STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

	)	
In re: David Bourgeois, MD	)	Docket No. MPS 045-0520
	)	

AMENDED STIPULATION AND CONSENT ORDER

NOW COME David Bourgeois, MD and the Vermont Board of Medical Practice and agree and stipulate as follows:

1. David Bourgeois, MD, ("Respondent") of Barton, Vermont holds Vermont medical license number 042.0007885 first issued by the Vermont Board of Medical Practice on January 4, 1989. Respondent is a physician.

2. Jurisdiction in this matter vests with the Vermont Board of Medical Practice ("the Board") pursuant to 26 V.S.A. §§ 1353-1354, 1370-74 and 3 V.S.A. §§ 809-814, and the Rules of the Board of Medical Practice, Section 40.1.2.

FINDINGS OF FACT

3. Respondent was a practitioner at North Country Primary Care (Barton/Orleans Clinic) in Barton, Vermont. Respondent now practices as a hospitalist at North Country Hospital in Newport, Vermont and Northeastern Regional Hospital in St. Johnsbury, Vermont. The patient care described in this Stipulation pertains to Respondent's practice as a primary care physician at North Country Primary Care (Barton/Orleans Clinic).

4. The Board opened the above-captioned matter in May of 2020 after receiving an anonymous tip expressing concern about Respondent's prescribing practices as a primary care physician at the Barton/Orleans Clinic. The matter was assigned to the South Investigative Committee of the Board ("the Committee") for investigation.

5. The Committee conducted an extensive investigation of Respondent's prescription practice for patients receiving controlled substances. This investigation included, but was not limited to, the review of medical records and prescribing histories for six chronic-pain patients whom Respondent treated with opioid medication.

6. The Committee's investigation identified practice deficiencies in the medical care Respondent provided for four of the six chronic-pain patients whose charts were reviewed. Respondent was the primary care provider for these four patients, hereafter referred to as Patients 1-4. The Committee's findings for Patients 1-4 included the practice concerns which follow.

7. Respondent treated Patient 1 for chronic knee, back and neck pain. Respondent treated Patient 1 with the opioid medications OxyContin and oxycodone at a high daily morphine milligram equivalent ("MME") of 315.

8. Respondent was aware that Patient 1 was at risk for taking her medication in a manner that was different than what he prescribed. He made a note in the patient's record on March 7, 2017 that Patient 1 was at risk for self-adjusting her medication, and that her medication should be supervised by her sister. He did not further document the basis for this concern.

9. On April 26, 2017 Patient 1 was admitted to the hospital after she drove her car off the road, into a tree. Her medical records indicate that she fell asleep at the wheel after

taking her morning medications without eating breakfast. At her next appointment with Respondent six days later, Respondent noted that Patient 1 was taking multiple doses of her prescribed OxyContin in one sitting, totaling 90 mg in the morning and 120 mg at nighttime per the patient's report. He failed to document the risks to the patient from her current medication regime and did not adjust the patient's treatment plan in light of those risks.

10. Respondent noted in Patient 1's medical record on November 28, 2017 that Patient 1 was missing a week's worth of her medication with a suspicion that the medication was taken by a family member. He noted at that visit that this was a reoccurring concern and he addressed it with the patient's family.

11. Patient 1 was hospitalized on November 30, 2018. During that hospitalization she required opioid medication at a dosage of approximately half of what she was prescribed by Respondent. This raised a concern of medication diversion. Respondent began a medication taper at that time but continued to prescribe for Patient 1 at an MME of 165 despite the concerns regarding medication usage during her treatment.

12. Respondent provided treatment to Patient 2 for chronic low back and shoulder pain. He prescribed both OxyContin and oxycodone acetaminophen to Patient 2 to manage these conditions at an MME of 300. His medical records note that he had a concern about Patient 2's level of sedation from this medication but Patient 2 was unable or unwilling to wean from it. Respondent failed to document that he appropriately followed up to address the risk to Patient 2 from sedation.

13. Respondent documented in Patient 2's medical record that Patient 2 had a urine drug screen on November 20, 2018 that was positive for benzodiazepine medication which

Patient 2 was not prescribed. Patient 2 denied using any benzodiazepine medication. Patient 2 subsequently had another urine drug screen that was positive for benzodiazepines on May 9, 2019. Respondent failed to document any interaction with Patient 2 in which he addressed this screening result, or to adjust Patient 2's treatment plan to account for the risks presented by this polypharmacy at his subsequent appointment on August 9, 2019.

14. Respondent provided treatment to Patient 3 for chronic abdominal pain beginning on January 13, 2017. Patient 3 was prescribed a combination of opioids at a high daily dosage of 300 MME from the beginning of her treatment with Respondent.

15. Patient 3 sought care from a gastroenterologist on April 17, 2017 who diagnosed her with opioid-induced bowel dysfunction. The gastroenterologist recommended that Patient 3 could benefit from hospital admission with an opioid withdrawal protocol. There is no documentation that Respondent considered this diagnosis or addressed the gastroenterologist's recommendation in his treatment plan for Patient 3.

16. Respondent saw Patient 3 for an appointment four days later at which he began prescribing lorazepam, a benzodiazepine medication, for her irritable bowel syndrome. Patient 3's medical record includes information that her provider at another hospital would no longer refill that prescription. Respondent's medical documentation supporting this prescribing choice does not sufficiently explain why the patient was previously receiving this prescription, why her prior doctor would no longer prescribe it, and the treatment plan for this medication. This combination of a high dose of opioids with a benzodiazepine medication, especially when not carefully monitored, carries the potential of life-threatening health risks as both opioid and benzodiazepine medications have sedative effects increasing the risk of overdose.

17. Patient 3 subsequently had a urine drug screen on June 17, 2017 performed at North Country Hospital that was positive for non-prescribed methadone. This test was followed by a second urine drug screen, ordered by Respondent on June 30, 2017, that was also positive for non-prescribed methadone. Respondent documented that the patient was denying self-treatment at her next appointment on September 19, 2017, and that he counseled her on the dangers of such medication use. However, he did not document awareness of the June 17th urine drug screen result in Patient 3's medical record. Respondent also issued early prescriptions for Patient 3's medications at this appointment after she explained that she needed an early refill as she would be visiting a dying relative.

18. Respondent provided Patient 3 with an eleven-day bridge prescription for her oral narcotics during this period of her treatment. On July 19, 2017 Respondent replaced Patient 3's oral narcotics after she reported throwing away her medication during an episode that Respondent described in Patient 3's record as "psychiatric decompensation and fighting with her fiancé and son."

19. Respondent provided additional fentanyl patches and oxycodone to Patient 3 on multiple occasions including March 23, 2020, May 19, 2020, and June 12, 2020 despite the concerns in her record for medication misuse. Patient 3 self-reported using more medication than prescribed to treat acute pain during this time. Respondent appeared to condone this practice as he noted that she could use more fentanyl patches than prescribed for three-day periods but after that time he would recommend that she visit the emergency room. The Committee finds that this was not safe patient care.

20. Respondent also prescribed two additional fentanyl patches and additional oral narcotics to Patient 3 on August 27, 2020 when she reported running out of her prescribed

medication seventeen days early. The prescription for oral narcotics was issued despite Patient 3's report that she was using the extra medication due to her self-treatment of a gastroparesis exacerbation, and the information in her medical record that she only used topical fentanyl for pain related to this condition as she was unable to absorb oral narcotics at those times.

21. Respondent treated Patient 4 for chronic back pain with opioids including methadone and oxycodone. Respondent noted in this patient's medical record that Patient 4 had a history of substance abuse and also a family history of addiction.

22. Patient 4 also received treatment from an orthopedic APRN, who on December 11, 2017 raised a concern that Patient 4's chronic use of prescribed opioid medications may be aggravating his pain. Respondent did not document consideration of this concern or any related changes in the patient's treatment modality.

23. Respondent frequently provided Patient 4 with replacement prescriptions for his opioid medication without documenting sufficient evaluation of whether the patient was at risk for medication misuse or engaging in sufficient follow up monitoring or treatment planning as necessary. Examples of this practice include:

- On February 21, 2017 Patient 4 told Respondent that he had lost an entire bottle of oxycodone in an accident right after getting it filled. Respondent did not document any assessment of a risk for prescription misuse at this appointment.
- At an office visit on April 1, 2019, Patient 4 reported that he had gotten four days' worth of his methadone and oxycodone medication wet while hunting and he needed replacement medication which Respondent provided.

- On July 25, 2019 the Patient reported that he ran out of both his oxycodone and methadone medication early after increasing his dose on his own. Respondent documented that he "once again" advised the patient against self-adjusting his medication.
- On September 17, 2020 Patient 4 arrived at the clinic requesting a replacement prescription because he dropped his methadone medication in the toilet. Respondent provided seven days of replacement methadone. Respondent also noted during the same visit that the Patient admitted overtaking his oxycodone medication. Respondent provided him with additional oxycodone. Respondent documented at this visit that a wean of the Patient's narcotics would be appropriate after surgical intervention but did not otherwise take proactive steps to address the potential for ongoing medication misuse.

CONCLUSIONS OF LAW

24. The Board may find unprofessional conduct when there is a "the failure to use and exercise on repeated occasions, that degree of care, skill, and proficiency that is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred." 26 V.S.A. § 1354(a)(22).

25. Respondent failed to meet this standard in his care of Patients 1-4. As detailed above, he maintained these four patients on high dosages of opioids while not adequately monitoring aberrant behavior that raised concerns for medication misuse. His treatment of

Patient 3 represented a gross failure to meet this standard as he was prescribing Patient 3 a complex polypharmacy involving opioids and a benzodiazepine medication during a period when she was exhibiting evidence of non-prescribed narcotic use, without adequate treatment modification or planning to try to ensure her safety due to this behavior.

26. Consistent with Respondent's cooperation with the Board, he agrees that if the State were to file charges against him it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. § 1354(a)(22).

27. Respondent agrees that the Board will enter as its facts and conclusions in this matter Paragraphs 1 through 34 herein, and further agrees that this is an adequate basis for the Board actions set forth in this Stipulation and Consent Order. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

28. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into this agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; he has concluded that this agreement is acceptable and in the best interest of the parties.

29. Respondent acknowledges that he is knowingly and voluntarily entering into this agreement with the Board. He acknowledges and agrees that at all times and in all communications and proceedings related to this matter before the Board he has had the right to be represented by counsel. Respondent has carefully reviewed and considered this Stipulation and Consent Order.

30. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of his own to contest any allegations by the State.

31. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be resolved by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

32. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this agreement, none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, and it shall be kept in strict confidence. It shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

33. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to the Federation of State Medical Boards Board Action Databank and the National Practitioner Data Bank. In exchange for the actions by the Board, as

set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

34. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

ORDER

WHEREFORE, based on the foregoing and the consent of Respondent, the Board enters as its facts and conclusions in this matter Paragraphs 1 through 34 above. It is hereby ORDERED that:

1. Respondent shall be REPRIMANDED for the conduct above.

2. Respondent's medical license shall be CONDITIONED as follows:

    a. Respondent shall successfully complete two AMA PRA Category 1 continuing medical education ("CME") courses on the following topics: prescribing opioids for chronic pain, and safe prescribing including best practices when prescribing controlled substances including benzodiazepines. Each CME course must be completed no later than six (6) months after this Stipulation is approved by the Board. Respondent shall seek prior approval, in writing, from the Committee for each CME course. These courses must be live in-person or live interactive courses offered remotely and should be eight or more credits apiece. Upon successful completion of each CME course, he shall provide the Committee with proof of attendance. Respondent shall also provide the

Committee with a brief written narrative of each CME course which will document what he learned from each course, and how he will apply that knowledge to his practice including an analysis of how he will incorporate the course information into his application of Vermont's prescribing rules. Respondent shall provide proof of attendance and the written narrative to the Committee. Respondent shall be solely responsible for all costs associated with meeting these CME requirements.

b. Respondent shall notify the Committee in writing prior to any change in employment and/or practice specialty, for which he requires his medical license.

c. Respondent shall retain the services of a "practice monitor" for three (3) years, subject to the terms and conditions set forth in the attached Practice Monitoring Agreement ("Agreement"), which is incorporated by reference and attached hereto as Exhibit A. The three (3) year practice monitoring requirement will not begin until the official "start date" as defined in the attached Agreement. Respondent shall comply with the terms and obligations of the Agreement. Respondent shall provide a copy of this Stipulation and Consent Order to the practice monitor. Respondent shall be responsible for ensuring that the practice monitor complies with the terms and obligations of the Agreement. If after two (2) years Respondent has received consistently positive reports from his practice monitor, he can submit a written request to the Committee to end the monitoring requirement. Such a request will not be considered by the Committee

until Respondent has provided two (2) years of favorable and timely monitoring reports. The decision whether to grant or deny the requested relief shall be solely within the discretion of the Committee. The practice monitoring requirement will not cease until the Committee has approved, in writing, Respondent's request to end the monitoring.

d. Respondent shall pay a $4,000 administrative penalty consistent with 26 V.S.A. § 1374(b)(2)(A)(iii). Payment shall be made to the "State of Vermont Board of Medical Practice," and shall be sent to the Vermont Board of Medical Practice office, at the following address: David Herlihy, Executive Director, Vermont Board of Medical Practice, P.O. Box 70, Burlington VT 05402-0070. Payment shall be due no later than one (1) month after this Stipulation and Consent Order is approved by the Board.

SIGNATURES

Dated at _____, Vermont, this ____ day of _____, 2025.

Signed by:
1/29/2025
60105E56DB1C422...
Suzanne Jones, PA-C
Chair, South Investigative Committee
Vermont Board of Medical Practice

Dated at Montpelier, Vermont, this ____ day of _____, 2025.

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1/29/2025
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Approval as to legal form
Megan Campbell, Esquire
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, VT 05609-1001

Dated at St. Johnsbury, Vermont, this 28th day of January, 2025.

David Bourgeois, MD

AS TO DAVID BOURGEOIS, MD
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Signed on Behalf of the Vermont Board of Medical Practice

By: _____
Rick Hildebrant
Chair
Vermont Board of Medical Practice

Vote documented in the Vermont Board of Medical Practice meeting minutes, dated Feb. 5 2025.

Dated: 02/05/2025

PRACTICE MONITORING AGREEMENT

Vermont Board of Medical Practice

David Bourgeois, MD

Docket No. MPS 045-0520

1. Pursuant to a Stipulation and Consent Order entered into by David Bourgeois, MD ("Dr. Bourgeois") and the Vermont Board of Medical Practice ("the Board") in docket no. MPS 045-0520, Dr. Bourgeois agrees to retain a practice monitor to monitor his medical practice only in the event that the South Investigative Committee ("the Committee"), in its sole discretion, determines practice monitoring is warranted. The purpose of this Practice Monitoring Agreement ("Agreement") is to set forth the terms of the practice monitoring component of Dr. Bourgeois's Stipulation and Consent Order (attached and incorporated by reference) only if it becomes applicable per the terms of the Stipulation. This Agreement will be signed by Dr. Bourgeois and the practice monitor approved by the Committee.
2. Dr. Bourgeois is responsible for selecting a practice monitor.
3. The practice monitor chosen by Dr. Bourgeois shall be a Vermont licensed physician with an unconditioned license who has experience treating chronic pain with opioid medication.
4. Dr. Bourgeois shall obtain approval from the Committee for his choice of practice monitor. Dr. Bourgeois shall submit in writing to the Committee the practice monitor's name, contact information, and curriculum vitae. The Committee retains discretion to approve or disapprove the choice of practice monitor for any reason. The Committee shall communicate in writing its decision to Dr. Bourgeois. If the

proposed practice monitor is not approved, Dr. Bourgeois remains responsible for using the procedure outlined in paragraphs 2 through 4 of this agreement to select and submit his choice of another proposed practice monitor for Committee consideration.

5. The Board shall not bear any of the costs associated with the practice monitor.
6. Dr. Bourgeois shall provide the practice monitor with a copy of the fully executed Stipulation and Consent Order.
7. The practice monitoring shall have a retroactive "start date" of November 1, 2024. The practice monitor will complete a practice monitoring report as described herein for the first ninety (90) day review period of November 2024, December 2024, and January 2025. Dr. Bourgeois will be responsible for providing that report to the Committee by February 13, 2025.
8. The practice monitor will follow all state and federal health privacy regulations and statutes, including, but not limited to, HIPAA, and will review and sign any necessary HIPAA authorizations, business associate agreements, or any other required documents to enable access to, and review of, patient protected health information.
9. The practice monitor shall perform a record review every ninety (90) days of Dr. Bourgeois's patients with a focus upon those prescribed opioid and/or benzodiazepine medication. The practice monitor shall select ten (10) of Dr. Bourgeois's patients who receive opioid and/or benzodiazepine medications and review their records, unless there are fewer than ten, in which case it shall be a total of ten including other patients prescribed other controlled substances.
10. The practice monitor shall review any other documents, records, files, logs, etc. that will provide the requisite information needed to prepare written monitoring reports.

11. The practice monitor shall speak with Dr. Bourgeois's co-workers as necessary to obtain the requisite information needed to prepare the written monitoring reports.
12. The practice monitor shall prepare a detailed, written practice monitoring report for each ninety (90) day review. The practice monitor shall meet with Dr. Bourgeois every ninety (90) days to discuss the findings of the monitor's record review. Dr. Bourgeois is responsible for ensuring that there is appropriate documentation of each ninety (90) day record review and discussion. Such documentation shall include the date of each record review, and the date and length of time of each discussion between the practice monitor and Dr. Bourgeois regarding the findings of each chart review. This documentation shall be submitted with each ninety (90) day practice monitoring report.
13. The practice monitor shall submit each written practice monitoring report to the Committee for three (3) full years. Dr. Bourgeois may request relief from this condition after two (2) full years of favorable reports. It will be up to the Committee's sole discretion whether to grant this modification to the length of practice monitoring.
14. Dr. Bourgeois shall be responsible for ensuring that the following is reviewed by the practice monitor and discussed and documented in the practice monitoring reports:
    a. Documentation of each chart review performed by the practice monitor during that review period including the findings of the chart review;
    b. Whether Dr. Bourgeois's prescribing practices, including the prescribing of opioid and/or benzodiazepine medications, is in accordance with the standard of care;

c. Whether Dr. Bourgeois's clinical monitoring of patients to whom he is prescribing opioid and/or benzodiazepine medication meets the standard of care;

d. Whether Dr. Bourgeois's medical recordkeeping is in accordance with the standard of care;

e. Whether Dr. Bourgeois's general medical treatment meets the applicable standard of care; and

f. Recommended improvements to Dr. Bourgeois's practice. Although the practice monitor will need to review patient charts to become familiar with patient medical history, the focus of the practice monitoring will be improving Dr. Bourgeois's practice prospectively.

15. Dr. Bourgeois shall be responsible for ensuring that the practice monitor's reports are timely submitted to the Committee.

16. At the end of the monitoring period, Dr. Bourgeois shall submit a written request to the Committee to end the requirement for monitoring. Such a request shall not be considered by the Committee until Dr. Bourgeois has provided favorable and timely monitoring reports for three complete years, or two complete years if the Committee approves Dr. Bourgeois's request for early relief from the monitoring requirement. The practice monitoring requirement shall not cease until the Committee has approved, in writing, Dr. Bourgeois's request to end the monitoring.

17. In the event that the practice monitor can no longer monitor Dr. Bourgeois's practice, Dr. Bourgeois shall notify the Committee in writing within five (5) business days. Within thirty (30) days of providing notice to the Committee, Dr. Bourgeois shall

submit the name of a proposed replacement practice monitor which will be subject to the approval process outlined in paragraphs two through four.

18. Upon notice to the Committee that the practice monitor can no longer serve, Dr. Bourgeois has sixty (60) days to obtain Committee approval for a new practice monitor. If a new practice monitor is not approved in that time, Dr. Bourgeois shall cease prescribing any opioids and/or benzodiazepines. Dr. Bourgeois shall not resume prescribing opioids or benzodiazepines until a new practice monitor is approved by the Committee and can begin monitoring his practice. The Committee will endeavor to communicate their decision regarding the approval of a new proposed practice monitor to Dr. Bourgeois within thirty (30) days of when he submits the proposed monitor's name, contact information, and curriculum vitae to the Committee. In the event that the Committee's response is delayed beyond thirty (30) days, that additional response time will not count toward the 60-day limit that Dr. Bourgeois has to find a new practice monitor or cease prescribing opioids and benzodiazepines.
19. The Committee retains the unfettered discretion to disapprove Dr. Bourgeois's practice monitor at any time. If the Committee disapproves Dr. Bourgeois's practice monitor, it will provide Dr. Bourgeois with written notice of the disapproval and a brief explanation of the reasons for its decision. Upon receiving this notice Dr. Bourgeois shall immediately notify his practice monitor that the monitor is no longer authorized to perform services under this Agreement. Consistent with paragraphs seventeen and eighteen above, Dr. Bourgeois will seek Committee approval for a new practice monitor. He will cease prescribing opioids and benzodiazepines if a new

monitor is not approved by the Committee within sixty (60) days until such time as the Committee approves a new monitor.

20. Dr. Bourgeois and the practice monitor agree that they have both read this Agreement in its entirety and agree to all of the terms and obligations set forth herein.

21. Dr. Bourgeois and the practice monitor agree that the terms of this Agreement cannot be amended or modified in any way without written approval of the Committee.

Signatures

St. Johnsbury

DATED at ~~Barton,~~ Vermont, this 28th day of January 2025

David Bourgeois, ~~MD~~

DATED at _____, Vermont, this _____ day of _____, 20__.

Signed by:
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1/29/2025

Practice Monitor