

**MAINE STATE BOARD OF LICENSURE IN MEDICINE**

IN RE: Abe N. Pahilan, M.D. ) DECISION AND ORDER II  
Complaint No. CR 05-116 )

**I. PROCEDURAL HISTORY**

Pursuant to the authority found in 32 M.R.S.A. Sec. 3263, et seq., 5 M.R.S.A. Sec. 9051, et seq. and 10 M.R.S.A. Sec. 8001, et seq., the Board of Licensure in Medicine (Board) met in public session to hold an adjudicatory hearing at the Board's offices located in Augusta, Maine on February 21, 2006. The purpose of the hearing was to decide whether Dr. Pahilan violated Board statutes and Rules and, if so, whether his license should be subject to discipline. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Chairman Edward David, M.D. J.D., Sheridan R. Oldham, M.D., Kimberly K. Gooch, M.D., David Nyberg, Ph. D. (Public Member), Daniel Onion, M.D., George Dreher, M.D., and Cheryl Clukey (public member). Dennis Smith, Ass't. Attorney General, presented the State's case. Dr. Pahilan did not appear and was not represented by legal counsel. The licensee was served by first class mail on or about January 17, 2006. James E. Smith, Esq. served as Presiding Officer. There were no conflicts of interest found to disqualify any member of the Board from participating in this proceeding. State's exhibits 1-30 were admitted into the Record.

**II. FINDINGS OF FACT**

**A. February 6, 2005 Decision**

The Board had previously conducted an adjudicatory hearing regarding Abe Pahilan, M.D. on February 6, 2005. The Decree in that matter stated that Dr. Pahilan, 56 years of age, has been licensed as a physician with a specialty in internal medicine since 1973. He was issued a license to

practice medicine in the State of Maine in 1992 and has since practiced his profession in Skowhegan and the Millinocket, Maine region. On November 25, 2002, the Board received a letter from patient A alleging that Dr. Pahilan had not forwarded A's medical records to him in a timely manner following his request for same. That failure resulted in the Board's issuance of a Letter of Guidance to Dr. Pahilan dated October 17, 2003.

On September 9, 2003, the Board received another complaint from patient A. This complaint was forwarded with a cover letter from the Board to Dr. Pahilan who received them on September 26, 2003. The letter from the Board stated, among other things, that "... you must respond to this complaint, in writing, within thirty days of your receipt of this notice. Failure to comply...could result in disciplinary action." Dr. Pahilan did not respond to the Board's correspondence within the 30 days mandated by 32 M.R.S.A. Sec. 3282.A. The Board subsequently contacted Dr. Pahilan's office on November 17, November 26, December 4, and December 22, 2003 but still did not receive a written response to the complaint. The Board then voted on its own motion to issue a complaint against the licensee for failure to respond to the Board's requests for a response.

The licensee testified at the February 6, 2005 hearing that he had not responded to either patient's A's complaint or the Board's subsequent complaint. He admitted that he had acted wrongly and exercised poor judgment regarding his failures to respond. Dr. Pahilan then apologized to the Board for his omissions. The Board then ordered that Dr. Abe Pahilan receive a Letter of Guidance for his failures to respond to A's complaint and the Board's correspondence.

### **B. February 21, 2006 Hearing**

At the February 21, 2006 hearing, the Board found that Dr. Pahilan violated the following provisions of Board statutes.

First, the licensee violated the provisions of 32 M.R.S.A. § 3282-A(2)(H) (violating any provision of Board statutes), to wit: section 3282-A(1), by not responding to the Board complaint within thirty (30) days. This finding, by a vote of 7-0, was based on the testimony of the Board's Administrative Secretary, Maureen Lathrop, and the absence of a written response by Dr. Pahilan in the Board's records. Ms. Lathrop attempted to contact Dr. Pahilan without success on numerous

occasions both by telephone and in writing regarding this hearing. These efforts included leaving messages on the physician's home and cell phones and other places.

Second, the Board found that Dr. Pahilan violated the provisions of 32 M.R.S.A. §3282-A(2)(F) which defines unprofessional conduct to be a violation of the standard of professional behavior that has been established in the practice of medicine. More specifically, the Board found that he violated the foregoing statute with regard to his treatment of patient SV in three different ways. On or about July 6, 2005, when he dispensed to patient SV a controlled substance, to wit: Kadian (long lasting morphine), which substance had been previously prescribed for VL who was another patient of the licensee. VL had picked up the prescription at the pharmacy on April 4, 2005. He ingested some but found the medication to be ineffective. He thereafter returned the unused drug to Dr. Pahilan in its original container. Subsequently, the same container was used to provide what is believed to be the same pills to patient SV. The wording on the bottle read, in part: "Every 12 hrs. 60 cap. KADIAN 100 MG." Although an attempt had been made to black out VL's name and address, they were still visible on the bottle which violated VL's patient confidentiality.

Karen Nelson, M.D. is a family practitioner. She testified that she was the covering physician in the Millinocket Regional Hospital's emergency room on July 10, 2005. At that time, SV, a 53 year old female, was admitted in an unconscious condition following an incidental narcotic overdose. Dr. Pahilan had prescribed SV Oxycodone, 100 tablets, 5 mg. on June 27, 2005 of which 40 remained on July 10. SV's family believed that she had been taking the Oxycodone at the same time as the Kadian. The patient's family thought that she had originally received 11 tablets of Kadian of which 7 remained in the bottle. Dr. Nelson testified that the 100 mg. of Kadian twice a day was inappropriate unless the patient had a very high tolerance for narcotic drugs, which SV did not. She determined that Dr. Pahilan had not explained the difference of the effects of Oxycodone and Kadian to SV or her family and that, under the circumstances, 100 mg. of Kadian was "way too much" to dispense to SV. In fact, if left untreated, SV most likely would have died at home. As it was, SV continued to have related problems for a while following her release from the hospital.

Dr. Nelson's testimony was supported by Dr. Daniel Herbert, an internist at Millinocket Regional Hospital who assumed the treatment of SV. This witness testified that a dosage of 100 m.g. is enough to make a person comatose if that individual is not used to that amount of the narcotic. He agreed with Dr. Nelson that 20 mg twice a day would have been the appropriate

maximum amount for the initial dosage for SV. Dr. Herbert further rendered his opinion that the Board statutes were violated when Dr. Pahilan prescribed the Kadian to SV and used the same bottle of Kadian and, most probably, the same pills that he had previously prescribed to VL. This practice is unprofessional in that there is no assurance that the pills in the bottle are of the type and/or strength that were originally prescribed. Furthermore, it is reckless to store such narcotics in a practitioner's office knowing of the criminal elements that such medication attracts.

Dr. Pahilan sent a letter to his patients dated September 21, 2005 in which he notified them that he would closing his medical practice. He confirmed that his office officially closed on September 23 and told the Board's investigator that his reasons for choosing to do so were several, including being on call 24-7, stress, isolation, and a lack of interaction with his peers. His medical license lapses on September 30, 2005.

### III.

### CONCLUSIONS OF LAW

The Board, following the close of evidence and based primarily on the above facts, and utilizing its training, expertise, and experience, concluded that:

1. Dr. Abe Pahilan violated the provisions of 32 M.R.S.A. §3282-A(2)(F) (unprofessional conduct) when he, on or about July 6, 2005, dispensed to patient SV a controlled substance, to wit: Kadian (morphine) which controlled substance had been previously prescribed for another patient. (Vote of 6-0-1)
2. Dr. Abe Pahilan violated the provisions of 32 M.R.S.A. §3282-A(2)(F) (unprofessional conduct) when he, on or about July 6, 2005, dispensed to patient SV a controlled substance, to wit: Kadian (morphine) in a bottle labeled with another patient's name, address, and health information that was marked over but readable, and which conduct constituted a breach of doctor-patient confidentiality. (Vote of 7-0)
3. Dr. Abe Pahilan violated the provisions of 32 M.R.S.A. §3282-A(2)(F) (unprofessional conduct) when he failed to respond to the Board's Notice of Complaint dated September 26, 2005. (Vote of 7-0)

4. Dr. Abe Pahilan violated the provisions of 32 M.R.S.A. §3282-A(2)(E)(1) which defines incompetence to be conduct that evidences a lack of ability of fitness to discharge the duty owed by the licensee to a client or patient or the general public. As regards the treatment of patient SV, Dr. Pahilan violated the foregoing statute when he:

a. dispensed to patient SV a controlled substance, to wit: Kadian (morphine) which controlled substance had been previously prescribed for another patient. (Vote of 7-0)

b. dispensed to patient SV a controlled substance, to wit: Kadian (morphine) in a bottle labeled with another patient's name, address, and health information that was marked over but readable, and which conduct constituted a breach of doctor-patient confidentiality. (Vote of 7-0)

c. On or about July 2005, prescribing and dispensing to patient SV a controlled substance, to wit: Kadian (morphine) 100 mg, and advising patient SV to take one capsule every twelve (12) hours, despite patient SV's medical history, including the fact that she was already prescribed and taking another controlled substance, to wit: Oxycodone 5 mg, one tablet every six (6) hours. (Vote of 7-0)

d. failed to respond to the Board's Notice of Complaint dated September 26, 2005. (Vote of 7-0)

#### IV.

#### SANCTIONS

The Board, as a result of the above findings which almost resulted in the death of his patient, and also considering the fact that Dr. Pahilan has received two Letters of Guidance in the past, ordered that:

1. Dr. Abe Pahilan's license to practice medicine in the State of Maine be and hereby is **REVOKED**. (Vote of 6-1) (The dissenting member would have voted for a lesser sanction since she believed that Dr. Pahilan had basically a long standing history of good medical practice)

2. Abe Pahilan **pay the Board's costs** of this hearing by June 14, 2006 which **total \$3600**. Hearing officer-( 15 mins. to review file prior to hearing; 4 hours presiding at the hearing; 3 hours and 15 mins. to write the Decision @ \$100= \$750); and investigation, copying costs, publication, binders

= \$2850. Payment shall be by **certified check or money order made payable to: "Maine Board of Licensure in Medicine"** and remitted to Randal L. Manning, Executive Director, 137 State House Station, Augusta, Maine 04333-0137. The costs are ordered in accordance with past Board practice and because licensees who do not violate Board Rules and statutes should not have to bear the costs of those who do. Additionally, the hearing may not have been necessary had Dr. Pahilan responded to the Board which failure is made more egregious by the fact that he had previously received a Letter of Guidance for similar behavior. The Board also considers that these costs will serve as a barrier to Dr. Pahilan should he consider applying for relicensure. (Vote of 5-2) (The dissenting members felt that Dr. Pahilan would be suffering financial hardships since he closed his practice.)

**SO ORDERED.**

Dated: March 14, 2006



Edward David, J.D., M.D. Chairman  
Maine Board of Licensure in Medicine

**V.**

**RIGHTS OF APPEAL**

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3, any party that decides to appeal this Decision and Order must file a Petition for Review within 30 days of the date of receipt of this Order with the District Court having jurisdiction. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Board of Licensure in Medicine, all parties to the agency proceedings, and the Maine Attorney General.

## MAINE STATE BOARD OF LICENSURE IN MEDICINE

IN RE: Abe N. Pahilan, M.D.

) DECISION AND ORDER

### **I. PROCEDURAL HISTORY AND DECISION**

Pursuant to the authority found in 32 M.R.S.A. Sec. 3263, et seq., 5 M.R.S.A. Sec. 9051, et seq. and 10 M.R.S.A. Sec. 8001, et seq., the Board of Licensure in Medicine (Board) met in public session to hold a hearing at the Board's offices located in Augusta, Maine on February 8, 2005. The purpose of the hearing was to decide whether Dr. Pahilan violated Board statutes and Rules in his treatment of patient A and his alleged failure to timely respond to Board complaints. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Acting Chairman Sheridan R. Oldham, M.D., Gary Hatfield, M.D., Bettsanne Holmes (public member), Kimberly K. Gooch, M.D., Daniel Onion, M.D., George Dreher, M.D., and Cheryl Clukey (public member). Ruth McNiff, Ass't. Attorney General, presented the State's case. Dr. Pahilan appeared and was not represented by legal counsel. James E. Smith, Esq. served as Presiding Officer. There were no conflicts of interest found to disqualify any member of the Board from participating in this proceeding. State's exhibits 1-6 and Respondent's exhibit 1 were admitted into the Record.

### **II. FINDINGS OF FACT AND CONCLUSIONS OF LAW**

Abe Pahilan, M.D., has been licensed as a physician with a specialty in internal medicine since 1973. He was issued a license to practice medicine in the State of Maine in 1992 and has since practiced his profession in Skowhegan and the Millinocket, Maine region. On November 25, 2002, the Board received a letter from patient A alleging that Dr. Pahilan had not forwarded A's medical records to him in a timely manner following his request for same. That failure resulted in the Board's issuance of a Letter of Guidance to Dr. Pahilan dated October 17, 2003.

On September 9, 2003, the Board received another complaint from patient A alleging that Dr. Pahilan had failed to properly diagnose and treat an enlarged heart. This complaint was forwarded with a cover letter from the Board to Dr. Pahilan who received them on September 26, 2003. The letter from the Board stated, among other things, that "... you must respond to this complaint, in writing, within thirty days of your receipt of this notice. Failure to comply... could result in disciplinary action." Dr. Pahilan did not respond to the Board's correspondence within the 30 days mandated by 32 M.R.S.A. Sec. 3282.A. The Board subsequently contacted Dr. Pahilan's office on November 17, November 26, December 4, and December 22, 2003 but still did not receive a written response to the complaint. The Board then voted on its own motion to issue a complaint against the licensee for failure to respond to the Board's requests for a response.


Dr. Pahilan testified that his treatment of patient A did not violate the standard of care. The Board unanimously agreed and dismissed that complaint. The licensee further stated that he had not responded to either patient's A's complaint or the Board's subsequent complaint. He admitted that he had acted wrongly and exercised poor judgment regarding his failures to respond. Dr. Pahilan then apologized to the Board for his omissions.

The Board, following the close of the evidence, voted 6-1 as follows.

1. Dr. Abe Pahilan shall receive a **Letter of Guidance** for his failures to respond to A's complaint and the Board's correspondence.
2. Dr. Abe Pahilan shall pay the Board's **costs of \$333** within 30 days of the date of this Decision. Hearing officer-(50 minutes pre and post-hearing; 1 hour and 45 minutes presiding at the hearing; 45 minutes to draft the Decision = \$333). Payment shall be by check or money order **made payable to: "Maine Board of Licensure in Medicine"** and remitted to Randal L. Manning, Executive Director, 137 State House Station, Augusta, Maine 04333-0137. Payment of costs are ordered since this matter most likely would have been resolved without the need for a hearing had Dr. Pahilan responded in a timely manner to Board correspondence.

**So Ordered.**

Dated: ~~March~~ March 8, 2005

  
Sheridan R. Oldham, M.D., Acting Chairman  
Maine Board of Licensure in Medicine

#### **APPEAL RIGHTS**

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3 and 10 M.R.S.A. Sec. 8003, any party that appeals this Decision and Order must file a Petition for Review in the Superior Court within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine State Board of Licensure in Medicine, all parties to the agency proceedings and the Attorney General.