

**CONSENT AGREEMENT
BETWEEN
BERNARD H. SMITH, D.O.
AND
THE STATE MEDICAL BOARD OF OHIO**

This CONSENT AGREEMENT is entered into by and between BERNARD H. SMITH, D.O., and THE STATE MEDICAL BOARD OF OHIO, a state agency charged with enforcing Chapter 4731, Ohio Revised Code.

BERNARD H. SMITH, D.O. (DR. SMITH), enters into this Agreement being fully informed of his rights under Chapter 119, Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

This CONSENT AGREEMENT is entered into on the basis of the following stipulations, admissions and understandings:

- A. THE STATE MEDICAL BOARD OF OHIO is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violating any of the laws contained within Chapter 4731 of the Ohio Revised Code or rules adopted pursuant thereto.
- B. DR. SMITH and THE STATE MEDICAL BOARD OF OHIO enter into this CONSENT AGREEMENT in lieu of formal proceedings based upon the allegations contained within the Notice of Opportunity for Hearing issued to DR. SMITH on or about April 11, 1990.

- C. DR. SMITH is licensed to practice medicine and surgery in the State of Ohio.
- D. DR. SMITH admits that he did prescribe and/or dispense the controlled substances in the amounts and over the periods of time as alleged in the Notice of Opportunity for Hearing dated April 11, 1990. DR. SMITH further admits that his records for the patients in question do not always accurately reflect the examination, evaluation and treatment rendered. By making the foregoing admissions, DR. SMITH specifically does not admit to violation of any provision of Chapter 4731, Ohio Revised Code or any rule adopted thereunder.

WHEREFORE, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, DR. SMITH knowingly and voluntarily agrees with THE STATE MEDICAL BOARD OF OHIO (BOARD), to the following terms, conditions and limitations:

- 1. The certificate of DR. SMITH to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, effective December 1, 1990.
- 2. DR. SMITH's certificate to practice medicine and surgery in the State of Ohio will be reinstated following the suspension and his compliance with the following:
 - (a) takes and passes the SPEX examination or any similar written examination which the Board deems appropriate to assess his clinical competency.
 - (b) submits an application for reinstatement accompanied by all the appropriate fees. As soon as the Board receives confirmation that DR. SMITH has passed the above-mentioned examination and filed a reinstatement application accompanied by all appropriate fees, the Board's Secretary shall immediately reinstate his certificate to practice.

3. DR. SMITH shall surrender his United States Drug Enforcement Administration Certificate (DEA) upon execution of this CONSENT AGREEMENT. He shall be ineligible to hold, and shall not apply for, registration with the DEA to prescribe, dispense or administer controlled substances. Further, DR. SMITH shall not prescribe, administer, dispense, order, write or disburse, or give verbal orders for any controlled substances.
4. On or before June 1, 1991, DR. SMITH shall provide documentation of successful completion of a minimum of 18 hours of Continuing Medical Education courses in the areas of pharmacology, chronic pain management and chemical dependency recognition and management. Such courses are to be approved in advance by the Board and shall not count toward fulfillment of the Continuing Medical Education required by Section 4731.281, Ohio Revised Code.
5. Upon reinstatement of his certificate, DR. SMITH shall obey all federal, state, and local laws and all rules governing the prescribing, administering and dispensing of drugs.
6. If the BOARD determines that DR. SMITH has violated any of the terms of this CONSENT AGREEMENT, following a hearing pursuant to Chapter 119 of the Ohio Revised Code, the BOARD may revoke DR. SMITH's license to practice medicine and surgery.
7. DR. SMITH hereby releases the BOARD, its members, employees, agents, and officers, jointly and severally, from any and all liability arising from this matter.

This CONSENT AGREEMENT shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code, and shall become effective upon the last date of signature below.

Further, this information may be reported to appropriate organizations, data banks and governmental bodies.

Bernard H. Smith, D.O.
BERNARD H. SMITH, D.O.

Henry G. Cramblett
HENRY G. CRAMBLETT, M.D.
Secretary

11-2-40
DATE

11/13/40
DATE

Thomas W. Hess
THOMAS W. HESS, ESQ.
Attorney for Dr. Smith

Timothy S. Jost
TIMOTHY S. JOST, J.D.
Supervising Member

11/5/50
DATE

11/5/50
DATE

Douglas C. Bonting for John C. Dowling
JOHN C. DOWLING, ESQ.
Assistant Attorney General

11/5/50
DATE

0638S

STATE OF OHIO
THE STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS OH 43215

April 11, 1990

Bernard H. Smith, D.O.
3049 Graham Road
Stow, OH 44224

Dear Doctor Smith:

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

1. In the routine course of your practice, you frequently prescribed or dispensed controlled substance stimulants, narcotic analgesics, minor tranquilizers and other controlled substances and dangerous drugs based on patient requests or patient complaints. This prescribing and dispensing was frequently done without utilization of diagnostic testing or other methods of evaluating the validity of the complaints or the nature or severity of the patient's reported pain, illness or injury, and without documentation of the patient's response to treatment. Your patient records routinely failed to document the patients' history, physical examinations performed or diagnoses established to justify the medications prescribed or dispensed by you to your patients. Instances of such practices include, but are not necessarily limited to, the following patients and the treatment rendered to them:
 - a. Patient 1 (as identified in the attached patient key, not subject to public disclosure): the use of controlled substance narcotic analgesics and hypnotics without adequate documentation of the patient's history, physical condition, diagnosis and response to treatment. On at least three occasions (January 19, 1988, April 22, 1988 and October 31, 1988), you prescribed one hundred (100) dosage units of Percodan to Patient 1

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without noting it in the patient record; on at least two additional occasions (November 29, 1988 and January 3, 1989), you noted smaller amounts of Percodan in the record than you in fact prescribed.

- b. Patient 2: prescribing of controlled substance narcotic analgesics without adequate documentation of the patient's history, physical condition, diagnosis and response to treatment. On at least three occasions (July 21, 1988, September 20, 1988 and November 28, 1988), you prescribed Percodan to Patient 2 without noting it in the patient record; on at least two occasions (May 6, 1988 and January 27, 1989), you prescribed one hundred (100) dosage units of Percodan to Patient 2 without noting a visit by her to your office or the fact that you had issued a prescription.
- c. Patient 3: initially consulted you on or about September 7, 1982, at which time she was approximately thirty-five (35) years old. Your record states "Hx of hyperactive child on Ritalin 10 mg tid for years." Your recorded no other history and no physical examination findings other than weight and blood pressure. You began prescribing Ritalin to Patient 3 at least by August 12, 1983 and continued regularly prescribing it at least through March 9, 1989. For most of that time, you were also dispensing controlled substance sympathomimetic amines to Patient 3 for weight control.
- d. Patient 4: The note of December 6, 1985 in Patient 4's chart says "Pat. insists on pain pills for back." Beginning at least on January 23, 1986 and continuing at least until February 7, 1989, you prescribed controlled substance narcotic analgesics for Patient 4 without ever recording findings from a physical exam or any diagnostic testing or other methods of evaluating the validity, nature or severity of Patient 4's reported back pain or Patient 4's response to treatment.
- e. Patient 5: initially consulted you on or about November 3, 1983 at which time you noted that he was a truck driver complaining of low back pain. Beginning at least by September 12, 1985 and

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continuing at least through February 20, 1989, you regularly prescribed controlled substance narcotic analgesics for Patient 5's complaints of back pain. On or about January 11, 1988, you completed a physical examination to recertify Patient 5 as a truck driver, at which time you indicated that his spine was normal and did not indicate that he was regularly taking Tylenol #4 for back pain. On July 7, 1987 and December 2, 1988, you prescribed Fastin, 30 mg with no indication in the patient record as to the purpose or diagnosis for which it was prescribed.

- f. Patient 6: long-term prescribing of controlled substances including Demerol, Percodan, Tylenol No. 4 and Valium 10 mg for a wrist injury sustained in 1984 at work, for a back injury when Patient 6 slipped and fell in a restaurant in 1987, and a back and neck injury when Patient 6 slipped and fell at work in 1988 without adequate documentation of the patient's history, physical condition, diagnoses and response to treatment.
- g. Patient 7: prescribing large quantities of Percodan for complaints of severe migraine, with no evidence that non-narcotic approaches were tried by you. On at least two occasions (August 25, 1988 and October 20, 1988), you prescribed one hundred (100) dosage units of Percodan to Patient 7 without noting a visit by her to your office or the fact that you had issued the prescription.
- h. Patient 8: long term use of narcotic analgesics, minor tranquilizers and Ritalin with concurrent long term dispensing of phendimetrazine and phentermine without having an adequate history or physical recorded or a diagnosis documented with appropriate follow-up on the effectiveness of the use of the controlled substances. On at least three occasions (July 22, 1988, September 1, 1988 and December 5, 1988), Ritalin prescriptions were issued by you without notation of that in the patient record.
- i. Patient 9: long term prescribing of Percodan for complaints of back pain without documenting the patient's history or physical examination and

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without establishing a diagnosis which would justify the pattern of prescribing. On at least nine (9) occasions between February 4, 1988 and February 21, 1989, you prescribed one hundred (100) dosage units of Percodan to Patient 9 without noting it in the patient record.

- j. Patient 10: prescribing various controlled substances and psychotropic drugs without establishing a diagnosis to support the use of the drugs; prescribing Tenuate (diethylpropion hydrochloride) while concurrently dispensing phentermine and phendimetrazine for weight control. On at least one occasion (July 22, 1988) you prescribed one hundred (100) dosage units of Ritalin to Patient 10, with the only notation being "fatigue." On at least one other occasion (October 24, 1988) you again prescribed Ritalin to Patient 10, but failed to note the prescription in the patient record.
- k. Patient 11: prescribing Demerol 100 mg, fifty (50) dosage units on at least three occasions for migraine headaches without having adequately tried non-narcotic treatments.
- l. Patient 12: prescribing large quantities of Darvocet N-100 without documenting an adequate history, physical examination or documentation of the patient's progress.
- m. Patient 13: prescribing Ativan, a schedule IV controlled substance and Tylenol No. 4 without documenting a history and physical examination or establishing a diagnosis. On at least one occasion (December 16, 1988) prescriptions were issued for one hundred (100) dosage units of Ativan and fifty (50) dosage units of Tylenol #4 without any notation in the patient record.
- n. Patient 14: prescribing Percodan, Talwin, Tylenol #4, Darvocet N-100 and Valium without adequate documentation of the patient's history, physical condition, diagnosis, and response to treatment. On at least one occasion (January 27, 1989), the record fails to reflect the prescribing of fifty (50) dosage units of Percodan.

- o. Patient 15: record reflects inadequate documentation of the patient's history, physical condition, diagnosis, and response to treatment. Although there are occasional notations of prescribing thyroid and diabetic medications, and fasting blood sugar results, no diagnosis is ever documented nor is there sufficient information in the patient record to support a diagnosis requiring these medications.

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

Further, the acts and/or omissions as alleged in paragraph (1) 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, the acts, and/or omissions occurring on or after November 17, 1986, as alleged in paragraph (1) above, individually and/or collectively, constitute "(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: Rule 4731-11-02(D), and 4731-11-02(C).
O.A.C.

2. The patient record of Patient 3 indicates that you have been dispensing Schedule III and IV controlled substances for weight reduction to Patient 3 on a regular basis since May 9, 1983 (at which time Patient 3 weighed 123 lbs.) and continued at least until February 23, 1989 (at which time she weighed 129 lbs.) The patient record fails to reveal that a good faith effort to lose weight without the use of controlled substances was made, and also fails to indicate that a thorough history was obtained, that a thorough physical examination was performed, or that recognized contraindications were ruled out.

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Although the patient record indicates that Patient 3 was taking phendimetrazine 35 mg twice daily, your dispensing logs, beginning at least on January 12, 1988, indicates that you were dispensing phentermine 30 mg to be taken in the morning and phendimetrazine 35 mg to be taken in the afternoon. The dispensing of controlled substance stimulants continued during periods when Patient 3 gained weight or failed to lose weight.

3. The patient record of Patient 4 indicates that on June 3, 1988, you prescribed 28 Preludin 25 mg tablets to be taken one tablet twice a day; and that on September 22, 1988, October 21, 1988 and November 17, 1988, you prescribed fourteen (14) Fastin 30 mg tablets to be taken once a day. At no time did you indicate a weight for Patient 4, nor did you indicate the purpose for which these controlled substances were prescribed. Your record does not indicate that a good faith effort was ever made by Patient 4 to lose weight without controlled substances, nor does it indicate that a thorough history was ever obtained, that a thorough physical was ever performed, or that recognized contraindications were ruled out.

4. The patient record of Patient 8 indicate that you have been dispensing Schedule III and IV controlled substances for weight reduction to Patient 8 on a regular basis since at least July 28, 1983 (at which time Patient 8 weighed 226 lbs.) until at least until March 2, 1989 (at which time he weighed 211 1/4 lbs.) Your record does not indicate that a good faith effort was ever made by Patient 8 to lose weight without controlled substances, nor does it indicate that a thorough history was ever obtained, that a thorough physical was ever performed or that recognized contraindications were ruled out. The dispensing of controlled substances continued during periods when Patient 8 gained weight or failed to lose weight; in at least four instances in 1988, your dispensing log indicates that phentermine and phendimetrazine were dispensed when no notation of a patient visit is in the patient record, and no weight is noted. On at least two occasions (December 19, 1988 and December 30, 1988), your patient record indicates that Patient 8 was dispensed phendimetrazine while the dispensing log indicates the patient was dispensed phendimetrazine and phentermine.

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5. The patient record of Patient 10 indicates that you have been prescribing or dispensing Schedule III and IV controlled substances for weight reduction to Patient 10 on a regular basis since at least January 21, 1988 (at which time Patient 10 weighed approximately 232 lbs.) and continued at least until March 21, 1989 (at which time Patient 10 weighed approximately 200 lbs.) Throughout most of this time, your patient record indicates that you were prescribing Tenuate (diethylpropion hydrochloride) to Patient 10, while your dispensing log indicates that you were concurrently dispensing phentermine 30 mg and phendimetrazine 35 mg. Further, the dispensing log indicates that these drugs were dispensed on numerous occasions without being noted in the patient record and on at least three occasions without a visit being noted on the patient record or a weight taken.

The acts and/or omissions as alleged in paragraphs (2) through (5) above, individually and/or collectively, constitute "failure to use reasonable care discrimination in the administration of drugs," and "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, the acts and/or omissions as alleged in paragraphs (2) through (5) 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, the acts and/or omissions as alleged in paragraphs (2) through (5), individually and/or collectively, constitute "(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: Rules 4731-11-02(C), 4731-11-02(D) and 4731-11-04(B).

6. On or about September 6, 1987, Patient 6 slipped and fell in a restaurant, claiming injury to his lumbar spine. Your patient record indicates that Patient 6 was seen in your office September 8, 1987 at which time there is no notation concerning the fall or injury which occurred two days earlier. On September

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10, 1987, Patient 6 was again seen at your office, at which time the fall was noted. In your letters of November 16, 1987 and September 15, 1988 to Patient 6's attorney, you state that Patient 6 was seen by you on September 10, 1987 for his back injury. However, in your October 8, 1987 itemized statement for care rendered in relation to this injury, you billed for an "office visit to back with treatment" for September 8, 1987. You also billed for nineteen office visits for "follow-up treatment for back injury" and for fifteen "ultra sound & Passive ROM exercises" from September 10, 1987 through October 26, 1987. However, your records fail to show that you performed any ultrasound or passive ROM exercises on or for Patient 6's back. In fact, your records show that you were providing ultrasound treatment to Patient 6's right wrist throughout this entire period and that you billed the Ohio Bureau of Worker's Compensation for each of these office visits and for ultrasound and passive ROM treatments as being treatments for a wrist injury sustained by Patient 6 in 1984.

The acts and/or omissions as alleged in paragraph (6) above, individually and/or collectively, constitute "publishing a false, fraudulent, deceptive, or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

The acts and/or omissions as alleged in paragraph (6) above, individually and/or collectively constitute the "obtaining of, or attempting to obtain money or anything of value by fraudulent misrepresentations in the course of practice," as that clause is used in Section 4731.22(B)(8), Ohio Revised Code.

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

You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before the 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.

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In the event that there is no request for such hearing received within thirty (30) 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, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Henry G. Cramblett, M.D.
Secretary

HGC:jmb

Enclosures:

CERTIFIED MAIL #P 746 510 146
RETURN RECEIPT REQUESTED

CC: George G. Keith, Esq.

CERTIFIED MAIL NO. P 746 514 607
RETURN RECEIPT REQUESTED