

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

Benjamin L. Gill, D.O.,

Appellant,

vs.

State Medical Board of Ohio,

Appellee.

Case No. 07CVF-09-11839

Judge E. Brown

FRANKLIN COUNTY, OHIO
2007 NOV 13 PM 12:05
CLERK OF COURTS - CV

NOTICE TO WITHDRAW APPEAL

Appellant, Benjamin L. Gill, D.O., hereby withdraws, without prejudice, the appeal in the instant case.

Respectfully submitted,



Elizabeth Y. Collis (#0061961)
Collis, Smiles & Collis, LLC
1650 Lake Shore Drive, Suite 225
Columbus, Ohio 43204
Tele: (614) 486-3909
Fax: (614) 486-2129
E-mail: beth@collislaw.com
Counsel for Appellant
Benjamin L. Gill, D.O.

CERTIFICATE OF SERVICE

I certify that a copy of the *Notice to Withdraw Appeal* was served upon Kyle Wilcox, Assistant Attorney General, Health and Human Services Section, 30 E. Broad Street, 26th Floor, Columbus, Ohio 43215, by first class U.S. mail, postage prepaid, on November 13th, 2007.



Elizabeth Y. Collis

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY OHIO
CIVIL DIVISION

Benjamin Gill, D.O.,	:	Case No. 07 CVF-09-11839
	:	
Appellant,	:	Judge Brown
	:	
vs.	:	
	:	
State Medical Board of Ohio,	:	
	:	
Appellee.	:	

COMMON PLEAS COURT
 FRANKLIN COUNTY, OHIO
 2007 SEP 14 PM 2:26
 CLERK OF COURTS-CV

**DECISION AND ENTRY DENYING APPELLANT'S MOTION FOR STAY,
FILED JUNE 9, 2006**

This matter is before the court on appellant's Motion for Stay filed on September 7, 2007. Appellee filed its Memorandum Contra Appellant's Motion for Stay on September 10, 2007. In his motion, appellant Benjamin Gill, D.O. moves the court to stay the August 8, 2007 order of appellee the State Medical Board of Ohio ("the Board"), permanently revoking his license to practice medicine.

This appeal is governed by R.C. 119.12, which provides that in an appeal from an order of the Board, a stay of Board order may be granted:

[I]f it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending the termination of the appeal, and the health, safety and welfare of the public will not be threatened by stay of the order.

The filing of an administrative appeal does not automatically entitle an appellant to a stay of execution of the administrative order pending judicial review.

Dr. Gill argues that he will suffer unusual hardship and

Case No. 07 CVF-09-11839

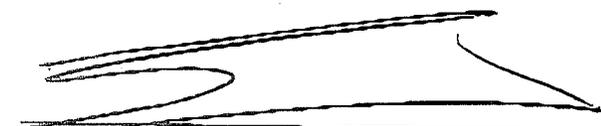
irreparable injury if the Board's order is allowed to take effect while this administrative appeal is pending. Dr. Gill asserts that, as a solo practitioner, he will suffer unusual hardship consisting of loss of income, loss of his property related to his practice, loss of his client base, loss of his employees, and loss of standing in the community. Dr. Gill further asserts that the public health, safety, and welfare will not be threatened if the order is stayed because Dr. Gill was permitted by the Board to practice medicine during the three years that his case was pending before the Board.

In response, the Board argues that Dr. Gill has not demonstrated either of the necessary requirements, and therefore, is not entitled to a stay of the Board's order. The Board asserts that Dr. Gill has presented no evidence or argument to establish that the hardships he has identified are "unusual" as required by R.C. 119.12. According to the Board, Dr. Gill's loss of income, property, employees, clients, and practice are all the natural result of the revocation of his medical license. Additionally, the Board asserts that the public health, safety, and welfare will be threatened if Dr. Gill is permitted to continue to practice medicine. Although the Board allowed him to practice while the administrative proceedings were pending, the Board asserts that the administrative proceedings ultimately demonstrated the serious deficiencies with Dr. Gill's practice, and that, in order to protect the public, such deficient practices should not be permitted to continue.

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Upon review of the evidence and arguments before the court, the court finds that Dr. Gill has failed to demonstrate that he will suffer an unusual hardship if the Board's order is not stayed. The loss of income, property, clients, employees, and reputation are all inherent results of the revocation of a medical license. Dr. Gill has not demonstrated that he will suffer some additional hardship as a result of the court's failure to stay the revocation of his license. The court further finds that the Board found several instances in which Dr. Gill's medical practice fell below the accepted standard of practice, including deficient recordkeeping and misuse of prescription drugs in treating patients. Given the Board's ultimate findings regarding the state of Dr. Gill's practice, the court concludes that, based on the limited record before it, there is reason to believe that the public health, safety, and welfare could be harmed by Dr. Gill's continued practice of medicine.

For the foregoing reasons, the court finds that Dr. Gill has not demonstrated that a stay is appropriate in this case. Therefore, Dr. Gill's Motion to Stay is DENIED.



Judge Eric Brown

14 Sept 2007
Date

Copies to:

Elizabeth Collis, counsel for appellant

Kyle Wilcox, assistant attorney general

IN THE COURT OF COMMON PLEAS STATE MEDICAL BOARD
FRANKLIN COUNTY, OHIO

2007 SEP -4 P 13 57

BENJAMIN L. GILL, D.O. :
767 East Turkeyfoot Lake Road :
Akron, Ohio 44319 :
Appellant, : Case No. _____ :
vs. : JUDGE _____ :
STATE MEDICAL BOARD OF OHIO :
30 E. Broad Street, 3rd Floor :
Columbus, Ohio 43215 :
Appellee :

NOTICE OF APPEAL

Benjamin L. Gill, D.O. (“Appellant”), pursuant to Ohio Revised Code Section 119.12, hereby appeals the final decision of the Ohio State Medical Board (“Appellee”), which **permanently revoked** Appellant’s license to practice medicine and surgery in the State of Ohio in Appellee’s *Entry of Order*, issued on August 8, 2007 and mailed to Appellant on August 22, 2007, a copy of which is attached hereto as Exhibit “A” (the “Appellant Entry of Order”).

Appellant asserts that the decision of the Appellee is not supported by reliable, probative, and substantial evidence and is not in accordance with law.

Appellee failed to prove that Dr. Gill practiced below the standard of care in violation of R.C. 4731.22(B)(6) and OAC 4731-11-04(C) for conduct prior to October 31, 1998 or OAC 4731-11-04(E) for conduct after October 31, 1998 or OAC 4731-11-

Certificate of Service

I certify that this *Notice of Appeal* was served upon Appellee, Ohio State Medical Board, 30 E. Broad Street, 3rd Floor, Columbus, Ohio 43215 by hand delivery this 4th day of September, 2007, and upon and counsel for Appellee, Kyle Wilcox, Esq., Assistant Attorney General, Office of the Ohio Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215 by regular U.S. mail postage prepaid on this 4th day of September, 2007.



Elizabeth Y. Collis (#0061961)

FILED FOR COURT
SEP 11 2007

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

August 8, 2007

Benjamin L. Gill, D.O.
767 E. Turkeyfoot Lake Road
Akron, OH 44319

Dear Doctor Gill:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 8, 2007, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

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

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

THE STATE MEDICAL BOARD OF OHIO

A handwritten signature in black ink, appearing to read "Lance A. Talmage".

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3933 5241 3622
RETURN RECEIPT REQUESTED

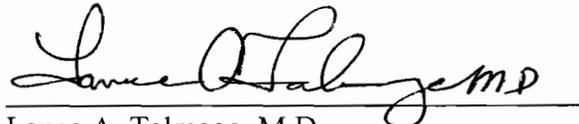
Cc: Elizabeth Y. Collis, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3933 5241 3639
RETURN RECEIPT REQUESTED

Mailed 8-22-07

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 8, 2007, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Benjamin L. Gill, 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.



Lance A. Talmage, M.D.
Secretary

(SEAL)

August 8, 2007

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

BENJAMIN L. GILL, D.O.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on August 8, 2007.

Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, 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.

It is hereby ORDERED that:

The certificate of Benjamin L. Gill, D.O., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective thirty days from the date of mailing of notification of approval by the Board. In the thirty day interim, Dr. Gill shall not undertake the care of any patient not already under his care.

(SEAL)



Lance A. Talmage, M.D.
Secretary

August 8, 2007
Date

2007 JUL 12 P 2 42

**REPORT AND RECOMMENDATION
IN THE MATTER OF BENJAMIN L. GILL, D.O.**

The Matter of Benjamin L. Gill, D.O., was heard by R. Gregory Porter, Hearing Examiner for the State Medical Board of Ohio, on September 26, 27, and 28, 2006.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated July 14, 2004, the State Medical Board of Ohio [Board] notified Benjamin L. Gill, D.O., that it had proposed taking disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action upon allegations concerning Dr. Gill's treatment of twenty-seven patients identified in a confidential Patient Key.

The Board alleged that Dr. Gill's conduct constitutes:

- “[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.”
- With regard to conduct alleged to have occurred prior to October 31, 1998: “‘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: 4731-11-04(B), Ohio Administrative Code. Pursuant to Rule 4731-11-04(C), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.”
- With regard to conduct alleged to have occurred on or after October 31, 1998, and prior to June 30, 2000: “‘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: 4731-11-04(C), Ohio Administrative Code. Pursuant to Rule 4731-11-04(E),

Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.”

- With regard to conduct alleged to have occurred on or after June 30, 2000: ““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: 4731-11-04(B) and (C), Ohio Administrative Code. Pursuant to Rule 4731-11-04(D), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.”
- “[V]iolating 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, Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.”

Accordingly, the Board advised Dr. Gill of his right to request a hearing in this matter. (State’s Exhibit 1A)

- B. By document received by the Board on August 11, 2004, Eric J. Plinke, Esq., requested a hearing on behalf of Dr. Gill. (State’s Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Kyle C. Wilcox and Damion M. Clifford, Assistant Attorneys General.
- B. On behalf of the Respondent: Elizabeth Y. Collis, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 1. Benjamin L. Gill, D.O., as upon cross-examination
 2. Kevin L. Hornbeck, R.Ph., D.O.

B. Presented by the Respondent

1. Jon Wills
2. Kevin D. Huffman, D.O.
3. Benjamin L. Gill, D.O.

II. Exhibits Examined

A. Presented by the State

State's Exhibits 1A through 1EE: Procedural exhibits. (Note that the Patient Key was removed from State's Exhibit 1A by the Hearing Examiner post-hearing. Further note that State's Exhibit 1W has been sealed to protect patient confidentiality.)

- * State's Exhibits 2 through 28: Copies of Dr. Gill's medical records for Patients 1 through 27.
- * State's Exhibit 29: Patient Key.

State's Exhibits 30 and 31: March 18 and June 11, 2004, reports of Kevin L. Hornbeck, R.Ph., D.O.

- * State's Exhibit 32: Copies of a July 25, 2003, Investigative Subpoena Duces Tecum, Patient Key, and keys to abbreviations used by Dr. Gill in his medical records.

State's Exhibit 33: Copy of document entitled "Patient Chart Abbreviations for Patient Charts Subpoenaed from Dr. Benjamin Gill."

State's Exhibit 34: Curriculum Vitae of Kevin L. Hornbeck, R.Ph., D.O.

State's Exhibits 36 through 38: Excerpts from the Ohio Administrative Code.

B. Presented by the Respondent

Respondent's Exhibits A through C: Copies of keys to abbreviations used by Dr. Gill in his medical records.

Respondent's Exhibit D: Copies of blank patient history and physical examination forms used by Dr. Gill in his medical practice.

Respondent's Exhibit E: Copy of the American Diabetes Association's 1,000 Calorie Diet.

Respondent's Exhibit F: Copies of Board Investigators' business cards.

Respondent's Exhibit H: Curriculum vitae of Kevin D. Huffman, D.O.

Respondent's Exhibits J and K: Copies of resolutions of the Ohio Osteopathic Association concerning the use of anorectic medications.

Respondent's Exhibit L: Copy of February 5, 2002, letter to the Board from Jon F. Wills, Executive Director, Ohio Osteopathic Association.

Respondent's Exhibit N: Copy of draft minutes of the April 10, 2002, meeting of the Board's Pain Management Committee, with attachments.

Respondent's Exhibits P and Q: Letters of support for Dr. Gill.

C. Admitted by the Hearing Examiner Post-Hearing

Board Exhibit A: November 13, 2006, State's Closing Argument.

Board Exhibit B: November 27, 2006, Respondent's Closing Argument.

Board Exhibit C: November 30, 2006, State's Rebuttal Closing Argument.

Board Exhibit's E and F: Post-hearing procedural exhibits.

* Note: Exhibits marked with an asterisk (*) have been sealed to protect patient confidentiality.

PROFFERED MATERIAL

The following document is not a part of the hearing record nor was it considered, but has been sealed from public disclosure and held as proffered material:

Board Exhibit D: Page 170 of the Hearing Transcript, which contains patient identifying information. (See Procedural Matters 2, below.)

PROCEDURAL MATTERS

1. At the close of the hearing, the record was held open to give the parties an opportunity to prepare written closing arguments. The hearing record closed on November 30, 2006, following receipt of the State's Rebuttal Closing Argument.

2. Patient-identifying information was redacted from Page 170 of the Hearing Transcript lines 7 through 15. The original, unredacted pages have been marked Board Exhibit D and retained as proffered material.
3. On July 10, 2007, a telephone conference was held among the Hearing Examiner and the parties' representatives. During that teleconference, the parties agreed to stipulate that diethylpropion is a schedule IV controlled substance.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background Information

Benjamin L. Gill, D.O.

1. Benjamin L. Gill, D.O., testified that he had obtained his osteopathic medical degree in 1963 from the Kirksville College of Osteopathic Medicine in Kirksville, Missouri. From 1963 through 1964, Dr. Gill participated in an internship at Ridgewood Hospital in Garden City, Michigan. Following completion of his internship, Dr. Gill established a private medical practice in Akron, Ohio, and joined the staff of Cuyahoga Falls General Hospital in Cuyahoga Falls, Ohio. Dr. Gill operated a solo general medicine practice until 1975, when he joined the practice of Dr. Harold Hunter, who specialized in bariatric medicine in Copley, Ohio. Dr. Gill joined the American Society of Bariatric Physicians [ASBP] at that time, and continued to practice with Dr. Hunter until 1976. In 1976, Dr. Gill left Dr. Hunter's practice and started a solo bariatric medicine practice on Turkeyfoot Lake Road in Akron, where he continues to practice bariatric medicine today. (Hearing Transcript [Tr.] at 19-24)
2. Dr. Gill testified that bariatric medicine is "the care and management of obese patients; obesity and associated conditions. Associated conditions, of course, are hypertension, diabetes, primarily." Dr. Gill further testified that bariatric medicine also encompasses endocrinological conditions "such as thyroid disorders and it has a lot to do with preventative medicine." (Tr. at 24)

With regard to his training in bariatric medicine, Dr. Gill estimated that, in the last 30 years, he has attended 10 or 12 annual conventions of the ASBP, as well as an additional 18 to 20 educational conferences. Dr. Gill also testified that he has thrice attended an obesity course offered at Harvard University, the last time having been about seven years prior to the hearing. (Tr. at 24-25, 553-555)

3. Dr. Gill testified that his current practice is 90 percent bariatric medicine, and that he has continued to do some general medicine that comprises about 10 percent of his practice. Dr. Gill further testified that he sees between 80 and 120 patients per week, or about 20 to 25 patients per day. Moreover, he testified that the weekly patient load varies because he sees patients on Mondays, Tuesdays, Thursdays, Fridays, and alternating Saturdays. Finally, Dr. Gill stated that he currently has between 1,000 and 1,200 patients in his practice. (Tr. at 27-28, 30-31)
4. Dr. Gill testified that he is not board certified, although he is eligible for certification in bariatric medicine. (Tr. at 25-26)

Kevin L. Hornbeck, D.O.

5. Kevin L. Hornbeck, D.O., testified as an expert witness on behalf of the State. Dr. Hornbeck graduated from Ohio Northern University in 1984 with a Bachelor of Science in Pharmacy, and practiced as a pharmacist from 1984 through 1986. Subsequently, in 1990, Dr. Hornbeck obtained his osteopathic medical degree from the West Virginia School of Osteopathic Medicine in Lewisburg, West Virginia. From 1990 through 1991, Dr. Hornbeck participated in an osteopathic rotating internship at Cuyahoga Falls General Hospital in Cuyahoga Falls, Ohio. Subsequently, from 1991 through 1994, Dr. Hornbeck participated in an internal medicine residency at Wright State University/Miami Valley Hospital in Dayton, Ohio. (St. Ex. 34; Tr. at 266-268)

Dr. Hornbeck was certified by the American Osteopathic Board of Internal Medicine in 1996. He holds teaching positions at the Ohio Northern University College of Pharmacy and at the Ohio University College of Osteopathic Medicine. Dr. Hornbeck testified that he holds privileges at Miami Valley Hospital in Dayton, Kettering Medical Center in Kettering, Ohio, and Sycamore Hospital in Miamisburg, Ohio. (St. Ex. 34; Tr. at 268-269)

6. After finishing his residency in 1994, Dr. Hornbeck opened a practice of internal medicine in Vandalia, Ohio. Dr. Hornbeck testified that he sees patients who suffer from diabetes, hypothyroidism, cardiac disease, and multiple medical problems. Dr. Hornbeck further testified that the average age of his patient population is about 55 years old, but that he has some patients in their late teens and some who are in their 90s. Moreover, Dr. Hornbeck testified that 100 percent of his practice is clinical. (St. Ex. 34; Tr. at 269-270)
7. Dr. Hornbeck testified that, at the request of the Board, he had reviewed Dr. Gill's medical records for Patients 1 through 27, relevant rules and regulations, a transcript of a Board investigatory deposition of Dr. Gill, and literature concerning bariatric medicine. (Tr. at 274-276)

Dr. Hornbeck testified that he had prepared two expert witness reports for the Board, one dated March 18, 2004, and another dated June 11, 2004. Dr. Hornbeck explained that one report addresses deficiencies with Dr. Gill's medical care and documentation, and the other addresses the inappropriate use of medication. (St. Exs. 30 and 31; Tr. at 286)

8. On cross-examination, Dr. Hornbeck testified that, during his medical training, he did not have specific training in bariatric medicine. However, Dr. Hornbeck testified that he has treated obese patients and has tried various means to help them lose weight. Dr. Hornbeck further testified that he has prescribed controlled substance anorectic medications, but that he has found that they do not work. (Tr. at 381)

Kevin D. Huffman, D.O.

9. Kevin D. Huffman, D.O., testified as an expert witness on behalf of Dr. Gill. Dr. Huffman obtained his osteopathic medical degree in 1987 from the Ohio University College of Osteopathic Medicine in Athens, Ohio. In 1988, Dr. Huffman completed a general practice internship at Firelands Community Hospital in Sandusky, Ohio. Since that time, Dr. Huffman has practiced at, and served as medical director of, bariatric and weight-loss clinics. Currently, Dr. Huffman does consulting work and is the President of American Bariatric Consultants. Dr. Huffman testified that one of his Ohio clients is The Cleveland Clinic Foundation. (Resp. Ex. H; Tr. at 448-449)

Dr. Huffman was certified by the America Osteopathic Board of Family Physicians in 1996 and by the American Board of Bariatric Medicine in 1998. (Resp. Ex. H)

10. Dr. Huffman testified that bariatric medicine is a relatively new field of medicine. He stated that there are currently no fellowships available in that field and that one becomes certified by the American Board of Bariatric Medicine by taking CME courses in bariatric medicine, sitting for a written and oral exam, and submitting to an office inspection. (Tr. at 450-451)

Testimony Concerning Medications and Terms Relevant to this Matter

Testimony of Dr. Hornbeck

11. Dr. Hornbeck defined controlled substance anorectic medication as “pharmaceutical products that are scheduled by the DEA and they are sympathomimetics, which means that they mimic the sympathetic nervous symptom to curb the appetite or to suppress the appetite.” Dr. Hornbeck further testified that such medications usually fall into controlled substance schedules III or IV. (Tr. at 276-277)

Dr. Hornbeck testified that the reason most anorectic medications are scheduled controlled substances is “because of a high potential for abuse.” (Tr. at 277)

12. Dr. Hornbeck testified that diuretics are pharmaceutical products that cause an increase in the body’s excretion of water, along with the electrolytes sodium and potassium. Dr. Hornbeck testified that diuretics are usually prescribed for the control of hypertension

or congestive heart failure. Dr. Hornbeck noted that the long-term effect of diuretics causes vasodilation, which lowers blood pressure. (Tr. at 277-279)

Dr. Hornbeck testified that diuretics should not be prescribed for weight loss. He further testified that they should not be used in patients who, for example, are not hypertensive or do not have congestive heart failure, or do not have bloating and water retention as a result of menses or hormones. (Tr. at 279)

13. Dr. Hornbeck testified that the term “Body Mass Index” [BMI] is a person’s weight in kilograms divided by his or her height in meters squared. It is a formula for determining whether a person is obese. (Tr. at 279-280)

Dr. Hornbeck testified that the term “co-morbid condition” as that term is used in this case refers to conditions that are exacerbated by excess body weight, such as diabetes, hypertension, and coronary artery disease. (Tr. at 280)

Testimony of Dr. Huffman

14. Dr. Huffman testified that anorectic medications work to control patients’ hunger and thus allow them to reduce calories more comfortably and sustain calorie restrictions for longer periods. Dr. Huffman further testified that controlled substance anorectic medications are more effective at controlling patients’ hunger than are noncontrolled anorectics. (Tr. at 454, 503)
15. Dr. Huffman testified that he is unaware of any studies that indicate that schedule IV controlled substance anorectic medications are habit forming or addictive. Moreover, Dr. Huffman testified that he had not seen any abuse or diversion of medication in his own practice. (Tr. at 459-460)

Testimony of Dr. Gill

16. Dr. Gill testified that neither schedule III or schedule IV controlled substance anorectic medications are prone to abuse. Moreover, Dr. Gill testified that they do not have addictive properties. (St. Ex. 43-45)

Sample Excerpt of Dr. Gill’s Medical Record for Patient 1

17. An example of Dr. Gill’s medical records appears below. The example includes Dr. Gill’s progress notes for Patient 1’s first five visits, and illustrates the basic structure of recordkeeping that Dr. Gill consistently employed throughout the medical records for Patients 1 through 27:

NAME		PHONE		EMPLOYER		
ADDRESS		AGE	SEX	HEIGHT	WEIGHT	NAME OF SPOUSE
CITY		STATE	ZIP	NORMAL WT	SPOUSE'S EMPLOYER	
INSURANCE				REFERRED BY		

DATE	WEIGHT	B.P.	HEART	PRESCRIPTIONS	MEDICATION
MEDS: None					
MAY 21 1991	146 1/2	124/88	✓ N.S.R.	2wk VIC	TRP — PPA
UA: CU Nitrite (+) Ph (OK)					
(1000 Ada Cal & Guidelines) Do Reg (Feb) done (K)					
JUN 04 1991	150 1/4	110/80	✓ N.S.R.	2wk trim-W	Era — St-S (L)
pt. hasn't filled the above R yet (chol. + your heart)					
JUN 17 1991	146 3/4	120/80	✓ N.S.R.	2wk Era	Era — Sts (P)
pt requested Am change					
JUL 01 1991	146	120/76	✓ (Enderon #6)	2wk Era	Era — Sts (L)
pt can't take WP — dries out eyes — has contacts.					
JUL 15 1991	143 1/4	120/70	✓ N.S.R.	2wk Era	Era — Sts (L)
on menses. (D/R) Enderon 5mg #24 TQMWF XOL					

(St. Ex. 2 at 20) [Note that patient-identifying information was redacted from the above.]

May 21, 1991, Initial Visit

- Dr. Gill testified that all of his patients filled out the top of the first progress note page. On additional pages of progress notes, either Dr. Gill or a nurse filled out the top of the pages. (Tr. at 583-585, 632-633)

Accordingly, in addition to the personal information redacted from the above image, Patient 1 had filled out her age (45), sex, height (5'5"), and weight (154 pounds) at the top of the page. Patient 1 had estimated her current weight to have been 154 pounds. (St. Ex. 2 at 20)

Dr. Gill testified that he did not measure a patient's height unless the height recorded by the patient at the top of his or her first page of progress notes seemed "really off." Dr. Gill stated, "I can pretty well eyeball them and tell what their height is and if—if there is a question about what they have written down * * * then we'll check their height, because it has to do with the BMI." (Tr. at 633-634)

19. Patient 1 was weighed by Dr. Gill's nurse and her weight was recorded as 146.5 pounds in the progress note dated May 21, 1991. The progress note also indicates that Patient 1 had not been taking any medication at that time, and had had a blood pressure of 126/88. The note also indicates "✓N.S.R." (St. Ex. 2 at 20)

Dr. Gill testified that N.S.R. means "normal sinus rhythm." Dr. Gill further testified: "The check mark means I checked the heart, in other words listened to it, and for years have used the term or the abbreviation normal sinus rhythm, which just means regular rate and rhythm. If there was a murmur or irregular heart rate, I would note that." (Tr. at 54) Dr. Gill also testified that he routinely listens to patients' lungs, although he does not ordinarily document that in the medical record. (Tr. at 54-55)

20. Dr. Hornbeck criticized Dr. Gill's documentation of "N.S.R.," normal sinus rhythm, in his physical examination findings. Dr. Hornbeck stated that a finding of normal sinus rhythm cannot be documented without an EKG or a rhythm strip. (Tr. at 283-284)
21. Dr. Gill agreed with Dr. Hornbeck's opinion that normal sinus rhythm can only be documented if an EKG or a rhythm strip is obtained. However, Dr. Gill testified that it was just a habit that he had developed after many years of practice that, to him, "N.S.R." means that he had listened to a patient's heart and found the rate and rhythm to be normal. Dr. Gill testified that he could have recorded N.R.R. for normal rate and rhythm. (Tr. at 100-101)
22. The progress note for the initial visit further indicates that Patient 1 had been given a 1,000 calorie American Diabetic Association diet and guidelines. There is a note to "Do Reg Lab" and another note beside it that says "done." Urinalysis results are documented. Additionally, the progress note states that Dr. Gill prescribed Dyazide #24 with no refills and instructed Patient 1 to take one every Monday, Wednesday, and Friday.¹ Finally, Dr. Gill prescribed or dispensed a two-week supply of substances identified by the abbreviations "VIC," "TRP," and "PPA 75 mg" for "AM," "Noon," and "PM," respectively. (St. Ex. 2 at 20)

Abbreviation charts provided by Dr. Gill indicate that "VIC" was used by Dr. Gill as an abbreviation for vitamin C, "TRP" was used by Dr. Gill as an abbreviation for time-release phenylpropanolamine, and "PPA 75 mg" was used by Dr. Gill as an abbreviation for phenylpropanolamine 75 mg. Dr. Gill testified that both vitamin C and phenylpropanolamine are noncontrolled substances and are available over-the-counter without a prescription. (St. Ex. 32 at 7; Resp. Exs. A, B, and C; Tr. at 86,² 111)

¹ Dr. Gill testified that Dyazide is a diuretic medication. (Tr. at 47)

² On page 86 of the hearing transcript, Dr. Gill testified that PPA and TRP contain phenylpropion. This appears to be an error. Dr. Gill's later testimony, along with written keys he provided, indicated that TRP and PPA instead contain phenylpropanolamine. (St. Ex. 32 at 7; Resp. Exs. A, B, and C; Tr. at 111)

23. The May 21, 1991, progress note does not include documentation of a diagnosis. (St. Ex. 2 at 20)
24. At her initial visit, Patient 1 filled out a patient history form. Her responses on that form include that she took vitamins, smoked cigarettes, and consumed soft drinks; that her mother had weight problems; that she ate breakfast, lunch, dinner, in the evening, and/or between meals, that she had the most problems with overeating in the evening; that she had previously been on a weight control program that included medication, that she had lost seven pounds, regained nine pounds, and that the program had lasted six months.³ (St. Ex. 2 at 33)

June 4, 1991, Visit

25. Dr. Gill next saw Patient 1 on June 4, 1991. The progress note indicates that she weighed 150¼ pounds, a gain of 3¾ pounds following her prior visit. The progress note further states that Patient 1 was “on menses,” that she “bloats,” and that those issues were discussed with the patient. In addition, the progress note states that Patient 1 had not “filled the above [prescription] yet,” presumably referring to the May 21, 1991, prescription for Dyazide. Furthermore, the progress note states that Dr. Gill or his staff provided Patient 1 with material concerning “Chol[esterol] & your heart.” Finally, Dr. Gill prescribed or dispensed a two-week supply of substances identified by the abbreviations “trim-W,” “Era,” and “St-S” for “AM,” “Noon,” and “PM,” respectively. (St. Ex. 2 at 20)
26. Evidence provided by Dr. Gill indicates that “Trim W” is phendimetrazine 35 mg in a white pill or capsule, “Era” is a yellow capsule containing phentermine HCL 30 mg, and “St-S” (or “Sts”) stands for Statobex, a brand name of phendimetrazine. (Resp. Exs. B and C; Tr. at 57-58)
27. Dr. Gill testified that phendimetrazine is a schedule III controlled substance, and that phentermine is a schedule IV controlled substance. (Tr. at 59)
28. Dr. Gill testified that, rather than issue prescriptions for anorectic medications, he dispenses anorectic medication directly to his patients from his office supply. (Tr. at 59-60)
29. With regard to his dosing instructions for controlled substance anorectic medications, Dr. Gill testified:

I use what we call three-a-day dosing, which is breakfast, lunch and dinner. They are instructed—all the medication we use, the patient’s instructed to take that medication an hour before they eat and we start out with certain medication and then we adjust it as we go along depending on the patient and

³ The meaning of Patient 1’s statements on the history form is open to interpretation. One could also interpret Patient 1’s responses to mean that she had regained nine pounds in six months. (St. Ex. 2 at 33)

depending on their schedule, their work schedule, how much they weigh, we'll adjust the medication and the dosage of it.

(Tr. at 58)

30. Finally with regard to the June 4, 1991, progress note, the letter "L" is circled next to the notation "St-s." Dr. Gill explained that such a notation meant that a nurse had given the patient a vitamin B-12 injection in the left arm. The letter "R" circled would refer to a vitamin B-12 injection in the right arm.⁴ (St. Ex. 2 at 20; Tr. at 74)

June 17, 1991, Visit

31. Among other things, the progress note dated June 17, 1991, states that Patient 1 had weighed 146.75 pounds, a loss of 3.5 pounds from the previous visit. It further states that Patient 1 had requested a change in her morning medication. The two-week medication regimen dispensed during the previous visit—phendimetrazine 35 mg before breakfast, phentermine HCL 30 mg before lunch, and phendimetrazine before dinner—changed to two doses of phentermine HCL 30 mg, one dose before breakfast and one dose before lunch, and phendimetrazine before dinner. (St. Ex. 2 at 20)

July 1, 1991, Visit

32. The progress note dated July 1, 1991, states, among other things, that Patient 1 had weighed 146 pounds, a loss of 0.75 pounds from the previous visit. It further states that Patient 1 could not take her diuretic because she was a contact lens wearer and it "dries out [her] eyes." In addition to the two-week controlled substance anorectic medication regimen dispensed at the previous visit, Dr. Gill prescribed or dispensed Enduron #6.⁵ (St. Ex. 2 at 20)

July 15, 1991, Visit

33. The progress note dated July 15, 1991, states that Patient 1 weighed 143.25 pounds, a loss of 2.75 pounds from the previous visit. The note further states that Patient 1 received a two-week supply of the same controlled substance anorectic medication regimen dispensed the last time. Finally, the note states that Dr. Gill prescribed Enduron 5 mg #24 with no refills, and instructed Patient 1 to take one every Monday, Wednesday, and Friday. (St. Ex. 2 at 20)

⁴ Because an issue concerning a vitamin B-12 injection was alleged only with regard to a more easily discernible notation in Patient 11's medical record, this information cannot be considered against Dr. Gill by the Hearing Examiner or the Board. See State's Exhibit 1A at paragraph 3(g).

⁵ Dr. Gill testified that Enduron is a diuretic. (Tr. at 64)

Paragraph 2 of the July 14, 2004, Notice of Opportunity for Hearing: Allegations that Dr. Gill Inappropriately Utilized Controlled Substance Anorectic Medication in the Treatment of Obesity

*Paragraph 2(a) of the Notice of Opportunity for Hearing [Notice] alleges: “Prior to initiating * * * treatment of Patients 1-27 with controlled substance anorectics, [Dr. Gill] failed to determine and/or document having determined, through a review of [his] records of prior treatment, or through a review of the records of prior treatment which another treating physician or weight-loss program has provided to [Dr. Gill], that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, and exercise, without the use of controlled substances, and that said treatment had been ineffective.” (St. Ex. 1A)*

34. Dr. Gill prescribed or dispensed controlled substance anorectic medication to Patients 1 through 27. (St. Exs. 2 through 28)
35. Five of Dr. Gill’s patient medical records contain no documentation concerning patients’ previous efforts to lose weight. This is true for Patient 3 (St. Ex. 4), Patient 8 (St. Ex. 9), Patient 12 (St. Ex. 13), Patient 19 (St. Ex. 20), and Patient 25 (St. Ex. 26).

In fourteen other cases, Dr. Gill documented that the patient had not been on a previous weight control program. This is true for Patient 4 (St. Ex. 5 at 5), Patient 5 (St. Ex. 6 at 5), Patient 7 (St. Ex. 8 at 16), Patient 10 (St. Ex. 11 at 8), Patient 11 (St. Ex. 12 at 14), Patient 14 (St. Ex. 15 at 6), Patient 15 (St. Ex. 16 at 6), Patient 16 (St. Ex. 17 at 6), Patient 17 (St. Ex. 18 at 5), Patient 18 (St. Ex. 19 at 5), Patient 22 (St. Ex. 23 at 5), Patient 23 (St. Ex. 24 at 6), Patient 26 (St. Ex. 27 at 5), and Patient 27 (St. Ex. 28 at 6).

Additionally, in eight cases, Dr. Gill’s medical record contains some documentation of a patient’s prior effort(s) to lose weight. For example:

- As stated previously with regard to Patient 1’s first visit to Dr. Gill, Patient 1 indicated on a patient history form that she had been in a weight-control program that included medication. No further information is recorded concerning Patient 1’s previous effort to lose weight. (St. Ex. 2 at 33)
- In his progress note for Patient 2’s first visit on January 24, 1997, Dr. Gill documented, “Pt has been on prev. W.C.P.” However, nothing further is documented concerning Patient 2’s previous effort to lose weight. (St. Ex. 3 at 12)
- In his progress note for Patient 6’s first visit on September 6, 1996, Dr. Gill documented, “pt was on a W.C.P. [with] her reg. Dr. – 200+ with 2nd preg.” No further information is recorded concerning Patient 6’s previous effort to lose weight. (St. Ex. 7 at 18)

- The following patient records also include some information concerning patients' prior efforts to lose weight: Patient 9 (St. Ex. 10 at 14), Patient 13 (St. Ex. 14 at 35), Patient 20 (St. Ex. 21 at 33), Patient 21 (St. Ex. 22 at 33), and Patient 24 (St. Ex. 25 at 33)

Finally, none of the aforementioned medical records contain documentation that Dr. Gill had determined, through a review of his records of prior treatment, or through a review of the records of prior treatment which another treating physician or weight-loss program had provided to Dr. Gill, that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, and exercise, without the use of controlled substances, and that said treatment had been ineffective. (St. Exs. 2, 3, 7, 10, 13, 20, 21, and 25)

36. Dr. Hornbeck testified that, prior to prescribing controlled substance anorectic medication to a patient, a physician must first document that the patient has made an earnest attempt at losing weight by eating less, exercising more, modifying his or her lifestyle, and through patient education. Dr. Hornbeck testified, "Those are the first things. Those have been standard forever." (Tr. at 290)
37. Dr. Gill testified that he routinely asks patients whether they had previously participated in a weight reduction program that was based on caloric restriction, nutritional counseling, behavior modification, and exercise. Dr. Gill further testified, "Obviously we assume that a majority of them have done that one way or the other." (Tr. at 66-67)

Paragraph 2(b) of the Notice alleges: "[I]n [his] treatment of Patients 3-6, 9, 10, 12-16, 18, 19, 21-27 with controlled substance anorectics, [Dr. Gill] failed to obtain and/or document that [he] obtained a thorough history, and/or [he] failed to perform and/or document that [he] performed a thorough physical examination of these patients." (St. Ex. 1A)

38. Dr. Gill's medical record for Patient 1, as discussed above, includes a typical example of Dr. Gill's documentation of a patient physical examination and history.
39. Dr. Hornbeck testified that a thorough patient history includes the patient's past medical history, social history, family history, and surgical history. Dr. Hornbeck added that this information must be documented in the medical record. (Tr. at 281-282)
40. Dr. Hornbeck testified that a thorough physical examination includes:
 - Noting the patient's general appearance, such as whether the patient is disheveled.
 - Obtaining vital signs, which include:
 - Blood pressure
 - Pulse
 - Respiratory rate
 - Temperature
 - If the patient has a pulmonary condition, pulse oximetry
 - HEENT: head, ears, eyes, nose, and throat

- Neck
- Cardiovascular system
 - Regular heart rate
 - Heart sounds
 - Carotid bruits
- Lung system
 - Listening to lungs
- Abdominal exam
- Extremities
 - check that pulses are equal
- Neurological system
 - Cranial nerves
 - Gait
 - Strength in the four limbs
- Male patient: may do prostate examination
- Female patient: may do gynecological examination

(Tr. at 281-282) Dr. Hornbeck added that the findings from the physical examination must be documented in the medical record. (Tr. at 282)

41. Dr. Hornbeck testified that Dr. Gill had failed to document a thorough patient history and a thorough physical examination throughout the medical records for Patients 1 through 27. (Tr. at 301, 370-371)
42. Dr. Hornbeck testified that, if he views Dr. Gill as a physician who specializes in a particular area of practice, bariatric medicine, then he believes that Dr. Gill's treatment and documentation "is markedly more inadequate." Dr. Hornbeck testified that specialists perform and document more in-depth examinations in their areas of expertise than do primary care physicians. (Tr. at 392-394)
43. Dr. Gill testified concerning the performance of patient histories and physical examinations prior to utilizing controlled substance anorectic medication:

You do a history and physical, ask them about their previous history of weight loss attempts and what's worked and what hasn't worked and look at family history to see if there is a family tendency toward obesity, obesity related diseases; do a brief physical examination.

My examinations were never real thorough in that most of my patients—all of my patients generally had a primary care physician. I was considered a specialist, so they—I either got referred the patients into me from another physician or primary care doc.

But I did a history and physical that included listening to the heart, [made] sure they had normal rhythm, listened to the lungs, pushed on their abdomen a

little bit, [made] sure there is no hepatomegaly or enlarged liver, looked at dependent edema, but didn't do breast exams or pelvic examination or anything more invasive because these patients had other physicians that were their primary care physicians.

(Tr. at 463-464)

44. Dr. Gill testified that he is now using more extensive forms to document patient histories and physical examinations, and presented examples of these documents at hearing. Dr. Gill further testified that he is reviewing additional forms given to him by Dr. Huffman that specifically cover bariatric physical examinations and follow-up visits, and he may begin using those in the future. (Resp. Ex. D; Tr. at 611-613)

Paragraph 2(c) of the Notice alleges: “[Dr. Gill] initiated treatment with controlled substance anorectics for Patients 4, 5, 10, 14, 15, 21 and 25-27 despite the fact that they had lost weight after their first visit while using non-controlled medications.” (St. Ex. 1A)

Patient 4

45. Patient 4, a male, first visited Dr. Gill's office on August 19, 1999. He was 24 years old, 5'10" tall, and weighed 246.5 pounds. Dr. Gill dispensed a two-week supply of noncontrolled, nonprescription substances identified by the abbreviations "CP" (chromium picolinate), "TRP" (time-released phenylpropanolamine), and "DEB" (phenylpropanolamine 37.5 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 5 at 5; St. Ex. 32 at 7; Tr. at 111)

At his next visit on September 2, 1999, Patient 4 weighed the same as previously, 246.5 pounds. Dr. Gill documented "pt req. stronger meds" and prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as "EP25" (diethylpropion 25 mg), "BW" (phentermine HCL 37.5 mg), and "era" (phentermine HCL 30 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 5 at 5; St. Ex. 32 at 9; St. Ex. 33 at 1; Tr. at 73)

Patient 5

46. Patient 5, a female, first saw Dr. Gill on January 15, 2000. She was 55 years old, 5'5" tall, and weighed 186 pounds. Dr. Gill dispensed a two-week supply of noncontrolled, nonprescription substances identified by the abbreviations "CP" (chromium picolinate), "TRP" (time-released phenylpropanolamine), and "DEB" (phenylpropanolamine 37.5 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 6 at 5; St. Ex. 32 at 7; Tr. at 111)

At her second visit on January 28, 2000, Patient 5 weighed 182 pounds, a loss of four pounds since her first visit. Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as "TP" (phendimetrazine 35 mg)

and “B35” (Bontril [phendimetrazine] 35 mg), with instructions to take TP before breakfast and dinner, and B35 before lunch. (St. Ex. 6 at 5; St. Ex. 32 at 9; Tr. at 70-72)

Patient 10

47. Patient 10, a female, first visited Dr. Gill’s office on two occasions in 1976. Dr. Gill prescribed or dispensed controlled substance anorectic medication to Patient 10 during those visits. (St. Ex. 11 at 9)
48. Patient 10 did not see Dr. Gill again until April 15, 1997. She was 51 years old, 5’7” tall, and weighed 216 pounds. Dr. Gill dispensed a two-week supply of noncontrolled, nonprescription medications abbreviated as “DEB” (phenylpropanolamine 37.5 mg), “TRP” (time-released phenylpropanolamine), and “PPA75” (phenylpropanolamine 75 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 11 at 8; St. Ex. 32 at 7; Resp. Ex. C; Tr. at 111)

Patient 10 next saw Dr. Gill on April 29, 1997. At that time, she weighed 212 pounds, a loss of four pounds from the previous visit. Nevertheless, Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as “TP” (phendimetrazine 35 mg), “gw” (phendimetrazine 35 mg), and “BP” (phendimetrazine 35 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 11 at 8; Tr. at 70-72)

49. Dr. Gill testified that, because the reason was not documented, he does not know why he had prescribed controlled substance anorectic medication to Patient 10 after she had lost weight using noncontrolled medication. (Tr. at 154-155)

Patient 14

50. Patient 14, a female, first saw Dr. Gill on May 1, 1999. She was 52 years old, 5’1” tall, and weighed 202.5 pounds. Dr. Gill dispensed a two-week supply of noncontrolled, nonprescription medications abbreviated as “CP” (chromium picolinate), “TRP” (time-released phenylpropanolamine), and “DEB” (phenylpropanolamine 37.5 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 15 at 6, 13; St. Ex. 32 at 7; Tr. at 111)

At her next visit one week later on May 8, 1999,⁶ Patient 14 weighed 198.5 pounds, a loss of four pounds using noncontrolled substances. However, Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as “TP” (phendimetrazine 35 mg), “era” (phentermine HCL 30 mg), and “D25” (diethylpropion 25 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 15 at 6; St. Ex. 32 at 9; St. Ex. 33 at 1; Tr. at 70-73)

⁶ Dr. Gill noted in his progress note: “1 wk due to vac – then 3 wks.” Her next visit was on May 29, 1999. (St. Ex. 15 at 6)

51. Dr. Gill testified that he did not document the reason for switching Patient 14 from noncontrolled to controlled substances on her second visit “other than the usual reason.” Dr. Gill further testified, somewhat cryptically:

They were looking for—either said the other medication wasn’t helping them or they wanted to try a different, quote, different medication. That medication, it just, you know, was not that effective.

We started them out on it and they usually request[ed], you know, more help or, you know, prescription medication to help them to do better even though she did lose a few pounds.

(Tr. at 187-188)

Patient 15

52. Patient 15, a male, first saw Dr. Gill on April 3, 1999. Patient 15 was 51 years old, 5’11” tall, and weighed 281.5 pounds. Dr. Gill dispensed a two-week supply of noncontrolled, nonprescription substances abbreviated as “CP” (chromium picolinate), “TRP” (time-released phenylpropanolamine), and “DEB” (phenylpropanolamine 37.5 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 16 at 6; St. Ex. 32 at 7; Resp. Ex. C; Tr. at 111)

At his next visit on April 17, 1999, Patient 15 weighed 264 pounds, a loss of 17.5 pounds since his first visit. However, Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as “TP” (phendimetrazine 35 mg), “era” (phentermine HCL 30 mg), and “D25” (diethylpropion 25 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 16 at 6; St. Ex. 32 at 9; St. Ex. 33 at 1; Tr. at 70-73)

Patient 21

53. Patient 21, a female, first saw Dr. Gill on May 11, 1993. She was 35 years old, 5’1” tall, and weighed 144 pounds. Dr. Gill dispensed a two-week supply of noncontrolled, nonprescription substances abbreviated as “VIC” (vitamin C), “TRP” (time-released phenylpropanolamine), and “PPA75” (phenylpropanolamine 75 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 22 at 20; St. Ex. 32 at 7; Resp. Ex. C; Tr. at 86, 111)

At her next visit on May 25, 1993, Patient 21 weighed 141.75 pounds, a loss of 2.25 pounds since her first visit. Nevertheless, Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as “TrimG” (phendimetrazine in a gray capsule), “era” (phentermine HCL 30 mg), and “Sts” (Statobex, a brand name of phendimetrazine), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 22 at 20; St. Ex. 32 at 9; St. Ex. 33 at 2; Tr. at 58, 73)

Patient 25

54. Patient 25, a female, first visited Dr. Gill on February 25, 1994. She was 34 years old, 5'0" tall, and weighed 136.5 pounds. Dr. Gill prescribed or dispensed a two-week supply of noncontrolled medications abbreviated as "D/C" (Ditex with chromium), "TRP" (time-released phenylpropanolamine), and "PPA75" (phenylpropanolamine 75 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 26 at 14; St. Ex. 32 at 7; Resp. Ex. C; Tr. at 111)

Patient 25 next visited Dr. Gill on March 11, 1994. At that time, she weighed 131.5 pounds, a loss of five pounds from her previous visit. Nevertheless, Dr. Gill documented that Patient 25 had complained that the medications were "no help." He prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as "TrimW" (phendimetrazine in a white capsule), "Era" (phentermine HCL 30 mg), and "Metra" (unknown), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 26 at 14; St. Ex. 32 at 9; St. Ex. 33 at 2; Tr. at 73)

55. Dr. Gill acknowledged that he had prescribed controlled substance anorectic medications to Patient 25 on March 11, 1994, after she had lost five pounds using noncontrolled medications. Moreover, he acknowledged that he had done so because Patient 25 had complained that the noncontrolled medications were not helping. He further acknowledged that the noncontrolled medications were, in fact, helping. (Tr. at 244)

Patient 26

56. Patient 26, a female, first visited Dr. Gill on January 5, 2001. She was 38 years old, 5'0" tall, and weighed 138.5 pounds. Dr. Gill prescribed or dispensed a two-week supply of noncontrolled medications abbreviated as "CP" (chromium picolinate), "TRP" (time-released phenylpropanolamine), and "DEB" (phenylpropanolamine 37.5 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 27 at 5; St. Ex. 32 at 7; Resp. Ex. C; Tr. at 111)

At her next visit on February 1, 2001, nearly one month later, Patient 26's weight was recorded as 138 pounds, a loss of one-half pound since her previous visit. Nevertheless, Dr. Gill documented that the patient had complained that the medication wasn't helping and prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as "TP" (phendimetrazine 35 mg), "BW" (phentermine HCL 37.5 mg), and B35 (Bontril, a brand name of phendimetrazine, 35 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 27 at 5; St. Ex. 32 at 9; Tr. at 70-72)

Patient 27

57. Patient 27 first saw Dr. Gill on June 26, 2000. She was 43 years old, 5'6" tall, and weighed 352 pounds. Dr. Gill prescribed or dispensed a two-week supply of noncontrolled,

nonprescription medications abbreviated as “CP” (chromium picolinate), “TRP” (time-released phenylpropanolamine), and “DEB” (phenylpropanolamine 37.5 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 28 at 6; St. Ex. 32 at 7; Resp. Ex. C; Tr. at 111)

At her next visit on July 10, 2000, Patient 27’s weight was recorded as 350 pounds, a loss of two pounds since her first visit. Nevertheless, Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as “D25” (diethylpropion 25 mg) and “D50” (diethylpropion 50 mg), to be taken before breakfast and dinner, respectively, as well as a noncontrolled medication abbreviated “TRP” (time-released phenylpropanolamine), to be taken before lunch. Dr. Gill did not document a reason for the change in medication. (St. Ex. 27 at 5; St. Ex. 32 at 7; St. Ex. 33 at 1; Tr. at 111)

In General

58. When asked why in some cases he had utilized controlled substance anorectic medication after a patient had lost weight on noncontrolled substances, Dr. Gill testified that it had been his routine practice to give a patient controlled substance anorectic medication on the second visit. Dr. Gill testified that he had done so “[t]o encourage them to stay on the program and encourage them to be successful in losing more weight even though they did lose some weight to begin with.” (Tr. at 597-598)
59. Dr. Huffman testified that, in general, patients who have been dieting for two weeks experience hunger. The stronger medication is more effective in curbing their hunger. (Tr. at 501-503)

Paragraph 2(d) of the Notice alleges: “[I]n [his] treatment of Patients 16, 17, 22 and 26 with controlled substance anorectics on or after October 31, 1998, [Dr. Gill] failed to determine and/or document that [he had] determined that the patients had a Body Mass Index [BMI] of at least thirty, or a BMI of at least twenty-seven with co-morbid factors.” (St. Ex. 1A)

Patient 16

60. Patient 16, a female, first saw Dr. Gill on September 10, 2001. She was 35 years old, 5’5” tall, and weighed 162 pounds. At her first visit, Dr. Gill documented Patient 16’s BMI as 27 and diagnosed obesity. Dr. Gill prescribed or dispensed controlled substance anorectic medications abbreviated as “TP” (phendimetrazine 35 mg), “B35” (Bontril [phendimetrazine] 35 mg), and “TP” (phendimetrazine 35 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 17 at 6, 11; St. Ex. 32 at 9; Tr. at 70-72)
61. Dr. Hornbeck testified that Dr. Gill had placed Patient 16 on controlled substance anorectic medications even though he had documented a BMI of 27 and no co-morbid conditions that would warrant the use of such medications. (Tr. at 343)

62. Dr. Gill acknowledged that Patient 16's BMI at her first visit had been 27. Dr. Gill further acknowledged that the Board's rules at that time required that, in order for controlled substance anorectics to be prescribed to a patient whose BMI is below 30 that there must be documented co-morbid conditions. Moreover, Dr. Gill acknowledged that he had not documented any co-morbid conditions for Patient 16. (Tr. at 193-194)

Patient 17

63. Patient 17, a female, first saw Dr. Gill on October 6, 2001. She was 34 years old, 5'5" tall, and weighed 173 pounds. At her first visit, Dr. Gill recorded her BMI as 29 and diagnosed obesity. Dr. Gill prescribed or dispensed controlled substance anorectic medications abbreviated as "TP" (phendimetrazine 35 mg) to be taken before breakfast and dinner, and "B35" (phendimetrazine 35 mg) to be taken before lunch. (St. Ex. 18 at 5; St. Ex. 32 at 9; Tr. at 70-72)
64. Dr. Gill acknowledged that he had not documented any comorbid factors with regard to Patient 17. (Tr. at 201)

Patient 22

65. Patient 22, a female, first saw Dr. Gill on August 14, 2001. She was 37 years old, 5'3" tall, and weighed 154.25 pounds. At her first visit, Dr. Gill noted her BMI to be 27 and diagnosed obesity. Dr. Gill prescribed or dispensed controlled substance anorectic medications abbreviated as "TP" (phendimetrazine 35 mg) to be taken before breakfast and dinner, and "B35" (phendimetrazine 35 mg) to be taken before lunch. (St. Ex. 23 at 5; St. Ex. 32 at 9; Tr. at 70-72)
66. Dr. Hornbeck testified that Dr. Gill had documented a BMI of 27, which is not obese, but did not document any co-morbid conditions. Dr. Hornbeck added that such a patient is "absolutely not" a candidate for controlled substance anorectic medications under the Board's rules. (Tr. at 359-360)
67. Dr. Gill acknowledged that he had documented Patient 22's BMI to be 27 but did not document any co-morbid factors. Dr. Gill further acknowledged that prescribing controlled substance anorectic medications under those circumstances violated the Board's rules. Moreover, Dr. Gill testified that he had erred in doing so. (Tr. at 227-228)

Patient 26

68. Patient 26, a female, first visited Dr. Gill on January 5, 2001. She was 38 years old, 5'0" tall, and weighed 138.5 pounds. Dr. Gill noted Patient 26's BMI to be 27 and diagnosed obesity. At her first visit, Dr. Gill dispensed only noncontrolled, nonprescription substances. However, at her next visit on February 1, 2001, after she had lost one-half pound, Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as "TP" (phendimetrazine 35 mg), "BW" (phentermine

HCL 37.5), and “B35” (phendimetrazine 35 mg) to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 27 at 5; St. Ex. 32 at 9; Tr. at 70-72)

69. Dr. Hornbeck testified that Patient 26 had a BMI of 27, was not obese, and that no co-morbid conditions were documented. Nevertheless, Dr. Gill prescribed or dispensed controlled substance anorectic medications to Patient 26. (Tr. at 370)
70. Dr. Gill acknowledged that, at Patient 26’s first visit, he had calculated Patient 26’s BMI to be 27, but had not documented any co-morbid factors. (Tr. at 248-249)

In General

71. Dr. Gill testified that, after the Board rule concerning minimum BMI levels became effective on October 31, 1998, his office began screening patients based upon their BMI. The receptionist would ask a patient calling for an appointment for his or her weight and height. If the patient had a BMI over 30, he or she would be scheduled for an appointment. If the patient’s BMI was below 30 but above 27, the receptionist would inquire whether the patient had a co-morbid condition such as diabetes, hypertension, or hyperlipidemia. If the patient had a co-morbid condition, he or she would be scheduled for an appointment. (Tr. at 565-567)
72. Dr. Gill testified that he had erred by not documenting co-morbid conditions for patients whose BMI had been below 30. Dr. Gill further testified that, under Ohio law, it is never okay to utilize controlled substance anorectic medication for a patient whose BMI is below 27. Finally, Dr. Gill testified that it is not his practice today to treat such patients. (Tr. at 604-606)
73. Dr. Huffman testified that, according to the National Institutes of Health, any patient with a BMI above 25 is at risk, and that treatment therapies may be initiated at that point. However, Dr. Huffman testified that in Ohio, by Board rule, a physician may only initiate therapy in a patient with a BMI of 30 or more, or in a patient with a BMI of 27 if a co-morbid condition is documented. (Tr. at 511-513)

Paragraph 2(e) of the Notice alleges: “During a period or periods beginning on or after October 31, 1998, [Dr. Gill’s] total course of treatment using controlled substance anorectics for weight reduction exceeded twelve weeks in Patients 1, 3, 4, 6-8, 10, 11, 13-15 and 26.” (St. Ex. 1A)

74. Effective October 31, 1998, Rules 4731-11-04(C)(8) and (C)(9), Ohio Administrative Code, required that, if the FDA labeling of a controlled substance being used for weight loss states that it is indicated for use for “a few weeks,” the total course of treatment using that substance shall not exceed twelve weeks. (St. Ex. 37)

Effective June 30, 2000, Rule 4731-11-04(C)(3), Ohio Administrative Code, added a requirement that “[a] physician shall not initiate a course of treatment utilizing a controlled

substance for purposes of weight reduction if the patient has received any controlled substance for purposes of weight reduction within the past six months.” (St. Ex. 38 at 39)

75. Dr. Hornbeck testified that, as far back as the 1970s, controlled substance anorectic medications were considered a temporary measure. Dr. Hornbeck further testified that there were “no long-term studies that showed the products to be efficacious for sustained weight loss.” (Tr. at 287-289)

Moreover, Dr. Hornbeck further testified that such medications are to be prescribed only for “a few weeks,” and that “a few weeks” has always been interpreted by the pharmacy and medical communities to mean twelve weeks. Furthermore, Dr. Hornbeck testified that it had meant one course of treatment that lasted twelve weeks, and not “12 weeks, stop, continue 12 more weeks.” (Tr. at 287-288)

Note, however, that effective June 30, 2000, the Board’s rules permit re-initiation of treatment if a patient has not received controlled substance anorectic medication during the previous six months. (St. Ex. 38 at 39)

76. Dr. Huffman testified that, when controlled substance anorectic medications first became available, they had been approved by the United States Food and Drug Administration [FDA] for use based upon short-term trials. Accordingly, the FDA-required package inserts say that they are to be used for a “few weeks.” Dr. Huffman further stated that, today, even though those medications may be safe and effective for long-term use, the same language is still included in the package inserts. Dr. Huffman testified that no pharmaceutical company is going to undertake the expense of long-term studies to change the package inserts for those medications, especially since they are now available in generic forms. (Tr. at 456-458)

Dr. Huffman testified that physicians have the right to use medications for uses other than those stated in the FDA-required package inserts, or to use them for approved uses differently from the way the package inserts instruct. However, Dr. Huffman further testified that a physician cannot use a medication in a way that would violate a Board rule or fall below the minimal standard of care. (Tr. at 459, 542-543)

Patient 1

77. Beginning on or after October 31, 1998, Dr. Gill treated Patient 1 with controlled substance anorectic medication during the following periods:
- November 13, 1998 (single visit);
 - March 8 through May 27, 1999;
 - November 8 through December 23, 1999; and
 - August 21 through November 3, 2000.

(St. Ex. 2 at 12, 14) None of these individual treatment periods alone exceeded twelve weeks, although combined they exceed twelve weeks. (St. Ex. 2 at 12, 14)

Patient 3

78. Beginning on or after October 31, 1998, Dr. Gill treated Patient 3 with controlled substance anorectic medication during the following periods:

- December 17, 1998, through March 23, 1999;
- September 23 through November 26, 1999;
- May 15 through July 17, 2000;
- December 22, 2000, through February 15, 2001;
- May 18 through July 23, 2001;
- October 23 through December 27, 2001;
- April 18 through June 20, 2002;
- November 12, 2002, through February 3, 2003; and
- May 5 through July 17, 2003.

(St. Ex. 3 at 23-27) Although none of these treatment periods exceeded twelve weeks, taken together, they exceed twelve weeks. Moreover, in several instances following June 30, 2000, the time between treatment periods was less than six months. (St. Ex. 3 at 23-26)

Patient 4

79. Dr. Gill treated Patient 4 with controlled substance anorectic medication during the following periods:

- September 2 through November 11, 1999;
- February 28 through May 25, 2000;
- September 9, 2000 (one visit); and
- January 20 through February 16, 2001.

(St. Ex. 5 at 5-6) The treatment period February 28 through May 25, 2000, exceeded twelve weeks by a few days. In addition, the combined periods beginning September 2, 1999, through May 25, 2000, exceeded twelve weeks. Further, Dr. Gill had restarted Patient 4 on controlled substance anorectic medication on two occasions—September 9, 2000, and on January 20, 2001—when Patient 4 had been treated with controlled substance anorectic medication less than six months previously. (St. Ex. 5 at 5-6)

Patient 6

80. Dr. Gill's medical record for Patient 6 indicates that, from the time period beginning on or after October 31, 1998, Patient 6 saw Dr. Gill sporadically until July 14, 2003. There were breaks between treatments; however, treatment periods from October 31, 1998, through

February 29, 2000, taken together, exceeded twelve weeks. Furthermore, Dr. Gill had restarted Patient 6 on controlled substance anorectic medication on August 21, 2000, and on January 27, 2001, when Patient 6 had been treated with controlled substance anorectic medication less than six months previously. (St. Ex. 7 at 11, 13-16)

Moreover, he had treated Patient 6 with controlled substance anorectic medication for the period beginning on October 14, 2002, and ending January 25, 2003. This time period exceeded twelve weeks. (St. Ex. 7 at 13)

Patient 7

81. Beginning November 1998, Patient 7 saw Dr. Gill sporadically, but received controlled substance anorectic medications at each visit. Patient 7 would often receive a two-week supply of controlled substance anorectic medication and then not return until well after the two-week period had ended. For example, Patient 7 received a two-week supply of multiple controlled substance anorectic medications on November 6, 1998; December 4, 1998; December 28, 1998; March 15, 1999; April 18, 1999; and May 21, 1999. Patient 7 then returned on November 9, 1999, and was seen sporadically until March 24, 2000. Subsequently, Patient 7 returned on September 1, 2000, and was seen six more times through September 21, 2001. Finally, Patient 7 returned June 24, 2002, and his next and last visit was July 16, 2002. (St. Ex. 8 at 13, 15)

Because of the sporadic nature of Patient 7's visits to Dr. Gill after October 31, 1998, it is difficult to ascertain when treatment periods began and ended. However, the period of November 6, 1998, through March 24, 2000, exceeded twelve weeks. In addition, Dr. Gill restarted Patient 7 on controlled substance anorectic medication on September 1, 2000, when Patient 7 had been treated with controlled substance anorectic medication less than six months previously. (St. Ex. 8 at 13, 15)

Patient 8

82. Following October 31, 1998, Dr. Gill treated Patient 8 with controlled substance anorectic medication on January 18, 1999; from February 5 through April 15, 2000; and on September 8 and November 6, 2000. On September 8, 2000, Dr. Gill had re-initiated treatment with controlled substance anorectic medication when Patient 7 had been treated with controlled substance anorectic medication less than six months previously. (St. Ex. 9 at 11)

Patient 10

83. Patient 10 saw Dr. Gill sporadically from November 13, 1998, through September 17, 2001, sometimes with months passing between visits. Dr. Gill prescribed or dispensed controlled substance anorectic medication to her at each visit. Because of the sporadic nature of Patient 10's treatment, it is difficult to tell when treatment periods began and ended. However, periods of treatment exceeded twelve weeks without any clearly identifiable breaks from April 20, 1999, through November 21, 2000, and from February 5 through

September 17, 2001. In addition, on February 5, 2001, Dr. Gill re-initiated treatment with controlled substance anorectic medication when Patient 10 had been treated with controlled substance anorectic medication less than six months previously. (St. Ex. 11 at 7-8)

Patient 11

84. For the period beginning February 10, 2001, and ending on June 14, 2001, Dr. Gill prescribed or dispensed controlled substance anorectic medication to Patient 11. This time period exceeded twelve weeks. (St. Ex. 12 at 12)

Patient 13

85. Following October 31, 1998, Dr. Gill treated Patient 13 with controlled substance anorectic medication during the following periods:

- November 2, 1998, through January 22, 1999;
- July 26 through October 5, 1999; and
- January 7 through April 4, 2000.

(St. Ex. 14 at 15-17) The combined periods of treatment exceeded twelve weeks. In addition, treatment period from January 7, 2000, through April 4, 2000, exceeded twelve weeks by a few days. (St. Ex. 14 at 15-17)

Patient 14

86. During his treatment of Patient 14, Dr. Gill treated her with controlled substance anorectic medication during the following periods:

- May 1 through July 24, 1999;
- October 30, 1999, through January 8, 2000; and
- July 15 through October 7, 2000.

(St. Ex. 15 at 5-6) The combined periods of treatment exceeded twelve weeks. (St. Ex. 15 at 5-6)

87. Dr. Gill denied that he had maintained Patient 14 on controlled substance anorectics for more than twelve weeks. Dr. Gill testified that she had taken controlled substance medications from May 8 to July 24, 1999, and was then placed on noncontrolled, nonprescription medication for maintenance. Subsequently, on October 30, 1999, she was restarted on controlled substance anorectics. (Tr. at 188-189)

Patient 15

88. During his treatment of Patient 15, Dr. Gill treated him with controlled substance anorectic medication during the following periods:

- April 3 through June 26, 1999;
- October 30, 1999, through January 8, 2000; and
- July 15 through October 7, 2000.

(St. Ex. 16 at 5-6) None of the individual courses of treatment exceeded twelve weeks. Combined, however, they exceed twelve weeks. (St. Ex. 16 at 5-6)

Patient 26

89. Dr. Gill treated Patient 26 with controlled substance anorectic medication from February 1 through May 11, 2001. This period exceeded twelve weeks.⁷ (St. Ex. 27 at 5)

Paragraph 2(f) of the Notice alleges: “[Dr. Gill] inappropriately prescribed and/or dispensed diethylpropion, a schedule IV controlled substance anorectic, to Patient 6 despite a reported prior history of seizures while taking Tenuate Dospan.” (St. Ex. 1A)

90. Patient 6, a female, first visited Dr. Gill’s office on September 6, 1996. She was 38 years old, 5’9” tall, and weighed 163.5 pounds. Dr. Gill’s progress note for that visit states that Patient 6 “has [history] of Seizure—(fell down steps)—4 yrs ago.” A circled asterisk appears above the word “Seizure.” Below, next to another circled asterisk, a note states “(c/o Tenuate interaction.)” (St. Ex. 7 at 18) (Emphasis in original)

91. Dr. Gill testified that Tenuate is a brand name for diethylpropion. (Tr. at 116-117)

92. On November 29, 1996, Dr. Gill prescribed or dispensed to Patient 6 a controlled substance anorectic medication abbreviated as “DIP50” (diethylpropion 50 mg) to be taken before breakfast and dinner, and a noncontrolled, nonprescription medication abbreviated as TRP (time-released phenylpropanolamine) to be taken before lunch. (St. Ex. 7 at 18)

Subsequently, Dr. Gill prescribed or dispensed to Patient 6 diethylpropion 50 mg, abbreviated in the medical record as either “DIP50” or “D50,” on numerous occasions through March 30, 1999. (St. Ex. 7 at 15-18)

93. Dr. Hornbeck testified that Dr. Gill had documented that Patient 6 had a history of seizure with Tenuate, yet prescribed the same medication in generic form. Dr. Hornbeck further testified: “I don’t understand why somebody that has a known—potential known interaction, why would somebody take that risk of prescribing the same medication,

⁷ Dr. Gill mistakenly testified that February 1 to May 11 is only ten weeks. (Tr. at 250) However, administrative notice is taken that the twelfth week following February 1, 2001, ended April 26, 2001.

especially with a seizure, especially when they can be driving a car.” Moreover, Dr. Hornbeck testified that, if a patient has had a seizure related to a medication, reusing that medication is contraindicated. (Tr. at 314-315)

94. Dr. Gill testified with regard to his note concerning Patient 6 having had a history of seizure and her complaint of having had a reaction to Tenuate. When asked what that note meant, Dr. Gill testified: “I really don’t—I don’t know. This is a nurse’s note, and I don’t know where the note of complaining of Tenuate interaction came from, because I don’t know what medication—whether she was on that medication at that time. I don’t know.” Moreover, Dr. Gill stated that he did not know if her seizure had resulted from her fall or as a reaction to taking Tenuate. (Tr. at 598-599)

Paragraph 3 of the Notice: Allegations that Dr. Gill Practiced Below the Minimal Standard of Care

Paragraph 3(a) of the Notice alleges: “[Dr. Gill] inappropriately concurrently dispensed and/or prescribed multiple controlled substance anorectics to Patients 1-27 with directions to take two or more of these drugs each day.” (St. Ex. 1A)

95. Using Dr. Gill’s care and treatment of Patient 1 as an example, during his course of treating Patient 1, he prescribed or dispensed the following to her for weight loss. Dates on which Dr. Gill prescribed or dispensed multiple controlled substance anorectic medications appear in **bold**.

DATE:	Medication, with instructions to take before:		
	Breakfast	Lunch	Dinner
05/21/91	vitamin C	phenylpropanolamine	phenylpropanolamine
06/04/91	phendimetrazine	phentermine HCL	phendimetrazine
06/17/91	phentermine HCL	phentermine HCL	phendimetrazine
07/01/91	phentermine HCL	phentermine HCL	phendimetrazine
07/15/91	phentermine HCL	phentermine HCL	phendimetrazine
07/29/91	unknown (“Metra”)	phendimetrazine	unknown (“R/B”)
08/12/91	phentermine HCL	phendimetrazine	unknown (“R/B”)
08/26/91	phentermine HCL	phendimetrazine	unknown (“R/B”)
09/09/91	phentermine HCL	phendimetrazine	unknown (“R/B”)
09/23/91	phendimetrazine	phentermine HCL	phendimetrazine
10/07/91	phentermine HCL	phendimetrazine	unknown (“R/B”)
10/21/91	phendimetrazine	phentermine HCL	phendimetrazine
11/04/91	phendimetrazine	phentermine HCL	unknown (“R/B”)
11/18/91	phenylpropanolamine	unknown (“Metra”)	phendimetrazine
12/02/91	phentermine HCL	phendimetrazine	unknown (“RB”)
12/16/91	phentermine HCL	phendimetrazine	unknown (“RB”)
01/13/92	phentermine HCL	phendimetrazine	unknown (“RB”)

DATE:	Medication, with instructions to take before:		
	Breakfast	Lunch	Dinner
01/27/92	phentermine HCL	phendimetrazine	unknown (“RB”)
02/10/92	unknown (“Metra”)	phentermine HCL	phendimetrazine
02/25/92	unknown (“RB”)	phendimetrazine	phentermine HCL
03/10/92	unknown (“RB”)	phendimetrazine	phentermine HCL
03/23/92	unknown (“RB”)	phendimetrazine	phentermine HCL
04/24/92	phenylpropanolamine	phenylpropanolamine	diethylpropion
05/08/92	phenylpropanolamine	phenylpropanolamine	phendimetrazine
05/22/92	phenylpropanolamine	diethylpropion	phenylpropanolamine
06/08/92	phendimetrazine	unknown (“RB”)	phenylpropanolamine
06/22/92	phendimetrazine	unknown (“RB”)	phenylpropanolamine
07/06/92	phenylpropanolamine	diethylpropion	phenylpropanolamine
07/17/92	phendimetrazine	unknown (“RB”)	phendimetrazine
08/07/92	phendimetrazine	unknown (“RB”)	phenylpropanolamine
08/24/92	phenylpropanolamine	Tenuate Dospan (diethylpropion 75 mg)	phenylpropanolamine
09/10/92	phenylpropanolamine	Tenuate Dospan	phenylpropanolamine
09/24/92	phenylpropanolamine	unknown (“R/B”)	phenylpropanolamine
10/08/92	phentermine HCL	unknown (“RB”)	phendimetrazine
10/22/92	phentermine HCL	unknown (“RB”)	phendimetrazine
12/22/92	phentermine HCL	unknown (“RB”)	phendimetrazine
01/08/93	phendimetrazine	phentermine HCL	unknown (“RB”)
01/22/93	phenylpropanolamine	diethylpropion	phenylpropanolamine
02/05/93	phentermine HCL	Tenuate Dospan	unknown (“RB”)
02/19/93	phentermine HCL	Tenuate Dospan	unknown (“R/B”)
03/19/93	phentermine HCL	Tenuate Dospan	unknown (“RB”)
04/09/93	phendimetrazine	unknown (“Metra”)	phendimetrazine
04/23/93	phendimetrazine	unknown (“Metra”)	phendimetrazine
05/07/93	phendimetrazine	unknown (“Metra”)	phendimetrazine
05/24/93	phendimetrazine	unknown (“Metra”)	phendimetrazine
06/18/93	phentermine HCL	diethylpropion	unknown (“RB”)
07/02/93	phentermine HCL	diethylpropion	unknown (“RB”)
07/16/93	phentermine HCL	diethylpropion	unknown (“RB”)
08/09/93	phentermine HCL	diethylpropion	unknown (“RB”)
08/23/93	phendimetrazine	unknown (“Metra”)	phendimetrazine
09/07/93	phentermine HCL	diethylpropion	unknown (“RB”)
09/20/93	phendimetrazine	unknown (“Metra”)	phendimetrazine
10/04/93	phentermine HCL	diethylpropion	unknown (“RB”)
11/15/93	phentermine HCL	diethylpropion	unknown (“RB”)
11/29/93	phentermine HCL	diethylpropion	unknown (“RB”)
12/14/93	phentermine HCL	diethylpropion	unknown (“R/B”)

DATE:	Medication, with instructions to take before:		
	Breakfast	Lunch	Dinner
01/28/94	phentermine HCL	diethylpropion	unknown (“RB”)
02/24/94	phendimetrazine	unknown (“Metra”)	phendimetrazine
03/11/94	phentermine HCL	diethylpropion	unknown (“RB”)
05/02/94	phentermine HCL	diethylpropion	unknown (“RB”)
05/16/94	phentermine HCL	diethylpropion	unknown (“RB”)
05/31/94	phentermine HCL	diethylpropion	unknown (“RB”)
06/13/94	phentermine HCL	diethylpropion	unknown (“RB”)
06/27/94	phentermine HCL	diethylpropion	unknown (“RB”)
07/11/94	phentermine HCL	diethylpropion	unknown (“RB”)
08/01/94	phentermine HCL	diethylpropion	unknown (“RB”)
09/15/94	phentermine HCL	diethylpropion	unknown (“RB”)
09/29/94	phendimetrazine	unknown (“Metra”)	phendimetrazine
10/13/94	phentermine HCL	diethylpropion	unknown (“RB”)
10/27/94	phentermine HCL	diethylpropion	unknown (“RB”)
12/13/94	phentermine HCL	diethylpropion	unknown (“RB”)
12/27/94	phentermine HCL	diethylpropion	unknown (“RB”)
01/09/95	phendimetrazine	unknown (“Metra”)	phendimetrazine
02/17/95	phendimetrazine	phendimetrazine	phendimetrazine
03/03/95	diethylpropion	phendimetrazine	phendimetrazine
03/17/95	diethylpropion	phendimetrazine	phendimetrazine
04/06/95	phentermine HCL	phentermine HCL	Ditex with chromium
04/20/95	phentermine HCL	phentermine HCL	Ditex with chromium
05/04/95	phentermine HCL	phentermine HCL	Ditex with chromium
05/25/95	phentermine HCL	phentermine HCL	Ditex with chromium
07/13/95	phendimetrazine	phendimetrazine	phendimetrazine
07/28/95	Ditex with chromium	phentermine HCL	phentermine HCL
08/11/95	phendimetrazine	unknown (“RB”)	phentermine HCL
08/25/95	phendimetrazine	unknown (“RB”)	phentermine HCL
09/08/95	phendimetrazine	unknown (“RB”)	phentermine HCL
09/22/95	diethylpropion	Ditex with chromium	diethylpropion
12/04/95	phendimetrazine	unknown (“RB”)	phentermine HCL
12/21/95	phendimetrazine	unknown (“RB”)	phentermine HCL
01/30/96	diethylpropion	phenylpropanolamine	diethylpropion
02/13/96	phenylpropanolamine	phenylpropanolamine	phenylpropanolamine
02/27/96	phendimetrazine	unknown (“RB”)	phentermine HCL
03/19/96	phendimetrazine	unknown (“RB”)	phentermine HCL
04/02/96	phendimetrazine	unknown (“RB”)	phentermine HCL
05/24/96	phendimetrazine	unknown (“RB”)	phentermine HCL
07/08/96	diethylpropion	phenylpropanolamine	diethylpropion
08/09/96	diethylpropion	unknown (“RB”)	diethylpropion

DATE:	Medication, with instructions to take before:		
	Breakfast	Lunch	Dinner
08/30/96	diethylpropion	unknown ("RB")	diethylpropion
10/07/96	diethylpropion	unknown ("RB")	phentermine HCL
10/21/96	diethylpropion	unknown ("RB")	phentermine HCL
12/03/96	diethylpropion	unknown ("RB")	phentermine HCL
12/17/96	diethylpropion	unknown ("RB")	phentermine HCL
04/10/97	diethylpropion	phendimetrazine	phentermine HCL
04/24/97	diethylpropion	phendimetrazine	phentermine HCL
05/08/97	diethylpropion	phendimetrazine	phentermine HCL
07/24/97	diethylpropion	phentermine HCL	phentermine HCL
08/07/97	diethylpropion	phentermine HCL	phentermine HCL
11/18/97	diethylpropion	phentermine HCL	phentermine HCL
12/11/97	diethylpropion	phentermine HCL	phentermine HCL
03/20/98	diethylpropion	phentermine HCL	phentermine HCL
04/03/98	diethylpropion	phentermine HCL	phentermine HCL
04/17/98	diethylpropion	phentermine HCL	phentermine HCL
05/01/98	diethylpropion	phentermine HCL	phentermine HCL
10/16/98	diethylpropion	phentermine HCL	phentermine HCL
10/30/98	diethylpropion	phentermine HCL	phentermine HCL
11/13/98	diethylpropion	phentermine HCL	phentermine HCL
03/08/99	diethylpropion	phentermine HCL	phentermine HCL
03/25/99	diethylpropion	phentermine HCL	phentermine HCL
04/23/99	diethylpropion	phentermine HCL	phentermine HCL
05/07/99	diethylpropion	phentermine HCL	phentermine HCL
05/27/99	diethylpropion	phentermine HCL	phentermine HCL
06/14/99	Meridia 10 mg #14, no refills, with instructions to take one pill daily		
11/08/99	chromium picolinate	phentermine HCL	phentermine HCL
11/22/99	chromium picolinate	phentermine HCL	phentermine HCL
12/06/99	chromium picolinate	phentermine HCL	phentermine HCL
12/23/99	phenylpropanolamine	phentermine HCL	phentermine HCL
08/21/00	phendimetrazine	phentermine HCL	phendimetrazine
09/14/00	phendimetrazine	phentermine HCL	phendimetrazine
09/28/00	phendimetrazine	phentermine HCL	phendimetrazine
10/16/00	phendimetrazine	phentermine HCL	phendimetrazine
11/03/00	phendimetrazine	phentermine HCL	phendimetrazine

(St. Ex. 2 at 11-20) The above medications were always prescribed or dispensed in two-week supplies. (St. Ex. 2 at 11-20) Further:

- Diethylpropion is a schedule IV controlled substance;
- Phentermine HCL is a schedule IV controlled substance;
- Phendimetrazine is a schedule III controlled substance; and

- Phenylpropanolamine, vitamin C, and Ditek with chromium are nonprescription, noncontrolled substances.

(Tr. at 59)

Dr. Gill had used abbreviations for all of the medications noted above except for Tenuate Dospan and Meridia. No single, all-inclusive key to Dr. Gill's abbreviations was made available at hearing; accordingly, the actual names of the medications were drawn from a variety of sources in the hearing record. (St. Ex. 32 at 7, 9; St. Ex. 33; Resp. Exs. A, B, and C; Tr. at 58, 70-73, 86, 111, 116-117, 172-173, 244-245)

96. In addition to Patient 1, each of Dr. Gill's medical records for Patients 2 through 27 reflects instances where he had dispensed or prescribed multiple controlled substance anorectic medications to the patient with instructions to take two or more of the medications each day. (St. Ex. 3 at 9, 11, 12; St. Ex. 4 at 23-40; St. Ex. 5 at 5-6; St. Ex. 6 at 5; St. Ex. 7 at 11, 13-18; St. Ex. 8 at 13, 15, 16; St. Ex. 9 at 13, 15, 16; St. Ex. 10 at 11-14; St. Ex. 11 at 7-8; St. Ex. 12 at 11-14; St. Ex. 13 at 11-14; St. Ex. 14 at 16-22; St. Ex. 15 at 5-6; St. Ex. 16 at 5-6; St. Ex. 17 at 5-6; St. Ex. 18 at 5; St. Ex. 19 at 5; St. Ex. 20 at 28-30, 33-38; St. Ex. 21 at 15-20; St. Ex. 22 at 15-20; St. Ex. 23 at 5; St. Ex. 24 at 5-6; St. Ex. 25 at 13-16; St. Ex. 26 at 11, 14; St. Ex. 27 at 5; St. Ex. 28 at 5-6; St. Ex. 32 at 9; St. Ex. 33; Resp. Exs. A, B, and C; Tr. at 70-73, 86, 111, 172-173)
97. In his June 11, 2004, report, Dr. Hornbeck stated that utilizing multiple anorectics at different times of the day constitutes an inappropriate use of such medication. Dr. Hornbeck further stated that such treatment "is not supported in the literature as a standard of care." Moreover, Dr. Hornbeck stated that such treatment is a "non-therapeutic approach to weight loss." (St. Ex. 31)
98. Dr. Gill testified that his "standard routine" that he had been "using for years" is to place patients on a regimen of using multiple anorectic medications each day. Dr. Gill further testified that he has been trained through his coursework in bariatric medicine to treat patients with combinations of anorectic medication. (Tr. at 68, 583)

Dr. Gill testified that he now routinely starts new patients on phendimetrazine 35 mg three times per day. Dr. Gill further testified that, subsequently, he sometimes changes one or two of those doses to a different medication. (Tr. at 630-631)

99. When asked about using anorectic medications in combinations, Dr. Huffman replied:

So if you closely watch the patient, you'll find that you can place medications at different times of the day to better control that hunger. And in some points—because, again, on some of the side effects of the medication, you may need to change the medications about.

So if the patient has a lot of hunger in the evening, you don't want to use a medication that's very stimulating. You may choose to use a medication like Meridia, Tenuate, so that it doesn't interfere with sleep.

So if you look at a typical family practice or another physician that doesn't have experience in weight management, they generally don't do that. They'll say here's a drug. I understand this works for weight loss, and give a patient a medication and they don't really look at—they don't watch the patient's diaries or food intake histories or ask them about hungers. So they very rarely will try to implement multi-drug therapies.

(Tr. at 455-456)

Paragraph 3(b) of the Notice alleges: "Despite Patient 3's elevated liver enzymes, [Dr. Gill] failed to obtain serial blood work to monitor the patient's liver function while prescribing Mevacor." (St. Ex. 1A)

100. During Patient 3's first visit to Dr. Gill's office on April 19, 1988, Dr. Gill ordered a blood test. The results of that blood test indicate, among other things, that Patient 3's GGTP was elevated at 252 U/L, with the reference range being 0-55 U/L. Further, Patient 3's ALT was elevated at 128 U/L, with the reference range being 0-45 U/L. Finally, Patient 3's AST was elevated at 95 U/L, with the reference range being 0-41 U/L. (St. Ex. 4 at 65)

The lab results also indicated that Patient 3 had elevated cholesterol and triglycerides. The elevated values for those were circled by hand and accompanied by a handwritten notation that they had been discussed with the patient. (St. Ex. 4 at 65)

101. Patient 3 next visited Dr. Gill's office on May 3, 1988. In his progress note for that visit, Dr. Gill recorded, among other things, that he had asked Patient 3 if he had a history of liver disease and that Patient 3 had replied that he did not. (St. Ex. 4 at 23; Tr. at 89-90)

102. On October 14, 1989, Dr. Gill ordered a lipid profile on Patient 3. The results of that test indicate that Patient 3's cholesterol value was 314 mg/dL, with the reference range being less than 200 mg/dL. Patient 3's triglycerides value was also elevated at 582 mg/dL with the reference range being 60-135 mg/dL. Dr. Gill's progress note dated October 31, 1989, states that Patient 3's cholesterol had been elevated, that Patient 3 had been given material concerning decreasing fat and cholesterol, and that Dr. Gill had prescribed or dispensed niacinamide 500 mg #100 with instructions to take one pill three times per day. (St. Ex. 4 at 38, 63)

Subsequently, on August 17, 1990, Dr. Gill began prescribing or dispensing Mevacor 20 mg to Patient 3. Dr. Gill prescribed or dispensed Mevacor to Patient 3 as follows:

Date	Medication and Quantity	Instructions
08/17/90	Mevacor 20 mg #16	Take one per day
10/04/90	Mevacor 20 mg #16	Take one per day
10/16/90	Mevacor 20 mg #16	None documented
10/29/90	Mevacor 20 mg #14	Take one per day
11/12/90	Mevacor 20 mg #14	None documented
09/12/01	Mevacor 20 mg #60 with two refills	Take one per day

(St. Ex. 4 at 34, 36)

103. Dr. Hornbeck testified that ALT, AST, and GGTP are liver enzymes. Dr. Hornbeck testified that lab results obtained by Dr. Gill on April 19, 1988, and October 14, 1989, had indicated that Patient 3's liver enzymes had been elevated. Dr. Hornbeck further testified that the levels ranged from two to four times the normal level. (Tr. at 302-303)

Additionally, Dr. Hornbeck testified that, during the course of Dr. Gill's treatment of Patient 3, Dr. Gill had prescribed Mevacor, a statin drug used to lower cholesterol, despite a history of elevated liver enzymes. Dr. Hornbeck further testified, "Mevacor has been shown to cause elevated liver enzymes or some sort of hepatitis involvement." Finally, Dr. Hornbeck testified that, if a patient already has a damaged liver, the physician should not select a medication that could damage the liver further and possibly cause liver failure. (Tr. at 305)

104. Dr. Gill testified that he had prescribed Mevacor to Patient 3 because Patient 3's cholesterol and triglycerides had been elevated. Dr. Gill further testified that he had given him a patient-information sheet on reducing fat and cholesterol. When asked if Mevacor is contraindicated for a patient with potential liver problems, Dr. Gill replied that he is not aware of any such contraindication at a dosage level of 20 mg. (Tr. at 93-94)
105. Dr. Huffman testified that many patients have elevated liver enzymes and take cholesterol lowering medications. However, Dr. Huffman acknowledged that Dr. Gill should have monitored Patient 3 with more frequent lab studies. (Tr. at 497-498)

Paragraph 3(c) of the Notice alleges: Dr. Gill "failed to perform and/or document an abdominal examination on Patient 4 despite elevated liver function tests." (St. Ex. 1A)

106. Patient 4, a male, first visited Dr. Gill on August 19, 1999. He was 24 years old, 5'10" tall, and weighed 246.5 pounds. The only physical examination findings that were documented consist of Patient 4's weight, blood pressure of 132/80, and normal sinus rhythm. Dr. Gill ordered a blood test, and the results of that test yielded, among other things, an elevated

value for ALT: 39 U/L, with a reference range of 5 – 37 U/L. Patient 4 also had high values for cholesterol, triglycerides, and LDL, as well as a low value for HDL. (St. Ex. 5 at 5, 7)

Dr. Gill's progress note for Patient 4's next visit states, among other things, "↑ lipids," "chol. & your heart," and that a copy of the lab report had been sent to Patient 4's regular physician. (St. Ex. 5 at 5)

107. Dr. Hornbeck testified that, in reviewing Dr. Gill's medical record for Patient 4, he found no physical examination had been documented other than weight and blood pressure, and found inappropriate documentation of normal sinus rhythm. Dr. Hornbeck further testified that, based upon Patient 4's elevated ALT, Dr. Gill should have documented whether Patient 4's abdomen was tender. Moreover, Dr. Hornbeck testified that, even though Patient 4 was overweight, it would have been possible for Dr. Gill to palpate Patient 4's abdomen. (Tr. at 308, 309)
108. Dr. Gill testified that Patient 4's ALT result of 39 had been slightly elevated. He attributed that result to a fatty liver. Dr. Gill testified that patients with high cholesterol and high LDL can develop a fatty liver and a slight elevation of liver enzymes. (Tr. at 101-102)

Dr. Gill testified that he had not performed a physical examination of Patient 4's abdomen. Dr. Gill stated that "in someone this heavy with an abdomen that big [it] is pretty hard to palpate the liver." Dr. Gill further testified that he tells such patients that he will try his best to help the patient lose some weight and that the lab work will be rechecked later. Finally, Dr. Gill testified that he had provided a copy of the lab report to Patient 4's primary care physician and had advised Patient 4 to consult his primary care physician. (Tr. at 107-108)

Paragraph 3(d) of the Notice alleges: Dr. Gill "failed to perform and/or document an appropriate work-up on findings of hyperglycemia and elevated ALT in Patient 8." (St. Ex. 1A)

109. A lab result for a blood sample taken on February 5, 2000, indicates that Patient 8's glucose level had been 168 mg/dL with the reference range being 70 – 105 mg/dL. Further her ALT level had been 41 U/L with the reference range being 5 – 37 U/L. A handwritten note on the lab report states that Dr. Gill had discussed the report with Patient 8. (St. Ex. 9 at 15)

An entry dated February 7, 2000, states that Patient 8's fasting blood sugar and triglycerides were elevated and to "please call patient and advise—keep appt., etc." (St. Ex. 9 at 11)

Progress notes indicate that Dr. Gill had rechecked Patient 8's fasting blood sugar on or around February 19, 2000, and that her fasting blood sugar had been 121. (St. Ex. 9 at 11)

Two visits later, on April 1, 2000, Dr. Gill rechecked Patient 8's fasting blood sugar, and it had been 145. Dr. Gill's progress note dated April 15, 2000, states that that result was discussed with her. (St. Ex. 9 at 11)

After April 15, 2000, Patient 8 did not see Dr. Gill again until September 8, 2000. The note for that visit states to "do F.B.S." At her next and final visit to Dr. Gill's office, on November 6, 2000, the note also says to do a fasting blood sugar. (St. Ex. 9 at 11)

110. Dr. Hornbeck testified that Patient 8 had had elevated ALT, and that Dr. Gill had failed to do a workup to look for inflammation of the liver or hepatitis. Dr. Hornbeck further testified that Patient 8 had had hyperglycemia, and that no hemoglobin A1C level had been obtained, which would have provided information concerning how high Patient 8's average blood sugar had been. (Tr. at 318)
111. With regard to Patient 8's abnormal lab results, Dr. Gill testified that he had discussed the abnormal results with Patient 8, which is reflected on the lab report itself, where it says that he had discussed it with Patient 8 on February 19, 2000. Moreover, Dr. Gill testified that he followed up with successive fasting blood sugar lab tests and discussions with Patient 8. Furthermore, Dr. Gill testified that, although he did not chart it, he believes that he had advised Patient 8 to see her regular physician concerning her high blood sugar levels. (St. Ex. 9 at 15; Tr. at 137-140)

Dr. Gill attributed Patient 8's elevated ALT to a high triglyceride level. (Tr. at 136-137)

Paragraph 3(e) of the Notice alleges: Dr. Gill "failed to perform and/or document an appropriate work-up on findings of elevated ferritin in Patients 9 and 12." (St. Ex. 1A)

Patient 9

112. A lab test result for a blood sample taken on January 3, 1997, indicates that Patient 9's ferritin level was 243.6 NG/ML, with the reference range being 11.3 – 196.2 NG/ML. Patient 9's cholesterol value was also elevated. At the top of the report, Dr. Gill indicated that he had discussed the report with Patient 9. Nothing further concerning Patient 9's elevated ferritin result is documented in the chart. (St. Ex. 10)
113. Dr. Hornbeck testified that an elevated ferritin level could be caused by different disease states, such as hemochromatosis, or an "acute phase reactant which is a sign of inflammation of some sort." (Tr. at 323-324)

Dr. Hornbeck testified that hemochromatosis is an "abnormal storage condition of iron in the body. Iron is deposited in places where it shouldn't go: pancreas, skin, eyes, nervous system, kidneys." Dr. Hornbeck testified that complications could include diabetes and fatigue. Dr. Hornbeck stated that the condition is hereditary. (Tr. at 324)

Dr. Hornbeck further testified that Dr. Gill should have either followed up himself or alerted Patient 9's regular physician to the problem. Simply discussing it with the patient had not been sufficient. (Tr. at 324-325)

114. Dr. Huffman testified that, if a patient presented with an elevated ferritin level, he would refer the patient to his or her primary care physician. Dr. Huffman added that he could find no documentation that Dr. Gill had done so. (Tr. at 508-511)
115. Dr. Gill testified that he could not find documentation that he had discussed the elevated ferritin level with Patient 9. (Tr. at 149-150)

Patient 12

116. A lab test result for a blood sample taken on July 18, 1996, indicates that Patient 12's ferritin level had been 259.6 NG/ML, with the reference range being 11.3 – 196.2 NG/ML. Aside from a progress note dated August 30, 1996, indicating that Dr. Gill had given Patient 12 a copy of the lab report, nothing further concerning Patient 12's elevated ferritin result is documented in the chart. (St. Ex. 13)
117. Dr. Hornbeck testified that Dr. Gill had documented no communication between Dr. Gill and Patient 12's primary care physician concerning Patient 12's elevated ferritin level. (Tr. at 332-333)
118. Dr. Gill acknowledged that he did not document any follow-up to Patient 12's high ferritin level, although he testified that he had given Patient 12 a copy of the lab report and probably discussed it with him. (Tr. at 174-175)

Paragraph 3(f) of the Notice alleges: Dr. Gill “continued to dispense and/or prescribe medication to Patient 10 despite [Dr. Gill’s] failure to appropriately evaluate and/or document the appropriate evaluation of a report of side effects.” (St. Ex. 1A)

119. In a progress note dated November 16, 1999, Dr. Gill noted, among other things, that Patient 10 had complained of “side effects.” No further information is documented concerning Patient 10's side effects. Nevertheless, for five subsequent visits through August 25, 2000, Dr. Gill continued to prescribe or dispense the same medications to Patient 10 as he had previously; namely, “era” (phentermine HCL 30 mg), “BW” (phentermine HCL 37.5 mg), and “TRP” (time-released phenylpropanolamine). (St. Ex. 11 at 7; St. Ex. 32 at 7, 9; Tr. at 73, 86, 111)
120. With regard to the documentation concerning side effects, Dr. Hornbeck testified: “[W]hat side effects? Nervousness, insomnia, personality changes? I don't know what side effects. * * * I mean, there is no further explanation of this.” (Tr. at 328) Dr. Hornbeck further testified that, if a patient reports side effects, the physician must determine if the patient has an allergy to the medication. Moreover, Dr. Hornbeck stated that some side effects can be life threatening. Accordingly, Dr. Hornbeck testified that it is important to document the

side effects and whether there was a drug allergy to ensure that the patient is never given the same medication again. (Tr. at 327-328)

121. Dr. Gill testified that he presumes that the side effects he referenced in his November 16, 1999, progress note were side effects of the medication that she was taking. Dr. Gill further testified that he does not know what those side effects were from looking at the chart. Moreover, Dr. Gill does not know why he had continued to prescribe the same medication to Patient 10. Finally, Dr. Gill acknowledged that it is important to document such information, and that it had been an oversight on his part not to do so. (Tr. at 157-158)

Paragraph 3(g) of the Notice alleges: Dr. Gill “caused a B-12 injection to be administered to Patient 11 despite the lack of an appropriate indication for the injection.” (St. Ex. 1A)

122. Dr. Gill’s medical record for Patient 11 notes several visits during which Patient 11 received a vitamin B-12 injection, including February 5, 2000. No reason for the injection was documented on any of these occasions. (St. Ex. 12 at 11-14)
123. Dr. Hornbeck testified that Patient 11 was given a vitamin B12 injection without any notation of a vitamin B-12 deficiency. (Tr. at 330)
124. Dr. Gill testified that on February 5, 2000, Patient 11 had come to his office for a vitamin B-12 shot. Dr. Gill further testified that it’s “part of the routine. If somebody wants a B-12 shot, we go ahead and give it to them. It’s a water-soluble vitamin. We don’t do lab tests to determine it, because it’s not necessary.” (Tr. at 164-165)
125. Dr. Huffman testified that vitamin B-12 injections or sublingual supplements can be given for the potential vitamin deficiency caused by caloric restriction. (Tr. at 477-478)

Paragraph 3(h) of the Notice alleges: Dr. Gill “failed to obtain and/or document a pulse or apical pulse from Patient 14 despite indications of significant hypertension and arthralgia, and [Dr. Gill] further failed to appropriately evaluate and/or document the appropriate evaluation of the affected systems.” (St. Ex. 1A)

126. Dr. Gill’s medical record for Patient 14 does not contain documentation of the patient’s pulse. The medical record further indicates that, at her first visit on May 1, 1999, Patient 14 had been taking medication prescribed by another physician that included Procardia XL 90 mg and Naldolol 20 mg. (St. Ex. 15)
127. Dr. Hornbeck believes that Dr. Gill’s failure to obtain or document a pulse or apical pulse is significant because Patient 14 had been taking a calcium channel blocker, Procardia XL 90 mg, and a beta blocker, Nadolol 20 mg. Both of those medications work to control hypertension. Dr. Hornbeck testified that “beta blockers work in the heart to slow the heart down to decrease blood pressure” and that calcium channel blockers work “on the arterial side of the heart to lower blood pressure.” Dr. Hornbeck further testified that it is important to take an apical pulse—to listen to the heart to determine the rate the heart is beating—in

order to ascertain that the Nadolol is working, especially in a patient who has documented hypertension. Dr. Hornbeck testified that, if the heart rate exceeds 70 beats per minute, the Nadolol is probably not working. (Tr. at 336-338)

In addition, Dr. Hornbeck testified that it appears from the medical record that Patient 14 had been taking Arthrotec for arthralgia. Dr. Hornbeck stated that arthralgia means joint pain. (Tr. at 339)

Further, in his March 18, 2004, report to the Board’s enforcement staff, Dr. Hornbeck stated that Dr. Gill had failed to perform an adequate examination of the affected systems. (St. Ex. 30 at 5)

Paragraph 3(i) of the Notice alleges: Dr. Gill “inappropriately dispensed and/or prescribed controlled substance anorectics to Patient 15 despite signs of significant hypertension.” (St. Ex. 1A)

128. Patient 15, a male, first saw Dr. Gill on April 3, 1999. Patient 15 was 51 years old, 5’11” tall, and weighed 281.5 pounds. The physical examination findings that were documented at that visit consist of blood pressure of 150/90 and normal sinus rhythm. In addition, it was noted that Patient 15 was taking several medications prescribed to her by another physician: Cardizem CD 300 mg per day, Monopril 40 mg per day, Cardura 2 mg twice per day, Axid 75 mg twice per day, and Propulsid 10 mg twice per day. Dr. Gill recorded a BMI of 39 and diagnosed obesity. At the first visit, Dr. Gill prescribed or dispensed a two-week supply of noncontrolled, nonprescription medications. (St. Ex. 16 at 6, 13)

At Patient 15’s next visit on April 17, 1999, Patient 15’s blood pressure had been 130/80. Dr. Gill prescribed or dispensed controlled substance anorectic medications abbreviated as “TP” (phendimetrazine 35 mg), “era” (phentermine HCL 30 mg), and “D25” (diethylpropion 25 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 16 at 6; St. Ex. 32 at 9; St. Ex. 33 at 1; Tr. at 70-73) Following that, Dr. Gill prescribed or dispensed controlled substance anorectic medication to Patient 15 on numerous occasions throughout his treatment of Patient 15. (St. Ex. 16 at 5-6)

129. Dr. Gill documented the following blood pressure readings for Patient 15 on visits where he prescribed or dispensed controlled substance anorectic medication:

Date	BP	Controlled Substance Medication(s) Prescribed or Dispensed by Dr. Gill
04/17/99	130/80	phendimetrazine, phentermine HCL, and diethylpropion
05/01/99	136/80	phendimetrazine, phentermine HCL, and diethylpropion
05/08/99	116/80	phendimetrazine, phentermine HCL, and diethylpropion
05/29/99	120/72	phendimetrazine and phentermine HCL
06/12/99	130/80	phendimetrazine and phentermine HCL
06/26/99	110/74	phendimetrazine and phentermine HCL
10/30/99	136/76	phentermine HCL

Date	BP	Controlled Substance Medication(s) Prescribed or Dispensed by Dr. Gill
11/13/99	n/a ⁸	phentermine HCL
11/27/99	128/84	phendimetrazine
12/11/99	128/78	phentermine HCL
12/18/99	130/76	phentermine HCL
01/08/00	136/78	phentermine HCL
07/15/00	140/92	phendimetrazine and phentermine HCL
07/29/00	120/90	phendimetrazine and phentermine HCL
08/12/00	120/86	phendimetrazine and phentermine HCL
08/26/00	130/80	phendimetrazine and phentermine HCL
09/09/00	122/80	phendimetrazine and phentermine HCL
09/23/00	110/80	phendimetrazine and phentermine HCL
10/07/00	130/86	diethylpropion and phentermine HCL

(St. Ex. 16 at 5-6)

130. Dr. Hornbeck testified that Patient 15 had had elevated blood pressure that was not well controlled. Dr. Hornbeck further testified that Patient 15 had been taking three different antihypertensive medications: Cardizem, a calcium channel blocker; Monopril, an ACE inhibitor; and Cardura, a centrally acting antihypertensive. Moreover, Dr. Hornbeck testified that, at Patient 15's first visit on April 3, 1999, he had had a blood pressure of 150/90 and was nevertheless placed on a noncontrolled medication, phenylpropanolamine. Dr. Hornbeck testified that phenylpropanolamine is a sympathomimetic drug that stimulates the heart. He added that it is not good to stimulate the heart of a patient who has high blood pressure. (Tr. at 339-341)

Dr. Hornbeck noted that Dr. Gill had later prescribed controlled substance anorectic medications:

But [it] must be noted in the record that the patient—the blood pressures were in range, you know, during that period. But still, you know, there was—there were at times when the bottom number was 90 or 92, but the systolic was within normal range.

(Tr. at 341-342)

131. Dr. Gill testified that, at his first visit on April 3, 1999, Patient 15's blood pressure had been elevated. Dr. Gill prescribed noncontrolled, nonprescription medications at the first visit. (St. Ex. 16 at 6; Tr. at 190-191)

⁸ The progress note indicates that Patient 15 "has poison ivy bad!" (St. Ex. 16 at 4)

Dr. Gill further testified that Patient 15's blood pressure had been normal at the time he began prescribing controlled substance anorectics on April 17, 1999. Moreover, Dr. Gill testified that, if Patient 15's blood pressure had been elevated, he would not have prescribed controlled substance anorectics. (Tr. at 191)

Paragraph 3(j) of the Notice alleges: Dr. Gill "failed to perform and/or document an appropriate work-up on findings of elevated AST and LDH in Patient 16." (St. Ex. 1A)

132. A lab report for a blood sample collected from Patient 16 on September 10, 2001, indicated, among other things, that her AST was elevated at 42 U/L with the reference range being 10 – 35 U/L; and her LDH was elevated at 312 U/L with a reference range of 100 – 190 U/L. (St. Ex. 17 at 7)
133. Dr. Hornbeck testified that Patient 16 had had abnormal levels of AST and LDH, but that there was no subsequent workup concerning abnormal values. Dr. Hornbeck testified that "those need to be explained. * * * [Y]ou just can't ignore those." (Tr. at 346)
134. Dr. Gill acknowledged that he had not documented any follow-up on Patient 16's abnormal AST and LDH results. (Tr. at 196-197)

Paragraph 3(k) of the Notice alleges: Dr. Gill "failed to perform and/or document an appropriate work-up on findings of elevated WBC in Patient 22." (St. Ex. 1A)

135. A lab report for a blood sample collected from Patient 22 on August 14, 2001, indicated, among other things, that her WBC [white blood cell] count was elevated at 15.7 thousand/ μ L with the reference range being 3.6 – 10.7 thousand/ μ L. (St. Ex. 23 at 9)
136. Dr. Hornbeck testified that a WBC count of 15.7 is significantly elevated, and that Dr. Gill did not document any follow-up. Dr. Hornbeck stated that such an elevated WBC count needs to be followed up because it could be a sign of infection, or it could be a sign of something else, such as lymphoma. (Tr. at 359-360)
137. Dr. Gill testified that he had not believed that it had been necessary to take steps to investigate the cause of Patient 22's elevated white blood cell count. (Tr. at 229)

Paragraph 3(l) of the Notice alleges: Dr. Gill "failed to perform and/or document an appropriate work-up on findings of elevated CPK in Patient 23." (St. Ex. 1A)

138. A lab report for a blood sample collected from Patient 23 on April 27, 2000, indicated, among other things, that his CPK was elevated at 517 U/L with the reference range being 10 – 228 U/L. At the top of the lab report there is a handwritten note that states that the report had been discussed with Patient 23 on May 11, 2000. (St. Ex. 24 at 7)
139. Dr. Hornbeck testified that CPK is an abbreviation for creatine phosphokinase, which is found in bone, muscle, and heart tissue. An elevated reading could result from many

causes, including muscle injury, trauma, and cardiac problems. Dr. Hornbeck stated that Patient 23's CPK was twice the normal value and needed to be evaluated. (Tr. at 361)

Dr. Hornbeck further testified that simply notifying the patient of an abnormal value is not sufficient. Dr. Gill should have communicated with Patient 23's primary care physician and documented whether the primary care physician would follow up. If Patient 23 did not have a primary care physician, then Dr. Gill needed to follow up and evaluate the patient through history and physical examination whether the patient had had trauma, or was having chest pains. (Tr. at 362-363)

140. Dr. Gill testified that CPK is a muscle enzyme. Dr. Gill further testified that Patient 23's CPK level had been "definitely elevated" and that he had talked to Patient 23 about it. Dr. Gill said that Patient 23 had advised that he had been lifting weights. Dr. Gill stated that if a patient overexerts himself working out, it can cause the CPK level to be elevated. However, Dr. Gill acknowledged that he had not documented any such specific information about his discussion with Patient 23. (Tr. at 234-236)

Paragraph 3(m) of the Notice alleges: Dr. Gill "continued to dispense and/or prescribe controlled substance anorectics to Patient 27 despite patient complaints of chest tightness and despite observed hypertension. Further, he failed to perform and/or document an appropriate work-up related to the patient's complaints of chest tightness." (St. Ex. 1A)

141. Patient 27 first saw Dr. Gill on June 26, 2000. She was 43 years old, 5'6" tall, and weighed 352 pounds. The physical examination findings consist of blood pressure of 150/88 and normal sinus rhythm. No further physical examination findings were documented. Dr. Gill noted Patient 27's BMI as 50+ and diagnosed obesity. Dr. Gill prescribed or dispensed a two-week supply of noncontrolled medications abbreviated as "CP" (chromium picolinate), "TRP" (time-released phenylpropanolamine), and "DEB" (phenylpropanolamine 37.5 mg), to be taken before breakfast, lunch, and dinner, respectively. (St. Ex. 28 at 6, 11)

At her next visit on July 10, 2000, Patient 27's blood pressure was 184/90 and her weight was recorded as 350 pounds. Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications abbreviated as "D25" and "D50" (diethylpropion 25 mg and 50 mg), to be taken before breakfast and dinner, respectively, as well as a noncontrolled medication abbreviated "TRP" (time-released phenylpropanolamine), to be taken before lunch. In addition, Dr. Gill prescribed Maxzide 50 mg #30, with no refills, with instructions to take one pill daily.⁹ (St. Ex. 27 at 6)

On August 21, 2000, among other things, Dr. Gill prescribed to Patient 27 Maxzide 50 mg #30 with one refill, with instructions to take one pill daily. (St. Ex. 27 at 6)

⁹ Dr. Gill testified that Maxzide is a diuretic. (Tr. at 47)

142. Dr. Gill documented the following blood pressure readings for Patient 27 during visits where he prescribed or dispensed controlled substance anorectic medication:

Date	BP	Generic Name(s) of Controlled Substance Medication(s)
07/10/00	184/90	diethylpropion
07/24/00	170/96	diethylpropion and phentermine HCL
08/07/00	150/96	diethylpropion and phentermine HCL
08/21/00	160/100	diethylpropion and phentermine HCL
09/05/00	160/98	diethylpropion and phentermine HCL
09/18/00	150/100 ¹⁰	diethylpropion and phendimetrazine
10/02/00	140/94	diethylpropion and phentermine HCL
10/01/01	138/84	phendimetrazine and phentermine HCL
10/16/01	134/84	phendimetrazine and phentermine HCL
10/29/01	134/84	phendimetrazine and phentermine HCL
11/13/01	128/82	phendimetrazine and phentermine HCL

(St. Ex. 28 at 5-6)

143. A progress note entry dated September 7, 2000, states that Patient 27 had called Dr. Gill's office and complained of "tight chest [with] WP [water pill]." The note further states that Patient 27 had been advised to try taking only one-half of her water pill each day and to call back if she had any further problems. (St. Ex. 28 at 6)

The progress note for Patient 27's next visit, September 18, 2000, indicates that Patient 27 had again complained of "meds bothering her." Also, as noted in the table above, Patient 27's blood pressure had been elevated at that visit, and Dr. Gill prescribed or dispensed a two-week supply of controlled substance anorectic medications. (St. Ex. 28 at 6)

144. Dr. Hornbeck testified that Dr. Gill's medical record for Patient 27 documents hypertension; nevertheless, Dr. Gill continued prescribing sympathomimetics to Patient 27 while her hypertension was not controlled. Dr. Hornbeck further testified that, despite Patient 27's continued problem with her blood pressure, there is no documentation that Dr. Gill had communicated with her primary care physician about controlling her blood pressure or further evaluating Patient 27. (Tr. at 372-373)

Moreover, Dr. Hornbeck testified that, when Patient 27 called Dr. Gill's office complaining of chest tightness, she had needed to be evaluated at that time. She may have been experiencing angina, a heart attack, asthma, or some other pulmonary problem. Dr. Hornbeck testified to the effect that, if someone calls Dr. Hornbeck's office complaining of chest tightness, that becomes a priority and everything else stops. However, in Dr. Gill's medical record, nothing else was documented. Finally, Dr. Hornbeck testified that

¹⁰ In addition, an arrow points from this reading to the statement "Plz rev - 160/105." (St. Ex. 28 at 6)

prescribing sympathomimetics to a patient who is complaining of chest tightness is “appalling.” (Tr. at 374, 377-378)

145. Dr. Gill testified that controlled substance anorectic medications are contraindicated in patients who have uncontrolled hypertension. He stated that was why, on July 10, 2000, when he first prescribed controlled substance anorectic medication to Patient 27, he had also prescribed Maxzide. He stated that she was to take Maxzide every day as an attempt to control her blood pressure. However, Dr. Gill acknowledged that her blood pressure of 184/90 on July 10, 2000, had been high. (Tr. at 252-253)
146. When asked if he had suggested to Patient 27 that she come to his office to be examined concerning her chest tightness, Dr. Gill replied that he had not; instead, he had “[j]ust told her to keep her regular appointment” which was already scheduled for September 18, 2000, eight days later. When asked if tightness in the chest could be a symptom of a heart-related problem, Dr. Gill replied, “Possibly.” (Tr. at 255-256)
147. Dr. Huffman testified that he saw nothing in Patient 27’s medical record that would be a contraindication to controlled substance anorectic medication therapy. Dr. Huffman further testified that Patient 27 had attributed the tightness in her chest to her diuretic, “so breaking the medicine in half and following up with that patient is appropriate.” (Tr. at 516-517)

*Paragraph 3(n) of the Notice alleges, in part: Dr. Gill “inappropriately prescribed diuretics to Patients 1-3, 6, 7, 10-13, 16, 19-21, 24 and 27 despite a lack of documented indication. * * ** (St. Ex. 1A)

Patient 1

148. As noted earlier in the Summary of the Evidence, on May 21, 1991, Dr. Gill prescribed to Patient 1 Dyazide #24 with instructions to take one tablet every Monday, Wednesday, and Friday. When asked if he could find in the medical record where he had documented the reason for prescribing Dyazide, Dr. Gill replied that he could not. When asked if he knew why he had prescribed it, Dr. Gill replied that he recalls that Patient 1 had complained of water retention. (St. Ex. 2 at 20; Tr. at 62-63)

As also noted previously, during Patient 1’s next visit on June 4, 1991, Dr. Gill noted that Patient 1 had been on her menses and that “pt bloats!” Dr. Gill also noted that he discussed that issue with Patient 1. Dr. Gill did not prescribe a diuretic at that visit but noted that she had not yet filled the Dyazide prescription he had given her during her first visit. (St. Ex. 2 at 20)

149. Dr. Gill’s medical record for Patient 1 indicates that, on July 1, 1991, Patient 1 had complained that she could not take Dyazide because it caused dryness in her eyes. Dr. Gill testified that he therefore decided to give Patient 1 another diuretic, Enduron. (St. Ex. 2 at 20; Tr. at 64)

150. During his treatment of Patient 1, Dr. Gill prescribed or dispensed diuretic medications to her as follows:

Date	Medication, Dosage, and Quantity	Instructions Documented
05/21/91	Dyazide #24	Take one every M-W-F
07/01/91	Enduron #6	Take one every M-W-F
07/15/97	Enduron 5 mg #24	Take one every M-W-F
11/04/91	Enduron 5 mg #24	Take one every M-W-F
08/24/92	Enduron 5 mg #24	Take one every M-W-F
01/22/93	Maxzide 25 mg #7	Take one every M-W-F
09/20/93	Maxzide 25 mg #7	Take one every M-W-F
11/15/93	Maxzide 25 mg #7	Take one every M-W-F
05/31/94	HCT [hydrochlorothiazide ¹¹] #24	Take one every M-W-F
04/06/95	Dyazide #24	Take one every M-W-F
07/28/95	Hydrochlorothiazide 25 mg #24	Take one every M-W-F
05/07/99	“Max” 50 mg #24	None documented

(St. Ex. 2 at 12, 15-20)

151. Dr. Hornbeck testified that Dr. Gill had utilized diuretic medication in his treatment of Patient 1 with no prior physical examination. Dr. Hornbeck further testified that Dr. Gill did not document a legitimate purpose for utilizing diuretics, such as hypertension, peripheral edema, or congestive heart failure. Moreover, Dr. Hornbeck testified that Dr. Gill’s failure to document a legitimate purpose for using diuretics led him to conclude that Dr. Gill had utilized diuretics for weight loss. Finally, Dr. Hornbeck testified that utilizing diuretics for weight loss is inappropriate. (Tr. at 288)

Dr. Hornbeck testified that diuretics cause a person to lose water and thereby lose weight. However, the weight loss is temporary and is regained as soon as the person replaces the lost fluid. (Tr. at 288-290)

152. Dr. Huffman testified that, on May 21, 1991, Dr. Gill had prescribed Dyazide for Patient 1, but that there was no documentation why it had been prescribed. Dr. Huffman stated that Patient 1’s diastolic blood pressure had been over 85, which could be a reason, but that Dr. Gill’s medical record does not include an assessment of Patient 1’s hypertension or a plan of treatment using Dyazide. (Tr. at 490)

Additional Patients

153. As with Patient 1, Dr. Gill’s medical records for Patients 2, 3, 6, 7, 10-13, 16, 19-21, 24 and 27 each reflect visits where Dr. Gill prescribed diuretic medication to the patient without documenting a basis for said prescribing. (St. Ex. 3 at 12; St. Ex. 4 at 23, 30,

¹¹ Dr. Gill testified that hydrochlorothiazide is a diuretic. (Tr. at 183)

32-35, 38, 39; St. Ex. 7 at 11, 13-16, 18; St. Ex. 8 at 16; St. Ex. 11 at 8; St. Ex. 12 at 11-14; St. Ex. 13 at 12-14; St. Ex. 14 at 19-21; St. Ex. 17 at 6; St. Ex. 20 at 27-29, 31-35, 37-38; St. Ex. 21 at 15, 18-20; St. Ex. 22 at 15-20; St. Ex. 25 at 13-16; St. Ex. 28 at 6; Tr. at 82-83, 88-89, 130, 158, 168-169, 196, 210-211, 220-221, 225-226, 239, 294, 297-298, 305-306, 317, 327, 329, 333-334, 343, 350, 352-354, 357, 366, 495)

*Paragraph 3(n) of the Notice further alleges: Dr. Gill “prescribed diuretics to Patient 12 without appropriate periodic evaluation and/or documentation of the appropriate periodic evaluation of potassium levels. * * *” (St. Ex. 1A)*

154. Dr. Gill prescribed or dispensed Maxzide 50 mg to Patient 12 on July 22 and December 29, 1997, and on January 27 and March 24, 1998. Further, Dr. Gill prescribed or dispensed Demadex 20 mg¹² on April 20, May 4, June 1, 1998; April 26, August 6, September 17, and December 30, 1999; and on August 14, 2000. (St. Ex. 13 at 12-14)
155. Dr. Hornbeck testified that Dr. Gill inappropriately gave Patient 12 diuretics, and that Dr. Gill failed to document evaluations of potassium levels while giving diuretics to Patient 12. (Tr. at 332)

Dr. Hornbeck testified that diuretics cause the body to increase the excretion of water. Along with the excretion of water, electrolytes such as potassium and sodium are also excreted. Dr. Hornbeck further testified that potassium is a closely regulated electrolyte, and that too much or too little potassium in the body could have lethal consequences. (Tr. at 278, 305)

156. Dr. Gill testified that a potential side effect of diuretics is low potassium. Dr. Gill further testified that, when a patient is on a diuretic, he routinely tells them to eat a banana or an orange every day to maintain a proper potassium level. (St. Ex. 13 at 11-14; Tr. at 176) However, this advice is not documented in Dr. Gill’s medical record for Patient 12. (St. Ex. 13)

Dr. Gill testified that he had ordered a lab test on April 27, 1999. The lab report indicates that Patient 12’s potassium level had been within the reference range. (St. Ex. 13 at 17; Tr. at 176-177)

Paragraph 3(n) of the Notice also alleges: Dr. Gill “failed to evaluate and/or document the evaluation of a finding of low sodium for Patient 13 while prescribing diuretics to the patient.” (St. Ex. 1A)

157. On November 19, 1993, Dr. Gill prescribed Maxzide 50 mg #6 with instructions to take one pill every Monday, Wednesday, and Friday. On June 23, 1994, Dr. Gill prescribed hydrochlorothiazide 25 mg # 24 with the same instructions. He repeated that prescription

¹² Dr. Gill testified that Demadex is a diuretic. (Tr. at 175)

on November 29, 1994, and June 29 and September 8, 1995. However, no reason for prescribing diuretic medications to Patient 13 was documented. (St. Ex. 14 at 19-21)

158. The results of a lab test for a blood sample collected on October 20, 1997, indicate, among other things, that Patient 13's sodium level was low at 133 MMOL/L with the reference range being 136 – 144 MMOL/L. The progress note for the following visit, December 1, 1997, makes no reference to the lab report. (St. Ex. 14 at 17, 23)

The last time that Dr. Gill prescribed diuretics to Patient 13 had been September 8, 1995, which was approximately two years before the aforementioned lab report had been obtained. (St. Ex. 14 at 16-19, 23)

159. Dr. Hornbeck testified that a low sodium level had been documented in Patient 13's chart but that there was no follow-up. Dr. Hornbeck testified that problems with a patient's sodium level need to be investigated even if, as in Patient 13's case, the sodium level is off by a small amount. Dr. Hornbeck stated that low or high sodium levels it can indicate that the patient has too much or too little water in his or her body. Dr. Hornbeck stated that it is an electrolyte used in every cell of the body. (Tr. at 333-335)

Paragraph 3(o) of the Notice alleges: “[Dr. Gill] inappropriately prescribed thyroid medications to Patients 2, 6, 11, 16, 24 and 27 for weight loss purposes and despite the fact that these patients were not hypothyroid. Further, [Dr. Gill] increased the dosage of Levoxyl for Patient 6 yet [he] failed to document any appropriate rationale for increasing that medication and failed to recheck the thyroid function. Further, [Dr. Gill] failed to obtain recent thyroid function levels for Patient 11 prior to initiating the prescribing of Synthroid. Further, [Dr. Gill] failed to obtain follow-up thyroid function tests for Patients 16 and 27.” (St. Ex. 1A)

Patient 2

160. On September 21, 2000, Patient 2 saw Dr. Gill after an interruption of nineteen months. Among other things, Dr. Gill ordered lab tests. The results of those tests indicate that Patient 2's T4 was 6.5 µG/dL and that the reference range for T4 is 4.5 – 10.9 µG/dL. Similarly, the lab readings for T-Uptake and FTI were within their reference ranges. However, next to the lab reading of 6.5 µG/dL for Patient 2's T4, a handwritten “↓” appears. (St. Ex. 3 at 11, 13-15)

At Patient 2's next visit on October 5, 2000, Dr. Gill noted “↓ T4” in the progress note and prescribed or dispensed Synthroid 0.05 mg #14 with instruction to take one tablet per day. Subsequently, on October 27, 2000, a note concerning a thyroid prescription was crossed out and the note stated that Patient 2 had received the thyroid results from the lab tests and wanted to see her regular physician. (St. Ex. 3 at 11)

On November 10, 2000, Dr. Gill prescribed or dispensed Synthroid 0.05 mg #14 for a second time. (St. Ex. 3 at 11)

161. Dr. Gill stated that the October 5, 2000, notation “↓ T4” means that Patient 2 “had a low T4 and thyroxin level * * *.” When referred to the lab result concerning Patient 2’s T4 level of 6.5 µG/dL, Dr. Gill testified that he would interpret that level to be “low normal,” and indicative of mild hypothyroidism. Dr. Gill further testified that the dose of Synthroid he had prescribed had been a very low dose. (Tr. at 74-77)

Dr. Gill added that “at the present time [he has] been trying to improve [his] notes” and that he could “perhaps do a better job at charting in regard to that.” Finally, Dr. Gill acknowledged that his chart would be clearer if he had documented the reasons why he had believed the patient had had hypothyroidism. (Tr. at 593-594)

162. Dr. Gill testified that Synthroid is “a brand name of levothyroxine, which is thyroid, a chemical name for the thyroid,” and is given first at low doses which are gradually increased as necessary to supplement the thyroid output “to get up to the normal range.” Finally, Dr. Gill testified that thyroid levels are rechecked during the process. (Tr. at 78-79)

163. Dr. Hornbeck testified that, after reviewing Dr. Gill’s medical record for Patient 2, he believes that Dr. Gill had given Patient 2 thyroid supplements for weight loss. (Tr. at 294)

Dr. Hornbeck testified that he had determined that Synthroid had been given for weight loss because, first, the values for which Dr. Gill tested—namely T4, T-uptake, and FTI—are not used to diagnose hypothyroidism or hyperthyroidism. Dr. Hornbeck testified that the values that reflect those conditions are TSH, Free T4, and Total T3. Furthermore, the values upon which Dr. Gill based his clinical decision were normal. With regard to Dr. Gill’s claim that the results were “low normal,” Dr. Hornbeck stated that patients can have low thyroid and be clinically hypothyroid, but the proper tests to make that determination were not conducted and/or documented. (Tr. at 295-296)

Moreover, Dr. Hornbeck testified that “it takes six weeks to reset the thyroid gland.” Accordingly, six weeks after beginning therapy with thyroid supplements, the physician must reevaluate the patient to determine if the patient is receiving the proper dose. Dr. Hornbeck testified that no such reevaluation had been performed. (Tr. at 296)

164. Dr. Hornbeck testified that hypothyroidism results from an underactive thyroid and is characterized by “fatigue, malaise, decreased reflexes, [and] organ systems [that] aren’t working as they should.” On the other end of the scale, hyperthyroidism results when “somebody has too much thyroid in their body. They have very brisk reflexes, they have faster heart rate, [and] usually they are thinner.” In addition, they could have thinning hair and/or decreased fat below their skin. (Tr. at 296-297)
165. Dr. Huffman noted that the T4 level in the lab report, which is within the normal range, has a down-arrow written next to it. Dr. Huffman believes that Dr. Gill may have noticed hypothyroid symptoms and wanted to raise her T4 level to a higher level in the normal

range to treat her symptoms. Nevertheless, Dr. Huffman testified that no such symptoms had been documented. (Tr. at 492-494)

Patient 6

166. On October 9, 1997, Dr. Gill first prescribed Levoxyl 0.05 mg #20 with instructions to take one pill per day.¹³ The progress note references a September 4, 1997, lab report. The note also states that Patient 6's TSH had been high, and that her T4 and T7 had been low. (St. Ex. 7 at 17)

The Hearing Examiner could find no September 4, 1997, lab report in the medical record, but found a report dated August 11, 1997, that appears to have been faxed to Dr. Gill by Patient 6's primary care physician. It bears a handwritten note that states that it had been discussed with Patient 6 on October 9, 1997. The lab report shows the following results (Dr. Gill added the arrows by hand to the report):

Test	Normal Results	Abnormal Results	Reference Range	Units
T4	↓ 6.9		4.5 – 11.0	μG/dL
T-Uptake	24.1		22 – 37	%
FTI	↓ 1.7		1.4 – 3.0	
TSH	3.2 ↑		0.35 – 5.5	μIU/mL

(St. Ex. 7 at 23)

167. At Patient 6's next visit on October 27, 1997, Dr. Gill increased Patient 6's dose of Levoxyl to 0.075 mg. He continued that dose on November 13, 1997. At Patient 6's next visit on January 22, 1998, Dr. Gill again raised the dose of Levoxyl, this time to 0.1 mg, and continued Patient 6 at that dose through March 20, 1998. No reason for increasing the dose was documented in any of the progress notes. (St. Ex. 7 at 17)

168. Dr. Hornbeck testified that Dr. Gill had prescribed Levoxyl to Patient 6, who was not hypothyroid, but documented no follow-up test six weeks later. Further, Dr. Hornbeck testified that Dr. Gill had initially started Patient 6 on Levoxyl 0.05 mg, had increased it to 0.075 mg, and had increased it again to 0.1 mg, the level at which it was maintained. However, Dr. Hornbeck testified that "the laboratory data doesn't correlate to when the increases were." (Tr. at 314-316)

169. Dr. Gill testified that he considers a T4 result of less than 8.0 μG/dL to be low normal. Dr. Gill also testified that Patient 6's TSH had been high, which indicated that her body had been producing a larger quantity of thyroid stimulating hormone to make her thyroid gland produce more thyroid. (Tr. at 118-120)

¹³ Dr. Gill testified that Lexoxyl is a brand name for levothyroxine and is used to treat thyroid deficiency. (Tr. at 119)

Dr. Gill acknowledged that, according to the lab report, all of the thyroid results had been within the reference ranges. However, Dr. Gill testified:

[E]ssentially the reference range is too wide. People [who] have normal thyroid function are essentially in the middle of that range. So that is a problem that we've had over the years where people are, say, low normal. They are within the reference range, but they are low normal and they have mild hypothyroidism. And they need—they have a thyroid deficiency so they need to be treated to get it up where it belongs.

(Tr. at 121)

170. On January 19, 1999, after a break in thyroid treatment, Dr. Gill prescribed or dispensed Levoxyll 0.05 mg to Patient 6, and then prescribed or dispensed Levoxyll 0.1 mg at her next visit on February 2, 1999. (St. Ex. 7 at 16)
171. The lab test results for a blood sample submitted by Patient 6 on January 5, 1999, states (Dr. Gill added the arrows by hand to the report):

Test	Normal Results	Abnormal Results	Reference Range	Units
T4	↓ 7.5		4.5 – 10.9	μG/dL
T-Uptake	24.2		22.5 – 37	%
FTI	↓ 1.8		1.4 – 3.1	
TSH	1.7 ↑		0.35 – 5.5	μIU/mL

(St. Ex. 7 at 21)

172. Dr. Gill testified that Patient 6 had been taking Levoxyll 0.1 mg previously. He testified that she not been to his office since October 1998 and he had wanted to restart her medication at a lower dosage. Dr. Gill testified that he had not documented the reason for the increase in the chart, but noted that he had obtained a lab test that indicated that her T4 and T7 were down. (Tr. at 125-126)

Patient 11

173. A lab report concerning a blood sample taken during Patient 11's first visit on August 9, 1999, stated, in part, that Patient 11's T4 level was 11.0 μG/dL with the reference range being 4.5 – 10.9 μG/dL. Further, Patient 11's T-Uptake level was 20.6% with the reference range being 22.5 – 37%. (St. Ex. 12 at 17) The Hearing Examiner could find no other lab reports in Dr. Gill's medical record for Patient 11. (St. Ex. 12)

A progress note dated March 6, 2000, states that Patient 11 had called Dr. Gill's office, and "wonders if she should be taking thyroid medication. [Complains of] lethargy, fatigue,

facial hair, [and weight] regain. Dr. Gill said a thyroid profile [with] TSH is needed before prescribing any med.” (St. Ex. 12 at 13)

Some time later, on April 5, 2001, Dr. Gill noted that Patient 11 had hypothyroid which he discussed with Patient 11. He prescribed or dispensed Synthroid 0.05 mg #14 at that visit.

At the following visit on April 19, 2001, Dr. Gill prescribed Synthroid 0.05 mg #100 with no refills, with instructions to take one tablet per day. Dr. Gill repeated this prescription on July 16, October 27, and November 5, 2001. (St. Ex. 12 at 11-12)

174. Dr. Hornbeck testified that Patient 11 had been placed on Synthroid with no recent blood work. Dr. Hornbeck further testified that Patient 11 had not been hypothyroid. Moreover, Dr. Hornbeck testified that Patient 11 had been taking birth control pills, which can alter the results of thyroid function tests. Dr. Gill would have needed further lab tests to determine if Patient 11 was truly hypothyroid. (Tr. at 330)
175. Dr. Gill acknowledged that there are no lab reports in Patient 11’s chart that state that she had hypothyroidism. (Tr. at 166)

Patient 16

176. A September 10, 2001, lab report indicates that Patient 16’s T4 was normal at 6.9 $\mu\text{G/dL}$ with the reference range being 4.5 – 10.9 $\mu\text{G/dL}$. A handwritten “↓” appears next to the T4 result. (St. Ex. 17 at 9)

On October 12, 2001, Dr. Gill prescribed or dispensed Synthroid 0.05 mg #14 with instructions to take one per day. His progress note for that visit states, among other things, that “↓ T4” had been discussed with Patient 16. (St. Ex. 17 at 6)

Subsequently, Dr. Gill’s progress note dated October 26, 2001, includes two references to Synthroid. The first indicates that Dr. Gill prescribed or dispensed Synthroid 0.05 mg #14 to be taken once per day. The second indicates that Dr. Gill prescribed Synthroid 0.05 mg #100 with no refills, to be taken once each day in the morning. (St. Ex. 17 at 6)

177. Dr. Hornbeck testified that Dr. Gill had placed Patient 16 on thyroid medication for purposes of weight loss. Dr. Hornbeck further testified that Dr. Gill failed to order any follow-up thyroid function test. (Tr. at 343)

Moreover, Dr. Hornbeck testified that lab results obtained by Dr. Gill for Patient 16 indicate that the thyroid values ordered—T4, T-Uptake, and FTI—were all within the normal ranges. Finally, Dr. Hornbeck testified that “nobody uses those to document hypo- or hyperthyroid conditions.” (Tr. at 344-345)

178. Dr. Gill acknowledged that he had prescribed Synthroid to Patient 16. Dr. Gill testified that he had interpreted Patient 16’s T4 result of 6.9 $\mu\text{G/dL}$ to be low normal. (Tr. at 194-196)

Patient 24

179. A lab report for a sample drawn from Patient 24 on May 4, 1998, indicates, among other things, that Patient 24's T4 level had been normal at 6.4 $\mu\text{G/dL}$ with the reference range being 4.5 – 11.0 $\mu\text{G/dL}$. In addition, the report indicated that Patient 24's FTI level had been normal at 1.9 with the reference range being 1.4 – 3.1. However, handwritten down-arrows [\downarrow] were marked next to both results. (St. Ex. 25 at 19)

A handwritten notation indicating that the lab results had been discussed with Patient 24 on October 27, 1988, appears at the top of the lab report. (St. Ex. 25 at 19)

Dr. Gill's progress note for Patient 24's October 27, 1988, visit includes the notations " $\downarrow\text{T4}$ " and " $\downarrow\text{T7}$." Three visits later, on December 10, 1998, Dr. Gill prescribed or dispensed Levoxyl 0.05 mg #20 to be taken once per day. At Patient 24's next visit, on January 7, 1999, Dr. Gill prescribed Levoxyl 0.1 mg #100, with no refills, to be taken once per day. (St. Ex. 25 at 13)

180. Dr. Hornbeck testified that Dr. Gill had placed Patient 24 on thyroid medication for purposes of weight loss. (Tr. at 366-367)

181. Dr. Gill testified that he had noted on the lab report and in his October 27, 1998, progress note that he had believed Patient 24's thyroid levels to be low, despite what the lab report says. Dr. Gill added that the "reference range is way too wide." (Tr. at 229-242)

Patient 27

182. A lab report for a blood sample drawn from Patient 27 on June 26, 2000, indicates, among other things, that Patient 27's T4 level was normal at 5.9 $\mu\text{G/dL}$, with the reference range being 4.5 – 10.9 $\mu\text{G/dL}$. A handwritten " \downarrow " appears next to the T4 result. A handwritten note at the top of the report indicates that Dr. Gill had discussed the report with Patient 27 on July 10, 2000. (St. Ex. 28 at 7)

Further, in his progress note dated July 10, 2000, Dr. Gill wrote " $\downarrow\text{T4}$ (Hypothy.)" and that that had been discussed with Patient 27. He prescribed or dispensed, among other things, Synthroid 0.05 mg #14 to be taken once per day. (St. Ex. 28 at 6)

Subsequently, Dr. Gill prescribed or dispensed Synthroid 0.05 mg to Patient 27 on July 24, 2000, and October 1, 2001. On October 16, 2001, he prescribed or dispensed Synthroid 0.1 mg. (St. Ex. 28 at 5-6)

183. Dr. Hornbeck testified that Dr. Gill had placed Patient 27 on thyroid medication for purposes of weight loss. Dr. Hornbeck further testified that Dr. Gill failed to order a recheck of Patient 27's thyroid function after he had placed her on Synthroid. (Tr. at 375-377)

184. Dr. Gill testified that he had noted on the lab report and in his July 10, 2000, progress note that he had believed Patient 27's thyroid levels to be low, despite what the lab report says. (Tr. at 253-254)

In General

185. Dr. Huffman testified that, among Dr. Gill's patient charts, there were cases in which Dr. Gill had given patients thyroid medication without documenting a purpose for the medication. Dr. Huffman testified that older physicians used to treat patients based on symptoms, and speculated that Dr. Gill may have seen some symptoms of hypothyroid such as fatigue, dry skin, constipation, or irregular periods. (Tr. at 478-480)

Paragraph 3(p) of the Notice alleges: Dr. Gill "inappropriately dispensed and/or prescribed Meridia to Patient 11 despite the fact that this patient was concurrently taking Prozac." (St. Ex. 1A)

186. Patient 11, a female, first saw Dr. Gill on August 9, 1999. Among other things, Dr. Gill documented Patient 11's current medications, which included Prozac. (St. Ex. 12 at 14)

Approximately two years later, on July 16, 2001, Dr. Gill prescribed Meridia 10 mg #30 with no refills to be taken once per day. (St. Ex. 12 at 12)

187. Dr. Hornbeck testified that Dr. Gill had inappropriately placed Patient 11 on Meridia while she was taking Prozac. Dr. Hornbeck testified that Prozac is a selective serotonin re-uptake inhibitor. It works in the brain to keep serotonin levels high, usually to treat depression. Dr. Hornbeck further testified that Meridia is a norepinephrine and serotonin re-uptake inhibitor. Dr. Hornbeck testified that the package insert for Meridia states that it should not be used with other selective serotonin re-uptake inhibitors. Furthermore, Dr. Hornbeck testified that Meridia is contraindicated in patients who are taking other centrally acting appetite suppressants. (Tr. at 329-330)

188. Dr. Gill testified that Meridia is an anorectic medication that works differently from the other anorectic medications discussed during the hearing. He denied that Meridia is contraindicated in a patient who is taking Prozac, but acknowledged that the package insert contains a caution to that effect. Dr. Gill further testified that he thinks that Patient 11 may have discontinued taking Prozac by the time he prescribed Meridia. (Tr. at 166-168) The medical record contains no documentation that Patient 11 had ceased taking Prozac. (St. Ex. 12)

Paragraph 3(q) of the Notice alleges: "[D]espite Patient 8's report of feeling sick on or about March 28, 1998, [Dr. Gill] failed to investigate and/or document any investigation of her symptoms and continued to dispense and/or prescribe controlled substance anorectics to her through May 9, 1998. Patient 8 subsequently reported on or about August 10, 1998, that she

had miscarried at three and one-half months. Further, despite Patient 19's report of being one week late for her period, [Dr. Gill] failed to obtain a pregnancy test and continued to dispense and/or prescribe controlled substance anorectics to her." (St. Ex. 1A)

Patient 8

189. In his medical record for Patient 8, Dr. Gill's progress note dated March 28, 1998, states, among other things, that Patient 8 "has been sick." No explanation of that note is documented. On that day, Dr. Gill prescribed or dispensed controlled substance anorectic medications. Subsequently, Dr. Gill saw Patient 8 on April 11, 25, and May 9, 1998, and prescribed or dispensed controlled substance anorectic medication to her at each visit. After May 9, 1998, Patient 8's next visited Dr. Gill on August 10, 1998. The progress note for that visit states that Patient 8 had had a miscarriage at 3½ months. (St. Ex. 9 at 13)
190. Dr. Hornbeck expressed concern regarding Dr. Gill's March 28, 1998, progress note stating that Patient 8 "has been sick," and Patient 8's report on August 10, 1998, that she had miscarried at 3½ months. Dr. Hornbeck testified that there had been no questioning or follow-up documented concerning Patient 8's complaint that she had been sick. Dr. Hornbeck testified that it "could have been a cold, gastroenteritis, or morning sickness." He believes that Dr. Gill should have performed a pregnancy test—which Dr. Hornbeck testified is quick and easy to do—to determine if Patient 8 had, in fact, been pregnant. Finally, Dr. Hornbeck testified that controlled substance anorectic medications are contraindicated for a pregnant patient. (Tr. at 318-320, 322)
191. Dr. Gill testified that a nurse had written the notation on March 28, 1998, that Patient 8 had been sick. When asked about that note, Dr. Gill replied:

Well, obviously with this note—and I think the note was put in the chart because the patient gained five pounds. So the nurse in talking to the patient just noted that patient has been sick. I think that's why she put that notation in the chart.

Now, I think just from memory, obviously I wouldn't just let that go. I would say, okay, well that's too bad. What have you been sick with? Again, you know, I have—I should have made a note in the chart whether she had a cold or sinus infection or whether she was just had maybe a slight case of the flu or something like that. I realize throughout the charts and different testimony there is definitely room for improvement on my charting.

(Tr. at 602) Dr. Gill added that there was nothing in the March 28, 1998, note that would have given him reason to believe that Patient 8 had been pregnant. (Tr. at 602-603)

Patient 19

192. Dr. Gill's progress note for Patient 19's December 5, 1988, visit indicates, among other things, that Patient 19 "states she's one week late for menses." Next to that, it states "get lab done." At that visit, Dr. Gill dispensed or prescribed a one-month supply of controlled substance anorectic medication abbreviated as "DIP" (diethylpropion) to be taken before breakfast, along with noncontrolled, nonprescription medications to be taken before lunch and before dinner. (St. Ex. 20 at 33)
193. In his March 18, 2004, report, Dr. Hornbeck stated: "It is documented that the patient was one week late for her menses. There is no pregnancy test obtained, and anorexiant were still dispensed even though the patient could possibly have been pregnant. Anorexiant are contraindicated in pregnancy." (St. Ex. 30 at 6)
194. Dr. Gill testified that he does not know why the nurse had made a note concerning Patient 19 being one week late for her menses. Dr. Gill stated that "they are late all the time." Moreover, Dr. Gill testified that, when Patient 19 first came to him seven years earlier in November 1981 she had been taking birth control pills. Dr. Gill stated, "I didn't document that continuing forward, but I don't think we were just that concerned about it." Finally, Dr. Gill acknowledged that he had not done anything to make sure that Patient 19 was not pregnant. (St. Ex. 20 at 38; Tr. at 211-212)
195. Dr. Gill testified that the note to "get lab done" had referred to Patient 19's regular lab test rather than a pregnancy test. (St. Ex. 20 at 33; Tr. at 211)

Paragraph 3 of the Notice, In General

196. In his March 18, 2004, report and in his testimony, Dr. Hornbeck stated that Dr. Gill's care and treatment of Patients 1 through 27 constituted a failure to conform to the minimal standard of care. (St. Ex. 30; Tr. at 293-294, 300-301, 317, 322-323, 328-329, 331, 333, 336, 339, 342, 346, 349-350, 353, 356, 358-360, 364, 368-371, 377)

Paragraph 4 of the Notice alleges, in part: "[Dr. Gill] failed to accurately reflect the utilization of controlled substances in the charts for Patients 1 through 27 by utilizing initials and terminology (such as ERA, RB, GW and Metra) to represent controlled substances from which an independent reviewer could not determine the type, quantity and/or dosage of the controlled substance being dispensed." (St. Ex. 1A)

197. Throughout his medical records for Patients 1 through 27, Dr. Gill used abbreviations for nearly all of the controlled substance anorectic medications that he prescribed or dispensed. (St. Exs. 2 through 28)
198. Very often throughout Dr. Gill's patient records, and as exemplified in his record for Patient 1, Dr. Gill used more than one abbreviation for the same medication. This is true

even if the same medication was dispensed at the same visit to be taken multiple times per day. For example:

- On April 20 and May 4 and 25, 1995, Dr. Gill prescribed or dispensed to Patient 1 medications abbreviated as “Era,” “P30,” and “DC,” to be taken before breakfast, lunch, and dinner, respectively. Both “Era” and “P30” are phentermine HCL 30 mg. (St. Ex. 2 at 15)
- On July 13, 1995, Dr. Gill prescribed or dispensed to Patient 1 medications abbreviated as “TP,” “GW,” and “TW” to be taken before breakfast, lunch, and dinner, respectively. “TP” is Dr. Gill’s abbreviation for phendimetrazine 35 mg in a trim, pink tablet; “GW” is another abbreviation for phendimetrazine 35 mg; and “TW” is yet another abbreviation for phendimetrazine 35 mg, contained in a white capsule. (St. Ex. 2 at 15; Resp. Ex. B; Tr. at 70-72, 172-173)
- On August 21, September 14, and September 28, 2000, Dr. Gill prescribed or dispensed medications abbreviated as “TP,” “era,” and “B35,” to be taken before breakfast, lunch, and dinner, respectively. Both “TP” and “B35” contain phendimetrazine 35 mg—”TP” is a trim, pink tablet and “B35” is 35 mg of Bontril, a brand name of phendimetrazine. (St. Ex. 2 at 11; St. Ex. 32 at 9; Tr. at 70-73)

199. During hearing, the State’s Assistant Attorney General questioned Dr. Gill concerning medication he had prescribed or dispensed to Patient 2. The following exchange took place concerning the differences (if any) among the medications identified in Dr. Gill’s medical record for Patient 2 as “TP,” “GW,” and “BP”:

Q. [By Mr. Wilcox] Can you tell us what those are?

A. [By Dr. Gill] It’s all phendimetrazine 35 milligrams.

Q. It’s three different brands?

A. It’s all the same medication. They are different colors and a lot—we go with a lot of color combinations to differentiate one from the other, but in this case they are all the same. It’s all the same medication.

Q. Okay.

A. Which is three a day. Three times a day is standard dosing schedule.

Q. So those aren’t three different medications, three different types, or are they?

A. See, some of this—no, it’s the same—it’s three of the same medications, just the abbreviations are for the color coding, because that’s how we identify it and

that's how the patients identify them. They know what the medication is, but it's easier if they say, well, you know, they just identify them by color usually.

Q. So TP means a color?

A. Well it stands for Trim pink. Years ago there was white, pink and yellow. So it's the same medication, same dosage, just different color.

Q. If it's the same medication, why are they different colors? Is that because the dosage is different?

A. No. The dosage is the same. They are from a different manufacturer or they may or may not be from a different manufacturer. Sometimes they are, sometimes they are not.

Q. Okay. Can you tell by looking at what you wrote there, the TP, GW, BP, can you tell what the dosage is?

A. Yes, because it's on our—it's on the regular inventory sheet for our dosage sheet and we know—we know all of them, you know. We know them by heart, but it's on the—it's on our dispensing record.

Q. Okay. But you are saying you can't tell by looking at the patient chart, but you could tell by looking at another record in your office that's not part of the patient chart?

A. Yes, other than I have them all memorized. I know what they all are.

Q. Okay. So for the TP, GW, BP, do you know what dosages those are?

A. 35 milligrams.

(Tr. at 70-72)

200. The following is a list of some of the abbreviations used by Dr. Gill in his medical records for Patients 1 through 27:

- B35: Bontril (phendimetrazine) 35 mg. (St. Ex. 32 at 9)
- BC: phentermine HCL 30 mg. (St. Ex. 33 at 1)¹⁴
- BP: phendimetrazine 35 mg. (Tr. at 70-72)
- BW: phentermine HCL 37.5 mg. (St. Ex. 32 at 9)
- CP: chromium picolinate. (Tr. at 111)

¹⁴ This document had been compiled by Board staff using an abbreviation key(s) provided by Dr. Gill and from statements made by Dr. Gill during an investigative deposition. (St. Ex. 33)

- D25: diethylpropion 25 mg. (St. Ex. 33 at 1)
- D50: diethylpropion 50 mg. (St. Ex. 33 at 1)
- DC: Ditex with chromium. (St. Ex. 32 at 7)
- DEB: Dr. Gill testified that DEB is phenylpropanolamine. (Tr. at 111) His key states that it's phenylpropanolamine PPA 37.5 mg. (St. Ex. 32 at 7)
- DIP: diethylpropion 25 mg. (St. Ex. 33 at 1)
- Dip50: diethylpropion 50 mg. (Tr. at 73)
- Ditex: a fiber pill. (St. Ex. 33 at 1)
- EP25: diethylpropion 25 mg. (St. Ex. 33 at 1)
- Era: a yellow capsule containing phentermine HCL 30 mg. (St. Ex. 32 at 9; Tr. at 73)
- grn: phendimetrazine 35 mg. (St. Ex. 33 at 1)
- GW: phendimetrazine 35 mg. (Tr. at 70-72)
- GY: Dr. Gill testified that GY means "green and yellow" and is phendimetrazine. (Tr. at 73) However, in his August 8, 2003, key, Dr. Gill states that GY is phentermine HCL 15 mg. (St. Ex. 32 at 9)
- Metra: Not defined anywhere in the hearing record.
- P30: phentermine HCL (presumably 30 mg). (St. Ex. 33 at 1)
- Phen30: phentermine HCL 30 mg. (St. Ex. 33 at 1)
- PPA: Dr. Gill testified that PPA is phenylpropion. (Tr. at 86) His key indicates that PPA is phenylpropanolamine. (St. Ex. 32 at 7)
- RB: In one document, RB is stated to be phentermine HCL in a red and black capsule. (St. Ex. 33 at 2) Nevertheless, at hearing, Dr. Gill made indirect statements indicating that RB was noncontrolled. (Tr. at 244-245) Another abbreviation key provided at hearing indicates that "RB" is a "Red & Black Capsule" but does not state what medication the capsule contained. (Resp. Ex. B)
- Sts: Statobex, a brand name of phendimetrazine. (Tr. at 58)
- Tenuate and Tenuate Dospan are brand name drugs that contain diethylpropion. (Tr. at 116-117)
- TP: Dr. Gill testified that TP stands for "Trim pink" and is phendimetrazine 35 mg. (Tr. at 70-72)
- TrimG: phendimetrazine in a gray capsule. (St. Ex. 33 at 2)
- TrimW: phendimetrazine in a white capsule. (St. Ex. 33 at 2)
- TrimP: phendimetrazine in a pink tablet. (St. Ex. 33 at 2)
- TRP: Dr. Gill testified that TRP is time-released phenylpropion, a non-controlled, non-prescription medication. (Tr. at 86) He later stated it is time-release phenylpropanolamine. (Tr. at 111) His key states that it is time-release phenylpropanolamine. (St. Ex. 32 at 7)
- TW: phendimetrazine 35 mg white. (Resp. Ex. B; Tr. at 172-173)
- VIC: vitamin C. (Tr. at 86)

201. In his June 11, 2004, report, Dr. Hornbeck stated:

It must be understood from the beginning that it was very difficult to go through the 27 charts that [Board staff] provided to me, due to the documentation being very poor. There were abbreviations that were used without adequate

explanation that Dr. Gill provided to interpret his records. There was inadequate explanation of abbreviations used throughout the charts.

(St. Ex. 31 at 1)

In addition, Dr. Hornbeck testified that he had had difficulty understanding the abbreviations that Dr. Gill used. (Tr. at 291, 300, 327, 347)

202. Dr. Gill testified that he uses abbreviations for medications because the names for the medications he uses in his practice are very long. He further testified that he had developed the abbreviations, and that other bariatric physicians also use abbreviations in their practices. Dr. Gill acknowledged that he did not have an abbreviation chart at the time that the Board subpoenaed his medical records. He testified that, today, he does have an abbreviation chart in his office.¹⁵ (Tr. at 57-59, 579-581)
203. Dr. Gill testified that, as of the date of his testimony, he is still using the same abbreviations for medications in his medical records as those at issue in this hearing. (Tr. at 629-630)

Additional Information

Prescribing

Testimony of Dr. Hornbeck

204. Using Patient 1 as an example, Dr. Hornbeck noted that, on July 15, 1991, Dr. Gill had given her “Era” (phentermine HCL 30 mg) to be taken twice per day. Dr. Hornbeck further testified that the daily dose for phentermine HCL is 30 or 37.5 mg. Dr. Hornbeck testified that Dr. Gill had therefore placed Patient 1 on twice the normal dose per day. Moreover, Dr. Hornbeck concluded that Dr. Gill had given Patient 1 another substance abbreviated as “Sts” which, to Dr. Hornbeck’s knowledge, Dr. Gill had been unable to identify.¹⁶ Furthermore, Dr. Hornbeck testified that Dr. Gill added Enduron, which is a diuretic. (St. Ex. 2 at 20; Tr. at 291-292) Finally, Dr. Hornbeck testified:

[H]e’s [giving] twice the maximum dose of phentermine, plus he used inappropriate use of a diuretic for weight loss. And this is consistent through the record, you know, from all the charts that [the Board staff] gave me. You know, you could probably look at one chart and cover 90 percent of the ones that [the Board staff] gave me.

(Tr. at 292-293)

¹⁵ No comprehensive abbreviation chart was presented by Dr. Gill as an exhibit at hearing.

¹⁶ Dr. Gill had testified earlier in the hearing, while Dr. Hornbeck was not present, that “Sts” contains phendimetrazine. (Tr. at 58)

205. With regard to Patient 2, Dr. Hornbeck noted that, over the entire period that Dr. Gill treated Patient 2—from January 24, 1997, until May 9, 2002—she gained 28 pounds. Dr. Hornbeck testified that, to him, it means “[f]ailure.” Dr. Hornbeck testified that “whatever was being done wasn’t being done correctly * * *.” Dr. Hornbeck added that the medical literature indicates that controlled substance anorectics can, at most, cause a five to seven percent reduction in weight. Moreover, Dr. Hornbeck testified that some of his patients want “a quick way to lose weight. I said if these products worked, you wouldn’t have fat doctors and fat nurses. We would be taking them. And they don’t work.” (St. Ex. 3 at 9, 11-12; Tr. at 299-300)
206. Dr. Hornbeck also testified that he believes that anorectic medications should not be prescribed to patients for long periods of time because the medication becomes less effective over time. (Tr. at 349)
207. Dr. Hornbeck testified that, overall, Dr. Gill had inappropriately prescribed anorectics to Patients 1 through 27, documented insufficient physical examinations and histories, and failed to follow up on various medical issues. Dr. Hornbeck further testified that, in addition to prescribing controlled substance anorectics, Dr. Gill inappropriately prescribed or dispensed other prescription drugs. Moreover, Dr. Hornbeck testified, “Whether they be diuretics or thyroid medications or B-12 injections, you know, these drugs are not over-the-counter for a reason, you know. They are potentially dangerous.” Finally, Dr. Hornbeck believes that Dr. Gill’s reckless prescribing of medications and his lack of follow-up had placed Patients 1 through 27 in danger. (Tr. at 378-379)

Testimony of Dr. Huffman

208. Dr. Huffman testified that, when a patient tries to lose weight simply by reducing caloric intake, “that will only last for so long. The hunger will take over.” Dr. Huffman testified that anorectic medication reduces the patient’s hunger so that the patient can reduce caloric consumption more comfortably and for longer periods. (Tr. at 454)

Testimony of Dr. Gill

209. Dr. Gill testified that the Board’s 1998 amendments to its controlled substance anorectic prescribing rules had had a very large impact on his practice. Dr. Gill further testified that the new requirements created a lot of turnover in his patient population and cut his patient volume to one-third of its previous level. (Tr. at 623-625) Dr. Gill further testified:

* * * I have many, many patients and hundreds and hundreds of charts clearly demonstrating the fact that before these rules when we were allowed to continue treating the patients as long as they were doing well, they were successful in losing the weight, they were successful in keeping the weight off.

* * *

* * * [T]he main problem that I see is that it's actually interfering with good patient care. People that are really in need of losing weight, maybe they have a family history of diabetes, some of them get discouraged and they are resorting to gastric bypass surgery. Patients that I know it's a medical problem. It's basically it's genetic inherited metabolic disease. They are resorting to surgery, going in and subjecting themselves and resorting to bariatric surgery whereas I know that if we could continue to treat them, they would be successful in losing the weight.

And I have many, many patients that are successful in keeping the weight off. This goes back years ago when we could put them on a low dose of anorectic medication, just the same way as we do with hypertension and diabetes, and those two in particular where you get them down to a lower weight and then you can put them—you are allowed to put them on a low dose anorectic medication similar to, of course, diabetes, hypertension, maybe depression. It's ongoing.

(Tr. at 625-626)

Recordkeeping

Testimony of Dr. Hornbeck

210. Dr. Hornbeck testified that it is important for a physician to keep accurate medical records for the purpose of continuity of care, and to ensure that others who review them can understand them. Dr. Hornbeck added that, if Dr. Gill were to stop practicing tomorrow, “there is no way somebody could walk in to his practice and pick up from square one and not miss a beat. You just can't. I mean the documentation is substandard.” (Tr. at 285-284)
211. Dr. Hornbeck testified that he does not agree with the adage that, if something is not documented in the medical record, then it was not done. Dr. Hornbeck explained that “not everything can be documented 100 percent in the medical field. I mean such as surgery or you know they have an op report that gives the highlights of the operation. They don't say I took a stitch here, I took a stitch here. It's not 100 percent, you know, that it was done.” (Tr. at 298)

Testimony of Dr. Huffman

212. When asked about the standard of care for medical recordkeeping, and whether it requires that another physician would be able to pick up a chart and understand generally the history and treatment of a patient, Dr. Huffman replied:

I don't think so. I don't think—I mean as long as that physician has documented what they have found and there is a way that that physician can,

you know, explain those terminologies, I don't think it has to be—I don't think I have to—I don't think the standard of care is that we have to be able to read and decipher every physicians' charts.

(Tr. at 468) Dr. Huffman added that, with abbreviation charts, he would have been able to understand Dr. Gill's medical records. (Tr. at 468)

213. Dr. Huffman testified that, in reviewing Dr. Gill's patient records, that Dr. Gill "just didn't document very well what was taking place. * * * I like to see a complete SOAP note, standard objective, subjective plan of treatment. And, you know, I picked up on some of his objective findings, subjective findings, but not consistently and so made it difficult to follow the flow." Dr. Huffman noted that the records contained lab studies and patient history forms, but that Dr. Gill did not consistently follow up on "positives." (Tr. at 469-470)

Testimony of Dr. Gill

214. Dr. Gill testified that he believes that his medical records are adequate as long as he can understand them. Dr. Gill further testified that he is familiar with the adage that, if something is not documented in the medical record, then it wasn't done. However, Dr. Gill believes that that is not necessarily true. Dr. Gill stated that there are many things that physicians discuss with their patients that may not be documented in the medical record. (Tr. at 40-41)
215. Dr. Gill testified that he had received training concerning medical recordkeeping during medical school and internship, and that that topic has also been covered during ASBP seminars and conferences that he has attended. (Tr. at 36-37)
216. When Dr. Gill was asked on cross-examination whether he is familiar with the SOAP method of charting, Dr. Gill replied:

That came about as a suggestion years and years ago and I don't use it. It's not necessary. Whatever's going on I just go ahead and chart it, but I don't use that—I don't use that abbreviation like every time they come in.

If something's you know—I don't know. If they have some subjective or objective complaint or we always emphasize they get into an exercise program. I routinely, you know—I'll chart that especially now if they get into Curves or YMCA or a natatorium, I'll chart that.

(Tr. at 634-635)

217. Dr. Gill testified that he had submitted to a Board investigative deposition in about 2002. Dr. Gill further testified that, since then, he has modified the patient history form that he uses. When asked whether he has made any changes to the physical examination he gives his patients, he replied that he has not, although he added that he may do more of a physical

examination on a subsequent visit depending on the results of the lab tests. Dr. Gill testified that such a physical examination could include palpating the patient's neck to check the patient's thyroid gland. (Tr. at 573-575)

Testimony of Jon Wills

218. Jon Wills testified that he is the Executive Director of the Ohio Osteopathic Association [OOA], and that he has worked for OOA for 31 years. Mr. Wills testified that OOA provides various services to its members such as offering continuing medical education, representing members before various boards and commissions, and public relations projects. Mr. Wills testified that, to be eligible for membership in OOA, a physician must be licensed to practice osteopathic medicine in Ohio and be a graduate of an approved medical school. (Tr. at 421-422)

Mr. Wills testified that he has known Dr. Gill for at least 15 years. Mr. Wills further testified that Dr. Gill has worked with OOA over the years concerning OOA's efforts to modify and liberalize the Board's anorectic prescribing rules. Dr. Gill's participation has included testimony at hearings and meeting with Board committees. In addition, Dr. Gill has worked with other physicians throughout the state concerning the treatment of obesity. Finally, Mr. Wills testified that, to his knowledge, Dr. Gill has worked within the regulatory system to try to gain more flexibility in the treatment of obesity. (Tr. at 430-433)

Letters of Support for Dr. Gill

219. By letter dated September 24, 2006, Nicholas G. Espinoza, D.O., stated, among other things, that he has known Dr. Gill casually as a colleague for about 14 years. Dr. Espinoza further stated that he has spoken with Dr. Gill concerning Dr. Gill's future plans for medical practice should the Board permit him to continue practicing, and noted that he (Dr. Espinoza) had been in a similar situation a few years ago. He said that he discussed with Dr. Gill the possibility of changing directions away from bariatric practice toward family practice, medical evaluations and/or occupational health, and that Dr. Gill expressed a willingness to consider such options. Finally, Dr. Espinoza asked that the Board fashion a penalty that permits Dr. Gill "a chance to close his medical career with some sense of control and dignity." (Resp. Ex. P)
220. By letter dated September 25, 2006, M. Terrance Simon, D.O.,¹⁷ expressed support for Dr. Gill. Dr. Simon stated that he believes Dr. Gill to be a competent and caring physician who works to improve the health of his community by treating obesity. Dr. Simon further stated that, as a family practice physician, he has referred his own patients to Dr. Gill and would not hesitate to continue doing so in the future. (Resp. Ex. Q)

¹⁷ Dr. Gill testified that Dr. Simon is a past president of OOA. (Tr. at 620)

Conclusion

221. Dr. Gill testified that he has never been sued for malpractice, nor has he been disciplined by the Board. (Tr. at 608, 618)
222. Dr. Gill testified concerning changes he plans to make to his practice should the Board permit him to continue practicing. Among other things, Dr. Gill testified that he intends to do a better job of keeping medical records, including documenting physical examinations and follow-ups to lab reports, and improving his notations. Dr. Gill further testified that he will follow up with patients to be sure that they have discussed abnormal lab results with their primary care physicians. (Tr. at 609-611)
223. Dr. Gill testified that, although he enjoys his practice very much, he would like to be able to retire now. However, financial circumstances prevent him from doing so. Dr. Gill testified that two of his wife's four children suffer from mental retardation and another suffers from multiple sclerosis. Dr. Gill testified that he is very much involved in caring for them and supporting them financially. In addition, Dr. Gill testified that both he and his wife have serious health conditions themselves: Dr. Gill's wife was diagnosed with lymphoma two years ago and he was diagnosed with prostate cancer five years ago and is still being treated for it. Finally, Dr. Gill testified that he would like to continue to work to provide financial support for his family. (Tr. at 627-629)

FINDINGS OF FACT

1. In the routine course of his practice, Benjamin L. Gill, D.O., undertook the treatment of Patients 1 through 27.
2. Dr. Gill inappropriately utilized controlled substance anorectics for purposes of weight reduction in the treatment of obesity for Patients 1 through 27 including, but not limited to the following:
 - (a) Prior to initiating his treatment of Patients 1 through 27 with controlled substance anorectics, Dr. Gill failed to determine and/or document having determined, through a review of his records of prior treatment, or through a review of the records of prior treatment which another treating physician or weight-loss program had provided to Dr. Gill, that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, and exercise, without the use of controlled substances, and that said treatment had been ineffective.
 - (b) Further, in his treatment of Patients 3-6, 9, 10, 12-16, 18, 19, 21-27 with controlled substance anorectics, Dr. Gill failed to obtain and/or document that he had obtained a thorough history, and/or he failed to perform and/or document that he had performed a thorough physical examination of these patients.

- (c) Further, Dr. Gill initiated treatment with controlled substance anorectics for Patients 5, 10, 14, 15, 21 and 25-27 despite the fact that they had lost weight after their first visit while using non-controlled medications.
 - (i) The evidence is insufficient to support this finding with regard to Patient 4. Dr. Gill's medical record for Patient 4 does not indicate that Patient 4 had lost weight after his first visit. At Patient 4's second visit on September 2, 1999, his weight had, in fact, remained the same.
 - (d) Further, in his treatment of Patients 16, 17, 22 and 26 with controlled substance anorectics on or after October 31, 1998, Dr. Gill failed to determine and/or document that he determined that the patients had a Body Mass Index [BMI] of at least 30, or a BMI of at least 27 with co-morbid factors.
 - (e) Further, during a period or periods beginning on or after October 31, 1998, Dr. Gill's total course of treatment using controlled substance anorectics for weight reduction exceeded twelve weeks in Patients 1, 3, 4, 6-8, 10, 11, 13-15, and 26. The medical record for each of those patients includes either:
 - Periods of treatment longer than twelve weeks after October 31, 1998;
 - After October 31, 1998 and before June 30, 2000, multiple treatment periods that, added together, exceed twelve weeks; and/or
 - Occasions after June 30, 2000, where Dr. Gill initiated treatment with controlled substance anorectic medication when the patient had been treated with controlled substance anorectic medication within the previous six months. In each of those cases, Dr. Gill's failure to wait the required period of time extended the course of treatment to a period greater than twelve weeks.
 - (f) Dr. Gill inappropriately prescribed and/or dispensed diethylpropion, a schedule IV controlled substance anorectic, to Patient 6 despite a reported prior history of seizure while taking Tenuate.
3. Further, in his treatment of Patients 1 through 27, Dr. Gill also practiced below minimal standards of care, including, but not limited to, the following:
- (a) Dr. Gill inappropriately concurrently dispensed and/or prescribed multiple controlled substance anorectics to Patients 1 through 27 with directions to take two or more of these drugs each day.
 - (b) Despite Patient 3's elevated liver enzymes, Dr. Gill failed to obtain serial blood work to monitor the patient's liver function while prescribing Mevacor.
 - (c) Dr. Gill failed to perform and/or document an abdominal examination on Patient 4 despite elevated liver function tests.

- (d) Dr. Gill failed to perform and/or document an appropriate work-up on findings of hyperglycemia and elevated ALT in Patient 8.

Although Dr. Gill followed up findings of hyperglycemia with additional fasting blood sugar tests, he failed to test Patient 8's hemoglobin A1c, which would have provided information concerning Patient 8's average blood sugar level. Accordingly, Dr. Gill's work-up was not appropriate.

- (e) Dr. Gill failed to perform and/or document an appropriate work-up on findings of elevated ferritin in Patients 9 and 12.
- (f) Dr. Gill continued to dispense and/or prescribe medication to Patient 10 despite his failure to appropriately evaluate and/or document the appropriate evaluation of a report of side effects.
- (g) Dr. Gill caused a B-12 injection to be administered to Patient 11 despite the lack of an appropriate indication for the injection.
- (h) Dr. Gill failed to obtain and/or document a pulse or apical pulse from Patient 14 despite indications of significant hypertension and arthralgia, and he further failed to appropriately evaluate and/or document the appropriate evaluation of the affected systems.
- (i) The evidence is insufficient to support a finding that Dr. Gill inappropriately dispensed and/or prescribed controlled substance anorectics to Patient 15 despite signs of significant hypertension. Rather, the evidence indicates that, during the time that Dr. Gill dispensed or prescribed controlled substance anorectic medication to Patient 15, his blood pressure readings had been within the normal range.
- (j) Dr. Gill failed to perform and/or document an appropriate work-up on findings of elevated AST and LDH in Patient 16.
- (k) Dr. Gill failed to perform and/or document an appropriate work-up on findings of elevated WBC in Patient 22.
- (l) Dr. Gill failed to perform and/or document an appropriate work-up on findings of elevated CPK in Patient 23.
- (m) Dr. Gill continued to dispense and/or prescribe controlled substance anorectics to Patient 27 despite patient complaints of chest tightness and despite observed hypertension. Further, Dr. Gill failed to perform and/or document an appropriate work-up related to the patient's complaint of chest tightness.

- (n) Dr. Gill inappropriately prescribed diuretics to Patients 1-3, 6, 7, 10-13, 16, 19-21, 24 and 27 despite a lack of documented indication.

Further, Dr. Gill prescribed diuretics to Patient 12 without appropriate periodic evaluation and/or documentation of the appropriate periodic evaluation of potassium levels.

- (i) The evidence is insufficient to support a finding that Dr. Gill failed to evaluate and/or document the evaluation of a finding of low sodium for Patient 13 while prescribing diuretics to the patient. Rather, the evidence indicates that Dr. Gill had ceased prescribing diuretics to Patient 13 for two years prior to any lab finding of low sodium for that patient.
- (o) Dr. Gill inappropriately prescribed thyroid medications to Patients 2, 6, 11, 16, 24 and 27 for weight loss purposes and despite the fact that these patients were not hypothyroid. Further, Dr. Gill increased the dosage of Levoxyl for Patient 6, yet he failed to document any appropriate rationale for increasing that medication and failed to recheck the thyroid function. In addition, Dr. Gill failed to obtain recent thyroid function levels for Patient 11 prior to initiating the prescribing of Synthroid. Finally, Dr. Gill failed to obtain follow-up thyroid function tests for Patients 16 and 27.
- (p) Dr. Gill inappropriately dispensed and/or prescribed Meridia to Patient 11 despite the fact that this patient was concurrently taking Prozac.
- (q) Despite Patient 8's report of feeling sick on or about March 28, 1998, Dr. Gill failed to investigate and/or document any investigation of her symptoms and continued to dispense and/or prescribe controlled substance anorectics to her through May 9, 1998. Patient 8 subsequently reported on or about August 10, 1998, that she had had a miscarriage at three and one-half months.

Further, despite Patient 19's report of being one week late for her period, Dr. Gill failed to obtain a pregnancy test and continued to dispense and/or prescribe controlled substance anorectics to her.

- 4. Dr. Gill failed to accurately document the utilization of controlled substances in the charts for Patients 1 through 27 by using abbreviations (such as ERA, RB, GW and Metra) to represent controlled substances from which an independent reviewer had great difficulty determining the type, quantity and/or dosage of controlled substances being dispensed.
- 5. No evidence was presented to support a finding that, although Dr. Gill subsequently identified the initials MetGW in one of his patient records as Metra Green phendimetrazine, Dr. Gill had been unable to identify this abbreviation during a deposition taken by Board staff upon review of his own patient records, and Dr. Gill was never able to conclusively identify the abbreviations A/D, MV and EP 25.

CONCLUSIONS OF LAW

1. The conduct of Dr. Gill as set forth in Findings of Fact 2, 3 and 4, with the exceptions of Findings of Fact 2(c)(i), 3(i), and 3(n)(i), constitutes “[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.
2. The conduct of Dr. Gill that occurred prior to October 31, 1998, as set forth in Findings of Fact 2(a) through 2(c) and 2(f) above constitutes “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 4731-11-04(B), Ohio Administrative Code, as in effect from November 11, 1986, until October 30, 1998. Pursuant to Rule 4731-11-04(C), Ohio Administrative Code, as in effect from November 11, 1986, until October 30, 1998, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.
3. The conduct of Dr. Gill that occurred on or after October 31, 1998, and prior to June 30, 2000, as set forth in Findings of Fact 2(a) through 2(c), 2(e) and 2(f), with the exception of Findings of Fact 2(c)(i), constitutes “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 4731-11-04(C), Ohio Administrative Code, as in effect from October 31, 1998, through June 29, 2000. Pursuant to Rule 4731-11-04(E), Ohio Administrative Code, as in effect from October 31, 1998, through June 29, 2000, violation of Rule 4731-11-04, Ohio Administrative Code also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.
4. The conduct of Dr. Gill that occurred on or after June 30, 2000, as set forth in Findings of Fact 2(a) through 2(e), constitutes “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: Rules 4731-11-04(B) and (C), Ohio Administrative Code. Pursuant to Rule 4731-11-04(D), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.
5. The conduct of Dr. Gill as set forth in Findings of Fact 4, constitutes “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, violation of Rule 4731-11-02, Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Benjamin L. Gill, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.



R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF AUGUST 8, 2007

REPORTS AND RECOMMENDATIONS

Dr. Kumar announced that the Board would now consider the Reports and Recommendations appearing on its agenda. He asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings of fact, conclusions of law, and orders, and any objections filed in the matters of: Mohammad Anvari-Hamedani, M.D.; Kristine M. Blazey, M.T.; Clyde Dennis Brown, M.D.; Benjamin L. Gill, D.O.; and Dale Anthony Humphrey, Jr., M.T. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Robbins	- aye
	Dr. Steinbergh	- aye
	Dr. Kumar	- aye

Dr. Kumar 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. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Robbins	- aye

Dr. Steinbergh - aye
Dr. Kumar - aye

Dr. Kumar noted that, in accordance with the provision in Section 4731.22(F)(2), 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 these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

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

Dr. Talmage left the meeting at this time.

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BENJAMIN L. GILL, D.O.

Dr. Kumar directed the Board's attention to the matter of Benjamin L. Gill, D.O. He advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

Dr. Kumar continued that a request to address the Board has been timely filed on behalf of Dr. Gill. Five minutes would be allowed for that address.

Dr. Gill was accompanied by his attorney, Elizabeth Y. Collis. Ms. Collis stated that she's put her position on this case, along with a recommendation for an alternative sanction, in her written objections. She stated that Dr. Gill will use the remainder of their time.

Dr. Gill stated that he would like to thank the Board for giving him the opportunity to appear before it today. Prior to the Board's making a determination in his case, he would like to tell the Board a bit about himself and about the facts leading to this case.

Dr. Gill stated that he has been licensed to practice medicine in Ohio since 1964. Since 1975 he has practiced bariatric medicine in Akron, Ohio, in a private medical practice. Dr. Gill stated that the Board has charged him with practicing below the minimal standard of care in his treatment of patients by failing to follow the Medical Board's weight loss medication rule, and for failing to clearly document the patient files, showing all the work that he had completed on each patient prior to initiating anorectic medication treatment.

Dr. Gill continued that the Medical Board has also charged him with prescribing diuretic or thyroid medications as a form of weight loss. As the evidence showed at the hearing, however, he never prescribed diuretics or thyroid medications to patients for weight loss. Dr. Gill stated that, throughout his practice, he

has always tried to put his patients first and provide each patient with the best possible medical care.

Dr. Gill advised that, as the evidence showed from the hearing, he also took steps over the years to continue to change his practice to comply with the implementation of the Medical Board weight loss rules. While there were no residency programs in bariatric medicine, he has sought training over the past 30 years, through conventions, lectures and seminars to learn more about the practice of bariatric medicine. He has been an active member of the Ohio Osteopathic Association, and the American Society of Bariatric Physicians to keep abreast of the best ways to treat overweight and obese patients.

Dr. Gill stated that he tried to model his practice after the training that he received over the years. As a bariatric physician, he was not the only physician treating his patients. Each patient also had a general practice physician. In his practice, he works hard to keep in contact with his patients' general practice physicians and alert them to any medical tests that they should review with their patients. He also counseled his patients whenever a questionable test result was found, and he advised them to further consult with their general physician.

Dr. Gill advised that the Medical Board has alleged that his records were hard to read because the notes were cryptic and because he used an abbreviation system to identify different medications and dosage amounts. Dr. Gill stated that over the years he tried to use a system that was easy to use and easy for his staff to understand. He feels that he was fortunate to have staff members stay with his practice for many years, and the staff was very familiar with his system of documentation. He also tried to be consistent in his use of abbreviations to avoid any confusion in the patient records. After initially learning from the Board investigator that his notes were hard to interpret, he provided the Board investigator with a legend outlining what each abbreviation meant, and he also posted a legend in the office for anyone else to be able to determine the meanings of abbreviations.

Dr. Gill stated that, prior to this case, he met with investigators from the Board on two or three occasions. He commented that the Board has reviewed his practice and his patient records and has never made suggestions to him to change his recordkeeping or to change the way he dispenses medication. Prior to prescribing medications for weight loss to patients, he has blood work taken for each patient to ensure that the patient was an appropriate candidate for anorectic medications. Throughout the treatment process, he also has additional medical tests completed for each patient to determine if they had any medical conditions that were contra-indicated for anorectic medications. Even after he prescribed medications for weight loss, he continued to counsel his patients at each visit on the changes they should be making to their diets and lifestyles. Dr. Gill stated that he had patients keep food logs, and his office provided patients with dietary guidelines, with recipes and portion amounts for them to eat so that they could make the changes needed in their lives for sustained weight loss.

Dr. Gill stated that the Medical Board has charged that he prescribed weight loss drugs to patients for longer than the twelve-week Medical Board rule. Dr. Gill stated that he believes that the evidence from the hearing showed that he attempted to follow the Medical Board rule and consistently took patients off the anorectic medications after twelve weeks and maintained them on a non-medical weight loss program for

six months. He only initiated anorectic medications to patients after six months if they were unable to maintain their weight loss, or if they had gained weight.

Dr. Kumar asked Dr. Gill to conclude his statement.

Dr. Gill stated that in his case the Hearing Examiner has recommended that his license should be permanently revoked. He asked that, based on the evidence in his case, the Medical Board issue a different sanction. As outlined by his counsel in the objections to the Report and Recommendation, he is requesting that Board suspend his license for one year and stay the suspension. He added that he would also be willing to take continuing medical education on recordkeeping, medication, distribution, or any other area of concern for this Board. He would also agree to work under a practice plan and to have his practice monitored by a local physician. He has spoken with Kevin D. Huffman, D.O., of Akron, who has agreed to monitor his practice and review his patient charts, if the Board allows him to continue to practice.

Dr. Gill stated that he is 69 years old. He has been blessed with good health, and he would like to continue to practice medicine for at least a few more years. After reviewing the evidence in his case, he would respectfully request that the Board allow him to continue his practice in Ohio, with a monitor overseeing his practice. His patients are good people, seeking help. They are not drug-seeking. His patients are trying to lose weight for legitimate health reasons. They are treated with care, compassion and a comprehensive weight management program. Obesity is a chronic disease requiring long-term care to help lower the risk of developing diabetes, heart disease, and certain types of cancer.

Dr. Gill stated that, if the Board does choose to suspend his license after 40 years of practice in Ohio, he respectfully requests a 30-day period of time to wind down his practice. He would like an opportunity to refer his patients to other physicians or to ensure that each patient has a general practice physician who will continue with their care.

Dr. Kumar asked whether the Assistant Attorney General wished to respond.

Mr. Wilcox stated that this hearing has demonstrated that Dr. Gill has engaged in a pattern of treatment, dating back to the 1980s up until the time his records were subpoenaed up in around July 2003. Mr. Wilcox contended that Dr. Gill's practice has fallen below the standard of care in many ways. The most immediate and glaring example of this is noticed when you look at his patient charts. The charts are very lacking in the substantive medical information, documented physical examinations, or thorough patient histories. Mr. Wilcox further stated that Dr. Gill has also used a system of abbreviations that are not standard and are extremely difficult, if not impossible, for an independent reviewer, or even at times at hearing, Dr. Gill, himself, to determine a type, quantity or dosage of controlled substance that he dispensed.

Mr. Wilcox stated that the charts are also so lacking in documentation that Dr. Gill's own expert witness, Dr. Huffman, stated at one point in his report: "I'm afraid I have to agree; Dr. Gill has substandard documentation in his medical records, which makes it nearly impossible to determine what was or was not

performed throughout the patient visits, or, for that matter, what specific medications were used.”

Mr. Wilcox stated that, in addition, Dr. Gill’s practice fell below the minimal standard of care in that he often prescribed multiple controlled-substance anorectic drugs with directions to take two or more of those drugs in one day. Dr. Gill repeatedly failed to follow the Board’s rules on prescribing controlled medications for the purpose of weight loss. He did this routinely, without documenting the need for these patients to be using such drugs, and he routinely prescribed such medications for long periods of time that, in cases, exceeded the twelve-week period allowed by Board rules. Mr. Wilcox stated that it was shown at hearing that many of these patients were clearly not obese patients, but were still prescribed multiple controlled-substance anorectics. Mr. Wilcox noted that, often, this would occur on the first patient visit.

Mr. Wilcox stated that, finally, Dr. Gill’s patient charts for these 27 patients in question often reflect that he either ignored or failed to document any follow-up work or consultations with primary care physicians regarding symptoms or test results that indicated a need to do so. In addition, the patient charts also reflect serious misuse of diuretic medications and thyroid medications that were used for apparent attempts to help patients lose weight. This misuse of medications is potentially very dangerous because many of these patients had aggravating co-morbid conditions, such as hypertension.

Mr. Wilcox stated that he thinks that the Report and Recommendation did an excellent job of summarizing this very lengthy case with many patients, and he would agree with what the Hearing Examiner has recommended.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER’S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF BENJAMIN L. GILL, D.O. DR. VARYANI SECONDED THE MOTION.

Dr. Kumar stated that he would now entertain discussion in the above matter.

Dr. Madia stated that, by looking at Dr. Gill’s records for the 27 patients, there is a common theme. The documentation is very poor. Dr. Madia expressed concern about the abbreviations used, noting that, in hospitals, the JCAHO has come up with standard abbreviations. The biggest medical mistakes happen using abbreviations. Somebody writes something, and the nursing staff, or whoever is following the orders, gives a different dose. There is a very clear-cut standard by the JCAHO now on what abbreviations should be used in both hospitals and in medical practice.

Dr. Madia stated that Dr. Gill gave anorectic medicine in improper doses and for longer periods than recommended, whether the patient needs it or not. Dr. Madia stated that he has seen in the records that some of the patients’ thyroid levels are normal, but Dr. Gill wrote in his note that the thyroid level is abnormal and he prescribed thyroid medicine in inappropriate doses, twice a day. Dr. Madia stated that he doesn’t know anyone who gives thyroid medication twice a day. It’s a once-a-day pill. Dr. Madia noted that Dr. Gill gave his patients diuretics. He commented that it is illegal to give horses diuretics before a race. You should not prescribe diuretics for weight loss. Dr. Madia stated that, in his opinion, this falls

below minimal standards of care.

Dr. Madia stated that, looking at all these things, and he could go on and on, he thinks that the evidence shows that Dr. Gill's standard of practice was clearly below the accepted standard of practice. He agrees with the Hearing Examiner's recommendation of permanent revocation.

Dr. Buchan stated that he thinks that Mr. Porter did an excellent job of reviewing this very long and difficult case. He did go through the 27 patient charts, and he thinks that the Findings of Fact are most accurate, and the Conclusions of Law are appropriate. It's a severe prescribing case. Dr. Buchan stated that he feels badly for Dr. Gill, adding that he believes that, in Dr. Gill's time, he has helped a lot of people. Dr. Buchan continued, however, that what he saw in the records of the last several years is such that the Board needs to stop this practice. Dr. Buchan stated that he believes that the Findings of Fact support permanent revocation. Dr. Buchan stated that he agrees with the Proposed Order, as written.

Dr. Robbins stated that he agrees with both Dr. Madia's and Dr. Buchan's statements. Dr. Robbins referred to page 62 of the Report and Recommendation and stated that he was particularly struck by Dr. Gill's response to whether or not he was familiar with the "SOAP" method of charting: "That came about as a suggestion years and years ago and I don't use it. It's not necessary." Dr. Robbins stated that he thinks that, maybe in years past, Dr. Gill did a lot of service to his patients, but with this kind of approach and this kind of recordkeeping, when his patients would have to go on to different providers, it's going to be very, very difficult. The records, essentially, will be of no use whatsoever. Dr. Robbins stated that he agrees with the Report and Recommendation, as written.

Dr. Steinbergh stated that this was a lengthy case and, in her opinion, very well outlined by the Hearing Examiner. Dr. Steinbergh stated that she doesn't think that the Board has to go into so much depth, as the record does, because the record is very complete and will hold up for any reason.

Dr. Steinbergh stated that she would like to mention a few concerns that support Mr. Porter's Report and Recommendation. She stated that, first of all, she found that the State's expert, Dr. Kevin Hornbeck, evaluated these cases thoroughly, and she agreed with each of his assessments and with each of his comments. She noted that Dr. Hornbeck is an internist, so one might think that he practices at a different level from Dr. Gill, but she happens to be an osteopathic family physician, a generalist like Dr. Gill, and like Dr. Huffman, Dr. Gill's expert. As such, she does feel that Dr. Hornbeck's approach to these cases was excellent.

Dr. Steinbergh stated that when she first approached this case, she thought that it was going to be a simple case of overprescribing controlled prescription anorectics. This case was that, but so much more. Dr. Steinbergh advised that everything documented in this hearing record goes to the fact that this is a very serious case of a physician whose practice falls below minimal standards in all areas of the record. Dr. Gill testified that his current practice is 90 percent bariatric medicine and 10 percent general medicine, he considers himself a specialist in bariatrics, and, from that description, he approaches the prescribing of medications differently from other primary care physicians. Dr. Steinbergh referred to paragraphs 97, 98

and 99 of the Summary of Evidence in the Report and Recommendation, where Dr. Hornbeck, Dr. Gill and Dr. Huffman discuss the use of multiple anorectics each day. She noted that Dr. Hornbeck testified that utilizing multiple anorectics at different times of the day constitutes an inappropriate use of such medication, and that such treatment is not supported in the literature as a standard of care. Dr. Gill testified that he was trained through his coursework in bariatric medicine to treat patients with combinations of anorectic medication. Dr. Huffman testified that family practitioners or other physicians who don't have experience in weight management generally prescribe one medication.

Dr. Steinbergh stated that the important piece is Dr. Huffman's testimony that these physicians (family practitioners or other physicians) "don't watch the patient's diaries or food intake histories or ask them about hunger and very rarely will try to implement multi-drug therapies." Dr. Steinbergh stated that she reviewed the patient charts, and she couldn't find any evidence of food diaries, food intake histories, any discussion of that. Dr. Steinbergh stated that that's not to say that Dr. Gill didn't talk to the patients about diet or exercise, but he shows no evidence of any clinical thought process in his patient records that indicates that Dr. Gill has a knowledge base specific to bariatrics. Dr. Steinbergh stated that she doesn't see anything specialty-oriented in his records.

Dr. Steinbergh commented on what she considers Dr. Gill's inability to approach metabolic diseases and the fact that Dr. Gill did not interact with specialists. She stated that there is documentation of some laboratory data, but whether it was normal or abnormal, there was no realization of abnormalities. There was no discussion with other specialists. There was no documentation that Dr. Gill had an appropriate conversation with a specialist. Many times Dr. Gill said that he told the patient that test results were abnormal. Dr. Steinbergh questioned what you do with that. She stated when she interacts with a specialist in any area of medicine, that physician has an approach that is specialty-specific but does not exclude other lab data or radiographic information that may need to be assessed by her or another specialist. This information is not ignored but is conveyed to her by a phone call, a written letter or both. Dr. Steinbergh stated that the primary care physician and the specialist should all be on the same page. Even if Dr. Gill is not considering himself to be the primary care physician, he has an obligation to communicate with either a primary care physician or a specialist regarding abnormalities.

Dr. Steinbergh stated that, in Dr. Gill's case, the medical care that was beyond the weight loss issue was mostly ignored. The importance of an abnormal liver test, chest pain, hypertension, and seizures as side effects of medication was ignored. Dr. Gill prescribed and continued to prescribe even with the knowledge of the side effects. Dr. Gill failed to properly evaluate patients for metabolic and hematologic diseases, and he failed to communicate abnormalities that he may not have wanted to treat himself.

Dr. Steinbergh stated that a great concern to her is the fact that there is a lack of documentation of clinical thinking. Nowhere in Dr. Gill's records could you follow any clinical thought process that would allow any other physician to understand his medical decisions.

Dr. Steinbergh stated, for these reasons, she feels that Dr. Gill fails to meet the standard of care of an osteopathic physician in the state of Ohio, and she concurs with the Proposed Order of permanent

revocation. Dr. Steinbergh stated that, at this stage of Dr. Gill's career, she does not see the possibility of appropriate remediation.

Dr. Steinbergh continued that she does, however, agree that the Board should give Dr. Gill 30 days to wind down his practice and to allow him to find other appropriate physicians to care for his patients.

DR. STEINBERGH MOVED TO AMEND THE EFFECTIVE DATE OF THE PROPOSED ORDER TO COMMENCE IN 30 DAYS, RATHER THAN TO BECOME EFFECTIVE IMMEDIATELY UPON MAILING OF THE ORDER, AND THAT HE SEE NO NEW PATIENTS DURING THAT PERIOD. DR. VARYANI SECONDED THE MOTION.

Dr. Kumar stated that he would now entertain discussion on the motion to amend.

Dr. Robbins stated that it's important that, as Dr. Gill goes through these 30 days, that he go through his charts and try to do what he can so that other physicians can understand them. He stated that to send the charts the way they are won't help anybody who takes care of these patients in the future. Dr. Robbins stated that Dr. Gill is going to have to do some diligence to write some narrative or something; otherwise, it will be no use.

Dr. Madia agreed, but added that whoever takes his patients might have to start all over again. He stated that he doesn't think, even if Dr. Gill writes more, it will be useful.

Dr. Kumar commented that it might give some idea of what was done before.

Dr. Varyani stated that it's important that Dr. Gill use this 30 days to refer his patients and not accept or see any new patients.

Dr. Steinbergh agreed.

A vote was taken on Dr. Steinbergh's motion to amend:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Talmage	- abstain
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Robbins	- aye
	Dr. Steinbergh	- aye
	Dr. Kumar	- aye

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF BENJAMIN L. GILL, D.O. DR. VARYANI SECONDED THE MOTION. A vote was taken:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Talmage	- abstain
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Robbins	- aye
	Dr. Steinbergh	- aye
	Dr. Kumar	- aye

The motion carried.



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

July 14, 2004

Benjamin L. Gill, D.O.
11 Starboard Circle
Akron, OH 44319

Dear Doctor Gill:

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

- (1) In the routine course of your practice, you undertook the treatment of Patients 1-27 (as identified on the attached Patient Key- Key confidential to be withheld from public disclosure).
- (2) You inappropriately utilized controlled substance anorectics for purposes of weight reduction in the treatment of obesity for Patients 1-27 including, but not limited to the following:
 - (a) Prior to initiating your treatment of Patients 1-27 with controlled substance anorectics, you failed to determine and/or document having determined, through a review of your records of prior treatment, or through a review of the records of prior treatment which another treating physician or weight-loss program has provided to you, that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, and exercise, without the use of controlled substances, and that said treatment had been ineffective.
 - (b) Further, in your treatment of Patients 3-6, 9, 10, 12-16, 18, 19, 21-27 with controlled substance anorectics, you failed to obtain and/or document that you obtained a thorough history, and/or you failed to perform and/or document that you performed a thorough physical examination of these patients.

Mailed 7-15-04

- (c) Further, you initiated treatment with controlled substance anorectics for Patients 4, 5, 10, 14, 15, 21 and 25-27 despite the fact that they had lost weight after their first visit while using non-controlled medications.
 - (d) Further, in your treatment of Patients 16, 17, 22 and 26 with controlled substance anorectics on or after October 31, 1998, you failed to determine and/or document that you determined that the patients had a Body Mass Index [BMI] of at least thirty, or a BMI of at least twenty-seven with co-morbid factors.
 - (e) Further, during a period or periods beginning on or after October 31, 1998, your total course of treatment using controlled substance anorectics for weight reduction exceeded twelve weeks in Patients 1, 3, 4, 6-8, 10, 11, 13-15 and 26.
 - (f) You inappropriately prescribed and/or dispensed diethylpropion, a schedule IV controlled substance anorectic, to Patient 6 despite a reported prior history of seizures while taking Tenuate Dospan.
- (3) Further, in your treatment of Patients 1-27, you also practiced below minimal standards of care, including, but not limited to, the following:
- (a) You inappropriately concurrently dispensed and/or prescribed multiple controlled substance anorectics to Patients 1-27 with directions to take two or more of these drugs each day.
 - (b) Despite Patient 3's elevated liver enzymes, you failed to obtain serial blood work to monitor the patient's liver function while prescribing Mevacor.
 - (c) You failed to perform and/or document an abdominal examination on Patient 4 despite elevated liver function tests.
 - (d) You failed to perform and/or document an appropriate work-up on findings of hyperglycemia and elevated ALT in Patient 8.
 - (e) You failed to perform and/or document an appropriate work-up on findings of elevated ferritin in Patients 9 and 12.
 - (f) You continued to dispense and/or prescribe medication to Patient 10 despite your failure to appropriately evaluate and/or document the appropriate evaluation of a report of side effects.

- (g) You caused a B-12 injection to be administered to Patient 11 despite the lack of an appropriate indication for the injection.
- (h) You failed to obtain and/or document a pulse or apical pulse from Patient 14 despite indications of significant hypertension and arthralgia, and you further failed to appropriately evaluate and/or document the appropriate evaluation of the affected systems.
- (i) You inappropriately dispensed and/or prescribed controlled substance anorectics to Patient 15 despite signs of significant hypertension.
- (j) You failed to perform and/or document an appropriate work-up on findings of elevated AST and LDH in Patient 16.
- (k) You failed to perform and/or document an appropriate work-up on findings of elevated WBC in Patient 22.
- (l) You failed to perform and/or document an appropriate work-up on findings of elevated CPK in Patient 23.
- (m) You continued to dispense and/or prescribe controlled substance anorectics to Patient 27 despite patient complaints of chest tightness and despite observed hypertension. Further, you failed to perform and/or document an appropriate work-up related to the patient's complaints of chest tightness.
- (n) You inappropriately prescribed diuretics to Patients 1-3, 6, 7, 10-13, 16, 19-21, 24 and 27 despite a lack of documented indication. Further, you prescribed diuretics to Patient 12 without appropriate periodic evaluation and/or documentation of the appropriate periodic evaluation of potassium levels. Further, you failed to evaluate and/or document the evaluation of a finding of low sodium for Patient 13 while prescribing diuretics to the patient.
- (o) You inappropriately prescribed thyroid medications to Patients 2, 6, 11, 16, 24 and 27 for weight loss purposes and despite the fact that these patients were not hypothyroid. Further, you increased the dosage of Levoxyl for Patient 6 yet you failed to document any appropriate rationale for increasing that medication and failed to recheck the thyroid function. Further, you failed to obtain recent thyroid function levels for Patient 11 prior to initiating the prescribing of Synthroid. Further, you failed to obtain follow-up thyroid function tests for Patients 16 and 27.

- (p) Further, you inappropriately dispensed and/or prescribed Meridia to Patient 11 despite the fact that this patient was concurrently taking Prozac.
- (q) Further, despite Patient 8's report of feeling sick on or about March 28, 1998, you failed to investigate and/or document any investigation of her symptoms and continued to dispense and/or prescribe controlled substance anorectics to her through May 9, 1998. Patient 8 subsequently reported on or about August 10, 1998, that she had miscarried at three and one-half months. Further, despite Patient 19's report of being one week late for her period, you failed to obtain a pregnancy test and continued to dispense and/or prescribe controlled substance anorectics to her.
- (4) You failed to accurately reflect the utilization of controlled substances in the charts for Patients 1 through 27 by utilizing initials and terminology (such as ERA, RB, GW and Metra) to represent controlled substances from which an independent reviewer could not determine the type, quantity and/or dosage of the controlled substance being dispensed. In addition, although you subsequently identified the initials MetGW, as those initials were contained in one of your patient records, as Metra Green phendimetrazine, you were unable to identify this abbreviation during a deposition taken by Board staff upon review of your own patient records, and you were never able to conclusively identify the abbreviations A/D, MV and EP 25.

Your acts, conduct, and/or omissions as alleged in paragraphs (2), (3) 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.

Further, your acts, conduct, and/or omissions that occurred prior to October 31, 1998, as alleged in paragraphs (2)(a)-(c) and (f) 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: 4731-11-04(B), Ohio Administrative Code. Pursuant to Rule 4731-11-04(C), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after October 31, 1998, and prior to June 30, 2000, as alleged in paragraphs (2)(a)-(c), (e) and (f) 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: 4731-11-04(C), Ohio Administrative Code. Pursuant to Rule 4731-11-04(E), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after June 30, 2000, as alleged in paragraphs (2)(a)-(e) 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: 4731-11-04(B) and (C), Ohio Administrative Code. Pursuant to Rule 4731-11-04(D), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.

Further, 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(D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02, Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), 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 days of the time of mailing of this notice.

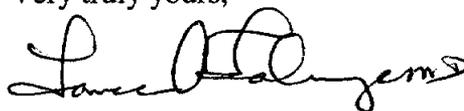
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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

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

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage". The signature is fluid and cursive, with the first name "Lance" being the most prominent.

Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5144 8434
RETURN RECEIPT REQUESTED

cc: Eric Plinke, Esq.
Porter, Wright, Morris & Arthur
41 S. High St.
Columbus, OH 43215-6194

CERTIFIED MAIL # 7000 0600 0024 5144 8441
RETURN RECEIPT REQUESTED