BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	Case No. 11-CRF-074
GEORGE PHILLIP NAUM, III, D.O.	*	

ORDER AND ENTRY

On July 13, 2011, the State Medical Board of Ohio issued a Notice of Opportunity for Hearing to George P. Naum, III, D.O., based on the Summary Restriction of License issued by the West Virginia Board of Osteopathy on or about June 8, 2011, against Dr. Naum's license to practice osteopathic medicine and surgery in that state.

It was subsequently reported to the Board that, on or about June 30, 2011, the West Virginia Board of Osteopathy entered an order, rescinding the previously issued Summary Restriction of License.

In that the above referenced July 13, 2011, Notice of Opportunity for Hearing was based entirely on the Summary Restriction of License issued by the West Virginia Board of Osteopathy and that the Summary Restriction has now been rescinded, it is hereby ORDERED that such Notice of Opportunity for Hearing be and is hereby DISMISSED WITHOUT PREJUDICE to future action.

This Order is entered by the State Medical Board of Ohio and on its behalf.

So ORDERED this 9th day of August 2011.

Lance A. Talmage, M.D.
Secretary

(SEAL)

August 9, 2011
Date

Jack C. Amato, M.D.
Supervising Member

August 9, 2011
Date

CERTIFIED MAIL NO. 91 7108 2133 3936 3082 6526
RETURN RECEIPT REQUESTED

Robert C. Angell, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3082 6533
RETURN RECEIPT REQUESTED

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

July 13, 2011

Case number: 11-CRF-074

George Phillip Naum III, D.O.
31 Fieldcrest Drive
Wheeling, WV 26003

Dear Doctor Naum:

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) On or about June 8, 2011, the West Virginia Board of Osteopathy issued an Order for Summary Restriction of License [Order] which, *inter alia*, prohibited you from prescribing any controlled substance to any new patients; required you to initiate a program to taper Controlled Substances medications for and to ultimately cease providing controlled substances to chronic pain management patients; and to prohibit you from the prescribing of more than one timed-release, extended-release, or extended duration opioid or synthetic opioid medication to be taken concurrently or within a concurrent period of time. The underlying basis for the Order involved the death of at least three of your patients as well as your repeated prescribing of controlled substances in unsafe amounts and dangerous combinations. Copies of the Order, Notice of Hearing, and Statement of Charges are attached hereto and incorporated herein.

The Order as alleged in paragraph (1) above, constitutes "[a]ny of the following actions taken by an agency responsible for authorizing, certifying, or regulating an individual to practice a health care occupation or provide health care services in this state or another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Mailed 7-14-11

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.

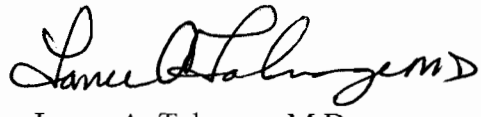
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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



Lance A. Talmage, M.D.
Secretary

LAT/DPK/flb
Enclosures

CERTIFIED MAIL #91 7199 9991 7030 3308 1533
RETURN RECEIPT REQUESTED

BEFORE THE WEST VIRGINIA BOARD OF OSTEOPATHY

WEST VIRGINIA BOARD OF OSTEOPATHY
Complainant,

v. Complaint No. 09-23

GEORGE P. NAUM, III, D.O.,
Respondent.

ORDER FOR SUMMARY RESTRICTION OF LICENSE

On the 8th day of June, 2011, the West Virginia Board of Osteopathy (hereinafter referenced as the "Board") met to review allegations that the Respondent, G.P. Naum, III, D.O., had engaged in unprofessional and unethical conduct. Whereupon, the Board determined that there was probable cause to believe the allegations against the Respondent and to issue a Statement of Charges based upon those allegations.

The Board then considered the nature of these charges and additional information regarding the nature of the Respondent's practice. Based upon this review, the Board notes the following findings:

1. The Board has found that there is probable cause to believe that the Respondent, George P. Naum, III, D.O., has engaged in unprofessional and unethical conduct and the Board has issued a Statement of Charges against the Respondent.

2. The charges against the Respondent include allegations that he has repeatedly prescribed Controlled Substances in unsafe amounts and dangerous combinations, which would be harmful to his patients' health and, in one case, lead to the death of one patient.

3. The charges against the Respondent also include allegations that he has repeatedly prescribed Controlled Substances to his patients without sufficiently monitoring them for adverse effects and for signs of misuse or abuse. The Board has found probable cause to

believe that this lack of appropriate patient monitoring was a contributing cause in the deaths of two other patients.

4. The Board has issued these charges against the Respondent based, in part, upon the recommendations and findings of a specialist in the field of pain management, who reviewed more than 20 of the medical charts of patients of the Respondent.

5. The Board also finds that the Respondent is likely to continue his practices of unsafe prescribing of medications and inadequate monitoring of the patients' conditions unless the Board takes immediate action.

For these reasons, the West Virginia Board of Osteopathy finds, pursuant to WEST VIRGINIA CODE section 30-1-8(e)(1), that the Respondent's continuation in the practice of osteopathic medicine and surgery constitutes an immediate danger to the public, which is grounds for a suspension of the Respondent's license to practice osteopathic medicine and surgery. However, since this risk primarily relates to the Respondent's prescribing of Controlled Substances, the Board finds that it is an appropriate, less invasive alternative to suspend only the Respondent's privileges to prescribe Controlled Substances in this State.

Now, therefore, the West Virginia Board of Osteopathy ORDERS that the Respondent's license to practice osteopathic medicine and surgery in this State shall be **RESTRICTED** as follows:

A. The Respondent may not prescribe, to any new patients, any medication or substance listed as a Controlled Substance under West Virginia or federal law;

B. The Respondent may not prescribe, to any current or established patients, any medication or substance listed as a Controlled Substance under West Virginia or federal law if that medication has not been prescribed within the ninety days immediately prior to this Order;

C. For all patients who are currently receiving treatment with Controlled Substances for the management of chronic pain, the Respondent shall initiate a program to cease providing those pain management services in a manner to minimize the adverse effects to those patients through a tapered reduction of all Controlled Substances within six to eight weeks of this order and or complete transfer to another health care provider within eight weeks of this Order;

D. In no event shall the Respondent prescribe more than one timed-release, extended-release, or extended duration opioid, or synthetic opioid, medication to any patient to be taken concurrently or within a concurrent period of time; and

E. The Respondent shall not prescribe any medication or substance listed as a Controlled Substance under West Virginia or federal law to any member of his family or to the spouse of any member of his immediate family.

This Order is effective immediately and shall remain in effect until further order of this Board or order by a court of competent jurisdiction.

The Board further ORDERS that this matter shall be set down for hearing at the date and location reflected in the attached Notice of Hearing to determine whether this summary action shall continue during the pendency of the Board's proceedings against the Respondent.

WEST VIRGINIA BOARD OF OSTEOPATHY

by: Ernest Miller DO
Ernest Miller, D.O.
President

Date: 8 June 2011

BEFORE THE WEST VIRGINIA BOARD OF OSTEOPATHY

WEST VIRGINIA BOARD OF OSTEOPATHY
Complainant,

v. **Complaint No. 2009-23**

GEORGE P. NAUM, III, D.O.,
Respondent.

NOTICE OF HEARING

TO: **George P. Naum, III, D.O.**
Naum Medical Associates
222 N 5th Street, Suite 102
Martins Ferry, OH 43935

You are hereby notified that on Thursday, June 23, 2011, at 1:00 PM, the West Virginia Board of Osteopathy will conduct a hearingupon above-styled complaint at the Board's offices at 405 Capitol Street, Suite 402, Charleston, West Virginia. The purpose of this hearing is to take evidence to determine whether there are sufficient grounds for the summary restriction of your license to practice osteopathic medicine and surgery. This hearing may be open to the public.

This hearing affects your legal rights and you may attend, with your attorney if so desired, to present evidence and legal argument in your defense. You have the right to cross-examine the witnesses presented against you and the right to offer witnesses and other evidence on your own behalf. If you require subpoenas to compel the attendance of witnesses or the production of documents, you may request subpoenas from the Board or from the Board's hearing examiner.

This hearing will be conducted in accordance with West Virginia Code §§ 30-1-1, *et seq.*, 30-14-1, *et seq.*, and 29A-5-1, *et seq.*, and the Code of State Rules, §§ 24-3-1 *et seq.* The hearing will proceed until all evidence is fully submitted and may be continued to receive additional testimony and evidence as needed.

Motions to continue these proceedings may granted upon a showing of good cause and should be submitted to the hearing examiner at this address:

Jennifer Narog Taylor, Esq.
1600 Louden Heights Road
Charleston, WV 25314

All other motions relating to this proceeding must be made in writing and submitted to the Board's office at 405 Capitol Street, Suite 402, Charleston, WV 25301. Copies of all motions should also be mailed to the hearing examiner, and to the attorney presenting the case for the Board:

Mr. Doren Burrell, Counsel
West Virginia Board of Osteopathy
405 Capitol Street, Suite 402
Charleston, WV 25301

Following the submission of all evidence, the hearing examiner will recommend findings of fact and conclusions of law, which may be approved, disapproved or modified by the West Virginia Board of Osteopathy.

BEFORE THE WEST VIRGINIA BOARD OF OSTEOPATHY

WEST VIRGINIA BOARD OF OSTEOPATHY,

Complainant,

v. **Complaint No. 09-23**

GEORGE P. NAUM, III, D.O.,

Respondent.

STATEMENT OF CHARGES

The West Virginia Board of Osteopathy (hereinafter identified as the "Board") has received a written complaint alleging that GEORGE P. NAUM, III, D.O., (hereinafter identified as the "Respondent") has engaged in unprofessional and unethical conduct in the prescribing of Controlled Substances.

After investigation of the allegations, including review of the response of the physician and of medical records provided by his office, the Board finds there is **probable cause** to believe that the Respondent has engaged in conduct, practices and acts, which may render him unqualified or unfit to be licensed and which constitute a willful departure from accepted standards of professional conduct.

The specific charges are as follows:

1. The Respondent, GEORGE P. NAUM, III, D.O., is a licensee of the Board and holds license number 1308 to practice osteopathic medicine and surgery in the State of West Virginia.

2. Under State and Federal law, a "Controlled Substance" is a drug, substance, or an immediate precursor of a drug or substance, that appears on a list or schedule of substances defined by statute, and that may only be possessed, created, prescribed, manufactured, or transferred under conditions restricted by state and federal law

3. The schedules for Controlled Substances range from Schedule I to Schedule V, where the substances listed in Schedule I carry the highest potential for abuse and those in Schedule V are deemed to have the lowest potential for abuse.

COUNT I

4. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

5. In the course of his practice, the Respondent has repeatedly prescribed Controlled Substances in amounts, frequency, and duration that would be deleterious to the health and safety of his patients, including Patients A, B, D, E, F, G, I, K, M, N, and Q*.

6. This conduct directly led to, and was a contributing cause of, the death of Patient A.

7. By prescribing Controlled Substances with such amounts, frequency, and duration, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

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* The identities of individual patients are provided in a Confidential Addendum to this Statement of Charges. This Confident Addendum is not a public document and should not be disclosed to anyone outside of this proceeding.

COUNT II

8. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

9. In the course of his practice, the Respondent has repeatedly prescribed Controlled Substances to Patients B, C, F, J, K, P and Q without taking reasonable precautions to monitor the patients' responses to these medications and to prevent and detect the misuse, abuse, and diversion of those medications.

10. These failures were contributing causes in the deaths of Patients B and C.

11. In prescribing Controlled Substances to patients without taking reasonable precautions to monitor the patients' responses to these medications, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT III

12. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

13. In the course of his practice, the Respondent has repeatedly prescribed medications, including Controlled Substances, to his patients in dangerous combinations with other medications, including in his treatment of Patients E, F, I, L, M, N, and P.

14. In prescribing medications to patients in unsafe and dangerous combinations, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT IV

15. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

16. In the course of his practice, the Respondent has repeatedly prescribed Controlled Substances to Patients G, H, I, J, and K, who were members of his family and closely related in terms of kinship and personal connection.

17. By prescribing Controlled Substances to members of his own family, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10. and §18.2.1.d (2010).

COUNT V

18. In 1997, in the course of his treatment of Patient H, the Patient explained that she did not have insurance coverage for the medication that the Respondent had prescribed for this patient, and the Patient asked if he could prescribe this medication to another individual in order to purchase this medication with proceeds from the other person's insurance coverage, to which the Respondent agreed.

19. By prescribing this medication in the name of a person for whom the medication was not intended, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT VI

20. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraph 18.

21. Patient H is a member of the Respondent's immediate family.

22. By prescribing this medication in the name of a person for whom the medication was not intended, in order to obtain the benefit of insurance proceeds for his patient and family member, the Respondent has engaged in dishonorable, unethical and unprofessional conduct of a character likely to deceive and harm the public, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §24-1-18.1.5.

COUNT VII

23. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

24. In the course of his practice, the Respondent has repeatedly prescribed medications, including Controlled Substances, to Patients F and I for medical conditions, and diagnoses of medical conditions, for which such medications are not indicated or recognized as appropriate treatment.

COUNT VIII

25. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

26. In the course of his practice, the Respondent has evaluated and treated patients E, L, N, O, and P, including treatment with Controlled Substances, and has failed to

maintain written records justifying the courses of these treatments, all of which is which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.21.

COUNT IX

27. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

28. In the course of his practice, the Respondent has evaluated and treated patients D, F, and I, including treatment with Controlled Substances, and has failed to refer these patients to specialists in other medical disciplines for the evaluation of other, more appropriate forms of treatment or therapy.

29. By failing to consider, or have his patients evaluated for, other, more appropriate forms of treatment or therapy, the Respondent has departed from, and failed to conform to, the standards of acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT X

30. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 3.

31. In the course of his practice, the Respondent has repeatedly prescribed Controlled Substances to his patients, including Patients B, C, and P when he knew, and should have known, that these substances would be used for other than an accepted, therapeutic purpose, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.5.

32. By prescribing Controlled Substances to patients when he knew, and should have known, that these substances would be used for other than an accepted, therapeutic acceptable and prevailing medical practice and the ethics of the osteopathic medical profession, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §18.1.10.

COUNT XI

33. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 32.

34. By engaging in all of the acts and omissions alleged above, the Respondent has engaged in dishonorable, unethical and unprofessional conduct of a character likely to deceive and harm the public, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §24-1-18.1.5.

COUNT XII

35. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 32.

36. By engaging in all of the acts and omissions alleged above, the Respondent has engaged in dishonorable, unethical and unprofessional conduct of a character likely to deceive and harm the public, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §24-1-18.1.5.

37. By engaging in all of the acts alleged above, the Respondent has committed a pattern of acts during the course of his medical practice that, under the attendant circumstances, constitute gross malpractice and gross negligence, all of which is a basis for disciplinary action pursuant to WEST VIRGINIA CODE §30-14-11(a)(5) and 24 CSR 1, §§ 24-1-18.1.5 and 24 -1-18.2.3.

COUNT XIII

38. The Board hereby reasserts, and incorporates by reference, all matters asserted in paragraphs 1 through 32.

39. By engaging in all of the acts alleged above, the Respondent has demonstrated a lack of professional competence to practice osteopathic medicine with a reasonable degree of skill and safety for patients, all of which is a basis for disciplinary action pursuant to 24 CSR 1, §§ 24-1-18.1.9.

CONCLUSION

Based upon all of the foregoing, the West Virginia Board of Osteopathy finds that there is **probable cause** to believe that the Respondent has engaged in unprofessional conduct and has engaged in conduct, practices and acts that constitute a departure from accepted standards of professional conduct in the practice of osteopathic medicine and surgery.

This matter shall, therefore, be set down for hearing, at a date and time to be arranged by counsel for the parties, to determine the truth of the allegations and to determine whether a final disciplinary sanction, if any, should be ordered by the Board.

WEST VIRGINIA BOARD OF OSTEOPATHY

by: Ernest Miller, D.O.

Ernest Miller, D.O.
President

Date: 8 June 2011

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 10-CRF-021
GEORGE PHILLIP NAUM, III, D.O.	*	

ORDER AND ENTRY

On March 10, 2010, the State Medical Board of Ohio issued a Notice of Opportunity for Hearing to George Phillip Naum, III, D.O., based on allegations that Dr. Naum had violated the minimal standards of care and departed from minimal standards of care in the selection or administration of drugs or other modalities in treatment that he rendered to 15 specified patients. If proven, the foregoing would constitute grounds for disciplinary action pursuant to Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code. Dr. Naum requested a hearing, which is currently scheduled to begin on February 14, 2011, before Hearing Examiner Gretchen Petrucci. To date, however, no presentation of evidence has commenced.

Subsequently, the Board obtained further investigatory information and determined that it would be administratively inefficient to pursue this matter at this time.

It is hereby ORDERED that the Notice of Opportunity for Hearing issued on March 10, 2010, pursuant to Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, be and is hereby DISMISSED WITHOUT PREJUDICE.

This Order is entered by the State Medical Board of Ohio and on its behalf.

So ORDERED this 12th day of October 2010.

Lance A. Talmage MD

Lance A. Talmage, M.D.
Secretary

(SEAL)

10-12-10
Date

Raymond J. Albert
Supervising Member

10/12/10
Date

CERTIFIED MAIL NO. 91 7108 2133 3936 3082 6946
RETURN RECEIPT REQUESTED

Robert C. Angell, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3082 6939
RETURN RECEIPT REQUESTED

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

March 10, 2010

Case number: 10-CRF-021

George Phillip Naum III, D.O.
31 Fieldcrest Drive
Wheeling, WV 26003

Dear Doctor Naum:

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) During the time period of in or about 2002 to in or about 2007, you provided care in the routine course of your practice for Patients 1 through 15 as identified on the attached Patient Key (Patient Key confidential and to be withheld from public disclosure).

(2) In your treatment of Patients 1-15, you practiced below minimal standards of care, including, but not limited to, the following:

(a) You excessively prescribed opiates to Patients 2, 4, 6, 7, 8, 9, 10, 12, 13, 14 and 15.

(b) You inappropriately failed to perform and/or timely perform and/or document the performance of urine drug screens on Patients 1, 2, 3, 6, 7 and 9.

(c) You inappropriately failed to refer Patients 1, 2, 3, 5 and 6 to detoxification programs and/or failed to document referral to detoxification programs.

Mailed 3-11-10

(d) You inappropriately and/or excessively prescribed Ambien, Soma, Imitrex, Restoril, Xanax, Adderall, Adipex, Ativan, Cymbalta, Klonopin, Tofranil and/or Compazine to Patients 1, 2, 5, 6, 7, 8, 10, 12, 13 and 15.

(e) You inappropriately prescribed antibiotics to Patients 5, 6 and 8.

(f) You failed to discuss and/or document the discussion of smoking cessation treatment with Patients 5 and 6.

(g) You failed to appropriately document injections that were administered to Patients 5, 7 and 14.

(h) You failed to enter into and/or timely enter into and/or document having entered into controlled substance medication agreements with Patients 1, 5, 6 and 13.

(i) You failed to enter into and/or timely enter into and/or document having entered into informed consent agreements with Patients 1, 5, 6, 9, 13 and 15.

(j) You failed to refer and/or timely refer and/or document the referral of Patients 1, 2, 3, 4, 6, 8, 10, 12, 13, 14 and 15 to specialists for potential psychiatric, addiction, gastroenterology, urological, neurological, ears nose and throat, and/or spinal surgery issues.

(k) You maintained inappropriately organized medical records for Patients 5, 6, 7 and 11.

(l) You failed to utilize and/or document the utilization of appropriate pain scales in Patients 1 through 15.

(m) You failed to address possible warning signs related to your prescribing of controlled substances to Patients 4, 5, 9, 10 and 11.

(n) You inappropriately continued to prescribe high dose opioids to Patient 1 despite reports that Patient 1 "walks into walls," "walks when she doesn't want to," as well as a report of a suicide attempt. You further failed to appropriately address and/or document the proper addressing of Patient 1's reported symptoms of walking into walls and walking when she does not want to. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

(o) You failed to appropriately address and/or document the proper addressing of Patient 2's potential cardiac issues, temporal arteritis, depression, excessive sluggishness, COPD and possible serotonin syndrome. You further failed to discuss and/or document the discussion of potential rebound headaches with Patient 2. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

(p) You failed to appropriately address and/or document the proper addressing of Patient 3's suicidal ideation and ADD and further failed to appropriately document any rationale for the combination of medications prescribed.

(q) You failed to appropriately address and/or document the proper addressing of Patient 4's etiology of symptoms of possible opiate-induced side effects such as nausea and hyperactive bowel sounds. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

(r) You failed to appropriately address and/or document the proper addressing of Patient 5's ER visit and/or he and his wife (Patient 6) having been assigned to "community service." You further inappropriately referred Patient 5 for cryoablation of the genitofemoral nerve. You further failed to appropriately document the rationale for your prescribing of Dilaudid, Medrol, Xanax and Neurontin to Patient 5. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

(s) You failed to appropriately address and/or document the proper addressing of Patient 6's Somatoform Disorder NOS and major depression. You further failed to perform and/or document the performance of appropriate examinations and/or tests. You further failed to perform and/or document the performance of an appropriate general history.

(t) You failed to appropriately address and/or document the proper addressing of Patient 7's cardiac status prior to prescribing Adderall, her symptoms of anxiety and distraught appearance, pins and needles sensations, possible cervical radiculopathy, the alleged flushing of her Adipex by her grandson and/or potential cervical myelopathy that can predispose a patient to falls and seizures. You further failed to appropriately document the rationale for your prescribing of Adderall and Adipex. You further failed to perform and/or document the performance of appropriate examinations and/or tests. You further failed to have properly recorded a Deep Tendon Reflex examination.

(u) You failed to appropriately address and/or document the proper addressing of Patient 8's possible serotonin syndrome, possible cauda equine or conus medularis syndromes, suicidal ideation, psychotic, anxiety, tearful, bladder and respiratory issues. You further failed to refer and/or document the referral of Patient 8 to a psychiatrist despite the patient's request for the same. You further failed to timely discuss and/or document the timely discussion of treatment options and pain etiology with Patient 8 and/or address a specialist's recommendation to not implant a pain pump. You further failed to perform and/or document the performance of appropriate examinations and/or tests. You inappropriately continued to prescribe controlled substances despite apparent non-compliance with a pain program.

(v) You inappropriately prescribed opioids to Patient 9 for neuropathic pain and failed to prescribe and/or document prescribing of membrane stabilizer medications. You further failed to appropriately address and/or document the proper addressing of Patient 9's neuropathy and the prior discharge of Patient 9 from a previous physician. You further failed to attempt to taper and/or document any attempt to taper the medications prescribed by you that could cause Alzheimer symptoms. You further failed to appropriately document the rationale for your prescribing of Dilaudid, oxycodone and Namenda. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

(w) You failed to appropriately address and/or document the proper addressing of Patient 10's possible knee, ankle, COPD, respiratory suppression, sleep apnea and/or hypoxia issues. You further failed to discuss and/or document the discussion of opioid issues with Patient 10. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

(x) You failed to appropriately address and/or document the proper addressing of Patient 11's possible respiratory issues.

(y) You failed to appropriately document the rationale for your prescribing of Xanax to Patient 12. You further failed to perform and/or document the performance of appropriate examinations and/or tests. You further inappropriately prescribed controlled medications for purportedly "painful lipomas."

(z) You inappropriately referred Patient 13 for implantation of a pain pump. You further failed to appropriately address and/or document the proper

addressing of Patient 13's motor vehicle accident and/or concussion. You further failed to perform and/or document the performance of appropriate examinations and/or tests. You further failed to address possible red flags related to your prescribing of controlled substances.

(aa) You failed to timely work up and/or address and/or document the proper addressing of Patient 14's risk assessment and/or depression. You further failed to perform and/or document the performance of appropriate examinations and/or tests and/or failed to timely request a spinal MRI.

(bb) You failed to timely work up and/or address and/or document the proper addressing of Patient 15's possible gastrointestinal issues, the high risk for drug abuse and/or drug diversion potential despite a high risk history and/or possible IBS as a possible side effect of your opiate prescribing. You further failed to appropriately document the rationale for your prescribing of Compazine. You further failed to perform and/or document the performance of appropriate examinations and/or tests.

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

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) 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.

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.

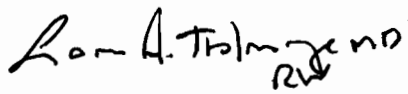
In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon

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,



Lance A. Talmage, M.D.
Secretary

LAT/DPK/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3936 3069 5245
RETURN RECEIPT REQUESTED