STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the matter of:	ORDER IMPOSING TEMPORARY
BRUCE COPLIN, M.D.	LIMITATIONS ON PRACTICE
License No. 25MA05198300	

This matter was opened before the New Jersey State Board of Medical Examiners upon the filing of a nine Count Verified Administrative Complaint on July 30, 2018, seeking the suspension or revocation of the license of Respondent Bruce Coplin, M.D., to practice medicine and surgery in the State of New Jersey. Within the Complaint, the Attorney General alleges, *inter alia*, that Dr. Coplin engaged in gross negligence and indiscriminate prescribing when treating eight "pain management" patients. One of the patients (R.C.) was in fact an undercover investigator and a second (C.H.) was a confidential informant; both R.C. and C.H. visited Respondent's office as part of a joint federal and state investigation of Respondent's practice, and both secretly video-taped their office visits.[1]

[1] The Attorney General also filed, on July 30, 2018, an Order to Show Cause noticing a hearing on the application for the temporary suspension of Respondent's license, a letter brief in support of that application, and a Certification of Deputy Attorney General Christina Ramundo in support of the Verified Complaint. Exhibits appended to DAG Ramundo's

In addition to seeking sanctions against Dr. Coplin at the conclusion of a plenary administrative hearing, the Attorney General sought the immediate entry of an Order temporarily suspending, or otherwise limiting, Dr. Coplin's medical license pending final resolution of this matter. The Attorney General alleged that Dr. Coplin's continued practice of medicine would present clear and imminent danger to the public health, safety and welfare, in turn supporting the temporary suspension of his license.

Dr. Coplin filed an Answer to the Complaint, a brief in opposition to the Complaint and a Certification of his counsel, John M. Hanamirian, Esq. with the Board on August 6, 2018. Exhibits appended to Mr. Hanamirian's certification included copies of the search and seizure warrants which were issued on February 9, 2018 and February 13, 2018 respectively, for searches of Respondent's office and home, a receipt for items seized, lists of

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certification included copies of all eight patient records, certifications of Enforcement Bureau Investigators April Amisson (who posed as patient R.C.) and of Kathleen Cefalu, R.N. (who participated in the execution of a search warrant at Respondent's office on February 13, 2018; Investigator Cefalu's certification details evidence that was found at the time that the search warrant was executed and summarizes information provided at that time by Respondent's office staff), a written report prepared by the State's expert, Paul Abend, D.O. (analyzing the medical records of all eight patients and opining on the care that Dr. Coplin provided to each of the eight patients), and video-taped recordings of undercover visits to Dr. Coplin's office.

"new" patients and "discharged patients,"[2] copies of all eight patient's medical records and an expert report of Michael F. Arrigo.[3] Respondent also presented his own affidavit in opposition to the application, wherein he outlined, *inter alia,* changes that he had made to his practice after he became aware of the federal investigation (i.e., following the searches of his office and home).

We conducted a hearing on the application for the temporary suspension of Dr. Coplin's license on August 8, 2018. Deputy Attorney General Christina Ramundo appeared for the Complainant Attorney General of New Jersey, and John M. Hanamirian,

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[2] Dr. Coplin offers a self-prepared list of "new" patients taken into his practice in 2016, and a list of 953 patients who he claims were discharged from his practice or were refused entry into his program over the past three years.

[3] Mr. Hanamarian sought to introduce Mr. Arrigo's expert report into evidence during the temporary suspension hearing. D.A.G. Ramundo objected, on the basis that Mr. Arrigo is not a physician and should be deemed unqualified to opine on standards of medical care. We agree that Mr. Arrigo is unqualified to offer any opinion on medical issues, however we allowed admission of the report for the limited purpose suggested by Mr. Hanamarian - namely, to question the validity of drawing any conclusions about Dr. Coplin's practice on the limited number of cases referenced in the Complaint.

We point out, however, that we question the relevance of Mr. Arrigo's report, even accepting the limited purpose for which it was offered, as the Attorney General is fully vested with discretion to determine what cases to predicate an Administrative Complaint upon. The issue before us presently, and the issue that will ultimately be before the OAL, is whether Dr. Coplin's provision of care to the eight patients who are the subject of this Complaint was provided in a manner that met appropriate standards of care, or whether it deviated from those standards to a point that supports the allegations made in the Verified Complaint.

Esq. appeared for Respondent. Senior Deputy Attorney General Steven Flanzman served as counsel to the Board. The parties ultimately agreed to enter stipulated complete copies of all eight patient records as Joint exhibits, and each party also moved into evidence the exhibits which were attached respectively to the certifications of counsel offered prior to the hearing.

We have reviewed and considered the records for all eight patients, the video-tapes made by the two undercover investigators of their office visits with Dr. Coplin, the expert reports offered by both parties, other exhibits in evidence, the testimony offered by Dr. Coplin and legal arguments made by counsel for both parties. Upon consideration of that record, we unanimously conclude that the Attorney General has palpably demonstrated that Dr. Coplin's continued, unrestricted practice of medicine would present clear and imminent danger to the public.[4]

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[4] The legal standard that governs our decision making is set forth at N.J.S.A. 45:1-22, which provides, in relevant part, that:

> A board may, upon a duly verified application of the Attorney General that either provides proof of a conviction of a court of competent jurisdiction for a crime or offense involving moral turpitude or relating adversely to the regulated profession or occupation or alleges an act or practice violating any provision of an act or regulation administered by such board, enter a temporary order suspending or limiting any license issued by the board pending plenary hearing on an administrative complaint; provided, however, no such temporary order shall be entered unless the application made to the board palpably demonstrates a clear and imminent danger to the public health, safety and welfare and notice of such application is given to the licensee affected by such order.

Our conclusion is fully supported by the evidence demonstrating what occurred (and, by extension, what did not occur) in Dr. Coplin's office during the office visits - particularly the "follow-up" visits - of the two undercover investigators. Indeed, those video-tapes provide us with a unique opportunity to go beyond what is recorded in a patient record, and instead observe - essentially through an open window -- exactly what occurred during specific patient visits.[5]

> If, upon review of the Attorney General's application, the board determines that, although no palpable demonstration of a clear and imminent danger has been made, the licensee's continued unrestricted practice pending plenary hearing may pose a risk to the public health, safety and welfare, the board may order the licensee to submit to medical or diagnostic testing and monitoring, or psychological evaluation, or an assessment of skills to determine whether the licensee can continue to practice with reasonable skill and safety. [emphasis added]

[5] The video tapes were made during the course of an investigation conducted jointly by the United States Drug Enforcement Administration (the "DEA") and the New Jersey Enforcement Bureau of the Division of Consumer Affairs (the "EB"). Between June 13, 2017 and November 20, 2017, R.C. video-taped six covert office visits, and C.H. video-taped four visits. R.C.'s initial office visit occurred on June 13, 2017, and she was seen for monthly follow-up visits on July 12, 2017, August 9, 2017, September 13, 2017, October 11, 2017 and November 9, 2017. C.H.'s initial visit occurred on August 9, 2017, and he was thereafter seen for follow-up visits on September 25, 2017, October 23, 2017 and November 20, 2017 (note: the video-tape for C.H.'s October 23, 2017 visit could not be viewed).

The video tapes of five of R.C. and/or C.H.'s visits were played during the temporary suspension hearing. Video-tapes of the remaining visits were admitted into evidence at the hearing and available for Board viewing. The limited findings made above are derived from review of those tapes.

What is clear from the videos is that Dr. Coplin prescribed opioids at all monthly "follow-up" visits without conducting any physical examination whatsoever, even to the extent of obtaining vital signs such as a blood pressure reading or pulse measurement (a curt physical examination was, in each case, conducted only at the time of each undercover's initial visit);[6] that all follow-up visits were extremely brief (generally lasting approximately two minutes or less);[7] that Dr. Coplin frequently increased the quantity of opioids prescribed for undercover patient "R.C." at her follow-up visits based on nothing more than her subjective statements and/or requests for greater quantities of drugs; that in both cases, the undercover investigators convinced Dr. Coplin to substitute Oxycodone 10 for Percocet within two to three office visits; that Dr. Coplin prescribed Ativan and Soma to R.C. based solely on her request for those drugs; that Dr. Coplin prescribed opioids to R.C. (and generally increased the quantity

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[6] Each of the follow-up office visits was preceded by an "interview" between one of Dr. Coplin's office staff (presumably nurses, but not presently established) and the patient. The follow-up office notes appear to have been fully filled out by the office staff member, based on information obtained during the interview. It appears further that recommendations for prescribing - even in one case for switching patient R.C. from Percocet to Oxycodone - were made by the nurse (see office visit of September 13, 2017). Our review of the videotapes in evidence suggests that Dr. Coplin did little beyond glancing at his nurses notes and then writing prescriptions in a manner consistent with his nurses recommendations.

[7] While there are no allegations of billing impropriety in the filed Complaint, we find it of concern that Dr. Coplin charged each patient (both of whom had presented as uninsured) $350 cash for the initial visit and $125 cash for each of the extraordinarily short follow-up visits.

prescribed from one office visit to the next) even though she consistently maintained that she had no pain at the time of her office visits; that Dr. Coplin continued to prescribe for each of the undercover investigators notwithstanding the fact that neither investigator ever went for the x-ray studies which Dr. Coplin ordered at the time of their initial visit; and that Dr. Coplin falsely recorded "physical examination" findings in his medical records for all of the follow-up visits, notwithstanding the fact that neither he nor his nurses conducted any such physical examination at any of those follow-up visits.

We also find that, in two instances, Dr. Coplin blithely ignored direct statements made to him by the undercover investigators that revealed that the "patients" had engaged in diversion of pills. Specifically, Dr. Coplin did nothing to address a statement made to him by R.C., during her visit on October 11, 2017, that she had sold some of her pills for rent money, and similarly did nothing to address a statement made to him by C.H., during his office visit on September 25, 2017, that he had to return some pills that he had previously "borrowed."[8] Likewise,

[8] Dr. Coplin maintains that he did not hear either investigator's comment, and suggests that the statements were made in "muffled" tones. He further maintains that, had he heard either comment, he would have immediately addressed the statements with the patients. While we anticipate that the question whether Dr. Coplin heard (or should have heard) the statements at issue will be more fully explored at the plenary hearing, we are constrained to point out that we did not perceive any reason why Dr. Coplin would not have been able to have hear R.C.'s or

we are concerned that Dr. Coplin may have had no reasonable basis to write even the initial prescriptions for Percocet to R.C. and C.H., based on the limited examination and history that he obtained from each, and that his decision to write prescriptions for Percocet unnecessarily exposed both patients to the risks associated with opioid use, including possible addiction. In short, through the open window created by the video-tapes in evidence, we have observed that Dr. Coplin repeatedly abrogated his responsibility as a licensee to exercise basic medical judgment, and in doing so placed his patients in imminent danger by writing prescriptions for opioids which were not medically necessary, and/or placed the public in imminent danger by engaging in acts that could have facilitated the diversion of opioids and other CDS.

Our finding of clear and imminent danger is buttressed by our review of the patient records for the six actual patients whose care is the focus of Counts 3-8 of the Complaint. Those six patients were treated for periods ranging from approximately one to five years for acute pain. In each case, it is apparent that Dr. Coplin generally did little more than write prescriptions at each patient's monthly office visit. The medical records do not reflect that he developed long-term treatment plans, or that he established long-term treatment goals for his patients, nor do they reflect his

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C.H.'s comments - rather, our viewing of the tapes suggests that Dr. Coplin instead essentially ignored both statements.

having made any meaningful efforts to attempt alternative therapies and/or to taper the amounts of opioids that he prescribed for his patients. Likewise, the records are devoid of suggestion that Dr. Coplin consistently sought to access information available to him through the Prescription Monitoring Program ("PMP") database.

Most disturbingly, in many of the six cases, Dr. Coplin continued unabated prescribing of opioids even in the face of classic "red flags" that should have strongly suggested to him that his patients were likely diverting the drugs he prescribed - such as repeated urine screens negative for prescribed drugs, and his receipt of communications from pharmacists and/or insurance carriers alerting him to concerns about his patient's behavior (to include concerns that individual patients were repeatedly filling prescriptions early and engaging in drug-seeking behavior that was suspicious for diversion). The records further reveal that Dr. Coplin simply ignored multiple communications he received from insurance carriers raising alarms that the quantities and/or combinations of drugs which patients were being prescribed could pose life-threatening health risks.

While we recognize that the charges against Dr. Coplin will be more fully explored and evidence more fully developed during a plenary hearing, we point out that we found the records of his prescribing for patient S.H. and her spouse R.H. to be

particularly alarming. Despite being in the same household, both S.H. and R.H. secured similar prescriptions for similar diagnoses from Dr. Coplin, and did so even though Dr. Coplin was in possession of significant evidence suggesting that both were engaging in inappropriate drug-seeking behaviors and likely diverting some or all of the CDS he prescribed. Likewise, we have identified Dr. Coplin's simultaneous prescribing of Fentanyl, Percocet and OxyContin to patient M.S. to be particularly disturbing, as his prescribing of all three opioids to one patient clearly could have exposed that patient to grave health risks (or was simply a conduit to allow for diversion).

Finally, our conclusion that Dr. Coplin's continued practice would present clear and imminent danger is also based on our review of the evidence offered supporting the allegations set forth in Count 9 of the Complaint (see Certification of Kathleen Cefalu, R.N., Exhibit P-2)[9]. Simply put, there can be no justification for Dr. Coplin's practice of pre-signing prescription

[9] Investigator Cefalu's certification details that on February 13, 2018, the DEA and the EB executed a search warrant at Respondent's medical office, during which records of over one hundred patients were obtained. During the course of that search, a New Jersey Prescription Blank pad was found pre-signed with Respondent's signature. Respondent was on vacation and thus not present in the office. Investigator Cefaulu states that Respondent's office staff admitted that they were authorized to write prescriptions for CDS (Oxycodone) for patients in Dr. Coplin's absence on the pre-signed prescriptions blanks. Of note, although denying that conduct in his filed Answer to the Complaint, Respondent conceded at the temporary suspension hearing that he had made an error in judgment in allowing that practice to occur.

blanks, and then authorizing his office staff to complete those prescription blanks and to distribute the prescriptions to patients (or to individuals other than the patient) when he was away on vacation. While we recognize that Dr. Coplin concedes that the practice was a "mistake" and that he has discontinued that practice, we find the dereliction of judgment evident in his ever having condoned or facilitated the conduct to be manifest.

Taken in conjunction with all other findings set forth above, we unanimously conclude that the Attorney General has palpably demonstrated that Dr. Coplin has engaged in a pattern of careless and reckless conduct when prescribing Controlled Dangerous Substances to his patients, which placed his patients and/or the public in clear and imminent danger. While we fully recognize that our finding is sufficient to support the entry of an Order of temporary suspension at this time, we have also sought to consider whether the public interest can be adequately protected by crafting and imposing limitations on Dr. Coplin's practice that will allow him to continue to engage in medical practice for the period of time that will be needed to allow for a full plenary hearing in this matter.[10] In considering that question, we necessarily must balance our paramount obligation to protect the public health,

[10] This Order will remain in place until there is a final action taken by the Board in this matter, which presumably will occur only after the matter is fully tried before an ALJ, an Initial Decision is issued and the Board thereafter votes whether to adopt, reject or modify that Initial Decision.

safety and welfare with our obligation to be fair to the Respondent, recognizing that his opportunity to present a full defense to all charges in the Administrative Complaint cannot occur in the limited setting of a temporary suspension application but must instead await the forthcoming plenary hearing.

In making our decision, we have considered that Dr. Coplin has no prior disciplinary history with the Board. Additionally, we have considered that the limited evidence before us does suggest that Dr. Coplin did take a number of appropriate steps at the time of each undercover's initial office visit, to include requiring each "patient" to execute a Pain Management Agreement (indeed, Pain Management Agreements were maintained in all eight cases) and submit to a urine test, ordering imaging studies, conducting a limited physical examination[11] and, at least in R.C.'s case, conducting a PMP look-up. Further, we recognized that although Dr. Coplin continued to prescribe to S.H. and D.H. for a protracted period of time (notwithstanding multiple red flags suggesting that both were diverting medicines), he did ultimately discharge both patients based on their drug seeking behaviors and evidence of diversion in August 2017.

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[11] Our observation that Dr. Coplin conducted a limited physical examination at the time of C.H. and R.C.'s initial visits should not be equated to any finding that the examination done at that time met the standard of care for such an examination. That issue, along with many others, will instead need to be further explored and developed during the plenary hearing.

Mindful that imposition of a temporary suspension is an extraordinary remedy which should be imposed only when a full cessation of practice is necessary to adequately protect the public interest, and that the primary focus of the concerns we have identified are upon Dr. Coplin's prescribing of Controlled Dangerous Substances, we are satisfied, on balance, that the public welfare can be adequately protected so long as Dr. Coplin is fully prohibited from prescribing any and all Controlled Dangerous Substances during the pendency of this matter. The concerns we have identified all are connected to Dr. Coplin's poor judgment in treating pain management patients and writing prescriptions. Stripped of the authority to write those prescriptions, the public interest can be adequately safeguarded.

We therefore Order that Dr. Coplin is to be prohibited from prescribing any and all Controlled Dangerous Substances to any and all patients, effective as of the close of business on August 23, 2018. We will thus allow for a fifteen day period during which Dr. Coplin may continue to write prescriptions for CDS (for established patients only). We point out that we do so based solely on our concern for the well-being of current patients, who might otherwise be immediately cut off from having any ability to obtain medically necessary CDS prescriptions and exposed to the

significant risks associated with sudden withdrawal from opioids (or other CDS).

WHEREFORE it is on this 21st day of August, 2018

ORDERED, effective on pronouncement on August 8, 2018:

Respondent Bruce Coplin, M.D. is hereby prohibited from prescribing, dispensing and/or administering any and all Controlled Dangerous Substances to any and all patients, effective as of the close of business on August 23, 2018. From August 8, 2018 through August 23, 2018, Dr. Coplin may continue to prescribe CDS, but only to established patients. Prior to August 23, 2018, Dr. Coplin shall make arrangements for the transfer of all patients presently under his care who may have any need to be prescribed CDS. The terms and limitations imposed herein shall remain in effect until further Order of this Board.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: 

Paul J. Carniol, M.D.
Board President

NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ACTIONS

All Orders filed by the New Jersey State Board of Medical Examiners are "government records" as defined under the Open Public Records Act and are available for public inspection, copying or Examination. See N.J.S.A. 47:1A-1, et seq., N.J.S.A. 52:14B-3(3). Should any inquiry be made to the Board concerning the status of a licensee who has been the subject of a Board Order, the inquirer will be informed of the existence of the Order and a copy will be provided on request. Unless sealed or otherwise confidential, all documents filed in public actions taken against licensees, to include documents filed or introduced into evidence in evidentiary hearings, proceedings on motions or other applications conducted as public hearings, and the transcripts of any such proceedings, are "government records" available for public inspection, copying or examination.

Pursuant to N.J.S.A. 45:9-22, a description of any final board disciplinary action taken within the most recent ten years is included on the New Jersey Health Care Profile maintained by the Division of Consumer Affairs for all licensed physicians. Links to copies of Orders described thereon are also available on the Profile website. See http://www.njdoctorlist.com.

Copies of disciplinary Orders entered by the Board are additionally posted and available for inspection or download on the Board of Medical Examiners' website.
See http://njconsumeraffairs.gov/bme.

Pursuant to federal law, the Board is required to report to the National Practitioner Data Bank (the "NPDB") certain adverse licensure actions taken against licensees related to professional competence or conduct, generally including the revocation or suspension of a license; reprimand; censure; and/or probation. Additionally, any negative action or finding by the Board that, under New Jersey law, is publicly available information is reportable to the NPDB, to include, without limitation, limitations on scope of practice and final adverse actions that occur in conjunction with settlements in which no finding of liability has been made, Additional information regarding the specific actions which the Board is required to report to the National Practitioner Data Bank can be found in the NPDB Guidebook issued by the U.S. Department of Health and Human Services in April 2015. See http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf.

Pursuant to N.J.S.A. 45:9-19.13, in any case in which the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, the Board is required to notify each licensed health care facility and health maintenance organization in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders entered by the Board is provided to the Federation on a monthly basis.

From time to time, the Press Office of the Division of Consumer Affairs may issue press releases including information regarding public actions taken by the Board.

Nothing herein is intended in any way to limit the Board, the Division of Consumer Affairs or the Attorney General from disclosing any public document.