 19-101-W and 19-164-B, Dr. Stewart practiced plastic surgery at STPS.

13. On July 14, 2019, the Board's Complaint Committee initiated Complaint No. 19-101-W against Dr. Stewart, based upon a written report submitted to the Board by Dr. Thaxton. *See* Exs 3 & 4.

14. Dr. Thaxton's report asserted that members of his office staff witnessed Dr. Stewart stealing pain medication from a patient's medication bottle on June 11, 2019. Dr. Thaxton went on to describe how he confronted Dr. Stewart and Dr. Stewart admitted to stealing the medication, further admitting that this conduct had been going on for "a while." *See* Ex 3.

15. On September 12, 2019, Dr. Stewart, through counsel, submitted his response to Complaint No. 19-101-W. Therein, Dr. Stewart acknowledged that he had developed a substance use disorder, particularly a dependency on narcotic pain medication. *See* Ex 5.

16. Dr. Stewart's response to Complaint No. 19-101-W went on to state that, as of June 14, 2019, he had ceased the practice of medicine, and had enrolled as a voluntary confidential participant in the West Virginia Medical Health Professionals Program ("WVMPHP"). Dr. Stewart further explained that he was in the process of

completing an inpatient treatment program at Pavillon in Mill Spring, North Carolina, at the direction of the WVMPHP. *See* Ex 5.

17. Dr. Stewart's response to Complaint No. 19-101-W also stated that he would not resume the practice of medicine until he was cleared to return by WVMPHP. *See* Ex 5.

18. Dr. Stewart was admitted to the inpatient treatment program at Pavillon on June 24, 2019, and was discharged from the program on September 14, 2019. Upon discharge, Pavillon approved Dr. Stewart's return to work, with certain limitations and parameters. *See* Ex 50 at BOM0934.

19. Pavillon's discharge summary included the following explanation of Dr. Stewart's conduct which led him to treatment:

Ex. 50 at BOM0929

20. On September 6, 2019, Dr. Stewart executed a Continuing Recovery Care Agreement ("CRCA") with WVMPHP for a term of five (5) years. *See* Ex 53.

21. In December 2019, approximately six months after ceasing practice at STPS, Dr. Stewart returned to clinical practice at Charleston Area Medical Center

("CAMC") in Charleston, West Virginia. Dr. Stewart is currently practicing plastic surgery at CAMC. Tr., Vol I at 111. *See* Ex 60.

22. On November 25, 2019, a separate complaint was filed with the Board against Dr. Stewart by a former patient, who will be referred to in this proceeding as "Patient A." *See* Ex 17.

23. Patient A's complaint against Dr. Stewart arose from a plastic surgery procedure which Dr. Stewart performed on her at STPS on January 15, 2019. Patient A's complaint raised concerns regarding Dr. Stewart's ability to practice medicine with reasonable skill and safety, and further alleged that Dr. Stewart solicited the unused remainder of her post-surgical pain medication which he previously prescribed for her. *See* Ex 17.

24. On January 10, 2020, Dr. Stewart, through counsel, submitted his response to Complaint No. 19-164-B. In that response, Dr. Stewart denied that he had failed to provide appropriate medical care to Patient A or acted unprofessionally with respect to her concerns following the procedure. Dr. Stewart went on to deny that he operated on Patient A while under the influence of any mind-altering substance. The response also indicated that Dr. Stewart had no recollection of asking Patient A for her unused pain medication so that it could be disposed of. *See* Ex 18.

25. The Board's Complaint Committee found probable cause to institute formal disciplinary charges against Dr. Stewart. Accordingly, on July 27, 2021, the Board issued the CNOH, which set forth the allegations of professional conduct against Dr. Stewart. *See* Ex 1.

26. Dr. Stewart, through counsel, submitted his Answer to the CNOH on or about September 3, 2021. In his Answer, Dr. Stewart largely admitted to engaging in the alleged professional misconduct allegations contained in the CNOH. Dr. Stewart asserted that his actions were "directly caused by his active, undiagnosed and untreated substance abuse disorder." *See* Ex 2.

27. At the evidentiary hearing, Dr. Stewart testified that his admissions set forth in his Answer remain true today. Tr., Vol I, at 36-39.

28. Dr. Jeffrey Thaxton has been practicing plastic surgery since 2004. After completing his residency in Colorado, Dr. Thaxton returned to West Virginia and joined Dr. Stewart's plastic surgery practice in Charleston, West Virginia. Tr., Vol I, at 122.

29. After Dr. Stewart left STPS in 2019, the practice was renamed Thaxton Plastic Surgery. Dr. Thaxton still practices plastic surgery there today. Tr., Vol I, at 122-23.

30. Dr. Thaxton and Dr. Stewart enjoyed a good working relationship when they worked together. Tr., Vol I, at 123.

31. On or about June 11, 2019, Dr. Thaxton confronted Dr. Stewart regarding taking pain medication from various patients after a staff member reported to him that Dr. Stewart had taken a patient's pain medication. Tr., Vol I, at 124.

32. When Dr. Thaxton confronted Dr. Stewart regarding the June 11, 2019, incident, Dr. Stewart admitted to taking some of the patient's medication while further acknowledging that this conduct had been going on for "a while." Tr., Vol I, at 124.

33. Prior to the June 11, 2019, incident, Dr. Thaxton had developed suspicions about Dr. Stewart taking pain medications from patients, although he had never witnessed this conduct himself. Tr., Vol I, at 124.

34. Dr. Thaxton advised Dr. Stewart to self-report to the Board of Medicine or Dr. Thaxton would proceed to report his conduct to the Board. Tr., Vol I, at 125-26.

35. Dr. Thaxton also advised Dr. Stewart to self-report to Brad Hill at WVMPHP. Tr., Vol I, at 125-26.

36. Shortly after these conversations, Dr. Thaxton reported Dr. Stewart to the Board of Medicine because he believed he "had an ethical obligation to report on what would be considered inappropriate behavior." Tr., Vol I, at 126.

37. Dr. Thaxton explained the standard practice for prescribing pain medication to patients at STPS involved prescribing such medication for post-operative pain. When a procedure was being performed at STPS's office, a prescription was provided to the patient at a pre-operative appointment. The patient would then get the prescription filled at a pharmacy and bring the pain medication to STPS on the day of their scheduled procedure for use postoperatively, if needed. Tr., Vol I, at 131-32.

38. STPS did not have a policy or practice of accepting and disposing of a patient's unused pain medication. Tr., Vol I, at 132.

39. Dr. Thaxton never observed Dr. Stewart being under the influence of drugs or alcohol, or visibly impaired while in the offices of STPS, nor did any patient or staff member ever report such conduct to him. Tr., Vol I, at 142-43.

40. Lisa Strawn has been a registered nurse for more than 35 years with significant experience in an operating room setting. Tr., Vol I, at 148-50.

41. Ms. Strawn began working for STPS as the circulating nurse in 2018. Her duties included getting patients ready for surgery, assisting in the operating room, working with patients during their post-operative recovery, and working in the clinic with new patients and patient follow-up visits. Tr., Vol I, at 151-52.

42. Ms. Strawn was the only nurse at STPS and has continued in that capacity with Thaxton Plastic Surgery. Tr., Vol I, at 150, 152.

43. Ms. Strawn worked with both Dr. Thaxton and Dr. Stewart after she began working at STPS. Tr., Vol I, at 152.

44. In June 2018, Ms. Strawn was working at STPS with Dr. Stewart, having just taken a patient into the operating room, when she observed Dr. Stewart in the adjacent pre-op room "rifling through a patient's belongings." Tr., Vol I, at 153-56. *See* Ex 9.

45. During the procedure, a secretary brought a pill she had found on the floor in the hallway to Dr. Stewart's attention. Dr. Stewart instructed the secretary to put the pill on the counter. Ms. Strawn later took the pill to Dr. Thaxton and expressed her concern that Dr. Stewart was stealing medication from patients. Tr., Vol I, at 153-54, 158-59. *See* Ex 9.

46. A few days later, Dr. Stewart approached Ms. Strawn and asked to speak to her privately. They went into a private room where Dr. Stewart told Ms. Strawn that he was bipolar with a drinking problem, and he had begun attending AA. Ms. Strawn described Dr. Stewart's demeanor at the time as "pretty tearful." Dr. Stewart made no mention of the pill that had been found on the clinic floor or taking medication from a patient. Tr., Vol I, at 159. *See* Ex 9.

47. Ms. Strawn also reported that, shortly after the June 2018 incident, another co-worker, Robin Sylvester, told her that she had seen Dr. Stewart taking a patient's medication and putting a pill in his scrub pocket. Tr., Vol I, at 160-61.

48. Following the June 2018 incident, Ms. Strawn made a concerted effort to keep patient medications away from Dr. Stewart by either taking them and giving them to the family, bringing the medications into the operating room, hiding the medications in drawers, or giving the medications to the scheduler, Penny Lesher, to be returned to the patient after the patient recovered. Tr., Vol I, at 161-62.

49. Ms. Strawn testified regarding another incident in June 2019 when Ms. Lesher approached her and stated that Dr. Stewart had gone out and asked Patient B for her medication. When Ms. Strawn brought Patient B in from the lobby for her surgery, Ms. Strawn asked the patient for her medication and then performed a pill count, finding the patient then had only 28 pills, two short of the prescribed 30. Tr., Vol I, at 163. *See* Ex 10.

50. Ms. Strawn reported what had transpired to Dr. Thaxton, and they then met with Dr. Stewart where Dr. Thaxton confronted Dr. Stewart regarding Patient B's missing pills, asking Dr. Stewart if he took the pills. Dr. Stewart dropped his head and admitted to taking the pills. Tr., Vol I, at 163-64. *See* Ex 10.

51. Dr. Thaxton then told Dr. Stewart that he needed to self-report his conduct to the West Virginia Board of Medicine. Tr., Vol I, at 164-65. *See* Ex 10.

52. At the hearing, Dr. Stewart reviewed the written statements which Ms. Strawn had provided to the Board of Medicine regarding the June 2018 and June 2019

incidents, stating that he did not dispute Ms. Strawn's statements. Tr., Vol I, at 45-46. *See* Exs 9 & 10.

53. Ms. Strawn did not recall any situation where she felt that a patient of Dr. Stewart's had been hurt or was in any danger. Tr., Vol I, at 175.

54. Robin Sylvester is an aesthetician who began working in that capacity at STPS in April of 2019. She is currently working for Thaxton Plastic Surgery. Tr., Vol I, at 182.

55. Ms. Sylvester's job involved providing skin care treatments for STPS patients. In this position, she had her own treatment room and worked with patients of both Dr. Stewart and Dr. Thaxton. Tr., Vol I, at 184.

56. In June of 2018, while organizing inventory in the pre-op/recovery area at STPS, Ms. Sylvester observed Dr. Stewart going through the belongings of a patient who was then in the operating room, heard the distinct sound of pills in a medicine bottle and then saw Dr. Stewart drop a pill into the pocket of his scrubs. Tr., Vol I, at 185-87. *See* Ex 15.

57. Dr. Stewart does not dispute Ms. Sylvester's written statement. Tr., Vol I, at 62.

58. Ms. Sylvester recalled telephonically reporting the incident to Ms. Strawn, who advised her to report the incident to Dr. Thaxton. On the following day, Ms. Sylvester told Dr. Thaxton what she had observed. Tr., Vol I, at 188-89. *See* Ex 15.

59. Shortly after Ms. Sylvester related the incident to Dr. Thaxton, Dr. Stewart approached her and said that he was an alcoholic and was going to treatment. Dr.

Stewart did not say anything about stealing a patient's medication. Tr., Vol I, at 189. *See* Ex 15.

60. Amy Moore has been employed at STPS and Thaxton Plastic Surgery for around five years as a surgical tech and medical assistant. Tr., Vol I, at 201.

61. On an unspecified date in or around December 2019, Ms. Moore observed Dr. Stewart ask Patient A for her medications. When the patient gave him the bottle, Ms. Moore saw Dr. Stewart take off the lid from the medication bottle, turn it over and appear to put some of the pills in his hand and immediately returned the bottle to the patient. Tr., Vol I, at 204-05. *See* Ex 12.

62. While working at STPS, Ms. Moore became aware that the staff was making an effort to keep pain medications away from Dr. Stewart. Tr., Vol I, at 205-06.

63. Although Ms. Moore primarily worked with Dr. Thaxton, on those few occasions when she worked with Dr. Stewart, she never believed that he was a risk to his patients or was under the influence of any mood or mind-altering substances. Tr., Vol I, at 210.

64. Penny Lesher worked for STPS as the patient care coordinator for the practice. She held that position for approximately six years, leaving in or about August 2021 to take another position with the West Virginia Department of Highways. Tr., Vol I, at 216-17.

65. Ms. Lesher's job duties as patient care coordinator included handling communications with all surgery patients. Tr., Vol I, at 217.

66. Ms. Lesher was working at STPS on June 11, 2019, and observed Dr. Stewart walk by her office with a plastic bag containing pill bottles. She reported what

she had seen to Ms. Strawn who promised to follow up and do a pill count of the patient's medications. She also spoke to Dr. Thaxton who promised that he would take care of the situation. Tr., Vol I, at 219-22. *See* Ex 14.

67. Ms. Lesher provided a written statement to the Board describing the June 11, 2019, incident. Tr., Vol I, at 218. *See* Ex 14. Dr. Stewart does not dispute anything in Ms. Lesher's written statement. Tr., Vol I, at 44-45.

68. In her role of patient care coordinator, Ms. Lesher encountered multiple patients who were attempting to return their medications to the office at the request of Dr. Stewart. Tr., Vol I, at 224-25.

69. Patient A saw Dr. Stewart for a breast lift and breast augmentation surgery in January 2019. Tr., Vol II, at 240-42.

70. During a follow-up appointment approximately one week after the surgery, Dr. Stewart asked Patient A if she still had her unused pain medication, further stating that the practice liked to dispose of unused medication. Patient A found the request "very odd" and never brought any medication to Dr. Stewart. Tr., Vol II, at 243-44, 260-61.

71. Patient A later filed a complaint against Dr. Stewart with the Board of Medicine on November 25, 2019. This complaint was designated as Complaint No. 19-164-B. Tr., Vol II, at 240-41. *See* Ex 17.

72. Although Patient A's complaint mentions Dr. Stewart's solicitation of unused pain medication, the focus of her complaint involved the unsatisfactory outcome of her surgical procedure, which Dr. Thaxton later resolved by performing corrective surgery in or about July 2019. Tr., Vol II, at 242-50. *See* Ex 17.

73. Patient A did not provide any evidence to establish that Dr. Stewart was impaired at the time he performed her surgery or that the treatment he provided violated the established standard of care. Tr., Vol II, at 251-59.

74. Patient A retained an attorney after filing her complaint against Dr. Stewart with the Board, but she never filed a civil lawsuit against Dr. Stewart or received a settlement from Dr. Stewart. Tr., Vol II, at 252-59.

75. Patient D was a patient of Dr. Stewart. Dr. Stewart most recently performed a procedure on her in April 2019. Tr., Vol II, at 339-40, 343.

76. Dr. Stewart prescribed pain medication for Patient D prior to her April 2019 procedure. Tr., Vol II, at 340.

77. During a post-operative appointment, Dr. Stewart asked Patient D whether she was experiencing pain and had needed her pain medication. Patient A told Dr. Stewart she had not had much pain and had not needed much of her pain medication. Tr., Vol II, at 341.

78. Dr. Stewart then offered to dispose of Patient D's pain medication, if she wanted to bring it with her to her next appointment. Tr., Vol II, at 341.

79. Patient D brought her remaining pain medication with her at her next office visit two or three weeks later and gave her remaining medication to Dr. Stewart during that visit. Tr., Vol II, at 342, 344.

80. Patient D stated that she had several procedures with Dr. Stewart before April 2019, and that she always enjoyed a good physician-patient relationship with Dr. Stewart. Indeed, she had previously recommended Dr. Stewart to several of her friends. Tr., Vol II, at 343.

81. The Board called Dr. Stewart as a witness on the first day of the hearing. He was recalled later in the proceeding by his counsel. Tr., Vol I, at 26-120; Vol III, at 99-131.

82. Dr. Stewart acknowledged that he stole pain medication, either hydrocodone or oxycodone, from his patients. Hydrocodone and oxycodone are controlled substances. Tr., Vol I, at 39.

83. Dr. Stewart further acknowledged that he stole pain medication from patients on multiple occasion over a period of years. Tr., Vol I, at 39.

84. Dr. Stewart admitted that the pain medication which he stole was medication which he had prescribed to his surgery patients for post-operative pain. Tr., Vol I, at 40.

85. Dr. Stewart stated that he stole the medication and "would crush it and snort it in the evenings after I got home from work." Tr., Vol I, at 40.

86. Dr. Stewart explained that he would use "about a quarter of a tablet" on a weekday and on a weekend, when he wasn't working, "potentially a whole tablet." A tablet contains 5 milligrams of oxycodone. Dr. Stewart found that oxycodone gave him energy to be able to do his chores around the house. Tr., Vol I, at 54.

87. Dr. Stewart further explained that his opioid use began in the early 2000s as a result of ongoing back pain related to a back injury for which he was hospitalized. He was prescribed pain medication upon discharge from the hospital. He then began obtaining additional pain medication from his wife who was prescribed medication for a medical condition. Later, Dr. Stewart began obtaining the medication from a friend. Tr., Vol I, at 99-100.

88. Dr. Stewart stated that he continued to support his opioid use for five to ten years by diverting pain medication from his patients, either by stealing it or by obtaining it under false pretenses. Tr., Vol I, at 103-04.

89. Dr. Stewart did not believe his conduct resulted in any patient harm, noting that he could have written another prescription if the patient needed more pain medication. Tr., Vol I, at 104.

90. Dr. Stewart recognized that writing prescriptions to himself for pain medication would appear "more flagrant" than simply stealing it from his patients. Tr., Vol I, at 105.

91. Dr. Stewart readily admitted that his conduct was inappropriate, unprofessional, and unethical. Tr., Vol I, at 106, 110-11.

92. Dr. Stewart related that he engaged in this behavior because he was addicted. Tr., Vol I, at 111.

93. The first time Dr. Stewart recalled diverting a patient's medication occurred while STPS was located in Kanawha City. He remembered a post-operative patient told him she did not have pain and had not needed her medications. The patient had her medications with her and Dr. Stewart offered to dispose of them for her. This was how he obtained her pain pills. Tr., Vol I, at 51-52.

94. When Dr. Stewart told the patient that he would dispose of her medications, he intended to take her medication for his own use and did not intend to dispose of the medication. Tr., Vol I, at 52-53.

95. After the first incident, this became a pattern, where Dr. Stewart would take his patient's medication on the pretext of disposing of the pills. As time went on, this occurred more frequently as he would use the pain medicine. Tr., Vol I, at 53-54.

96. Dr. Stewart ordinarily prescribed pain medication to his patients at a pre-operative visit, instructing the patients to fill the prescription at a pharmacy and bring their medications to STPS on the day of their scheduled procedure to use post-operatively. Tr., Vol I, at 40-41.

97. Dr. Stewart recalled that on the day of the June 11, 2019, incident that Dr. Thaxton reported to the Board, Dr. Stewart approached the patient in the waiting room, asking for her medications on the pretense of checking them. Dr. Stewart then took two tablets from the container and returned the medication bottle to the patient, telling her he had checked the medicine. Tr., Vol I, at 41-42.

98. Dr. Stewart believed the medicine involved in the June 2019 incident was either oxycodone or Percocet. Tr., Vol I, at 42.

99. On June 11, 2019, Dr. Thaxton called Dr. Stewart back to the working area at the end of the day to speak with him and Ms. Strawn. They asked Dr. Stewart if he had stolen pills from the patient and he admitted doing so. Tr., Vol I, at 46.

100. Dr. Stewart did not recall Dr. Thaxton instructing him to self-report his conduct to the Board. Tr., Vol I, at 47-49.

101. Dr. Stewart knew Dr. Hall from his medical school class and from Dr. Hall starting the WVMPHP. Tr., Vol I, at 49.

102. Dr. Stewart recalled telling Dr. Thaxton that he would be calling the WVMPHP. Tr., Vol I, at 50.

103. Following the June 11, 2019, incident, Dr. Stewart worked the remainder of the week but did not return to STPS thereafter. Tr., Vol I, at 51.

104. Dr. Stewart also admitted to stealing medications directly from his patients' belongings in the pre-operative/post-operative room at STPS while the patients were in the operating room. Tr., Vol I, at 54-55.

105. Dr. Stewart reviewed Ms. Strawn's written statement describing a separate incident from June 12, 2018, where she had witnessed Dr. Stewart steal pain medications from a patient's belongings while the patient was in the operating room getting prepared for surgery. Dr. Stewart did not dispute Ms. Strawn's statement. Tr., Vol I, at 55-58. *See* Ex 9.

106. Dr. Stewart also reviewed a written statement from Ms. Sylvester describing an incident on June 14, 2018, where she also witnessed Dr. Stewart stealing medications from a patient's belongings in the STPS recovery room. Dr. Stewart likewise did not dispute Ms. Sylvester's description of how he stole the patient's medication while the patient was in the operating room. Tr., Vol I, at 61-62. *See* Ex 15.

107. Dr. Stewart recalled telling Ms. Sylvester that he was checking the patient's medications, attempting to cover up what he was doing. Tr., Vol I, at 62.

108. Dr. Stewart also acknowledged that he separately approached Ms. Strawn and Ms. Sylvester after these incidents, telling each of them that he was an alcoholic and would be going to AA, but did not mention stealing medication. Tr., Vol I, at 60, 62-63.

109. Dr. Stewart admitted that he continued to steal patients' medications from their belongings at STPS after June 2018 until he eventually got caught and was reported to the Board. Tr., Vol I, at 68.

110. Dr. Stewart conceded that this course of conduct continued for a period of time that may have covered as much as ten years. Tr., Vol I, at 65-70.

111. Dr. Stewart likewise confirmed that he represented to patients that he would dispose of their medications as a false pretext to get patients to give him their medications which he would then take for his personal use. Tr., Vol I, at 70.

112. Dr. Stewart agreed that obtaining medications from patients in such a manner was not an acceptable practice, nor was it a policy at STPS to have patients return unused medication for disposal by the physician. Tr., Vol I, at 71.

113. Dr. Stewart admitted that he never disposed of any medications that a patient returned to him under this pretext. Tr., Vol I, at 70-71.

114. Dr. Stewart similarly acknowledged obtaining medications from patients under the pretext of facilitating their proper disposal was "probably" the main method by which he obtained their medications, as opposed to taking one or two pills under the pretext of checking their medications. Tr., Vol I, at 72.

115. Dr. Stewart did not recall soliciting unused pain medication from Patient A, but acknowledged that such conduct was typical of his behavior at the time, and he had no reason to dispute Patient A's allegation. Tr., Vol I, at 73-74.

116. In regard to Patient D, Dr. Stewart recalled going out into the parking lot at STPS to ask Patient D if she had brought her unused pain medication, with the intent of collecting such medications if she did. Tr., Vol I, at 91-92.

117. Dr. Stewart also recalled the incident alleged by Ms. Moore in her written statement occurring in a similar fashion to her recollection. Dr. Stewart stated that he may have taken two pills under the pretext he was checking the patient's medications. Tr., Vol I, at 78-80. *See* Ex 12.

118. Dr. Stewart further admitted stealing medication from Patient E, taking two or three pills from her vial under the pretext of checking her medication. Tr., Vol I, at 80-81.

119. Patient E's medical record indicates that Dr. Stewart prescribed Percocet for Patient E on January 23, 2018, and Patient E's procedure took place on February 9, 2018. *See* Ex 49 at BOM0768 & BOM0824.

120. Dr. Stewart also admitted to diverting fentanyl from the STPS operating room by extracting small amounts of leftover medication from the nearly empty vials left by the anesthesiologist after a lengthy procedure. Although this only resulted in a quarter of a milliliter, this provided an adequate amount for Dr. Stewart to later inject intravenously. Tr., Vol I, at 94-95.

121. Dr. Stewart stated that he diverted fentanyl from his office every few months, whenever the opportunity would arise. Tr., Vol I, at 96.

122. Dr. Stewart also acknowledged that he diverted fentanyl during the same period when he was stealing and diverting pain medications from his patients. Tr., Vol I, at 96.

123. Dr. Stewart further agreed that his behavior in the office, at times, was erratic and volatile, as described by several members of his staff in their testimony. He would sometimes come into the office jovial and happy, while other times he would be

sullen and depressed. He would occasionally become so frustrated he would smack his desk or hit a wall. Tr., Vol I, at 63-64.

124. Dr. Stewart explained that his emotional state did not affect his ability to provide medical care to his patients. He was able to function by changing his attitude around patients so that he appeared as a doctor without any problems. Tr., Vol I, at 64.

125. Dr. Stewart understands that he may be disciplined despite his successful voluntary participation in a recovery program. Tr., Vol I, at 108.

126. Dr. Stewart described his experience undergoing inpatient treatment at Pavillon in North Carolina, his ongoing recovery, and his active participation in the WVMPHP, noting how the experience has greatly impacted and changed his life for the better. Tr., Vol III, at 99-103.

127. Thus far, Dr. Stewart has been in full compliance while participating in the WVMPHP for three years, with two years remaining on his five-year contract. Tr., Vol III, at 108.

128. Dr. Stewart related how recovery is a life-long process and he can never have a drink of alcohol or any mind-altering substance. Dr. Stewart intends to continue his recovery and involvement in AA and Caduceus following his completion of the WVMPHP contract, because these activities are critical to his continued well-being. Tr., Vol III, at 109.

129. Dr. Stewart noted how he has suffered personal and professional consequences as a result of his addiction and conduct, including the loss of his private practice at STPS, loss of patients, and harm to his reputation. Dr. Stewart recognizes

that his actions caused damage to others, including his family and co-workers. Tr., Vol III, at 115-18.

130. Dr. Stewart stated that he believes he is in a better place now, personally and professionally, than he has ever been. Tr., Vol III, at 119-20.

131. Peter D. Ray, MD ("Dr. Ray") appeared as an expert witness for the Board. Dr. Ray is a plastic surgeon, with specialized training in pediatric and craniofacial plastic surgery. He has been licensed to practice medicine and surgery in West Virginia since 2015. Tr., Vol II, at 349, 351-52.

132. Dr. Ray was retained by the Board as an independent consultant to provide an expert opinion regarding his area of medical specialty and related professional conduct allegations raised by Patient A with respect to Complaint No. 19-164-B. Tr., Vol II, at 359-60. *See* Ex 25.

133. On November 4, 2020, Dr. Ray issued an expert report on a list of subjects for which the Board sought his expert opinion, including Dr. Stewart's medical treatment of Patient A and additional issues relating to the professional conduct of plastic surgeons. Tr., Vol II, at 359-61. *See* Exs 25 & 26.

134. Dr. Ray graduated from medical school at the State University of New York at Buffalo in 1995. He completed his post-graduate medical training at the University of Alabama-Birmingham ("UAB") in Alabama. At UAB, Dr. Ray completed a general surgery residency in 2002, a plastic surgery residency in 2006, and a fellowship in craniofacial and pediatric plastic surgery in 2007. *See* Ex 24.

135. Following his fellowship, Dr. Ray remained on staff at UAB until he was recruited to join Cabell Huntington Hospital ("CHH") in 2015. Dr. Ray is currently

employed on staff at CHH as a plastic surgeon and serves as the Chief of Staff. Dr. Ray's current practice includes providing support for the Edwards Cancer Center for breast reconstruction, general plastic surgery, as well as face trauma call for St. Mary's Hospital and CHH. Dr. Ray noted that he manages most, if not all, pediatric burn cases in West Virginia. Tr., Vol II, at 351-52.

136. Dr. Ray is certified in plastic surgery by the American Board of Plastic Surgery. Tr., Vol II, at 356. *See* Ex 24.

137. Dr. Ray is currently the Chair of the National Quality Performance and Metrics Committee for the American Society of Plastic Surgery, a national professional organization comprised of board-certified plastic surgeons, which helps to establish national policy. Dr. Ray previously served as President of the Cabell County Medical Society. Tr., Vol II, at 352-54.

138. Dr. Ray previously served as Chair of the Medical Credentials Committee at CHH, the committee which reviews and makes recommendations regarding individuals applying for clinical privileges at CHH. Tr., Vol II, at 354-55.

139. Dr. Ray has also served as a physician in the U.S. Army since 1995, primarily as a combat surgeon. Dr. Ray has been deployed on numerous occasions overseas, including in central Asia, Afghanistan, Guatemala, Germany, and Bosnia. Most recently, Dr. Ray served on a six-month deployment to Tripler Army Medical Center in Hawaii. Tr., Vol II, at 357-358.

140. The Board sought expert testimony from Dr. Ray with respect to certain issues arising from Patient A's allegations in Complaint No. 19-164-B. *See* Exs 25 & 26.

141. The Board requested that Dr. Ray review Patient A's medical record and opine on whether Dr. Stewart's pre-operative, operative, or post-operative treatment of Patient A conformed to the medical standard of care. Based upon his review, Dr. Ray's expert opinion was that the medical care and treatment Dr. Stewart provided to Patient A conformed to the standard of care. Tr., Vol II, at 361, 373-74. *See* Ex 25.

142. Dr. Ray further opined that it is not within the bounds of physician professional conduct for the physician to request that the patient's unused pills be given to the physician's office for disposal. Dr. Ray explained that this is not an acceptable practice, and he could not find any policy or guideline which would approve of such a policy. In Dr. Ray's opinion, a pharmacy would be the proper place to return controlled substance medications for disposal. Tr., Vol II, at 363-64. *See* Ex 25.

143. Based upon his review of Patient A's medical record, Dr. Ray further opined that there was no basis for any plastic surgeon to request that Patient A return her unused prescription medication to the plastic surgeon. Tr., Vol II, at 364-65. *See* Ex 25.

144. Dr. Ray responded to an inquiry regarding whether a physician's absence from practice over a period of time would affect his or her ability to successfully re-enter practice by stating it would depend upon the individual physician and the length of time away from practicing medicine. Tr., Vol II, at 366.

145. Dr. Ray clarified that, while the results may vary, an absence of a year or more could be a basis for legitimate concern regarding the physician's skills, perhaps warranting some residency-type of training. Tr., Vol II, at 378-79.

146. Michael A. Sucher, M.D. ("Dr. Sucher") appeared via videoconference as an expert witness for the Board. Tr., Vol II, at 262-82.

147. Dr. Sucher was called by the Board to provide expert testimony with respect to matters relating to his medical specialty, including addiction medicine and the role and function of physician health programs ("PHPs") in the professional discipline, treatment and recovery of physicians who meet the eligibility criteria for participation in a PHP. *See* Exs 22 & 23.

148. Dr. Sucher issued a report providing his expert opinion on a list of subjects concerning which the Board sought his expert opinion. *See* Ex 23.

149. Dr. Sucher graduated from the School of Medicine at Wayne State University in Detroit, Michigan, in 1972. Dr. Sucher then completed his internship at Sinai Hospital in Detroit, Michigan, followed by a one-year residency in diagnostic radiology at the Indiana School of Medicine. Dr. Sucher began practicing as an emergency physician in 1974 at Scottsdale Memorial Hospital in Scottsdale, Arizona. He continued practicing emergency medicine until 1994. Tr., Vol II, at 265-66. *See* Ex 21.

150. Dr. Sucher gradually transitioned medical specialties from emergency medicine to addiction medicine. Dr. Sucher developed an interest in addiction medicine from personal experience. Dr. Sucher's mother passed from addictive disorders in 1985. In addition, Dr. Sucher personally developed an addiction and went through treatment in 1985. Tr., Vol II, at 266-68, 277-78.

151. Dr. Sucher became certified by the American Society of Addiction Medicine in 1986 and began practicing addiction medicine in the early 1990s. Tr., Vol II, at 266.

152. Dr. Sucher established the first Physician Health Committees for Scottsdale Memorial Hospital in the late 1980s. He began consulting with the Arizona Medical Board in 1991, assisting with evaluating potentially impaired professionals. Tr., Vol II, at 268.

153. Dr. Sucher served as one of the initial medical directors for the physician and professional health programs for the Arizona Medical Board and the Arizona State Board of Dental Examiners from 1992 until November 2019, when he transferred these programs to Community Bridges, Inc., and served that institution as Chief Medical Officer until he retired in April 2020. He currently serves as Senior Medical Director for Community Bridges, which is the largest integrated behavioral health program in Arizona, with over 30 sites and more than 100 providers who offer a full range of addiction, psychiatric and primary care services. Tr., Vol II, at 268-70. *See* Ex 21.

154. Dr. Sucher also served as the President of the California Physicians Health Program from its founding in 2008 until May 2020. In addition, he has served as the President of the Nevada Professional Assistance Program since August 2017. Tr., Vol II, at 268-70. *See* Ex 21.

155. In or about 2008-09, Dr. Sucher created Promises, a professional evaluation and treatment program, and served as its medical director for approximately two years. Tr., Vol II, at 271.

156. From 2011 to 2016, Dr. Sucher served as the medical director for Community Medical Services, which is the largest opioid treatment program in Arizona, and operates programs in Montana, North Dakota, Ohio, Illinois, Michigan, Indiana, Texas and Alaska. He continues to serve as an attending addiction medicine physician for Community Medical Services within their Arizona facilities. *See* Ex 21.

157. In 2019, Dr. Sucher became the Executive Medical Director at Meadows Behavioral Healthcare, a nationally known treatment facility for substance use disorders, sexual compulsivity and misconduct, a position which he continues to hold. In that capacity, he also serves as the medical director of Meadows Malibu, a wholly owned Meadows Behavioral Healthcare facility in Malibu, California. Tr., Vol II, at 270. *See* Ex 21.

158. Dr. Sucher currently practices in the field of addiction medicine, serving as a member of the medical staff at multiple Arizona hospitals. He also holds teaching positions throughout the greater Phoenix metropolitan area. *See* Ex 21.

159. As a consultant to Community Bridges, Inc., Dr. Sucher now serves as senior medical director of the CBI Professional Medical Monitoring Program and as Program Director of the CBI/Honor Health Addiction Medicine Fellowship. Dr. Sucher organized the initial Addiction Medicine Fellowship Program in Arizona in 2018. Tr., Vol II, at 271-72. *See* Ex 21.

160. Over a period exceeding 30 years, Dr. Sucher has worked with somewhere between 2,500 and 3,000 physicians through his case work with the physician health programs in Arizona, California, and Nevada. Tr., Vol II, at 274.

161. Dr. Sucher has been recognized as a Distinguished Fellow of the American Society of Addiction Medicine ("ASAM") and was awarded Diplomate Status by the American Board of Addiction Medicine in 2009. He is certified as a Medical Review Officer by ASAM. Dr. Sucher is a past president of the Arizona Society of Addiction Medicine. Tr., Vol II, at 275-76. *See* Ex 21.

162. Dr. Sucher has authored or co-authored numerous publications in the sphere of addiction medicine, relapse and recovery, and related issues, and is a nationally recognized speaker on addiction medicine and professional health issues. Tr., Vol II, at 275-77. *See* Ex 21.

163. Dr. Sucher is currently licensed to practice medicine in Arizona, California, and Nevada. Tr., Vol II, at 277.

164. Dr. Sucher has previously testified as an expert witness in the subject of addiction medicine in approximately 50 hearings before the Arizona Medical Board and 8 to 10 hearings before the California Medical Board. Dr. Sucher has also participated in numerous hearings before the Arizona State Board of Dental Examiners, and various other health care boards. Tr., Vol II, at 281-82.

165. Dr. Sucher explained that a Physician Health Program ("PHP") is a program to help assess, refer to treatment, and monitor physicians and/or other health professionals to help them reach a diagnosis or diagnoses, typically related to a substance abuse disorder and mental health issue, and to determine whether the providers are fit for duty. Tr., Vol II, at 283.

166. PHPs typically have a working relationship with the regulatory board, such as the medical board. The PHP's role is to assure that physicians and other health

professionals are in stable recovery and are fit for duty and safe to practice their profession. Approximately 47 or 48 states currently have PHPs. Tr., Vol II, at 283-84.

167. Prior to the development of PHPs, physicians who suffered from substance use disorders and addictions were considered "bad doctors" or as having "poor moral character." Upon recognizing that physicians were ill and could be treated, PHPs evolved to help ill physicians become healthy and to serve as advocates, support their recovery and provide the help that was needed. Prior to PHPs, the only recourse a licensing board had to address substance use disorder in physicians was in the form of disciplinary action. PHPs evolved to provide a licensing board with an additional avenue to support and monitor a recovering physician. Tr., Vol II, at 284-85.

168. Although PHPs are not identical in all states, nearly all PHPs include similar elements such as drug testing, case management, relapse prevention, support groups, and coordinating and overseeing all medical care and medications. Tr., Vol II, at 285-86.

169. PHPs ordinarily include both voluntary and non-voluntary participants. A voluntary participant is an individual who, independent of a licensing board, seeks help through the PHP, frequently being encouraged by family members, partners, or others. A non-voluntary participant is one who comes to a licensing board's attention and is mandated to seek the services of the PHP. Regardless of whether a participant is voluntary or non-voluntary, the services provided are the same or very similar. Tr., Vol II, at 287-87.

170. The services provided to a PHP participant for a potential substance use disorder would typically involve an individual assessment, drug testing, diagnoses, and

recommendations for treatment, if appropriate. Once treatment is completed, the physician is monitored by the PHP, including overseeing their practice, attendance at meetings, and drug testing. Depending on severity, monitoring can generally range from two to five years, although individual circumstances may vary. The PHP may provide reports to the regulatory board for non-voluntary participants or, in the event a participant is non-compliant or not safe to practice, the PHP would alert the regulatory board. Tr., Vol II, at 287-88.

171. Dr. Sucher was provided and reviewed documents and records pertaining to Dr. Stewart's participation in the West Virginia Medical Professional Health Program ("WVMPHP"). Dr. Sucher concluded that Dr. Stewart "appears to be in full compliance with the program requirements and doing very well in his recovery." Tr., Vol II, at 292-93.

172. Dr. Sucher also testified that Dr. Stewart, in the course of his recovery, has taken responsibility for his actions. Tr., Vol II, at 292-93, 309.

173. Dr. Sucher issued a report on November 16, 2020, responding to a list of subjects on which the Board sought his expert opinion, including questions related to physician diversion of controlled substance medications. Tr., Vol II, at 291-93. *See* Ex 23.

174. Dr. Sucher observed that, outside the context of a physician legitimately conducting a pill count for patient monitoring purposes, it is never within the bounds of professional conduct or ethics for a physician to ask a patient to return unused controlled substance medication to the physician. Tr., Vol II, at 294. *See* Ex 23.

175. Dr. Sucher explained that it is professional misconduct for a physician to covertly take a patient's medication prior to the time when the patient may need the medication, and such conduct "represents potential harm to the patient if they don't have all of their medication." Tr., Vol II, at 296-97.

176. Dr. Sucher further noted that physician diversion of patients' medications could result in "inadequate or incomplete treatment" and when pain medication is involved, "somebody may have pain that they shouldn't be experiencing." Conduct of this nature can "erode the doctor-patient relationship and the level of trust and confidence that's necessary for an effective doctor-patient relationship." Likewise, such behavior by a physician may "erode the trust of the public in the medical profession in general." Tr., Vol II, at 301-02.

177. Dr. Sucher opined that it is professional misconduct for a physician to divert unused remainders of fentanyl or other medications used during a surgical procedure. Tr., Vol II, at 297.

178. Dr. Sucher also observed that a physician's diversion of patient medications for personal use, when engaged in by a physician during the course of an active, undiagnosed or untreated substance use disorder, still constitutes professional misconduct. He noted that it is not "uncommon for undiagnosed, untreated addicts to do this, but it's still unprofessional conduct." Tr., Vol II, at 297-98.

179. Dr. Sucher also confirmed that taking medications from a patient's belongings or during the course of a purported pill count was theft, as well as professional misconduct. Tr., Vol II, at 298.

180. Dr. Sucher proclaimed that the role of a PHP is not to usurp the disciplinary authority of a licensing board. Tr., Vol II, at 285.

181. Dr. Sucher further explained that a physician's voluntary participation in a PHP does not preclude a licensing board from taking disciplinary action against the physician for engaging in professional misconduct. Tr., Vol II, at 299-300.

182. Dr. Sucher also noted that a physician's success in recovery does not preclude a licensing board from imposing discipline for professional misconduct. Tr., Vol II, at 304-05.

183. In Dr. Sucher's over 30 years of experience working with PHPs and thousands of physicians, it is not uncommon for physician PHP participants, including plastic surgeons, to be subject to disciplinary action, including removal from practice, by their licensing board. Such disciplinary actions have included limitations or practice restrictions, license suspensions and license revocations. Tr., Vol II, ay 302-03.

184. Dr. Sucher also observed that, of those physicians whose license was suspended or revoked for a period of time, the majority "are able to return to practice at a later time." Tr., Vol II, at 303.

185. Dr. Sucher opined that an absence from practice for a year or less is generally not an issue while an absence of more than two years often is an issue. The physician's specialty, amount of continuing education, and years of experience are all factors which impact the consequences of an extended absence from the practice of medicine. Tr., Vol II, at 304.

186. Dr. Sucher also testified that the imposition of professional discipline should not jeopardize a physician's successful recovery. Tr., Vol II, at 305.

187. Dr. Sucher confirmed that substance use disorder should be viewed as an illness, even when the affected individual is a physician. Tr., Vol II, at 320, 322-23.

188. Dr. Sucher found no evidence to suggest that any surgical mishaps occurred due to Dr. Stewart's addiction situation. Tr., Vol II, at 313-14.

189. Dr. Sucher testified that he is not aware of any evidence to indicate that Dr. Stewart is currently unfit or unsafe to treat patients and that, in his opinion, Dr. Stewart has a good prognosis for continued recovery. Tr., Vol II, at 329.

190. Dr. Sucher's personal history with addiction involved being addicted to cocaine, entering inpatient treatment following an intervention, and entering into a voluntary public rehabilitation agreement with the Arizona Medical Board which was in effect for two years. Notably, the Arizona Medical Board did not revoke or suspend Dr. Sucher's license for cocaine addiction. Similarly, California, where Dr. Sucher was also licensed, revoked his license, but immediately stayed the revocation, placing him on probation under various terms and conditions for five years. Tr., Vol II, at 278-79, 306-07, 312-13, 321-22.

191. Dr. Sucher did not meet with Dr. Stewart or speak with him as he determined that the written material provided by the Board was adequate to support his expert opinions. Tr., Vol II, at 309.

192. Greg Skipper, M.D. ("Dr. Skipper") appeared via videoconference as an expert witness for the Respondent. Tr., Vol IV, at 144-98.

193. Dr. Skipper is a Distinguished Fellow of the American Society of Addiction Medicine, is board certified by the American Board of Internal Medicine and is a Diplomate of the American Board of Addiction Medicine. Tr., Vol IV, at 146.

194. Dr. Skipper graduated from the School of Medicine at the University of Alabama in 1974, and then participated in a six-month residency in physical rehab medicine, completing his residency in internal medicine at the University of California San Diego in July 1978. Shortly after completing his residency, Dr. Skipper became certified in internal medicine. Tr., Vol IV, at 147-48.

195. Dr. Skipper practiced internal medicine and some cardiology in Portland, Oregon, from 1980 to 1993, when he went into addiction medicine on a full-time basis. Tr., Vol IV, at 148-49.

196. Dr. Skipper initially became interested in addiction medicine as a result of his own recovery from opioid addiction, following a knee injury and knee surgery. Tr., Vol IV, at 149.

197. In 1989, Dr. Skipper helped found a treatment program that subsequently grew into a large center, Springbrook Hazelden. He worked there for four years and became board certified in addiction medicine from the American Board of Addiction Medicine in 1991 or 1992. Tr., Vol IV, at 150.

198. Dr. Skipper helped to start a fellowship in addiction medicine at Oregon Health Science University while he was on the faculty as an internist. Tr., Vol IV, at 151-52.

199. Dr. Skipper was one of the founders of the PHP in Oregon. Tr., Vol IV, at 154.

200. In 1999, Dr. Skipper moved to Montgomery, Alabama, where he served as the medical director of the Alabama PHP until 2011. Tr., Vol IV, at 155-56.

201. During his tenure in Alabama, Dr. Skipper had occasion to serve as a mentor to Dr. Bradley Hall, when he began serving in a similar capacity with the West Virginia PHP. Tr., Vol IV, at 156-57.

202. In 2011, Dr. Skipper moved to Los Angeles, California, where he started the Center for Professional Recovery, an evaluation and treatment program for professionals, primarily physicians. Dr. Skipper continues working at the Center at this time. Tr., Vol IV, at 157-58.

203. Dr. Skipper is currently involved with the California Board of Medicine, working to reestablish a PHP in California. Tr., Vol IV, at 159.

204. Since becoming a specialist in addiction medicine, Dr. Skipper has worked with and treated an estimated 2,500 physicians dealing with substance use disorder. Tr., Vol IV, at 160.

205. Dr. Skipper reviewed documents and records relating to this matter, including Dr. Stewart's medical and treatment records. On May 24, 2022, he conducted an addiction medicine assessment of Dr. Stewart in order to assess his recovery. The assessment process took approximately two hours. Dr. Skipper also spoke with Dr. Brad Hall as a collateral source who has direct knowledge of Dr. Stewart's treatment and recovery. Tr., Vol IV, at 165-67.

206. Based upon his assessment, Dr. Skipper opined that Dr. Stewart appears to be doing well and is stable in recovery. Indeed, out of a top possible score of 100, Dr. Stewart scored in the "high 90s" on the recovery assessment tool, placing him in the top 10% of people he sees. Tr., Vol IV, at 172-73.

207. Dr. Skipper concluded that Dr. Stewart has truly embraced recovery. Tr., Vol IV, at 174.

208. Dr. Skipper observed that some physicians become better physicians when they recover from addiction. They tend to become more humble and compassionate, and take better care of their patients. Tr., Vol IV, at 174.

209. Dr. Skipper reviewed Dr. Sucher's written report and agreed with Dr. Sucher that Dr. Stewart engaged in professional misconduct. Tr., Vol IV, at 176.

210. Dr. Skipper acknowledged that having an active, undiagnosed and untreated addiction does not excuse a physician from the consequences of professional misconduct. Tr., Vol IV, at 180.

211. Dr. Skipper proposed that Dr. Stewart has already suffered certain consequences for his conduct of diverting prescription medications in that he has acknowledged that his behavior was improper, was removed from his practice while undergoing inpatient treatment, incurred expenses related to treatment and monitoring, and has severed relationships with family and friends. Tr., Vol IV, at 176-77, 180-81.

212. Based upon his experience, Dr. Skipper contends that physicians do not require discipline by their medical boards in order to understand the effects of their past behavior. Tr., Vol IV, at 178.

213. In his experience, Dr. Skipper has seen physicians who engaged in professional misconduct due to substance abuse disorders and were subject to disciplinary action from a licensing board, including removal from practice, who thereafter successfully returned to practice. Tr., Vol IV, at 186.

214. After thoroughly reviewing Dr. Sucher's written report, Dr. Skipper had no disagreement with any of the opinions rendered by Dr. Sucher. Tr., Vol IV, at 193.

215. Dr. Skipper agreed that while a PHP has a role in monitoring the treatment and assessment of physicians, whether physician misconduct is subject to disciplinary action is a matter to be determined by their licensing board. Tr., Vol IV, at 194.

216. Dr. Bradley P. Hall serves as the medical director of the WVMPHP, a position he has held since the WVMPHP was established in 2007. Tr., Vol IV, at 7-8.

217. After college at WVU, Dr. Hall graduated from the WVU School of Medicine in 1988. Tr., Vol IV, at 8.

218. Dr. Hall practiced family medicine until 2005, when he became interested in addiction medicine, and physician health programs ("PHPs") specifically. At that time, he became aware that West Virginia was one of only three states that did not then have a PHP. Tr., Vol IV, at 9.

219. Dr. Hall has been involved in the leadership of PHPs on a national level through the Federation of State Physician Health Programs, the organization that represents all PHPs. Dr. Hall is a past president of the Federation and currently remains on the Federation's board. Tr., Vol IV, at 10-11.

220. Dr. Hall worked with the Board of Medicine, the Board of Osteopathic Medicine, and other stakeholders to establish the WVMPHP. The goals of the WVMPHP are to protect the public and successfully rehabilitate physicians. Tr., Vol IV, at 11-12.

221. The WVMPHP is an independent non-profit 501(c)(3) corporation that works collaboratively with organized medicine. The WVMPHP has an independent

board of directors that is composed of appointees from stakeholder organizations. Tr., Vol IV, at 12-13, 61.

222. The WVMPHP is not a state agency. Under the applicable statutory structure, the Board can designate which entities may serve as a PHP. Pursuant to that authority, the Board has designated the WVMPHP to serve as a PHP for its licensees, as well as medical students and residents, and the WVMPHP has performed in that capacity since it was designated by the Board at the time of its establishment in or about 2007. Tr., Vol IV, at 61-63.

223. The WVMPHP works with the Board of Medicine and the Board of Osteopathy through contractual agreements. According to Dr. Hall, the relationship between the WVMPHP and the Boards has "always been built off principles of collaboration, communication, accountability, and transparency." Tr., Vol IV, at 13.

224. The goals and purposes of the WVMPHP include establishing a stable, viable, long-term program while providing a service to participants that allows them to get well, and move on personally and professionally with their lives. Tr., Vol IV, at 13-14.

225. Referrals may bring participants to the WVMPHP through the Board, employers, family, friends, or the individuals themselves. Tr., Vol IV, at 17.

226. PHPs throughout the country operate under standards and guidelines established by the Federation of State Physician Health Programs. Dr. Hall explained that there may be some variations in PHP programs from state to state, but there is overall consistency. Tr., Vol IV, at 18-19.

227. When an individual is referred to the WVMPHP, the process begins with an interview in Dr. Hall's office to obtain a history and an overall picture of what is going

on with the person that led to the referral. Dr. Hall will explain how the WVMPHP works and how to navigate through their employment situation. Tr., Vol IV, at 19-20.

228. The participant will then be given a WVMPHP referral to an approved center where they will undergo a healthcare professional's assessment, which involves a multi-disciplinary evaluation, interviews, collateral information and neuropsychological testing, as required. This leads to an overall assessment of diagnoses and recommendations. The approved centers may also provide treatment to the participant. Tr., Vol IV, at 19-20.

229. Subsequent to the global assessment and initial treatment, the approved center will develop an aftercare plan in which the participant enters into an agreement with the WVMPHP which parallels the aftercare plan. The WVMPHP monitors the participant and provides support to assist them in remaining compliant with their aftercare program. Tr., Vol IV, at 21.

230. WVMPHP monitoring extends to drug testing of urine, hair and blood to validate compliance. The WVMPHP also monitors the participants ongoing treatment through their providers and workplaces. Consequently, the WVMPHP is able to endorse the participants' compliance and wellbeing through a written report. The WVMPHP further provides guidance and support to assist the participant in navigating their return to work, as well as ongoing compliance and wellbeing. Tr., Vol IV, at 21-23.

231. Monitoring represents a deterrence function, keeping professionals in the program aware that they are not only accountable to themselves, but they have someone else accountable for monitoring their recovery. Tr., Vol II, at 79.

232. The duration or level of a WVMPHP agreement is dependent on the diagnoses and severity of the addiction. A person with a full-blown addiction will be with the WVMPHP for five years. Tr., Vol IV, at 21.

233. According to Dr. Hall, the WVMPHP has a success rate between 85 and 90 per cent for participants who come in and successfully complete the program, although there may be non-compliant events during their rehabilitation. Tr., Vol IV, at 24-25.

234. The WVMPHP is required to report every non-compliance event to the Board. Non-compliance events may include relapse, missed drug tests, medication non-compliance, or a failure to follow the directions of their providers or the terms of their WVMPHP agreement. Tr., Vol IV, at 25-26, 91

235. Dr. Hall confirmed that Dr. Stewart has been a voluntary participant in the WVMPHP since June 15, 2019, when he interviewed Dr. Stewart on a Saturday for participation in the program. Tr., Vol IV, at 30, 39.

236. In June of 2019, Dr. Hall was contacted by Dr. Thaxton before he first spoke to Dr. Stewart. Dr. Hall discussed the WVMPHP and its process with Dr. Thaxton. Dr. Hall also spoke with Dr. Thaxton after his meeting with Dr. Stewart, to confirm that he had met with Dr. Stewart regarding the WVMPHP. Tr., Vol IV, at 31-32.

237. When Dr. Hall first met with Dr. Stewart, it was his assessment that Dr. Stewart needed to undergo assessment and evaluation. Dr. Stewart agreed with this approach and arrangements were made for Dr. Stewart to go to Pavillon for evaluation and treatment. Tr., Vol IV, at 33-36.

238. Dr. Stewart subsequently went to Pavillon in North Carolina where he spent approximately three months undergoing evaluation and treatment. Pavillon then developed an aftercare program for Dr. Stewart, which WVMPHP incorporated into an agreement that parallels the aftercare program, and which Dr. Stewart agreed to and signed. Tr., Vol IV, at 41-42.

239. Whether a participant is fit to return to practice is determined by the treatment center before the participant departs from the center. Tr., Vol IV, at 46.

240. On September 6, 2019, Dr. Stewart executed his WVMPHP agreement, which is entitled a Continuing Recovery Care Agreement ("CRCA"), for a period of five years. Tr., Vol IV, at 45. *See* Ex 53.

241. As stipulated in the CRCA, WVMPHP endorsed Dr. Stewart's return to work consistent with Pavillon's recommendations. Tr., Vol IV, at 45-46. *See* Ex 53 at BOM1001.

242. Dr. Hall explained that it is important for recovering individuals to return to work and resume being a productive member of society. He went on to note that returning to work is healthy, good for one's wellbeing, and represents part of a successful recovery. Tr., Vol IV, at 47.

243. Dr. Hall verified that Dr. Stewart has been fully compliant with all terms of his CRCA since its execution on September 7, 2019. Tr., Vol IV, at 51.

244. Dr. Hall observed that all of Dr. Stewart's random screenings have been negative for drug, alcohol or other mood-altering substances. Tr., Vol IV, at 51. *See* Ex 54.

245. Dr. Hall further observed that Dr. Stewart is "uniquely fit for recovery" and "he's done everything we've asked [him] to do." In Dr. Hall's experience over the past 20 years, Dr. Stewart falls in the top 10 per cent of program participants. Tr., Vol IV, at 52-53.

246. Based upon his interchanges with Dr. Stewart, Dr. Hall described Dr. Stewart as "one of the winners." Tr., Vol IV, at 53.

247. Dr. Hall also noted that Dr. Stewart's participation in the Charleston chapter of Caduceus, a closed healthcare meeting of providers, "has been very active and very exemplary." Tr., Vol IV, at 54.

248. While WVMPHP participants are required to attend certain meetings as part of their recovery and maintenance, Dr. Hall noted that Dr. Stewart goes to more meetings than required. Tr., Vol IV, at 56.

249. Dr. Hall described the two kinds of participants in the WVMPHP as those who are ordered to participate in the WVMPHP by a Board process, and those who come to the WVMPHP through a voluntary, confidential process. Tr., Vol IV, at 64-65.

250. As explained by Dr. Hall, the WVMPHP distinguishes between physician illness and physician impairment, with the WVMPHP operating under an illness model. This is because a physician can have an illness without being impaired. Tr., Vol IV, at 66.

251. Dr. Hall testified that substance use disorder is an illness, and the WVMPHP serves individuals suffering from substance use disorder and mental illness. A majority of the participants in the WVMPHP have diagnoses of substance use

disorders, which would include the non-therapeutic use of mood or mind-altering substances, including alcohol. Tr., Vol IV, at 66-67.

252. Unlike an illness such as substance use disorder, impairment involves a physician who is unable to practice medicine and surgery due to a health condition or an illness. An impairment does not necessarily involve a chronic condition, and may be resolved, while an illness may continue in remission or otherwise. Tr., Vol IV, at 68-69.

253. This relationship between illness and impairment is important in the realm of patient safety because impairment, which may be temporary, can be the result of an illness that is untreated. Tr., Vol IV, at 69.

254. A physician who has undiagnosed, untreated alcoholism, or other substance use disorder, can be impaired if they are using drugs or alcohol in the workplace. According to Dr. Hall, physicians who are suffering from an undiagnosed, untreated substance use disorder may not recognize their impairment. Tr., Vol IV, at 69-71.

255. Dr. Hall explained that part of the initial intake and assessment for WVMPHP participants is to assess potential impairment due to the high-stakes nature of practicing medicine. Tr., Vol IV, at 72-73.

256. The majority of physicians who seek assistance from the WVMPHP have been encouraged to do so by someone, often by an employer such as a hospital or practice group. Tr., Vol IV, at 75.

257. In some situations, participants come to the WVMPHP because of a pending complaint with the Board of Medicine or the Board of Osteopathic Medicine. In those cases, Dr. Hall would explain the Board's complaint processes. Tr., Vol IV, at 75.

258. Dr. Hall is mandated to notify the Board whenever a participant is involved in a non-compliance event. Tr., Vol IV, at 76-77.

259. A WVMPHP participant may remain in a confidential status to the Board if they successfully complete their WVMPHP contract without a non-compliant event. Tr., Vol IV, at 81.

260. There are some circumstances where a participant will authorize the WVMPHP to disclose their participation to the Board. For example, a participant who is completing residency and seeking licensure may want to demonstrate that they are in active recovery and have the endorsement of the WVMPHP to practice safely. Tr., Vol IV, at 81-82.

261. If a complaint is filed with the Board against a participant, and the complaint involves allegations of physician impairment, the participant may ask the WVMPHP to disclose their participation to the Board in conjunction with their response to the complaint. Tr., Vol IV, at 84-85.

262. At Dr. Stewart's request, Dr. Hall disclosed Dr. Stewart's participation in the WVMPHP to the Board by letter dated September 12, 2019, because Dr. Stewart then had a complaint pending against him before the Board. Tr., Vol IV, at 87-88. *See* Ex 5 at BOM0021.

263. The purpose in disclosing a participant's identity to the Board due to a pending complaint is to give the Board comfort that immediate Board action to protect the public is not necessary because the individual is being monitored by the WVMPHP, and any concern of impairment or non-compliance is immediately reported to the Board by the WVMPHP. Tr., Vol IV, at 90-92.

264. Dr. Hall stated that physician impairment in the workplace represents professional misconduct. Tr., Vol IV, at 94.

265. Dr. Hall acknowledged that a physician suffering from substance use disorder can engage in various types of professional misconduct other than impairment in the workplace. Tr., Vol IV, at 94.

266. Physicians who are suffering from substance use disorder will have typically engaged in some type of illegal, unethical or unprofessional conduct in the course of obtaining mood or mind-altering substances they are ingesting for non-therapeutic reasons. Tr., Vol IV, at 94-96.

267. Dr. Hall was not aware of the specific allegations of professional misconduct against Dr. Stewart which are set forth in the CNOH. Tr., Vol IV, at 88-89, 100-01.

268. Dr. Hall agreed that it is the Board's responsibility to determine whether or not professional misconduct has occurred and whether disciplinary action is appropriate against a licensee. Tr., Vol IV, at 98.

269. Dr. Hall further explained that the WVMPHP does not opine, endorse or have the authority to determine whether a physician has engaged in professional misconduct nor whether disciplinary action is appropriate. Tr., Vol IV, at 98-99.

270. Dr. Hall acknowledged that the WVMPHP has no role in imposing discipline for professional misconduct arising out of or associated with substance use disorder, noting that the imposition of discipline for such conduct rests solely with the Board. Tr., Vol IV, at 107.

271. Dr. Hall confirmed that it is not the role of the WVMPHP to take a position on whether discipline should be imposed against a participant. Tr., Vol IV, at 109, 115.

272. Dr. Hall expressed no dispute or disagreement with any of the expert opinions offered by Dr. Sucher in his written report. Tr., Vol IV, at 110. *See* Ex 23.

273. In Dr. Hall's experience, some physicians in the WVMPHP have been disciplined and removed from work for a period of time, and successfully returned to practice thereafter. Tr., Vol IV, at 119.

274. The WVMPHP never tells or assures participants that they might not be subject to collateral consequences from underlying conduct through participation in the WVMPHP. Tr., Vol IV, at 119.

275. John David Hayes, MD ("Dr. Hayes") is employed at the Charleston Area Medical Center ("CAMC") as chief of the division of plastic surgery. Dr. Hayes has been employed by CAMC since 2011 and has been chief of plastic surgery since 2014. Tr., Vol III, at 8-9.

276. At the time of the evidentiary hearing in this matter, there were four full-time physicians, including Dr. Stewart, and one part-time physician, in the plastic surgery group at CAMC. One of those full-time physicians was scheduled to leave in August 2022, with a possibility that this individual would return as a per diem physician, if needed. Tr., Vol III, at 10-11.

277. The CAMC plastic surgery group covers 100% of the hand trauma at CAMC as well as any form of plastic surgery trauma. The vast majority of their calls for trauma services involve hand trauma. Dr. Hayes noted that surgery trauma can include

a very broad spectrum that may cover any sort of reconstructive surgical procedure. Tr., Vol III, at 11.

278. In order to meet the demand for plastic surgery services at CAMC, the surgeons rotate call to accommodate the trauma patients. Tr., Vol III, at 11-12.

279. Dr. Hayes has been working with Dr. Stewart since Dr. Stewart joined CAMC's plastic surgery department in December 2019. Tr., Vol III, at 12-13.

280. Dr. Hayes also serves as Dr. Stewart's workplace monitor regarding Dr. Stewart's participation in the WVMPHP. Dr. Hayes is required to complete a monthly review reporting to WVMPHP on Dr. Stewart's work schedule, attendance, staff interaction, and patient care. He is also required to confirm in his report that Dr. Stewart does not have any interaction with or access to narcotic medications. Tr., Vol III, at 13-14.

281. Dr. Hayes observed that Dr. Stewart's performance during the past two and one-half years has been excellent and free of issues. Dr. Hayes has not encountered any problem with Dr. Stewart's practice, professional conduct, or actions. Tr., Vol III, at 13-14.

282. In April 2020, after Dr. Stewart had been practicing at CAMC for approximately five months, Dr. Hayes submitted a letter of support on behalf of Dr. Stewart to the Board, complimenting Dr. Stewart on his professionalism and patient care since joining CAMC. Tr., Vol III, at 14-15. *See* Ex 60.

283. Dr. Hayes reported that Dr. Stewart has been a great addition to the CAMC plastic surgery group, and he has looked to Dr. Stewart for his wisdom and

experience as a plastic surgeon. Indeed, Dr. Stewart has been the lead surgeon for some of the more complex procedures in the operating room. Tr., Vol III, at 16-18.

284. In April 2020, Dr. Hayes' young daughter became ill on a day he had two patients scheduled for surgery. One of the patients required breast cancer surgery, which involves a long procedure. Dr. Stewart was the first call he made to have another plastic surgeon cover these patients. Tr., Vol III, at 18-19.

285. Dr. Hayes affirmed that he would call Dr. Stewart to take care of his family or any of his patients. Tr., Vol III, at 19-20.

286. When Dr. Stewart came to CAMC, he disclosed to Dr. Hayes that he had a drug addiction. Dr. Hayes also became aware that Dr. Stewart had taken patients' medication for himself, although Dr. Hayes did not know the details concerning how Dr. Stewart went about taking patients' medication. Tr., Vol III, at 21.

287. While working at CAMC, Dr. Stewart does not have access to narcotic medications. The plastic surgery office only stocks lidocaine and all medications in the hospital are controlled through the Pyxis system and administered by nursing staff or anesthesia staff. Tr., Vol III, at 21.

288. Dr. Hayes explained that it is very difficult to recruit new plastic surgeons, and especially, experienced plastic surgeons, to practice with CAMC in Charleston, West Virginia. Dr. Hayes described CAMC as a "revolving door" for physicians, noting that it would be particularly difficult to find someone with Dr. Stewart's experience and skills to replace him at CAMC. Tr., Vol III, at 23-24.

289. Dr. Hayes reported that he was having no success replacing the single plastic surgeon who was leaving the practice, even though the position has been listed since sometime the previous year. Tr., Vol II, at 24.

290. As Dr. Stewart's WVMPHP workplace monitor, Dr. Hayes has had an opportunity to oversee Dr. Stewart's surgical skills and clinical competency since Dr. Stewart returned to practice at CAMC after a six-month absence. Dr. Hayes has been completely satisfied with Dr. Stewart's surgical skills since he joined CAMC and noted no issues or problems with his reentry to practice. Tr., Vol III, at 27-28.

291. Dr. Hayes observed that if Dr. Stewart would have to be absent from the practice for six months to a year, if there was an available slot in the plastic surgery group, Dr. Stewart would be welcomed back. Tr., Vol III, at 29.

292. Shelda A. Martin, MD ("Dr. Martin"), is the Associate Chief Medical Officer for CAMC Memorial Division. She is also the medical director for the Ron White program which provides care for HIV patients. Dr. Martin also serves as chair of the substance use disorder task force and diversion committees for CAMC. She previously served as the Associate Chief Medical Officer for Ambulatory and Physicians. Tr., Vol III, at 34.

293. Dr. Martin participated in Dr. Stewart's onboarding process when he was hired in December 2019. Dr. Martin met with Dr. Stewart for an hour to determine if he would be a good hire or not. Tr., Vol III, at 37.

294. Dr. Martin authored the February 2020 letter of support for Dr. Stewart which CAMC sent to the Board. Tr., Vol III, at 38. *See* Ex 58.

295. Dr. Martin's February 2020 letter to the Board was prepared at Dr. Stewart's request and was intended to inform and assure the Board of the limitations that were in place governing Dr. Stewart's employment at CAMC. Tr., Vol III, at 38-39. *See* Ex 58.

296. The February 2020 letter states that CAMC is aware of Dr. Stewart's participation in the WVMPHP, his inpatient treatment at Pavillon, his addiction and manner of drug diversion, and his ongoing WVMPHP compliance and treatment. The letter informs the Board that Dr. Stewart has on-site monitoring in both the operating room and office setting, and Dr. Stewart does not have access to narcotic medications. Tr., Vol III, at 40-44. *See* Ex 58.

297. Prior to Dr. Stewart becoming employed by CAMC, he disclosed his drug addiction to Dr. Martin, as well as the manner in which he diverted medications from patients. He explained that he told patients to bring their medications to the office and would obtain their pills by telling patients he would dispose of their unused medications. Dr. Stewart also disclosed that he had an issue with fentanyl, but Dr. Martin did not recall the details. Tr., Vol III, at 40-41.

298. Dr. Stewart further acknowledged to Dr. Martin that his conduct had been unethical and unprofessional. Tr., Vol III, at 45.

299. Dr. Martin has referred patients to Dr. Stewart which have all resulted in good outcomes for the patients. Tr., Vol III, at 47.

300. If Dr. Stewart should be removed from practice for some period of time, Dr. Martin opined that CAMC would lose someone who is recovery-oriented, has years of wisdom and experience, and who is seen as a leader and mentor for other

physicians. Dr. Martin also asserted that such an absence would adversely affect patient care.

301. CAMC was aware that Dr. Stewart had not been practicing for six months when he began his employment there in December 2019. Tr., Vol III, at 50.

302. Dr. Martin observed that Dr. Stewart had no clinical or performance issues when he returned to practice medicine and surgery at CAMC in December 2019. Tr., Vol III, at 50.

303. CAMC was also aware that a complaint against Dr. Stewart was pending with the Board of Medicine at the time Dr. Stewart was hired in December 2019. Tr., Vol III, at 51.

304. Dr. Martin was also aware that Dr. Stewart obtained patients' medications at STPS by stealing the medications from patients' personal belongings while they were in the operating room. Dr. Martin agreed that this involved serious misconduct. Tr., Vol III, at 52.

305. Dr. Martin also affirmed that, should Dr. Stewart be out of practice for six months to a year, CAMC would "absolutely" welcome him back to the plastic surgery group, if a position was available. Tr., Vol III, at 52-53.

306. Richard Keith Umstot, Jr., MD ("Dr. Umstot"), is a physician practicing general acute care, trauma and critical care surgery at CAMC. Dr. Umstot is employed by WVU Physicians of Charleston and serves as an Assistant Professor of Surgery with West Virginia University. Tr., Vol III, at 55-56.

307. Dr. Umstot and his partners staff CAMC's emergency room and ICU for unassigned trauma call. Tr., Vol III, at 57.

308. Dr. Umstot first met Dr. Stewart when they were in medical training together, and they became friends and co-residents. Since Dr. Stewart became employed at CAMC, Dr. Umstot has interacted with Dr. Stewart and they have treated common patients between them. Tr., Vol III, at 58-59.

309. Dr. Umstot observed that trauma patients often have complex injuries and wounds that need the expertise, training, and experience of a plastic surgeon. Tr., Vol II, at 59.

310. From Dr. Umstot's perspective, Dr. Stewart has maintained or elevated the quality, availability, and complexity of plastic surgery care for multiple trauma patients at CAMC. Tr., Vol III, at 60.

311. Dr. Umstot opined that losing Dr. Stewart's services at CAMC for a period of a few months would be detrimental to patient care. Tr., Vol III, at 61.

312. Kari R. Hunter ("Ms. Hunter") is a Physician Assistant who has worked at the CAMC Plastic Surgery Center since July 2018. Tr., Vol III, at 64.

313. Ms. Hunter first met Dr. Stewart when he joined CAMC in December 2019. She has worked with Dr. Stewart in the operating room, clinic, and inpatient settings. Ms. Hunter ordinarily works with Dr. Stewart in the operating room twice each week. Tr., Vol III, at 64-65.

314. Ms. Hunter related that Dr. Stewart is attentive to detail and is a meticulous surgeon that gets good results for his patients. She also observed that Dr. Stewart is attentive to patient concerns and is a good communicator with patients and their families. Tr., Vol III, at 67-68.

315. Ms. Hunter observed that Dr. Stewart's top priority is making sure he "gets good results and happy patients." Tr., Vol III, at 67.

316. Ms. Hunter is aware of Dr. Stewart's substance use disorder involving opioids but she has never had any concerns regarding Dr. Stewart's conduct and behavior, either in the operating room or in the clinic setting. Tr., Vol III, at 66, 69.

317. From Ms. Hunter's perspective, should Dr. Stewart take a leave of absence, it would be "extremely detrimental to our entire community because he's probably the best plastic surgeon we have at a level one trauma center." Tr., Vol III, at 69-70.

318. Ms. Hunter did not work with Dr. Stewart before December 2019. Tr., Vol III, at 70.

319. Laura G. Huffman ("Ms. Huffman") was previously employed as the Department Manager for the CAMC Plastic Surgery Division from June 2018 to April 2022. She continues to work at CAMC in another division. Tr., Vol III, at 74.

320. In her capacity of department manager, Ms. Huffman had a variety of administrative duties, including physician recruitment. Tr., Vol III, at 75.

321. Ms. Huffman did not know Dr. Stewart before he was hired by CAMC in December 2019. Ms. Huffman was involved in recruiting and hiring Dr. Stewart. Tr., Vol III, at 76.

322. Ms. Huffman recalled that Dr. Stewart was very open about his substance use disorder and recovery during the hiring process. Tr., Vol III, at 77.

323. Ms. Huffman related that 90 per cent of the plastic surgery work at CAMC involves trauma and cancer patients, while the other 10 per cent involves cosmetic surgeries. Tr., Vol III, at 75.

324. Ms. Huffman explained that Dr. Stewart was the busiest and most productive plastic surgeon in the plastic surgery division and well liked and sought after by his patients. Tr., Vol III, at 77-78.

325. Ms. Huffman opined that if Dr. Stewart was required to take time away from his practice at CAMC, it would adversely impact the availability of care for patients, particularly breast cancer and trauma patients. Dr. Stewart's absence would put a strain on the call schedule for the remaining plastic surgeons. Tr., Vol III, at 80-81.

326. Ms. Huffman has seen physicians refer their patients to Dr. Stewart and be willing to have them placed on a waiting list so they would be seen by Dr. Stewart. Tr., Vol III, at 79.

327. Ms. Huffman agreed that the loss of any of the currently employed plastic surgeons would have the same adverse result. Tr., Vol III, at 82.

328. Fred Timothy Kerns, MD ("Dr. Kerns"), is a physician employed at CAMC who currently serves as the Director of the infectious Disease Division and as Director of Epidemiology. Dr. Kerns has been practicing in Charleston since 1982. Tr., Vol III, at 84.

329. Dr. Kerns has been acquainted with Dr. Stewart during the past three decades while practicing medicine in Charleston. Dr. Kerns has referred and shared patients with Dr. Stewart since Dr. Stewart has been at CAMC. Dr. Kerns observed that

Dr. Stewart sees referred patients promptly and has good outcomes. Tr., Vol III, at 86-88.

330. Dr. Kerns stated that Dr. Stewart is an experienced plastic surgeon who has had a beneficial impact on patient care at CAMC. Tr., Vol III, at 90.

331. Prior to the hearing, Dr. Kerns sent two e-mails to the Board in support of Dr. Stewart, noting Dr. Stewart's professionalism and competency, acknowledging that Dr. Stewart was his "plastic surgeon of choice." Tr., Vol III, at 89-93. *See* Exs 61 & 62.

332. Dr. Kerns could not recall referring a patient to Dr. Stewart before Dr. Stewart came to CAMC. Tr., Vol III, at 95-96.

333. Donna J. Slayton, MD ("Dr. Slayton"), is an anesthesiologist who works at CAMC for General Anesthesia Services. Dr. Slayton has been working at CAMC for 32 years. Tr., Vol III, at 132-33.

334. Dr. Slayton knows Dr. Stewart because they are neighbors, as well as from working with him in the operating room. She has worked with Dr. Stewart since the early 1990's, in both the hospital setting and in Dr. Stewart's private office. Tr., Vol III, at 133-34.

335. Dr. Slayton usually works with Dr. Stewart two days a week since he joined CAMC, working with him in the operating room on a variety of plastic surgery cases. Tr., Vol III, at 134-36.

336. Dr. Slayton considers Dr. Stewart an excellent plastic surgeon and one of her favorite plastic surgeons. Dr. Slayton has been a patient of Dr. Stewart and has referred family and friends to him. Tr., Vol III, at 137-38.

337. Dr. Slayton proposed that if Dr. Stewart were removed from practice, it would delay patients' access to care. Tr., Vol III, at 141.

338. Dr. Slayton opined that, as an anesthesiologist, it would be difficult to re-enter practice if she had to take a year off from the practice of medicine. Tr., Vol III, at 140.

339. Dr. Slayton previously worked with Dr. Stewart at Dr. Stewart's private office when it was located in Kanawha City. When Dr. Stewart began working at CAMC after a six-month absence from clinical practice she saw no evidence that this had affected his surgery skills. Tr., Vol III, at 146.

340. Thomas P. McIlwain, MD ("Dr. McIlwain"), is currently employed by CAMC where he serves as its Chief Medical Officer, a position he has held for nearly nine years. In his capacity as Chief Medical Officer, Dr. McIlwain oversees medical affairs, credentialing, and peer review matters. While at CAMC, he has previously held responsibility for quality, safety, and utilization management, among a number of other duties and responsibilities. Tr., Vol III, at 124-25.

341. Dr. McIlwain serves on the board of the WVMPHP as the representative designated by the West Virginia Hospital Association. Tr., Vol III, at 126.

342. At the time CAMC hired Dr. Stewart, the hospital was aware of Dr. Stewart's participation in the WVMPHP and the circumstances surrounding his addiction, diversion of medications from patients, and his recovery. Dr. McIlwain stated that CAMC has been and continues to be supportive of Dr. Stewart's recovery. Tr., Vol III, at 131-32.

343. CAMC employs a number of physicians who are actively enrolled and have treatment contracts with the WVMPHP. Dr. McIlwain proposed that CAMC has adequate means of oversight to ensure that these physicians are practicing and functioning within the guardrails that are appropriate to ensure that safe and effective care is delivered. Tr., Vol III, at 132.

344. Dr. Stewart schedules time to update Dr. McIlwain on his performance, his state of recovery, and his active participation with the WVMPHP and its programs on a periodic basis. Tr., Vol III, at 132.

345. From Dr. McIlwain's perspective, Dr. Stewart has done very well since joining CAMC in December 2019. Dr. Stewart is considered a valuable member of the medical staff. Dr. McIlwain has received favorable comments from both staff and patients regarding Dr. Stewart. Tr., Vol III, at 133.

346. Like all physicians, CAMC requires Dr. Stewart to be recredentialed every two years, to be reappointed to the medical staff. Tr., Vol III, at 134.

347. Dr. McIlwain observed that, depending on the circumstances, disciplinary action taken by a medical licensing board can affect a physician's ability to obtain credentialing so as to maintain privileges and employment. Tr., Vol III, at 134.

348. According to Dr. McIlwain, any physician whose capacity to practice medicine is sanctioned by a medical licensing board would cease to have privileges at CAMC, and would have no guarantee of reinstatement. Tr., Vol III, at 135.

349. Dr. McIlwain believes that patients at CAMC benefit from having Dr. Stewart as a member of CAMC's medical staff. Tr., Vol III, at 136.

350. CAMC has previously hired physicians who have disciplinary actions taken against their medical license by the Board and has also reinstated credentials and privileges to physicians after their licenses were disciplined by the Board. CAMC was aware that Dr. Stewart had a pending complaint against him before the Board at the time the decision was made to hire him. Tr., Vol III, at 137-38.

351. When CAMC hired Dr. Stewart, the hospital was aware that he had not practiced medicine or surgery for six months while he was going through treatment for substance use disorder. Tr., Vol III, at 139.

352. Dr. McIlwain opined that Dr. Stewart's successful performance at CAMC would assist Dr. Stewart in becoming recredentialed at CAMC if he was required to cease practicing for a period of time due to Board action. Tr., Vol III, at 139-40.

353. According to Dr. McIlwain, CAMC would welcome Dr. Stewart's return if he was required to take time out from practicing medicine. Tr., Vol III, at 141-42.

Consistent with the foregoing Findings of Fact, the undersigned Hearing Examiner concludes, as a matter of law:

CONCLUSIONS OF LAW

1. West Virginia Code § 30-3-1, *et seq.*, provides the West Virginia Board of Medicine ("Board") with authority to issue licenses to practice medicine and surgery in this state, and with authority to act as the regulatory and disciplinary body for the practice of medicine in this state. W. Va. Code § 30-3-5 & 30-3-7(a)(1); 11 C.S.R. 1A § 1.1, *et seq.* (2007).

2. The Board is authorized to establish regulations necessary to carry out the purposes of the West Virginia Medical Practice Act. W. Va. Code § 30-3-7(a)(1). *See* 11 C.S.R. 1A § 1.1, *et seq.* (2007).

3. The Board has jurisdiction over the subject matter and over the Respondent. W. Va. Code § 30-3-5.

4. Dr. Stewart's license to practice medicine and surgery in the State of West Virginia is subject to regulation and discipline by the Board. W. Va. Code § 30-3-5 & § 30-3-7(a).

5. The practice of medicine and surgery in West Virginia is a privilege, not a right. W. Va. Code § 30-3-1; *Healy v. W. Va. Bd. of Medicine*, 203 W. Va. 52, 55, 506 S.E.2d 89, 92 (1998); *Devernja v. W. Va. Bd. of Medicine*, 185 W. Va. 594, 596, 408 S.E.2d 346, 348 (1991).

6. The practice of medicine is a high calling; a professional license is a high privilege; the state may attach to its possession conditions which are "onerous and exacting." *Barsky v. Bd. of Regents*, 305 N.Y. 89, 98, 111 N.E.2d 222, 226 (1953), *aff'd*, 347 U.S. 442.

7. The West Virginia Medical Practice Act sets forth conduct which may render an individual unqualified for licensure or subject to discipline or other restrictions upon licensure. W. Va. Code § 30-3-14.

8. The Board has a general mandate to ensure "a professional environment that encourages the delivery of quality medical services" to protect the public interest. W. Va. Code § 30-3-2.

9. The inherent object of the statute regulating the practice of medicine and surgery is the protection of the public health. Syl. Pt. 2, *Vest v. Cobb*, 138 W. Va. 660, 76 S.E.2d 885 (1953).

10. The Board has a general mandate to ensure "a professional environment that encourages the delivery of quality medical services" to protect the public interest. W. Va. Code § 30-3-2.

11. The Board issued a timely CNOH in this matter on July 27, 2021. *See* W. Va. Code § 30-1-5(c).

12. Dr. Stewart was properly served with the CNOH via certified mail and in accordance with the requirements of W. Va. Code § 56-2-1.

13. The Respondent and Petitioner had legally sufficient notice of the public hearing in this matter. *See* W. Va. Code § 30-3-14(i); 11 C.S.R. 3 § 11.4 (2010).

14. The Petitioner complied with the procedural requirements set forth in W. Va. Code § 30-1-5(c) and any delay in proceeding to hearing in this matter was either attributable to Dr. Stewart or was affirmatively waived by Dr. Stewart.

15. Dr. Stewart executed a waiver agreement wherein he knowingly and voluntarily waived certain procedural and timeline rights as set forth in the waiver. *See* Ex 38.

16. Pursuant to regulation, the Board may designate a Hearing Examiner to conduct hearings. The undersigned Hearing Examiner is a licensed attorney and was so designated in this case by the Board. Such hearing was conducted pursuant to West Virginia Code and the Board's Legislative and Procedural Rules. *See* W. Va. Code §

30-3-14(b); W. Va. Code § 29A-5-1, *et seq.*; 11 C.S.R. 1A § 12 (2007); 11 C.S.R. 3 § 11, *et seq.* (2010).

17. At hearing, the rules of evidence as applied in civil cases in the circuit courts of this state were followed. *See* 11 C.S.R. 3 § 11.5(c) (2010). All exhibits entered into evidence at hearing are authentic and valid and were admitted with the proper evidentiary foundation.

18. In a proceeding such as this, it is proper to take into consideration Board precedent. *See* W. Va. Code § 29A-2-9.

19. Credibility is determined by the Hearing Examiner in administrative cases, based upon thorough evaluation of witness testimony. *See Darby v. Kanawha County Bd. of Educ.*, 227 W. Va. 525, 711 S.E.2d 595 (2011). The Hearing Examiner is uniquely situated to make such determinations and such determinations are binding unless patently without basis in the record. *Webb v. W. Va. Bd. of Medicine,* 212 W. Va. 156, 569 S.E.2d 225, 232; *Martin v. Randolph County Bd. of Educ.*, 195 W. Va. 297, 304, 465 S.E.2d 399, 406 (1995). Credibility determinations may be based upon many factors, including the following: the general demeanor and comportment of the witness at hearing; the bias or interest of the witness; the consistency or inconsistency of the statements of the witness; the witness' ability and acuteness to observe; the memory of the witness; the reputation for honesty of the witness; and other factors which tend to cause the trier of fact to believe or disbelieve the testimony of the witness. *See Franklin D. Cleckley, Handbook on Evidence for West Virginia Lawyers*, § 607.02(1)(b) (5th Ed. 2012).

20. Dr. Michael A. Sucher, called by the Petitioner, and Dr. Greg Skipper, called by the Respondent, were well-qualified expert witnesses who provided credible testimony concerning various issues relating to the field of addiction medicine and physicians' health programs, as applied to the issues raised in this matter. Dr. Peter D. Ray, also called by the Petitioner, was a highly-qualified expert witness in the field of plastic surgery, who provided credible testimony regarding the applicable standards of care in West Virginia. *See* W. Va. Rules of Evidence 72. *See generally*, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993); *Wilt v. Buracker*, 191 W. Va. 39, 443 S.E.2d 196 (1993), *cert. denied*, 571 U.S. 1129 (1994).

21. The undersigned Hearing Examiner finds the testimony of witnesses Jeffrey Thaxton, MD, Lisa Strawn, RN, Robin Sylvester, Amy Moore, Penny Lester, Patient A., Patient D, John David Hayes, MD, Shelda Martin, MD, Richard Umstot, MD, Kari Hunter, Laura Gail Huffman, Fred Kerns, MD, Phillip Bradley Hall, MD, Donna Jean Slayton, MD, and Thomas McIlwain, MD, to be credible.

22. The undersigned Hearing Examiner found the testimony of Dr. Stewart to be credible, as well as candid. Dr Stewart consistently responded to questions frankly and directly, without dissembling or evasion, including numerous inquiries which elicited responses that would ordinarily be considered adverse to his interests.

23. Any inconsistency with the foregoing findings of fact or with the documentary evidence admitted was not a result of any deliberate untruthfulness or bias. Rather, any inconsistency was a result of a difference of opinion, lack of knowledge, misperception or misrecollection.

24. The Petitioner bears the burden of proving the allegations in the Complaint and Notice of Hearing by clear and convincing evidence. W. Va. Code § 30-3-14(b); *Webb*, *supra*, at 156-57, 231-32.

25. The West Virginia Supreme Court of Appeals defines clear and convincing proof as that measure or degree of proof which produces in the mind of the trier of fact a firm belief or conviction as to the allegations sought to be established. *Webb, supra,* at 156, 232, *citing Wheeling Dollar Savings & Trust Co. v. Singer*, 162 W. Va. 502, 510, 250 S.E.2d 369, 374 (1978) (*quoting Cross v. Ledford*, 161 Ohio St. 469, 477, 120 N.E.2d 118, 123 (1954)).

26. In the absence of a statutory definition, "dishonorable, unethical and unprofessional conduct" and "conduct which has the effect of bringing the medical profession into disrepute" may be measured by the standards of the medical profession after a hearing; expert testimony is not required. *See Mingo County Med. Soc'y v. Simon*, 124 W. Va. 493, 20 S.E.2d 807 (1942). *Accord*, *Batoff v. State Bd. of Psychology*, 561 Pa. 419, 750 A.2d 835 (2000); *Petition of Grimm*, 138 N.H. 42, 635 A.2d 456 (1993); *Perez v. Missouri State Bd. of Registration for the Healing Arts*, 803 S.W.2d 160 (Mo. 1991); *Croft v. Arizona State Bd. of Med. Examiners*, 157 Ariz. 203, 755 P.2d 1191 (Ariz. 1988); *Fleischman v. Connecticut Bd. of Examiners in Podiatry*, 22 Conn. App. 181, 576 A.2d 1302 (App. Ct. of Conn. 1990). *See also Jaffe v. State Dep't of Health*, 135 Conn. 339, 64 A.2d 330 (1949).

27. The Board has promulgated legislative rules which "delineate conduct, practices or acts which, in the judgment of the board, constitute professional negligence, a willful departure from accepted standards of professional conduct or

which may render an individual unqualified or unfit for licensure, registration or other authorization to practice." W. Va. Code § 30-1-8(c).

28. The Board's Legislative Rule, Series 1A, *Licensing and Disciplinary Procedures: Physicians; Podiatrists*, enumerates additional conduct for which discipline may be imposed. 11 C.S.R. 1A § 12 (2007).

29. Based upon the testimony and evidence presented, the Board established by clear and convincing evidence that Dr. Stewart engaged in dishonorable, unethical and unprofessional conduct by diverting, collecting, accepting and/or stealing, both overtly and covertly, opioid pain medications from his patients that he had prescribed.

30. The Board further established by clear and convincing evidence that Dr. Stewart, on a regular basis over the course of five to ten years, stole and/or fraudulently obtained and diverted opioid pain medication from his patients for his own personal use by:

(a) Stealing opioid pills from patients' medication bottles directly from the patients' personal belongings while the patients were in the operating room being prepared for surgery and/or while patients were recovering from surgery;

(b) Instructing or requesting patients to return their unused opioid pain medication to his office under the false pretext that he would properly dispose of the medication; and

(c) By stealing pills directly from patients' medication bottles while falsely telling the patients he needed to "check" their medications on the day of the procedure.

31. The Board also established, by clear and convincing evidence, that Dr. Stewart engaged in conduct in violation of the West Virginia Medical Practice Act and the Board's legislative rules, as follows:

(a) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.1.e (2007), related to engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public or any member thereof; and/or

(b) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.1.j (2007), related to engaging in unprofessional conduct, including, but not limited to, any departure from or failure to conform to, the standards of acceptable and prevailing medical practice or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby; and/or

(c) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.2.d (2007), related to conduct which is calculated to bring or has the effect of bringing the medical profession into disrepute, including, but not limited to, any departure from or failure to conform to the standards of acceptable and prevailing medical or podiatric practice within the state, and any departure or failure to conform to the current principles of medical ethics of the AMA.

32. The Board established by clear and convincing evidence that Dr. Stewart engaged in a pattern of dishonorable, unethical and unprofessional conduct by making deceptive, untrue or fraudulent representations in the practice of medicine and by engaging in a deceptive and/or fraudulent trick or scheme to divert pain medication from his patients over the course of many years.

33. The Board established by clear and convincing evidence that Dr. Stewart, on a regular basis and over the course of five to ten years, engaged in deceptive and fraudulent tricks and schemes to steal, obtain and divert pain medications from his patients by:

(a) Stealing opioid pills directly from patients' medication bottles obtained by pilfering their personal belongings while the patients were in the operating room being prepared for surgery and/or while patients were recovering from surgery;

(b) By instructing or requesting patients to return their unused opioid pain medication to his office under the false pretext that he would dispose of the medication; and

(c) By stealing pills directly from patients' medication bottles by falsely telling the patients he needed to "check" their medications on the day of their procedure.

34. The Board established by clear and convincing evidence that Dr. Stewart has engaged in conduct in violation of the West Virginia Medical Practice Act and the Board's legislative rules, as follows:

(a) W. Va. Code § 30-3-14(c)(9) and 11 C.S.R. 1A § 12.1.s (2007), related to making deceptive, untrue or fraudulent representations in the practice of medicine or by having employed a trick or scheme in the practice of medicine which fails to conform to the generally prevailing standards of treatment in the medical community;

(b) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.1.e (2007), related to engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public or any member thereof;

(c) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.1.j (2007), related to engaging in unprofessional conduct, including, but not limited to, any departure from or failure to conform to, the standards of acceptable and prevailing medical practice or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby; and

(d) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.2.d (2007), related to conduct which is calculated to bring or has the effect of bringing the medical profession into disrepute, including, but not limited to, any departure from or failure to conform to the standards of acceptable and prevailing medical or podiatric practice within the state, and any departure or failure to conform to the current principles of medical ethics of the AMA.

35. At the time of the events pertinent to these Complaints, the Board's legislative rule addressing dispensing of prescription drugs by practitioners, 11 C.S.R. 5 (2017) provided in § 8.1: "In accord with current federal Drug Enforcement Agency (DEA) regulations, licensees of the Board are prohibited from accepting unused and/or unwanted controlled substances from or on behalf of patients."

36. The Board established, by clear and convincing evidence, that Dr. Stewart violated 11 C.S.R. 5 § 8.1 (2017), when he diverted, collected, accepted and/or stole, either overtly or covertly, unused and/or unwanted controlled substance medications from patients.

37. Dr. Stewart's conduct in violation of 11 C.S.R. 5 § 8.1 (2017) constitutes unprofessional conduct and provides grounds for disciplinary action pursuant to W. Va. Code § 30-3-14(c)(17). 11 C.S.R. 5 § 11 (2017), and 11 C.S.R. 1A § 12.2.h (2007).

38. The Board established by clear and convincing evidence that Dr. Stewart engaged in a pattern of stealing and diverting, for his own personal use, the remainders of IV fentanyl vials from the STPS operating room following surgical procedures.

39. Accordingly, the Board established, by clear and convincing evidence, that Dr. Stewart engaged in conduct in violation of the West Virginia Medical Practice Act and the Board's legislative rules, as follows:

(a) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.1.e (2007), related to engaging in dishonorable, unethical or unprofessional conduct of character likely to deceive, defraud or harm the public or any member thereof;

(b) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.1.j (2007), related to engaging in unprofessional conduct, including but not limited to, any departure from or failure to conform to, the standards of acceptable and prevailing medical practice or the ethics of the medical profession, irrespective of whether to not a patient is injured thereby; and

(c) W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.2.d (2007), related to conduct which is calculated to bring or has the effect of bringing the medical profession into disrepute, including, but not limited to, any departure from or failure to conform to the standards of acceptable and prevailing medical or podiatric practice within the state, and any departure or failure to conform to the current principles of medical ethics of the AMA.

40. The Board established, by clear and convincing evidence, that Dr. Stewart knowingly and intentionally engaged in a pattern of conduct over a period of years in which he prescribed opioid pain medication to patients and then collected, diverted,

accepted, and/or stole, either overtly or covertly, unused portions of these prescribed opioid pain medications for his own personal use.

41. The Board established, by clear and convincing evidence, that Dr. Stewart's professional misconduct also violates W. Va. Code § 30-3-14(c)(17) and 11 C.S.R. 1A § 12.2.a (2007), in that Dr. Stewart prescribed a controlled substance: (1) with the intent to evade any law with respect to the sale, use or disposition of controlled substances; and (2) for his personal use.

42. The Board met its burden of proving the substantive allegations of professional misconduct set forth in Counts 1, 2, 3, 4 and 5 of the Complaint and Notice of Hearing by clear and convincing evidence. *See* Webb, s*upra*, at 569, 231.

43. Pursuant to W. Va. Code § 30-3-14(c), the Board has the authority to discipline Dr. Stewart if the Board finds him unqualified to practice medicine based upon his conduct which violated the West Virginia Medical Practice Act.

44. The West Virginia Medical Practice Act and the Board's Legislative Rules mandate that the Board protect the public interest, safety, health and welfare. W. Va. Code § 30-3-1, *et seq.*; 11 C.S.R. 1A § 1, *et seq.* (2007).

45. Further, the Board has a mandate to ensure "a professional environment that encourages the delivery of quality medical services" to protect the public interest. W. Va. Code § 30-3-2.

46. Protection of the public interest requires that the Board demand a high degree of integrity from members of the medical profession. *Vest*, *supra*; *W. Va. Bd. of Medicine v. Romulo Dela Rosa, M.D.* (1989); *W. Va. Bd. of Medicine v. Lagrimas B. Sadorra, M.D.* (1988).

47. The protection of the public interest requires that the Board impose appropriate sanctions on a licensee who engages in unethical or unprofessional conduct.

48. Pursuant to West Virginia Code § 30-3-14(j), the Board may enter an Order imposing disciplinary sanctions when, subsequent to a notice and hearing, it is found that the licensee has violated West Virginia Code § 30-3-14(c) and/or the legislative rules promulgated pursuant to the Medical Practice Act.

49. The Board is authorized to impose one or more of the following disciplinary measures, as appropriate:

(1) Deny his or her application for a license or other authorization to practice medicine and surgery or podiatry;

(2) Administer a public reprimand;

(3) Suspend, limit or restrict his or her license to practice medicine and surgery or podiatry for up to five years;

(4) Revoke a license or authorization to practice medicine and surgery or podiatry or to prescribe or dispense controlled substances, including for the life of the licensee;

(5) Require a licensee to submit to care, counseling or treatment designated by the Board as a condition for initial or continued licensure or renewal of licensure or other authorization to practice medicine and surgery or podiatry;

(6) Require participation in a program of education;

(7) Require supervised practice for a specified period of time; and

(8) Assess a fine of not less than $1,000 nor more than $10,000.

W. Va. Code § 30-3-14(j).

50. The Board is further authorized by legislative rule to impose other sanctions and penalties, and to assess the costs of the Board's investigation and administrative proceedings against the licensee. 11 C.S.R. 1A § 12.3.g (2007).

51. In determining an appropriate sanction or sanctions for Dr. Stewart's established violations, the lack of any prior reported discipline regarding Dr. Stewart in West Virginia, or any other jurisdiction, may be considered as a mitigating factor.

DISCUSSION AND ANALYSIS

In arriving at a recommendation for a fair and equitable penalty to be imposed upon Dr. Stewart for established misconduct in violation of the standards of conduct required for physicians and surgeons in West Virginia, it is important to give due consideration to each of the equities which compete for fulfillment in this matter. Dr. Stewart violated multiple professional ethical standards over a significant time period before his actions were detected and challenged. Although there was no evidence that any patients suffered any physical injury or pain from his conduct, this is as much due to happenstance as any deliberate intent to avoid harm. Certainly, there was credible evidence that when patients recognized what Dr. Stewart had been doing, the physician-patient relationship was sometimes shattered, even if Dr. Stewart performed his medical duties in accordance with established standards. Similarly, the office staff and his physician business partner lost confidence in his professionalism and suffered from the turmoil of a broken partnership while simultaneously experiencing the diminished reputation of what had been a thriving and respected medical practice.

To his credit, Dr. Stewart is not contesting any of the charges in the Board's complaint, admitting to each of the pertinent allegations. This itself may be considered a

step forward in the rehabilitation process. He has also taken the initiative, without an order from the Board, to address his situation through the recovery process available in the WVMPHP. The evidence of record indicates that the WVMPHP in which Dr. Stewart has actively and successfully participated is as good at what it does as any PHP in the country. It is clearly doing its part to rehabilitate physicians who suffer from an illness involving substance use disorder and then return them to meaningful and productive lives. The witnesses, whether appearing in Dr. Stewart's corner, or representing a neutral entity or an interested party in the form of the Board, displayed a consistent consensus that Dr. Stewart is not merely going through the motions of rehabilitation to regain his license. Rather, there is a convincing chorus which proclaims that Dr. Stewart really gets it. He has admitted his misconduct, acknowledged his addiction status, and has been working diligently to overcome his disorder and maintain flawless compliance with the program.

While the addiction medicine experts presented by both the Board and Dr. Stewart concurred in the conclusion that Dr. Stewart has responded to the PHP rehabilitation process in conformance with all expectations, the testimony of Dr. Brad Hall, who runs the WVMPHP, was particularly compelling. It was clear to the undersigned Hearing Examiner that while Dr. Hall will not make any recommendation as to whether discipline is proper or appropriate in a particular matter, he will provide the Board with an honest opinion, and not pull any punches, when providing his evaluation of a participant. In this context, Dr. Hall's enthusiasm and admiration for how Dr. Stewart has reacted to the requirements of the WVMPHP was apparent and obvious,

providing clear and convincing evidence that Dr. Stewart's rehabilitation as a safe and productive physician has proceeded as well as anyone could hope for.

As illustrated by the life experiences of the outstanding addiction medicine expert witnesses, Dr. Sucher and Dr. Skipper, presented by the Board and Dr. Stewart respectively, substance abuse can be a challenging condition to overcome. Each of these highly credible witnesses acknowledged that there must be certain consequences for a physician's misconduct, even if it results from an illness in the form of a substance use disorder. Notwithstanding the need to attach appropriate consequences to physician misconduct, any penalties assessed must be appropriate not only to the offenses committed, but to the offender. In the present matter, the Board has discretion to impose any of the penalties available under the Medical Practice Act and the Board's implementing rules and regulations. Dr. Stewart has not contested any of the charges alleged by the Board in its complaint. Rather, Dr. Stewart has acknowledged that he violated the rules as charged, has taken responsibility for his conduct, and expressed genuine remorse for what he did.

Dr. Stewart's misconduct is not excused by the fact that his diversion and theft of patient medications and left-over fentanyl was generated by an undiagnosed and untreated substance use disorder. The Board correctly proposes that these actions warrant consequences. However, it is also clear that some penalties have already been extracted from Dr. Stewart in that he lost a thriving, successful plastic surgery practice, has paid out of pocket for a three-month stint in a North Carolina rehabilitation facility and the ongoing random hair, blood, and urine testing that has transpired while he

remains in the WVMPHP has been charged to Dr. Stewart. Thus, Dr. Stewart's misconduct has generated some significant adverse consequences.

In considering an appropriate penalty, the Board must also assess whether the penalty imposed provides a deterrent to discourage other medical providers from engaging in a similar course of conduct. There is almost no expectation that a rational physician would seek to emulate the overall consequences that have affected Dr. Stewart's life and practice resulting from his admitted misconduct. Moreover, anyone considering the entire situation ought to recognize that Dr. Stewart's outcome could have been far worse had he not fully embraced the opportunity to deal with his addiction through the WVMPHP.

The penalty imposed should fit not only the offense but the offender. In considering this paramount aspect of assessing a fair and appropriate penalty, there is overwhelming evidence that additional time away from the practice of medicine is not needed to rehabilitate Dr. Stewart or to maintain his abstention from drugs and alcohol. It is also reasonably apparent that separating Dr. Stewart from the active practice of medicine and surgery for six months to a year would not necessarily diminish his skills or prevent his return to effective practice at the end of such an absence. Although Board precedent also constitutes a factor which may be considered in arriving at an appropriate level of punishment, the undersigned Hearing Examiner finds that none of the previous actions cited by either of the parties sufficiently resembles this particular fact pattern to establish persuasive precedential value. However, any physician who engages in a pattern of conduct such as seen here should anticipate some adverse

consequences, up to and including a loss of license, depending on the totality of the circumstances.

The uncontroverted evidence before the undersigned Hearing Examiner makes it abundantly clear that the greatest injury resulting from revoking Dr. Stewart's privilege to practice medicine would inure to the patients who would otherwise benefit from his caring and skillful treatment. Not only would trauma and breast cancer patients experience diminished access to quality care, CAMC's status as a trauma center could be jeopardized. While Dr. Stewart's proven and admitted misconduct could easily support an extended suspension from the practice of medicine, this approach does not make any sense in the context of this matter. The penalty of removing a capable and competent physician from a practice that is beneficial to the community should be applied only when it is truly necessary to protect the public interest. Dr. Stewart has been practicing in accordance with his WVMPHP restrictions and his CRCA limitations for an extended time period without relapse or delinquency. Accordingly, in addition to a public reprimand, the public interest can be appropriately protected in this matter by revoking Dr. Stewart's medical license for a period of eighteen months or thereabouts, and then staying such revocation, provided, that Dr. Stewart remains fully compliant with the WVMPHP requirements and the provisions of his CRCA.

RECOMMENDED DECISION

Based upon the Foregoing Findings of Fact and Conclusions of Law, the Hearing Examiner **RESPECTFULLY RECOMMENDS** that the West Virginia Board of Medicine find that Respondent violated the West Virginia Code and the Board of Medicine's

Legislative Rules as set forth herein; and, **FURTHER,** that the Board issue a determination that:

(a) Dr. Stewart be issued a **PUBLIC REPRIMAND** for his professional misconduct in violation of the West Virginia Medical Practice Act.

(b) Dr. Stewart's license to practice medicine and surgery in West Virginia be **REVOKED**. However, such revocation of Dr. Stewart's license should be **STAYED** through September 6, 2024, while Dr. Stewart remains in the WVMPHP, in accordance with his current Continuing Recovery Care Agreement. At the expiration of Dr. Stewart's agreement with the WVMPHP, he may petition the Board to have his license reinstated on a probationary basis, for such period of time and subject to such practice restrictions as the Board deems necessary and appropriate.

Pursuant to 11 C.S.R. 3 § 14 (2010), the Board may adopt, modify, or reject any findings of fact and conclusions of law recommended by the Hearing Examiner. The Board may also modify the recommended decision with a reasonable justification in the interest of public safety. *See Berlow v. W. Va. Bd. of Medicine*, 193 W. Va. 666, 458 S.E.2d 469 (1995).

Entered: **October 24, 2022**

Lewis G. Brewer, Esquire
Designated Hearing Examiner
WV State Bar No. 446