



JOHN ELIAS BALDACCI  
GOVERNOR

STATE OF MAINE  
BOARD OF LICENSURE IN MEDICINE  
137 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0137

EDWARD DAVID, M.D.J.D.  
CHAIRMAN

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*Certified Mail# 70033110000415227873  
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December 5, 2006

Bernard P. Vigna, M.D.  
51 Harpswell Rd.  
Brunswick, ME 04011

**Re: End of Suspension**

Dear Dr. Vigna:

This is to confirm that your suspension ended as of November 10, 2006. The Board will make reports to the National Practitioner Data Bank and to the Federation of State Medical Boards documenting a close to your suspension.

You are still subject to the other terms and conditions of the Board Order dated June 13, 2006. This Order includes probation for a period of ten (10) years.

Please let me know if you have any questions. I can be reached at 287-6931.

Sincerely,

Maria A. MacDonald  
Field Investigator

Cc: Dennis Smith  
Emily Bloch

*Certified Mail # 70033110000415227880  
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## II.

### FINDINGS OF FACT

#### **A. C.M., C.P. and G.M.**

Bernard Vigna, Jr., was first licensed as a physician in the State of Maine on July 20, 1988. His specialty is neurology, and the majority of his patients have either Alzheimer's Disease, Parkinson's Disease, and/or peripheral nerve problems. Dr. Vigna last practiced as a physician on March 29, 2006 when he had a spinal fusion.

At some point in early November or late October 2005, Dr. Vigna's medical secretary received a call from a pharmacist at a local pharmacy. The pharmacist had concerns regarding the amount of prescriptions that were being filled for Dr. Vigna's former wife, C.P. C.P. is a neuro-physiologist. The secretary was somewhat concerned since there was no office record of any treatment or prescriptions regarding C.P. The same secretary subsequently discovered that Dr. Vigna was also treating and prescribing drugs for his girlfriend, C.M. Again, there was no record of treatment or prescriptions maintained by Dr. Vigna for this patient. These concerns prompted the secretary to file a complaint with the Board.

In October of 1999, Dr. Vigna began having sexual relations with C.M. while she was under his care. He first wrote a prescription for her in June of 1999 and subsequently for his wife on September 16 of that year. The licensee failed to maintain copies of these prescriptions in C.M.'s file because they were living together and he was not prescribing the narcotics in an office context. His failure to keep records was particularly egregious due to the amounts and nature of the narcotics prescribed for both individuals. For example, from July 2, 2004 until March 23, 2006, the date on which Dr. Vigna surrendered his Drug Enforcement Agency License, this physician prescribed more than 200 prescriptions for C.M., each containing an average of 30 to 60 pills, mostly Hydrocodone and Roxicodone. From July 2, 2004 until October 31, 2005, pharmacy records indicate that more than 100 prescriptions were filled for C.P. These were also for Hydrocodone with an average quantity of 42 pills per prescription.

On several occasions, subsequent prescriptions for these women were written by Dr. Vigna before prior prescriptions expired. For example, as regards C.P., Dr. Vigna on August 28, 2004 prescribed 42 tablets of Hydrocodone for a period of eight days. On August 30, 2004, the patient

returned and refilled a prescription to last for seven days. The next prescription was filled on September 7, 2004 for the same amount of pills. This would seem to indicate that 336 pills were prescribed between August 28th and August 30th at which time another 294 pills were obtained by the patient from Dr. Vigna.

## **B. Detective Seth Blodgett**

On December 21, 2005, Detective Seth Blodgett, Board Investigator, interviewed Dr. Vigna. At that time, Dr. Vigna stated that he prescribed pills to C.P. due to her neck, hip, and back pain as well as a bleeding disorder. Since she was unable to take many over-the-counter pain relievers, he prescribed the Hydrocodone for pain. However, he did not perform any formal examinations of C.P. but rather described his examinations as "on the fly." He further stated that he had no reason for not maintaining a medical record for his former wife.

Apparently, Dr. Vigna prescribed pills for C.P. when she felt she needed some. He admitted that he was prescribing too much Hydrocodone for her and was aware that she could develop a dependency on the narcotic. He further admitted that the prescribing "got out of hand." The licensee realized that he used poor judgment in his treatment of C.P. but reasoned that she appeared to be in a lot of pain and felt that she needed the narcotics. Eventually, C.P. took it upon herself to "taper off" the Hydrocodone during which process Dr. Vigna did not prescribe medication for the purpose of aiding her in this endeavor.

Dr. Vigna also addressed his relationship and treatment of C.M. with the Detective. She was experiencing pain in her leg for which she sought treatment from Dr. Vigna. They developed a friendship in June 1999 which evolved into a sexual relationship in October of that year. Dr. Vigna and C.P. separated in early 2000 and Dr. Vigna moved in with C.M. in the summer of 2002. Dr. Vigna gave his opinion to Detective Blodgett that the narcotics that he had been prescribing to C.M. were justified since other pain medications had not proven effective. At the conclusion of the interview with Detective Blodgett, Dr. Vigna admitted that the prescribing was "out of control" and that he was willing to do whatever it would take to maintain this license.

### **C. Daniel Onion, M.D.**

Daniel Onion, M.D., testified for the Board as an expert witness. Dr. Onion has been a physician for more than 35 years. He testified that he selected 11 patient records to review in this matter. Although not a violation of Board Rules or statutes, Dr. Onion found no record of any random drug testing or pain contract with any patient which would have been the best practice regarding some of these individuals.

One patient, K.J., was treated by Dr. Vigna primarily with narcotic drugs from at least 1999 through 2006. This individual also had a serious problem relating to alcohol abuse. There was no acknowledgement of this individual's excessive refills and neither was there a flow sheet indicating which narcotics had been prescribed on what day. The records of K.J. also indicate that he had been requesting gradual increases in dosage and early refills and was investigated by the police for drug-related activity. Dr. Vigna was aware of the above and also that a prescription for Percocet which had been written for another patient had disappeared while on the counter at his office at the same time when K.J. arrived to pick up his OxyContin prescription.

Dr. Vigna discharged this individual on March 29, 2001 and prescribed Percocet at the time of his discharge. He then had a change of heart and continued to treat K.J. as evidenced by a prescription for K.J. on April 2, 2001. Dr. Vigna could not provide a rational reason why he continued to prescribe OxyContin and other narcotics for this patient.

Other examples of inappropriate treatment of KJ are reflected by a note dated October 25th, 2001 wherein K.J. "said he'd left his OxyContin in a cab last night - called cab company - said they didn't have it - what does he do?" The records reflect that Dr. Vigna then prescribed another order of OxyContin for K.J. At other times, Percocet and Duregesic patches were prescribed when the doctor had no record of seeing his patient on those days. On July 22, 2002, K.J.'s sister left a message with Dr. Vigna that she would be arriving at his office the next day regarding her brother. Apparently, K.J. was removing the narcotic from his patches and injecting same into his system. According to the sister's telephone note, she was "wild that you keep giving him prescriptions." The next day, a telephone note from Dr. Vigna's records reveals that K.J. called needing "a prescription for Percocet."

K.J. apparently agreed to enter a rehabilitation program at St. Mary's Hospital on July 24th, 2002. However, from that time forward until 2006, Dr. Vigna continued to prescribe narcotics for

K.J. Additionally, K.J. apparently was still drinking "quite a bit" according to his sister who told this to Dr. Vigna on April 14, 2003.

#### **D. Dr. Vigna**

Dr. Vigna testified that he has initiated counseling for himself and will be seeing a psychiatrist in the next week to deal with his various problems. However, he still did not consider that his treatment of C.M. was inappropriate. He testified that in his opinion, the prescribing of narcotics without medical records and documentation and his nonreferral of C.M. for treatment by a pain specialist or other physician did not amount to a gross deviation of the standard of care. In his opinion, other physicians would not have differed in their treatment from that of Dr. Vigna. However, he did agree that it would have been a better idea to maintain records regarding C.M.'s treatment and he understood that it was not a good idea to treat loved ones, relatives or significant others. C.M. is no longer a patient of Dr. Vigna since he referred her during March of 2006 to another medical provider as a result of the Board complaint.

Dr. Vigna admitted that he thought it was incompetent and unprofessional as well as unethical to continue to prescribe drugs to his former wife, C.P., without proper record keeping. Moreover, she had at least three other care providers that Dr. Vigna did not provide with a list of the drugs that he was prescribing for C.P. He had no good answer at the hearing in this matter to explain why he failed to keep records and why he failed to inform other providers of his patients' prescriptions.

Dr. Vigna also testified that, on a couple of occasions, he prescribed narcotic medications for his employees, particularly G.M. He did not consider G.M. to be a patient in the "strictest sense" and did not keep a copy of the narcotics which he prescribed for her due to time constraints and also because he "assumed she would." Dr. Vigna also admitted to requesting some Hydrocodone back from G.M. on occasion in order to ease his back pain prior to his surgery in March.

Dr. Vigna further testified that he continued to prescribe narcotic medications to C.M and failed to keep copies of any prescriptions for her even after being interviewed by Detective

Blodgett and receiving the Board's complaint. Additionally, he only stopped prescribing medications to C.M., C.P. and G.M. after surrendering his DEA registration on March 16, 2006.

During his testimony, Dr. Vigna, admitted that he had never read the American Medical Association's code of ethics. Neither had he read the ethical standards established by the Board. Moreover, he could not recall reading an article concerning doctor-patient boundaries and relationships although he had taken a course some 12 or 13 years ago which including record keeping.

Dr. Vigna testified that even subsequent to the Board's complaint, he has not reviewed the Board's statutes and rules or ethics. His general attitude regarding ethics appears to be that they are not to be seriously entertained. In fact, his prior exposure to any ethical course was a lunchtime voluntary attendance course in medical school entitled "Ethics for Lunch," which title aptly describes his attitude toward that subject.

### III.

### CONCLUSIONS OF LAW

The Board, after review of the evidence, found and concluded by a vote of 7-0 that Dr. Vigna violated the provisions of:

1. 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 for which the licensee is licensed;
2. 32 M.R.S.A. §3282-A(2)(E)(1) which defines incompetence to be conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public;
3. 32 M.R.S.A. §3282-A(2) which is a violation of any provision of the Board statutes or rules;
4. Board Rules, Chapter 10, Sexual Misconduct by engaging in a sexual relationship with a patient, CM;

5. Board Rules, Chapter 11, Use of Controlled Substances for Treatment of Pain; more specifically:

Section 2, Principles of Proper Patient Management:

- A. Failure to conduct a proper evaluation of the patient;
- B. Failure to create and tailor a treatment plan for pain management;
- C. Failure to create or employ a written pain management agreement with the patients;
- D. Failure to refer patients as necessary for additional evaluation and treatment and/or consultation with pain specialists;
- E. Failure to periodically review the efficacy of your treatment of the patients' pain with the medications you prescribed
- F. Failure to properly document in the patients' medical records the evaluation of the patients, the reason for prescribing the controlled substances, the overall pain management treatment plan, any consultations received or sought, periodic review of the status of the patient, drug treatment outcomes and rationales for changes in drug dosages, and every prescription provided.

More specifically, Dr. Vigna violated the foregoing Board statutes and/or rules by:

- a. Inappropriately prescribing controlled drugs to his wife, CP, his girlfriend, CM, and an office employee, GM;



b. Failing to create or maintain appropriate medical records concerning his diagnosis, treatment, and prescribing practices with regard to controlled drugs that he prescribed for his wife, CP, his girlfriend, CM, and his office employee, GM;

c. Inappropriately prescribing controlled drugs to and/or failing to create or maintain appropriate medical records concerning his diagnosis, treatment and prescribing practices with regard to controlled drugs that he prescribed for the following patients:

- RB - treated 11/09/00-11/09/05
- NG - treated 05/28/02-12/29/05
- WM - treated 03/18/02-10/24/05
- LS - treated 06/06/03-11/21/05
- CM- treated 01/07/97-09/10/99
- RB- treated 03/29/04-10/24/05
- BE- treated 04/17/03-11/15/05
- WS - treated 02/26/92-06/20/05
- KJ- treated 03/30/99-04/15/05
- TE- treated 12/04/98-10/06/05

d. Inappropriately requesting and/or accepting and using controlled drugs from his office employee, G.M., and his girlfriend, C.M., which controlled drugs he had prescribed for their medical care and treatment.

**IV.**

**SANCTIONS**

The Board, utilizing its experience, training, and expertise, by a vote of 7-0, hereby orders that:


1. Dr. Bernard Vigna be given a Reprimand since his actions are particularly egregious in his violation of sexual boundaries and over prescription of narcotics without appropriate record keeping.
2. Dr. Bernard Vigna's license to practice medicine is hereby suspended for a period of six months beginning May 9, 2006.
3. Dr. Bernard Vigna's license is hereby placed on probation for a period of ten years, which term may be periodically reviewed by the Board but not before its October 2006 meeting. During the first six months of probation, he shall receive a 3286 evaluation. His therapist shall be provided with a copy of this order and decision as well as the 3286 evaluation. The evaluation shall contain projective testing, and personality profiles including rescue fantasies and interpersonal needs. The Board reserves the right to further address the conditions of probation by amending these requirements pursuant to a Consent Decree or an additional proceeding at any future time prior to the expiration of probation. Additionally, Dr. Vigna shall appear before the Board prior to the expiration of his suspension in order to address his fitness to practice as a physician.
4. Dr. Vigna shall **pay the Board's costs** of this hearing by May 9, 2008 which **total \$11,212.51**. Hearing officer-( 2.30 hrs/mins. pre-hearing review of record and conference of counsel; 8.30 hrs/mins. presiding at the hearing; 7 hours to write the Decision @ \$115= \$2070); and copying costs (\$8,469.25; publication, \$386.98; staff time-\$286.28). Payment shall be by **certified check or money order made payable to: "Maine Board of Licensure in Medicine"** and remitted to Randal C. Manning, Executive Director, 137 State House Station, Augusta, Maine 04333-0137. The costs are ordered in accordance with past Board practice regarding serious offenses and actions that require additional staff time and large costs related to reproduction of patient records and because licensees who do not violate Board Rules and statutes should not have to bear the costs of those who do.
5. During the 270-day period of suspension, Dr. Vigna shall attend the following courses pre-approved by the Board:

- A. Medical ethics;
- B. Boundary issues;
- C. Record keeping;
- D. Pain management including basic pharmacology and pain management drugs.

6. Dr. Vigna needs to convince the Board that he has satisfactorily completed the above terms of probation or his license to practice medicine may be subject to additional sanctions including nonrenewal.

**SO ORDERED.**

Dated: June 13, 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 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.