

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
BOARD OF MEDICINE**

**IN RE:**

**BENSON W. YU, M.D.**

**License No.: MD19992**

**Respondent**

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**CONSENT ORDER**

This matter comes before the District of Columbia Board of Medicine (the "Board" or "D.C. Board") pursuant to the Health Occupations Revision Act (HORA). D.C. Official Code § 3-1201.01, *et seq.* (2009). The HORA authorizes the Board to regulate the practice of medicine in the District of Columbia and, in doing so, the Board has broad jurisdiction to impose a variety of disciplinary sanctions upon a finding of a violation of the HORA. D.C. Official Code, § 3-1201.03; *Mannan v. District of Columbia Board of Medicine*, 558 A.2d 329, 333 (D.C.1989). The Council of the District of Columbia, in amending the HORA, "intended to strengthen enforcement of its licensing laws." *Davidson v. District of Columbia Board of Medicine*, 562 A.2d 109, 113 (D.C.1989). And the HORA "was designed to 'address modern advances and community needs *with the paramount consideration of protecting the public interest.*'" *Joseph v. District of Columbia Board of Medicine*, 587 A.2d 1085, 1088 (D.C.1991) (*quoting* Report of the D.C. Council on Consumer and Regulatory Affairs on Bill 6-317, at 7 (November 26, 1985)) (emphasis added by court).



Respondent has been licensed to practice medicine and surgery in the District of Columbia since February 11, 1993. Respondent is also licensed in Virginia.

By an order dated August 29, 2013 (the "Virginia Suspension Order"), the Virginia Board of Medicine (the "Virginia Board") summarily suspended Respondent's license to practice medicine in Virginia, because his prescription habits demonstrated an "incompeten[ce] to practice medicine and surgery with reasonable skill and safety and represent[ed] a danger to patients and the public," as evidenced by the factual allegations set forth in the Statement of Particulars supporting the summary suspension of Respondent's Virginia license. The summary suspension of Respondent's license to practice medicine in Virginia, therefore, was based on allegations of professional incompetence, mismanagement and the prescription of scheduled controlled substances without legitimate medical purposes.

The Board received notice of the Virginia Suspension Order and subsequently recommended to the Director of the District of Columbia Department of Health (D.C. Department) that Respondent's license to practice medicine in the District be summarily suspended under D.C. Official Code § 3-1205.15. Respondent did not contest the D.C. summary suspension.

Subsequent to the District of Columbia action, Respondent voluntarily entered into a Consent Order with the Virginia Board (the "Virginia Consent Order") on September 25, 2014 to resolve the allegations stated in the aforementioned Statement of Particulars. In the Statement of Particulars, the Virginia Board chronicled information regarding 13 patients (one of whom expired in connection with Respondent's prescription of Xanax (alprazolam) and Oxycontin (oxycodone), to whom Respondent provided patient care from 2005 until 2013. Specific information as to each of the allegations regarding each patient is set forth in the Statement of Particulars. The Virginia Board specifically alleged the following:

- Respondent treated a patient for bipolar disorder, including depression and anxiety, by prescribing Zyprexa (olanzapine), Celexa (citalopram), Ativan (lorazepam) (Schedule IV), and Xanax (alprazolam) (Schedule IV), despite the fact that there was no evidence of proper screening or evaluation of such disorder to reach this diagnosis at any time prior to or during the relevant treatment period, nor was there any evidence of a referral to a mental health practitioner for proper assessment and treatment at any time during the relevant treatment period.
- Respondent prescribed Xanax (alprazolam) for anxiety, at times concomitantly with Ativan (lorazepam) (Schedule IV), from October 8, 2009, when the patient was 13 years old, and continuing through approximately February 15, 2013, instead of referring the patient for appropriate evaluation and/or adjunct psychological counseling.
- Respondent failed to adequately respond to indications that a patient required immediate treatment from a mental health care practitioner.
- Respondent prescribed, from October 10, 2006 through December 28, 2012, benzodiazepines, including Xanax (alprazolam), Klonopin (clonazepam) (Schedule IV) and /or Ativan lorazepam, to treat a patient's anxiety, panic attacks and "stress-related symptoms," instead of referring the patient for appropriate evaluation and treatment, and/or adjunct psychological counseling.
- Respondent concomitantly prescribed to four patients multiple benzodiazepine medications and/or failed to cancel refill prescriptions, after diagnosing these patients with Attention Deficit Disorder with Hyperactivity (ADHD), and prescribing to them ADD/ADHD medications without sufficient objective evidence or diagnostic testing or studies to support those diagnoses. Respondent prescribed to some of these patients Adderall (amphetamine salts) (Schedule II) and/or Concerta (methylphenidate) (Schedule II) and/or Vyvanse

(lisdexmfetamine) (Schedule II) in escalating doses and/or quantities throughout the relevant period, and continued to prescribe these medications despite the patients' behavior that indicated abuse and/or misuse of these medications.

- Respondent failed to follow up on referrals to other practitioners or to consult and coordinate his care and treatment of these patients with physicians to whom he referred his patients or with physicians who were otherwise involved in the care of his patients.

- Contrary to sound medical judgment, on or about December 19, 2008, Respondent prescribed Percocet (oxycodone/ADAP) (Schedule II) 10 mg #45 and Xanax (alprazolam) 2 mg #90 to a then 17 year-old patient two days after she was treated at a hospital emergency department for a closed head injury following a physical assault by the patient's father (another of Respondent's patients), causing the 17 year-old patient to hit her head on a concrete wall. This patient's sister (another of Respondent's patients) had previously reported (on or about September 3, 2008) to Respondent that family members were abusing pills, marijuana and other substances, and that the 17 year-old patient had stolen all of the sister's Ambien (zolpidem) (Schedule IV). Moreover, the sister reported (on or about December 2, 2008) to Respondent that the 17 year-old patient had taken the sister's Ambien (zolpidem) and Lexapro (escitalopram) medications, and that 20 dosage units of Xanax (alprazolam) were missing. Thereafter, the 17 year-old patient expired on or about December 20, 2008, after ingesting lethal quantities of Xanax (alprazolam) and oxycodone.

- Respondent failed to obtain complete patient histories for 12 of the 13 subject patients whose records were reviewed, and failed to obtain histories for past intervention and treatment for chronic pain conditions, prior to prescribing controlled substances, for nine of these 12 patients.

- From 2005 to 2013, Respondent regularly prescribed narcotics, benzodiazepines or other controlled substances for 11 of the 13 subject patients whose records were reviewed when those patients did not present to his office for an examination.
- Respondent diagnosed medical conditions and prescribed narcotics and/or other controlled substances to seven of the 13 subject patients whose records were reviewed without sufficient objective evidence or diagnostic testing or studies to justify the prescriptions.
- Respondent allowed 11 of the 13 subject patients whose records were reviewed to have access to large quantities of controlled substances and failed to address the escalation or abuse of narcotics and benzodiazepine therapies and other noncompliance with his medication regimen and treatment plan, and failed to appropriately treat or refer these patients for treatment for substance abuse.
- Approximately five months after a patient's last treatment date, Respondent accessed the patient's prescription history from the Virginia Department of Health Professions' Prescription Monitoring Program (PMP) for a purpose not related to establishing a treatment history, and he did not use the PMP report for the care and treatment of this patient.
- Respondent provided deceitful false or information to the personnel/faculty of a dental school related to one of Respondent's patients, for whom Respondent had prescribed Adderall (amphetamine salts) and/or Vyvanse (lisdexamfetamine) between October, 2011 and March, 2013. Respondent reported that this patient exhibited symptoms supporting hypoglycemic episodes in order for the patient to retake an examination, when there was no documentation of hypoglycemic episodes in the patient's medical record or any history of such events.
- Respondent failed to properly manage and maintain accurate and complete records for 12 of the 13 subject patients whose records were reviewed.

Each of the foregoing allegations was supported by specific factual information set forth in the Statement of Particulars supporting the Virginia order for summary suspension. The foregoing allegations are also the factual basis on which the Virginia Board issued the Virginia Consent Order.

On October 29, 2014, the D.C. Board considered the terms of the Virginia Consent Order and recommended to the Director of the D.C. Department of Health to vacate the summary suspension of Respondent license. On that recommendation, the Director vacated the summary suspension on November 25, 2014. The D. C. Board further determined that the Virginia Consent Order warranted reciprocal action with respect to Respondent's District of Columbia medical license. Accordingly, the D.C. Board voted to issue the instant Consent Order to Respondent.

#### **Conclusions of Law**

The D.C. Board is authorized, pursuant to D.C. Official Code § 3-1205.14(a)(3), to take reciprocal action when a licensee under the Board's governance has been disciplined by a licensing authority of another jurisdiction for conduct that would be grounds for Board action. In pertinent part, D.C. Official Code § 3-1205.14(a)(3) states:

Each board, subject to the right of a hearing as provided by this subchapter, on an affirmative vote of a quorum of its appointed members may take one or more of the disciplinary actions...against any person permitted by this subchapter to practice a health occupation regulated by the board in the District who is **disciplined by a licensing or disciplinary authority...of any jurisdiction for conduct that would be grounds for disciplinary action under this section.** (Emphasis added)

The foregoing allegations demonstrating "incompeten[ce] to practice medicine and surgery with reasonable skill and safety and represent[ed] a danger to patients and the public," and resulting in professional incompetence, mismanagement and the prescription of scheduled controlled

substances without legitimate medical purposes, as evidenced in the Statement of Particulars, had they occurred in the District, would be a violation of numerous statutory and regulatory provisions under D.C. law, including D.C. Official Code §§ 3-1205.14(a)(5), (24), (25), (26) and (37), as well as 17 DCMR §§ 4612.1, 4612.7, 4612.8, 4616.1, 4616.4, 4616.5, 4616.6, 4616.7, 4616.8, 4616.9, 4616.10, 4616.11, 4616.12 and 4616.14. Therefore, Respondent may be disciplined reciprocally under D.C. Official Code § 3-1205.14(a)(3).

Accordingly, Respondent's violation of the HORA and the Board's regulations provide the D.C. Board with a basis in law and fact to warrant reciprocal, disciplinary action.

### **ORDER**

Based upon the foregoing, it is by the District of Columbia Board of Medicine hereby, **ORDERED**, that Respondent's license to practice medicine in the District of Columbia is hereby **SUSPENDED** for eighteen (18) months from the date of the summary suspension of his license in the District of Columbia, or October 4, 2013, until April 4, 2015, when Respondent's license shall be reinstated by operation of the expiration of the period of suspension; and it is further

**ORDERED**, that Respondent shall satisfactorily comply with all terms of the Virginia Consent Order, dated September 25, 2014; and it is further

**ORDERED**, that the Board accepts Respondent's completion of continuing medical education already submitted to the Board for approval, consisting of the following: 1) PRIMED Certificate of Completion (6 credits completed 9/29/14); 2) Virginia Commonwealth University School of Medicine Pain Management CME (3.25 credits completed 2/16/13); 3) University of California, Irvine, School of Medicine PBI Medical

Record Keeping (17 credits completed 2/23-24/13); and 4) University of Nebraska Medical Center Modules 1, 2 and 3 (totaling 7.25 credits completed 2/17/13); and it further

**ORDERED**, that, at such time as Respondent's license is reinstated, the license shall be subject to the following conditions:

1. Respondent may not, and is hereinafter prohibited, from prescribing, administering or dispensing any Schedule II, III and IV controlled substances for a minimum of twenty-four (24) months from the date of reinstatement (April 4, 2015) of his license; and

2. The D.C. Board may reinstate Respondent's privileges to prescribe Schedule II, III and IV controlled substances prior to expiration of the foregoing 24-month period only upon: a) petition for good cause shown; b) approval of the petition by the D.C. Board; and c) after a personal appearance by Respondent before the Board; and it is further

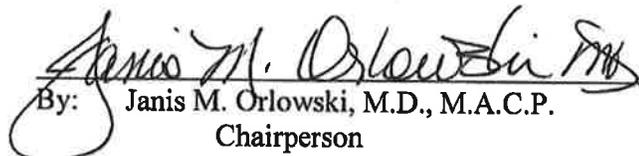
**ORDERED**, that the D.C. Board shall report to the National Practitioner Database that the summary suspension against Respondent's license number MD19992, has been vacated; and it is further

**ORDERED**, that Respondent shall comply with all laws, rules, and regulations of the District of Columbia; and it is further

**ORDERED**, that if Respondent fails to satisfactorily fulfill the terms of this Consent Order the D.C. Board may issue a notice of intent to take formal disciplinary action against Respondent's license.

DISTRICT OF COLUMBIA BOARD OF MEDICINE

1-8-15  
Date

  
By: Janis M. Orłowski, M.D., M.A.C.P.  
Chairperson

**CONSENT OF RESPONDENT**

- My signature on the foregoing Consent Order signifies my acceptance of the terms and conditions of the Consent Order and my agreement to be bound by its provisions. \_\_\_\_\_  
(initial)
- I acknowledge the validity of this Consent Order, as if made after a hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf, and to all other substantive and procedural due process protections provided by the laws of the District of Columbia and the United States of America. \_\_\_\_\_ (initial)
- I also recognize that I am waiving my right to appeal any adverse ruling of the Board had this matter gone to a hearing. \_\_\_\_\_ (initial)
- I expressly acknowledge that by signing this Consent Order, I am voluntarily waiving my right to require the Board to charge me through a notice of intent to take disciplinary action with a violation of this agreement and to require the government to prove such violation by a preponderance of the evidence before suspending my license based upon the failure to satisfactorily fulfill the terms of the Consent Order. \_\_\_\_\_ (initial)
- I also expressly acknowledge by signing this Consent Order, I am waiving my right to confront witnesses, give testimony, to call witnesses on my behalf, and to other substantive and procedural due process protections provided by the laws of the District of Columbia and the United States of America. \_\_\_\_\_ (initial)
- I further expressly acknowledge that by signing this Consent Order, I am waiving my right to appeal this Consent Order, as well as waiving any and all rights, whatsoever, I would have to challenge or appeal that Board's decision to suspend my license based on the failure to satisfactorily fulfill the terms of the Consent Order. \_\_\_\_\_ (initial)

• I acknowledge that in the event that the Board suspends my license based on the failure to satisfactorily fulfill the terms of the Consent Order, my sole remedy and recourse will be to respond within the time period set forth in this Consent Order with proof of my compliance and that if I fail to do so, my sole remedy and recourse will be to comply with the terms of this Consent Order to the satisfaction of the Board.   f   (initial)

• I have had an opportunity to review this document and to consult with my own legal counsel. I choose willingly to sign this Consent Order, and I understand its meaning and effect.   f   (initial)

12/29/14  
Date

Benson W. Yu  
Benson W. Yu, M.D., License No. MD19992

Sworn to and subscribed before me this 29<sup>th</sup> day of December, 2014.

Sharon Z. Brennan  
Notary Public  
My Commission Expires: 3/20/18

**THIS CONSENT ORDER CONSTITUTES A DISCIPLINARY ACTION AND SHALL BE DEEMED A PUBLIC DOCUMENT AND SHALL BE DISTRIBUTED AS APPROPRIATE.**