

The court document for this date cannot be found in the records of the Ohio State Medical Board.

Please contact the Franklin County Court of Common Pleas to obtain a copy of this document. The Franklin County Court of Common Pleas can be reached at (614) 462-3621, or by mail at 369 S. High Street, Columbus, OH 43215.

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

CIVIL DIVISION

JOHN B. GARDINER, D.O., :

APPELLANT, :

vs. :

CASE NO. :

MEDICAL BOARD, STATE OF OHIO, :

APPELLEE. :

STATE MEDICAL BOARD
OF OHIO
96 MAR -1 PM 4:15

NOTICE OF APPEAL

Notice is hereby given that Appellant, John B. Gardiner, D.O., hereby appeals to the Court of Common Pleas of Franklin County, Ohio from the Order of the State Medical Board of Ohio, entered on the 15th day of February, 1996, permanently revoking the certificate of John B. Gardiner, D.O. to practice osteopathic medicine and surgery in the State of Ohio. A copy of the State Medical Board's Entry of Order is attached hereto as Exhibit "A".

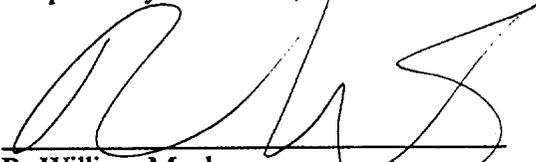
The grounds of this appeal are as follows:

1. The State Medical Board's Order permanently revoking Appellant's certificate to practice medicine is not supported by reliable, probative and substantial evidence and is not in accordance with law.

2. R.C. 119.10, the Ohio statutory framework which requires the Attorney General to represent the State Medical Board as its legal advisor and to also prosecute cases in front of the State Medical Board is unconstitutional, as it deprives Dr. Gardiner of due process of law as guaranteed by the federal and state constitutions.

3. Appellant may raise additional issues after Counsel for Appellant has had the opportunity to further review the entire record in this matter.

Respectfully submitted,



R. William Meeks
Ohio Supreme Court # 0014114



Samuel H. Shamansky
Ohio Supreme Court # 0030772
511 South High Street
Columbus, Ohio 43215
(614) 228-4141

Attorneys for Appellant

STATE MEDICAL BOARD
OF OHIO
95 MAR - 1 PM 4: 16

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing was duly served upon the State Medical Board of Ohio, 77 South High Street, 17th Floor, Columbus, Ohio, and Anne B. Strait, Assistant Attorney General, State of Ohio, 30 East Broad Street, Columbus, Ohio 43215, this 1 day of ^{March}~~February~~, 1996.


R. WILLIAM MEEKS



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

February 16, 1996

John B. Gardiner, D.O.
25 Tibet Road
Columbus, Ohio 43202

Dear Doctor Gardiner:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Esq., Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on February 14, 1996, including Motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal may be taken to the Franklin County Court of Common Pleas only.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Thomas E. Gretter, M.D.
Secretary

TEG:em
Enclosures

CERTIFIED MAIL RECEIPT NO. P 348 887 174
RETURN RECEIPT REQUESTED

cc: R. William Meeks, Esq. / Samuel H. Shamansky, Esq.

CERTIFIED MAIL RECEIPT NO. P 348 887 175
RETURN RECEIPT REQUESTED

Mailed 2-20-96



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of R. Gregory Porter, Esq., Attorney Hearing Examiner, State Medical Board; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on February 14, 1996, including Motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of John B. Gardiner, D.O., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

A handwritten signature in cursive script, reading "Thomas E. Gretter, M.D.", written over a horizontal line.

Thomas E. Gretter, M.D.
Secretary

(SEAL)

2/15/96

Date



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

JOHN B. GARDINER, D.O.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on the 14th day of February, 1996.

Upon the Report and Recommendation of R. Gregory Porter, Hearing Examiner, Medical Board, in this matter designated pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

The certificate of John B. Gardiner, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio, except that Dr. Gardiner shall not order, purchase, prescribe, dispense, administer, or possess any controlled substances, except for those prescribed for his personal use by another so authorized by law. Additionally, Dr. Gardiner's DEA certificate, currently in the possession of the Board's representative, shall be surrendered to the appropriate authorities. Further, in the thirty (30) day interim, Dr. Gardiner shall not undertake the care of any patient not already under his care.

Thomas E. Gretter, M.D.

Secretary

(SEAL)

2/15/96

Date

11-11-95 11:15

**REPORT AND RECOMMENDATION
IN THE MATTER OF JOHN B. GARDINER, D.O.**

The matter of John B. Gardiner, D.O., came on for hearing before me, R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on December 18 and 19, 1995.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated August 9, 1995 (State's Exhibit 1), the State Medical Board notified John B. Gardiner, D.O., that it proposed to take disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio, based upon the following allegations:
1. Citing Dr. Gardiner's care of Patients 1 through 12 (identified in a Patient Key to be withheld from public disclosure) as examples, the Board alleged that "[a]s demonstrated in [Dr. Gardiner's] patient records, [Dr. Gardiner] excessively and inappropriately prescribed controlled substances and dangerous drugs to Patients 1 through 12 Such prescribing was routinely done despite documentation in [Dr. Gardiner's] records that these patients were exhibiting drug-seeking behavior, including drug selling, and that the patients were abusing and/or dependent on the drugs which [Dr. Gardiner was] prescribing to them."
 2. Citing Dr. Gardiner's care of Patients 1 through 13 (Patient 13 also identified in the Patient Key to be withheld from public disclosure) as examples, the Board alleged that "While treating Patients 1 through 13, [Dr. Gardiner] routinely failed to evaluate and assess the Patients' complaints, and [Dr. Gardiner] failed to respond or follow-up to changes in the Patients' complaints and/or conditions."
 3. "Additionally, for Patients 1 through 12, [Dr. Gardiner] routinely failed to indicate the diagnosis and purpose for which controlled substances were utilized."

4. "Additionally, for Patients 1 through 13, [Dr. Gardiner] routinely failed to maintain patient records reflecting [Dr. Gardiner's] evaluation, examination, and treatment of the patients."

The Board further alleged that:

[Dr. Gardiner's] acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "(f)ailure to use reasonable care discrimination in the administration of drugs," and/or "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, [Dr. Gardiner's] acts, conduct, and/or omissions as alleged in paragraphs (1), (2), and (4) above, individually and/or collectively, constitute "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

[Dr. Gardiner's] acts, conduct, and/or omissions as alleged in paragraph (3) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

[Dr. Gardiner's] acts, conduct, and/or omissions as alleged in paragraph (4) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(C), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative

Code, violation of Rule 4731-11-02(C), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), and further, if such violation is committed purposely, knowingly, or recklessly, it also constitutes a violation of 4731.22(B)(3), Ohio Revised Code.

Dr. Gardiner was advised of his right to request a hearing in this Matter.

- B. By letter received by the Board on August 24, 1995 (State's Exhibit 2), R. William Meeks, Esq., and Samuel H. Shamansky, Esq. requested a hearing on behalf of Dr. Gardiner.

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Anne B. Strait, Assistant Attorney General.
- B. On behalf of Respondent: Samuel H. Shamansky, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 1. John B. Gardiner, D.O., as on cross-examination
 2. Martin Macklin, M.D., Ph.D.
 3. Matthew Lloyd Cook, M.D.
- B. Presented by Respondent:

John B. Gardiner, D.O.

II. Exhibits Examined

In addition to State's Exhibits 1 and 2, noted above, the following exhibits

were identified by the State and admitted into evidence:

- A. State's Exhibit 3: August 25, 1995, letter to R. William Meeks, Esq., and Samuel H. Shamansky, Esq., from the Board, advising that a hearing had been set for September 8, 1995, and further advising that the hearing was postponed pursuant to §119.09, Ohio Revised Code.
- B. State's Exhibit 4: September 19, 1994, letter to Attorneys Meeks and Shamansky from the Board, scheduling a hearing for October 16 through 20, 1995. (2 pp.)
- C. State's Exhibit 5A: Respondent's October 5, 1995, Motion for Continuance. (3 pp.)
- D. State's Exhibit 5B: October 10, 1995, Entry granting the Respondent's motion for continuance and rescheduling the hearing for December 18 through 22, 1995.
- E. State's Exhibit 6: Patient key. (Note: This exhibit has been sealed to protect patient confidentiality.)
- F. State's Exhibit 7: Curriculum Vitae of Martin Macklin, M.D., Ph.D. (3 pp.)
- G. State's Exhibit 8: Curriculum Vitae of Lloyd Matthew Cook, M.D. (4 pp.)
- H. State's Exhibit 9: Certified copy of documents from the State Medical Board of Ohio, In the Matter of John B. Gardiner, consisting of the following: April 25, 1984, Entry of Order; March 14, 1985, Report and Recommendation; excerpt of minutes of the April 11, 1984, meeting of the Board; June 17, 1982, notice of opportunity for hearing to Dr. Gardiner from the Board; excerpt of minutes of the December 5, 1984, meeting of the Board; excerpt of minutes of the June 12, 1985, meeting of the Board; excerpt of minutes of the December 4, 1985, meeting of the Board; excerpt of minutes of the June 11, 1986, meeting of the Board; excerpt of minutes of the December 3, 1986, meeting of the Board; and December 15, 1995, Certification. (37 pp.)
- I. State's Exhibits 10 through 22: Copies of Dr. Gardiner's patient records for Patients 1 through 13, respectively. (Note: These exhibits have been sealed to protect patient confidentiality.)

13-00720-0005

- J. State's Exhibit 23: Copy of article entitled, *Principles of Pain Management*, by Gregory W. Albers, M.D., and Stephen J. Peroutka, M.D., Ph.D., from Current Therapy in Internal Medicine. (4 pp.)

III. Post-Hearing Admissions to the Record

On the Hearing Examiner's own motion, the following additional exhibits are admitted to the record:

- A. Board Exhibit A: Excerpt from *Drug Facts and Comparisons*, dated June 1989, concerning Fioricet and Fiorinal. (2 pp.)
- B. Board Exhibit B: Excerpt from 1991 *Physicians' Desk Reference*, 45th Ed., concerning Fioricet.
- C. Board Exhibit C: Rule 4731-11-02, Ohio Administrative Code. (3 pp.)

SUMMARY OF THE EVIDENCE

All transcripts of testimony and exhibits, whether or not specifically referred to hereinafter, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

1. Several individuals, including Dr. Gardiner, testified as experts in this matter:
 - a. John B. Gardiner, D.O., testified on his own behalf, and was called by the State to testify as if upon cross-examination. Dr. Gardiner received his Doctor of Osteopathy degree from the Kansas City College of Osteopathic Medicine and Surgery in 1955. He interned at Doctor's Hospital in Columbus from 1955 to 1956. In 1980, Dr. Gardiner took a fellowship in manipulation, and is certified in that area by the American Academy of Osteopathy. (Transcript Volume I [Tr. Vol. I], 13-15)

Dr. Gardiner set up practice in the Clintonville area of Columbus in 1956, and has practiced at the same location for nearly 40 years. He has been in solo practice for all of this time, although a few practitioners interested in manipulation have worked with him. Dr. Gardiner testified that his practice primarily includes nursing-home patients and Industrial Commission cases. Dr. Gardiner believes that the structure problems

often suffered by patients who suffer from work-related injuries can benefit from his expertise. (Tr. Vol. I, 15-18)

- b. Martin Macklin, M.D., Ph.D., testified as an expert for the State of Ohio. Dr. Macklin received a Ph.D. in Biomedical Engineering from Case Western Reserve University in 1967. He received his Doctor of Medicine degree from that same institution in 1977. From 1977 to 1978, Dr. Macklin interned at University Hospitals of Cleveland, Ohio, and from 1978 through 1981 was a resident in psychiatry at the same facility. Dr. Macklin is board certified in both psychiatry and addictionology. (State's Exhibit [St. Ex. 7]; Tr. Vol. I, 66-67)

Dr. Macklin has had a number of professional appointments, including Medical Director of Woodside Hospital, Youngstown, Ohio, from 1989 through 1994. He is currently Clinical Assistant Professor of Psychiatry, Northeastern Ohio Universities College of Medicine, and Vice President of Medical Affairs at Geauga Hospital, Chardon, Ohio. Dr. Macklin's curriculum vitae was admitted to the record as St. Ex. 7. (St. Ex. 7; Tr. Vol. I, 67-70)

Dr. Macklin testified that he reviewed relevant patient records, and did research concerning the drug Soma, in preparation for his testimony in this Matter. (Tr. Vol. I, 73)

- c. Lloyd Matthew Cook, M.D., testified as an expert for the State of Ohio. Dr. Cook received his Doctor of Medicine degree from the State University of New York Health and Science Center at Syracuse in 1983. Dr. Cook completed an internship at the University of Medicine and Dentistry of New Jersey in 1984, and completed his residency at that same institution in 1986. Dr. Cook is board certified in internal medicine. (St. Ex. 8; Tr. Vol. II, 5-6)

From 1986 until 1990, Dr. Cook worked for the National Health Service Corps at the Cleveland Neighborhood Health Services Hough Norwood Family Health Care Center, first as Staff Physician, later as Assistant Medical Director. Since 1990, Dr. Cook has been in private general practice. In addition, Dr. Cook has worked as a part-time physician for the Salvation Army since 1988. Dr. Cook's curriculum vitae was admitted to the record at St. Ex. 8. (St. Ex. 8; Tr. Vol. II, 6-9)

Dr. Cook testified that he reviewed 13 patient records in preparation for his testimony in this Matter. (Tr. Vol. II, 18)

being abused. However, in cases where the patient really needs the drug, it should be prescribed in very small quantities. (Tr. Vol. I, 78)

Dr. Macklin said that medications containing controlled substances, such as the opiates or synthetic opiates (propoxyphene, codeine, or hydrocodone), usually do not work well for chronic pain. Patients develop a tolerance to the pain-killing effect, which causes the pain to break through, so doses therefore have to be increased. Patients taking narcotic analgesics can also experience a rebound effect whereby pain can be worse upon its return than it was before the drug was taken. This can be a particular problem in treating migraine headaches. (Tr. Vol. I, 82-84)

If a patient has symptoms of depression, Dr. Macklin testified it is a good idea for the physician to ask the person whether or not they have had suicidal thoughts. Dr. Macklin thinks "it's important to document what [the physician has] asked them and whether or not they have some suicidal thoughts." Patients don't get upset about such questions, and are often relieved by an opportunity to talk about it. If the patient is having thoughts about suicide, "a wise general practitioner at that point would refer [the patient] to a psychiatrist basically to take the risk." (Tr. Vol. I, 90-91) There should be documentation of the suicidal thoughts, as well as the patient's quality of sleep, appetite, mood, and appearance. (Tr. Vol. I, 89)

3. **Dr. Cook** testified that the patient records that he reviewed in preparation for this case failed to conform to the minimal standards of care for record keeping by a physician. The minimum amount of information that patient records should contain would be:

- Patient complaints, and an objective evaluation of the patient complaints based on a physical exam, including any diagnostic or laboratory tests; and
- An assessment, which should include the physician's diagnoses, the patient's response to treatment, and a plan for continued care.

(Tr. Vol. II, 19)

In his review of Dr. Gardiner's patient records, Dr. Cook found the minimum information missing. "[G]enerally there was just simply a listing of what drugs were prescribed for the patient." (Tr. Vol. II, 20) Moreover, Dr. Cook characterized the majority of the patients' complaints as acute pain syndromes, as opposed to chronic pain syndromes. These were diagnoses

which one would expect a patient to recover from. "In fact, most people generally do get better within a couple of months from these types of injuries." (Tr. Vol. II, 20-21)

Dr. Cook testified concerning the appropriate procedure a physician should follow when faced with the possibility of prescribing potentially abusable drugs. The first step would be to take a history to establish whether the pain is related to an injury or medical condition. This should be followed by an examination, documentation of objective findings, and a plan of treatment based on the patient's individual needs. All of this needs to be documented in the patient records as a matter of routine. (Tr. Vol. II, 10-12)

Dr. Cook described drug-seeking behavior. Such patients often want a particular medication. They want frequent refills. They want stronger medication. They visit multiple physicians asking for pain medications. They claim their medication got lost, or their child flushed it down the toilet, or some similar scenario. Dr. Cook testified that a physician generally wants to believe what the patient is telling him or her, but such behavior raises a red flag that the patient might be abusing or addicted to drugs. (Tr. Vol. II, 12-13)

Dr. Cook said that a physician should document drug-seeking behavior in the medical record. When such behavior is noticed, the physician should discuss his or her concerns with the patient, and make the patient aware of the physician's policy concerning the prescribing of potentially abusable medications. (Tr. Vol. II, 13)

Dr. Cook testified that if a physician believes he is dealing with a patient who has an addiction problem, the physician should first inform that patient that the physician will no longer prescribe potentially abusable drugs to that patient. Next, the physician should seek alternative treatment modalities for management of the pain symptoms, if the physician believes the patient is really in pain. (Tr. Vol. II, 13-14)

Dr. Cook testified concerning the various methods available for treating chronic pain. Motrin and related substances are used for management of chronic pain symptoms resulting from arthritis and certain musculoskeletal conditions. Narcotics should only be used on a short-time basis, less than one month. Antidepressants can treat a patient's perception of pain, and are currently popular in the treatment of chronic pain. Antiseizure medications such as Tegretol or Dilantin are useful in the treatment of neuropathic pain, which diabetics can suffer. Physical therapy, behavior modification, or nerve blocks may also be employed. Dr. Cook referred to the article concerning pain

management excerpted from *Current Therapy in Internal Medicine*, which is a standard text in the field of internal medicine. This article was admitted to the record as St. Ex. 23. (Tr. Vol. II, 14-18)

4. **Dr. Gardiner** testified that when a patient came into his office, Dr. Gardiner would take a history from the patient and try to determine what the problem was. (Tr. Vol. I, 18-19) Dr. Gardiner stated that he always reviewed everything in the chart, even if his medical assistant wrote something down. He testified that he usually made the entries himself, however. (Tr. Vol. I, 20-21) Dr. Gardiner testified that when his medical records refer to "sound," he is referring to ultrasound treatments. (Tr. Vol. I, 23) He said that OMTC refers to cranial manipulation. (Tr. Vol. I, 22) Dr. Gardiner testified that his assistant helped to apply some treatments, such as heat and ultrasound, the Spinalator, and the traction device. She would also administer some shots. (Tr. Vol. I, 24-25) Nevertheless, Dr. Gardiner testified that he saw every patient on every office visit. (Tr. Vol. I, 25)

Dr. Gardiner said that many of his patients suffered from chronic pain. Dr. Gardiner testified that he treated such patients with muscle relaxants, such as Soma, Flexoril, Parafon Forte, or Norgesic, plus he would give the patients pain pills. He stated that he now uses Tylenol Extra Strength, and anti-inflammatories, such as Ultram, which are non-controlled. In the past, Dr. Gardiner would prescribe controlled substances if the patient suffered from severe pain. (Tr. Vol. I, 26-27)

Dr. Gardiner testified that his practice has changed; he now has "a better clientele" that consists of mostly firemen and policemen. These patients do not want controlled substances. Dr. Gardiner said that "[a]nybody that wants anything controlled don't come in anymore, I've finally learned that." (Tr. Vol. I, 27)

5. **Patient 1**, male, d.o.b. 9-30-56, first saw Dr. Gardiner on 10-7-87. (St. Ex. 10, p. 13) Patient 1 had been involved in a car accident on September 20, 1987. Dr. Gardiner's diagnoses were: "traumatic headaches, concussion, cervical strain, numbness in right thigh, left rib fracture, right piriformis tight, neuritis in right leg." (St. Ex. 10, pp. 33, 39) During the course of Dr. Gardiner's treatment of Patient 1, Patient 1 was involved in two additional car accidents. Further, Patient 1 suffered a seizure on 8-19-90 that required hospitalization. Patient 1 died on 10-17-90 from a heart attack. (St. Ex. 10)

At hearing, Dr. Gardiner testified:

Well, I suppose the arthritis at C7 in his neck was probably from whiplash in his accidents. He had a minimal annulus bulge at L5-S1. On examination he had a sacral torsion to the right, that's the sacrum, that's the base of the spine, and it was in a torsion to the right.

His right piriformis was tight, that sometimes is a muscle over the right sciatic nerve, and that can cause sciatic neuritis when the muscle is tight. I worked on those things trying to free up his sciatic nerve.

We thought he had epilepsy at one time, and he was on Xanax for that most of the time, but we sent him to a specialist and he ruled out epilepsy, so we took him off the Xanax.

He had neuritis in the right leg, that was from the right piriformis being tight. He had chronic dorsal lumbar ligamentous strain, his low back was in strain, he had lumbar instability due to pars defect at L5 and a possible fracture at L4-L5, so he did have quite a bit of back problems.

He had an MI with cardiac arrest, he had whiplash to the neck, he had traumatic headaches, he had injury to the right foot, a linear fracture of the dorsal phalanges of the fifth toe, that gave him a lot of problems And he had a very low tolerance for pain.

(Tr. Vol. I, 30-31)

Dr. Gardiner further testified that he kept switching the medications that Patient 1 took so that Patient 1 "wouldn't get addicted to anything. I put him on Disalcid and Flexeril. We took him off the Dilantin. That was for his epilepsy, which we thought maybe he had." (Tr. Vol. I, 31-32) Patient 1 also received Halcion, which Dr. Gardiner explained, "I use that once in a while to help them sleep." (Tr. Vol. I, 32) Patient 1 also took Soma. When asked if he had ever considered that Soma might have caused Patient 1's seizures, Dr. Gardiner stated that he had not. "Soma is more of a muscle relaxant, I thought that would probably relax him more. Sometimes I use Soma as a sleep agent. It seems to make them drowsy and they seem to relax and sleep better sometimes, so [I] sometimes use Soma just to help them relax." (Tr. Vol. I, 32)

Dr. Gardiner testified that he never suspected that Patient 1 was abusing his medications. "His wife never reported any problems with him at all. He was a very good patient and he came in regularly, and I never thought he abused anything." (Tr. Vol. I, 33)

Dr. Gardiner testified that he never suspected that Patient 1 had heart problems. The patient never complained of pain [presumably chest pain] or shortness of breath. During the course of Dr. Gardiner's treatment of Patient 1, he had several different accidents. Dr. Gardiner testified that Patient 1 never showed much improvement in his complaints of pain during the period that Dr. Gardiner treated him. (Tr. Vol. I, 29-30)

A review of Dr. Gardiner's medical records for Patient 1 indicate that Dr. Gardiner often prescribed Xanax, Percocet, Stadol, Soma, Halcion, Talacen, and Darvocet N-100. Patient 1 visited Dr. Gardiner quite regularly, usually several times per month. Dr. Gardiner prescribed or administered one or more of the aforementioned drugs to Patient 1 at practically every visit, along with the Spinalator, heat, liniment, ultrasound, and OMT. (St. Ex. 10, pp. 27-35, 68-73, 91-105, 145-157)

6. Dr. Macklin testified that most of the diagnoses mentioned by Dr. Gardiner in Dr. Gardiner's testimony were reflected in Patient 1's chart. (Tr. Vol. I, 92)

Dr. Macklin testified that Patient 1 suffered from an injury to his foot as a result of an industrial accident. Additionally, Patient 1 was treated for injuries received in three separate automobile accidents. Dr. Macklin further noted that Dr. Gardiner kept a separate chart for each accident or industrial injury. (Tr. Vol. I, 92)

Dr. Macklin referred to a 3-22-89 letter to Dr. Gardiner from Dr. Mazo, a neurologist, in which Dr. Mazo wrote, "I feel no treatment is necessary at the present moment other than just minor analgesics." (Tr. Vol. I, 92, quoting St. Ex. 10, p. 47) In spite of Dr. Mazo's recommendation, Patient 1 continued to receive prescriptions for Percocet, Talacen, and Soma. (Tr. Vol. I, 93) Further, Dr. Macklin referred to a letter to Dr. Gardiner from Dr. Papp, dated May 2, 1990, in which Dr. Papp advised that Patient 1 be discontinued from the narcotic analgesics. Dr. Macklin noted that Dr. Gardiner did not follow Dr. Papp's advice. (St. Ex. 10, pp. 175-177; Tr. Vol. I, 94-95)

Dr. Macklin testified that in August 1990, a pharmacist called Dr. Gardiner's office and informed Dr. Gardiner that Patient 1 was going to two different pharmacies to get prescriptions filled. The pharmacist expressed his opinion

that Patient 1 was receiving far too much medication, and told Dr. Gardiner's office that the pharmacy refused to fill a prescription for Soma. (Tr. Vol. I, 96)

Dr. Macklin testified that Patient 1's wife called Dr. Gardiner's office on 8-20-90 to say that Patient 1 was in the hospital, having suffered a seizure on 8-19-90. She further informed Dr. Gardiner that Patient 1 had not had any Soma on 8-18-90 and only Darvocet on 8-19-90. Dr. Macklin testified that the wife of Patient 1 must have intuited or been told that this was a withdrawal seizure. Dr. Macklin said that, paradoxically, Soma is an unscheduled drug, but its primary metabolite, meprobamate, is a Schedule IV drug. Moreover, Dr. Macklin said:

So that it's well known and is published everywhere that withdrawal seizures occur from meprobamate, ... and they tend to occur 24 to 48 hours after [the patient] stops taking meprobamate.

So this guy stopped taking meprobamate on Saturday and had a seizure on Sunday. It's impossible to prove that, but it essentially certainly fits the pattern very nicely for a withdrawal seizure from meprobamate.

Indeed, that's a reason that very few people prescribe that medicine anymore, because withdrawal seizures are so much more common. It's so easy to kill yourself with meprobamate, and it really has no therapeutic utility, and it really hasn't since the benzodiazapines [Valium and related substances] became available.

Since a primary metabolite of Soma is meprobamate, I would guess the same argument could be made for Soma.

(Tr. Vol. I, 97-98)

Dr. Macklin testified that it appeared that Patient 1 had been receiving prescriptions for Soma, along with other drugs, on a regular basis since May 1988. (St. Ex. 10; Tr. Vol. I, 98-102)

Patient 1 died on 10-17-90. Dr. Macklin said the autopsy report indicated that Patient 1 died from a heart attack. "What precipitated it is not clear from the record, although somebody like this, the suspicion obviously comes up that it could be withdrawal from Soma again, because cardiac arrhythmias can occur, although there is no way of knowing in this instance." (Tr. Vol. I, 102)

Dr. Macklin testified that Dr. Gardiner failed to use reasonable care discrimination in the administration of drugs in that Dr. Gardiner continually prescribed the same medications to Patient 1 without documenting any benefits that were obtained, or any alternative treatments. Additionally, there was evidence that Patient 1 had a seizure from withdrawal from Soma, which was not properly addressed. Finally, there were comments from third parties noted in the medical records that were not addressed. (Tr. Vol. I, 94, 103)

Further, Dr. Macklin testified that Dr. Gardiner's care and treatment of Patient 1 fell below the minimal standards of care. This was reflected in Dr. Gardiner's prescribing practices. Dr. Gardiner referred Patient 1 to consultants but did not follow the consultants' advice. No rationale for this was contained in the record. There was no documentation that Dr. Gardiner had ever even considered the consultants' recommendations. (Tr. Vol. I, 103-104)

7. **Patient 2**, female, d.o.b. 4-28-57, first visited Dr. Gardiner on 5-21-85. (St. Ex. 11, p. 10) She visited Dr. Gardiner on numerous occasions, often two to four times per month, until her death on 3-7-92. During this time period, Dr. Gardiner prescribed drugs such as Darvocet N-100, Tylox, Halcion, Soma, and Stadol. Dr. Gardiner prescribed or administered one or more of these substances at most of Patient 2's visits. (St. Ex. 11, pp. 1-12, 152-156, 209-211, 250-258)

From 12-27-91 until 3-6-92, Dr. Gardiner prescribed the following medications to Patient 2:

12-27-91	42 Darvocet N-100 with 2 refills 50 Soma 350 mg.
12-30-91	40 Tetracycline 250 mg.
1-16-92	50 Darvocet N-100 50 Soma 350 mg.
1-23-92	50 Darvocet N-100 42 Soma 350 mg.
1-30-92	50 Darvocet N-100 with 3 refills 42 Soma 350 mg. with 3 refills

2-27-92 50 Darvocet N-100
 42 Soma 350 mg.
 Stadol 1 cc.

3-6-92 50 Darvocet N-100
 42 Soma 350 mg.

This totals 526 unit doses of Darvocet N-100, and 394 unit doses of Soma 350 mg. during a 10-week period. (St. Ex. 11, pp. 156, 211(front and back))

Dr. Macklin testified that Patient 2 died on 3-7-92 from an overdose of Darvocet. The autopsy report showed lethal doses of acetaminophen and propoxyphene (ingredients of Darvocet), as well as a lethal level of norpropoxyphene, which is a metabolite of propoxyphene. Dr. Macklin noted that it is unknown whether Patient 2 overdosed intentionally or unintentionally. (St. Ex. 11, pp. 388-390; Tr. Vol. I, 118-119)

8. Concerning the circumstances of Patient 2's death, Dr. Gardiner testified, "A friend of this girl called me and said that [Patient 2] had been in a bar all the day [Patient 2] died, and that she took 30 -- she was drunk and took 30 Soma pills is the way I got it. So that's the way that she died." (Tr. Vol. I, 33)
Dr. Gardiner testified that he was not aware that Patient 2 drank. (Tr. Vol. I, 33-34)

Dr. Gardiner testified that he didn't have very good control of Patient 2. (Tr. Vol. I, 34) Dr. Gardiner also treated Patient 2's husband. He was a truck driver, who Dr. Gardiner testified "was gone all the time, so he wasn't very reliable in reporting how she was doing." (Tr. Vol. I, 34)

Dr. Gardiner testified concerning his diagnoses for Patient 2. He testified that Patient 2 was injured in a truck accident, and fractured her right clavicle.

[Patient 2] had a strained right shoulder from that, traumatic headaches, bruised left ankle, bruised left knee, chondromalacia with patella-tracking syndrome. She also had a bad wing transverse process with pseudarthrosis of S1 and a status post fracture of the right clavicle.

Now, that right clavicle healed, but it had such a big callous on it, callous formation when it healed that it pressed on her axillary nerve and gave her a lot of numbness and pain in her arm.

...

[W]hen [Patient 2] had her truck accident, she had traumatic headaches, brachial plexus problems, whiplash to the neck and occipital muscles were tender, skull movement was poor, she probably locked up her skull when she hit her head, the top of her head was very tender.

...

[Patient 2] had headaches every day, pain in her right shoulder and right arm, weakness and numbness in her right arm. Those were some of her complaints.

(Tr. Vol. I, 35-37)

Dr. Gardiner stated that he "was treating her pretty regularly to get that clavicle out of the way so she wouldn't have so much axillary neuritis." (Tr. Vol. I, 36) Dr. Gardiner testified that Patient 2 did not seem depressed, that she seemed to be a happy person most of the time. He did not suspect depression, or evaluate Patient 2 for depression. Nevertheless, he did prescribe Buspar to her occasionally for anxiety. (Tr. Vol. I, 37)

Dr. Gardiner prescribed Darvocet N-100 for Patient 2 for her headaches and for the neuritis in her arm.

9. Dr. Macklin testified that the diagnoses he found in Patient 2's charts were the ones that Dr. Gardiner gave in his testimony. (Tr. Vol. I, 105)

Dr. Macklin testified that Patient 2 was given a number of medications, including Darvocet, Soma, Fioricet, Tranxene, Tylox, Halcion, Phenergan, and Xylocaine injections. Among other things, Patient 2 had been hospitalized for migraine headaches in March 1990 under another doctor, Dr. Smith. (Tr. Vol. I, 105)

Dr. Macklin pointed out an entry in the progress notes dated 8-21-89, that said, "Pharmacist called and patient is seeing two other doctors and getting Darvocet N." The person who wrote the remark also wrote "Note" in big letters so that it would be noticed. Dr. Macklin stated that seeing multiple physicians is a common form of drug-seeking behavior. Dr. Macklin further testified that Patient 2 received 30 Darvocet N-100 from Dr. Gardiner on 8-1-89, 8-9-89,

8-15-89, and on 8-21-89—the same date as the call from the pharmacist. (St. Ex. 11, p. 11; Tr. Vol. I, 105)

Dr. Macklin noted several instances where physical symptoms noted in Patient 2's records were apparently not followed up by an exam. Dr. Macklin mentioned that examples of this problem can be found in entries dated 9-28-87, 10-26-87, 7-20-87, and 8-24-87, as well as others. (Tr. Vol. I, 107-111)

Another problem noted by Dr. Macklin were third-party communications that were not followed up. For example:

- On 11-16-88 there was a letter from Aetna in which concern was expressed regarding the amount of propoxyphene prescribed to both Patient 2 and Patient 2's husband. (St. Ex. 11, p. 51; Tr. Vol. I, 112-113)
- A letter dated 6-15-91 from Dr. Papp, an orthopedic surgeon, recommended anti-inflammatory medication and physical therapy for Patient 2. (St. Ex. 11, p. 261; Tr. Vol. I, 113)
- In January 1991 there was an episode where Patient 2 was seen in an emergency room after being burned in a cooking fire. A report from the hospital stated that Patient 2 had taken two Soma at 8:00 p.m. She put some grease on the stove to make french fries, then fell asleep on the couch. Her children woke her up. She burned her hand throwing flour on the fire. Dr. Macklin noted that "the way the emergency room record is written, I'd be concerned that my medicine made her drowsy if it was my patient." He noted further that Soma has a sedative effect that people do not develop much tolerance for. In his opinion, the sedative effect of Soma would have been greater than the sedative effect of Darvocet. (St. Ex. 11, p. 239; Tr. Vol. I, 113-115)
- On February 26, 1991, Patient 2 was seen in an emergency room with a complaint of severe headaches. She told the ER personnel that she ran out of Darvocet, and her physician was out of town until March 4. She was examined in the ER, and a diagnosis of vascular headache was rendered. She was administered Nubain and Phenergan at the ER, and given a prescription for 20 Darvocet. Dr. Macklin noted that Patient 2 received a prescription from Dr. Gardiner on 2-12-91 for 50 Darvocet and 50 Soma, both with two refills. He noted that, if Patient 2 was indeed out of Darvocet on 2-26-91, then she went through 150 Darvocet in the space of two weeks. (St. Ex. 11, pp. 237, 256; Tr. Vol. I, 116-117)

Dr. Macklin testified that Dr. Gardiner failed to use reasonable care discrimination in the administration of drugs in his treatment of Patient 2. Dr. Macklin stated that Dr. Gardiner did not continue to evaluate what medications were necessary. "When there were some reports about her drug-seeking behavior, [Dr. Gardiner] continued to prescribe. When there was concern by third-party payers about his prescribing practices or by the orthopedic surgeon that he referred [Patient 2] to, there was no modification of [Dr. Gardiner's] practice." (Tr. Vol. I, 119-120)

Additionally, Dr. Macklin testified that Dr. Gardiner's treatment of Patient 2 fell below the minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Macklin stated that, with the exception of an effort to follow-up Patient 2's abdominal complaints with x-rays, there was not even a minimal physical exam documented in the charts to determine the causes of Patient 2's physical complaints. Moreover, Darvocet was prescribed on a regular basis without regard to its addictive potential and without exploring other treatment modalities for headaches. (Tr. Vol. I, 120-121)

10. Patient 3, female, d.o.b. 8-31-59, was a patient of Dr. Gardiner's from 8-15-89 until her last visit to his office on 8-7-91. During this time, she made numerous visits to Dr. Gardiner's office. (St. Ex. 12, pp. 7-16a) She died on 8-24-91 from an overdose of salicylates, codeine, and butalbital. (St. Ex. 12, p. 50)
11. Dr. Gardiner testified that his diagnoses on Patient 3 were "low back strain, sacral torsion on the left, numbness in the left leg and somatic dysfunction cranial." (Tr. Vol. I, 41)

Dr. Gardiner testified that he prescribed Tylenol 4, Soma, and Xanax to Patient 3. Dr. Gardiner stated that Tylenol 4 contains a full grain of codeine. He also prescribed Disalcid, which is a non-steroidal anti-inflammatory. Additionally, Dr. Gardiner prescribed Doxepin 100 mg. Dr. Gardiner said that he prescribed Doxepin as a sleeping pill "a good bit." (Tr. Vol. I, 37-39) When asked if he prescribed it for Patient 3 as a sleeping aid or as an anti-depressant, Dr. Gardiner [who had his medical records for Patient 3 in front of him] replied, "I imagine I used it for sleep. I see here I gave her 15 of 100 milligrams on 3-28-90, gave her 15, one at bedtime. I'm sure I used that for sleep." (Tr. Vol. I, 39) When asked if his medical records for Patient 3 reflected the purpose for the prescription, Dr. Gardiner replied, "Well, it says one at bedtime, and I'm sure that's the reason I used it at night to help her sleep." (Tr. Vol. I, 39)

Dr. Gardiner testified that he never suspected that Patient 3 was abusing the drugs that he prescribed for her. He stated that, after Patient 3 died, Patient 6, who was a friend of Patient 3, called Dr. Gardiner and told him that Patient 3 had been addicted to cocaine and had sold some of her medications. Dr. Gardiner stated that he had not been previously aware of those activities. (Tr. Vol. I, 39) He was also told that Patient 3 sold some of her medicine, which Dr. Gardiner was also unaware of. (Tr. Vol. I, 40)

Dr. Gardiner testified that Patient 3 "had the worst back problem of any person that came in. ... She would come in, and she'd complain of back pain more than anybody I ever had. I don't know whether she was using me or not, but on reflection I kind of feel that she was using me." (Tr. Vol. I, 40) Dr. Gardiner complained that he could never get x-rays though, because the Industrial Commission would not approve x-rays for Patient 3.

12. Dr. Macklin testified that the musculoskeletal diagnoses that were in Dr. Gardiner's medical records for Patient 3 were those to which Dr. Gardiner testified to. Dr. Gardiner treated Patient 3 primarily with Soma, Tylenol with codeine, Xanax, Darvocet, and doxepin (Sinequan). "The record does not document why any of these medicines are given in particular, and including the Sinequan." (St. Ex. 12, pp. 7-16a; Tr. Vol. I, 122-123) Dr. Macklin noted that, although the Sinequan was prescribed for use at bedtime, Soma and Xanax are also sedating and could have been used for that purpose. (Tr. Vol. I, 123)

Dr. Macklin referred to the following entries in Dr. Gardiner's medical records for Patient 3 concerning Patient 3's drug usage:

- The entry on 11-6-89, probably written by staff, said, "Someone called & said [Patient 3] is selling her meds and if you give her anything else they'll call the medical bureau on you." (St. Ex. 12, p. 9b; Tr. Vol. I, 124)
- An entry dated 11-17-89, again probably written by staff, starts out with the word "Note" written in large letters, and said, "[Patient 3] called and begged for meds. Said if she got meds she won't tell she got them from us. She also called Dr. Hopper & numerous times begged for meds. When Barb told her no she cussed her and hung up on her. (This happened while you were gone.)" (St. Ex. 12, p. 9b; Tr. Vol. I, 124)
- A note written between entries dated 3-12-90 and 3-28-90 said, "Big Bear Drug Store called 3-15-90. Said [Patient 3] called and said she was from Dr. Gardiner's office and to give her Tylenol #4, Soma, Xanax. The Lady at the Drug Store said it sounded like [Patient 3] and she was very

nervous so she ask to speak to the Dr. and she said he was busy so the Drugist [sic] said she got wise to her and would not fill the Rx." (St. Ex. 12, p. 10b; Tr. Vol. I, 124-125)

- A note dated 9-29-90 states, "[Patient 3] called and was so drugged she could hardly talk & said she got mugged & all her meds stolen." (St. Ex. 12, p. 12b; Tr. Vol. I, 126)
- A note dated 11-5-90 said, "Messageplex called & [Patient 3] called [Sunday] & wanted her Xanax. Service referred her to Emerg. room. Later that same day ... [Patient 3] called Dr. Little & wanted meds called in. When I called her back she said she wanted only her refill because her grandma is dying & she has to go out of town. I said NO." (St. Ex. 12, p. 13B; Tr. Vol. I, 126) Dr. Macklin noted that the next time Patient 3 came in, on 11-20-90, Dr. Gardiner prescribed Ceclor (an antibiotic), 42 Soma, 30 Xanax, and 42 Tylenol #4. The progress notes do not indicate why the Ceclor was prescribed. (Tr. Vol. I, 127)
- One note dated 8-12-91 said, "[Patient 3] sold meds to someone ... who overdosed on them. A man caller said if you give [Patient 3] any more meds he's turning you in. He's already called the police. (This message was on recorder)" (St. Ex. 12, p. 16a; Tr. Vol. I, 127)
- Another note dated 8-12-91 said, "A lady called today & taped her conversation with us stating that [Patient 3] is abusing her meds, selling them & giving them out to her friends. The lady said she is turning you in to the Medical Board for investigation." (St. Ex. 12, p. 16a; Tr. Vol. I, 127)

Dr. Macklin testified that Patient 3 died on 11-24-91. He stated that the toxicologist's report indicated that the level of salicylates, codeine, and butalbital were consistent with lethal administration. Dr. Macklin noted that Dr. Gardiner's progress notes for Patient 3 do not indicate that he prescribed butalbital for her. (St. Ex. 12, pp. 50-57; Tr. Vol. I, 128)

Dr. Macklin testified that Dr. Gardiner's care and treatment of Patient 3 constituted a failure to use reasonable care discrimination in the administration of drugs, based upon the numerous indications that Patient 3 was abusing her medication. (Tr. Vol. I, 130-131)

Dr. Macklin also testified that Dr. Gardiner's care and treatment of Patient 3 fell below the minimal standards of care for similar practitioners in the same

or similar circumstances. Dr. Macklin stated that some of the issues brought to light by notes that the office staff put into the charts should have been addressed. The standard of care for a physician receiving such reports is, at the very least, to talk to the patient, and to note in the chart that the issues were discussed. (Tr. Vol. I, 131-135)

Further, Dr. Macklin stated that it would have been prudent to discontinue the medications that were being abused. He said that it is not good enough to substitute one abusable drug for another, since many of the medications are essentially interchangeable. For example Tylenol with codeine contains an opiate, and Darvocet contains propoxyphene, a synthetic opiate. Anyone addicted to one could easily substitute the other. For that reason, Dr. Macklin said he disagreed with Dr. Gardiner's method of switching medications to prevent abuse. "Doesn't work, it just doesn't work." (Tr. Vol. I, 132-134)

Finally, Dr. Macklin stated that it was inappropriate for Dr. Gardiner to continue to prescribe abusable drugs to Patient 3, in light of the information that Dr. Gardiner had concerning Patient 3's selling and abusing such medication. It was inappropriate to prescribe abusable drugs to such a patient without an overwhelming necessity for them. Dr. Macklin said that the appropriate course of action would have been to decrease the amount of medication taken by Patient 3, and to do so in a fairly short period of time. Alternatively, the patient should have been enrolled in a substance abuse program. (Tr. Vol. I, 134-135)

13. **Patient 4**, male, d.o.b. 7-29-61, was a patient of Dr. Gardiner's. Although Dr. Gardiner's billing records indicate that Patient 4 was a patient as early as 4-17-87, St. Ex. 13 did not contain any progress notes dated earlier than 5-14-90. (St. Ex. 13, pp. 32-44, 51) Nevertheless, Patient 4 visited Dr. Gardiner on numerous occasions between 5-14-90 and 9-2-92, usually more than once per month. Dr. Gardiner prescribed or administered one or more of the following medications to Patient 4 at nearly every visit: Fioricet, Soma, Percocet, Vicodin, and Tylenol with codeine. (St. Ex. 13, pp. 32-44)
14. Dr. Gardiner testified that Patient 4 lost his wife, and was jobless, and that his family refused to support him. "He slept in his car. He'd come to the office and sleep right out in front of the office, and nobody would befriend him at all. So I took care of him and tried to teach him that he is -- that the good Lord was going to look after him, nobody else would, and to have a little respect for himself. So that's why I tried to help Patient 4." Patient 4 attempted to commit suicide in March 1991. (Tr. Vol. I, 41-42)

Dr. Gardiner testified that Patient 4 had an industrial injury. He diagnosed Patient 4 as suffering from:

[L]umbar strain, pelvic torsion, sacral torsion, that's where the sacrum, the base of the spine, is in torsion.

He had left piriformis tight, that was what was giving him his left -- neuritis in his left leg, he had retrolisthesis of L5 on S1, that's where one vertebrae slips on the other, usually is arthritis in that condition.

He also had instability of the lumbar spine at L3-4, L4-5, he had disk narrowing at L5-S1 and chronic traumatic lumbar ligamentous strain.

(Tr. Vol. I, 42-43)

Dr. Gardiner testified that he treated Patient 4 with Soma, Fioricet, Robaxin, Vicodin, Percocet, Zantac, and Sinequan. Concerning Dr. Gardiner's prescription of Sinequan for Patient 4, Dr. Gardiner testified that it helped Patient 4 rest and also helped his depression. "He slashed his wrists once or twice. I found that most patients that slash their wrists, all they want is attention, so I never really felt that he was trying to commit suicide." (Tr. Vol. I, 43) Dr. Gardiner stated that he eventually got Patient 4 on Fioricet (and Soma), which Dr. Gardiner testified was the least addicting drug that was effective. Dr. Gardiner stated that Patient 4 was eventually able to go back to work as a truck driver. (Tr. Vol. I, 43-44)

When Dr. Gardiner was asked if he ever had any reason to believe that Patient 4 was addicted to drugs, or was abusing the drugs that Dr. Gardiner prescribed for him, Dr. Gardiner replied that Patient 4 had a very forceful personality, and was difficult to reason with. Dr. Gardiner stated that he had to get rid of Patient 4 as a patient. He acknowledged that Patient 4 took a lot of Fioricet, but Dr. Gardiner believed that Patient 4 needed it so that Patient 4 could work. (Tr. Vol. I, 44-45)

15. Dr. Macklin testified that the musculoskeletal diagnoses that he found in Patient 4's chart were consistent with Dr. Gardiner's testimony. (Tr. Vol. I, 135-136)

Dr. Macklin noted Patient 4 was hospitalized in March 1991 after cutting his wrists attempting suicide. At the time Patient 4 was discharged from the

hospital, the psychiatrist gave two diagnoses: "adjustment reaction with mixed emotional features," and "chronic substance abuse/addiction (prescription medication for pain, Soma, Fioricet, Xanax, Percocet, et cetera)." (St. Ex. 13, pp. 3, 17; Tr. Vol. I, 137)

Dr. Macklin further noted that Patient 4 again visited the emergency room on 5-7-91, and the physician at that time noted a clinical impression of drug intoxication. The following day he released himself from the hospital against medical advice. (St. Ex. 13, pp. 24-25; Tr. Vol. I, 137-139)

Dr. Macklin referred to the following entries contained in Dr. Gardiner's progress notes for Patient 4:

- On 6-12-90 it was noted that "[Patient 4] said he lost his pills at his brother's house, his wife flushed them." (St. Ex. 13, p. 32 (back); Tr. Vol. I, 139)
- A note dated 6-13-90 said, "[a female relative of Patient 4] called and said [Patient 4] took all his pills. When she tried to stop him, he beat her up. She called to stop him from getting more pills, but [Patient 4] already had them." (St. Ex. 13, p. 32 (back); Tr. Vol. I, 139)
- A note dated 1-8-91 said, "Police confiscated meds 1-7-91" (St. Ex. 13, p. 36 (back); Tr. Vol. I, 139)
- A note dated 3-15-91 said, "[Patient 4] cut his wrists Wed 3-13 trying to kill himself. Doc has talked to [Patient 4] 3/14 & 3/15 regarding this suicide attempt. On 3/15 [Patient 4] reportedly took a bunch of meds & drank poison. Doc sent [Patient 4] to Dr. West Hosp. to see Dr. Pelt. We are to call PRS Katherine @ ... if he is to be admitted. This has to be done within 24 hrs. of admition [sic]." This note is followed by, "BWC [Ohio Bureau of Worker's Compensation] says if you give any meds you will be held responsible for anything [Patient 4] does to hurt himself or anyone else. NO MEDS Allowed!" (St. Ex. 13, p. 37 (back); Tr. Vol. I, 140)
- On 5-8-91, Patient 4 again presented to the hospital, this time with a complaint of hematemesis (vomiting blood). It was noted in the discharge summary that Patient 4 was a difficult patient who regularly insisted on being given narcotic medication for his back pain. He refused a psychiatric appointment or pain clinic appointment. He was discharged on 5-16-91,

and given 30 Percocet by the hospital at that time. He was referred back to the care of Dr. Gardiner. (St. Ex. 13, pp. 30-31; Tr. Vol. I, 140-144)

Dr. Macklin testified that Patient 4 was a difficult patient to deal with. It appeared to Dr. Macklin that the attending physician at the hospital was just interested in getting Patient 4 stabilized, and letting Dr. Gardiner deal with his drug-seeking behavior. Dr. Macklin testified that Dr. Gardiner continued to prescribe Fioricet, Percocet, and Soma to Patient 4 through 1991 and 1992. (Tr. Vol. I, 144-145) (It bears mentioning at this point that the Hearing Examiner could not find any instance of prescribing of Percocet to Patient 4 by Dr. Gardiner after Patient 4's May 1991 hospitalization. However, Dr. Gardiner prescribed 10 Vicodin, a Schedule III controlled substance, on two occasions: 9-9-91 and 9-30-91. [St. Ex. 13, pp. 40 (front and back)])

16. It is worth noting that Fioricet, which contains butalbital 50 mg., acetaminophen 325 mg., and caffeine 40 mg., is not a controlled substance. Nevertheless, the manufacturer's product information included a warning that butalbital is habit-forming and potentially abusable. Paradoxically, Fiorinal, which contains butalbital 50 mg., aspirin 325 mg., and caffeine 40 mg., is a Schedule III controlled substance. (Board Exhibits A and B)
17. In addition to those mentioned by Dr. Macklin, the following entries appear in Dr. Gardiner's medical records for Patient 4:
 - 5-21-91: "On 5-16-81 when released from hospital Dr. Mitchell gave [Patient 4] Percocet 5 #30 1q4 hrs. PRN Serax 30 mg. #30 & Carafate 1 gram. On 5-20-91 has started aggravating Dr. Mitchell's office for more drugs. Dr. Mitchell will not fill any more meds for him. (St. Ex. 13, p. 39 (back))
 - 7-22-91: Patient 4 received 30 Fioricet, to take one every 4 hours. (St. Ex. 13, p. 39 (back))
 - 7-25-91: Note on chart said, "just got meds Monday" with an arrow pointing to the 7-22-91 date, which was circled. Nevertheless, Dr. Gardiner prescribed, among others, 30 Soma 350 mg. and 30 Fioricet.
18. Dr. Macklin testified that someone who has attempted suicide once is more likely to attempt it again than someone who has never tried in the first place. Additionally, Dr. Macklin stated that substance abusers are at higher risk for suicide, because it decreases inhibitions to act, and because the CNS depressant

effect of these substances can make someone who already feels bad feel even worse. (Tr. Vol. I, 145-147) A CNS depressant "exacerbates a mood someone has in advance." (Tr. Vol. I, 147) Nevertheless, the only indication in Dr. Gardiner's medical records for Patient 4 that Dr. Gardiner referred Patient 4 to a psychiatrist was at the time Patient 4 made the attempt. Dr. Macklin testified that it was below the standard of care for Dr. Gardiner to continue to prescribe abusable drugs to Patient 4 without taking other action, "because it certainly sets the patient up for another suicide attempt." (Tr. Vol. I, 147)

Dr. Macklin did not agree with the notion that Patient 4 cut his wrists merely as a means of getting attention. (Tr. Vol. I, 147-148)

Dr. Macklin testified that Dr. Gardiner's care and treatment of Patient 4 constituted a failure to use reasonable care discrimination in the administration of drugs, because of Patient 4's history of attempted suicide and drug dependence. (Tr. Vol. I, 148-149)

Dr. Macklin testified that Dr. Gardiner's care and treatment of Patient 4 fell below the minimal standards of care. "I think similar practitioners would have addressed the addiction problem and would have at least made note of whether he was depressed, suicidal, at some subsequent point in the record." Continued prescribing of controlled substances was also a problem. (Tr. Vol. I, 149)

19. Dr. Gardiner stated that **Patient 5** was an industrial case. He testified that he diagnosed her as having arthritis in her spine, as well as carpal tunnel syndrome on her right.

She had chondromalacia of the medial condyle of the patella, she had that scraped a time or two and still had a lot of pain in her knee. She had migraine headaches, her right piriformis was tight, her spine was in a scoliosis, had neuritis in her right leg, had sacral torsion, the iliopsoas was tight on the right side, her right -- she had a right shoulder-hand syndrome, hysterical neurosis and conversion reaction, hypertrophic changes of the lumbar facets, central disc bulge at L4-L5, scoliosis, and arthritis of the right knee.

(Tr. Vol. I, 45-46)

Dr. Gardiner further testified that Patient 5 was very emotional. He referred her to a psychiatrist who diagnosed her as suffering from hysterical neurosis. (Tr. Vol. I, 46)

Dr. Gardiner testified that “[Patient 5’s] husband was a preacher and we went over her medications a number of times, he thought she was getting addicted several times and he [husband of Patient 5] reduced her medications. She was on Tylenol quite -- Tylenol with codeine quite a bit, and we got her down to Tylenol one quarter grain was finally the lowest dose we could get her on that she’d still be fairly comfortable, so we went over her medications a number of times and talked to her, and that was the lowest dose I could get her on that she’d stay comfortable.” (Tr. Vol. I, 46-47)

Dr. Gardiner also treated Patient 5 with Stadol nose spray, which he testified was effective for migraines. Dr. Gardiner testified that he has not had trouble with patients getting addicted to Stadol. He also treated Patient 5 with Sinequan on occasion. When asked if the Sinequan was prescribed for depression or for sleep, Dr. Gardiner replied, “Probably for sleep. I use a good bit of Sinequan for sleep. It’s noncontrolled and I don’t have to get into habit-forming drugs with it. (Tr. Vol. I, 48)

When Dr. Gardiner was asked if he was aware that Patient 5 had in the past been treated for drug dependency, he replied, “Well, I imagine she had been since she was on codeine probably most of her -- most of the time that I treated her.” Additionally, Dr. Gardiner stated that Patient 5 had a very low pain threshold. (Tr. Vol. I, 48)

Dr. Gardiner testified that Patient 4 is no longer a patient. Dr. Gardiner testified that when the Medical Board charges came out, he got rid of any patients that he had. “It was a good way to get rid of all my chronics.” (Tr. Vol. I, 47-48)

20. Dr. Macklin testified that the diagnoses concerning Patient 5 that appear in Patient 5’s medical records are consistent with Dr. Gardiner’s testimony. Medications prescribed to Patient 5 were Soma, Fioricet, Xanax, Tylenol with codeine, Stadol nasal spray, and Sinequan.

Dr. Macklin drew attention to the following entries in Dr. Gardiner’s medical records for Patient 5:

- A note dated 8-22-88 said, “Dr. Kahn called & [Patient 5] was in asking for her meds.” (St. Ex. 14, p. 21a; Tr. Vol. I, 150-151)
- A note dated 3-9-89 said, “[Patient 5] called. Said her purse got grabbed at Cub food and her Rx. was in them. Dr. gave her more this time.” (St.

Ex. 14, p. 17b; Tr. Vol. I, 151) She was prescribed 30 Fioricet and 30 Soma 350 mg. that date. (St. Ex. 14, p. 17b)

- A note dated 4-27-89 said, "90 soma & fioricet in 7 days." (St. Ex. 14, p. 16a; Tr. Vol. I, 151) On that date, Patient 5 was given Xylocaine and prescribed 30 Sinequan 150 mg., 30 Soma 350 mg., and 30 Fioricet. (St. Ex. 14, p. 16a)
- A note dated 10-27-89 said, "Doctor Kaplan's office hasn't given [Patient 5] any meds since 87 because they got fed up with her and also they found out she was coming here also. They will never give her any meds again." (St. Ex. 14, p. 12a (emphasis original); Tr. Vol. I, 151-152)
- A note dated 11-21-89 said, "Pt. lied about meds, she shouldn't get any more controlled [sic] meds per Doc." Nevertheless, Dr. Macklin stated that Dr. Gardiner prescribed Tylenol No. 4 to Patient 5 on 1-23-90, and on other occasions. Dr. Macklin also noted that Patient 5 continued to receive Soma, which is noncontrolled. He also noted that Patient 5 continued to receive Fioricet, which he mistakenly identified as a controlled substance. (St. Ex. 14, pp. 12a, 11b; Tr. Vol. I, 152-153)

It appears that Patient 5 was prescribed 30 Tylenol No. 4, among other things, on 12-27-89, 1-2-90, 1-9-90, 1-15-90 (after having received 30 Fioricet on 1-12-90), 1-19-90 (after having received 30 Fioricet on 1-18-90), 1-23-90, 1-27-90, 2-4-90 (after having received 30 Percocet on 2-1-90), 2-11-90 (after having received 30 Percocet on 2-8-90), 2-19-90, 3-7-90, 3-12-90, 3-16-90, 3-19-90, 3-26-90, 3-29-90, 4-2-90, 4-5-90, 4-9-90, 4-12-90, 4-16-90, 4-19-90, 4-23-90, 4-26-90, 4-30-90, 5-3-90, 5-7-90, 5-10-90, 5-14-90 (quantity 42) (after having received 1 cc. Stadol on 5-11-90), 5-21-90 (quantity 42) (after having received 30 Fioricet on 5-17-90), 5-25-90 (quantity 20), 5-29-90 (quantity 25), 6-1-90 (quantity 25), 6-4-90 (quantity 21), 6-7-90 (quantity 21), 6-11-90 (quantity 40), and so on. There are also numerous prescriptions for Soma 350 mg., as well as occasional prescriptions for Xanax 1 mg. (St. Ex. 14, pp. 12a-8b)

- A note dated 2-23-90 said, "Dr. Little called & [Patient 5] was in the office & wanted soma & tylenol 4." (St. Ex. 14, p. 10a; Tr. Vol. I, 153)
- An emergency room sheet from Mt. Carmel East indicated that Patient 5 presented there on 9-9-90 complaining of left flank pain. It was noted on the sheet that Patient 5 had presented to that facility numerous times in the past for migraine headaches, and in October 1989 for a near-fatal drug overdose. (St. Ex. 14, pp. 26-27)

- A note dated 6-29-92 said, "Crosby [Drugs] called & said on Fri [Patient 5's] husband called & she had taken all of her Fioricet & was sick. Her husband was concerned over the amount of meds given her. Crosby suggests you cut her down." (St. Ex. 14, p. 84b; Tr. Vol. I, 153-154)

On 7-6-92, Patient 5 received prescriptions for 42 Tylenol No. 4 and 42 Soma 350 mg. On 7-10-92, she received 30 Premarin 1.25 mg (estrogen) and 30 Ativan 1 mg. On 7-20-92 Patient 5 received 42 Tylenol No. 4, 42 Soma 350 mg., and 30 Sinequan 150 mg. On 7-31-92, she received 30 Ativan 1 mg., 42 Soma 350 mg., and 42 Tylenol No. 4. Such prescribing continued thereafter, although Dr. Gardiner prescribed Tylenol No. 3 on 9-2-92, and Tylenol No. 2 on 10-5-92 and thereafter. Tylenol No. 2 contains a smaller quantity of codeine than Tylenol No. 4. (St. Ex. 14, pp. 84b-79a; Tr. Vol. I, 158)

- Dr. Macklin noted that Patient 5 had been diagnosed in 1982 by a psychologist as suffering from a conversion hysteria. A conversion hysteria is a mental disorder that converts emotional factors into physical symptoms. However, Dr. Macklin stated, "I don't know what it referred to for this patient, because I don't have anything to go on beyond just the diagnosis." (St. Ex. 14, pp. 123-126; Tr. Vol. I, 154-156)
- Dr. Papp, an orthopedic surgeon, wrote a letter to Dr. Gardiner dated 8-19-92, in which Dr. Papp reported his findings concerning his evaluation of Patient 5. Dr. Macklin testified that, among Dr. Papp's diagnoses, there was a diagnosis that there were "psychological factors affecting physical condition, as well as a diagnosis of chronic pain." (St. Ex. 14, p. 125; Tr. Vol. I, 156-157) Dr. Papp expressed an opinion in his letter that Patient 5 needed psychological or psychiatric care, and that it was unlikely that manipulative therapy or other such modalities would be of much help. He suggested referring Patient 5 to the chronic pain clinic at Ohio State University for evaluation and treatment. Dr. Papp further recommended that Patient 5 be taken off narcotics and be given Tylenol Extra Strength instead. (St. Ex. 14, pp. 123-126; Tr. Vol. I, 157-158)

Dr. Macklin testified that under these circumstances, the standard of care for a family physician would require the physician to at least acknowledge the consultant's comments, and to either note how the family physician intended to deal with the problem, or refer the patient to someone else. Dr. Macklin stated that if the family physician had made repeated attempts to refer the patient to, for example, a psychiatrist, but the patient

refused to cooperate, most family physicians would try to treat the problem themselves, but there would be documentation of that fact. There was no documentation here. (Tr. Vol. I, 160-161)

- Dr. Macklin testified that an operative note was prepared by a Dr. Murphy following a cystoscopy on Patient 5 on 1-11-93. It is stated therein that the anesthesiologist found out from Patient 5's husband that Patient 5 had "a history of taking large amounts of Percocet over a long period of time, supposedly for migraine." (St. Ex. 14, pp. 105-106; Tr. Vol. I, 158-159)
- A note dated 5-13-93 said, "[Patient 5] going away for 7 days. Brother w/ heart attack. Wanted enough Stadol all at one time. We gave her 2 vials." In the margin it was noted, "Crosby's called." (St. Ex. 14, p. 79a; Tr. Vol. I, 159)
- An undated note below an entry dated 7-20-93 said, "[Patient 5] is going to her Mom's. She's ill. She wants to pick up her refill early. Doc hesitated but said ok. Called Rx ... Rite Aid. [Patient 5] was in hurry to get home & stopped by Rite Aid. Not Crosby's." (St. Ex. 14, p. 79b; Tr. Vol. I, 159-160)

Dr. Macklin testified that Dr. Gardiner failed to use reasonable care discrimination in the administration of drugs. Evidence of Patient 5's abuse of the drugs that Dr. Gardiner was prescribing to her was repeatedly documented in Dr. Gardiner's medical records for Patient 5. Moreover, there were references in the medical records of consultants who advised against the prescribing of such drugs. In spite of that, Dr. Gardiner made no attempt to discontinue prescribing abusable and addicting drugs to Patient 5. (Tr. Vol. I, 161)

Dr. Macklin testified that Dr. Gardiner's treatment of Patient 5 fell below the minimal standards of care of similar practitioners under the same or similar circumstances, because "a similar practitioner would have addressed many of these issues, or at least noted an attempt to address them." (Tr. Vol. I, 161-162)

21. Dr. Gardiner testified that **Patient 6**, male, d.o.b. 1-7-57, was an industrial case. Patient 6 was a truck driver who suffered from "cervical, Dorsal, and bilateral sprain and strain... . He had lacerations of his little finger on his right hand. Also I sent [Patient 6] to a specialist, and he said he had a right reflex sympathetic dystrophy of his right fifth finger. He evidently had a good deal of pain in that hand." Dr. Gardiner testified further that "I tried him on several different drugs, had him on Soma, Darvocet N, Disalcid, Tylenol 4 and Sinequan, and Halcion occasionally." Dr. Gardiner said that Patient 6 was on these medications off and on. "The PDR says that you should give any

controlled substance for short periods of time, so that's what I did, and I tried to switch him off and on so he wouldn't get addicted to anything." (St. Ex. 15, p. 58; Tr. Vol. I, 49)

Dr. Gardiner stated that, towards the end of his treatment of Patient 6, Patient 6's mother called Dr. Gardiner. "I guess she was concerned about him, and when she called, why, I cut him off any controlled substances at all." This occurred in September 1991, at which time Dr. Gardiner referred Patient 6 to a pain clinic. Dr. Gardiner testified that Patient 6 came in one more time after that, on 1-24-92, at which time Dr. Gardiner prescribed Darvon "to help him taper off the medication." (St. Ex. 15, pp. 26-27; Tr. Vol. I, 49-50)

When asked if he kept different charts on the same patient for different industrial cases, Dr. Gardiner acknowledged that he did. In instances when the patient was getting treatments for two different conditions, Dr. Gardiner testified that the Industrial Commission would not pay him for two conditions on the same day, so he would have the patient come on a different day to have a second condition treated. (Tr. Vol. I, 52-53)

22. Dr. Cook testified that Dr. Gardiner's medical records for Patient 6 consisted of two charts. The first chart covered the period from October 1989 through January 24, 1992. The second chart covered the period from October 17, 1989, through October 13, 1991. Dr. Cook said that there were numerous instances of duplicate dates of service noted on the two separate charts. (Tr. Vol. II, 21)

Dr. Cook testified that the chart that begins on page 58 of St. Ex. 15 did not include any medical examination, evaluation, assessment, or diagnosis. Dr. Cook stated that, although there is a consultant's report at St. Ex. 15, page 67, that indicated that Patient 6 had suffered a laceration of the right little finger, no diagnosis actually appears in Dr. Gardiner's records. (Tr. Vol. II, 21-25) [The Hearing Examiner noted during his review of the records that the words "Laceration - little finger on right hand," or similar verbiage, appears on the front of several patient ledgers. (St. Ex. 15, pp. 70-73)]

Dr. Cook testified concerning Dr. Cunningham's 10-16-91 report that appears in St. Ex. 15, pages 67 through 69. In that report, Dr. Cunningham, whose specialty appears to be occupational and preventative medicine, expressed his opinion that Patient 6 had reached his maximum level of recovery from his injury to his right little finger, which had occurred on 7-21-89. Dr. Cook quoted Dr. Cunningham's report: "[Patient 6] does not require rehabilitation, referral at this time, and he does not require any medication in reference to this claim, and he has not required any since three weeks postoperatively.

11/22/91 10:07
[Patient 6 had undergone outpatient microscopic surgery on 7-31-89. (St. Ex. 15, p. 67)] On the basis of this claim and this claim only, this individual does not require an analgesic or tranquilizer medication. These statements are made with all medical probability and certainty. In reference to this claim and this claim only, this individual is fully employable without restrictions, and has been since 1989, in my medical opinion.” (St. Ex. 15, p. 69; Tr. Vol. II, 25-26)

The medical records that Dr. Gardiner kept for Patient 6’s injury to his little finger begin in October 1989 and end on January 24, 1992. Dr. Cook stated that the records consist largely of a listing of the medications prescribed to Patient 6, “basically combinations of Soma, Darvocet, Xanax, [and] Halcion... .” Dr. Cook testified that he believes that Dr. Gardiner’s prescribing of controlled substances and Soma was excessive, considering the injury. “I would concur with Dr. Cunningham’s evaluation for someone who had a lacerated finger; rarely would pain be prolonged over years related to an injury like this, and thus the frequency and the duration of treatment is unwarranted.” (St. Ex. 15, pp. 58-64; Tr. Vol. II, 26-27)

Dr. Cook noted that Patient 6 had received an earlier consult from Dr. Kerr, a hand surgeon, on 11-30-89. Dr. Kerr sent Dr. Gardiner a report dated that same day. Dr. Kerr informed Dr. Gardiner that “with this injury [Patient 6] ought to be able to return to just about any type of employment and certainly return to work that he was doing before. To reiterate once again, if [Patient 6] feels he can’t do it I would enroll him in the Industrial Commission’s job work hardening program and if that fails, [Dr. Gardiner] might think about retraining. I can’t imagine that it would [fail].” (St. Ex. 15, p. 92; Tr. Vol. II, 28-31)

The medical records that begin on page 1 of St. Ex. 15 include a diagnosis of “cervical dorsal and bilateral sprain and strain as well as contusion of the rib cage.” Dr. Cook testified that he would not characterize these diagnoses as chronic problems. (Tr. Vol. II, 23) Dr. Cook said that the treatment that Dr. Gardiner rendered in this chart was “pretty identical treatment for what [Patient 6] received for the laceration of his finger,” namely, Darvocet, Soma, Xanax, and Halcion. (Tr. Vol. II, 28)

Dr. Cook drew attention to a letter written by Dr. Gardiner dated 9-20-91. In this letter, Dr. Gardiner stated that Patient 6 was ready for drug rehabilitation to withdraw from medication that he was taking for his industrial accidents. Dr. Gardiner stated that he weekly prescribed 50 Darvocet N-100, 50 Soma 350 mg., 30 Xanax .5 mg. to Patient 6, and sometimes additionally prescribed 30 Halcion .25 mg. as a sleep aid. Dr. Gardiner noted that Patient 6 had been

starting to overdo his drug usage. Dr. Cook said that "Dr. Gardiner adequately assessed the patient, that [Patient 6] did have some drug dependence, and this was mostly due to the medications that he was being prescribed." (St. Ex. 15, p. 27; Tr. Vol. II, 31-32) Dr. Cook noted that Patient 6 did not see Dr. Gardiner from that time until 1-24-92. (Tr. Vol. II, 33)

When Patient 6 did return to Dr. Gardiner on 1-24-92, he received prescriptions for 50 Darvocet N-100 with 1 refill, 50 Soma 350 mg. with 1 refill, and 30 Sinequan 25 mg. There was a note on the 1-24-92 entry that said, "Prescriptions given to help pt. taper off medication." (St. Ex. 15, p.59) Dr. Cook testified that most people would find fault with the idea of giving a patient the same medicines he was addicted to, after such a long interval, to help him taper off. In general, if a physician wants to taper a patient off medication, "[y]ou wouldn't give him a refill." (Tr. Vol. II, 34-35) The physician should instruct the patient to take a pill once every eight hours for a couple days, then once every 12 hours, then once a day, "but to give a refill would be, again, promoting their addiction, it would be very difficult under these circumstances to taper them." (Tr. Vol. II, 35) The physician would have to follow the amount that the patient was using very carefully, perhaps to the point of giving the patient the medication at the physician's office or having someone else direct the patient's care. (Tr. Vol. II, 35)

Dr. Cook testified that Dr. Gardiner's prescribing in the case of Patient 6 constituted a failure to use reasonable care discrimination in the administration of drugs, based on the nature of Patient 6's injury and the duration of the therapy. (Tr. Vol. II, 36)

Dr. Cook also testified that Dr. Gardiner's care and treatment of Patient 6 fell below the minimal standards of care, because "the diagnosis didn't warrant the treatment that was rendered." (Tr. Vol. II, 36)

23. Dr. Gardiner testified that **Patient 7** suffered from low back pain, arthritis, degenerative joint disease, COPD, chronic gastritis, anemia, hypertension, and was post MI. He fell two stories and landed on his back. (Tr. Vol. I, 53-54)

Dr. Gardiner stated that he did not think that Patient 7 abused his medications. Dr. Gardiner prescribed "Dennatal, had him on a little Soma once in a while, Fiorinal 3 and Tylenol 4, I tried to cut his codeine down as much as I could." (Tr. Vol. I, 55)

24. Dr. Cook testified that Dr. Gardiner's medical records for Patient 7 indicate that Patient 7 suffered from degenerative joint disease, including low back

pain, arthritis of all fingers and the right wrist, and chronic obstructive pulmonary disease. The only examination took place on 1-7-80. Dr. Gardiner's records primarily list medications prescribed. The medications that Dr. Gardiner prescribed for Patient 7 consisted of varying combinations of Percodan, Talwin, Fiorinal No. 3, Sinequan, Tylenol No. 4, Soma, Dicyclomine, Donnatal, and vitamin B-12 injections. (Tr. Vol. II, 37-38)

Dr. Cook testified concerning entries contained in Dr. Gardiner's medical records for Patient 7:

- A note dated 3-2-92 said, "Someone called & said that [Patient 7] has heart problems & takes too many Soma. He usually takes most of them (Soma) at the same time." (St. Ex. 16, p. 5) (emphasis original)

Dr. Cook said that after getting a message like that, the physician has to address medication usage with the patient. The patient is overdosing on his medication. "There are acute toxicity syndromes associated with taking Soma. And there would be a particular concern in a patient who has heart or lung problems, that would be a concern." (Tr. Vol. II, 38-39)

Dr. Gardiner's medical records do not indicate that this problem was ever addressed. In fact, Dr. Gardiner prescribed 80 Soma 350 mg. to Patient 7 on 3-12-92, 60 Soma 350 mg. (and 42 Fiorinal No. 3) on 4-1-92, and on numerous occasions thereafter. (St. Ex. 16, pp. 5(back) to 2)

- A note dated 5-12-92 said, "MEDS NOT DUE UNTIL FRIDAY." (St. Ex. 16, p. 5(back))

Dr. Cook testified that this was after a prescription and refill for Fiorinal No. 3, Soma, and Dicyclomine were given to Patient 7 [on 5-1-92]. (St. Ex. 16, p. 5(back); Tr. Vol. II, 39-40)

- A note dated 8-6-92 said, "Wanted Tyl 3 or 4 or Percocet called in at [phone #]" (St. Ex. 16, p. 4(back))

Dr. Cook pointed out that, according to the preceding entry dated 7-27-92, Patient 7 had received prescriptions for 42 Fiorinal No. 3 with one refill, 100 Dicyclomine 20 mg., and 60 Soma 350 mg.

- A note dated 11-20-92 said, "Told [Patient 7] to call back the 24th. Should [or Would] have enough Fiorinal til 24th. He was in the 17th." (St. Ex. 16, p. 2(back))

Dr. Cook noted that on 11-17-92 Patient 7 had received prescriptions for 42 Fiorinal No. 3, 60 Soma 350 mg., Dicyclomine, and some other substance whose name is illegible. It therefore appears that Patient 7 was given 42 Fiorinal, and then was looking for more three days later. Dr. Cook described this as "very excessive" usage. (Tr. Vol. II, 41-42)

It appears that a prescription for 42 Fiorinal No 3 was called in for Patient 7 on 11-24-92. (St. Ex. 16, p. 2(back))

- A note dated 1-26-93 said, "Pt. was drinking when he came in the office." (St. Ex. 16, p. 2; Tr. Vol. II, 42)

Dr. Cook stated that an event like that should cause concern on the doctor's part about the interaction between alcohol and the drugs that Patient 7 was being prescribed. Dr. Cook would be concerned about the interaction of alcohol with Soma, and with CNS depressant drugs. (Tr. Vol. II, 42-43)

Dr. Cook testified that Dr. Gardiner used poor care discrimination in his prescribing, and overprescribing, of drugs to Patient 7. (Tr. Vol. II, 43)

Dr. Cook further testified that Dr. Gardiner's care and treatment fell below the minimal standards of care, because of the number of prescriptions given. (Tr. Vol. II, 43)

25. Dr. Gardiner testified that **Patient 8** was an industrial case. Dr. Gardiner treated him for:

[F]irst degree spondylolisthesis at L5-S1. Now, that's a slippage of the last vertebrae on the sacrum, and that would cause a lot of pain in the legs, probably a lot of arthritis in that area, too.

He had sprain and strain of the low back, he had strain and sprain to his shoulders, dorsal and cervical sprain, sacral torsion to the right, somatic dysfunction of the cranial area.

He also had a lot of headaches, he had right sciatic neuritis due to the -- due to piriformis being tight in one hip, he had pelvic torsion and chronic infection of the right ethmoid.

(Tr. Vol. I, 55)

Dr. Gardiner did not have any reason to believe that Patient 8 was abusing his medications. "He took his medications as I prescribed them, and he never gave me any hassle at all." (Tr. Vol. I, 56) Dr. Gardiner testified that Patient 8 improved to the point that the Industrial Commission cut him off. (Tr. Vol. I, 56)

26. Dr. Cook testified that Dr. Gardiner's dates of service for Patient 8 spanned between 4-12-89 through 11-7-93. Dr. Cook stated that the initial visit related to an industrial injury that apparently occurred on 1-16-87, based on reports from BWC— Dr. Gardiner's records did not include the date of injury. Further, Dr. Gardiner's records did not mention the obtaining of Patient 8's records of treatment up to 4-12-89. Moreover, Dr. Cook testified that the records do not document the nature of Patient 8's symptoms, and there is no physical examination charted. (Tr. Vol. II, 43-45)

Patient 8 was prescribed Soma, Darvocet N-100, Naprosyn, and physical therapy. Patient 8 also received Fioricet and Mono-Gesic. Dr. Cook noted that on 4-19-89 Patient 8 requested Vicodin or Fiorinal No. 3 for severe back pain, and was told to take Extra Strength Tylenol. (Tr. Vol. II, 45-46)

Dr. Cook testified that in the time period of April and May 1989, Patient 8 was receiving the following abusable or controlled substances: Darvocet, Darvocet N-100, Soma, and Xanax. (Tr. Vol. II, 46)

Dr. Cook testified that Dr. Gardiner referred Patient 8 to an orthopedist on 5-25-89, which was appropriate. (St. Ex. 17, p. 111(back); Tr. Vol. II, 47)

Dr. Cook testified that Patient 8 was started on Stadol injections on 1-25-90. There was no documentation of an exam, nor a reason documented for the change in therapy. There was no indication in the file for giving Stadol injections to Patient 8. (St. Ex. 17, p. 106(back); Tr. Vol. II, 47-48)

Dr. Cook testified concerning entries contained in Dr. Gardiner's medical

records for Patient 8:

- A note dated 7-24-89 said, "Sheriff called from Indiana & was picked up for selling marijuana." Dr. Cook testified that a message such as this indicates that the patient may be selling his prescription medication as well. Nevertheless, on 8-4-89, Patient 8 was prescribed Soma, Darvocet, and Xanax. Such prescribing continued thereafter. (St. Ex. 17, pp. 110, 110(back); Tr. Vol. II, 48-49)
- An undated note between two entries dated 11-26-90 and 12-5-90 said, "Workman's Comp will not pay for any addictive meds and they will not pay for Stadol injects." (St. Ex. 17, p. 101 (emphasis original); Tr. Vol. II, 49)
- A notation written in the margin across an entry dated 1-14-91 said, "No addicting drugs!" (St. Ex. 17, p. 100 (emphasis original); Tr. Vol. II, 50) Dr. Cook interpreted these records to say that Patient 8 should not be receiving abusable drugs. Nevertheless, Patient 8 received Xanax on 1-28-91, and an injection for Stadol on 2-1-91.
- Dr. Gardiner received an undated notice from BWC that disapproved Patient 8 for payment for prescriptions for Xanax, Darvocet, and Tylenol No. 3. A handwritten comment on the notice states, "All these are addicting & therefore potentially harmful. These are to be tapered to zero over 4 wks & will not be auth thereafter." (St. Ex. 17, p. 5; Tr. Vol. II, 51-52)

Dr. Cook testified that Dr. Gardiner's prescribing practices concerning Patient 8 constituted a failure to use reasonable care discrimination in the administration of drugs. Dr. Cook said that his opinion was "based on the fact that the patient was definitely at high risk for abuse of narcotic medications based on his arrest for selling marijuana and his request for pain medications, and that neither of these issues were ever addressed by Dr. Gardiner." (Tr. Vol. II, 52)

Dr. Cook stated that Dr. Gardiner's treatment of Patient 8, fell below the minimal standards of care, because of "the lack of examination, evaluation, and assessment in addressing these issues regarding the patients pain medication. (Tr. Vol. II, 52)

27. **Patient 9**, male, d.o.b. 8-13-56, was a patient of Dr. Gardiner's. The Hearing Examiner was unable to determine when this patient first saw Dr. Gardiner. Billing records indicated that he was a patient before 7-14-89, because he had

a large balance due (\$1,013.00) prior to that date. Nevertheless, no progress notes were found that dated earlier than 1-24-90. The latest entry in the progress notes is dated 8-26-93. (St. Ex. 18)

As in other records, entries usually consist merely of a date, a list of therapies given, such as "Spinalator, Heat, Lin, Sound, OMT-C, Ind.," and a list of the drugs prescribed. Patient 9 visited Dr. Gardiner about once every two weeks. He was regularly prescribed Fiorinal until 4-10-90, after which he was regularly prescribed Fioricet. Patient 9 was also regularly prescribed Soma 350 mg. Patient 9 was occasionally prescribed Phenergan, Vicodin, or Percocet, as well as Advil, Prozac, or Sinequan. He also received Xylocaine injections on occasion. (St. Ex. 18, pp. 27-38(back))

28. Dr. Gardiner testified that Patient 9 was brother to Patient 4.

His diagnoses were traumatic headaches, he had a lot of migraine headaches, too, he had sacral torsion, pelvic torsion, his sphenoid was side bent to one side, he had dorsal and cervical strain.

He was on Motrin at one time, he was on Fiorinal caps, had Soma at one time, Vicodin, Phenergan for the nausea and stayed on nasal spray for his migraines, and he took mostly Fioricet. We settled on Fioricet mainly as the pill that seemed to control his headaches the best.

(Tr. Vol. I, 56-57)

Dr. Gardiner stated, "He seemed to be a person that couldn't tolerate much adversity, I suppose." (Tr. Vol. I, 57) However, Dr. Gardiner said that he did not seem depressed. "He just seemed to have chronic headaches that we just couldn't find any solution for." (Tr. Vol. I, 57-58)

29. Dr. Macklin testified that the musculoskeletal diagnoses that he found in Dr. Gardiner's medical records for Patient 9 were those to which Dr. Gardiner testified. Dr. Macklin stated that Patient 9 had suffered an industrial injury in February 1988 and had a past history of drug dependency.

Dr. Macklin testified that Patient 9's history of drug dependency was documented in a 6-5-91 letter to Dr. Gardiner from Dr. Moomaw, a psychiatrist. The letter indicated that Patient 9 had a history of polysubstance abuse extending back to the age of 15. The patient reported to Dr. Moomaw that he had been sober for seven years. Dr. Moomaw reported that he had

diagnosed Patient 9 as suffering major depressive symptoms. Dr. Moomaw placed Patient 9 on Prozac 20 mg., one per day, and instructed Patient 9 to return for follow-up care. Dr. Moomaw also thought that Patient 9's headaches were a physical manifestation of psychological difficulties. (St. Ex. 18, pp. 2-3; Tr. Vol. I, 162-165)

Dr. Moomaw did not indicate in his 6-5-91 letter that Patient 9 was suicidal. (St. Ex. 18, pp. 2-3)

Dr. Macklin testified that even though Patient 9's headaches were the result of psychic stress, the pain would still be real. Although it is a difficult judgment call, narcotic drugs could be appropriate if the patient is under great physical distress, but only on an acute basis. (Tr. Vol. I, 165-166) "[O]ngoing treatment with narcotics is not helpful for headaches, ... it just doesn't work." (Tr. Vol. I, 166) Moreover, Dr. Moomaw recommended ongoing psychiatric treatment as the appropriate course for this patient. Dr. Macklin testified that pain medications would not help to get rid of Patient 9's headaches. (Tr. Vol. I, 166)

Dr. Macklin testified that Patient 9's reported history of polysubstance abuse would make most physicians wary of prescribing anything to Patient 9 that could be abused. Dr. Gardiner, however, prescribed a number of such substances to Patient 9, namely: Soma, Fiorinal, Fioricet, Vicodin, Percocet, Xanax and Stadol NS. (Tr. Vol. I, 164)

Dr. Macklin testified that the substance abuse issue regarding Patient 9 was never addressed by Dr. Gardiner, and the issue of psychiatric treatment was not addressed correctly. (Tr. Vol. I, 167)

Dr. Macklin testified concerning entries contained in Dr. Gardiner's medical records for Patient 9:

- An undated note concerning a phone call from BWC indicated that BWC needed, within the week, a detailed up to date medical report concerning Patient 9's condition, and justification for continued drug prescribing. The note indicated that Patient 9's "excessive use of drugs is being investigated by BWC and Narcotics." His medications were not paid for occasionally "because the computer kicks out any thing that's over the prescribed dose." (St. Ex. 18, p. 8; Tr. Vol. I, 167)

Dr. Gardiner responded to the above note by letter dated 8-10-92. Among other things, he indicated that Patient 9 took no more than six Fioricet

per day, and six Soma per day, plus Advil, Prozac, and Phenergan. (St. Ex. 18, p. 11; Tr. Vol. I, 167-168)

- On 4-5-93, Patient 9 visited the emergency room at Doctors Hospital seeking refills of his pain medication. Patient 9 indicated that his family physician, whom he had attempted to visit that day, was out of his office until 4-12-93. Patient 9 reported that he took Soma, one tablet four times per day, Fioricet, one tablet four times per day, and Stadol NS as needed. The ER physician noted that he discussed chronic pain evaluation with Patient 9, and that Patient 9 was "very reluctant to alter his course of therapy." (St. Ex. 18, p. 4; Tr. Vol. I, 168-169) Nevertheless, Patient 9 expressed a willingness to schedule a follow-up appointment with a Dr. Massau. (St. Ex. 18, pp. 4-5; Tr. Vol. I, 169)

Dr. Macklin testified that Patient 9 had received a number of prescriptions on 3-15-93. He received Stadol spray with one refill, 42 Fioricet with three refills, and Soma, 60 (?-illegible), with one refill. Dr. Macklin agreed that if Patient 9 had run out of these medications by 4-5-93 that it would mean that Patient 9 was taking more medication than he was directed. (St. Ex. 18, p. 37; Tr. Vol. I, 170)

Dr. Macklin testified that Dr. Gardiner's treatment of Patient 9 constituted a failure to use reasonable care discrimination in the administration of drugs. Patient 9 had a history of substance abuse, and demonstrated continuing substance abuse during Dr. Gardiner's treatment by using an excessive number of medications. There was no attempt by Dr. Gardiner to control Patient 9's medication usage, or to wean him off addicting substances. (Tr. Vol. I, 170-171)

Furthermore, Dr. Macklin testified that Dr. Gardiner's treatment of Patient 9 fell below the minimal standards of care. Dr. Gardiner never addressed the issue raised in Dr. Moomaw's report concerning the psychological origin of Patient 9's headaches. Moreover, the diagnosis of whether or not Patient 9 actually suffered from migraines is not included in the chart. The letter that Dr. Gardiner wrote in response to BWC's concerns stated that the patient considered his headaches to be migraines. The letter should have said that Dr. Gardiner considered them to be migraines. Finally, there should have been documentation in the medical records describing the symptoms that led Dr. Gardiner to believe that Patient 9's headaches were migraines. (Tr. Vol. I, 171-172)

30. Dr. Gardiner testified that Patient 10 had a number of back problems. Dr. Gardiner treated Patient 10 with Darvocet N, Soma, Naprosyn, Xanax, Zantac, and Mobigesic. Dr. Gardiner stated that Patient 10 did not abuse his medications, and did not call him in between times of treatment. Dr. Gardiner tried to vary the medications that he prescribed so that Patient 10 wouldn't become addicted. (Tr. Vol. I, 58)
31. Dr. Cook noted that the dates of service for this patient were 8-29-89 through 9-2-93. Dr. Cook indicated that Patient 10 was first seen by Dr. Gardiner for an industrial injury that occurred on 7-16-88. Dr. Gardiner diagnosed Patient 10 with headaches, pelvic torsion, numbness outside right leg, trigger on left side of back, and sacral torsion. Treatment consisted of traction, heat, physical therapy, and drugs. Drugs prescribed were Darvocet N-100, Soma, Cortisone, Naprosyn, and Xylocaine injections. Dr. Cook testified that Dr. Gardiner's prescribing appeared excessive at times, particularly for Darvocet N-100. (Tr. Vol. II, 53-54)

Dr. Cook drew attention to specific entries contained in Dr. Gardiner's medical records for Patient 10:

- A undated note that appears above an entry dated 10-25-91 said, "Crosby is filling meds early. [Patient 10] isn't due for meds until 10-25-91. Pharmacy suggests not giving so many refills." Dr. Cook stated that this request was ignored; similar quantities and refills were prescribed at Patient 10's next visit and recorded in the entry dated 10-25-91. (St. Ex. 19, p. 21; Tr. Vol. II, 54-55)
- A note dated 6-29-92 said, "[Patient 10] called & wants more Darvocet-N called in. His wife tripped over a log & hurt her leg & she's been taking his meds. He is 10 days early." (St. Ex. 19, p. 22 (emphasis original); Tr. Vol. II, 55) Dr. Cook stated that this kind of scenario is indicative of drug-seeking behavior.

That same day, 6-29-92, Dr. Gardiner called in a prescription for Tylenol Extra Strength. At Patient 10's next visit on 7-9-92, however, he received prescriptions for 60 Soma 350 mg. with one refill, 60 Tylenol No. 4 with one refill, among other things. (St. Ex. 19, p. 22)

- A letter from Dr. Matrka, an orthopedist, states that Dr. Matrka believes Patient 10 to be capable of going back to work. Moreover, Dr. Matrka wrote, "I do not feel that this patient requires the chronic use of medications and follow-up occurring at approximate intervals of six

months would be adequate. I do not feel there is an indication for further therapy." (St. Ex. 19, pp. 8-9; Tr. Vol. II, 56)

Dr. Cook testified that, for 8-6-92 and thereafter, Dr. Gardiner continued to prescribe controlled substances or other drugs. "In fact, there was no alteration in the treatment of care plans for this patient." (Tr. Vol. II, 57)

Dr. Cook testified that Dr. Gardiner's prescribing of drugs to Patient 10 constituted a failure to use reasonable care discrimination in the administration of drugs, due to the types of drugs prescribed and the duration of therapy. (Tr. Vol. II, 57)

Dr. Cook further testified that Dr. Gardiner's treatment of Patient 10 fell below the minimal standards of care, for the same reasons noted in the preceding paragraph. (Tr. Vol. II, 57-58)

32. Dr. Gardiner testified that **Patient 11** "had a diagnosis of lumbar strain, arthritis of L2-L3, sacral torsion to the left and her right piriformis muscle tight which was giving her neuritis in one leg." Patient 11 was on Darvocet N, Soma, Disalcid, Phrenilin Forte, Naprosyn, Vistaril, Sinequan, Xanax, and Tagamet. Dr. Gardiner testified that the Sinequan was "[p]robably for sleep." Concerning the Xanax, Dr. Gardiner testified that Patient 11 was having marital problems, so Xanax was probably used for anxiety. (Tr. Vol. I, 59)
33. Dr. Cook testified that Dr. Gardiner's dates of service for this patient were from 3-18-86 through 8-10-93. The first visit took place on 3-18-86, but there was no follow-up until 7-15-88.

Patient 11 came to Dr. Gardiner for treatment for a work injury that occurred about May 1988. Dr. Gardiner diagnosed lumbar strain and pelvic torsion. Patient 11 saw Dr. Gardiner a number of times, but Dr. Cook testified that the first medical evaluation with history, physical examination and assessment occurred on 4-21-92. Dr. Cook stated that this appeared to have been necessitated by a request from BWC for documentation of the necessity of treatment. (Tr. Vol. II, 58-59)

Dr. Cook referred to entries in the medical records that indicate Patient 11 was seeking drugs. An entry dated 6-5-92 indicates that Patient 11 was driving the pharmacist crazy over a quantity of Soma that Patient 11 claimed the pharmacist owed her. Another entry dated 6-23-92 indicates that Patient 11 was seeing multiple physicians to obtain drugs. Dr. Cook stated that there was no response to these entries, merely a continuation of the

prescribing, which included Darvon and Sinequan. Dr. Cook could find no reason or indication for Sinequan in the medical records. (St. Ex. 20, p. 13(back); Tr. Vol. II, 59-61)

Dr. Cook drew attention to a report dated 2-3-93 from Dr. Hutchison, an orthopedist working for the Industrial Commission. Dr. Hutchison could find no objective evidence that Patient 11 suffered any degree of permanent partial impairment. (St. Ex. 20, pp. 35-36(back); Tr. Vol. II, 60-62)

Dr. Cook testified that Dr. Gardiner's prescribing of medication to Patient 11 constituted a failure to use reasonable care discrimination in the administration of drugs. "Based on the medical record review and overall substandard record keeping, there was little to no justification for the medications or physical treatments that were rendered to this patient, and the only documentation that did occur was at specific request by third-party interests. (Tr. Vol. II, 61-62)

Dr. Cook testified that Dr. Gardiner's treatment of Patient 11 fell below the minimal standards of care, for the same reasons as stated in the preceding paragraph. (Tr. Vol. II, 62)

34. Dr. Gardiner testified that Patient 12 had fractured his L2-L3 vertebrae prior to becoming his patient. Dr. Gardiner acknowledged that he did not obtain Patient 12's medical records to verify the injury, but took the patient's word for it. Patient 12 told Dr. Gardiner that he suffered pain as a result of that injury. Dr. Gardiner testified that he prescribed Fiorinal 3, Soma, Vistaril, Phrenilin Forte, Ecotrin, Darvocet N, Mobigesic, Toradol, and Lodine. He also prescribed Sinequan, probably to help Patient 12 sleep. Dr. Gardiner testified that he switched Patient 12's medications to try to find an effective one that was not controlled. (Tr. Vol. I, 60-61)

Dr. Gardiner could not recall precisely when Patient 12's injury occurred. He believed that it happened several years before Patient 12 came to see him. (Tr. Vol. I, 61-62)

35. Dr. Cook testified that Patient 12 was diagnosed with a fracture of the lumbar vertebrae following a fall from a roof. Dr. Cook stated that "there was no physical examination or assessment noted, there is no x-ray report or any record of one being done when the injury occurred. Patient was subsequently prescribed a regimen of Tylenol No. 4, Soma and Vistaril, and later subsequently changed to Fiorinal, Soma and Vistaril." (Tr. Vol. II, 63)

Dr. Cook testified that if a patient comes to a physician complaining that his back hurts as a result of having fractured his back, it is necessary for the physician to document the nature of the injury. (Tr. Vol. II, 63)

Dr. Cook drew attention to the following entries contained in Dr. Gardiner's medical records for Patient 12:

- A note dated 10-7-91 said "Pharmacy called & said [Patient 12] has called & harassed them every day to get an early refill on Soma. They gave it to him on 10-6-91 so he'd leave them alone. They say please give him no more RF on Soma. Dr. Cook noted that Dr. Gardiner's prescribing practices did not change. (St. Ex. 21, p. 7 (emphasis original); Tr. Vol. II, 63-65)

On 10-15-91, Dr. Gardiner prescribed for Patient 12 50 Vistaril 100 mg., 30 Fiorinal No. 3 with one refill, and 30 Soma 350 mg. with one refill. (St. Ex. 21, p. 7)

- A note dated 4-29-92 said, "Crosby drugs call today and said [Patient 12] had been trying to get his Rx refilled early again. This makes the second time and they said he bugs them all the time." (St. Ex. 21, p. 8(back); Tr. Vol. II, 65)

On 5-7-92, Dr. Gardiner prescribed 30 Darvocet N-100 with one refill, 30 Fiorinal No. 3, and 30 Soma 350 mg. with one refill. (St. Ex. 21, p. 8(back))

- A note dated 6-9-92 said, "[Patient 12] called & wanted meds early again - Doc said NO." (St. Ex. 21, p. 9(back); Tr. Vol. II, 65)
- A note dated 11-6-92 said "Called early for RF on Soma. MM said no." (St. Ex. 21, p. 9(back); Tr. Vol. II, 65)
- A note dated 6-21-93 said, "[Patient 12] called & said Crosby's wouldn't give him his refill on his Tylenol #3 he got 6-8-93. I told him he didn't get T#3 & he said he was confused." (St. Ex. 21, p. 10; Tr. Vol. II, 65-66)

Dr. Cook testified that there was no record of Dr. Gardiner addressing any of the issues raised in the above-referenced notes. Moreover, there was no documentation of the patient's progress. (Tr. Vol. II, 66)

Dr. Cook testified that Dr. Gardiner's prescribing of medications to Patient 12 constituted the failure to use reasonable care discrimination in the administration of drugs, "[b]ased on the failure to document patient's progress and the need for continuing use of this medication... ." (Tr. Vol. II, 66-67)

Dr. Cook testified that Dr. Gardiner's treatment of Patient 12 fell below the minimal standards of care, for the same reasons as in the preceding paragraph. (Tr. Vol. II, 67)

36. Dr. Gardiner's medical records for Patient 13, female, d.o.b. 12-5-58, note that on 10-19-92, her first visit, that "Pt. has been off alcohol 4 months." Her weight is recorded for her last visit on 3-3-93. Dr. Gardiner recorded a total of six visits from this patient. Dr. Macklin noted that, other than the aforementioned notes, there is nothing contained in the records of a medical history being taken, a physical examination being performed, a diagnosis, or a plan of treatment, except that her weight was noted on her last visit. The only items contained are the drugs and amounts prescribed and the amount of the bill. (St. Ex. 22, p. 2; Tr. Vol. I, 172-173)
37. Dr. Gardiner testified that Patient 13 informed him that she was an alcoholic the first time she came in. She told him that she had been to Riverside Hospital, and Dr. Gardiner assumed that she had been treated at that hospital's psychiatric ward. "Most of the time when Riverside treats an alcoholic," Dr. Gardiner testified, "why, they give them a pretty good screen. That was one of the reasons that I didn't screen her. I asked her if she was suicidal and she denied it." (Tr. Vol. I, 62)

Dr. Gardiner testified that he prescribed Antabuse for Patient 13 to help her fight her alcohol problem. He also prescribed Sinequan to help her rest. "She seemed a little depressed, and I thought maybe that would help her sleep a little bit." He also prescribed Zoloft, to be taken in the morning, because Dr. Gardiner felt that she was depressed. Dr. Gardiner testified that he did not refer Patient 13 to a psychiatrist because he thought she had already gone through that at Riverside. "Probably on reflection I should have sent her to a psychiatrist." (Tr. Vol. I, 62-64)

38. Patient 13 committed suicide by taking an overdose of Sinequan on or about March 30 or April 1, 1993. This act occurred in a motel room in Worthington, Ohio. The toxicology report prepared by the Franklin County Coroner's Office stated that there was no alcohol in her blood, and that diazepam and nordiazepam were present at therapeutic levels. However, the doxepin level

was noted as "consistent with massive lethal administration." Sinequan is a brand name for doxepin HCL. (St. Ex. 22; Tr. Vol. I, 64)

The investigating detective noted that some pill bottles were found in Patient 13's room. An empty bottle found on the table near the bed was labeled for "Doxepin HCL, 150 mg." The detective noted that it had been prescribed by Dr. John Gardiner on March 30, 1993. The quantity that the bottle had contained was not noted. (St. Ex. 22, p. 3 of the police report)

It was evident from other prescription bottles found at the scene that Patient 13 had been seeing other doctors besides Dr. Gardiner. Three empty bottles were found in Patient 13's purse. One was labeled for "Toradol, 10 mgs." prescribed by Dr. Haninger, and two others were labeled for "Anaprox - D.S., 550 mgs.," both prescribed by Dr. Douglas Goff. (St. Ex. 22, p. 4 of the police report)

It is worth noting that there is no visit for March 30, 1993, recorded in Dr. Gardiner's medical records for Patient 13. At Patient 13's visit on March 3, 1993, Dr. Gardiner prescribed 30 Zoloft 50 mg., and 30 Sinequan 150 mg. with one refill. The detective reported that he contacted the drug store that filled the doxepin prescription, and was told "that a prescription had been issued to [Patient 13] on March 30, 1993." The detective noted that he then contacted Dr. Gardiner's office, and was told by the receptionist that Patient 13 had been treated by Dr. Gardiner for depression, but that Patient 13 had not been to Dr. Gardiner's office since March 3, 1993. (St. Ex. 22, p. 5 of the police report, and p. 2 of the medical records; Tr. Vol. I, 178-179)

39. Dr. Macklin testified that Patient 13 was prescribed Sinequan 100 mg. per day on her first three visits, and increased to 150 mg. per day on her fourth visit. On the fifth visit, Antabuse 250 mg. per day was added, and on the last visit, Zoloft 50 mg. per day was added. Dr. Macklin agreed that, on the basis of these records, it cannot be determined whether Dr. Gardiner prescribed Sinequan as a sleep aid or for depression. (Tr. Vol. I, 173-174)

Dr. Macklin testified that Antabuse is useful when it is combined with other treatment for alcoholism. It is not very effective by itself. Dr. Macklin would recommend using it in conjunction with Alcoholics Anonymous meetings and counseling. There is no indication in Dr. Gardiner's medical records for Patient 13 that Patient 13 was participating in any other therapies. (Tr. Vol. I, 175-176)

Dr. Macklin testified that Dr. Gardiner's treatment of Patient 13 fell below the minimal standards of care:

There was no indication in the medical records as to why this patient was receiving any of these medications, we can intuit that the Antabuse was for alcoholism because it's the sole use of this medication, there is no indication of whether any other treatment modalities for alcoholism were pursued, whether the patient was attending Alcoholics Anonymous or any other self-help group, and there is no indication of any mental status exam in the evaluation of suicidality or depressive symptomatology.

(Tr. Vol. I, 181)

40. Dr. Macklin acknowledged that medical education, in the past, may have been less attuned to addictive behaviors than it is today. Nevertheless, Dr. Macklin stated that physicians are responsible for keeping their knowledge current, and for continuing to educate themselves. Physicians are expected to practice competently regardless of when they were educated. (Tr. Vol. I, 184-187; 200)
41. Dr. Gardiner testified that he currently has about 1400 active charts. He stated that the thirteen patients that were the subject of this hearing constitute only about 0.9% of his total practice. (Tr. Vol. II, 72, 75)
Dr. Gardiner acknowledged that quite a few of his current patients suffer from chronic pain, but since Dr. Gardiner started treating policemen and firemen, most of them do not want controlled substance medications. (Tr. Vol. II, 76)

Dr. Gardiner said that a lot of the patients that came into his office complaining of persistent pain were trying to work, and needed medication to continue working. Dr. Gardiner testified that he decided which medications to use based on the patients' complaints. He stated that patients were evaluated each time they came in. He would meet face-to-face with each patient and would discuss the effectiveness of their pain medication. (Tr. Vol. II, 72-73)

Dr. Gardiner testified that he voluntarily turned his DEA certificate over to his representative, who turned it over to the State's representative. Now, if Dr. Gardiner treats a patient with chronic pain, he tries to use Tylenol Extra Strength, or other NSAIDs such as Motrin. He stated that he is getting good results from them. He no longer prescribes controlled-substance narcotics, and refers patients who use such medications elsewhere. Nevertheless, Dr. Gardiner acknowledged that he still prescribes Soma on occasion if a patient asks for it, although he tries to stay below four per day. Dr. Gardiner

said he prefers to employ other medications such as Parafon Forte, Robaxin, Skelaxin, and Flexeril. He also acknowledged that he still prescribes Stadol nose spray. "It's a noncontrolled substance, and it's very good for migraine headaches, and I have quite a few patients that have migraine headaches." (Tr. Vol. II, 73-77)

42. Dr. Gardiner was disciplined previously by the Board for violation of Sections 4731.22(B)(2) and (6), Ohio Revised Code. (St. Ex. 9)

FINDINGS OF FACT

1. The evidence presented is sufficient to support a finding that John B. Gardiner, D.O., "excessively and inappropriately prescribed controlled substances and dangerous drugs to Patients 1 through 12... . Such prescribing was routinely done despite documentation in [Dr. Gardiner's] records that these patients were exhibiting drug-seeking behavior, including drug selling, and that the patients were abusing and/or dependent on the drugs which [Dr. Gardiner] was prescribing to them," as alleged in the State Medical Board's August 9, 1995, notice of opportunity for hearing. Specifically:
 - a. Dr. Gardiner treated Patient 1, male, d.o.b. 9-30-56, from October 1987 until October 1990. Patient 1 visited Dr. Gardiner on numerous occasions during this time period. Dr. Gardiner administered or prescribed one or more of the following substances at nearly all of these visits: Xanax, Stadol, Percocet, Stadol, Soma, Halcion, Talacen, and Darvocet N-100. During the course of his treatment of Patient 1, Dr. Gardiner received opinions from a consulting neurologist that Patient 1's symptoms could be related to drug withdrawal, and from a consulting orthopedist that the treatment of Patient 1 with narcotics should be discontinued. Nevertheless, Dr. Gardiner continued to prescribe the aforementioned medications.

Patient 1 suffered a seizure on 8-19-90 that required his hospitalization. Additionally, Patient 1 died on 10-17-90 as the result of a heart attack. Although there was testimony by the State's expert that these events may have been linked to Dr. Gardiner's prescribing of Soma to this patient, this testimony was speculative in nature. The evidence is insufficient to support a finding that these events were related to Dr. Gardiner's care and treatment of Patient 1.

- b. Dr. Gardiner treated Patient 2, female, d.o.b. 4-28-57, from 5-21-85 until 3-6-92. Patient 2 visited Dr. Gardiner on numerous occasions during this time period. Dr. Gardiner prescribed drugs such as Darvocet N-100, Tylox, Halcion, Soma, and Stadol. Dr. Gardiner prescribed or administered one or more of these substances at most of Patient 2's visits. Such prescribing continued in spite of warnings from pharmacists that Patient 2 was obtaining drugs from other physicians, and an inquiry by Patient 2's insurance carrier concerning the amount of propoxyphene that Dr. Gardiner was prescribing. Between the dates of 1-27-91 and 3-6-92, Dr. Gardiner prescribed for Patient 2 a total of 526 unit doses of Darvocet N-100, and 394 unit doses of Soma 350 mg. in seven office visits. Patient 2 died on 3-7-92 from an overdose of propoxyphene, one of the active ingredients in Darvocet N-100. It is not known whether Patient 2's death was intentional or unintentional.
- c. Dr. Gardiner treated Patient 3, female, d.o.b. 8-31-59, from 8-15-89 until 8-7-91. Patient 3 visited Dr. Gardiner's office regularly during this time period. Dr. Gardiner prescribed such medications as Tylenol with codeine, Darvocet N-100, Xanax, Soma, and Sinequan to Patient 3 at many of these visits. This prescribing continued despite warnings, documented in Patient 3's chart, that Patient 3 was abusing her medication, selling her medications, and engaging in drug-seeking behavior. Patient 3 died on 8-24-91 from an overdose of codeine and butalbital.
- d. Patient 4 visited Dr. Gardiner's office regularly between 5-14-90 and 9-2-92. Dr. Gardiner prescribed or administered one or more of the following medications to Patient 4 at nearly every visit: Fioricet, Soma, Percocet, Vicodin, and Tylenol with codeine. This prescribing continued despite multiple warnings contained in the medical records that Patient 4 was abusing his medications and engaging in drug-seeking behavior. Such warnings included a note that Patient 4's drugs were confiscated by police on 1-14-91. Further, Patient 4 attempted suicide by cutting his wrists on 3-13-91, and by taking medications and poison on 3-15-91. The discharge report following the suicide attempts included a diagnosis of "chronic substance abuse/addiction (prescription medication for pain, Soma, Fioricet, Xanax, Percocet, et cetera)."

Furthermore, as alleged in the Board's August 5, 1995, notice letter, "[s]imilar patterns of excessive and inappropriate prescribing, and of [Dr. Gardiner's] continued prescribing of controlled substances and dangerous drugs, despite

such documentation of drug dependence and/or abuse and of drug seeking or selling..., are also found in the records [for] Patients 5 – 12.”

2. The evidence is sufficient to support a finding that, in Dr. Gardiner’s treatment of Patients 1 through 13, Dr. Gardiner “routinely failed to evaluate and assess the Patient’s complaints, and [Dr. Gardiner] failed to respond or follow-up ... changes in the Patient’s complaints and/or conditions,” as alleged in the Board’s August 9, 1995, notice letter.
 - a. Despite documentation in Dr. Gardiner’s medical records for Patients 1 through 12 concerning evidence that such patients were drug dependent or engaging in drug-seeking behavior, Dr. Gardiner failed to alter his course of treatment for said patients, and continued to prescribe controlled substances, and other potentially abusable and dangerous drugs, to Patients 1 through 12.
 - b. Dr. Gardiner failed to evaluate and assess the mental status of Patients 2, 3, 4, and 13, who were apparently depressed and potentially suicidal.
 - i. Dr. Gardiner treated Patient 13 from 10-19-92 until 3-3-93. Dr. Gardiner prescribed Sinequan, Zoloft, and Antabuse to Patient 13 without examining and/or evaluating Patient 13 for depression, alcoholism, or suicidal ideation. Further, Dr. Gardiner did not attempt to obtain records of any prior treatment of Patient 13 for alcoholism or depression. On or about April 1, 1993, Patient 13 committed suicide by ingesting, among other things, a lethal dose of doxepin, which had been prescribed to her by Dr. Gardiner.
 - ii. Dr. Gardiner similarly failed to evaluate the mental status of Patients 2 through 4.
3. Dr. Gardiner routinely failed to indicate the diagnosis and/or purpose for which controlled substances were administered, dispensed, or prescribed for Patients 1 through 12.
4. Dr. Gardiner routinely failed to complete and maintain patient records reflecting his examination, evaluation, and treatment of Patients 1 through 13.

CONCLUSIONS OF LAW

1. As set forth in Finding of Fact 1, above, the acts, conduct, and/or omissions of John B. Gardiner, D.O., individually, and/or collectively, constitute “[f]ailure to use reasonable care discrimination in the administration of drugs,” as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, despite the fact that there was no expert testimony directly on this point, the evidence presented in this Matter is sufficient to support a conclusion that, as set forth in Finding of Fact 1, above, the acts, conduct, and/or omissions of Dr. Gardiner, individually and/or collectively, constitute “failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as that clause is used in Section 4731.22(B)(2), Ohio Revised Code. Members of the Board who are physicians possess the necessary specialized knowledge to determine this issue, and expert testimony is unnecessary. (*State Medical Board v. Murray* (1993), 66 Ohio St.3d 527; *In re Howard M. Shelley, M.D.* (Dec. 31, 1992), Franklin App. No. 92AP-440, unreported.)

2. The acts, conduct, and/or omissions of Dr. Gardiner, as set forth in Findings of Fact 1, 2, and 4, above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.
3. The acts, conduct, and/or omissions of Dr. Gardiner, as set forth in Finding of Fact 3, above, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the Board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, this violation of Rule 4731-11-02(D), Ohio Administrative Code also constitutes violation of Sections 4731.22(B)(2) and (6), Ohio Revised Code.

Rule 4731-11-02(D), Ohio Administrative Code, states:

A physician shall complete and maintain accurate medical records reflecting his examination, evaluation, and treatment of all his patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient

and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based.

The evidence is sufficient to support a conclusion that Dr. Gardiner's failure "to indicate the diagnosis and/or purpose for which controlled substances were administered, dispensed, or prescribed for Patients 1 through 12," violated this rule.

4. The evidence presented would support a conclusion that the acts, conduct, and/or omissions of Dr. Gardiner constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the Board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(C), Ohio Administrative Code. However, the Board alleged in its August 9, 1995 notice letter that Rule 4731-11-02(C), Ohio Administrative Code, was violated by conduct which formed the basis for Finding of Fact 4. A finding that "Dr. Gardiner routinely failed to complete and maintain patient records reflecting his examination, evaluation, and treatment of Patients 1 through 13," as found in Finding of Fact 4, above, does not support a conclusion that Dr. Gardiner violated Rule 4731-11-02(C), Ohio Administrative Code.

☆ ☆ ☆ ☆ ☆

The State presented convincing evidence that Dr. Gardiner's care and treatment of Patients 1 through 13 demonstrated a serious lack of sound medical judgment. His record keeping was deficient, and he failed to adequately examine and evaluate these patients. In the cases of Patients 1 through 12, Dr. Gardiner persisted in dangerous and inappropriate prescribing practices without regard to the advice and information provided by other physicians, pharmacists, police, and friends and families of the patients. Although it is conceivable that Dr. Gardiner's motives were benign, he ignored advice from fellow physicians, and disregarded obvious signs of drug-seeking behavior that were documented in his medical records. He persisted in these dangerous practices, without regard to the actual and potential disastrous consequences to patients. Such conduct, which is compounded by the fact that Dr. Gardiner was previously disciplined by this Board, demonstrates that Dr. Gardiner's problems are not amenable to remedial measures, and that his continued practice poses a danger to the public.

PROPOSED ORDER

The certificate of John B. Gardiner, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio, except that Dr. Gardiner shall not order, purchase, prescribe, dispense, administer, or possess any controlled substances, except for those prescribed for his personal use by another so authorized by law. Additionally, Dr. Gardiner's DEA certificate, currently in the possession of the Board's representative, shall be surrendered to the appropriate authorities. Further, in the thirty (30) day interim, Dr. Gardiner shall not undertake the care of any patient not already under his care.

A handwritten signature in black ink, appearing to read 'R. Gregory Porter', written over a horizontal line.

R. Gregory Porter
Attorney Hearing Examiner



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

EXCERPT FROM THE DRAFT MINUTES OF FEBRUARY 14, 1995

REPORTS AND RECOMMENDATIONS

Dr. Stienecker announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Dr. Stienecker asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: William H. Allen, Jr., M.D.; Carolyn T. Beyer, D.O.; John B. Gardiner, D.O.; Stephen W. Gilreath, M.D.; Alexander D. Hassard, M.D.; Neal E. Holleran, M.D.; Peter M. Ilievski, M.D.; James L. Kegler, M.D.; Albert S. Miller, M.D.; Venus Navarro-Julian, M.D.; Moorthy S. Ram, M.D.; Ronald J. Richter, M.D.; Arvind M. Talati, M.D.; and Stephen J. Weiss, M.D.

A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Gretter	- aye
	Dr. Egner	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye
	Ms. Noble	- aye
	Mr. Sinnott	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Dr. Stienecker	- aye

Dr. Stienecker asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Gretter	- aye
	Dr. Egner	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye

Ms. Noble	- aye
Mr. Sinnott	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Dr. Stienecker	- aye

In accordance with the provision in Section 4731.22(C)(1), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of this matter.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....
REPORT AND RECOMMENDATION IN THE MATTER OF JOHN B. GARDINER, D.O

.....
DR. GARG MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF JOHN B. GARDINER, D.O. DR. AGRESTA SECONDED THE MOTION.

.....
A vote was taken on Dr. Garg's motion:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- aye
	Dr. Gretter	- abstain
	Dr. Egner	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye
	Ms. Noble	- aye
	Mr. Sinnott	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43260-0015 • (614) 466-3031

August 9, 1995

John B. Gardiner, D.O.
25 Tibet Road
Columbus, OH 43202

Dear Doctor Gardiner:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) As demonstrated in your patient records, you excessively and inappropriately prescribed controlled substances and dangerous drugs to Patients 1 through 12 (as identified on the attached Patient Key - Key confidential to be withheld from public disclosure). Such prescribing was routinely done despite documentation in your records that these patients were exhibiting drug-seeking behavior, including drug selling, and that the patients were abusing and/or dependent on the drugs which you were prescribing to them.

Examples of such prescribing include, but are not limited to, the following:

- (a) You treated Patient 1, a thirty-year-old male, from December 1986 until October 1990. The controlled substances and dangerous drugs that you prescribed to Patient 1 on various occasions during this time period included Talwin, Percocet, Stadol, Soma, Halcion, Xanax, and Darvocet N-100. This prescribing continued despite opinions from a consulting neurologist that the etiology of Patient 1's symptoms might be related to drug withdrawal, and from a consulting orthopedist that the treatment of Patient 1 with narcotics should be discontinued.
- (b) Patient 2 was twenty-eight years old on her first visit to you on May 21, 1985. During her numerous office visits until her death from an overdose of propoxyphene in March 1992, you frequently

Mailed 8/10/95

August 9, 1995

prescribed medications such as Darvocet N-100, Soma, Fioricet, Tylox, Halcion and Tranxene despite warnings from pharmacists that Patient 2 was obtaining drugs from other physicians, and questions by her insurance carrier as to the amount of propoxyphene which was being prescribed by you. In fact, from on or about December 27, 1991, until the day before Patient 2's death, March 7, 1992, you prescribed at least 526 units Darvocet-N 100 mg and 470 units Soma in the course of seven office visits. On the date of Patient 2's last visit, you prescribed 50 units Darvocet-N 100 mg and 42 units Soma 350 mg. The following day, March 7, 1992, the Patient expired due to a lethal dose of propoxyphene (Darvocet).

- (c) Your records concerning your treatment of Patient 3, who was thirty years old at the time of her initial office visit on August 15, 1989, also reflect numerous warnings from third parties that Patient 3 was abusing the medications you were prescribing to her, and was also selling some of those medications. Your records further reflect instances of drug-seeking behavior by Patient 3. Despite these warnings that Patient 3 was possibly addicted to or was otherwise abusing controlled substances, particularly benzodiazepines and narcotics, you frequently prescribed Tylenol No. 3, Xanax, Darvocet N-100, Soma, and Doxepin to Patient 3, until her suicide on August 24, 1991, from an overdose of codeine and butalbital.

- (d) You continued to prescribe controlled substances and dangerous drugs to Patient 4, a twenty-eight-year-old male, despite warnings that began as early as June 1990 that Patient 4 was abusing the medications and engaging in drug-seeking behavior. The medications which you prescribed to Patient 4 on a frequent basis included Soma, Percocet, Fioricet, Vicodin and Xanax. On January 7, 1991, a notation in your records indicates that the police confiscated Patient 4's medications; nevertheless, on January 14, 1991, you issued another prescription of Fioricet to Patient 4. In addition, your records reflect that Patient 4 attempted suicide by cutting his wrists on March 13, 1991, and by taking medications and poison on March 15, 1991. The discharge diagnosis subsequent to the suicide attempt included "chronic substance abuse, addiction (prescription medications for pain--Soma, Fioricet, Xanax, Percocet, etc.)."

Similar patterns of such excessive and inappropriate prescribing and of your continued prescribing of controlled substances and dangerous drugs, despite such documentation of drug dependence and/or abuse and of drug seeking or selling behavior, are also found in the records of Patients 5 - 12.

- (2) While treating Patients 1 through 13, you routinely failed to evaluate and assess the Patients' complaints, and you failed to respond or follow-up to changes in the Patients' complaints and/or conditions.

Instances of such conduct include, but are not limited to, the following:

- a) As mentioned in Paragraph 1 above, your records for Patients 1 through 12 contain documentation regarding drug dependence and drug seeking behavior; despite such documentation, you failed to alter your treatment plans and, in fact, continued to prescribe controlled substances and dangerous drugs to Patients 1 through 12.
- b) In your treatment of Patients 2, 3, 4, and 13, you failed to evaluate and assess the mental status of these patients who were depressed and potentially suicidal. Instances of such treatment include, but are not limited to, the following:
 - i) You treated Patient 13 from October 19, 1992, until March 3, 1993. You did not conduct a mental status exam nor did you evaluate her for depression or suicidal ideation. Despite not performing such an exam and evaluation, you prescribed Sinequan, Antabuse, and Zoloft to Patient 13. On or about April 1, 1993, Patient 13 committed suicide by ingesting a lethal dose of antidepressants prescribed by you.

Similar patterns of such failure to evaluate and assess the mental status of depressed and potentially suicidal patients, are also found in the records of Patients 2 through 4.

- (3) Additionally, for Patients 1 through 12, you routinely failed to indicate the diagnosis and the purpose for which controlled substances were utilized.
- (4) Additionally, for Patients 1 through 13, you routinely failed to maintain patient records reflecting your evaluation, examination, and treatment of the patients.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "(f)ailure to use reasonable care discrimination in the administration of drugs," and/or "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1), (2) and (4) above, individually and/or collectively, constitute "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Your acts, conduct, and/or omissions as alleged in paragraph (3) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02 (D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

Your acts, conduct, and/or omissions as alleged in paragraph (4) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(C), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(C), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6) and further, if such violation is committed purposely, knowingly or recklessly, it also constitutes a violation of Section 4731.22(B)(3), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

April 25, 1984

John B. Gardiner, D.O.
25 Tibet Road
Columbus, OH. 43202

Dear Doctor Gardiner:

Please find enclosed a certified copy of the Entry of Order, the Report and Recommendation of Oscar W. Clarke, M.D., Member, State Medical Board of Ohio and a certified copy of the Motions by the State Medical Board, meeting in regular session on April 11, 1984, amending said Report and Recommendation as the Findings and Order of the State Medical Board.

You are hereby notified that you may appeal this Order to the Court of Common Pleas of the county in which your place of business is located, or the county in which you reside. If you are not a resident and have no place of business in this state, you may appeal to the Court of Common Pleas of Franklin County, Ohio.

To appeal as stated above, you must file a notice of appeal with the Board setting forth the Order appealed from, and the grounds of the appeal. You must also file a copy of such notice with the Court. Such notices of appeal shall be filed within fifteen (15) days after the date of mailing of this letter and in accordance with Section 119.12, Revised Code.

THE STATE MEDICAL BOARD OF OHIO


Joseph P. Yut, M.D.
Secretary

Encls.

CERTIFIED MAIL NO. P34 9335255
RETURN RECEIPT REQUESTED

cc: W. Vincent Rakestraw, Esq.
8 E. Broad St.,
Columbus, OH. 43215

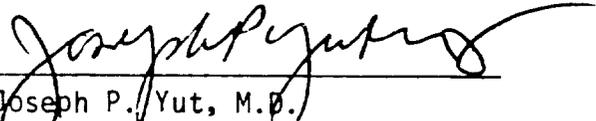
CERTIFIED MAIL NO. P34 9335256
RETURN RECEIPT REQUESTED

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Oscar W. Clarke, M.D., Member, State Medical Board of Ohio; and the attached copy of the Motions approved by the State Medical Board, meeting in regular session on April 11, 1984, amending said Report and Recommendation as the Findings and Order of the State Medical Board constitutes a true and complete copy of the Findings and Order of the State Medical Board in the matter of John B. Gardiner, D.O., as it appears in the Journal of the State Medical Board of Ohio.

(SEAL)



Joseph P. Yut, M.D.
Secretary

4-25-84
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *
*
JOHN B. GARDINER, D.O. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 11th day of April, 1984.

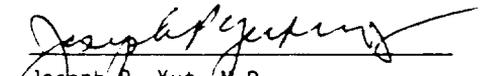
Upon the Report and Recommendation, a true copy of which is attached hereto and incorporated herein, of Oscar W. Clarke, M.D., the Hearing Member in this matter designated pursuant to R.C. 4731.23, which Report and Recommendation was amended by vote of the Board on the above date, the following order is hereby entered on the Journal of the State Medical Board for the 11th day of April, 1984, and made part of the Board's proceedings:

It is hereby ordered that the license of John B. Gardiner, D.O., to practice osteopathic medicine and surgery in Ohio:

1. Be suspended for one year.
2. All but sixty (60) days of said suspension be stayed.
3. That Dr. Gardiner be placed on probation for two years from the effective date of this order.
4. That Dr. Gardiner personally appear before this Board or its agent every six (6) months during his probation, and thereafter as the Board should request. He shall answer all questions of this Board truthfully and to the best of his knowledge.

The Order is effective June 1, 1984.

(SEAL)



Joseph P. Yut, M.D.
Secretary

4-25-84
Date

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

'84 MAR 14 P 3:01

REPORT AND RECOMMENDATION
IN THE MATTER OF
JOHN B. GARDINER, D.O.

The matter of the State Medical Board's citation against John B. Gardiner, D.O. came before Jerauld D. Ferritto, D.P.M., Hearing Officer and Member of the Board on September 22, November 24, and December 15, 1982. Because Dr. Ferritto's term as a Board Member expired prior to the issuance of a Report and Recommendation in this matter, the case and record was reassigned to me, Oscar W. Clarke, M.D., President of the State Medical Board, and this is my Report and Recommendation to the Board regarding the hearing of John B. Gardiner, D.O.

SUMMARY OF EVIDENCE

1. On September 22, 1982 the administrative hearing of John B. Gardiner, D.O. commenced before Jerauld D. Ferritto, D.P.M., Medical Board member and hearing officer.
2. Dr. Gardiner was represented by counsel; Vincent Rakestraw and Stuart Eagleson of Chester, Hoffman & Willcox.
3. The State was represented by Jeffrey J. Jurca, Assistant Attorney General.
4. Mr. Jurca and Mr. Rakestraw requested that Dr. Ferritto continue the hearing to allow them to submit briefs on whether or not the physician-patient privilege would be violated by conducting the hearing under normal board procedure. Mr. Rakestraw raised the issue that Dr. Gardiner would not be able to testify concerning his treatment of the patient involved because of the physician-patient privilege. (Transcript at 1-6)
5. The request for a continuance was granted for an indefinite time to allow counsel for both parties to prepare briefs on the issue. (Transcript at 7)
6. The State submitted a brief on the privileged communication issue on October 13, 1982.
7. The defendant submitted a memorandum of law on the physician-patient privilege on October 13, 1982.
8. On October 27, 1982 Dr. Ferritto ordered that the physician-patient privilege would be protected by the identity protection procedures utilized by the Board in all hearings. Therefore, the hearing could

'84 MAR 14 P 3:02

proceed with the patient remaining anonymous and being referred to only by number.

9. On November 24, 1982, the hearing proceeded with opening statements from both parties.
10. Mr. Jurca proceeded to present the State's case by entering Exhibits 1 through 8 onto the record. They were comprised of the citation letter, scheduling letters, the memoranda of law and the order concerning the physician-patient privilege. (Transcript at 6-8)
11. The parties stipulated that Patient 1 had been convicted of a charge of deception to obtain a dangerous drug in violation of Section 2925.22(A), O.R.C. in the summer of 1981. (Transcript at 8)
12. Mr. Jurca proceeded to call John B. Gardiner, D.O. as his first witness, as if on cross-examination, and he testified under oath as follows:
 - A. He graduated from the Kansas City College of Osteopathic Surgery and Medicine, interned at Doctor's Hospital and has been a general practitioner for twenty-six years. (Transcript at 9-10)
 - B. That he currently practices on Tibet Rd. in the north end of Columbus.
 - C. That he wrote the three prescriptions to Patient 1 on May 17, 1982 and that there is no indication the prescriptions had been forged or altered. (Transcript at 11)
 - D. That the first prescription was for a Dulcolax suppository, 10 milligrams, 50 tablets, one at bedtime, and Doriden, 5 milligrams, 100 tablets, one at bedtime.
 - E. That the second prescription was for Tetracycline, 500 milligrams, on b.i.d., twice a day, 1000 tablets. This prescription also included Darvon Plain, 65 milligrams, 5000 tablets, two every four hours. (Transcript at 12)
 - F. That the third prescription was for Lasix, 40 milligrams, 400 tablets, one daily and also Valium, 10 milligrams, 1000 tablets, one three times a day. (Trnascript at 13)
 - G. That all three of the prescriptions were dated May 17, 1982.
 - H. That when he wrote the prescriptions, he did not know that Patient 1 had been convicted or arrested for a drug offense. (Transcript at 13-14)
 - I. That in 1981, Judge Johnson of the Municipal Court did write

'84 MAR 14 P 3:02

a letter of inquiry regarding Patient 1 but the letter only asked for his diagnosis and medication and didn't reveal the reasons why he was before the court.

- J. That he was contacted by Charles Eley of the State Medical Board regarding the prescriptions. (Transcript at 14)
 - K. That when Mr. Eley came to his office, he told him that the prescriptions were in excess and that Mr. Eley wanted the voluntary surrender of his license. (Transcript at 16-18)
 - L. That he had made an error in judgment concerning his prescribing. (Transcript at 17)
 - M. That he didn't know Patient 1 had an arrest or conviction for a drug violation until we sent him the citation letter.
13. The parties stipulated that Dr. Gardiner did write the prescriptions for Patient 1 on May 17, 1982 as described in his testimony. (Transcript at 18)
14. Mr. Jurca proceeded with the State's case by calling Charles Eley, who testified under oath as follows:
- A. That he is currently an investigator for the Ohio Medical Board and has been for three years.
 - B. That he was a police officer for the Upper Sandusky Police Department for approximately twelve years. (Transcript at 20)
 - C. That on May 25, 1982 he was alerted by the Columbus Police Department that Dr. Gardiner had written six prescriptions for Patient 1 and they could be obtained from Sainato Pharmacy in Reynoldsburg. (Transcript at 20)
 - D. That Officer Decaminada of the Columbus Police indicated the pills totaled 7,500.
 - E. That on May 26, 1982 he met with Officer Decaminada at Sainato Pharmacy and obtained the prescriptions.
 - F. That the medication was not dispensed by the pharmacist because Patient 1 did not have the necessary \$571.75 to pay the bill for the medication. (Transcript at 22)
 - G. That before Patient 1 could return with the money, he and Officer Decaminada picked up the canceled but unfilled prescriptions.
 - H. That on the same day, he, Officer Decaminada and Jerry McDaniels,

'84 MAR 14 P 2:02

State Medical Board investigator, met with Dr. Gardiner in his office. (Transcript at 24)

- I. That they told Dr. Gardiner they were there to discuss the six prescriptions written on May 17, 1982.
 - J. That Dr. Gardiner inspected the prescriptions and stated that he wrote them for Patient 1. (Transcript at 24)
 - K. That Officer Decaminada had told him, Mr. Eley, on July 21, that Patient 1 had been arrested and charged with obtaining drugs by deception.
 - L. That he asked Dr. Gardiner if he was aware of the charges against Patient 1 and Dr. Gardiner stated he knew the patient had been arrested because he had a letter from Judge Johnson. (Transcript at 25)
15. Mr. Rakestraw proceeded to cross-examine Mr. Eley who testified as follows:
- A. That Mr. Sainato canceled the prescription but did not disburse the drugs.
 - B. That Mr. Sainato called the Pharmacy Board to verify the large amount and talked with James Tudor, Investigator. (Transcript at 26)
 - C. That Mr. Tudor called Dr. Gardiner and verified that he had written the prescriptions. Dr. Gardiner stated that they were written because Patient 1's insurance had run out. (Transcript at 26-27)
 - D. That Mr. Tudor told Mr. Sainato that he knew of no law to prevent him from dispensing the drugs, but they weren't dispensed because the patient didn't have the money.
 - E. That he knew of no law which prevented the prescriptions of that many pills. (Transcript at 27)
 - F. That when he met with Dr. Gardiner, Dr. Gardiner knew that Patient 1 had been arrested but that he didn't discuss which statute he had been arrested under.
 - G. That he asked Dr. Gardiner to voluntarily surrender his license because of the large amount of substances he prescribed to Patient 1. (Transcript at 29)
 - H. That he told him if he surrendered, he would have to go back

'84 MAR 14 P 3:02

before the Board and ask to be reinstated to get his license back. Also, that he possibly would never get his license back. (Transcript at 29)

- I. That Dr. Gardiner did surrender his medical license and D.E.A. certificate.
 - J. That the decision to request a surrender of license is made by Mr. Lee, Administrator, or his supervisor, Edward Valentine, or Dr. Cramblett or Dr. Ruppertsberg. (Transcript at 30)
 - K. That in this case the decision was made by Mr. Lee, Mr. Valentine and himself with Officer Decaminada.
 - L. That the decision to request a voluntary surrender is always referred to the members of the Board or the staff whenever possible. (Transcript at 31)
 - M. That Dr. Gardiner was concerned and puzzled when he asked him if he knew of Patient 1's drug arrest.
16. Mr. Jurca proceeded to question Mr. Eley on redirect examination and he testified as follows:
- A. That after Dr. Gardiner surrendered his license on the 26th, he made an appointment for the next day at 10:00 a.m. because he felt there would be a need for discussion concerning reinstatement and the procedures. (Transcript at 34)
 - B. That on the 27th, he and Officer Decaminada met with Dr. Gardiner and Mr. Eagleson, his attorney, at Dr. Gardiner's office.
 - C. That he referred Mr. Eagleson's legal questions to Sherry Cato, Staff Counsel for the Medical Board and that Dr. Gardiner indicated that another physician would be taking over his practice. (Transcript at 34-35)
 - D. That at the first meeting with Dr. Gardiner, he did not threaten Dr. Gardiner and there was no indication at that time that Dr. Gardiner wanted legal counsel.
 - E. That in the course of his duties as an investigator he checks up on prescribing practices of physicians and that Darvon and Valium have become subject to abuse. (Transcript at 36)
 - F. That he has never seen a prescription for Darvon in the amount of dosage units that Dr. Gardiner had written.
 - G. That he has never seen a prescription for Valium for 1000 units

'84 MAR 14 P 2:02

other than by Dr. Gardiner. (Transcript at 38)

17. Mr. Rakestraw proceeded to question Mr. Eley on recross and he testified as follows:
 - A. That he knew Dr. Gardiner's license had been reinstated and that he is practicing and writing prescriptions for patients. (Transcript at 38)
 - B. That Dr. Gardiner now writes for 50 tablets per two weeks instead of 100 per month.
 - C. That his prescribing since the time of the violation has been high as to the number of pills. (Transcript at 39)
 - D. That Dr. Gardiner was reinstated because he went through the legal procedure to ask for it to be reinstated.
18. Dr. Ferritto, hearing officer, proceeded to question Mr. Eley and he testified as follows:
 - A. That the patient never received the pills.
 - B. That to his knowledge the pharmacist never called Dr. Gardiner. (Transcript at 42)
 - C. That the pharmacist tried to find out whether or not the amount would be valid to be filled by calling the Pharmacy Board.
 - D. That it was his impression that if Patient 1 would have had the money, the pharmacist would have dispensed the medication. (Transcript at 44)
 - E. That Dr. Gardiner never showed him the letter concerning Patient 1 from Judge Johnson. (Transcript at 46)
 - F. That he asked Judge Johnson for a copy of the letter, but he did not give him a copy. The whole file was missing.
 - G. That he advised Dr. Gardiner of his rights prior to the surrender by going over the voluntary surrender form word-for-word and telling him he did not have to surrender his license. (Transcript at 47)
19. Mr. Jurca proceeded to call Richard Howard Fertel, Ph.D. on behalf of the State and he testified on direct examination as follows:
 - A. That he works at the Ohio State University, College of Medicine, Department of Pharmacology. (Transcript at 52)

'84 MAR 14 PM 12

- B. That he teaches medical and graduate students and does research.
- C. He identified his curriculum vitae, marked as State's Exhibit 1, and acknowledged that it contains an accurate summary of his publications and record.
- D. That he has a Ph.D. in pharmacology from Washington University in St. Louis. (Transcript at 53)
- E. That Doriden is the tradename of a generic drug called glutethimide which is a sedative and hypnotic used to calm people down or put them to sleep.
- F. That Doriden has a very high addiction liability and withdrawal can be severe. (Transcript at 54)
- G. That Lasix is a diuretic used in the treatment of hypertensive cases where less potent diuretics are not effective.
- H. That Lasix is also used in the treatment of severe edema, and is designed to decrease the amount of fluid in the body. (Transcript at 54)
- I. That Lasix is harmful if a patient who is taking it is not careful, hypokalemia may occur. They excrete potassium and severe dizziness can result due to ionic imbalance. A patient taking it should be under supervision.
- J. That Valium is the tradename for the generic name diazepam. It is very widely prescribed as a minor tranquilizer. It is relatively safe if used by itself. (Transcript at 55)
- K. That Valium can cause side effects of psychological dependence and habituation. There are not severe withdrawal symptoms.
- L. That Tetracycline is an antibiotic that can cause some potential changes in the kidneys and liver. (Transcript at 56)
- M. That if used excessively, Tetracycline can cause kidney damage.
- N. That Darvon is a tradename for propoxyphene which is an analgesic that works like morphine and other opiates.
- O. That Darvon has about the same addiction liability as codeine. (Transcript at 56)
- P. That the five medications described will have a strong interaction on the nervous system if they were taken together.

'84 MAR 14 P 3:02

- Q. That as for specifics, the drugs indicate that they should be used with great caution, by themselves, and should not be used with alcohol or other central nervous system drugs. (Transcript at 58)
- R. That the highest dosage unit available with respect to Valium is 10 milligrams.
- S. That as to Joint Exhibit 1, the amount prescribed for Doriden, 100 tablets, is roughly a three-month supply. Doriden has the least going for it in terms of medical utility. Because of its addiction liability and the problems with withdrawal, there are other drugs that should probably be used in place of it. (Transcript at 60-61)
- T. That as to the Doriden, it is enough for someone who wanted to do themselves damage. On the other hand, if you were prescribing a hypnotic for someone that cannot sleep, I suppose this would be within reasonable ranges. (Transcript at 61)
- U. That as to the 5,000, 65 mg. Darvon, it is something like a three-year supply. If someone were to need that kind of analgesia over that period of time, probably some other drug would be a better choice. It depends on the pain and so on, but it is just an incredible, I do not know how much space 5,000 of these takes up, but it is incredible. (Transcript at 61.)
- V. That as to the Tetracycline, there is an awful lot of Tetracycline being prescribed. Normally, you would use one to two grams a day, thus this 1,000 grams is over a year's supply for a standard infection. I cannot imagine why anybody would prescribe that many for a specific infection. (Transcript at 61)
- W. That as to the Lasix, the amount looks very high because it is a very potent drug and the patient should be under supervision. The number suggests the patient would not be going back. (Transcript at 62)
- X. That the 10 milligrams of Valium capsules at the maximum dosage suggested would last about eight months, if taken every day at the maximum dose. It is surprisingly high. (Transcript at 62)
- Y. That neither the Tetracycline nor the Lasix should be prescribed without the patient first undergoing some sort of physical exam. As to the central nervous system drugs, it is a matter of opinion. A good physician would discuss the problem as it exists with the patient, then make a decision. (Transcript at 62-63)
- Z. That as to the,three central nervous system drugs, they should

'84 MAR 14 P 102

not be prescribed together. That he sees no valid reason for prescribing them together and their potential for interaction and abuse is very high. (Transcript at 63).

20. Mr. Rakestraw proceeded to cross-examine Dr. Fertel and he testified as follows:
 - A. That he has no personal knowledge of Patient 1's medical history.
21. Mr. Jurca proceeded on redirect examination and Dr. Fertel testified as follows:
 - A. That the opinions he has expressed are directed at the drugs themselves and their potential for interaction and would not change because he doesn't have medical information on Patient 1. (Transcript at 64)
 - B. That the three drugs should never be prescribed together for one patient. The potential for abuse is exceptionally high. (Transcript at 64-65)
22. Mr. Rakestraw proceeded on recross examination and Dr. Fertel testified as follows:
 - A. That in terms of recommended figures, he uses Goodman and Gillman, an established pharmacology text, Facts and Figures and the Physician's Desk Reference. But Goodman and Gillman is probably the best source. (Transcript at 66)
23. State's Exhibit 1, which is Dr. Fertel's curriculum vitae, was admitted into the record. (Transcript at 67)
24. The State having rested its case, upon motion of Mr. Rakestraw, the hearing was continued until December 15, 1982 at 10:00 a.m.
25. On December 15, 1982 the hearing proceeded with Mr. Rakestraw presenting his case by calling Dr. Gardiner on direct examination. He testified as follows:
 - A. That he has been practicing for twenty-six years, mostly in a general practice. (Transcript at 5)
 - B. That he has treated Patient 1 since 1978, on a monthly basis, and has prescribed two to four prescriptions each month. (Transcript at 5-6)
 - C. That Patient 1 never had a problem with his medications, took them as they were prescribed, and he was confident that Patient 1 could handle the medications prescribed. (Transcript at 6)

'84 MAR 14 P 2:02

- D. That in May, 1982, Patient 1 told him that he was losing his job and medical insurance and asked him to prescribe medication for an extended period of time for that reason.
 - E. That at that time he felt the prescriptions were appropriate and did not know that Patient 1 had been charged with a drug-related offense. (Transcript at 6-7)
 - F. That he didn't ever tell Mr. Eley that he knew Patient 1 had been convicted of a drug offense. He only told him that Judge Johnson wrote him a letter asking for his diagnosis and treatment regarding Patient 1, who had been involved in an automobile accident. (Transcript at 7)
 - G. That since May, 1982, he only prescribes thirty tablets for any controlled drug and gives no refills.
26. Mr. Jurca proceeded on cross-examination and Dr. Gardiner testified as follows:
- A. That he is Board certified in manipulation by the American Academy of Osteopathy and is also in the Cranial Academy.
 - B. That Patient 1 came in and specifically asked for medications that he wanted on occasion. That he checked with some pharmacist about his medication. (Transcript at 9)
 - C. That the fact this patient requested specific medications did not arouse suspicions in his mind as to his motives because he was sick and needed everything prescribed.
 - D. That he doesn't know if Patient 1 ever requested Valium from him, but that he needed the Valium for his condition. (Transcript at 9-10)
 - E. That he doesn't know if Patient 1 requested anything particularly, other than what he prescribed him.
 - F. That Patient 1 would come back at a later time and say he wanted more of what he was given before. That he felt Patient 1 needed this type of medication to keep his nerves calmed down. (Transcript at 10)
 - G. That he had, previous to May, 1982, prescribed Doriden, Lasix, Valium, Tetracycline and Darvon Plain for Patient 1.
27. Mr. Rakestraw proceeded on redirect examination and Dr. Gardiner testified as follows:

'84 MAR 14 PM 12

- A. That he knew Patient 1 worked at a kidney dialysis center, which is a medical-related occupation. (Transcript at 12)
28. Dr. Ferritto, hearing officer, proceeded to question Dr. Gardiner, and he testified as follows:
- A. That the only thing Judge Johnson's letter asked was for Patient 1's medication and diagnosis. The letter did not indicate Patient 1 had been arrested or convicted. (Transcript at 13)
 - B. That Patient 1 requested Darvon, Valium, Tetracycline, and so forth, and that is when he wrote the prescriptions. (Transcript at 14).
 - C. That he saw Patient 1 every month and usually prescribed Doriden, five-tenths of a milligram, thirty tablets to be taken one at bedtime. This was because he was extremely nervous and couldn't sleep.
 - D. That he prescribed Lasix for his blood pressure and Patient 1 needed it all the time, every day. They were forty milligram tablets, quantity of thirty. (Transcript at 17)
 - E. That he prescribed Valium for Patient 1's epilepsy as an anticonvulsant, ten milligrams, three times per day, one hundred tablets at a time.
 - F. That he prescribed Tetracycline for Patient 1's acne, five hundred milligrams, twice per day, sixty per prescription, with a prescription being written every couple months. (Transcript at 20)
 - G. That he prescribed Darvon Plain 65, twelve per day to control Patient 1's headaches. That he checked with Eli Lilly and twelve per day could be taken without harm. (Transcript at 21)
 - H. That Patient 1 would take two Darvon Plain 65 every four hours and he would prescribe a month's supply so he could check him each month. (Transcript at 21-22)
 - I. That Patient 1 was the only patient he ever prescribed more than one hundred Darvon Plain 65 to on one prescription. At times Patient 1 got more than two or three hundred.
29. Mr. Jurca proceeded to question Dr. Gardiner on further cross-examination and he testified as follows:
- A. That Valium is a valid treatment for epilepsy as an anticonvulsant.
 - B. That he didn't run any tests to establish the extent of the epileptic

'84 M-14 P. 12

problem, but he did receive a paper from Ohio State University showing tests in the past. (Transcript at 23-24)

- C. That Patient 1 had CAT scans for his headaches in order to rule out a brain tumor. Also, that he did do cranial manipulation on Patient 1 and his head was in a torsion; twisted, and the membranes were on tension.
 - D. That he checked with Eli Lilly and they told him that even if Valium was being prescribed, you could prescribe up to twelve Darvon per day. (Transcript at 25)
 - E. That Eli Lilly had documented evidence of up to six months with twelve per day, with no addiction and no withdrawal symptoms, however this documentation was not in cases where the patient was also receiving Valium.
 - F. That he didn't inform the Eli Lilly people that the patient was also receiving Doriden, Lasix or Tetracycline. (Transcript at 25-26)
30. Dr. Ferritto questioned Dr. Gardiner further and he testified as follows:
- A. That he did write the prescription for 100, five-tenths milligrams of Doriden for Patient 1 on May 17, 1982 and had written prescriptions before for that amount and also since for that amount. (Transcript at 28)
 - B. That on May 17, 1982, he wrote a prescription for 400 Lasix, 40 milligrams, but usually writes for 30 tablets and had never written one for 400 tablets prior to May 17, 1982. (Transcript at 28-29)
 - C. That on May 17, 1982 he did write a prescription for 1,000 Valium, 10 milligrams, but had never before written for that amount.
 - D. That on May 17, 1982 he wrote the prescription for 100 Tetracycline, 5 milligrams but had never written for that amount in the past. (Transcript at 29-30)
 - E. That on May 17, 1982 he wrote the prescription for 5,000 Darvon Plain 65 and Patient 1 could take up to twelve per day.
 - F. That over a prolonged period of time it is possible that Patient 1 was becoming dependent on Darvon 65. (Transcript at 30)
 - G. That this patient had a condition where he needed the Darvon and he had to weigh the fact against the possibility for addiction.

'84 MAR 14 PM 2

- H. That he would not have written for 5000 tablets had it not been for Patient 1's economic condition. (Transcript at 31)
 - I. That he agrees giving a patient access to 5,000 Darvon Plain 65s was not the right thing to do, but he expected the pharmacist to give the medication over a prolonged period, although he never called or told the pharmacist to do so. (Transcript at 31-32)
31. After brief closing arguments by both parties, the hearing was concluded.

FINDINGS OF FACT

1. John B. Gardiner, D.O. has been a general practitioner of osteopathy for twenty-six years and currently practices in Columbus, Ohio.

The fact is established by Dr. Gardiner's testimony. Transcript at p. 9-10, transcript at p. 5.
2. Dr. Gardiner has treated Patient 1 since 1978 on a monthly basis, prescribing two to four prescriptions per month.

This fact is established by Dr. Gardiner's testimony, Transcript at p. 5-6.
3. Dr. Gardiner wrote the prescriptions listed on the Board's citation letter, on May 17, 1982, in the drugs and amounts indicated, to Patient 1.

This fact is established by Dr. Gardiner's testimony, transcript at p. 11-13, the stipulation of both parties, transcript at p. 18, Mr. Charles Eley's testimony, transcript at p. 24 and Joint Exhibit 1.
4. Patient 1 was arrested and convicted of a charge of deception to obtain a dangerous drug in violation of Section 2925.22(A), Ohio Revised Code, in the summer of 1981.

This fact is established by stipulation of both parties, transcript at p. 8 and Mr. Charles Eley's testimony, transcript at p. 25.
5. Patient 1 tried to get the prescriptions filled, but the pharmacist wouldn't give him the medications until he returned with enough money.

This fact is established by Mr. Charles Eley's testimony, transcript at 22, 26, 41-42.
6. Based on the record before me, Patient 1 is the only patient for whom Dr. Gardiner had ever prescribed these large quantities and except for

'84 MAR 14 P 102

the Doriden and Darvon Plain 65s, had never, prior to May 17, 1982, prescribed such large numbers of tablets for Patient 1.

This fact is established by Dr. Gardiner's testimony, transcript at p. 22, 28-30.

7. On May 17, 1982, Patient 1 told Dr. Gardiner that he was losing his job and his medical insurance and asked him to prescribe the medication for an extended period of time.

This fact is established by Dr. Gardiner's testimony, transcript at p. 6 and Mr. Charles Eley's testimony, transcript at p. 27.

8. Dr. Gardiner would not have written a prescription for 5,000 Darvon Plain 65 milligram tablets had it not been for Patient 1's economic condition.

This fact is established by Dr. Gardiner's testimony, transcript at p. 31.

9. Patient 1 requested the medications specifically and that is when Dr. Gardiner wrote the prescriptions, not being suspicious as to his motives for the specific requests.

This fact is established by Dr. Gardiner's testimony, transcript at p. 9, 10 and 14.

10. When Dr. Gardiner wrote the prescriptions, he didn't know Patient 1 had been convicted or arrested for a drug offense. He didn't find out until he received the citation letter.

This fact is established by Dr. Gardiner's testimony, transcript at 7-8, 13, 14, and 17.

11. In 1981, Dr. Gardiner did receive a letter from Judge Johnson of the Municipal Court asking for Patient 1's diagnosis and medication, however the letter didn't reveal the reasons why he was before the Court. He only knew he had been arrested.

This fact is established by Dr. Gardiner's testimony, transcript at 7-8, 13, 14, and 25.

12. Judge Johnson did not give a copy of the letter to Mr. Eley because the file was not available.

This fact is established by Mr. Eley's testimony, transcript at p. 46.

13. Doriden is the tradename of a generic drug called glutethimide which

'84 MAR 14 P 3:02

is a sedative and hypnotic used to calm people down or put them to sleep and it has a very high addiction liability with possible severe withdrawal.

This fact is established by the expert testimony of Richard Howard Fertel, Ph.D. in Pharmacology, transcript at p. 54.

14. Lasix is a diuretic used in the treatment of hypertensive cases and edema and is designed to decrease the amount of fluid in the body. A patient should only take Lasix under proper supervision because hypokalemia can occur.

This fact is established by the expert testimony of Dr. Fertel, transcript at p. 54-55.

15. Valium is the tradename for diazepam, which is widely prescribed as a minor tranquilizer and is relatively safe when used by itself. Its use can result in habituation and psychological dependence, but the withdrawal symptoms are not severe.

This fact is established by the expert testimony of Dr. Fertel, transcript at p. 55.

16. Tetracycline is a broad spectrum antibiotic that can cause changes in the kidneys and liver and if used excessively, kidney damage.

This fact is established by the expert testimony of Dr. Fertel, transcript at p. 55-56.

17. Darvon is a tradename for propoxyphene which is an opiate-like analgesic having about the same addiction liability as codeine.

This fact is established by the expert testimony of Dr. Fertel, transcript at p. 56-54.

18. The five medications prescribed together for an individual would have an interaction. One is euphoria, one is a sedative, all are minor tranquilizers. The drugs indicate that they should be used with great caution by themselves, and should not be used with alcohol or other central nervous system drugs.

This fact is established by the expert testimony of Dr. Fertel, transcript at 57-58.

19. Dr. Fertel has no personal knowledge concerning Patient 1's medical history.

This fact is established by Dr. Fertel's testimony, transcript at p. 64.

'84 MAR 14 P 3:02

CONCLUSIONS

1. Regarding Paragraph 1 of the citation letter which relates Dr. Gardiner's prescribing to Patient 1 on May 17, 1982, I conclude that such actions by Dr. Gardiner do constitute a violation of Section 4731.22(B)(2), Ohio Revised Code, to wit: failure to use reasonable care discrimination in the administration of drugs, or failure to employ scientific methods in the selection of drugs or other modalities for treatment of disease.

This conclusion is based upon and supported by:

- A. Findings of Fact 7, 8 and 9, which indicate that Dr. Gardiner wrote the prescriptions because Patient 1 was losing his job and medical insurance. They indicate further that Dr. Gardiner wouldn't have written the prescriptions had it not been for Patient 1's economic situation. Also, Dr. Gardiner wrote the prescriptions when Patient 1 specifically asked for the drugs in question, not being suspicious as to the patient's motives. These facts were based upon Dr. Gardiner's own admissions and testimony.
- B. Findings of Fact 13 through 18, which indicate that Doriden, Lasix, Valium, Tetracycline and Darvon are drugs which should be used with great caution by themselves and not combined with other central nervous system drugs.
- C. The expert testimony of Dr. Fertel as to Doriden, transcript at 60-61: "Let me say about Doriden, I think of all the drugs here, I think Doriden has the least going for it in terms of medical utility. Because of its addiction liability and the problems with withdrawal, there are other drugs that should probably be used in place of it.
- D. The expert testimony of Dr. Fertel as to the 5000 Darvon 65 mg. tablets, transcript at 61: "The Darvon, 5000 65 milligram Darvon is something like a three-year supply, at the maximum suggested dosage, and my feeling about that is: if someone were to need that kind of analgesia over that period of time, probably some other drug would be a better choice."
- E. The expert testimony of Dr. Fertel as to the Tetracycline prescription, transcript at 61: "As to the Tetracycline, there is an awful lot of Tetracycline being prescribed here. Normally you would use one to two grams a day of this, and this is 1000 grams, so that is over a year's supply for standard infections. I cannot imagine why anybody would prescribe that many for a specific infection."
- F. The expert testimony of Dr. Fertel as to the Lasix prescription,

'84 MAR 14 P 3:02

transcript at 62: "The Lasix, I would -- The amount I would say looks high to me. Again, because it is a very potent drug that the patient should be under supervision when, in my opinion, when using a drug of this type. This kind of prescription suggests -- this number suggests that this patient would not be going back."

- G. The expert testimony of Dr. Fertel as to the Valium prescription, transcript at 62: "The Valium -- Now 1,000 10 milligrams of Valium capsules at the maximum dosage suggested would last about eight months, if taken every day at the maximum dose. Again, it is surprisingly high to me."
- H. The expert testimony of Dr. Fertel as to the three central nervous system drugs (Doriden, Valium and Darvon), transcript at 63: "First of all, they should not be prescribed together, in my opinion. I see no valid reason for prescribing them together. The main thing I notice in looking at this, is the potential for interaction and abuse of the three central nervous system drugs is very high." Also, transcript at 64-65: "However, these three drugs, in my opinion, should never be prescribed together for one patient. I think the potential for abuse is exceptionally high."
- I. Dr. Gardiner's testimony, transcript at 7, which indicates that since May, 1982 he has cut his prescribing of Valium as much as he can, and only prescribes 30 tablets of any controlled drug, giving no refills and only small doses.
- J. Dr. Gardiner's testimony, transcript at 23-24, which indicates that he had been prescribing Valium to Patient 1 for treatment of epilepsy as an anticonvulsant, however, he did not conduct any tests to establish the extent of the epileptic problem. Instead, he based his treatment upon one past record from Ohio State University.
- K. Dr. Gardiner's testimony, transcript at 25-26, which indicates that his instructions to allow Patient 1 to take up to 12 Darvon Plain 65s per day were based upon contact with Eli Lilly Pharmaceutical Company, even though their decision was not based upon evidence of a patient taking Valium, Doriden, Lasix or Tetracycline at the same time as the Darvon. Further, Dr. Gardiner's testimony, transcript at 27, indicates he did not know the maximum amount of Darvon that could be prescribed for a patient taking Valium.
- L. Dr. Gardiner's testimony, Transcript at 30, which indicates he realized that over a prolonged period of time it is possible that Patient 1 could become addicted to Darvon.

'84 MAR 14 P 3:02

- M. Dr. Gardiner's testimony, transcript at 31, which indicates that he agrees that giving a patient access to 5,000 Darvon Plain 65 mg. tablets was not the right thing to do. Further, Dr. Gardiner stated he expected the pharmacist to give the medication over a prolonged period, however, he did not call or tell the pharmacist to do so.

Therefore, because Dr. Gardiner allowed his medical judgment to be controlled by 1) Patient 1's alleged economic condition, 2) Patient 1's specific requests for controlled substances which should be prescribed only with caution and knowledge of interaction, 3) his reliance upon the pharmacist to police his prescriptions, and 4) his lack of knowledge of the patient's background to warrant the prescribing of such large amounts of tablets, I conclude that Dr. Gardiner's actions do constitute a violation of Section 4731.22(B)(2), Ohio Revised Code.

2. Regarding Paragraph 1 of the citation letter which relates to Dr. Gardiner's prescribing to Patient 1 on May 17, 1982, I conclude that such actions by Dr. Gardiner do not constitute a violation of Section 4731.22(B)(3), Ohio Revised Code, to wit: selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

This conclusion is based upon and supported by:

- A. Findings of Fact 10 and 11, which indicate that Dr. Gardiner was not aware that Patient 1 had been arrested and convicted for a drug offense at the time he wrote the prescriptions on May 17, 1982. They indicate further that Dr. Gardiner had received a letter from Judge Johnson concerning Patient 1, but that the letter didn't explain the reason Patient 1 was before the Court. It only asked about Patient 1's medical situation.
- B. Finding of Fact 12 which indicates the letter did exist but was unavailable to Charles Eley, Board investigator.
- C. The testimony of Dr. Gardiner, transcript at 17, which indicates he didn't know Patient 1 had an arrest or conviction for a drug violation until he received the citation letter.
- D. The testimony of Charles Eley, Board investigator, transcript at 27, which indicates that Dr. Gardiner only knew that Patient 1 had been arrested when the prescriptions were written, but he didn't know it was a drug charge and conviction.
- E. The testimony of Charles Eley, Board investigator, transcript at 33, which indicates Dr. Gardiner was puzzled when he asked him if he knew Patient 1 had been arrested for drug violations.

'84 MAR 14 P 2:02

- F. The testimony of Dr. Gardiner, transcript at 6-7, which again indicated that he did not know that Patient 1 had been charged with a drug-related offense when he wrote the prescriptions. Also, that he had never told Mr. Eley that he knew Patient 1 had been arrested or convicted of a drug-related offense. He only told Mr. Eley that Judge Johnson had written a letter asking for Patient 1's diagnosis and treatment.

The State has not presented sufficient evidence to show that Dr. Gardiner knew Patient 1 had been arrested and convicted of a drug-related offense at the time he wrote the prescriptions on May 17, 1982. Thus, I cannot find that Dr. Gardiner has violated Section 4731.22(B)(3), Ohio Revised Code. The evidence is insufficient to show prescribing for other than legal and legitimate therapeutic purposes. The record indicates that the therapeutic purposes were legal and legitimate, even though the amounts and combinations prescribed were in bad medical judgment, as found in Conclusion 1 above.

3. Regarding Paragraph 1 of the citation letter, which relates Dr. Gardiner's prescribing to Patient 1 on May 17, 1982, I conclude that such actions by Dr. Gardiner do constitute a violation of Section 4731.22(B)(6), Ohio Revised Code, to wit: a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established.

This conclusion is based upon and supported by:

- A. The same facts and testimony which supported the Section 4731.22(B)(2), Ohio Revised Code violation, discussed in Conclusion of Law 1(A) through 1(M).
- B. The testimony of Charles Eley, Board investigator, transcript at 26-27, which indicates that the pharmacist, Frank Sainato, told him that he had never seen that large amount of tablets written on a prescription so he called the Pharmacy Board to make sure it was legal to fill the prescription.
- C. The testimony of Charles Eley, Board investigator, transcript at 36-38, which indicates that in the course of his duties as an investigator for the Board, he checks on the prescribing practices of physicians. That Darvon and Valium have become subject to abuse and in his experience with the Board he has never seen a prescription for Darvon in the large amount (5,000) for which Dr. Gardiner wrote for Patient 1. Nor has he ever seen a prescription for Valium in the large amount (1,000) written by Dr. Gardiner.

Therefore, because of the evidence discussed in Conclusion of Law 1 indicating that Dr. Gardiner allowed his medical judgment to be

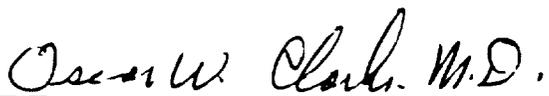
'84 MAR 14 P 3:02

controlled by Patient 1's alleged economic problems; the expert testimony of Dr. Fertel regarding the interaction and common use of the controlled substances involved; Dr. Gardiner's own admissions that he made an error in judgment and that giving a patient access to 5,000 Darvon tablets, which is an addictive drug, was not the right thing to do; and Mr. Eley's testimony which indicates in his experiences as a Board investigator he has never seen prescriptions written in such large amounts, I conclude that Dr. Gardiner's actions do constitute a violation of Section 4731.22(B)(6), Ohio Revised Code: his actions failed to conform to minimal standards of care of similar practitioners under similar circumstances, whether or not there is injury to a patient.

PROPOSED ORDER

It is hereby ORDERED that the license of John B. Gardiner, D.O. to practice osteopathic medicine and surgery in Ohio:

1. Be suspended for sixty (60) days.
2. That said sixty-day suspension be stayed.
3. That Dr. Gardiner be placed on probation for one year from the effective date of this Order.
4. That Dr. Gardiner personally appear before this Board every six (6) months during his probation, and thereafter as the Board should request. He shall answer all questions of this Board truthfully and to the best of his knowledge.



Oscar W. Clarke, M.D.
Hearing Member

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

EXCERPT FROM THE MINUTES OF APRIL 11, 1984

REPORT AND RECOMMENDATION IN THE MATTER OF JOHN B. GARDINER, D.O.

Mr. Bumgarner, Mr. Schmidt, Ms. Yale and Mr. Prunte remained out of the room.

Dr. Lovshin asked if each member of the Board received, read and considered the hearing record, the proposed findings and order, and any objections filed to the proposed findings and order in the matter of John B. Gardiner, D.O. A roll call was taken:

ROLL CALL:	Dr. O'Connor	- aye
	Dr. Lancione	- aye
	Dr. Buchan	- aye
	Dr. Rauch	- aye
	Mr. Johnston	- aye
	Dr. Yut	- aye
	Dr. Peerless	- aye
	Dr. Oxley	- aye

Dr. Lovshin read Dr. Clarke's proposed order in the above-captioned matter, the original of which shall be maintained in the exhibits section of this journal.

DR. BUCHAN MOVED THAT THE PROPOSED ORDER BE AMENDED TO DELETE THE STAY OF THE SUSPENSION, AND THAT THE PROBATIONARY PERIOD BE EXTENDED FROM ONE YEAR TO TWO YEARS FROM THE EFFECTIVE DATE OF THE ORDER. ALL OTHER CONDITIONS REMAIN THE SAME. MR. JOHNSTON SECONDED THE MOTION. A discussion followed.

Mr. Johnston noted that this doctor prescribed over 7,000 pills in one day.

Dr. O'Connor asked if the Board would have to go through another hearing process if it was learned that Dr. Gardiner was still prescribing in an unorthodox manner. Mr. Lee stated that a hearing would be necessary to determine that.

Mr. Johnston withdrew his second to Dr. Buchan's motion. Dr. Buchan withdrew his motion.

MR. JOHNSTON MOVED THAT THE PROPOSED ORDER BE MODIFIED TO STATE AS FOLLOWS:

IT IS HEREBY ORDERED THAT THE LICENSE OF JOHN B. GARDINER, D.O. TO PRACTICE OSTEO-PATHIC MEDICINE AND SURGERY IN OHIO:

1. BE SUSPENDED FOR ONE YEAR.
2. ALL BUT SIXTY (60) DAYS OF SAID SUSPENSION BE STAYED.
3. THAT DR. GARDINER BE PLACED ON PROBATION FOR TWO YEARS FROM THE EFFECTIVE DATE OF THIS ORDER.

4. THAT DR. GARDINER PERSONALLY APPEAR BEFORE THIS BOARD EVERY SIX (6) MONTHS DURING HIS PROBATION, AND THEREAFTER AS THE BOARD SHOULD REQUEST. HE SHALL ANSWER ALL QUESTIONS OF THIS BOARD TRUTHFULLY AND TO THE BEST OF HIS KNOWLEDGE.

DR. BUCHAN SECONDED THE MOTION. A discussion followed.

Dr. Rauch expressed concern that the order in this case was much stricter than the order in the case immediately previous. Dr. Lovshin stated that he didn't feel it was proper for the board to discuss a case that had already been decided on.

A roll call vote was taken on Mr. Johnston's motion:

ROLL CALL VOTE:	Dr. O'Connor	- abstain
	Dr. Lancione	- abstain
	Dr. Buchan	- aye
	Dr. Rauch	- nay
	Mr. Johnston	- aye
	Dr. Yut	- aye
	Dr. Peerless	- aye
	Dr. Oxley	- aye
	Dr. Lovshin	- aye

The motion carried.

DR. YUT MOVED TO AMEND ITEM 4 OF THE ORDER TO STATE THAT HE WOULD APPEAR BEFORE "...THE BOARD OR ITS AGENT..." DR. BUCHAN SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Connor	- aye
	Dr. Lancione	- abstain
	Dr. Buchan	- aye
	Dr. Rauch	- aye
	Mr. Johnston	- aye
	Dr. Yut	- aye
	Dr. Peerless	- aye
	Dr. Oxley	- aye

The motion carried.

Mr. Rakestraw at this time advised the Board that shortly after the investigation and hearing in this case, Dr. Gardiner limited his dispensing of pills to no more than 100 per prescription. Dr. Gardiner does realize the mistake he made. Mr. Rakestraw reminded the Board that the prescription in question in this case was never filled.

Mr. Rakestraw continued that the last two years have been an education for Dr. Gardiner, and he has had no problems since the time of his infraction. Mr. Rakestraw stated that he believed that Dr. Gardiner will be willing to abide by the suspension and probation in the same vein as he has accepted everything else. Mr. Rakestraw added that he personally felt that the probation may be too long.

Dr. O'Connor asked Mr. Rakestraw if Dr. Gardiner is dispensing Doriden in quantities of 100. Mr. Rakestraw stated that he didn't know, but added that Dr. Gardiner is aware of his mistake and has limited his prescriptions accordingly.

Dr. Buchan stated that it sounds as though there may have been more than one incident involved in this case. Mr. Rakestraw stated that there was only the one incident, and added that Dr. Gardiner was trying to help the patient, and that is the reason he prescribed so many pills at one time. There have been no further problems, even though the investigation and hearing happened some time ago.

MR. JOHNSTON MOVED TO APPROVE AND CONFIRM DR. CLARKE'S FINDINGS OF FACT, CONCLUSIONS, AND THE AMENDED PROPOSED ORDER IN THE MATTER OF JOHN B. GARDINER, D.O. DR. BUCHAN SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Connor	- aye
	Dr. Lancione	- abstain
	Dr. Buchan	- aye
	Dr. Rauch	- nay
	Mr. Johnston	- aye
	Dr. Yut	- aye
	Dr. Peerless	- aye
	Dr. Oxley	- aye

The motion carried.

DR. BUCHAN MOVED THAT AN EFFECTIVE DATE OF JUNE 1, 1984 BE PLACED ON THE MOTION. DR. YUT SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. O'Connor	- aye
	Dr. Lancione	- aye
	Dr. Buchan	- aye
	Dr. Rauch	- abstain
	Mr. Johnston	- aye
	Dr. Yut	- aye
	Dr. Peerless	- aye
	Dr. Oxley	- aye

The motion carried.

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

June 17, 1982

John B. Gardiner, D.O.
25 Tibet Road
Columbus, OH 43202

Dear Doctor Gardiner:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine under the provisions of Section 4731.22, Ohio Revised Code, whether or not to limit, reprimand, revoke, suspend, place on probation, refuse to register, or reinstate your certificate to practice osteopathic medicine and surgery for one or more of the following reasons:

1. On or about May 17, 1982, you prescribed the following drugs in the indicated strengths and amounts for a patient who is identified in the attached key (to be withheld from public disclosure):

<u>Patient No.</u>	<u>Date</u>	<u>Substance</u>	<u>Amount</u>
1	5/17/82	Doriden 5 mg.	100
	5/17/82	Lasix 40 mg.	400
	5/17/82	Valium 10 mg.	1000
	5/17/82	Tetracycline 500 mg.	1000
	5/17/82	Darvon Plain 65 mg.	5000

At the time you wrote the prescriptions listed above, you knew that said patient had been convicted of drug charges. In fact, said patient had been convicted of "Deception to Obtain Dangerous Drugs", a violation of Section 2925.22, Ohio Revised Code.

Your acts, conduct, and omissions as described in Paragraph 1, individually and/or collectively, constitute "failure to use reasonable care discrimination in the administration of drugs, or failure to employ scientific methods in the selection of drugs or other modalities for treatment of disease" as one or both of those clauses is used in Section 4731.22(B)(2), of the Revised Code.

Further, your acts, conduct, and omissions as described in Paragraph 1, individually and/or collectively, constitute "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes" as that clause is used in Section 4731.22(B)(3) of the Revised Code.

Further, your acts, conduct, and omissions as described in Paragraph 1, individually and/or collectively, constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established" as that clause is used in Section 4731.22(B)(6) of the Revised Code.

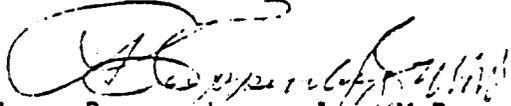
Pursuant to Chapter 119., Ohio Revised Code, please be advised that you may, request a hearing on this matter. If you wish to request such a hearing, that request must be made within thirty (30) days of the time of mailing of this notice.

You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or you may present your position, arguments, or contentions in writing, or that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event there is no request for such hearing made within thirty (30) days of the time of mailing of this notice, the State Medical Board of Ohio may, in your absence and upon consideration of this matter, determine whether or not to limit, reprimand, revoke, suspend, place on probation, refuse to register, or reinstate your certificate to practice medicine or surgery in the State of Ohio.

A copy of Section 4731.22 is enclosed for your review.

Very truly yours,


Anthony Ruppertsberg, Jr., M.D.
Secretary

AR:jmb

Enclosures:

CERTIFIED MAIL #P349 642 283
RETURN RECEIPT REQUESTED

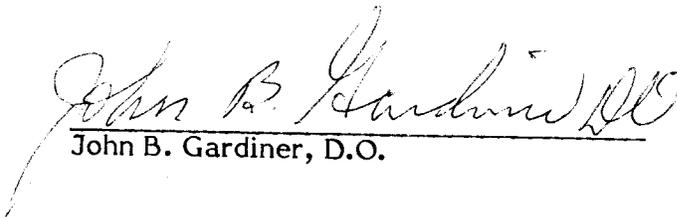
cc: W. Vincent Rakestraw, Attorney at Law
8 East Broad Street
Columbus, OH 43215

CERTIFIED MAIL NO. P30 5155408
RETURN RECEIPT REQUESTED

STATE OF OHIO
THE STATE MEDICAL BOARD

Based on the mutual rescission of Doctor John B. Gardiner's voluntary surrender of his license to practice medicine and surgery in Ohio, Dr. Gardiner's license is hereby reinstated by the Ohio State Medical Board. This reinstatement is effective on June 7, 1982.

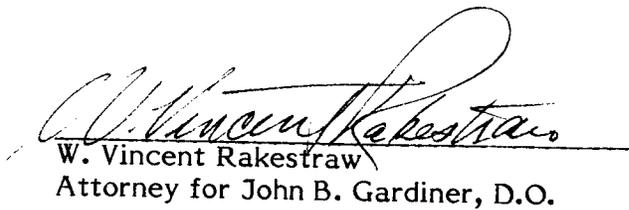
By agreeing to reinstate the medical license of John B. Gardiner, D.O., the Medical Board does not waive its rights to proceed with any disciplinary action or any other action.


John B. Gardiner, D.O.

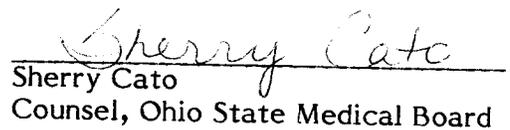
6-4-82
(Date)


Anthony Ruppertsberg, Jr.
Secretary, Ohio State Medical Board

6-7-82
(Date)


W. Vincent Rakestraw
Attorney for John B. Gardiner, D.O.

June 4, 1982
(Date)


Sherry Cato
Counsel, Ohio State Medical Board

June 4, 1982
(Date)

VOLUNTARY SURRENDER OF LICENSE
TO PRACTICE OSTEOPATHIC MEDICINE AND SURGERY

I, John B. Gardiner, D.O., am aware of my rights to representation by counsel, the right of being formally charged and having a formal adjudicative hearing, and do hereby freely execute this document and choose to take the actions described herein.

I, John B. Gardiner, D.O., do hereby voluntarily, knowingly, and intelligently surrender my license to practice osteopathic medicine and surgery, No. 0775, to the Ohio State Medical Board.

I understand that as a result of the surrender herein that I am no longer permitted to practice osteopathic medicine and surgery in any form or manner in the State of Ohio.

Signed this 5th day of July, 1945 in the office of THE BOARD.

John B. Gardiner D.O.

[Signature]
WITNESS

John M. Deacon #262 C.P.D. NARCOTICS
WITNESS

Chas. A. Eley

Sworn to and signed before me this _____ day of _____, 19____.

Notary Public