

FILED
COURT OF APPEALS
FRANKLIN COUNTY OHIO

IN THE COURT OF APPEALS OF OHIO 05 AUG -9 PM 1:53
TENTH APPELLATE DISTRICT CLERK OF COURTS

Barbara A. Reed, M.D., :

Appellant-Appellant, :

v. :

State Medical Board of Ohio, :

Appellee-Appellee. :

No. 05AP-166

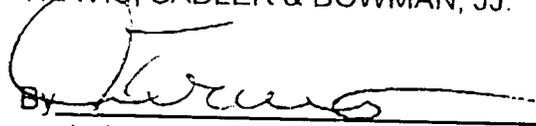
(C.P.C. No. 04CV7265)

(REGULAR CALENDAR)

JUDGMENT ENTRY

For the reasons stated in the opinion of this court rendered herein on August 9, 2005, appellant's assignments of error are overruled. Therefore, it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs assessed against appellant.

TRAVIS, SADLER & BOWMAN, JJ.

By 

Judge Alan C. Travis

STATE MEDICAL BOARD
OF OHIO
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IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

Barbara A. Reed, M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 05AP-166
State Medical Board of Ohio,	:	(C.P.C. No. 04CV7265)
Appellee-Appellee.	:	(REGULAR CALENDAR)

O P I N I O N

Rendered on August 9, 2005

Hammond, Sowards & Williams, and James M. McGovern, for appellant.

Jim Petro, Attorney General, and Kyle C. Wilcox, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

TRAVIS, J.

{¶1} Appellant, Barbara A. Reed, M.D., appeals from a February 16, 2005 judgment of the Franklin County Court of Common Pleas. The common pleas court affirmed an order of appellee, State Medical Board of Ohio ("the board"), which revoked appellant's license to practice medicine in Ohio. The board found that appellant's conduct in the practice of medicine was a departure from or a failure to conform with minimal standards of care; that appellant failed to use reasonable care discrimination in the

selection and administration of drugs; that appellant failed to maintain minimum standards of care of similar practitioners under the same or similar circumstances; and that appellant failed to complete and maintain accurate medical records reflecting her examination, evaluation and treatment of her patients.

{¶2} Appellant was awarded her medical degree in 1949. After obtaining her license, appellant has practiced medicine since then.

{¶3} In a nine-page letter dated September 10, 2003, the board notified appellant that it intended to determine whether or not to limit, revoke, permanently revoke, or suspend appellant's license to practice medicine in Ohio. The letter outlined specific instances in which the board alleged that appellant's acts or omissions in her medical practice warranted disciplinary action against her license.

{¶4} Pursuant to Chapter 119 of the Ohio Revised Code, appellant was advised of her right to request a hearing on the allegations, the time and place for filing the request, and of her right to be present, to be represented by counsel, to present evidence and examine witnesses both for and against her. Appellant received the letter on September 12, 2003 and on September 26, 2003, made a timely written request for a hearing.

{¶5} The hearing was conducted on February 17 and 18, 2005, by Board Hearing Examiner Gregory Porter. Appellant appeared and elected to proceed without counsel.

{¶6} From the evidence and testimony, the hearing examiner found that appellant had excessively and inappropriately prescribed controlled substances and

dangerous drugs to 11 patients without obtaining a patient history, without performing a physical examination, and without diagnostic testing to evaluate the patient complaints. Further, on a number of occasions, appellant prescribed controlled substances and dangerous drugs despite knowing that the patients were abusing the controlled substances or were exhibiting "drug-seeking behavior."¹

{¶7} The hearing examiner also found that appellant prescribed lengthy courses of antibiotics, thus placing her patients at risk for developing bacterial infections resistant to commonly used antibiotics, and that she inappropriately prescribed potent, broad-spectrum antibiotics that should be reserved for select clinical circumstances to avoid the development of resistant bacterial strains. The hearing examiner determined that appellant failed to maintain medical records that accurately reflected her evaluation of the patient's symptoms, her examination of the patient, the use of controlled substances in treatment, and the diagnosis and purpose for which controlled substances were being prescribed.

{¶8} The hearing examiner concluded that appellant's conduct of her medical practice displayed grounds for discipline under R.C. 4731.22(B)(2), (6), (20) and Ohio Adm.Code 4731-11-02(D). Specifically, appellant failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific

¹ As an example, appellant has cared for Patient 5 since 1999. Appellant frequently prescribed analgesic controlled substances for Patient 5 for claimed back pain and anxiety without performing and documenting an appropriate evaluation and assessment of Patient 5's symptoms. The prescriptions for Xanax and Darvocet were provided to Patient 5 despite clear "drug-seeking behavior" by the patient, including patient preference for a particular controlled substance, patient overdose on Darvocet and Soma and patient anger and rudeness in seeking more "pain pills." Finding of Fact 1(e). Other examples of inappropriate prescribing of controlled substances were documented as well, including frequent prescriptions for analgesic controlled substances, sedative-hypnotics and antidepressants without corresponding diagnoses or assessments of patient complaints. Findings of Fact 1(f), (g), (h), (i), and (j).

methods in the selection of drugs or other modalities for the treatment of disease. R.C. 4731.22(B)(2). Additionally, appellant's care of certain patients was a departure from or a failure to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. R.C. 4731.22(B)(6). Finally, appellant failed to complete and maintain accurate records reflecting her examination, evaluation, diagnosis and treatment of patients, and failed to accurately reflect the use of controlled substances and the purpose for which those controlled substances were prescribed. Ohio Adm.Code 4731-11-02(D). As a result, the hearing examiner concluded that appellant's continued practice of medicine presented a danger to the public and recommended that her license be permanently revoked.

{¶9} Appellant objected to the hearing examiner's report and recommendation. On June 9, 2004, the full board conducted a hearing on the report and recommendations and appellant's objections. Appellant was provided with notice of the hearing and again, elected to appear without counsel.

{¶10} The board revoked appellant's license based on findings that she had prescribed, dispensed or administered controlled substances without an appropriate prior examination of patients; that she failed to use acceptable methods in the selection of drugs; that her treatment of patients failed to conform to minimal standards of care, and that she failed to maintain proper medical records, all of which violated the Medical Practices Act and/or rules of the board.

{¶11} Appellant sets forth the following assignments of error for review:

1. The lower court judgment affirming the Board Order was an abuse of discretion because the Board Order is not supported

by the requisite evidence due to the incompetent testimony provided by the Board's expert witness.

2. The lower court judgment affirming the Board Order was an abuse of discretion because the Board's allegations are barred by the doctrine of laches.

3. The lower court judgment affirming the Board Order was an abuse of discretion because the Board's Order is based, in part, on improper argument by the Assistant Attorney General.

4. The lower court judgment affirming the Board Order was an abuse of discretion because Dr. Reed's rights to due process were repeatedly violated by the Board.

5. The lower court judgment affirming the Board Order was an abuse of discretion because the Board failed to consider mitigating circumstances justifying a reduction in the degree of discipline to be imposed.

6. The lower court judgment affirming the Board Order was an abuse of discretion because the permanent revocation of Dr. Reed's license is too harsh a sanction for what transpired.

{¶12} In an appeal from an order of the board under R.C. 119.12, a reviewing trial court must affirm if the order of the agency is supported by reliable, probative and substantial evidence and is in accordance with law. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619. The reviewing court may not substitute its judgment for that of the administrative agency.

{¶13} "Reliable" evidence is dependable; that is, evidence that can be confidently trusted, with a reasonable probability that the evidence is true. "Probative" evidence is relevant evidence that tends to prove the issue in question. "Substantial" evidence is evidence with some weight, importance and value. *Our Place, Inc. v. Ohio Liquor Control Comm.* (1992), 63 Ohio St.3d 570, 571.

{¶14} Appellate review of the sufficiency of the evidence in an appeal under R.C. 119.12 is even more limited than that of the trial court. An appellate court determines only whether the trial court abused its discretion. *Pons*, supra. An abuse of discretion is not merely an error in judgment, but a perversity of will, passion, prejudice, partiality or moral delinquency. Absent an abuse of discretion on the part of the trial court, a court of appeals may not substitute its judgment for that of the board or the trial court. *Pons*, at 621.

{¶15} When reviewing orders from the board, courts must accord due deference to the board's interpretation of the technical and ethical requirements of the medical profession. " * * * The purpose of the General Assembly in providing for administrative hearings in particular fields was to facilitate such matters by placing the decision on facts with boards or commissions composed of [people] equipped with the necessary knowledge and experience pertaining to a particular field. * * * " *Arlen v. State Medical Board* (1980), 61 Ohio St.2d 168, 173, quoting *Farrand v. State Med. Bd.* (1949), 151 Ohio St. 222, 224.²

{¶16} In her first assignment of error, appellant asserts that the board erroneously relied upon incompetent medical testimony to support its findings and order. Appellant argues that the Board's witness, Joseph Clark, M.D., was not qualified to testify on medical issues because Dr. Clark did not qualify as an expert in the practice of medicine pursuant to Evid.R. 601(D). Appellant reasons that the testimony of Dr. Clark should

² Appellate review of questions of law is plenary. *Univ. Hosp., Univ. of Cincinnati College of Medicine v. State Emp. Relations Bd.* (1992), 63 Ohio St.3d 339, paragraph one of the syllabus.

have been excluded and, without the testimony of Dr. Clark, the evidence is insufficient to support the board's order.

{¶17} Appellant does not question Dr. Clark's qualifications to practice medicine or to provide medical advice and opinion on medical issues. Dr. Clark received his medical degree in 1978. He has practiced medicine in Ohio since 1988 and in the State of Alabama since 1979. He holds board certification by the National Board of Medical Examiners and the American Board of Internal Medicine. Dr. Clark holds medical privileges at a number of hospitals in the Cleveland area and is an Assistant Clinical Professor of Medicine at Case Western Reserve University School of Medicine in Cleveland, Ohio. Currently, Dr. Clark is a staff physician at NorthEast Ohio Neighborhood Health Services, Inc., located in Cleveland, Ohio. He has been a staff physician and assistant medical director of the Franklin Memorial Primary Health Center in Mobile, Alabama. Although Dr. Clark's administrative duties as medical director of NorthEast Ohio Neighborhood Health Services have reduced his active clinical practice to approximately 20 percent of his professional time, he remains an active medical practitioner and supervises a number of other medical providers of a broad range of services to patients. Therefore, absent Evid.R. 601(D), the admissibility of Dr. Clark's professional opinions would not be at issue.

{¶18} Evid.R. 601 deals with general rules of competency of witnesses. As pertinent to this appeal, Evid.R. 601(D) provides that every person is competent to be a witness except:

A person giving expert testimony on the issue of liability in any claim asserted in any civil action against a physician * * *

arising out of the diagnosis, care, or treatment of any person by a physician * * * unless the person testifying is licensed to practice medicine * * * by the state medical board * * * and unless the person devotes at least one-half of his or her professional time to the active clinical practice in his or her field of licensure, or to its instruction in an accredited school.
* * *

The object of Evid.R. 601 is to declare all witnesses competent to testify unless specifically designated as incompetent. Therefore, unless a witness falls within the express terms of exclusion, the preference is for competency.

{¶19} The traditional rules of evidence are relaxed in administrative hearings. *Haley v. Ohio State Dental Bd.* (1982), 7 Ohio App.3d 1. Ohio Adm.Code 4731-13-25 provides that "[t]he 'Ohio Rules of Evidence' may be taken into consideration by the board or its hearing examiner in determining the admissibility of evidence, but shall not be controlling." Thus, compliance with Evid.R. 601(D) is not required before the board may hear expert opinion testimony on issues pending before the board. When coupled with the unquestioned medical credentials of Dr. Clark, Ohio Adm.Code 4731-13-25 supports the admissibility of his testimony.

{¶20} Moreover, "[e]xpert testimony as to a standard of practice is not mandatory in a medical disciplinary proceeding to determine whether a physician's conduct falls below a reasonable standard of medical care." *Arlen*, syllabus. Accord *State Medical Board v. Murray* (1993), 66 Ohio St.3d 527. Expert testimony may be necessary "when the trier of facts is confronted with issues that require scientific or specialized knowledge or experience beyond the scope of common occurrences. However, the need for expert opinion testimony is negated where the trier of facts, such as in the instant cause, is possessed of appropriate expertise and is capable of drawing its own conclusions and

inferences." *Arlen*, at 173. Thus, expert opinion testimony was not required for the board to make findings in this case. When coupled with the expertise of those board members who are licensed physicians, fact testimony alone was sufficient for the board to reach its conclusions without regard to the opinion testimony of Dr. Clark. Although Dr. Clark's testimony was not required to support the board's actions, we find that the hearing examiner did not commit error in admitting the professional opinions of Dr. Clark on the issues before the board. The first assignment of error is overruled.

{¶21} Appellant's second assignment of error asserts that the equitable doctrine of laches barred the board from taking action against appellant. We disagree.

{¶22} As a general rule, in the absence of a statute to the contrary, when the government takes action to enforce a public right, or to protect the public interest, laches is not a defense. *Ohio State Bd. of Pharmacy v. Frantz* (1990), 51 Ohio St.3d 143; *McCutcheon v. Ohio State Medical Bd.* (1989), 65 Ohio App.3d 49, 56. "[I]n order to successfully invoke the equitable doctrine of laches it must be shown that the person for whose benefit the doctrine will operate has been materially prejudiced by the delay of the person asserting [the] claim." *Smith v. Smith* (1959), 168 Ohio St. 447, paragraph three of the syllabus.

{¶23} Appellant argues that the delay in bringing disciplinary proceedings prejudiced her ability to defend herself because she had difficulty in recalling her rationale for the treatment of various patients. This argument ignores the fact that one of the allegations against appellant was her failure to maintain proper medical records. Time did not alter appellant's medical records. Those records demonstrated that appellant did not

properly document the subjective and objective symptoms of her patients, whether she performed scientific testing to verify or refute the symptoms, her assessment of the patient's medical condition and her treatment plan, all of which are necessary to conform with minimal standards of the practice of medicine under the rules of the board. See Ohio Adm.Code 4731-11-02(D).

{¶24} Additionally, appellant was charged with failure to use reasonable care in the selections and administration of various controlled substances and dangerous drugs. The board alleged that appellant prescribed controlled substances and dangerous drugs in quantities and with refills far beyond accepted medical practice. Even if appellant could not recall specific information for individual patients, had there been a medically sound, theoretical basis for prescribing large quantities of controlled substances and numerous refills to patients in general, appellant could have offered that medically approved explanation.

{¶25} Instead of offering a generally accepted, medically sound reason to prescribe in large quantities and with authorization for multiple refills, appellant's responses support the findings of the hearing examiner and the board. For example, when board counsel questioned appellant's failure to obtain throat cultures to verify or rule out a bacterial infection, appellant stated she stopped doing so because the hospital that ran the tests falsified her records and it was just money in the bank for the hospital. (Tr. Vol. I, at 29, 31.)

{¶26} When questioned about her prescription for 500 milligrams of amoxicillin, a powerful antibiotic, to be taken four times a day, rather than the standard 250 milligram

dose to be taken three times a day, appellant explained that she wrote the prescription "because the patient came in and said, 'Well, the other doctors up and down the street are giving us 500 milligrams instead of the 250,' and she jumped all over me and said that she would rather have the 500, because she said it was the same price * * * as the 250." (Tr. Vol. I at 33.)³ Appellant explained that she allowed two refills to be ordered at the patient's discretion, by stating, "she could give them to her husband if she felt like it, which a lot of these people do, give them to somebody else in the family. It happens over and over again, as you know." (Tr. Vol. I, at 32.)

{¶27} Whether the equitable doctrine of laches should be applied in a case is a question primarily addressed to the discretion of the trial court. *Gardner v. Panama Railroad Co.* (1951), 342 U.S. 29, 72 S.Ct. 12. Appellant has failed to demonstrate an abuse of the trial court's discretion on this issue. The second assignment of error is overruled.

{¶28} In her third assignment of error, appellant asserts that the board's order was based upon improper argument by the board's counsel. At page 12 of her corrected brief, appellant sets forth the following portion of the argument made by the assistant attorney general:

She rarely, if ever, identifies the reasons for her treatments or prescriptions in these records. Certainly, no subsequent treatment provider would get any use out of these records.

* * *

³ The physician's desk reference recommends that amoxicillin be limited to three 250 mg. doses per day for ten days. In contrast, with two refills approved, appellant authorized 90 doses of amoxicillin. (Tr. Vol. I, at 35.)

Mr. Wilcox commented that Dr. Reed's attitude seems to be that, as long as her patients ask for a Schedule IV drug, or lower, and not Schedule II drugs, that it is okay for her to give them out in large quantities.

Appellant states that the argument by board counsel was unsupported by the facts of the case and that the board erroneously relied on the argument to revoke appellant's license.

{¶29} The portion of the argument quoted by appellant appears to be taken from the minutes of the board. The minutes of board meetings are not verbatim, but are a summary of the proceedings. Because the minutes are in summary form, the court cannot know precisely what counsel argued. However, for purposes of appeal, the court will accept that the summary reflects the substance of the argument.

{¶30} Counsel should be afforded great latitude in closing argument. *State v. Champion* (1924), 109 Ohio St. 281, 289. "The assessment of whether the permissible bounds of closing argument have been exceeded is, in the first instance, a discretionary function to be performed by the trial court. Such determination will not be reversed on appeal absent an abuse of discretion." *Pang v. Minch* (1990), 53 Ohio St.3d 186, paragraph three of the syllabus. However, where gross and abusive conduct occurs, the trial court is bound, sua sponte, to correct the prejudicial effect of counsel's misconduct. *Pesek v. Univ. Neurologists Assn., Inc.* (2000), 87 Ohio St.3d 495, 501, citing *Snyder v. Stanford* (1968), 15 Ohio St.2d 31, 37.

{¶31} In this instance, we find that counsel argued permissible inferences that could be drawn from the evidence presented. First, in a number of instances, appellant's medical records were, to say the least, sparse, and it is reasonable to argue that those limited records contained insufficient information to meet the minimum standards required

of medical practitioners. Second, on a number of occasions, evidence was presented that appellant failed to properly discriminate in making medical decisions to prescribe certain scheduled drugs. The arguments and inferences may be drawn from the record of proceedings and were noted in the summary of evidence set out in the report and recommendation of the hearing examiner. Counsel did not make an improper argument or stray from the facts of the case. The third assignment of error is overruled.

{¶32} In her fourth assignment of error, appellant argues that the board repeatedly denied her right to due process of law. Appellant concludes that she was denied due process in three particulars: because there was insufficient evidence to support the board's findings; because the board ignored appellant's explanation for her decisions to prescribe controlled substances to patients; and because the board ignored her attempts to mitigate the penalty imposed.

{¶33} The concepts of weight and sufficiency of evidence are qualitatively different in a criminal trial. In a criminal trial, a conviction may be reversed and remanded for a new trial where the verdict is against the manifest weight of the evidence. Under those circumstances, the reviewing appellate court is said to sit as a "thirteenth juror" and the due process clause is not implicated. A criminal conviction based upon insufficient evidence denies due process. *Tibbs v. Florida* (1982), 457 U.S. 31, 102 S.Ct. 2211; *Jackson v. Virginia* (1979), 443 U.S. 307, 99 S.Ct. 2781. In a civil trial, due process requirements are not subject to the heightened constitutional considerations of a criminal trial. Instead, in a civil case, the tests for weight and sufficiency of the evidence are essentially the same.

{¶34} Ohio Adm.Code 4731-11-05(B) requires a physician to complete and maintain medical records for patients. The records must include a diagnosis, the purpose for which a substance or drug is prescribed and information upon which the diagnosis leading to the use of the substance or drug is based.

{¶35} Evidence was presented that appellant failed to maintain proper medical records under the standards of the board. Under the test set forth in *Our Place, Inc.*, supra, that evidence was reliable in that it was believable. The evidence was probative, because it tended to prove the issue in question. The evidence was substantial because it had some weight, importance and value. Therefore, there was credible evidence to support the board's finding that appellant failed to maintain her patient records as required by board rule. The fact that appellant disagrees with the finding does not mean there was no evidence upon which to base the board's decision. Findings based on sufficient evidence did not deny appellant due process of law.

{¶36} In like manner, we reject the claim that the board ignored appellant's explanation of her clinical decisions in treating patients. There was evidence presented that appellant lacked a medically approved basis for administering various antibiotics and controlled substances and her conduct with regard to controlled substances did not conform to the standards of the profession. It is not for this court to question whether certain medical practices conform to accepted standards of the medical profession. The

board found appellant's explanation wanting.⁴ We are not in a position to substitute our judgment for that of the board.

{¶37} In the final portion of her fourth assignment of error, appellant asserts she was denied due process of law because the board failed to consider her offer of mitigation. The minutes of the board show that the board reviewed the complete record of the proceedings before the hearing examiner, including appellant's testimony. The board heard appellant's oral presentation at the hearing. Aware of its own records, the board knew that appellant had practiced medicine for many years with no previous disciplinary action taken against her license. In the absence of some affirmative indication that the board refused to consider appellant's presentation or her history, we must presume the board considered those matters in mitigation, but gave them little or no weight.⁵ Moreover, while the board may consider both aggravating and mitigating circumstances, it is not required to do so. *Urban v. State Medical Bd.*, Franklin App. No. 03AP-426, 2004-Ohio-104. The fourth assignment of error is overruled.

{¶38} In her fifth assignment of error, appellant maintains that the board failed to consider mitigating factors when it determined the appropriate sanction to impose. Having reviewed the record, we find that this assignment of error lacks merit. As

⁴ Appellant explained that she prescribed three times the recommended number of doses of amoxicillin and double the recommended strength because her patient demanded the prescription and because the patient might give extra doses to her husband. Appellant's own testimony demonstrates that appellant did not use appropriate discrimination in prescribing controlled substances. Appellant's failure to offer any sound medical reason for her decision to prescribe controlled substances is unlike the facts of *Lawrence v. State Medical Bd.* (Mar. 11, 1993), Franklin App. No. 92AP-1018, cited by appellant. In *Lawrence*, the hearing officer inconsistently found that the physician kept thorough patient records, but found the records were difficult for a third-person, the non-physician hearing examiner, to interpret. That is not the case in the within appeal.

⁵ On this point, we part company with the trial court which concluded the board did not consider mitigation.

discussed above, the board reviewed the testimony before the hearing examiner, heard appellant's oral presentation and was aware of appellant's considerable length of service to her patients and lack of disciplinary action against her. Although the minutes do not specifically address the subject of mitigation, there is no indication that the board ignored appellant's presentation.

{¶39} Furthermore, while the guidelines of the board permit the board to consider mitigating circumstances when hearing a disciplinary case, those guidelines do not require the board to do so. See *Urban*, supra. The board is free to ignore mitigation when deciding what penalty to impose.

{¶40} Once reliable, probative and substantial evidence is found to support an order by the board, the reviewing court may not modify a sanction authorized by statute. *Henry's Café, Inc. v. Board of Liquor Control* (1959), 170 Ohio St. 233. See, also, *Hale v. Ohio State Veterinary Medical Bd.* (1988), 47 Ohio App.3d 167. Permanent revocation of a medical license is within the range of acceptable choices for discipline available to the board. The board was free to favorably view the many years of medical practice provided by appellant, the many years of service without any disciplinary blemish, her absence of dishonest or selfish motive, her disclosure of her failings before the board and other mitigation presented. The board could have limited or suspended appellant's license, placed appellant on probation or reprimanded appellant. R.C. 4731.22(B). The board was free to opt for a form of interim rehabilitation or remedial measure. Instead, the board elected to permanently revoke appellant's license. Permanent revocation is permitted by statute. *Id.* Even if this court were to view those mitigating factors favorably

and disagree with the penalty the board imposed, the court has no power to modify the board's choice of sanction.⁶ The fifth assignment of error is overruled.

{¶41} In her sixth and final assignment of error, appellant asserts that revocation of her license to practice medicine is an excessive sanction. As a matter of law, we are compelled to deny this assignment of error because we have no authority to act as appellant asks. The determination of the appropriate sanction in an administrative hearing is strictly for the agency. *Henry's Café, supra*; *Roy v. Ohio State Med. Bd.* (1992), 80 Ohio App.3d 675.

{¶42} We agree that revocation of a professional license is a harsh result. We agree that after a lifetime of professional service, it is regrettable that appellant will have her license to practice medicine revoked. However, we are not permitted to substitute our judgment for that of the board. As long as the order of the board is supported by reliable, probative and substantial evidence and is in accordance with law, we must affirm. *Farrand; Henry's Café, supra*. The sixth assignment of error is overruled.

{¶43} Having overruled all of appellant's assignments of error, the judgment of the Franklin County Court of Common Pleas is affirmed.

Judgment affirmed.

SADLER and BOWMAN, JJ., concur.

BOWMAN, J., retired, of the Tenth Appellate District assigned to active duty under the authority of Section 6(C), Article IV, Ohio Constitution.

⁶ This is not to say that the State Medical Board is above review or can operate without due regard to the principles of due process of law. See the concerns expressed in *State Med. Bd. v. Murray* (1993), 66 Ohio St.3d 527, at 538, Pfeiffer, J., concurring.

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

BARBARA A. REED, M.D.	:	
	:	CASE NO. 04CVF-07-7265
Appellant,	:	
	:	JUDGE M. HOLBROOK
Vs.	:	
	:	
STATE MEDICAL BOARD OF OHIO	:	
	:	
Appellee.	:	

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STATE MEDICAL BOARD OF OHIO

ORDER GRANTING APPELLANT, BARBARA A. REED, M.D.'S, MOTION FOR SUSPENSION OF AGENCY ORDER PENDING A DECISION AND ENTRY ON HER APPEAL BY THE TENTH DISTRICT COURT OF APPEALS

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the June 9, 2004 Order of the State Medical Board of Ohio (mailed July 2, 2004) which permanently revokes Appellant, Barbara A. Reed, M.D.'s, license to practice medicine and surgery in Ohio effective July 16, 2004. Dr. Reed's appeal to this Court was filed July 13, 2004. Dr. Reed's Motion for Suspension of Agency Order was filed July 14, 2004 and granted July 15, 2004. On February 16, 2005, the Court filed its Judgment Entry affirming the Board's Order. Dr. Reed has now moved for a further Stay of the Board's Order pending her upcoming appeal to the Tenth District Court of Appeals. For the reasons stated in Dr. Reed's Motion and for other good cause shown, it is hereby

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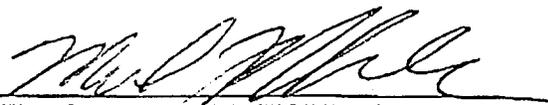
COMPTROLLER GENERAL
FRANKLIN COUNTY, OHIO

ORDERED, ADJUDGED AND DECREED that the State Medical Board of Ohio Order issued June 9, 2004 and mailed July 2, 2004 is suspended until the filing of a final decision and order by the Tenth District Court of Appeals in Dr. Reed's appeal of this Court's Judgment Entry filed February 16, 2005, ^{which occurs first,} conditioned upon Dr. Reed: 1) closing her medical office located at 177 Park Avenue West, Mansfield, Ohio and not evaluating

or treating any patients; and 2) limiting her practice of medicine to what is necessary to fulfill her duties as Deputy Coroner of Richland County, Ohio.

IT IS SO ORDERED.

2-17-05
Date


JUDGE MICHAEL HOLBROOK

STATE MEDICAL BOARD
OF OHIO
2005 FEB 17 P 4: 15

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

HEALTH & HUMAN
FEB 24 2005
SERVICE SECTION
FILED
COURT OF APPEALS
FRANKLIN COUNTY, OHIO
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CLERK OF COURTS

BARBARA A. REED, M.D.

Appellant,

Vs.

STATE MEDICAL BOARD OF OHIO

Appellee.

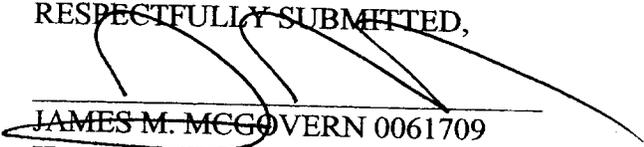
CASE NO. 04CVF-07-7265

JUDGE D. O'Neill

NOTICE OF APPEAL

Notice is hereby given that Barbara A. Reed, M.D., appeals to the Court of Appeals of the Franklin County, Ohio, Tenth Appellate District, from the attached Judgment Entry Affirming the State Medical Board's July 2, 2004 Order Permanently Revoking Dr. Reeds' Ohio Medical License, entered in this action on the 16th day of February, 2005.

RESPECTFULLY SUBMITTED,


JAMES M. MCGOVERN 0061709

HAMMOND, SEWARDS & WILLIAMS

556 E. Town Street

Columbus, OH 43215

(614) 228-6061/(614) 228-5883 fax

Counsel for Barbara A. Reed, MD

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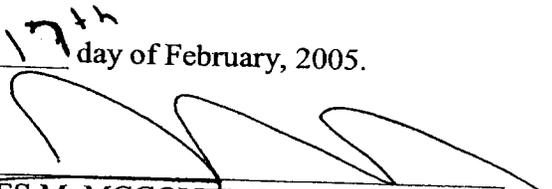
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FRANKLIN CO. OHIO
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CLERK OF COURTS

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a true and accurate copy of the foregoing was served upon the following:

Kyle Wilcox
Assistant Attorney General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, OH 43215

by regular US Mail, postage prepaid, this 17th day of February, 2005.



JAMES M. MCGOVERN

0061709

TERMINATION NO. 18
BY J.J.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

FINAL APPEALABLE ORDER

BARBARA A. REED, M.D.,

Appellant,

v.

STATE MEDICAL BOARD OF OHIO,

Appellee.

Case No. 04CVF-07-7265

JUDGE HOLBROOK

**JUDGMENT ENTRY AFFIRMING THE STATE MEDICAL BOARD'S
JUNE 9, 2004 ORDER PERMANENTLY REVOKING
APPELLANT'S LICENSE TO PRACTICE MEDICINE AND SURGERY IN
OHIO**

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the June 9, 2004 Order of the State Medical Board of Ohio which permanently revoked Appellant Barbara A. Reed, M.D.'s license to practice medicine and surgery in Ohio. For the reasons stated in the decision of this Court rendered and filed on February 2, 2005, which decision is incorporated by reference as if fully rewritten herein, it is hereby:

ORDERED, ADJUDGED AND DECREED that judgment is entered in favor of Appellee, State Medical Board of Ohio, and the June 9, 2004 Order of the State Medical Board in the matter of Barbara A. Reed, M.D., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

2-24-05
Date


JUDGE MICHAEL HOLBROOK

FILED COURT
COMMON PLEAS CO. OHIO
FRANKLIN CO. OHIO
2005 FEB 16 PM 3:26
CLERK OF COURTS - CV

APPROVED:

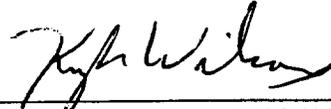
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K.W.)



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Counsel for the State Medical Board

FILED
COMMON PLEAS COURT
COURT OF COMMON PLEAS, FRANKLIN COUNTY, CIVIL
DIVISION
2005 FEB -3 PM 3:10

BARBARA A. REED, : CASE NO. 04CV-7265
CLERK OF COURTS :
APPELLANT, : JUDGE HOLBROOK
: :
VS. : :
: :
STATE MEDICAL BOARD : :
OF OHIO, : :
: :
APPELLEE. : :

HEALTH & HUMAN
SERVICES SECTION
FEB - 7 2005

DECISION ON MERITS OF APPEAL

Entered this 2nd day of February, 2005.

This action comes before the court upon appeal by Barbara A. Reed, M.D. pursuant to R.C. Chapter 119 from an order of the Ohio State Medical Board (Board). The Board at its June 9, 2004 meeting voted to permanently revoke Doctor Reed's Ohio medical license. The parties have filed their briefs in the record has been submitted. For the reasons set forth below, the court affirms the decision of the Board.

PROCEDURAL BACKGROUND.

The Board notified Dr. Reed by a letter of notice of opportunity dated September 10, 2003 that it intended to consider whether to sanction Dr. Reed based upon four allegations. The first allegation was that Dr. Reed had prescribed excessive and/or inappropriate controlled substances, antibiotics and dangerous drugs to 11 patients. The second allegation was that the doctor failed to adequately document her medical records to support the diagnosis of vitamin B 12 deficiency and to warrant an injection of this

vitamin to three of her patients. The third allegation was that the doctor failed to document and/or demonstrate an active clinical thought process following SOAP (subjective complaints, objective findings, analysis and plan of treatment). The fourth allegation was that the doctor failed to maintain records accurately reflecting diagnosis that necessitated the use of controlled substances in the treatment of 11 of her patients.

The Board informed the doctor that they believed the allegations constituted violation of R.C. Section 4731.22(B)(2)- constituting a failure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease; 4731.22(B)(2)- constituting failure 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; 4731.22(B)(6)- acts constituting a departure from, or the failure to inform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to the patient is established; section 4731.22(B)(20)- constituting violating or attempting to violate, directly or indirectly, for assisting in or abetting a violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the Board. The Board assigned Attorney Hearing Examiner Gregory Porter for a hearing in which Dr. Reed appeared representing herself. The hearing was conducted

on February 17, and 18, 2004. The Hearing Examiner issued his report and recommended to the Board that the doctor's license be permanently revoked. The Board approved the proposed findings of fact and conclusions of law of the Hearing Examiner and imposed a permanent revocation of the doctor's medical license.

STANDARD OF REVIEW

R.C. 119.12 and the multitude of cases addressing that section govern the Court's review of a decision of an administrative agency, such as the Commission. The most often cited case is that of *Univ. of Cincinnati v. Conrad*¹. The *Conrad* decision states that in an administrative appeal filed pursuant to R.C. 119.12, the trial court must review the agency's order to determine whether it is supported by reliable, probative and substantial evidence and is in accordance with law.

The Court states at pages 111 and 112 that "In undertaking this hybrid form of review, the Court of Common Pleas must give due deference to the administrative resolution of evidentiary conflicts. For example, when the evidence before the court consists of conflicting testimony of approximately equal weight, the court should defer to the determination of the administrative body, which, as the fact-finder, had the opportunity to observe the demeanor of the witnesses and weigh their credibility. The findings of the agency are not conclusive. Where the court, in its appraisal of the

¹ 63 Ohio St. 2d 108, 407 N.E.2d 1265, (1980)

evidence, determines that there exist legally significant reasons for discrediting certain evidence relied upon by the administrative body, the court may reverse, vacate or modify the administrative order. Where it appears that the administrative determination rests upon inferences improperly drawn from the evidence adduced, the court may reverse the administrative order.

The *Conrad* case has been cited with approval numerous times.² Although a review of applicable law is de novo, the reviewing court should defer to the agency's factual findings.³

ANALYSIS OF LEGAL ARGUMENTS

Prior to commencement of analysis of the contended errors asserted by Appellant, a brief recapitulation of certain undisputed evidence must be offered. Appellant cannot deny that she, as to patient 1, from 1994 to 2002, prescribed at least nine thirty-day doses of amoxicillin, generally in 500mg tablets, with 14 separate possible refills as well as the stronger antibiotic, Keflex, eleven times for thirty days, with 20 possible refills. Appellant testified that she knew it was possible that the medication might be shared. She failed to account for the possibility that such long term drug regimens could put the patient at risk of developing drug resistant infections. This

² *City of Hamilton v. State Employment Relations Bd.* (1994), 70 Ohio St. 3d 210, 638 N.E.2d 522; *Ohio Historical Soc. v. State Emp. Relations Bd.* (1993), 66 Ohio St. 3d 466, 471, 613 N.E.2d 591

³ *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 614 N.E.2d 748. Rehearing denied by: *Pons v. State Medical Bd.* (1993), 67 Ohio St. 3d 1439, 617 N.E.2d 688.

same tendency for over prescribing occurred with other patients. Appellant also failed to adequately document medical bases for prescribing Darvocet, Zanax, or Restoril as well as other sedatives and anti-depressants. The prescription for Restoril was continued for four months in addition to at least one other medication and despite limitations for use of Restoril as short term medication. Additionally, Appellant offered no substantive basis for her prescription and administration of Vitamin B12 supplements. The tenor of Appellant's testimony as to patients with possible addiction issues was that she didn't prescribe the "harder" drugs to them.

Appellant posits that the decision of the Board is not supported by reliable, probative, and substantial evidence and is not in accordance with applicable law. Appellant's first specific contention of error is that the evidence offered by the Board is incompetent based upon the contention that the Board's expert did not qualify as an expert witness. The second alleged error is that the Board's allegations are barred by the doctrine of laches. The third offered argument is that the attorney general was allowed to address the Board and his statements were made upon facts which were not in evidence. The fourth argument by appellant is that the doctor's rights to due process were repeatedly violated. The specific contention is that the Board's order failed to consider mitigating circumstances justifying a reduction in the degree of discipline imposed. The final argument offered is that the permanent revocation of the doctor's license is too harsh a sanction for what

transpired.

Appellant contends that the testimony of Dr. Clark, offered as the Board's expert witness, was improperly allowed. The record reflects that Dr. Clark serves as the medical director for NorthEast Ohio Neighborhood Health Services, Inc. He supervises all of the physicians and staff and spends approximately 20% of his practice in clinical treatment of patients. Appellant cites Evidence Rule 601(D) which requires that to be qualified as an expert in a medical malpractice action, the physician must devote at least one half of his or her time to active clinical practice. As the Board points out, the evidence rules are not binding upon hearings before the Board.⁴ Even if the rules of evidence did apply, the court would find that Dr. Clark's expertise was sufficient for the Board's consideration. It must also be noted that the majority of Board members are themselves physicians. A review of the record shows that Dr. Clark's testimony was probative and persuasive and the court finds no error in accepting his testimony in determining whether appellant violated the regulatory provisions as cited in the notice of opportunity.

Appellant argues that the doctrine of laches should apply. It is evident that the Board delved back as far as 1988 in scrutinizing appellant's practice.

⁴ *Urban v. State Med. Bd.*, 2004 Ohio 104, 2004 Ohio App. LEXIS 99 (Ohio Ct. App., Franklin County Jan. 13, 2004); Motion Denied by *Urban v. State Med. Bd.*, 102 Ohio St. 3d 1408, 2004 Ohio 1763, 806 N.E.2d 561, 2004 Ohio LEXIS 765 (2004); appeal Denied by *Urban v. State Med. Bd.*, 102 Ohio St. 3d 1461, 2004 Ohio 2569, 809 N.E.2d 33, 2004 Ohio LEXIS 1271 (2004)

Were there not more recent examples supporting the claimed violations then the doctrine might apply. However the record reflects the course of treatment for patient 1 from 1994 to 2002. Similarly, while one instance of treatment of patient 2 is reflected from 1988, the second significant issue of treatment regimen is from 1999. A review of the records for treatment of the other nine patients and issues arising there from indicates that the more recent events for those patients were occurring in 2001 and 2002. The circumstances are not descriptive of the Board's review of only ancient instances of treatment.

As noted by the Board there is no statute of limitations restricting the Boards authority to review past treatment. The Court will also note that utilization of the doctrine of laches normally falls within the equitable powers of record and review of this matter is not under the Court's equitable powers but rather is proscribed by statute. Appellant's assignment of error in this regard is not well taken.

Appellant's third assignment of error was that Assistant Attorney General Wilcox made statements to the Board relying upon facts which were not in evidence. Arguments before the Board are simply that, arguments. The Board had the report of its Hearing Examiner, the statement offered by Dr. Reed. The interaction between Board members evidences that the Board did not simply take attorney Wilcox's statements and incorporate them into its decision. This alleged error is not persuasive.

Appellant's fourth contention of error is that the Board denied her due process. More specifically, Appellant offers that the Board unfairly disciplined her for the absence of detailed notations as to patient histories and a lack of physical examinations and diagnostic findings. Appellant does not deny that her record-keeping was based upon patient cards measuring 3 x 5 inches. Appellant stated that she didn't realize in her record keeping that the records would be of any interest to anybody else, such that she wrote as little as possible. Setting aside the issues with prescription of antibiotic, combinations of tranquilizers and sedatives, and scheduled drugs, the other major issue was the lack of adequate record-keeping. While Appellant complains that it was unfair to have her recount patient history, it is exactly the lack of detailed records which created her inability to verify diagnosis, observations, and treatment regimens. The record reflects that Appellant was able to recall significant amounts of information about her patients. Nonetheless, her mental recollection of treatments and bases for does not obviate the need for adequate records. The court must find that the record supports the Boards conclusions on the issue of record-keeping.

Appellant also offers that the Board failed to follow disciplinary guidelines in mitigation of a sanction levied on appellant. Appellant has offered nine separate considerations that the Board should have considered. There is sufficient case law negating appellant's position in this regard. Case law

holds that the Board *may* consider aggravating and mitigating circumstances in deciding what penalty to impose, but it is not required to do so.⁵

The absence of prior discipline, the absence of dishonest or selfish motive, the fact that incidents were isolated and unlikely to recur, full and free disclosure to the Board, remorse, remoteness of conduct, absence willful or reckless misconduct, and interim rehabilitation or remedial measures are clearly factors that the Board may consider in fashioning the sanction to be imposed. Interpretation of review under Chapter 119 has led to a restriction on the court's ability to reweigh the Board's penalty even in light of such factors.

Consideration of appellant's last contention of error can be resolved by reference to a single case, that being *Henry's Cafe, Inc. v. Board of Liquor Control* (1959), 170 Ohio St. 233; 163 N.E.2d 678. The court will premise this last analysis of appellant's assignments of error by echoing the refrain of numerous courts in the recent years. Were it within the authority of this court to modify the Medical Board's penalty, it would do so. It appears that appellant has been an active practitioner since her licensing in 1949. Much of the record reflects a caring physician who opted to help some of her elderly patients live without regard to some of the restrictions that might be more appropriate for younger individuals. The evidence that the Board presented while cumulatively damning does not bear any indication of specific harm to

⁵ *Urban v. State Med. Board, id.*

any patient. Appellant's contention that the Board failed to consider mitigating circumstances is correct. Despite such failure, this contention is not a legally reversible ground. That does not make the ultimate sanction of revocation more palatable. It is un rebutted that Dr. Reed has not been previously disciplined, her failure to maintain proper records or to prescribe medications was not motivated by personal gain or ill will, or had an adverse impact on her patients. The Board has substantial latitude as to the requirement of further training or continuing education but chose in this instance not to implement any alternative remedial measures. Appellant is also correct as to her contention that the 11 instances relied upon for a determination of violations by the Board cover a period from 1988 through 2002. While the actual number of patients that the doctor has treated over that period is not a matter of record, it does appear probable that the doctor has treated thousands of patients over that period of time. Regardless of the belief that the Board had lesser stringent options that it could have used to help remedy Appellant's shortcomings, it is clear that the Board had reliable substantial and probative evidence to support its finding as to the 11 patients in question. The Court is left with no alternative but to affirm the decision of the Board. Counsel shall prepare a Judgment Entry pursuant to Local Rule 25.01.



Judge Michael Holbrook

Appearances:

**James M. McGovern
556 East Town Street
Columbus, OH 43215
Attorney for Appellant**

**Kyle C. Wilcox
Assistant Attorney General
30 East Broad Street, 26th Floor
Columbus, OH 43215-3400
Attorney for Appellee**

STATE MEDICAL BOARD OF OHIO

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

2004 JUL 16 A 9 14

BARBARA A. REED, M.D.

Appellant,

Vs.

STATE MEDICAL BOARD OF OHIO

Appellee.

CASE NO. 04CVF-07-7265

JUDGE D. O'Neill

2004 JUL 15 AM 11:30
CLERK OF COURTS

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO

ORDER GRANTING APPELLANT, BARBARA A. REED, M.D.'S, MOTION FOR SUSPENSION OF AGENCY ORDER

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the June 9, 2004 Order of the State Medical Board of Ohio (mailed July 2, 2004) which permanently revokes Appellant, Barbara A. Reed, M.D.'s, license to practice medicine and surgery in Ohio effective July 16, 2004. Dr. Reed's appeal to this Court was filed July 13, 2004. Dr. Reed's Motion for Suspension of Agency Order was filed July 14, 2004. For the reasons stated in Dr. Reed's Motion and for other good cause shown, it is hereby

ORDERED, ADJUDGED AND DECREED that the State Medical Board of Ohio Order issued June 9, 2004 and mailed July 2, 2004 is suspended until the filing of a final decision or order by this Court in the appeal, conditioned upon Dr. Reed: 1) closing her medical office located at 177 Park Avenue West, Mansfield, Ohio and not evaluating or treating any patients; and 2) limiting her practice of medicine to what is necessary to fulfill her duties as Deputy Coroner of Richland County, Ohio.

IT IS SO ORDERED.

Date

JUDGE O'NEILL

IN THE COURT OF COMMON PLEAS STATE MEDICAL BOARD
FRANKLIN COUNTY, OHIO OF OHIO
CIVIL DIVISION 2004 JUL 13 P 1:52

BARBARA A. REED, M.D.
177 Park Ave. W
Mansfield, OH 44902

Appellant,

Vs.

STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Flr.
Columbus, OH 43266-0306

Appellee.

CASE NO.

JUDGE

04CVF07 7265

NOTICE OF APPEAL

Barbara A. Reed, MD, through her undersigned counsel, hereby gives Notice of her appeal of the attached adjudication Order of the State Medical Board of Ohio, which was mailed on July 2, 2004. The Board's Order is not supported by reliable, probative and substantial evidence and is not in accordance with law. In accordance with R.C. 119.12, the original of this Notice is being filed with the State Medical Board of Ohio and a copy is being filed with the Franklin County Court of Common Pleas.

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
2004 JUL 13 PM 2:44
CLERK OF COURTS - CV

RESPECTFULLY SUBMITTED OHIO STATE MEDICAL BOARD

JUL 19 2004

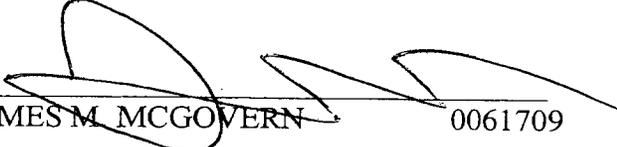

JAMES M. MCGOVERN 0061709
HAMMOND, SEWARDS & WILLIAMS
556 E. Town St.
Columbus, OH 43215
(614) 228-6061/(614) 228-5883 fax
Counsel for Barbara A. Reed, MD

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a true and accurate copy of the foregoing was served upon the following:

Kyle Wilcox
Assistant Attorney General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, OH 43215

by regular US Mail, postage prepaid, this 13th day of July, 2004.



JAMES M. MCGOVERN

0061709

OHIO STATE MEDICAL BOARD

JUL 19 2004



State Medical Board of Ohio

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

June 9, 2004

Barbara A. Reed, M.D.
177 Park Avenue West
Mansfield, OH 44902

Dear Doctor Reed:

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 June 9, 2004, 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 a Notice of Appeal with the State Medical Board of Ohio and 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

Lance A. Talmage, M.D.
Lance A. Talmage, M.D.
Secretary *TAD*

LAT:jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5150 2341
RETURN RECEIPT REQUESTED

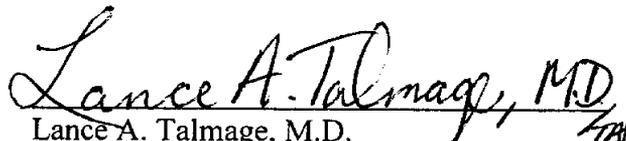
Cc: James M. McGovern, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5150 2983
RETURN RECEIPT REQUESTED

Mailed 7/2/04

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 June 9, 2004, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and Barbara A. Reed, M.D., 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)

June 9, 2004

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

BARBARA. A. REED, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on June 9, 2004.

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 Barbara A. Reed, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED effective two weeks from the date of mailing of the Order, absent the Board's receipt of Dr. Reed's permanent surrender within two weeks of June 9, 2004.

(SEAL)


Lance A. Talmage, M.D.
Secretary

June 9, 2004

Date

2004 MAY 14 A 9 53

**REPORT AND RECOMMENDATION
IN THE MATTER OF BARBARA A. REED, M.D.**

The Matter of Barbara A. Reed, M.D., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on February 17 and 18, 2004.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated September 10, 2003, the State Medical Board of Ohio [Board] notified Barbara A. Reed, M.D., that it had proposed to take disciplinary action against her certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations concerning Dr. Reed's care and treatment of eleven specified patients.

The Board asserted that the alleged conduct of Dr. Reed that occurred before March 9, 1999, constitutes "[f]ailure to use reasonable care discrimination in the 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, as in effect before March 9, 1999."

The Board further asserted that the alleged conduct of Dr. Reed that occurred on or after March 9, 1999, constitutes "[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."

In addition, the Board asserted that the alleged conduct of Dr. Reed 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."

Furthermore, the Board asserted that the alleged conduct of Dr. Reed 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: 4731-11-02(D), Ohio Administrative Code, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code."

Accordingly, the Board advised Dr. Reed of her right to request a hearing in this matter. (State's Exhibit 1A)

- B. By document received by the Board on September 29, 2003, Dr. Reed requested a hearing. (State's Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Kyle C. Wilcox, Assistant Attorney General.
- B. On behalf of the Respondent: Dr. Reed, having previously been advised of her right to be represented by counsel, appeared on her own behalf.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Barbara A. Reed, M.D., as upon cross-examination
 - 2. Walter J. Clark, Jr., M.D.
- B. Presented by the Respondent
Barbara A. Reed, M.D.

II. Exhibits Examined

- A. Presented by the State
 - 1. State's Exhibits 1A through 11: Procedural exhibits.
 - 2. State's Exhibit 2: Copy of a September 16, 2003, report of Walter J. Clark, Jr., M.D.
 - 3. State's Exhibit 3: Dr. Clark's curriculum vitae
 - * 4. State's Exhibit 4: Patient Key.
 - * 5. State's Exhibits 5 through 15: Copies of Dr. Reed's medical records for Patients 1 through 11, respectively.

B. Presented by the Respondent

1. Respondent's Exhibit A: Copy of a signature list from MedCentral Health System, Mansfield, Ohio.
2. Respondent's Exhibit B: Copy of Dr. Reed's wallet card identifying her as an Assistant Coroner with the Richland County Coroner's Office.
3. Respondent's Exhibit C: Campaign flyer supporting the re-election of Stephen Banko, M.D., as Richland County Coroner.

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

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

1. Barbara A. Reed, M.D., testified that she had obtained her medical degree in 1949 from The Ohio State University College of Medicine. Dr. Reed completed an internship at Buffalo General Hospital in Buffalo, New York; two years of residency in internal medicine at Indianapolis General Hospital; and an additional year of residency at City Hospital in Cleveland, Ohio. Dr. Reed stated that she is not board certified in internal medicine. She explained, "I couldn't get any of the men to sign up at that time for me to get my boards, although I was board eligible at the time. There was so much prejudice against the ladies that I could not get any of them to sign at that time." (Hearing Transcript Volume I [Tr. Vol. I] at 15-17)

Dr. Reed testified that she has practiced internal medicine in Mansfield, Ohio, for many years. Dr. Reed testified that, briefly, she had practiced in partnership with her husband, who was also a physician. In discussing her husband, the following exchange occurred:

Q. (By Mr. Wilcox): Okay. Was he from the Mansfield area?

A. (By Dr. Reed): No, he was from Turkey; Istanbul.

Q. Okay.

A. And they still tap my telephone, the one that's listed in his name. I see all kinds of funny things.

Q. Who is 'they?' You say somebody taps your telephone?

A. Yeah, I think so.

Q. The police, you mean?

A. I think, what is it, CIA, or some of these people that are interested in foreign affairs. Anyway, his phone always has little funny things on it every once in a while. It doesn't sound right to me.

(Tr. Vol. I at 20-22) Dr. Reed noted that her husband is now deceased. She stated, "It's a tough business; some of the boys don't hold up as well." (Tr. Vol. I at 21)

Dr. Reed testified that she is currently licensed to practice medicine in Ohio, and in no other state. (Tr. Vol. I at 16)

2. Walter J. Clark, Jr., M.D., testified as an expert witness on behalf of the State. Dr. Clark testified that he had obtained his medical degree in 1978 from Howard University Medical School in Washington, D.C. Following graduation, Dr. Clark entered a flexible internship at Mt. Sinai Hospital in Cleveland, Ohio. After completing his internship in 1979, Dr. Clark began service as a public health officer in Mobile, Alabama, where he worked as a solo general practitioner to fulfill a scholarship commitment to the National Health Service Corps. Dr. Clark served in that capacity until 1982, at which time he entered a residency in internal medicine at the University of South Alabama. Dr. Clark spent two years in that residency program. In 1984, he returned to his previous practice in Mobile which, by that time, had expanded to include multiple providers. Dr. Clark testified that, in 1987, after learning that he needed six more months of residency training to qualify for certification by the American Board of Internal Medicine, he returned to the University of South Alabama to complete the necessary training. Dr. Clark testified that he was board certified in internal medicine in 1988. (State's Exhibit [St. Ex.] 3; Hearing Transcript Volume II [Tr. Vol. II] at 6-8)

Dr. Clark testified that he has been licensed to practice medicine in Ohio since 1988, and in Alabama since 1979. (St. Ex. 3; Tr. Vol. II at 8)

Dr. Clark testified that he is currently the Medical Director for Northeast Ohio Neighborhood Health Services, Inc. [NONHS] Dr. Clark further testified that NONHS is a network of community health centers. Dr. Clark's duties include overseeing the services of all physicians, mid-level practitioners, and nursing staff at NONHS. Dr. Clark testified that the physicians' practices include pediatrics, family medicine, obstetrics/gynecology,

dermatology, and internal medicine. Finally, Dr. Clark testified that his practice is currently about twenty percent clinical. (St. Ex. 3; Tr. Vol. II at 9-10)

Dr. Clark further testified that he holds privileges at the University Hospitals of Cleveland, and at Huron Hospital Cleveland Clinic Health System. (Tr. Vol. II at 12)

3. Dr. Clark testified that, in preparation for his testimony, he had reviewed a series of medical records sent to him by the Board that represented care rendered by Dr. Reed to eleven patients. Dr. Clark further testified that he had also reviewed applicable statutes and administrative rules. (Tr. Vol. II at 14-15)

Dr. Clark further testified that he is familiar with the statutes and rules governing the prescribing of controlled substances in Ohio, and that he has had occasion to utilize such medications in his practice. (Tr. Vol. II at 12-13)

4. Dr. Clark testified that he had limited his review of Dr. Reed's medical records to events occurring in 1988 and thereafter. Dr. Clark testified that he had chosen that date because that had been the year that he became licensed to practice medicine in Ohio. Dr. Clark testified that he had not felt comfortable opining on the practice of medicine in Ohio prior to that year. Accordingly, even though some of Dr. Reed's medical records go further back in time than 1988, those earlier records are not relevant to Dr. Clark's opinion in this matter. (Tr. Vol. II at 162-163)

General Information Concerning Dr. Reed's Medical Records

5. Dr. Reed testified that she keeps her patient records on 3" by 5" cards, except for x-rays and laboratory reports, which are stored separately from her patient record cards. Dr. Reed testified that "the floors would be falling out of [her] office" if she kept all of her patient records on letter-size paper. With regard to x-ray and laboratory results, Dr. Reed testified that she records pertinent information, such as positive lab results, on the 3" by 5" cards. However, she does not typically record negative lab results on the cards. (Tr. Vol. I at 24-26)
6. When asked if her medical records adequately reflected her examination of her patients, and the utilization of controlled substances in the treatment of those patients, Dr. Reed replied,

Well, some of these were done 15, 10, 20 years ago, and things are changing. So we—Yeah, I agree I did not write very much on the records because I didn't have the space, and I didn't realize that it would be of any interest to anybody else, so I wrote as little as possible.

But when you go over it with a fine tooth comb and ask for all these little details—I see that I could have added a whole lot more to the record down through the years, which I did not. But I used to be busy; now we're not busy. Now we don't do anything * * * but talk.

(Tr. Vol. I at 156-157)

7. When asked if another physician who took over Dr. Reed's patients would be able to follow her record keeping, Dr. Reed replied that she had recorded diagnoses and had been clear which medications had been prescribed. Dr. Reed further testified that her handwriting is legible. (Tr. Vol. I at 157-158)
8. A scanned copy of the front and back of one of Dr. Reed's 3" by 5" cards follows. Note that patient identifying information has been redacted.

not allergic
 smile B.D. 5-18-54

Aug 11-98. 134 lbs. Cold Sore throat $\frac{150}{30}$
 Nervous (Mother) Rx Amoxicillin 500 qd
 Rx Polibutin A C TV 3^{40x1} Rx Provera 2.5mg qd for 3 wks
 Rx Provera 2.5mg qd for 2 wks each month 30
 Rx Meprobamate 400mg QID for acute pharyngitis
 Sept 5, 98 133 Bee sting on R. arm's $\frac{130}{30}$ Celestone loc (H)
 6mg Olan 4mg #24 30
 Bee sting

Oct. 10-98. Nervous. Rx Meprobamate 400mg QID #50x2 30
 Dec 5, 98 Flu $\frac{132}{84}$ Sore throat Ear ache Libri Tylen
 High cholesterol (290?) Rx Keflex 250mg QID 30x2
 Polibutin A C TV 3^{40x1} Rx Meprobamate 400mg QID 30
 Dec 19, 98 Terri Still has a sore throat
 and drainage from the sinuses Libri 24 30
 Cholesterol 233 Z Pak (letab) B12
 Rx Tussi Organidin TV 3^{40x1} Rx acute pharyngitis
 Feb 6, 99 133 $\frac{1}{2}$ Earache Sinus. Nose bleed
 Headache Nervous. $\frac{150}{30}$ Very constipated.
 Ears look OK mother had open heart surgery last
 week at Riverside. Had 5 by passen, Sides Dr Behi.
 Rx Keflex 250mg QID #30x2 Provera 2.5mg qd for 2 weeks
 Provera 1.25mg qd for 3 wks #60x2 Rx PBZ 50mg 30x4 35
 Meprobamate 400mg QID #50x2
 Hyperlipidemia Otitis media

(St. Ex. 5 at 3 [top of page] and 4 [top of page])

9. Dr. Clark testified that the standard for medical documentation at this time, and for at least the preceding fifteen years, has been the SOAP format. Dr. Clark explained that SOAP is an acronym that stands for subjective, objective, assessment, and plan. Medical records kept in this format will include subjective commentary, objective findings, an assessment, and a plan. (Tr. Vol. II at 18)

Dr. Clark testified that Dr. Reed's method of keeping medical records departed from the standard of medical documentation. Dr. Clark further noted that it represented an outdated method of keeping medical records. However, Dr. Clark indicated that a SOAP note documented on a 3" by 5" card would still be acceptable. (Tr. Vol. II at 18-19, 162-163)

10. Dr. Reed testified that she is unfamiliar with the SOAP format of medical recordkeeping. (Tr. Vol. I at 26)

Patient 1

11. Patient 1 is a female born May 18, 1954. (St. Ex. 5 at 1 [top])

Dr. Reed's Prescribing of Antibiotics to Patient 1

12. Dr. Reed prescribed antibiotics to Patient 1 on the following occasions:

Date	Medication	Relevant Findings and/or Diagnosis
09/02/94	amoxicillin 500 mg #30, 2 refills, QID	ear infection
01/14/95	amoxicillin 250 mg #30, 2 refills	sore throat, slight inflammation, slight cough, acute pharyngitis
07/05/95	amoxicillin 500 mg #30, 2 refills, QID	sore throat, acute pharyngitis
02/21/96 ¹	amoxicillin 500 mg #30, 2 refills	sore throat, cough, phlegm
04/05/96	Doxycycline 100 mg #15, 2 refills, BID	cold & fever (no temperature recorded), "Roof of mouth is sore * * * Has been taking amoxicillin but it does not seem to help this time. Pharynx is not infected. * * * Ears are inflamed," otitis media
04/05/97	Keflex 250 mg #30, 2 refills, QID	sore throat, earache
05/16/97	Doxycycline 100 mg #15, 2 refills, BID	sore throat, cough, "throat & ears are not inflamed"

¹ The medical record states February 21, 1995; however, it follows a note dated July 5, 1995. From the context, it appears that the correct date is February 21, 1996. (St. Ex. 5 at 2 [top])

01/31/98	amoxicillin 500 mg #30, 2 refills, QID	sore throat, "No remarkable pharyngitis. Right maxillary gets numb. May be sinus"
08/11/98	amoxicillin 500 mg #30, 2 refills, QID	cold, sore throat, acute pharyngitis
12/05/98	Keflex 250 mg #30, 2 refills, QID	flu, sore throat, earache
12/19/98	Z-Pak	sore throat, sinus drainage
02/06/99	Keflex 250 mg #30, 2 refills, QID	earache, sinus, "ears look okay"
03/08/99	Cipro 500 mg #10, 3 refills, BID	sore throat x 3 weeks, "coughing some"
05/08/99	Keflex 250 mg #30, 2 refills, QID	sore throat, earache, coughing, "ear is inflamed," acute bronchitis, otitis media
07/26/99	Keflex 250 mg #30, 1 refill, QID	cold, sinus, sore throat, hurts all over
10/16/99	Keflex 250 mg #30, 2 refills, QID	flu x 3 weeks, coughing, chest pain, "some bulging of the eardrums but no inflammation"
12/31/99	Keflex 250 mg #30, 2 refills, QID	earache, sore throat, "Ears ok," acute sinusitis
02/18/00	amoxicillin 500 mg QID	"Wants a different antibiotic from Keflex"
03/11/00	amoxicillin 500 mg #30, 2 refills, QID	sore throat, cold, sinus drainage, "No pharyngeal inflammation," acute sinusitis
08/14/00	Keflex 250 mg #30, 2 refills, QID	sore throat & cold for three days, "Very inflamed throat"
11/07/00	Keflex 250 mg #30, 2 refills, QID	cold, nauseated, sore throat, "coughing some," strep throat
12/19/00	amoxicillin 500 mg #30, 1 refill, QID	sore throat, coughing, sinus drainage
02/12/01	Cipro 500 mg #14, 2 refills, BID	headache, sinus trouble, drainage, acute sinusitis
04/07/01	Keflex 250 mg #30, 2 refills, QID	coughing
05/17/01	Z-Pak 250 mg, 1 refill	sinus, sore throat, chest hurts, eyeballs hurt, chills
09/27/01	Z-Pak 250 mg, 1 refill	sore throat, "very inflamed pharynx," acute bronchitis
12/28/01	Keflex 250 mg #30, 2 refills, QID	cold
02/08/02	Z-Pak 250 mg, 1 refill	sore throat, earache
02/18/02	Cipro 500 mg #10, 1 refill, BID	unresolved pain in neck and head

(St. Ex. 5 at 1-8) Note that no body temperature was documented by Dr. Reed during any of these visits. Further note that, with regard to episodes that concerned complaints of sore throat or diagnoses of acute pharyngitis, there was no documentation concerning the presence or absence of lymphadenopathy or pharyngeal exudate. (St. Ex. 5 at 1-8)

13. Patient 1 visited Dr. Reed's office on January 14, 1995. Dr. Reed's medical record for that visit states, "122 lbs. Sore throat, Tired, Slight inflammation, Slight cough." Dr. Reed noted "Acute pharyngitis," and prescribed "30 x 2" Amoxicillin 250 mg. No dosing frequency was documented. Dr. Reed testified that the notation "30 x 2" meant that the patient could receive 30 pills with "the option of getting two refills if she needed them." (St. Ex. 5 at 1 [top]; Tr. Vol. I at 32)
14. Dr. Reed testified that she commonly prescribes antibiotics to her patients who present with a sore throat and inflammation. When Dr. Reed was asked if she conducts throat cultures on such patients, she replied, "We used to. We sent them over to the hospital, and it was totally worthless. They always sent back, 'No pathogens demonstrated,' and it was worthless, totally worthless, so we quit doing that." Furthermore, Dr. Reed testified:

We have been having trouble with the hospital ever since they—it's been worse, of course, since they closed—See, we had two hospitals in Mansfield, and when one hospital was not satisfactory, we would send them over to the other hospital, and they either confirm it or get another reading, and it was very, very handy. It worked great; just great. And then, of course, this insurance thing came out and they closed, of course, as you know, half the hospitals in the country, and we were unfortunate enough to lose our one—our other hospital, so we have only one hospital left. And so those of us who sent most of our work to the other hospital were kind of left high and dry without any hospital affiliation.

* * *

So it's very, very difficult for us to get any accurate or—readings from the hospital at the present time.

* * *

So we don't do it because it's just—it's just money in the bank for them, and it's of no benefit to us.

(Tr. Vol. I at 29-31) Accordingly, Dr. Reed testified that she diagnoses acute pharyngitis "[b]y observation. I mean, you can tell right away, strep—frequently streptococcus, you can see a certain inflammation, exudate a lot of times. There may be a yellowish exudate on the tonsils. You do this by examination. That's what we were taught, by looking." Finally, Dr. Reed acknowledged that she does not document these observations "too thoroughly," although she notes on the record that there was inflammation. Dr. Reed added, "I'm sure my records are very minimal compared to what you would like to have." (Tr. Vol. I at 31-32)

15. Dr. Clark testified that acute pharyngitis is a condition of the throat whereby the pharynx is inflamed. Dr. Clark noted that acute pharyngitis can be either bacterial or viral. Dr. Clark further testified that acute pharyngitis is an assessment the physician can make from looking at the throat, and observing a reddened pharynx. Dr. Clark testified, "if it's red, if you see exudate, then you can make the diagnosis pretty reliably of at least acute pharyngitis." However, Dr. Clark added that if the physician then decides to treat the condition with antibiotics, the physician is in essence determining that the condition is bacterial in nature, "because there is currently no treatment for viral acute pharyngitis, which is a very common cause of acute pharyngitis." (Tr. Vol. II at 19-20)

Dr. Clark testified that, to diagnose bacterial acute pharyngitis, first there should be pus or exudate in the tonsil area, which raises the suspicion that it is bacterial in origin. Then the physician must do either a throat culture or a Quickstrep test. (Tr. Vol. II at 20-21)

Dr. Clark testified that throat culture is a time-tested and inexpensive way of making a determination concerning bacterial infections of the throat. Dr. Clark testified that it takes about three days to complete and can be done entirely in a physician's office. Dr. Clark testified that, if a bacterial infection is suspected, a physician can start a throat culture, and can also initiate antibiotic therapy presumptively. Dr. Clark testified that if the throat culture is positive for bacterial growth, the patient can remain on antibiotics. Alternatively, if the throat culture fails to yield bacterial growth, the physician needs to contact the patient and inform the patient to discontinue the antibiotics that were presumptively initiated. (Tr. Vol. II at 21-23)

Dr. Clark testified that "Quickstrep" is a trade name for an antigen test for streptococcal infections of the throat that has been available at least since 1989 or 1990. If the test is positive, the physician knows there is a strep infection. However, a negative result does not rule out infection. Dr. Clark testified that physician still must do a throat culture if the Quickstrep test is negative. (Tr. Vol. II at 20-21, 165-166)

Accordingly, Dr. Clark concluded that it would have been appropriate to start Patient 1 on amoxicillin based on findings of fever and exudate on the throat. Dr. Clark stated, "It's called presumptive therapy. It's guilty until proven innocent. It's okay if there's enough signs and symptoms that point to a likely bacterial problem." However, Dr. Clark testified that such signs and symptoms had not been documented in Dr. Reed's medical record for Patient 1 for the January 14, 1995, visit. (St. Ex. 5 at 1 [top]; Tr. Vol. II at 23-24)

Moreover, Dr. Clark testified that the symptoms that are noted, namely "Sore throat, * * * slight inflammation, slight cough," should lead a physician to suspect a viral source of infection, rather than bacterial. Finally, Dr. Clark testified that it had been inappropriate to presumptively treat Patient 1 with antibiotics based on the information documented. (St. Ex. 5 at 1 [top]; Tr. Vol. II at 24)

16. Patient 1 saw Dr. Reed on July 5, 1995. Dr. Reed noted that Patient 1 weighed 124 pounds, and her blood pressure was 106/75. Dr. Reed further noted that Patient 1 had a sore throat, and was tired. On that date, Dr. Reed prescribed, among other things, amoxicillin 500 mg #30 with two refills, to be taken four times daily. (St. Ex. 5 at 2 [top])
17. Dr. Reed testified that she had prescribed amoxicillin for Patient 1's sore throat, and had prescribed two refills in case Patient 1 needed them, "[o]r she could give them to her husband if she felt like it, which a lot of these people do, give them to somebody else in the family. It happens over and over again, as you know." Moreover, Dr. Reed testified that she had prescribed the 500 mg dose rather than 250 mg because the patient had wanted that dose, and had told Dr. Reed that she could get the 500 mg for the same price as the 250 mg. Furthermore, Dr. Reed testified that she had prescribed that Patient 1 take them four times per day,

because nobody ever follows the doctor's directions. And these drug companies have discovered that when you write for four times a day, you're lucky to have the patient take it three times a day * * *.

And this has been written up in the journals. I'm sure you have read this lately. There's been quite a bit of controversy about it.

(Tr. Vol. I at 32-33)

When asked if she knew what the standard dosage for amoxicillin is, Dr. Reed replied that, back in the 1950s and 1960s:

when we first started practicing here, the Health Department came over and gave lecture after lecture after lecture telling us to prescribe more, more, more Penicillin, that we weren't using nearly enough at that time.

We were having a tremendous influx of black people from Alabama coming up to work in our mills, and 95 percent of them had a positive serology test for syphilis, so we were giving them enormous doses of penicillin at that time.

* * *

So the dosage of penicillin went up and up and up, and the Health Department was bugging us all the time to give more, a higher dosage. And apparently we did a good job and eradicated it, because now they don't even take a serology when a person is admitted to the hospital.

(Tr. Vol. I at 34-35) Dr. Reed acknowledged that the newer editions of the Physicians' Desk Reference [PDR] recommend that amoxicillin be prescribed for ten days of therapy,

and be taken three times per day. Dr. Reed stated, however, that the older editions of the PDR had not said that. (Tr. Vol. I at 35)

18. Dr. Clark testified that amoxicillin is a synthetic penicillin, and was an upgrade over an earlier medication called ampicillin. Dr. Clark testified that ampicillin was to be taken four times per day; however, when amoxicillin became available, “it was touted as being a superior drug because now you can just give it three times a day as opposed to four times a day.” Dr. Clark further testified that Dr. Reed’s instruction that the patient take amoxicillin four times per day had not been appropriate. (St. Ex. 5 at 2 [top]; Tr. Vol. II at 24-26)

Dr. Clark further testified that providing a quantity of thirty pills with two refills is an excessive amount. Dr. Clark testified that a regimen of amoxicillin is normally prescribed for ten days; ninety tablets at the appropriate dosage level of three pills per day would yield a thirty-day course of therapy. (Tr. Vol. II at 26-27)

19. Patient 1 saw Dr. Reed on March 8, 1999. Dr. Reed noted in her medical record for that visit, “134 lbs. Sore throat for 3 weeks. Coughing some.” Dr. Reed prescribed, among other things, Cipro 500 mg #10 with three refills, to be taken twice daily. (St. Ex. 5 at 5 [bottom])
20. Dr. Reed testified that she had prescribed Cipro for Patient 1’s sore throat and for otitis media, noting that Patient 1 had also had a “very severe ear infection.” Dr. Reed directed attention to the bottom of that card, where it stated “Otitis media” and, noting that it would be “very confusing” to others, stated that she had put the diagnosis for that visit at the bottom of the card, below a notation for another office visit on May 8, 1999. [Note, however, that one of Patient 1’s presenting complaints on May 8 had been “Ear ache in L ear.”] (St. Ex. 5 at 5 [bottom]; Tr. Vol. I at 36-37)
21. Dr. Clark testified that Cipro is an advanced antibiotic that physicians rely upon to treat infections that could otherwise require hospitalization, “[b]ut in this instance, the Cipro apparently was utilized for a sore throat.” (St. Ex. 5 at 5 [bottom]; Tr. Vol. II at 27-28) Dr. Clark further testified that Cipro may be used to treat staph infections of the skin, or infections of the kidney, with a course of therapy lasting two weeks. Dr. Clark found it difficult to comment on an appropriate length of therapy as utilized in this instance by Dr. Reed, because “[i]t’s not utilized in the setting of treating sore throats.” (Tr. Vol. II at 29-30) Finally, Dr. Clark testified that, ironically, even though Cipro is a very strong antibiotic for treating certain types of infections, it is not as strong as penicillin for treating strep bacterial acute pharyngitis, nor is it indicated for treating ear infections. (Tr. Vol. II at 30)
22. Dr. Reed testified that she was not aware that Cipro is usually reserved for maladies such as serious staph infections, and stated that the PDR states that it is indicated “primarily for cystitis and pharyngeal infections.” Dr. Reed added that it is very expensive; therefore, she does not use it as a first choice drug. (Tr. Vol. I at 37)

23. Patient 1 saw Dr. Reed on August 14, 2000. Dr. Reed noted, "135 lbs. Sore throat & cold for 3 days. Wants to go to Branson, Mo. Cholesterol 173 Triglycerides 128. Liver profile is normal. Very inflamed throat. 120/40. [illegible] mitral systolic [murmur?]. Has poison ivy on arms." Dr. Reed prescribed, among other things, Keflex 250 mg #30 with two refills, to be taken four times per day. (St. Ex. 5 at 6 [top])
24. Dr. Reed testified that she had prescribed Keflex to Patient 1 at that visit because Patient 1 had had a very inflamed throat, acute pharyngitis. Dr. Reed noted that, at the bottom of the card, below her notes for two later visits, the diagnosis states, "Strep throat." Dr. Reed further testified that she had diagnosed strep throat based on observation only, and reiterated her earlier assertion that "the throat cultures are totally worthless in [her] community." (St. Ex. 5 at 6 [top]; Tr. Vol. I at 37-38)
25. Dr. Clark stated that Keflex is a synthetic drug in the penicillin family, but it is utilized for treating "gram-positive germs" such as staph, and to some extent strep. However, Dr. Clark testified that it would not be within the standard of care to prescribe it for a sore throat. (St. Ex. 5 at 6 [top]; Tr. Vol. II at 30-31)
26. Dr. Clark testified that his opinion, which he believes he shares with a lot of physicians, is that powerful antibiotics such as Keflex and Cipro have their uses, and those uses are very important, but their usefulness will decline if they are overutilized. Dr. Clark further testified that the more germs are exposed to these antibiotics, the faster they will become resistant to them. Those germs could then spread into the community and cause illnesses that cannot be treated with conventional medicine. The result would be that people who have bacterial pharyngitis that is easily treatable now would have to be hospitalized and given intravenous therapy. Moreover, Dr. Clark testified that "the cost of treating individuals with infections skyrockets as we lose the potency of these drugs." (Tr. Vol. II at 32-33)
27. Dr. Reed testified that she has used Keflex frequently, and disagreed that it is a powerful antibiotic that should be reserved for more serious infections. Subsequently, the following exchange occurred:
 - Q. (By Mr. Wilcox): Have you ever heard of the concept of if strong antibiotics are over prescribed, or prescribed frequently in a population * * *, that bacterias will be able to, I guess, build up an immunity to them at a quicker pace? Are you familiar with that concept?
 - A. (By Dr. Reed): Well, I suppose it sounds logical. I mean, it's reasonable.
 - Q. And have you ever heard about that as far as cautions in prescribing these types of medications?

- A. Well, usually we don't prescribe them until we have used everything else first. Then if you have a problem, why you have to go to something else.
- Q. Okay.
- A. And then you have sensitivities and allergies, and sometimes people are allergic to everything.

(Tr. Vol. I at 39)

Dr. Reed's Prescribing of Meprobamate to Patient 1

28. Dr. Reed prescribed to Patient 1 Meprobamate 400 mg #50 with two refills, to be taken four times per day, on the following dates: April 5, 1996; April 5 and December 1, 1997; January 31, June 1, August 11, October 10, and December 5, 1998; and February 6, 1999. Dr. Reed issued the same prescription, but with three refills, to Patient 1 on May 8, July 26, and October 16, 1999; September 1 and November 7, 2000; and February 12 and September 27, 2001. On February 8, 2002, Dr. Reed prescribed to Patient 1 Meprobamate 400 mg #50 with four refills, to be taken three or four times per day. No indications were given for these prescriptions other than occasional notations that the patient was either "nervous" or "very nervous." (St. Ex. 5 at 1-8)
29. Dr. Reed testified that meprobamate is a Schedule IV controlled substance. (Tr. Vol. I at 45)

Dr. Reed testified that she had prescribed meprobamate to Patient 1 for anxiety, nervousness, and nervous tension. When asked if she had ever diagnosed or documented a nervous disorder for Patient 1, Dr. Reed testified, "Well, when people are nervous, they are nervous. They tell you they can't sleep, they stay awake all night, the kids are getting on their nerves, they want to kill their husband. Yeah, they are nervous." Dr. Reed further testified that she just documented, "nervous." Dr. Reed testified that nervous patients usually tell her that they are nervous, it is usually quite obvious that they are, and added, "When they tell you that they want to finish off all their relatives, why, you know they are nervous." (St. Ex. 5 at 6; Tr. Vol. I at 43-45) The following exchange then occurred:

- Q. (By Mr. Wilcox): So if a patient comes into your office and they say, 'I'm just feeling nervous. The kids are driving me nuts. My husband is driving me nuts', you would go ahead and prescribe a drug like Meprobamate?
- A. (By Dr. Reed): Yes.
- Q. What else might you prescribe? Xanax?

A. Goodness. Well, it used to be Valium, but we don't use that anymore much, practically. But now they all want Ativan or Xanax. Everybody wants Xanax for nerves. It's like Valium was 20, 30 years ago.

Q. When you say 'they all want it', is that—

A. The public.

Q. Does that mean they come to your office—

A. 'I want some Xanax. I need some Xanax. I'm nervous', that's right, they do. They ask for it. The neighbor lady gave them some and it helped. It's just like Valium was 40 years ago; everybody wants it.

(Tr. Vol. I at 43-46)

30. Dr. Clark testified that meprobamate "is one of the earlier tranquilizers" available to physicians to treat anxiety disorders. (Tr. Vol. II at 36-37)

Dr. Clark testified that simply documenting that a patient is nervous is not sufficient to justify prescribing meprobamate. Dr. Clark testified that when an internal medicine physician attempts to treat a patient for a psychiatric condition, the physician must base the diagnosis on acceptable criteria, such as the Diagnostic and Statistical Manual of Mental Disorders [DSM]. Dr. Clark testified that, for example, the physician should look for symptoms of fatigue, restlessness or irritability, problems with concentration, muscle tension, and sleep disorders. Dr. Clark testified that a patient with three or four of those symptoms could possibly be diagnosed as having an anxiety condition. Moreover, Dr. Clark testified that it is important to ensure that the patient is appropriately diagnosed before any trial of medication is attempted. Finally, Dr. Clark testified that he had found no such analysis in Dr. Reed's medical records. (Tr. Vol. II at 36-38)

Dr. Reed's Failure to Counsel or Document Counseling Patient 1 Concerning a Low-Lipid Diet as Part of Her Treatment Plan for Hyperlipidemia

31. Dr. Clark testified concerning Patient 1's visit on December 31, 1999, and Dr. Reed's diagnosis and treatment of hyperlipidemia. Dr. Clark testified that hyperlipidemia is the condition of having high lipid levels in the blood. (St. Ex. 5 at 5 [middle]; Tr. Vol. II at 33-34) However, Dr. Clark further testified:

The standard of care in managing hyperlipidemia is, No. 1, to determine which type of hyperlipidemia it is. If it's related to cholesterol, then you do one thing; if it's related to triglycerides, then you do another thing. If it's related to both, then you do both of those things.

But the bottom line to treating most hyperlipidemias is to first deal with the dietary aspects of it. You have to recommend certain kinds of diets which are low in these kinds of fats. For instance, if it is high cholesterol we're dealing with, then the first thing that must occur is the recommendation of the patient having to be placed on a diet that's low in cholesterol.

The triglycerides, it might be because of diabetes. And again, the big important treatment for diabetes is dietary. So it all boils down generally to diet, and that is what appears to be missing from this—from the medical record that I have before me.

(Tr. Vol. II at 34-35) Finally, Dr. Clark testified that the standard of care would require that discussion of such dietary issues should be documented in the medical record.
(Tr. Vol. II at 35)

32. Dr. Reed testified that, with patients who have hyperlipidemia, “we try to talk them into a diet, of course. Yes, we definitely try to inform them of * * * dietary restrictions.” When asked if that would be something that she would normally document in the patient's medical records, Dr. Reed replied, “Probably not. * * * I would say that I probably never write down things like that. * * * We just automatically do it.” (Tr. Vol. I at 41-42)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 1

33. Dr. Clark testified that, in his opinion, Dr. Reed's treatment of Patient 1 had failed to conform to the minimal standard of care. Dr. Clark further testified that, in his opinion, Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, and failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. Moreover, Dr. Clark testified that Dr. Reed failed to maintain minimal standards applicable to the selection of or administration of drugs.
(Tr. Vol. II at 16-17, 43-45)

Patient 2

34. Patient 2 is a female born March 3, 1940. (St. Ex. 6 at 1)

Dr. Reed's Treatment of Patient 2 for Sore Throat on October 18, 1988

35. Patient 2 saw Dr. Reed on October 18, 1988. Dr. Reed recorded, “137 lbs. Sore throat.” No findings were documented concerning the patient's body temperature or the presence of lymphadenopathy or pharyngeal exudate. Dr. Reed prescribed, among other things, Sumycin #20. (St. Ex. 6 at 2 [bottom])

36. Dr. Clark testified that Sumycin is a tetracycline-related antibiotic. Dr. Clark testified that it would be an appropriate medication to prescribe to a patient who has bacterial pharyngitis. However, Dr. Reed's medical record for that visit states only that the patient had a sore throat. Dr. Clark testified that there is no documentation of fever or exudate on the throat. (St. Ex. 6 at 2 [bottom]; Tr. Vol. II at 50-52)

Dr. Reed's Treatment of Patient 2 for Cystitis on April 20, 1999

37. Patient 2 saw Dr. Reed on April 20, 1999. Dr. Reed recorded, "179 lbs. urine → neg sugar trace prot 6.0 pH neg blood * * * Back pain. Dysuria. Cordura & ? Bl pr med Takes Lipitor, Tamoxafen, Trental. No lumps felt. Had a R. mastectomy for Ca of the breast. Oct 1997 at MGH—Dr. Maxwell." Dr. Reed also recorded a blood pressure of 170/90. Dr. Reed listed diagnoses of acute cystitis, carcinoma of the breast, sinusitis, "Ca," hypertension, and dermatitis. She prescribed Bactrim DS #10 with two refills, to be taken twice daily; and Darvocet N-100 #30 with one refill. (St. Ex. 6 at 2 [bottom])
38. Dr. Clark testified that acute cystitis is an inflammation of the inner lining of the bladder. Dr. Clark further testified that it could be caused by an infection or by other causes. Dr. Clark testified that the standard of care would be to perform a urinalysis that looks for signs of infection and inflammation. (Tr. Vol. II at 46-47)

Dr. Clark testified that Dr. Reed's medical records indicate that a urinalysis had been performed on April 20, 1999. However, Dr. Clark testified that the documented results of that urinalysis do not support a diagnosis of an infection of the bladder. Dr. Clark testified that, first, there was no indication of white blood cell (leukocytes) in the urine. Dr. Clark testified that, if leukocytes had been tested for and found—or, alternatively, if leukocytes had not been found but infection had still been suspected—then the next step would have been to do a urine culture; Dr. Clark testified that "urine culture is the standard of care." Dr. Clark testified that he could find no evidence either of a test for leukocytes in the urine, or of a urine culture, in Dr. Reed's medical records. Finally, Dr. Clark testified that the medical record does not support a prescription for Bactrim as presumptive treatment for a bladder infection. (St. Ex. 6 at 2 [bottom]; Tr. Vol. II at 47-50)

39. In his written report, Dr. Clark stated, "There was no documentation of an abdominal examination (i.e., suprabupic or flank regions) or a pelvic exam to discern the reason for the patient's presenting complaint of dysuria." With regard to the urinalysis performed by Dr. Reed, Dr. Clark wrote that "the urinalysis that was collected * * * only demonstrated trace protein rather than signs of inflammation (i.e., positive nitrite, positive leukocytes, or positive blood.) (St. Ex. 2 at 2)
40. Dr. Reed testified that she had believed that the urine test she performed had been sufficient at the time to diagnosis cystitis. Dr. Reed further testified that the test that she uses now is more extensive. Moreover, Dr. Reed testified that the indication of trace protein was abnormal and suggestive of acute cystitis. Finally, Dr. Reed acknowledged

that she had not documented a pelvic examination that day, and it is unlikely that she would have performed one unless the patient had requested it. (Tr. Vol. I at 49-51)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 2

41. Dr. Clark testified that, in his opinion, Dr. Reed's treatment of Patient 2 fell below the minimal standard of care. Dr. Clark further testified that, with regard to Dr. Reed's treatment of Patient 2 on October 18, 1988, and April 20, 1999, Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 45-46, 51-52)

Dr. Reed's Prescribing of a Controlled Substance to Patient 2

42. Although not addressed by Dr. Clark in his testimony or his written report, on April 20, 1999, Dr. Reed prescribed Darvocet N-100 #30 with one refill to Patient 2 for "[b]ack pain." There was no documentation of any evaluation or examination by Dr. Reed concerning that complaint. (St. Ex. 6 at 2 [bottom]) Darvocet N-100 is a Schedule IV controlled substance. (Tr. Vol. I at 78)

Patient 3

43. Patient 3 is a male born on September 9, 1937. (St. Ex. 7 at 1)

Dr. Reed's Treatment of Patient 3 for Arthritis

44. On May 2, 1988, Dr. Reed recorded,

Left hand almost paralyzed. Has severe arthritis in all the fingers. Has muscle atrophy of hands. Has severe pain in the [left] elbow and down the left forearm. * * * Drinks about six beers per day. Thumb is deformed now and feels like it draws. * * * Has been off work for a month. * * * Odor of ethanol on breath.

Dr. Reed prescribed, among other things, Motrin. (St. Ex. 7 at 3 [bottom] and 4 [bottom])

45. On May 9, 1988, Dr. Reed recorded, "Has x-ray of left wrist & left hand by Ceocarelli which showed osteoarthritis & possible rheumatoid arthritis of M.P. & P.I.P. Pain in tail bone also. * * * Can't do his job. Odor of ethanol. Severe pain in wrists. * * *" Dr. Reed diagnosed osteoarthritis, rheumatoid arthritis, and peptic ulcers. She prescribed, among other things, Tylenol No. 3 #30. (St. Ex. 7 at 4 [bottom]) Note that the x-ray reports referred to in Dr. Reed's note are not included in the medical record. (St. Ex. 7) However, there is x-ray evidence from 1981 of a "large gastric ulcer." (St. Ex. 7 at 18)

From May 1989 through November 1994, Patient 3 did not see Dr. Reed. (St. Ex. 7 at 2 [top])

46. On December 12 and 16, 1994, and on January 13, 1995, Dr. Reed issued prescriptions to Patient 3 for Tylenol No. 3 #30. Subsequently, from January 27, 1995, through March 4, 2002, Dr. Reed issued prescriptions to Patient 3 on a monthly basis for Tylenol No. 3, #30, with one refill. The bases documented for these prescriptions varied; sometimes it was for “painful joints,” sometimes pain in the hands, other times back pain, elbow pain, wrist pain, knee pain, shoulder pain, and/or leg pain. (St. Ex. 7 at 1-10)
47. Dr. Reed testified that Patient 3 suffers from “very severe arthritis.” Dr. Reed testified that some patients tell her that they have arthritis, or she can “look at their joints, and when they are all swollen up, it’s pretty obvious that they have arthritis.” Dr. Reed further testified that there are also blood tests to detect certain types of arthritis, such as gout arthritis, which Dr. Reed testified is very common in her area. (St. Ex. 7 at 1; Tr. Vol. I at 53-54) Note, however, that there is no documentation in Dr. Reed’s medical record for Patient 3 that any such blood test had been conducted. (St. Ex. 7)

When asked if she had documented any musculoskeletal examination of Patient 3, Dr. Reed stated that “it says here that he has a swollen left knee.” Dr. Reed had evidently been referring to her note dated October 9, 1978, which stated, in part, “Off work 6 months with swollen left knee. Dr. Gibson at General.” (St. Ex. 7 at 1; Tr. Vol. I at 54)

48. Dr. Reed acknowledged that she had prescribed Tylenol No. 3, a controlled substance, for Patient 3, and that Patient 3 had not been able to take certain analgesics “because of his bleeding ulcers, and he had a terrible time with bleeding ulcers.” Dr. Reed further testified that Tylenol No. 3 contains codeine, and is addictive, but that Patient 3 “seemed to tolerate it very well and didn’t seem to over-use it, as far as I could see.” (Tr. Vol. I at 54-55)

When asked if she discusses the potential addictive nature of Tylenol No. 3 with patients who receive it, Dr. Reed replied, “Sometimes we do.” Whereupon the following exchange took place:

- Q. (By Mr. Wilcox): Okay. Why only sometimes? Shouldn’t you do it all the time?
- A. (By Dr. Reed): Probably should.
- Q. Okay. But there are times when you don’t? Is there a reason why you don’t? Just forget, or—
- A. I don’t know.

(Tr. Vol. I at 54-55)

49. Dr. Reed testified concerning the May 9, 1988, notation indicating an odor of ethanol on Patient 3's breath. She stated that she had noted that because drinking alcohol had not been recommended because of Patient 3's peptic ulcer. (Tr. Vol. I at 57-58) Dr. Reed further testified that Patient 3's abuse of alcohol had not concerned her with regard to prescribing Tylenol No. 3. Dr. Reed testified, "I don't think it's much of a problem; at least it never has been with him. He's not a person that I have ever seen over-do his medications. Some people do, but I've never seen him." (Tr. Vol. I at 58)

Concerning the issue of prescribing controlled substances to a patient who is an alcohol abuser, the following exchange took place:

- Q. (By Mr. Wilcox): Now, Dr. Reed, if a patient is an alcohol abuser, what does that tell you as a doctor? If someone comes in and you know they abuse alcohol, does that send up a red flag that maybe you've got to be careful prescribing any kind of scheduled or controlled substances to that person?
- A. (By Dr. Reed): I don't see any correlation between drinking alcohol and taking drugs. I mean, no, I don't. I guess I don't.
- Q. So you wouldn't be concerned if someone abused alcohol, that they could maybe potentially be a high risk to abuse prescription drugs? You don't think those two correlate at all?
- A. I wouldn't think there would be any—I've never noticed. The people that take drugs, take drugs; the people that take alcohol, like their alcohol. It's not customary for them to mix them too much.

(Tr. Vol. I at 56-57)

50. Dr. Clark testified that Tylenol No. 3 is a Schedule III controlled substance. Dr. Clark further testified that it is a medication that patients can become addicted to. (Tr. Vol. II at 53-54)

Dr. Clark testified that he could find very little in Dr. Reed's medical records for Patient 3 to justify her diagnoses of arthritis and asthma that appear in various parts of the record. Moreover, Dr. Clark testified that he "found very little to substantiate the rationale" for the prescribing of controlled medications, such as Tylenol No. 3, to this patient. (Tr. Vol. II at 52-53)

Dr. Clark testified that, prior to prescribing a medication such as Tylenol No. 3, the physician must first determine how much pain the patient has, where the pain is located,

and how the pain is affecting the patient's life. Dr. Clark further testified that the physician should also discuss with the patient the potential for addiction, although he stated that the standard of care does not require documenting such discussions. (Tr. Vol. II at 54-55)

51. Dr. Clark testified that he would be concerned if a patient to whom he was prescribing narcotic medications was suspected of abusing alcohol. Dr. Clark further testified that such information

pretty much establishes that this is a patient that might have a drug abuse problem, or could be led down the pathway to drug abuse very easily. And it's these kinds of patients that are generally out of the scope of practice for your general practitioner, general internist. It would be this kind of patient that you would refer to a pain specialist if pain was a problem."

(Tr. Vol. II at 55) Moreover, Dr. Clark testified that he would not prescribe Tylenol No. 3 to a patient who appeared to have a problem with addiction to drugs or alcohol. Dr. Clark further testified that it would not be within the standard of care to prescribe Tylenol No. 3 to this patient. (St. Ex. 7 at 3 [bottom] and 4 [bottom]; Tr. Vol. II at 55-57)

52. In his written report, Dr. Clark wrote,

The patient was treated on many occasions for 'severe arthritis,' however there was either minimum or absent documentation of musculoskeletal findings to substantiate the rationale for concluding that the patient had arthritis worthy of treatment with controlled substances. In only rare instances was there clear documentation of the delineation of the patient's joint symptomatology (i.e., which joints, their range of motion, localization of back discomfort).

(St. Ex. 2 at 3) (Emphasis in original)

Dr. Reed's July 24, 2000, Diagnosis of Asthma for Patient 3

53. Patient 3 visited Dr. Reed on July 24, 2000. Dr. Reed recorded, "133 lbs. Hands and elbows are very painful." No objective findings other than weight were documented. Dr. Reed diagnosed arthritis and asthma, and prescribed, among other things, Marax #30 with two refills, to be taken two or three times daily. (St. Ex. 7 at 8 [top])

Dr. Reed's medical record for Patient 3 indicates that she had prescribed Marax to Patient 3 on one previous occasion, January 28, 2000, for a diagnosis of acute upper respiratory infection. However, no diagnosis of asthma appears in the medical record prior to July 24, 2000. (St. Ex. 7)

54. Dr. Reed testified that Marax is a medication used to treat asthma. When asked what tests she had performed to diagnose asthma in Patient 3, Dr. Reed replied that she did not perform any tests, but had listened to the patient's lungs and heard wheezing. (Tr. Vol. I at 59-60)
55. In his written report, Dr. Clark stated that, on July 24, 2000, Patient 3 "was diagnosed with 'asthma,' however there is no documentation of the physical assessment to substantiate this diagnosis." (St. Ex. 2 at 3)

Dr. Reed's Prescribing of Amoxicillin to Patient 3

56. Dr. Reed prescribed amoxicillin to Patient 3 on the following occasions:

Date	Medication	Relevant Findings and/or Diagnosis
05/23/95	amoxicillin 500 mg, #30, 2 refills, QID	"Cough. Cold. Red throat."
11/28/95	amoxicillin 500 mg #30, 2 refills, QID	"Head cold"
02/23/96	amoxicillin 500 mg, #20, 2 refills	"Red throat"
07/29/96	amoxicillin 500 mg #30, 2 refills, QID	"Sinuses flare up. * * * Coughing a lot. Red throat."
11/25/96	amoxicillin 500 mg, #30, 2 refills, QID	"Bronchitis"
03/03/97	amoxicillin 500 mg, #30, 2 refills, QID	"Caught cold. Right ear."
01/14/98	amoxicillin 500 mg, #30, 2 refills, QID	"Red throat. Coughing a lot."

(St. Ex. 7 at 3-7) Note that the patient's body temperature was not documented for any of these visits. (St. Ex. 7 at 3-7)

57. In his written report, Dr. Clark stated,

On multiple occasions, the patient was prescribed prolonged courses of amoxicillin without the benefit of objective findings to substantiate the rationale for its use. This placed the patient at great risk for developing bacterial infections resistant to commonly used antibiotics. The patient was often prescribed amoxicillin at a dosing schedule of four times a day (QID) as opposed to the PDR recommended three times a day (TID).

(St. Ex. 2 at 3)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 3

58. Dr. Clark testified that Dr. Reed's treatment of Patient 3 had, in many instances, departed from the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that, in many instances, Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment

of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 52, 58-59)

Dr. Reed's Prescribing of Meprobamate to Patient 3

59. The Hearing Examiner could not find any instance where meprobamate had been prescribed to this patient, as had been charged in the Board's September 10, 2003, notice of opportunity for hearing. (St. Ex. 1A, St. Ex. 7)

Patient 4

60. Patient 4 is a female born on December 13, 1928. (St. Ex. 8 at 1)

Dr. Reed's Prescribing Antibiotics to Patient 4 for Sore Throat

61. On December 22, 1993, Dr. Reed recorded in Patient 4's medical record, among other things, "Allergic to Pen." (St. Ex. 8 at 2) Dr. Reed stated that this notation had meant that Patient 4 was allergic to penicillin. (Tr. Vol. I at 65)

62. Dr. Reed prescribed antibiotics to Patient 3 to treat sore throat on the following occasions:

Date	Medication	Relevant Findings and/or Diagnosis
07/08/97	Erythromycin 250 mg #30, 2 refills, QID	"Cold. Sore throat. Coughing. Red throat."
09/16/97	Vibramycin 100 mg #10, 2 refills	"Cold. Sore throat. Headache. Coughing. * * * Acute pharyngitis."
01/14/98	Cipro 500 mg #10, 1 refill, BID	"Cold & sore throat. Coughing all night. Moderate inflammation of throat. Ears hurt."
12/02/98	Cipro 500 mg #20, 2 refills, BID	"Sore throat. Coughing."
02/16/99	Cipro 500 mg #10, 2 refills, BID	"Cold - sore throat. Very red throat. [Right] otitis media."
03/29/99	Z-Pak 250 mg, 1 refill	"Severe cold. Sore throat. Earache. Inflammation of throat. Ears ok,"
08/14/00	Z-Pak, 1 refill	"Sore throat. Ears hurt. Headache."
09/26/00	Z-Pak, 1 refill	"Sore throat & earache. * * * Bright red pharynx."
08/08/01	Z-Pak 250 mg, 1 refill	"Caught cold. Sore throat."
09/28/01	Z-Pak 250 mg, 2 refills	"Cold. Sore throat."
12/01/01	Z-Pak 250 mg, 2 refills	"Sore throat."

(St. Ex. 8) There was no documentation for any of these visits of the patient's body temperature, lymphadenopathy, or pharyngeal exudate. (St. Ex. 8)

63. On February 8, 2000, Dr. Reed recorded, “Caught cold. Coughing. Was out in the cemetery down in Kentucky. Very red throat.” No temperature was recorded. Dr. Reed’s prescriptions that day included Z-Pak with one refill. (St. Ex. 8 at 6) Dr. Reed testified that Z-Pak contains azithromycin, which is an antibiotic. (Tr. Vol. I at 66-67)

Dr. Reed testified that she had prescribed Cipro and Z-Pak to Patient 4 because Patient 4 had been allergic to penicillin. Dr. Reed acknowledged that there may be other alternatives to penicillin besides Cipro and Z-Pak, but she had not been aware of them. Dr. Reed stated that pharmaceutical company representatives used to visit her and tell her about the new drugs that were becoming available, but that that no longer happens. (Tr. Vol. I at 69-70)

64. With regard to Dr. Reed’s treatment of Patient 4 on February 8, 2000, in which Dr. Reed had prescribed Z-Pak to treat a cold, coughing and a very red throat, Dr. Clark testified that the medical records do not support such a prescription. First, the notation that there was a very red throat is not accompanied by information that there was pus in the throat, or fever. That, plus the notation that the patient had caught a cold and was coughing, would point to a virus as the cause of the illness. Moreover, Dr. Clark testified that there is no documentation that a throat culture had been performed that indicated a bacterial cause for the infection. Accordingly, Dr. Clark stated that Dr. Reed had inappropriately utilized the antibiotic. Finally, Dr. Clark testified that “it’s generally been accepted that these medications should be reserved for select clinical circumstances in order to maintain their overall use in the general population, and to prevent the emergence of resistant bacteria.” (St. Ex. 8 at 6 [middle]; Tr. Vol. II at 62-65)
65. On September 28, 2001, Dr. Reed prescribed Z-Pak 250 mg with two refills to Patient 4 for “Cold. Sore throat.” (St. Ex. 8 at 7) The following exchange occurred with regard to Dr. Reed’s prescribing of Z-Pak with two refills:

Q. (By Mr. Wilcox): [T]here was a Z-Pak prescribed, six tablets, and then it says ‘Times 2 refills.’

My question is, I myself have had a Z-Pak I think prescribed to me before. Is it unusual to write a Z-Pak with two prescriptions or two refills?

A. (By Dr. Reed): We used to.

Q. Okay. Is that something you normally do? Isn’t it normally you take the pills in the Z-Pak and that’s supposed to be—

A. Usually sufficient, uh-huh. They generally don’t get the refills, but we usually do put a refill on just in case we’re out of town or just in case

they run out over the weekend or something like that. I almost always put a refill available.

* * *

- Q. Let me ask you this question: In theory, then, if a person took their Z-Pak, finished the pills that it came with, the six pills or whatever it does, they would still be able to go and get two more prescriptions that they could then give to somebody else?
- A. Yes.
- Q. Or use in any way they want?
- A. Yes, they can.
- Q. Doesn't that concern you?
- A. Not really.
- Q. [Why doesn't] that concern you?
- A. Because so often if one person in the family—so often somebody else in the family has it. It's so common.
- Q. So it wouldn't bother you if they are passing drugs amongst themselves?
- A. They pass drugs back and forth like crazy anymore. It just shocks me when I talk to people and they said, 'My neighbor gave me some of the best pills last week, I'd like to have some of those.' It's so common anymore, it's scary.
- Q. And why does that scare you, because you don't know if some person could have a reaction to the medication, right?
- A. That's what the public is doing these days.
- Q. But is that one reason why it might scare you, you might not—someone might not know if they are allergic to a medication because they haven't seen their doctor?
- A. We like to know what people are taking, and they find out what it is, and then they come in and say, 'I had some of Susie's pills and they were

just wonderful. I'd like to have some of those, too,' and it's become very common.

Q. When people come in and say that, do you often say—do you often give them pills? What do you say to them?

A. Well, if it's something that isn't too much of a problem, yeah, we give it to them.

(Tr. Vol. I at 70-72)

66. Dr. Reed testified that she had prescribed Cipro to Patient 4 on January 14, 1998, and on February 16, 1999, because the patient had had ear infections. Dr. Reed further testified that she diagnoses ear infections by looking in the patient's ears, if they look "really red or swollen" and possibly have discharge. However, Dr. Reed acknowledged that she had not documented any of those observations in this record. (Tr. Vol. I at 67-68)
67. Dr. Clark testified that Cipro is not an appropriate antibiotic to prescribe for otitis media. Moreover, Dr. Reed had issued the prescriptions with two refills available; Dr. Clark testified that it is not within the standard of care to prescribe Cipro with two refills. Moreover, Dr. Clark testified that he would not accept an explanation that the two refills had been issued because family members may also need the medication, and that such practice would also fall below the minimal standard of care. (St. Ex. 8 at 6 [middle]; Tr. Vol. II at 61-62)

Dr. Reed's Treatment of Patient 4 for Cystitis

68. On November 26, 1993, Dr. Reed rendered a diagnosis of cystitis. The only objective findings noted for that visit were the patient's height and weight. Dr. Reed prescribed Septra DS #28 with one refill, to be taken twice per day. (St. Ex. 8 at 1) Again, on July 26, 1996, Dr. Reed recorded a diagnosis of acute cystitis. The only objective finding noted was the patient's weight. On that occasion, Dr. Reed prescribed Bactrim DS #20 with two refills, to be taken twice daily. (St. Ex. 8 at 3 [top])

Dr. Reed also treated Patient 4 for cystitis on November 14, 1994; July 7, September 15, and December 6, 1995; July 14, 1998; and August 13 and December 17, 1999. (St. Ex. 8)

69. With regard to Dr. Reed's treatment of Patient 4 on July 26, 1996, Dr. Clark testified that there was not sufficient information documented in the medical record to support a diagnosis of acute cystitis. Dr. Clark further testified that the standard of care required at least a urinalysis to support the diagnosis. Dr. Clark noted, however, that Bactrim would have been an appropriate antibiotic to treat cystitis had that been an appropriate diagnosis. (St. Ex. 8 at 3 [top]; Tr. Vol. II at 65-66)

70. In his written report, Dr. Clark stated, "On multiple occasions the patient was treated for 'cystitis,' however there was no documentation of an assessment to substantiate the rationale for concluding that the patient indeed had cystitis of bacterial origin." (St. Ex. 2 at 4)

Dr. Reed's Prescribing Librax to Patient 4

71. Dr. Reed testified that Librax is a "very effective" sedative, and that it "cuts down on the nervous tension." Dr. Reed further testified that it is useful for treating over-activity in the gastrointestinal tract. Dr. Reed testified that Librax is not a controlled substance. (Tr. Vol. I at 74-77)
72. For Patient 4's visit on June 6, 1994, among other things, Dr. Reed made the notation, "She likes Librax." The other notations for that visit state "226 lbs. urine neg. 6.0 pH. Sinuses hurt (Used Vancenase inhaler 2 to 4 times a day.) Diabetes for 14 years." Dr. Reed also recorded a blood pressure of 140/80. Dr. Reed prescribed, among other things, Librax 2.5 mg #30 with four refills, to be taken two or three times per day. (St. Ex. 8 at 3 [bottom])

With regard to Patient 4's visit on June 6, 1994, Dr. Reed testified that she usually prescribed Librax for over-activity in the gastrointestinal tract, but that she had not recorded the reason for her prescription on that occasion. Dr. Reed further testified, "She likes it. And apparently it helps when she has all this trouble with her bladder, too." Dr. Reed testified that she "[p]robably" had prescribed it for Patient 4 because Patient 4 had asked for it. Dr. Reed further stated, "sometimes people find something that works well for them and they come in and ask for it." Finally, Dr. Reed stated, "I kind of had the feeling that she had been taking it for some time, and probably somebody else had given it to her to start with." (Tr. Vol. I at 76-79)

Dr. Reed's medical records indicate that she had also prescribed Librax #30 with four refills to Patient 4 on April 28 and September 15, 1995; September 16, 1997; December 2, 1998; August 13, 1999; February 8 and November 13, 2000; May 1, August 8, and December 14, 2001; and February 22, 2002. Moreover, Dr. Reed prescribed Librax #30 with five refills on December 6, 1995, and February 17, 1997. (St. Ex. 8)

When asked if it was unusual to prescribe that much Librax, Dr. Reed stated that "[i]t is apparently very mild." (Tr. Vol. I at 76)

73. With regard to Patient 4's February 17, 1997, visit, during which Dr. Reed prescribed Librax 2.5 mg #30 with five refills, Dr. Reed testified that she had prescribed that medication for "gastric upset; gastrointestinal cramping." Note, however, that the only symptoms that Dr. Reed recorded on that date were "Cold. Flu. Coughing. Hoarse." (St. Ex. 8 at 4 [top]; Tr. Vol. I at 75-76)
74. Dr. Clark testified that there appeared to be no justification for prescribing Librax to Patient 4 other than the notation for one visit that "[s]he likes Librax." Dr. Clark further

testified that Librax is a medication that is used to treat problems such as irritable bowel. Moreover, Dr. Clark testified that, “[i]n every instance where Librax was prescribed,” there was no justification for such prescribing documented in the medical record. (St. Ex. 8; Tr. Vol. II at 66-68)

Dr. Clark’s Opinions Concerning Dr. Reed’s Treatment of Patient 4

75. Dr. Clark testified that Dr. Reed’s treatment of Patient 4 had failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that, in most instances, Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 59-60, 70-71)

Patient 5

76. Patient 5 is a female, born March 14, 1962. (St. Ex. 9 at 1)

Dr. Reed’s Treatment of Patient 5 for Back Pain and Anxiety

77. From May 13, 1999, through February 22, 2002, Dr. Reed issued prescriptions on a monthly basis to Patient 5 for Darvocet N-100 #30 with one refill; Xanax 1 mg #30 with two refills, and Soma 350 mg #50 with one refill. On one occasion, February 4, 2000, a prescription for Ativan 1 mg #30 with two refills was substituted for the Xanax prescription. Notations in the medical record occasionally reference back pain and nervousness. (St. Ex. 9)
78. Dr. Reed testified that she had prescribed Darvocet to Patient 5 for pain, Soma for muscle pain and aching, and Xanax for stress. (Tr. Vol. I at 82)
- Dr. Reed testified that her prescriptions for Xanax 1 mg #30 with two refills to be taken three times per day would have given the patient a thirty-day supply. Dr. Reed stated that that is “pretty common.” (Tr. Vol. I at 82-83)
79. Dr. Clark testified that he “found very little evidence in the medical record beyond just the notation of back pain and nervousness that there was an attempt to discern the nature of those problems and come up with some objective findings to lead to an appropriate assessment” (Tr. Vol. II at 79-80)

With regard to Dr. Reed’s treatment of Patient 5 for back pain, Dr. Clark testified that he could find no documentation in Dr. Reed’s medical record that reflected a thorough examination of the patient for back pain or the origins of the back pain. (Tr. Vol. II at 72)

Dr. Clark testified that, when evaluating a patient who complains of back pain,

[T]he first thing is we get a good history about the back pain, how long it has been there and how it is affecting you right now. And then * * * we examine the patient.

We try to figure out where is the locality of that discomfort, specifically where in the back, upper back, lower back, close to the tailbone, those kinds of things.

(Tr. Vol. II at 72-73) Dr. Clark further testified that, with a good history and physical examination, x-rays are not necessary if controlled substances are not being used, because “[t]he medicines themselves can be utilized as a therapeutic trial to rule out certain kinds of problems.” When asked what a physician should do for such a patient prior to using controlled substances, or Soma, Dr. Clark replied,

Soma, in particular, is a medication that’s utilized for muscle relaxation, so the medical records should at least demonstrate that there’s some muscle involvement in that individual suffering with pain.

So—But even in that situation, you provide a course of therapy that’s brief to address the muscle nature of that pain, or when you prescribe medication, a controlled substance, a scheduled substance, a product like Darvocet, then that raises the bar in terms of the kinds of things you have to do.

And one of the things you really have to do at that point is get an x-ray, an x-ray that provides you some view of the person’s spine and how it’s impacted.

You may have to do some testing, rule out some inflammation problems, connective tissue diseases, those kinds of things, but you really have to narrow your diagnosis, your differential diagnosis before you resort to using controlled substances for more than a brief period.

(Tr. Vol. II at 73-74) Dr. Clark further testified that the notation “back pain” is not sufficient documentation to justify the use of medications such as Darvocet and Soma. Dr. Clark noted that there was a notation in the medical record dated May 13, 1999, that Patient 5 “Had x-rays at MGH.” However, Dr. Clark testified that the medical record does not indicate what those x-rays had revealed. (St. Ex. 9 at 1 [middle]; Tr. Vol. II at 74-75)

Finally, with regard to Dr. Reed’s prescribing to Patient 5 for back pain, Dr. Clark testified that there is no indication in the medical record that Dr. Reed had tried other medications or forms of treatment, such as physical therapy, before employing narcotic medication. (Tr. Vol. II at 75-76)

80. With regard to Dr. Reed's prescribing of Xanax to Patient 5, Dr. Clark testified that Xanax is an anxiolytic drug similar to Valium that is utilized to treat anxiety disorders.
(Tr. Vol. II at 80)

Dr. Clark further testified that a medication such as Xanax is only appropriate if the patient's anxiety problem is internal, and a result of a chemical imbalance in the patient's body. Xanax can be used to try to correct that imbalance. However, the physician must be "very clear" that he or she is treating an anxiety condition that is internal, and which warrants medication. Dr. Clark testified that if the anxiety is caused by external forces—i.e., the result of something stressful that is happening to the patient—then the physician may need to consult with the patient, or to console the patient. Dr. Clark stated that the physician could in some cases prescribe a short-term regimen of medication to help the patient sleep, which would help give the patient the mental strength he or she needs to get over the external problem. (Tr. Vol. II at 80-81)

81. When asked if much of her practice is devoted to prescribing pain and anti-anxiety medications, Dr. Reed replied that there are "[a] lot of nervous people in the world." She further stated a lot of her patients want "nerve pills." Dr. Reed related an episode concerning an acquaintance whose grandson killed his father because his father refused to give him money for drugs. Dr. Reed related another episode in which Dr. Reed's secretary had not liked the look of a patient, "and [she] told the patient that—to go fly a kite, can't see you today, and that patient went right out and killed a man for money for drugs." Finally, Dr. Reed testified,

It just kind of scares you how desperate these people are for drugs. It's scary. It's really scary. And so when these people come in and want nerve pills, yeah, I do, I definitely give them nerve pills, because I hate to see them go out and shoot my neighbors.

(Tr. Vol. I at 87-89)

Dr. Reed's Continued Prescribing of Controlled Substances Despite Drug-Seeking Behavior

82. On May 28, 1999, Dr. Reed recorded, "274 lbs. Fell & cut her head 3 days ago. Says she has 6 staples in the back of her head. Head aches. Not infected. She would really rather have Vicodin. Refused." Dr. Reed prescribed Darvocet N-100 #30 with one refill.
(St. Ex. 9 at 7 [middle])
83. With regard to Patient 5's request for Vicodin, Dr. Reed testified,

See, that's the problem. We have these people go up to the emergency room. The emergency room doctors always give them Vicodin or Oxycontin, and

then they come back to us and they say, 'Hey, that was fantastic stuff that they gave me in the emergency room.'

But these Indian doctors just write for Vicodin like crazy, and it makes me very upset because I refuse to write for it. And I tell the patients that we don't—I don't know how to spell it,' that I just don't write for that, either one of those.

(Tr. Vol. I at 90-91) Dr. Reed further testified that she instead prescribes medications such as Darvocet to her patients "because they are much milder. And if they take too many, they don't kill themselves. And I try to get them to spread it out and get back on the over-the-counter [medications], if I can." (Tr. Vol. I at 91-92)

84. Dr. Clark testified that asking for a controlled substance by name is drug-seeking behavior. Dr. Clark further testified that this is a strong indication that the patient could be addicted to the medication, or perhaps may want to sell the medication. Moreover, Dr. Clark testified that Dr. Reed did the right thing by refusing the patient's request for Vicodin, but that at this point the patient should have been discharged from Dr. Reed's practice. (St. Ex. 9 at 7; Tr. Vol. II at 78-79)
85. On August 4, 1999, Dr. Reed recorded in her medical record for Patient 5, "Back pain & Headaches. 3 children." She prescribed Darvocet N-100 #30 with one refill, Soma 350 mg #50 with one refill, and Xanax 1 mg #30 with two refills, to be taken three times per day. (St. Ex. 9 at 1 [bottom])

The next note recorded in the medical record, dated the following day, states, "Phone Aug. 5, 1999, 6 AM. She is in the ER with possibly an overdose of Darvocet & Soma but not admitted." (St. Ex. 9 at 1 [bottom])

Dr. Reed's medical record for Patient 5 indicates that her next visit took place on September 8, 1999. Dr. Reed recorded:

250 lbs. Clock was not working & she took the batteries out and put them in the TV remote so she thinks she took the pain pills too close together. Her father is going on kidney dialysis and he has been living with her. She thinks she has too much stress. She also has two grand children now. Thinks she is under a lot of stress. * * * Has lost 20 lbs. Much back pain.

(St. Ex. 9 at 1 [bottom] and 7 [bottom]) At that visit, Dr. Reed prescribed Darvocet N-100 #30 with one refill; Soma 350 mg #50 with one refill, to be taken four times per day; and Xanax 1 mg #30 with two refills, to be taken three times per day. (St. Ex. 9 at 7 [bottom])

86. Dr. Reed testified that Patient 5 had informed her that "they had misdiagnosed her," and that she had taken the pills "just a little closer together because she was nervous and

forgot.” Dr. Reed further testified that one of Patient 5’s relatives had taken her to the ER. Moreover, Dr. Reed testified that Patient 5 had not been admitted to the hospital. (Tr. Vol. I at 81-82)

When Dr. Reed was asked if she had been concerned about continuing to prescribe the same medications to Patient 5 that she had overdosed on in August, Dr. Reed replied, among other things, that the medications were very mild. (Tr. Vol. I at 84-86)

87. Dr. Clark testified that the notation that the patient had been taken to the ER for a possible overdose of Darvocet and Soma would indicate to him that the patient had been overusing the medication. Moreover, Dr. Clark testified that, once the patient had demonstrated a tendency to abuse the medications that Dr. Reed had prescribed to her, the patient had gone beyond the scope of Dr. Reed to treat. Dr. Clark stated, “This patient should [have been] referred to someone who can manage this particular type of patient if [the patient had a] bona fide reason for pain control.” (St. Ex. 9 at 1 [bottom]; Tr. Vol. II at 76-77) Moreover, after noting that Dr. Reed had continued to prescribe Darvocet N-100, Soma, and Xanax to Patient 5 after that episode, Dr. Clark testified,

I would say that it is dangerous to prescribe to this patient who had * * * been in the emergency room for an overdose for Darvocet and Soma, to then soon thereafter be prescribed the same medication and nothing has been performed to address the fact that this person did over-utilize or abuse these medications.

(Tr. Vol. II at 78)

88. A note in Dr. Reed’s medical record for Patient 5 dated June 20, 2000, states, “Too soon! Back pain, offered urine test - could not go and give one. Very rude & mad wanted pain pills. Refused meds per Dr. Reed, too soon[.]” (St. Ex. 9 at 4 [top])

Dr. Reed testified that her secretary had recorded the June 20, 2000, note. Dr. Reed further testified that Patient 5 had never been rude to Dr. Reed. However, Dr. Reed testified that her secretary “gets very uptight over lots of things, and fights with people right and left.” (Tr. Vol. I at 92-93)

Concerning the issue of Patient 5 seeking medication too early, Dr. Reed testified that her secretary had probably checked the patient’s records, noted that Patient 5 had recently received medication, and informed Dr. Reed that it was too soon after the patient’s previous prescription. Dr. Reed testified that she “probably agreed with her.” (Tr. Vol. I at 93)

89. In his written report, Dr. Clark stated that the notation that Patient 5 had been “‘rude & mad’ in her quest to obtain more ‘pain pills’ * * * is another example of drug-seeking behavior.” (St. Ex. 2 at 5)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 5

90. Dr. Clark testified that, with regard to her treatment of Patient 5, Dr. Reed had failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 71-72, 83-84)

Patient 6

91. Patient 6 is a female born on June 20, 1937. (St. Ex. 10 at 2)

Dr. Reed's Prescribing of Analgesic Controlled Substances, Sedative-Hypnotics, and Antidepressants to Patient 6

92. From about May 1988 through June 1992, Dr. Reed prescribed Doriden 0.5 mg and meprobamate 400 mg to Patient 6 on nearly a monthly basis for headache, back pain, and nervousness. In June 1992, Dalmane 30 mg was substituted for Doriden, and Darvon Compound 65 was added. In May 1993, Darvocet N-100 was substituted for the Darvon, and the nearly monthly prescribing of Dalmane, meprobamate, and Darvocet N-100 continued through September 1994. In September 1994, after the patient complained of being very nervous and depressed, that she "can't stand the kids all the time," and that "she can't live like this anymore," Dr. Reed prescribed Ativan 1 mg, Darvocet N-100, and Tofranil. Subsequently, beginning in October 1994, Dr. Reed resumed prescribing Dalmane, meprobamate, and Darvocet N-100 to Patient 6 on a monthly basis, occasionally with prescriptions for Tofranil. This pattern continued through April 1996. (St. Ex. 10 at 2-15)

In June 1996, Patient 6 reported to Dr. Reed that she had seen a psychiatrist, and that she had been hospitalized for fourteen days in May. Dr. Reed's medical records for Patient 6 do not reveal the basis for the hospitalization. In any case, Dr. Reed documented prescribing lorazepam 0.5 mg, ProSom, and Wellbutrin to Patient 6 on June 4, 1996. On July 30, 1996, Dr. Reed prescribed Motrin 600 mg, Darvocet N-100, and Restoril 30 mg. On August 2, 1996, Dr. Reed prescribed Ativan 0.5 mg. On August 21, 1996, she prescribed lorazepam 0.5 mg, Wellbutrin, and Dalmane 30 mg. (St. Ex. 10 at 14-16)

On September 23, 1996, Dr. Reed documented that Patient 6 had told her that she was "[v]ery anxious and depressed. Can't even go to her door if she has visitors." Dr. Reed prescribed Wellbutrin, lorazepam 0.5 mg, ProSom 1 mg, and Darvocet N-100. She continued prescribing this combination monthly through December 1996. In January 1997, Restoril 30 mg was substituted for the ProSom, Ativan was specifically named instead of the generic name lorazepam, and that combination was prescribed monthly through April 1997. In April 1997, Soma 350 mg was added, and Dr. Reed continued to prescribe

Wellbutrin, Ativan, Restoril, Darvocet N-100, and Soma to Patient 6 on nearly a monthly basis through January 2002. (St. Ex. 10 at 16-25)

Dr. Reed testified that Dalmane is a “sleeping pill,” and is a Schedule IV controlled substance. Dr. Reed further testified that meprobamate is “a nerve tablet” and is also a Schedule IV controlled substance. Moreover, Dr. Reed testified that Darvon Compound-65 is a “pain pill * * * a mild one,” and is also a Schedule IV controlled substance. (Tr. Vol. I at 100-101, 103)

93. Dr. Reed testified that Patient 6 usually wanted “ten or 12 different medications” when she came to see Dr. Reed. When asked if she gave Patient 6 the medications she wanted, Dr. Reed replied, “Sometimes she’ll come in with a list of all the things that she’s out of, and I try to narrow it down.” (Tr. Vol. I at 100)
94. On September 23, 1992, Dr. Reed recorded only the patient’s weight and blood pressure. She prescribed, among other things, Dalmane 30 mg #15 with one refill, Darvon Compound 65 #30 with one refill, and Meprobamate 400 mg #50 with one refill. (St. Ex. 10 at 8 [top])

When asked if anyone would be able to tell from her medical record why she had prescribed medication to Patient 6 that day, Dr. Reed replied,

No, I didn’t write down any of her problems because they are so extensive that it’s hard to put it all in one page. But her daughter was raped by an African, and they are very religious folks, and they didn’t know what to do about it.

And they don’t believe in abortions or that sort of thing, so they went ahead and had the black baby and nobody—nobody wanted to take care of it. And they didn’t know what to do with it, and it was just a nightmare. And this girl practically was ready to commit suicide, she was so depressed over the whole situation.

* * *

[Patient 6] became very depressed, very anxious. And they finally dumped it on her doorstep, and I think she ended up having to take care of it.

* * *

It’s been a very tragic situation. But no, I didn’t write any of that down. I did not put any of that in because I didn’t think that was necessary to put in all these things.

We sit down and talk these things over and try to work things out, and maybe that's why I have so many nervous people.

(Tr. Vol. I at 101-103)

Dr. Reed testified that Patient 6 had been extremely depressed, and was very close to being suicidal "at one point." Dr. Reed testified that, when confronted with a patient who she thinks is suicidal, "[u]sually we just talk to them and try to get their problems worked out. And sometimes if they are too bad, why we send them to a psychiatrist or suggest they go to see a psychiatrist, or go to the—there's a clinic that takes care of psychiatric people." (Tr. Vol. I at 104)

Dr. Reed further testified that a psychiatrist had placed Patient 6 on Wellbutrin for her depression. Dr. Reed testified that she had prescribed Ativan to Patient 6 for Patient 6's nervous tension, and Restoril to help her sleep. (Tr. Vol. I at 104-105)

95. Dr. Clark testified that Dr. Reed's medical record for Patient 6 documents many occasions where the patient had back pain, or was very nervous or very depressed. However, Dr. Clark further testified that there was "very little documentation" concerning Dr. Reed's assessment of the patient's medical condition. Moreover, Dr. Clark testified that "[t]here was no evidence in the medical record that monitoring of the [patient's] progress took place." (Tr. Vol. II at 85-86)

Dr. Clark further testified that there was x-ray evidence of disorders of the back that could lead to back pain. Dr. Clark testified that an April 2002 x-ray "suggested that there was degenerative disk disease and narrowing of the L5 and S1 * * *." However, Dr. Clark further testified that there were "no other kinds of assessments, x-ray assessments or radiological assessments of the back, like CT scan or MRI, to substantiate the case of a patient having severe back pain." (Tr. Vol. II at 86)

With regard to the patient's nervousness, Dr. Clark testified, "There was nothing in the medical record to highlight what were the features of this individual's nervousness or anxiety, and features that we would like to see to make the diagnosis of an anxiety condition that warrants the prescribing of a controlled substance." (Tr. Vol. II at 86-87)

Dr. Reed's Failure to Assess Patient 6 as a Suicide Risk on August 23, 2000

96. Dr. Reed's note for August 23, 2000, states, "172 lbs. Says she is so depressed today she can hardly stand it." Dr. Reed listed diagnoses of hypertension, arthritis, and "Acute depression." There is no documentation of an assessment to determine whether Patient 6 was suicidal. (St. Ex. 10 at 22 [bottom] and 23 [bottom])

Dr. Reed testified that Patient 6 had been very depressed. (Tr. Vol. I at 106)

Dr. Reed's Prescribing Hazardous Combinations of Medication to Patient 6 Without Clear Indications of Medical Necessity

97. Dr. Reed's medical records indicate that on a number of visits she had prescribed a combination of meprobamate and Dalmane to Patient 6. (St. Ex. 10 at 8 [top])

Dr. Reed testified that the Dalmane was prescribed as a sleeping pill, and the meprobamate for anxiety and tension. Dr. Reed further testified that she had never seen any problems resulting from having prescribed those medications together. (Tr. Vol. I at 108-109)

98. Dr. Reed's medical records further indicate that on a number of other visits she had prescribed a combination of Restoril and Soma to Patient 6. (St. Ex. 10 at 16 [top])

Dr. Reed testified that she does not see any problem, and has never encountered any problem, with prescribing those two medications together. (Tr. Vol. I at 109)

99. On three occasions, in September, November, and December 1996, Dr. Reed prescribed a combination of lorazepam (or Ativan) and ProSom to Patient 6. (St. Ex. 10 at 17 [bottom])

Dr. Reed testified that lorazepam is the generic name for Ativan. (Tr. Vol. I at 115)

100. Dr. Clark testified that he was concerned about Dr. Reed's prescribing of certain combinations of medication to Patient 6. With regard to Dr. Reed's prescribing of Dalmane and meprobamate, he testified that Dalmane and meprobamate are both in the same family of tranquilizer/sedative medications. Taken together, the dangerous effects of those medications increases. Dr. Clark further testified that such prescribing is inappropriate without additional information concerning a bona fide anxiety condition, and information concerning whether the patient had a sleep disorder, which is the usual reason for prescribing Dalmane. (Tr. Vol. II at 87-89)

Similarly, Dr. Clark testified that Dr. Reed's prescribing of combinations of lorazepam, Restoril, and Soma, as well as combinations of lorazepam and ProSom, had also been inappropriate. Dr. Clark testified that all of these medications are sedating, and that taking those medications together "can certainly cause a great deal of sedation and drunkenness in a patient." Dr. Clark further testified that continued use of such a combination of medications could lead the patient to develop a tolerance and an addiction to the medications. Moreover, Dr. Clark testified that it would not change his opinion if any of the medications had been prescribed to be taken at bedtime, because it's not clear in the medical record when the other medications were supposed to be taken. (Tr. Vol. II at 89-92)

Dr. Clark further noted that the PDR recommends that Restoril and ProSom be prescribed for short periods of time only. Dr. Clark testified that he would consider a period of "[s]even to ten days at best" to be a short-term period. (Tr. Vol. II at 92)

101. When Dr. Reed was asked if Restoril is a medication that should be prescribed only in seven to ten-day regimens, the following exchange took place:

A. (By Dr. Reed): That's why I don't quite understand. You tell me that, and then this General Motors can prescribe 500 of them. I don't understand why they are on a different scale than we are. I just don't understand this at all.

Q. (By Mr. Wilcox): Well, I don't know about General Motors and what they are—

A. Well, I can show you. I can show you. I have the—I just don't understand why they can prescribe hundreds of them, and we're criticized for prescribing more than ten.

Q. We're just trying to figure out your knowledge of that particular medication. I mean, in your opinion, Restoril, you think, can be prescribed for 30 days?

A. Yes. Yes, I do. And General Motors prescribes it for a year.

(Tr. Vol. I at 105)

Dr. Reed's Prescribing of Antibiotics to Patient 6

102. Between February 9, 1988, and March 22, 2002, Dr. Reed prescribed courses of antibiotics to Patient 6 on sixty-two occasions. (St. Ex. 10 at 4-24)

103. In his written report concerning Patient 6, Dr. Clark stated, "The patient was often prescribed courses of antibiotics without the benefit of objective findings to substantiate the rationale for their use. This placed the patient at great risk for developing bacterial infections resistant to commonly used antibiotics." (St. Ex. 2 at 6)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 6

104. Dr. Clark testified that Dr. Reed's treatment of Patient 6 had, "in most instances," failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs.
(Tr. Vol. II at 84-85, 93-94)

Patient 7

105. Patient 7 is a female born on November 22, 1944. (St. Ex. 11 at 1)

Dr. Reed's Prescribing of Controlled Substances to Patient 7 for Back Pain and Anxiety

106. From December 1990 through April 2002, nearly each month, Dr. Reed prescribed either Darvon Compound 65 or Darvocet N-100 to Patient 7 for back pain, and either Tranxene or Xanax for anxiety. (St. Ex. 11 at 1-15)

107. With regard to Dr. Reed's treatment of Patient 7 for back pain, Dr. Clark testified that an x-ray from August 12, 1997, had indicated that Patient 7 had "[m]ild levoscoliosis of the lumbar spine' and '[d]egenerative changes * * * in the lower lumbar facet.'" However, Dr. Clark further testified that a subsequent x-ray dated March 5, 1999, revealed no significant abnormality of the lumbar spine. (St. Ex. 11 at 21, 24; Tr. Vol. II at 95-97)

108. Dr. Reed testified that Patient 7 suffered from degenerative arthritis in her back, which was confirmed by an x-ray report dated August 12, 1997. (St. Ex. 11 at 21; Tr. Vol. I at 116-117)

Regarding Dr. Clark's testimony that a subsequent x-ray had revealed no significant abnormality of the lumbar spine, Dr. Reed testified that the later x-ray report had concerned the cervical spine. (St. Ex. 11 at 23; Tr. Vol. I at 117) Note that, although one of the later x-ray reports does refer to the cervical spine, another x-ray report dated March 5, 1999, states that there was "[n]o significant abnormality in the lumbar spine." (St. Ex. 11 at 23, 24)

109. Dr. Clark testified that, based on the 1997 x-ray findings, a physician would be justified in beginning treatment with non-steroidal anti-inflammatory drugs, or with acetaminophen. However, Dr. Clark further testified that, prior to starting such a patient on a controlled substance medication that has abuse potential, the physician would have been obligated to perform further investigation of the spine, such as CT scans and, from the early 1990's onward, MRI studies. Dr. Clark testified that he could find no documentation of either having been performed on Patient 7. (Tr. Vol. II at 97-98)

110. Dr. Reed testified that she "[v]ery seldom" ordered MRI scans for her patients, unless "they work at General Motors or have that kind of insurance." Dr. Reed stated that most of her patients are "on the lower end of the income scale." (Tr. Vol. I at 117-118)

Dr. Reed testified that she would "[s]ometimes" do an examination of a patient with back problems in the absence of MRI or CT scans by physically touching the patient. Dr. Reed further testified, however, that she does not normally document such an examination, and probably had not documented such an examination for Patient 7. (Tr. Vol. I at 118-119)

111. With regard to Dr. Reed's treatment of Patient 7 for anxiety, Dr. Clark testified that Tranxene is an anxiolytic medication related to Valium. Dr. Clark testified that Dr. Reed's

medical record makes reference to “anxiety,” but that there was no documentation of any examination to confirm whether the anxiety was internal or external, or any detail as to the “features associated with the anxiety that the doctor was attempting to treat.” (St. Ex. 11 at 5 though 10; Tr. Vol. II at 99-101)

In his written report, Dr. Clark stated that “[t]here was no notation in the medical record that demonstrated the physician’s vigilance for issues surrounding the potential of this patient becoming addicted to and physiologically tolerant of the controlled substances utilized in this setting.” (St. Ex. 2 at 7)

112. Dr. Reed testified that she had prescribed Tranxene for Patient 7’s anxiety. When asked if she had documented anything other than “anxiety” in the patient’s medical record with regard to that diagnosis, Dr. Reed testified that Patient 7 was the sister-in-law of Patient 6 and that that family had problems with their children. (Tr. Vol. I at 119-120)
113. Dr. Reed testified that she had not heard of any potential for addiction concerning Tranxene, although she noted that it is a sedative. When asked if it is possible to become addicted to Tranxene, Dr. Reed replied, “I mean, a lot of people, they start taking their pills and they keep on taking their pills.” When asked if she believed that any of her patients are addicted to the medications that she prescribes, Dr. Reed replied, “Very likely. It always worries me that they—I keep trying to spread it out and try to get them to reduce the dosage, and take over-the-counter things to make their prescription last longer * * * so they can get off it.” (Tr. Vol. I at 124-125)

Dr. Reed’s Prescribing of Antibiotics to Patient 7

114. On October 14, 1994, Dr. Reed prescribed to Patient 7, among other things, Ampicillin 250 mg #20 with two refills, to be taken four times daily. Dr. Reed did not document any evaluation, diagnosis, or patient symptoms other than the patient’s weight and blood pressure. Moreover, no body temperature was documented. (St. Ex. 11 at 8 [bottom])

Further, on February 3, 1996, Dr. Reed again prescribed to Patient 7, among other things, Ampicillin 500 mg #30 with two refills, to be taken four times daily. Dr. Reed did not document any evaluation, diagnosis, or patient symptoms other than back and hip pain, family problems, and weight. Moreover, no body temperature was documented. (St. Ex. 11 at 8 [middle])

On December 4, 1996, Dr. Reed prescribed to Patient 7, among other things, amoxicillin 500 mg #30 with two refills, to be taken four times per day. Dr. Reed did not document any evaluation, diagnosis, or patient symptoms other than arthritis and the patient’s weight. Moreover, no body temperature was documented. (St. Ex. 11 at 9 [bottom])

Furthermore, on October 7, 1997, Dr. Reed prescribed to Patient 7, among other things, amoxicillin 500 mg #30 with two refills. Dr. Reed did not document any evaluation or

patient symptoms other than the patient's weight, although she documented a diagnosis of bronchitis. No body temperature was documented. (St. Ex. 11 at 10 [middle])

In addition, on January 28, 1998, and again on December 29, 1999; February 27, 2001; and September 26, 2001, Dr. Reed prescribed to Patient 7, among other things, amoxicillin 500 mg #30 with two refills, to be taken four times per day. Dr. Reed did not document any evaluation, diagnosis, or patient symptoms other than the patient's weight and, sometimes, blood pressure. Moreover, no body temperature was documented during any of these visits. (St. Ex. 11 at 9 [top], 12 [bottom], 13 [bottom], 13 [middle])

Finally, on April 17, 1998, Dr. Reed documented in her medical record for Patient 7 the patient's weight, "Cough & cold. Red pharynx. Took a whole bottle of Amoxicillin. Wants something else." No body temperature or other objective findings were documented. Dr. Reed prescribed Cipro 500 mg #5 with two refills, to be taken twice per day. (St. Ex. 11 at 10 [top])

115. Dr. Clark testified that Dr. Reed had prescribed antibiotic medication such as amoxicillin and Cipro to Patient 7 a number of times. Dr. Clark further testified that he could find no documentation in the medical record to justify such prescribing. (Tr. Vol. II at 102)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 7

116. Dr. Clark testified that, in most instances, Dr. Reed's treatment of Patient 7 failed to conform to the minimal standard of care for similar practitioners in the same or similar circumstances. Dr. Clark further testified that Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 94-95, 102-103)

Patient 8

117. Patient 8 is a female born October 6, 1965. (St. Ex. 12 at 1)

Dr. Reed's Prescribing of Controlled Substance Analgesics and Anxiolytics to Patient 8

118. From February 9, 1988, through April 22, 2002, Dr. Reed prescribed Xanax 0.5 mg or 1 mg to Patient 8 on 108 occasions. The complaints or diagnoses underlying these prescriptions were occasionally noted as "very nervous," "nervous," and "anxiety." (St. Ex. 12 at 5-18)

Moreover, from November 18, 1988, through April 22, 2002, Dr. Reed prescribed to Patient 8 controlled substance analgesics—usually Darvocet N-100 but occasionally Darvon Compound 65 or Tylenol No. 3—on seventy occasions. The complaints or

diagnoses underlying these prescriptions were occasionally noted as headaches, severe headaches, back pain, and lumbosacral strain. (St. Ex. 12 at 5-18)

119. Dr. Clark noted that there were frequent references to severe headaches and nervousness in Dr. Reed's medical record for Patient 8. However, Dr. Clark further testified that he could find no documentation concerning examinations to investigate the causes of Patient 8's headaches or her nervousness. Moreover, Dr. Clark testified that he could find no documentation in the medical record to suggest that any treatment other than prescriptions for controlled substances had been utilized to treat the patient's headaches and anxiety. (St. Ex. 12 at 6-8; Tr. Vol. II at 106-110)

Furthermore, Dr. Clark testified, "It seems as though that there's a lot of medication of this particular class [sedatives & tranquilizers] that was prescribed to this particular patient, a patient who exhibited clear signs of either drug seeking or drug abuse, and that this patient was probably addicted to the medication and was having some difficulty." Dr. Clark further testified that there had been no documentation of an evaluation as to how the patient was progressing on those medications. Moreover, Dr. Clark testified that there was no documented attempt to wean the patient off of those medications. Finally, Dr. Clark testified that such continued prescribing had violated the standard of care. (Tr. Vol. II at 116-117)

120. With regard to Patient 8's headaches, Dr. Clark stated in his written report that Dr. Reed had treated Patient 8 "for headaches of unknown etiology for multiple years. The medical record does not demonstrate any form of diagnostics to ensure that the headaches were of benign nature. At a minimum, CT scan would have been appropriate, given the long history of headaches and treatment." (St. Ex. 2 at 8)
121. When Dr. Reed was asked if she had tried to find out what was causing Patient 8's headaches, had sent Patient 8 to a neurologist, or had documented any anxiety disorder that Patient 8 had suffered from, she replied, "I don't know what you would document. If you're nervous, you're nervous. Sometimes we document the fact that they are drinking six cups of coffee or 12 Pepsis a day, or something like that, but most of the time there's really nothing to document." (Tr. Vol. I at 129)

Dr. Reed testified that she had prescribed Xanax for Patient 8's anxiety, "[b]ecause it's so very popular, and we were trying to get all these people off of Valium[.]" When asked if there were any other non-scheduled drugs that would help a patient with her nerves, Dr. Reed replied, "You have some suggestion?" Dr. Reed added, "I don't know, but everybody comes in these days, wants Xanax. It's the in-thing right now. It's funny, medicine runs in cycles. Certain drugs become very, very popular, and then all of a sudden they fade away." (Tr. Vol. I at 130)

122. An x-ray report dated April 23, 2002, gives the following impressions: "Degenerative disc disease and narrowing at the level of L5-S1." (St. Ex. 12 at 1)

Dr. Reed testified that the x-ray indicates that Patient 8 suffered from degenerative arthritis. (Tr. Vol. I at 126) Note, however, that the date of the x-ray report is one day following the last prescription documented for controlled substance analgesics. (St. Ex. 12 at 1, 18)

Dr. Reed's Prescribing of Xanax and Restoril in Combination to Patient 8

123. From April 28, 1992, through March 22, 2002, on fourteen occasions, Dr. Reed prescribed both Xanax and Restoril to Patient 8 during the same visit. (St. Ex. 12 at 10-18) The purpose of these medications was noted on April 28, 1992, as "Wants sleeping med & nerve med * * *." (St. Ex. 12 at 10 [top])
124. In his written report, Dr. Clark stated, "On multiple occasions the patient was prescribed a hazardous combination of Restoril and Xanax in the same setting. It was not apparent in the medical record as to the rationale for * * * this combination or the indication for either dug alone." (St. Ex. 2 at 8)
125. Dr. Reed testified that she has not had any problem with prescribing both Xanax and Restoril to patients. Dr. Reed testified, "Of course, they are both sedatives, but one you can take in the daytime and the other you take at night." (Tr. Vol. I at 136)

Dr. Reed's Continued Prescribing of Controlled Substances to Patient 8 after Patient had Displayed Drug-Seeking Behavior or Signs of Drug Abuse

126. On October 21, 1991, Dr. Reed documented, "Wants Valium. Refused. Has headaches. Wants 3 weeks off work for sinusitis." Although Dr. Reed refused to give Patient 8 Valium, she prescribed Darvocet N-100 #30, Serax 15 mg #30 with two refills, and Placidyl 0.5 mg #15 with one refill. Further, there were no objective findings documented other than a weight of 133 pounds. (St. Ex. 12 at 9 [top])

Dr. Reed testified that she had refused the patient's request for Valium because Valium "had so many bad side effects," including causing violent mood swings. (Tr. Vol. I at 131) Nevertheless, Dr. Clark testified that Serax is another medication that is related to Valium, and is a Scheduled IV controlled substance, as is Valium. (St. Ex. 12 at 9; Tr. Vol. II at 111-112)

127. On May 12, 2000, Dr. Reed recorded, among other things, "She would really like some Percocet." Dr. Reed prescribed, among other things, Xanax 2 mg #30 with two refills, to be taken three times per day. (St. Ex. 12 at 16 [middle])

Dr. Reed testified that "[s]he apparently got [Percocet] in the emergency room and found that it was very attractive; habit forming." (Tr. Vol. I at 133)

Dr. Clark testified that “any time a patient expresses a preference for a controlled substance by name, then that suggests drug seeking, and drug seeking is one of the features that should alert the provider of the potential for drug abuse.” (St. Ex. 12 at 16 [middle]; Tr. Vol. II at 113-114)

128. On October 21, 2000, Dr. Reed recorded, among other things, “Very nervous. Has been having severe headaches and much back pain. Went to the ER last week and was refused treatment. They were very nasty to her she says. She can’t sleep now.” Dr. Reed prescribed Xanax, Darvocet N-100, Soma, and Dalmane that day. (St. Ex. 12 at 16 [bottom])

With regard to that notation, the following exchange occurred:

- Q. (By Mr. Wilcox): [Was Patient 8 refused treatment] because she was trying to get drugs from the emergency room?
- A. (By Dr. Reed): Of course, because they always give them high-powered stuff in the emergency room, and they love to go over there and get all they can get. We have a terrible time with these people. Whenever they have been to the emergency room we know that they are going to ask for them high-powered pain killers.
- Q. Did you prescribe—
- A. They can sell some of those on the street for a nice handy little sum, too, they tell me.
- Q. Do you think they could also sell Xanax on the street, or Darvocet?
- A. I don’t think they get much—would get much for that. It’s not a priority, not like Vicodin and Oxycontin. That’s the ones that really they sell for big bucks.

(Tr. Vol. I at 134-135)

129. A Mansfield Hospital Emergency Department Report dated May 31, 2001, concerning Patient 8 states, with regard to Patient 8’s past medical history, “Positive for seizures, *substance abuse*, nervous problems, hypothyroidism and headaches.” (St. Ex. 12 at 22) (Emphasis added)

Dr. Clark testified that that is a red flag that suggests “that this is not the first time this individual has presented to this particular hospital.” Dr. Clark further testified that it would be unusual for a patient to indicate to medical personnel that he or she has a history of substance abuse. (St. Ex. 12 at 22; Tr. Vol. II at 114-115)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 8

130. Dr. Clark testified that Dr. Reed's treatment of Patient 8 had failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that, "in most instances," Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 105-106, 117-118)

Patient 9

131. Patient 9 is a male born on November 4, 1975. (St. Ex. 13 at 1)

Dr. Reed's Treatment of Patient 9 for Pain

132. Dr. Reed's medical record for Patient 9's visit on June 21, 1999, indicates that, several months earlier, the patient had been in an automobile accident, had gone to the hospital, and had been "told he had a severe whiplash. Now his neck cracks and hurts & [he] can't sleep at night." (St. Ex. 13 at 1 [middle], 2 [middle])

When asked if she had obtained Patient 9's hospital records to confirm that he had suffered severe neck damage, Dr. Reed replied, "It's very hard for us to get records from the hospital now. * * * They are very uncooperative." (Tr. Vol. I at 137)

133. From June 21, 1999, through April 5, 2002, Dr. Reed treated Patient 9 for neck pain with frequent prescriptions for Darvocet N-100 #30 with one refill; during this period, she issued twenty-five such prescriptions. Dr. Reed's medical records contain frequent references to the patient's complaints of pain and discomfort. From the outset, on June 21, 1999, Dr. Reed diagnosed the condition as "arthritis." However, there is no documentation of a physical examination of the patient concerning his complaint of neck pain. Moreover, there is no record of any radiological evaluation of the patient's neck; the only radiological reports in the medical record concern hand and chest x-rays. (St. Ex. 13)

134. In his written report, Dr. Clark stated,

The patient was treated for 'neck pain' on a continuous basis for more than 2 years. It would have been appropriate, after at least 6 months of treatment, for the patient to receive a radiological evaluation of the neck to dismiss the possibility of an anatomical pathological lesion and help further discern the nature of the problem.

(St. Ex. 2 at 9)

Dr. Reed's Treatment of Patient 9 with Prescriptions for Xanax

135. On thirteen occasions between April 2, 2001, through April 5, 2002, Dr. Reed prescribed Xanax 1 mg #30 with two refills to Patient 9. No basis for these prescriptions is documented. Furthermore, there is no documentation of any evaluation or assessment of the patient with regard to nervousness or anxiety, nor is any treatment plan documented. The only notation in the medical record that could even tangentially provide a basis for such medication is dated March 15, 2000—over one year before the prescribing started—in which Dr. Reed noted that Patient 9 “[s]eems very nervous.” There is also a reference dated July 10, 2000, that Patient 9 was having trouble sleeping. (St. Ex. 13 at 2-4)

Dr. Reed's Prescribing of Restoril to Patient 9 for Excessive Periods of Time

136. Dr. Reed prescribed Restoril 30 mg #30 with one refill, to be taken at bedtime, to Patient 9 on three occasions: June 21 and July 14, 1999, and April 7, 2000. (St. Ex. 13 at 1-2)
137. In his written report, Dr. Clark stated, “On several occasions the patient was prescribed Restoril supposedly for sleep inducement purposes. The regimens prescribed were for 30-day periods, which is longer than that indicated in the setting of temporary relief of sleep disorders after all other causes are ruled out.” (St. Ex. 2 at 9)
138. With regard to her prescribing Restoril for 30 days at a time with a refill authorized, Dr. Reed testified, “I’ve not had any problem with it. And General Motors prescribes it for a year, so I don’t understand why this is such a problem. This Medco affiliated with General Motors is certainly passing out the sleeping pills and the pain pills and everything else.” (Tr. Vol. I at 141)

Dr. Reed's Prescribing of Controlled Substances to Patient 9, in General

139. Concerning Dr. Reed’s prescribing of controlled substances such as Darvocet N-100, Xanax, and Restoril, Dr. Clark testified that in most instances there was “scant documentation,” and even that concerned only the patient’s subjective complaint. There is no documentation of evaluations, suggestions for other treatments, or referrals. Moreover, with regard to the patient’s subjective complaint of nervousness, there is no assessment by Dr. Reed that substantiates a diagnosis of anxiety disorder. (Tr. Vol. II at 122-125)
140. Dr. Reed acknowledged that she had frequently prescribed Darvocet N-100 and Xanax to Patient 9. When asked if she had discussed with Patient 9 the potential for addiction with these drugs, Dr. Reed replied that she had prescribed Naprosyn for Patient 9 at one point. When asked if she had been concerned about the addictive potential of these drugs, Dr. Reed replied, “Well, they are so mild that I think if anybody is going to be addicted, it’s to something like that that they can cope with. And I refuse to use those high-powered

ones. With these mild things, I think they can spread it out and hopefully eventually discontinue their use.” (Tr. Vol. I at 138-139)

Dr. Reed’s Continued Prescribing of Controlled Substances to Patient 9 Despite Patient 9’s Drug-Seeking Behavior

141. On April 7, 2000, Dr. Reed noted, among other things, “Thinks he would like to try codeine.” Dr. Reed did not prescribe codeine at that visit, but did prescribe Darvocet N-100, Restoril, and Soma. (St. Ex. 13 at 1 [bottom])

Concerning Patient 9’s request for codeine, Dr. Reed testified, “He heard about it.” (Tr. Vol. I at 139)

142. On June 28, 1999, the following note was recorded in Dr. Reed’s medical record for Patient 9: “Phoned—speech slurred wanted his Darvocet—Lost Bottle that was a refill—Then said he got his refill.” Nothing else was documented that day. (St. Ex. 13 at 2 [bottom])

Dr. Clark testified that “generally when you hear about slurred speech you think about intoxication.” (Tr. Vol. II at 121-122)

Dr. Reed testified that she had not written the June 28, 1999, note, and that Patient 9 had “[a]pparently talked to one of the girls in the office * * * [and] he didn’t sound right to her, so she just hung up on him.” (Tr. Vol. I at 140) Dr. Reed further testified that, when such a thing occurs, it bothers her, and that is why “we try to get them off the high-powered stuff. So when they ask for Codeine or Percocet, we just say no.” (Tr. Vol. I at 140-141)

Dr. Clark’s Opinions Concerning Dr. Reed’s Treatment of Patient 9

143. Dr. Clark testified that Dr. Reed’s treatment of Patient 9 had failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 118-119, 125-126)

Patient 10

144. Patient 10 is a female born January 15, 1959. (St. Ex. 14 at 1)

Dr. Reed’s Prescribing of Controlled Substances to Patient 10

145. On July 5, 1996, Dr. Reed prescribed Darvocet N-100 #20 to Patient 10, evidently for “extreme menstrual cramps.” Dr. Reed documented that Patient 10 had stated that “[s]he

would really like to have Vicodin or codeine,” but that Dr. Reed had refused. (St. Ex. 14 at 2 [middle] and 3 [middle])

On January 30, 1999, Dr. Reed began prescribing to Patient 10 Darvocet N-100 #30 with one refill, and Ativan 1 mg #30 with two refills, to be taken three times per day. Complaints of tension headaches and “[c]an’t sleep” were documented that day. These prescriptions were repeated on March 1, 1999. Subsequently, on May 1, 1999, Dr. Reed recorded, among other things, “Headaches” and “Would like to try Fioricet instead of Darvocet. Her husband likes this, too.” Dr. Reed prescribed Fioricet #30 with one refill, and Ativan 1 mg #30 with two refills, to be taken three times per day. At Patient 10’s next visit on May 29, 1999, Dr. Reed prescribed Fioricet and Ativan as before, and added a prescription for Darvocet N-100 #30 with one refill. Dr. Reed continued prescribing these three medications to Patient 10 on a monthly basis through May 27, 2000, with one exception: on January 11, 2000, Dr. Reed substituted Ultram #30 with one refill for Darvocet N-100. Finally, as bases for this prescribing, Dr. Reed occasionally documented complaints and/or diagnoses of headaches, back pain, and lumbosacral strain. (St. Ex. 14 at 3-5)

Further, beginning July 3, 2000, Dr. Reed prescribed Fioricet, Darvocet N-100, and Ativan to Patient 10 as before, and added a prescription for Soma 350 mg #50 with one refill, to be taken four times per day. Dr. Reed continued prescribing these four medications on a monthly basis to Patient 10 through March 30, 2001, with one exception: on January 20, 2001, Darvon Compound 65 #30 with one refill was substituted for Darvocet N-100. During this period, Dr. Reed occasionally documented complaints and/or diagnoses of headaches, back pain, lumbosacral strain, and kidney stones. (St. Ex. 14 at 4-5)

Subsequently, on April 30, 2001, Dr. Reed substituted a prescription for Xanax 1 mg #30 with two refills for the Ativan. From that date until February 16, 2002, Dr. Reed prescribed Fioricet, Darvocet N-100, Xanax, and Soma to Patient 10 on a monthly basis. During this period, Dr. Reed occasionally documented complaints and/or diagnoses of back pain and lumbosacral strain. (St. Ex. 14 at 6-7)

146. In his written report, Dr. Clark stated,

The patient was treated on many occasions for ‘lumbosacral strain,’ however there was no documentation of musculoskeletal findings to document the rationale for concluding that the patient had back pain worthy of treatment with controlled substances. It was not apparent in the medical record as to how the patient was affected by the pain, to what extent her range of motion was limited, whether there were neurological findings associated with the back pain (i.e., sciatica from nerve root irritation), or to what extent the back pain interfered with her daily activities.

(St. Ex. 2 at 10) Dr. Clark further stated,

The patient was being treated presumptively for anxiety disorder, however, there was no documentation of a psychological assessment in the medical record to support this diagnosis and thereby justify a largely uninterrupted course of sedative-hypnotics as a treatment plan.

(St. Ex. 2 at 10)

147. Dr. Clark testified that lumbosacral strain is a condition whereby the ligaments and tendons in the area of the lumbar and sacral spine are pulled, strained, or sprained. Dr. Clark further testified that Dr. Reed had noted that as a possible diagnosis for Patient 10. However, Dr. Clark testified that he could find no documentation of a through physical examination that would have led to such an assessment. Moreover, Dr. Clark testified that such a physical examination, had it occurred, should have been included in the medical record. (St. Ex. 14 at 4 [top]; Tr. Vol. II at 127-128)

Dr. Clark testified that it is important to document the reasons for prescribing medications, because the physician wants to be able to show that they are effective in controlling the patient's condition, whether that condition is hypertension, diabetes, or depression and anxiety. There must be a documented justification for the medication being prescribed. Otherwise, a subsequent treating physician could be placed in the unenviable position of having to wean the patient from the medication. Dr. Clark testified that that is a "painful process for both the physician and the patient" when a physician inherits "that kind of a situation." (Tr. Vol. II at 133-134)

148. Dr. Reed testified that she had not performed any physical examination concerning the diagnosis of lumbosacral strain. Dr. Reed testified that the patient had accepted the patient's assertion that she had back pain. (Tr. Vol. I at 143)

Dr. Reed's Prescribing of a Combination of Fioricet, Darvocet, Ativan, and Soma to Patient 10

149. As noted above, Dr. Reed prescribed to Patient 10 a combination of Darvocet N-100, Fioricet, Ativan, and Soma between July 2000 and March 2001. This occurred on seven occasions. (St. Ex. 14 at 4-5)
150. In his written report, Dr. Clark stated,

Without clear indication for medical necessity, the patient was prescribed on multiple occasions the following hazardous combination of drugs that are prone to abuse:

- Fioricet, Darvocet, Soma, and Ativan[.]

(St. Ex. 2 at 10)

Dr. Clark testified that “Soma is not a controlled substance, but it is an abused drug. It causes alteration of the sensorium in the treatment of muscle spasms and things of that sort.” (Tr. Vol. II at 129)

151. Dr. Clark testified that is dangerous to prescribe a combination of drugs such as Fioricet, Darvocet, Soma, and Ativan to a patient. Dr. Clark testified that each of those medications alter a patient’s sensorium and, taken together, can affect their mental status. Dr. Clark noted that he would not want someone who is taking this combination of medications to drive a school bus. Moreover, when asked if he would even want to be on the same road as the patient, Dr. Clark replied, “Absolutely not.” (Tr. Vol. II at 130-131)
152. When asked if it would be hazardous to prescribe a combination of Fioricet, Darvocet, Ativan, and Soma to a patient, Dr. Reed replied, “I don’t like to do it, but there’s lots of people take all of them without any problems.” When asked if such a combination of medications would make one “woozy,” Dr. Reed replied, “I would think so. I wouldn’t want to [take such a combination of medications], but it always astounds me what people do take.” (Tr. Vol. I at 148-149)

Dr. Reed’s Continued Prescribing of Controlled Substances to Patient 10 Despite Patient 10’s Drug-Seeking Behavior

153. On July 5, 1996, Dr. Reed recorded, among other things, “Says she can not take ASA.” (St. Ex. 14 at 2 [middle]) Dr. Reed testified that ASA is aspirin. (Tr. Vol. I at 146)

Subsequently, on January 20, 2001, Dr. Reed recorded, among other things, “Now says she is not allergic to ASA and would like to try Darvon Comp 65 #30 x 1.” Dr. Reed prescribed Darvon Compound 65 that day, along with Ativan 1 mg #30 with two refills, Fioricet #30 with one refill, and Soma 350 mg #50 with one refill. (St. Ex. 14 at 5 [top])

Dr. Clark testified that Darvon Compound 65 contains propoxyphene, as does Darvocet, but, unlike Darvocet, it contains aspirin rather than acetaminophen. (Tr. Vol. II at 130)

Dr. Clark testified that Patient 10’s statement that she was not allergic to aspirin, and that she would like some Darvon Compound 65, appeared to have been drug-seeking behavior. (St. Ex. 14 at 5 [top]; Tr. Vol. II at 129-130)

Dr. Reed testified that she is concerned about giving a patient something that the patient is allergic to, and she is also concerned that a patient may lie to her just to obtain medication. (Tr. Vol. I at 147)

154. On May 1, 1999, Dr. Reed recorded, among other things, “Would like to try Fioricet instead of Darvocet. Her husband likes this, too.” Dr. Reed prescribed Fioricet and Ativan. (St. Ex. 14 at 3 [top])

Dr. Clark testified that Fioricet is not a scheduled drug; but, like Fiorinal, which *is* a scheduled drug, Fioricet contains butalbital, a barbiturate. Dr. Clark further testified that the only difference between Fiorinal and Fioricet is that Fiorinal contains aspirin and Fioricet contains acetaminophen. (Tr. Vol. II at 128-129)

When asked if she should prescribe medication because a patient's spouse may be able to take it as well, Dr. Reed responded, "It does happen." When asked if she thought that was a good thing or a bad thing, Dr. Reed responded, "Well, it's probably not the best thing." (Tr. Vol. I at 144-145)

Dr. Clark's Opinions Concerning Dr. Reed's Treatment of Patient 10

155. Dr. Clark testified that, "in most instances," Dr. Reed's treatment of Patient 10 had failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that, "in most instances," Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 127, 134-135)

Patient 11

156. Patient 11 is a female born December 18, 1933. (St. Ex. 15 at 1)

Dr. Reed's Prescribing of Antibiotics to Patient 11

157. Dr. Reed prescribed antibiotics to Patient 11 as follows:

Date	Medication	Relevant Findings and/or Diagnosis
09/17/93	amoxicillin 500 mg #30, 2 refills	None
02/28/94	amoxicillin 500 mg #30, 2 refills, QID	"Bad cough & cold. Red throat & red [right] ear."
08/01/94	amoxicillin 500 mg #30, 2 refills, QID	"Severe sinus infection. Has been taking Amox & Benadryl."
02/13/95	amoxicillin 500 mg #30, 2 refills, QID	"Yellow drainage" from sinuses. "Red throat." "Acute sinusitis." "Also wants Keflex #30 for * * * daughter."
05/15/95	amoxicillin 500 mg #30, 2 refills, QID	"Bad sore throat. Very inflamed. Took 2 Pen capsules."
08/15/95	amoxicillin 500 mg #30, 2 refills, QID	"She says she has a sinus infection."
10/31/95	amoxicillin 500 mg #30, 2 refills, QID	"Sinuses are swollen."
12/22/95	amoxicillin 500 mg #30, 2 refills, QID	"Wants Pen for her cold like we gave her husband."

06/05/96	amoxicillin 500 mg #30, 2 refills, QID	None.
04/08/97	amoxicillin 500 mg #30, 2 refills, QID	“Sinus infection. Ears hurt too. Red throat.” “Some bulging of the drums.”
06/06/97	amoxicillin 500 mg #30, 2 refills, QID	“Sore throat.”
09/23/97	amoxicillin 500 mg #30, 2 refills, QID	“Sore throat.”
12/15/97	amoxicillin 500 mg #30, 2 refills, QID	None
02/09/98	ampicillin 500 mg #30, 2 refills, QID	None
05/20/98	ampicillin 500 mg #30, 2 refills, QID	None
07/08/98	Cipro 500 mg #20, 1 refill, Q 12 hours	None
09/21/98	amoxicillin 500 mg #30, 2 refills, QID	None
12/29/98	amoxicillin 500 mg #30, 2 refills, QID	“Red throat.”
02/20/99	Keflex 250 mg #30, 2 refills, QID	“Sinus infection. “Fever.” [No temperature documented.] “Acute sinusitis.”
09/24/99	Keflex 250 mg #30, 2 refills, QID	“Cold & sinus.”
12/21/99	amoxicillin 500 mg #30, 2 refills, QID	None
04/03/00	amoxicillin 500 mg #30, 2 refills, QID	“Sore throat.” “Acute pharyngitis.”
07/10/00	amoxicillin 500 mg #30, 2 refills, QID	None
09/13/00	amoxicillin 500 mg #30, 2 refills, QID	None
02/02/01	Keflex 250 mg #30, 2 refills	“Acute bronchitis.”
01/26/02	amoxicillin 500 mg #30, 2 refills, QID	“Bronchitis.” “Took Ampicillin today and last night.”

(St. Ex. 15 at 1-8) No body temperature was documented for any of the visits noted above. Moreover, on occasions when Dr. Reed had noted a complaint of sore throat and/or diagnosed acute pharyngitis, she failed to document the presence or absence of lymphadenopathy or pharyngeal exudate. (St. Ex. 15 at 1-8)

158. When asked if Dr. Reed’s prescribing of amoxicillin to Patient 11 had been appropriate, Dr. Clark replied,

Well, first of all, Amoxicillin comes in several strengths; 250 milligram strength, 500 milligram strength. So this is a super strength of Amoxicillin. Being prescribed four times a day is inappropriate because it’s a three-times-a-day drug, and for reasonable indications like sinusitis, like even bacterial pharyngitis, it would be prescribed for ten days of therapy. And here it appears to be for the intended use for a longer period of time.

(Tr. Vol. II at 138) Further, after noting that Dr. Reed had frequently prescribed antibiotics to Patient 11 in the absence of valid indications, Dr. Clark stated, “[T]he more antibiotics that are being utilized in the public—in the community, in the population as a whole, the greater the chance that germs will pop up that are resistant to these antibiotics * * *.” This could eventually result in Patient 11 coming down with an infection that would not respond to conventional treatment. (Tr. Vol. II at 138-140)

159. In response to criticism of her treatment of Patient 11, Dr. Reed offered the following:

- Dr. Reed testified that diabetic patients such as Patient 11 “are so very susceptible to infections, especially respiratory infections and urinary tract infections; very common.” (Tr. Vol. I at 153)
- Dr. Reed acknowledged that she had not always recorded the reasons for her antibiotic prescriptions for Patient 11. (Tr. Vol. I at 152-154)
- Dr. Reed disputed that she had prescribed amoxicillin for a period of thirty days. Dr. Reed testified, “I just prescribed it for—they can get refills if they need them. * * * And as I said—Well, you probably see there that the rest of the family was sick, too, so they probably passed it around.” (Tr. Vol. I at 155)
- Dr. Reed acknowledged that she had prescribed amoxicillin 500 mg to be taken four times per day, and that it instead should have been prescribed to be taken three times per day. Dr. Reed further testified that, after she had received the Board’s notice of opportunity for hearing, she looked the medicine up in a new edition of the PDR, and saw that “it’s changed.” (Tr. Vol. I at 154)

Dr. Clark’s Opinions Concerning Dr. Reed’s Treatment of Patient 11

160. Dr. Clark testified that Dr. Reed’s treatment of Patient 11 “in most instances” had failed to conform to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Clark further testified that, “in most instances,” Dr. Reed had failed to use reasonable care discrimination in the administration of drugs, failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease, and failed to maintain minimal standards applicable to the selection or administration of drugs. (Tr. Vol. II at 134-136)

Dr. Reed’s Prescribing of a Controlled Substance to Patient 11

161. Although not addressed by Dr. Clark in his testimony or his written report, on December 22, 1995, Dr. Reed prescribed, among other things, Ativan 1 mg #30 with two refills, to be taken three times per day. Dr. Reed’s medical records indicate only that Patient 11 was “[v]ery depressed,” had stated that “[s]he can’t take it any more,” and that she was under a lot of stress due to family problems. Dr. Reed also documented that Patient 11 had told her that “[t]he Tofranil did not seem to help.” In addition to the prescription for Ativan, Dr. Reed also prescribed Desyrel 50 mg #30 with one refill, to be taken at bedtime, and a Maxair Autohaler for asthma. (St. Ex. 15 at 3 [middle] and 4 [middle])

Dr. Reed's Administration of Vitamin B12 Injections to Patient 1 and Patients 3 through 7

162. Concerning injections of vitamin B12:

- During the course of her treatment of Patient 6 from 1988 onward, Dr. Reed gave injections of vitamin B12 to Patient 6 on at least 146 occasions. (St. Ex. 10 at 4-25)
- During the course of her treatment of Patient 7, Dr. Reed gave injections of vitamin B12 to Patient 7 on at least seventy-eight occasions. (St. Ex. 11 at 1-15)
- During the course of her treatment of Patient 4, Dr. Reed gave injections of vitamin B12 to Patient 4 on seventeen occasions. (St. Ex. 8)
- During the course of her treatment of Patient 3 from 1988 onward, Dr. Reed gave injections of vitamin B12 to Patient 3 on sixteen occasions. (St. Ex. 7 at 2-10)
- During the course of her treatment of Patient 5, Dr. Reed gave injections of vitamin B12 to Patient 5 on eleven occasions. (St. Ex. 9)
- During the course of her treatment of Patient 1, Dr. Reed gave injections of vitamin B12 to Patient 1 on nine occasions. (St. Ex. 5 at 1-8)

163. Dr. Reed testified, "People come in all the time asking for [a vitamin B12 injection] when they feel tired and rundown and think they are coming down with something." Dr. Reed further testified that, if a patient asks her for a B12 injection, she complies. In addition, Dr. Reed explained, "They always asked for it because they feel so much better when they take it. They feel more like they are able to cope with all their problems." Dr. Reed added that she did not charge the patients for vitamin B12 injections. Dr. Reed stated that she usually administers about one cc of the vitamin. Dr. Reed further testified that she uses the injections herself. Moreover, Dr. Reed testified, "If they find it helps them, I see no contraindication for it." (St. Ex. 7 at 1 [middle] and 5 [top, middle, and bottom]; Tr. Vol. I at 62-64, 121-122)

Dr. Reed further testified that she "wouldn't dream of taking [vitamin B12] orally * * * [b]ecause 99 percent of it is destroyed in the stomach, so it's much more effective if you give it as a shot." Dr. Reed added that "[f]or some reason the acidity in the stomach destroys so much of it." (Tr. Vol. I at 123)

164. Dr. Clark testified that vitamin B12 is an important material used by the human body to form blood cells. Dr. Clark disputed Dr. Reed's assertion that a large portion of the vitamin B12 that is ingested with food is destroyed in the stomach. Dr. Clark stated that, in fact, it is the acids in the stomach that encourages the body's absorption of vitamin B12. Accordingly, Dr. Clark stated that injections of vitamin B12 are unnecessary unless the patient suffers from a deficiency of the vitamin, and is unable to ingest the vitamin by

mouth. Dr. Clark testified that, in cases of pernicious anemia, the patients *are* unable to absorb sufficient quantities of vitamin B12 orally, and injections are necessary. Dr. Clark testified that a blood test to identify vitamin B12 deficiency is simple, widely available, and inexpensive. (Tr. Vol. II at 38-43)

Moreover, Dr. Clark testified that the only valid purpose for parenteral administration of vitamin B12 is to treat a patient who cannot absorb vitamin B12 via the oral route, and who has a deficiency of that vitamin as proven by a blood test. Furthermore, Dr. Reed testified that “you want to avoid needles wherever possible,” because of the possibility that the needle could hit a nerve or be contaminated, or the injector could suffer a needle-stick injury. (Tr. Vol. II at 43)

165. In his written report, with regard to Patient 1 and 3 through 7, Dr. Clark stated that Dr. Reed’s medical record for each patient “does not lend support to the diagnosis of a vitamin B12 deficiency, particularly one that requires parental administration of this vitamin as opposed to the oral route.” (St. Ex. 2 at 1, 3-7)

Additional Information

166. With regard to Dr. Reed’s care and treatment of Patient 1 through 11, Dr. Clark stated in his written report,

[T]here was only sparse demonstration by the physician via the documentation that an active clinical thought process was engaged that involved and integrated the following: the collection of subjective findings (from the patient); followed by the collection of objective findings (by the physician); then establishing differential diagnoses; and, challenging these differential diagnoses with a regimen of trial medications or the furtherance of diagnostic testing to hone in on the true diagnoses * * *.

(St. Ex. 2 at 1-11) With the exception of his report concerning Patient 2, Dr. Clark added,

[A]nd, finally performing follow-up care with accompanying medical record documentation relative to the progress of the patient along the continuum of care.

(St. Ex. 2 at 1, 3-11)

167. While questioning Dr. Clark on cross-examination, Dr. Reed indicated that, in her community, people have been murdered by drug addicts seeking money to support their habit. Dr. Reed asked, “What is the medical profession doing about this? I mean, that’s why—that’s why I have been giving these very mild ones that keep them from killing somebody. And it’s worked well for me, I don’t know why it’s such a terrible problem.” Dr. Clark testified that drug-addicted patients should be referred to an addiction provider,

or to other appropriate services. Dr. Reed then indicated that, in her community, there are no providers to whom she could refer her patients.

Dr. Clark replied that if it is true that there were no addiction services available in her community, Dr. Reed should have adjusted her practice to address these issues. Dr. Clark continued,

It is not a far cry for an internist or general practice physician or family medicine physician to now take up the specialty of substance abuse or addiction, become an addiction provider. It takes some additional training, certification, and more importantly, documentation.

When you have—And you can have a regimen, a protocol, an addiction protocol in your practice. It's all about documentation. It's all about applying the sweat to that protocol for any patient that comes with that particular problem.

So yes, you could make that part of your scope of practice as a physician who has to deal with that if there are no other providers in the community who will serve the patients in that capacity, but then that puts a higher level of burden on that particular physician, because now he or she has to take on some additional responsibilities that they weren't necessarily trained for in school.

(Tr. Vol. II at 148-150)

168. In setting forth her defense, Dr. Reed testified that employees at a General Motors facility in Mansfield are being prescribed large quantities of controlled substance medications such as Vicodin. Dr. Reed further testified that “[t]hey are just flooding our county with drugs and narcotics,” which is increasing the rate of crime, and making it difficult for local physicians to treat patients. Dr. Reed added, “And you think it’s terrible if we prescribe more than ten. You see why I’m confused?” (Tr. Vol. I at 163-165)
169. Dr. Reed asked Dr. Clark concerning his opinion regarding the prescribing of sleeping pills, and of the propriety of prescribing sleeping pills along with other medications such as sedatives, tranquilizers, or anxiety medication. Dr. Clark replied,

I prescribe sleeping pills based on a reasonable gathering of subjective information, attached to some objective findings with the intent that if this individual has been placed on this medication, they come back and see me, I’ll query them as to how well they did with that problem. But I will then limit how much medication they get for that particular problem because I’m—
No. 1, I’m comfortable with my diagnosis.

If I find out that they continue to have a sleeping problem, or problems with insomnia, then I have to start to think about other causes for it.

There may be medical conditions; there may be problems with—alcohol abuse is very common cause for people having insomnia. There could be a psychiatric problem, depression. Anxiety can lead to sleep disorders.

* * *

So I don't have a problem in prescribing sleeping pills because I understand they have their use, but I also abide by what is considered appropriate use.

Do I have a problem with sleeping pills being utilized with other sedative-like drugs?

* * *

Yes, I do. That patient is beyond my scope of practice. That person not only has an insomnia problem—perhaps related to their anxiety condition—but also needs more sedative to calm their anxiety condition, then that person is out of my league. That person needs to be seen by a psychiatrist. I wash my hands of that particular situation.

(Tr. Vol. II at 155-157)

170. Dr. Clark testified on cross-examination that complaints such as “the kids are driving me crazy” require consultation, not medication. Dr. Clark further testified that anxiolytic medications such as Valium are useful for treating internal causes of anxiety by correcting a chemical imbalance in the patient's body. However, complaints such as “the kids are driving me crazy” point to an external cause for the anxiety, and those do not require drugs. Dr. Clark further testified that mothers with small children should not be prescribed such medications because those medications leave them less able to respond to emergencies, such as a house fire. Accordingly, Dr. Clark testified that he tells such patients, “I'd rather you be a nervous wreck awake all night, than snowed under.” Moreover, Dr. Clark testified,

So my patients who need those drugs, who feel they need the drug—First of all, they may come in expressing a need for something, I give them something, and that is advice. But I don't give them drugs if it's an external situation that's leading them to that.

If it's an external situation that's leading to a few nights of restlessness, lack of sleep, for instance, a death in the family, yes, very appropriate to give them a sedative to help them rest, because they need all that energy to get through those—through that morbid situation, they need that rest so they can be of help.

(Tr. Vol. II at 157-160)

171. In her defense, Dr. Reed testified,

Well, I find it very difficult to see that there's so much objection to giving these people mild narcotics that they don't overdose on, or it's very difficult for them to overdose on these very, very mild ones, and it keeps them from having convulsions, seizures, and they are able to go to work and they quit going around killing everybody.

I think it's—I don't know, I don't think it's all that bad, myself. I mean, maybe it's—you have a completely different opinion, but these people are all alive and doing reasonably well. And they can—are able to go back to their usual activities. I think that's important.

(Tr. Vol. II at 175)

Dr. Reed further testified,

It's very difficult to get these people into drug rehab programs. They go in for a few weeks, they come back out, they are back out on the street and they get street drugs again and start all over again, the same thing all over again.

So I don't know, I think this has worked very successfully for me. Maybe you people have a different idea, different programs, but we try to get them into rehab if they will go, but they go right back into the problem.

(Tr. Vol. II at 175-176)

172. Dr. Reed acknowledged that she is not very familiar with the statutes and rules governing the practice of medicine in Ohio, and those governing the prescribing of medication, especially controlled substances, in Ohio. (Tr. Vol. I at 158-159)

173. In her defense, Dr. Reed presented a signature list labeled by hand as coming from MedCentral Health Systems, Mansfield, Ohio. The signature list bears a number of illegible signatures. Dr. Reed testified concerning that document, "Those are the signatures of the doctors on the staff, and you're supposed to guess which doctor signed it." Dr. Reed criticized the poor penmanship evidenced by that document, and added, "You can't even tell which doctor wrote the orders. * * * And I think it's kind of shocking. I just think it's shocking." (Respondent's Exhibit [Resp. Ex.] A; Tr. Vol. I at 160-161)

In addition, Dr. Reed brought with her to hearing a National Republican Congressional Committee National Leadership Award which was signed by Congressman Tom DeLay,

and which was presented to Barbara Reed, M.D., Honorary Co-chairman, Physicians' Advisory Board. (See Tr. Vol. I at 159-160)

174. Dr. Reed testified that she is an assistant county coroner in Richland County, Ohio. Dr. Reed further testified that she herself had been the county coroner a number of years ago. (Resp. Ex. B; Tr. Vol. I at 161-162)

FINDINGS OF FACT

1. In the routine course of her practice, Barbara A. Reed, M.D., undertook the treatment of Patients 1 through 11. As demonstrated in Dr. Reed's patient records, she excessively and/or otherwise inappropriately prescribed controlled substances and dangerous drugs to Patients 1 through 11 without obtaining appropriate histories and performing accurate physical examinations, without utilizing diagnostic testing or other methods of evaluating the validity of the patients' complaints or the nature or severity of the patients' reported pain, without devising treatment plans, without periodically reassessing the effectiveness of the treatment, and/or without appropriately documenting the above actions. In addition, at times, such prescribing occurred despite her knowledge that the patients were abusing controlled substances or exhibiting drug-seeking behavior. Further, Dr. Reed failed to provide and/or document the rationale for prescribing prolonged courses of antibiotics, placing the patients at great risk for developing bacterial infections resistant to commonly used antibiotics, and she prescribed potent broad spectrum antibiotics that should be reserved for select clinical circumstances in order to maintain their overall use in the population and impede the emergence of resistant bacterial strains.

Examples of such prescribing and/or conduct include, but are not limited to, the following:

- a. In her care of Patient 1 since 1994, Dr. Reed frequently treated Patient 1 for a sore throat; however, she failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis that warranted fifteen days of uninterrupted treatment with amoxicillin as opposed to the Physicians' Desk Reference [PDR] recommended ten days. She prescribed amoxicillin on February 21, 1995; Cipro on March 8, 1999; and Keflex on August 14, 2000, in manners that constituted inappropriate treatment plans for true streptococcal pharyngitis. Placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics, Dr. Reed often prescribed prolonged courses of antibiotics; however, she failed to document the diagnosis. Additionally, without documenting the justification, she inappropriately prescribed amoxicillin at a dosing schedule of four times per day as opposed to the PDR recommended three times per day. Dr. Reed also failed to document the patient's body temperature, and the presence or absence of lymphadenopathy or pharyngeal exudate. On some occasions, instead of prescribing penicillin or amoxicillin, Dr. Reed inappropriately prescribed ciprofloxacin or azithromycin to Patient 1 without any documentation of the rationale

or basis for utilizing these potent broad spectrum antibiotics that should be reserved for select clinical circumstances to maintain their overall usefulness in the population and to avert the emergence of resistant bacterial strains.

Dr. Reed's treatment of Patient 1 included inappropriately prescribing frequent doses of meprobamate for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Further, Dr. Reed failed to document any concern regarding the potential of this patient becoming addicted to and physiologically tolerant of meprobamate.

Dr. Reed appropriately diagnosed Patient 1 as having hyperlipidemia; however, she failed to counsel and/or failed to document that she had counseled the patient concerning a low-lipid diet as part of the treatment plan.

- b. In her care of Patient 2 since 1988, Dr. Reed treated Patient 2 for a sore throat; however, she failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis that warranted antibiotic treatment. She further failed to document the patient's body temperature, and the presence or absence of lymphadenopathy or pharyngeal exudate.

In 1999, Dr. Reed treated Patient 2 for acute cystitis, despite that the urinalysis only demonstrated trace protein rather than signs of inflammation or infection such as positive nitrite, positive leukocytes, or positive blood. Further, she failed to perform and/or document a suprapubic, flank abdominal, or pelvic examination to discern the reason for the patient's presenting complaint of dysuria.

- c. In her care of Patient 3 since 1988, Dr. Reed frequently and inappropriately treated Patient 3 for severe arthritis; however, she often failed to document instances of the delineation of the patient's joint symptomatology such as: which joints, their ranges of motion, and the localization of back discomfort. Further, she failed to perform and/or document musculoskeletal evaluations to support the diagnosis and the prescribing of Tylenol with codeine over multiple years. Further, despite that Patient 3 had an odor of alcohol on his breath on one occasion, in light of the evidence regarding Patient 3, Dr. Reed inappropriately prescribed Tylenol with codeine to Patient 3.

On July 24, 2000, Dr. Reed diagnosed Patient 3 with asthma; however, she failed to perform and/or document a physical assessment to substantiate this diagnosis.

On multiple occasions, Dr. Reed prescribed to Patient 3 prolonged courses of amoxicillin; however, she failed to perform and/or document objective findings to substantiate the rationale for its use, placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics. Dr. Reed also prescribed

amoxicillin at a dosing schedule of four times per day as opposed to the PDR recommended three times per day.

- d. In her care of Patient 4 since 1993, Dr. Reed treated Patient 4 for a sore throat on many occasions; however, she failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis. Although this patient was noted as being allergic to penicillin, Dr. Reed inappropriately prescribed ciprofloxacin or azithromycin to Patient 4 without any documentation of the rationale or basis for utilizing these potent broad spectrum antibiotics that should be reserved for select clinical circumstances to maintain their overall usefulness in the population and to avert the emergence of resistant bacterial strains. She also failed to document the patient's body temperature, and the presence or absence of lymphadenopathy or pharyngeal exudate.

Dr. Reed frequently treated Patient 4 for cystitis; however, she failed perform and/or document an appropriate evaluation and assessment of the patient's symptoms to conclude that the patient had cystitis of bacterial origin.

Dr. Reed prescribed to Patient 4 a steady regimen of Librax over multiple years. On the first instance that Dr. Reed prescribed this medication, the only reason documented in the medical record was simply, "She likes Librax." Further, although Librax is generally prescribed for the treatment of irritable bowel syndrome, Dr. Reed failed to perform and/or document an appropriate evaluation, diagnosis, and/or assessment of the patient's symptoms.

- e. In her care of Patient 5 since 1999, Dr. Reed's treatment of Patient 5 included inappropriately prescribing frequent doses of analgesic controlled substances for the diagnosis of back pain and Xanax for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Similarly, Dr. Reed frequently inappropriately prescribed Darvocet without adequate documentation of an evaluation and assessment of the patient's medical conditions, the response to treatment, or any consideration about the appropriateness of the amount of Darvocet being prescribed. During the course of Dr. Reed's treatment, even though Patient 5 had displayed the following drug-seeking behavior, she continued to inappropriately prescribe controlled substances.
- On May 28, 1999, Dr. Reed documented that Patient 5 expressed a preference for Vicodin.
 - On August 4, 1999, Dr. Reed prescribed to Patient 5 Darvocet and Soma and, the following day, Patient 5 was treated in the emergency department for an apparent overdose of these drugs.

- On June 20, 2000, Dr. Reed noted in the patient record that Patient 5 was very “rude & mad” in her effort to obtain more “pain pills.”
- f. In her care of Patient 6 since 1988, Dr. Reed’s treatment of Patient 6 included inappropriately prescribing frequent doses of analgesic controlled substances, Xanax, sedative-hypnotics, and antidepressants for the corresponding diagnoses of back pain, anxiety, and sleep and depression disorders without performing and/or documenting an appropriate evaluation and assessment of the patient’s symptoms. Further, on August 23, 2000, despite Dr. Reed documenting, “she is so depressed today she can hardly stand it,” Dr. Reed failed to perform and/or document an assessment of the complaint to determine if Patient 6 was in fact suicidal.

Dr. Reed inappropriately prescribed Restoril and ProSom for periods far greater than short term as recommended by the PDR. Further, without clear indication for medical necessity, she inappropriately prescribed to Patient 6 the following combinations of drugs which were hazardous due to their combined effect on the sensorium:

- Meprobamate and Dalmane;
- Lorazepam, Restoril and Soma;
- Lorazepam and ProSom.

Although Dr. Reed often prescribed courses of antibiotics, she failed to perform and/or document an appropriate evaluation, diagnosis, assessment of the patient’s symptoms, and the rationale for their use, thus placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics.

Patient 6 was treated on many occasions for sore throat; however, Dr. Reed failed to perform and/or document a throat culture to substantiate the diagnosis of bacterial-based acute pharyngitis.

- g. In her care of Patient 7 since 1990, Dr. Reed’s treatment of Patient 7 included inappropriately prescribing frequent doses of Xanax for the diagnosis of back pain, and Tranxene for the diagnosis of anxiety, without performing and/or documenting an appropriate evaluation and assessment of the patient’s symptoms. In 1997, a lumbar spine x-ray revealed possible lumbar facet degenerative disease, but subsequent x-rays were reported as appearing normal. Although Patient 7 continued to complain of severe back pain, Dr. Reed failed to order more advanced radiological studies of the back and continued to inappropriately prescribe analgesic controlled substances. Further, she failed to document any concern about this patient becoming addicted to and physiologically tolerant of the controlled substances prescribed by her in this setting.

Placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics, Dr. Reed's treatment of Patient 7 included inappropriately and frequently prescribing antibiotics including the following: amoxicillin on October 14, 1994; February 3 and December 4, 1996; October 1, 1997; January 20, 1998; December 29, 1999; and February 27 and September 26, 2001; and Cipro on April 17, 1998. Additionally, Dr. Reed failed to perform and/or document an appropriate evaluation, diagnosis, and/or assessment of the patient's symptoms.

- h. In her care of Patient 8 since 1988, Dr. Reed's treatment of Patient 8 included inappropriately prescribing frequent doses of Xanax for a diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. On multiple occasions Dr. Reed prescribed to Patient 8 a hazardous combination of Restoril and Xanax; however, she failed to document the rationale for this combination or for the use for either drug alone.

Dr. Reed's treatment of Patient 8 included inappropriately prescribing frequent doses of analgesic controlled substances for headaches of unknown etiology for multiple years. However, she failed to perform and/or document any form of diagnostics, and she failed to undertake any additional pertinent studies to ensure that the headaches were of benign nature.

During the course of Dr. Reed's treatment, even though Patient 8 had displayed the following drug-seeking behavior and/or signs of drug abuse, Dr. Reed continued to inappropriately prescribe controlled substances.

- On October 21, 1991, the patient requested Valium and, although this request was refused, Dr. Reed prescribed Serax, a medication related to Valium.
 - On May 12, 2000, the patient was noted as indicating a preference for Percocet.
 - On May 31, 2001, an emergency department encounter revealed that the patient had a history of substance abuse.
- i. In her care of Patient 9 since 1999, Dr. Reed documented that Patient 9 suffered from pain and discomfort; however, Dr. Reed failed to perform and/or document a corresponding physical examination. Additionally, Dr. Reed treated Patient 9 for neck pain by frequently prescribing analgesic controlled substances for more than two years; however, Dr. Reed failed to order a radiological evaluation of Patient 9's neck to dismiss the possibility of an anatomical pathological lesion and help further discern the nature of the problem.

Dr. Reed's treatment of Patient 9 included inappropriately prescribing frequent doses of sedative-hypnotics for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms.

Further, Dr. Reed prescribed to Patient 9 a steady regimen of Xanax during 2001; however, she failed to document a diagnosis or a treatment plan. Additionally, on several occasions Dr. Reed prescribed Restoril for 30-day periods, which is longer than that indicated in the setting of temporary relief of sleep disorders.

During the course of Dr. Reed's treatment of Patient 9, even though Patient 9 had displayed the following drug-seeking behavior, Dr. Reed continued to inappropriately prescribe controlled substances.

- On June 28, 1999, Dr. Reed documented that Patient 9 had had slurred speech on the phone and that he had requested Darvocet, claiming that he lost his bottle that had a refill. However, Dr. Reed also documented that the patient reported later in the conversation that he in fact got a refill.
 - On April 7, 2000, Dr. Reed documented that the patient, "Thinks he would like to try Codeine." Dr. Reed denied this request; however, she instead prescribed Darvocet.
- j. In her care of Patient 10 since 1996, Dr. Reed's treatment of Patient 10 included inappropriately prescribing frequent doses of controlled substances and sedative-hypnotics for the corresponding diagnoses of back pain and anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Further, Dr. Reed failed to document the localization of back discomfort, the range of motion, and any neurological findings associated with the back pain, such as sciatica from nerve root irritation. She also failed to undertake any additional pertinent studies.

Without a clear indication of medical necessity, Dr. Reed frequently prescribed to Patient 10 a hazardous combination of drugs that are prone to abuse, specifically, Fioricet, Darvocet, Soma, and Ativan. During the course of Dr. Reed's treatment, even though Patient 10 had displayed the following drug-seeking behavior, she continued to inappropriately prescribe controlled substances.

- On May 1, 1999, although Dr. Reed documented that the patient verbally expressed a preference for Fioricet instead of Darvocet and that, "Her husband likes [Fioricet] too," Dr. Reed inappropriately prescribed Fioricet to Patient 10.
 - Despite previously documenting that Patient 10 was allergic to ASA, Dr. Reed inappropriately prescribed Darvon Compound 65 after Patient 10 said that she was no longer allergic to ASA and requested Darvon Compound 65.
- k. In her care of Patient 11 since 1993, Dr. Reed treated Patient 11 for a sore throat on many occasions. However, Dr. Reed failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of

bacterial-based acute pharyngitis to such an extent that it warranted fifteen days of uninterrupted treatment with amoxicillin as opposed to the PDR recommended ten days, which is an inappropriate treatment plan for true streptococcal pharyngitis. Further, Dr. Reed failed to document the patient's body temperature or the presence or absence of lymphadenopathy or pharyngeal exudate. Moreover, placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics, Dr. Reed often prescribed prolonged courses of antibiotics, generally amoxicillin, once at the patient's request; however, she failed to document the underlying diagnosis. Additionally, without documenting the justification, Dr. Reed inappropriately prescribed amoxicillin at a dosing schedule of four times per day as opposed to the PDR recommended three times per day.

2. When treating Patients 1 and 3 through 7, on multiple instances, Dr. Reed gave the patients injections of vitamin B12. She failed to document in the medical records support of a diagnosis of a vitamin B12 deficiency, particularly one that requires parenteral administration of this vitamin, rather than oral administration.
3. When treating Patients 1 through 11, Dr. Reed failed to document and/or demonstrate an active clinical thought process that involved and integrated the following: the collection of subjective findings from the patient; followed by the collection of objective findings by the physician; establishing differential diagnoses; and then challenging these differential diagnoses with a regimen of trial medications or the furtherance of diagnostic testing to hone in on the true diagnoses.

In addition, with regard to Patients 1 and 3 through 11, Dr. Reed failed to document follow-up care with accompanying medical record documentation relative to the progress of the patient along the continuum of medical care.

4. When treating Patients 1 through 3 and 5 through 11, Dr. Reed routinely failed to maintain records that accurately reflected her evaluation, examination, and the utilization of controlled substances in the treatment of those patients, and the diagnoses and purposes for which the controlled substances were being utilized.
5. With regard to Findings of Fact 4, above, concerning Dr. Reed's care and treatment of Patient 4, the Hearing Examiner could find no evidence that Dr. Reed had prescribed controlled substances to Patient 4. Specifically, there is no evidence in the hearing record that Librax is a controlled substance.
6. The Hearing Examiner could not find any instance where meprobamate had been prescribed to Patient 3, as had been charged in the Board's September 10, 2003, notice of opportunity for hearing.

CONCLUSIONS OF LAW

1. The conduct of Barbara A. Reed, M.D., as set forth in Findings of Fact 1 through 3, that occurred before March 9, 1999, constitutes “[f]ailure to use reasonable care discrimination in the 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, as in effect before March 9, 1999.
2. The conduct of Dr. Reed as set forth in Findings of Fact 1 through 3 that occurred on or after March 9, 1999, constitutes “[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.
3. The conduct of Dr. Reed as set forth in Findings of Fact 1 through 4 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.
4. Rule 4731-11-02(D), Ohio Administrative Code, requires as follows,

A physician shall complete and maintain accurate medical records reflecting the physician’s examination, evaluation, and treatment of all the physician’s patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based.

Ohio Adm.Code 4731-11-02(D), as in effect since September 1, 2000. (Note that the only change from the earlier version of this rule, as in effect from November 17, 1986, through August 31, 2000, was to make the language gender-neutral.)

Accordingly, the conduct of Dr. Reed 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: 4731-11-02(D), Ohio Administrative Code, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

* * * * *

The evidence is clear that Dr. Reed’s continued practice presents a danger to the public.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Barbara A. Reed, M.D., to practice 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.

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

R. Gregory Porter, Esq.
Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF JUNE 9, 2004

REPORTS AND RECOMMENDATIONS

Dr. Davidson announced that the Board would now consider the findings and orders appearing on the Board's agenda. She asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of Veena V. Sengupta, M.D.; Gary Allen Blahnik, M.T.; Jeffrey Thomas Jones, P.A.; Willie L. Josey, M.D.; Grant F. Koher, D.O.; Barbara A. Reed, M.D.; Irene Shulga, M.D.; and Kristopher N. Wankewycz, M.T. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Dr. Davidson	- aye

Dr. Davidson 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. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Dr. Davidson	- aye

Dr. Davidson 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.

Dr. Davidson stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

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

.....

BARBARA A. REED, M.D.

Dr. Davidson directed the Board's attention to the matter of Barbara A. Reed, M.D. She advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

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

Dr. Reed thanked the Board for the opportunity to address it. Dr. Reed advised that she is a member of the Humane Society, and she hates to see animals suffer. She hates to see people suffer, too. She stated that it surprised her to no end when she was told that she should limit the antibiotics given to the elderly folks. They told her that she shouldn't give the elderly so many refills or so many antibiotics, but should limit that because they might be needed for the younger folks. Dr. Reed stated that she still takes care of classmates, who have been out of school for quite a while. It makes her very happy to go to her class reunion and see that they're still alive. She's very happy to give them antibiotics, but now she will not continue to give them extra refills, if that's the way the Board wants it.

Dr. Reed stated that there is also concern about suffering, and she has a lot of patients who are in a lot of pain. She has to prescribe some controlled substances. Dr. Reed stated that she has been trying to prescribe the lowest possible class of narcotic that will cover the pain. She stated that she has decided to cut back on refills on that. She added that she hopes that that will make the Board happy. She stated that she'll try to comply.

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

Mr. Wilcox spoke in support of the Hearing Examiner's Report and Recommendation in this matter. Mr. Wilcox stated that Mr. Porter did a thorough job of summarizing this entire case. Although Dr. Reed has

had a long medical career, it has become clear that Dr. Reed can no longer practice medicine safely. Obviously, Dr. Reed's methods of recordkeeping are outdated and insufficient. She rarely, if ever, identifies the reasons for her treatments or prescriptions in these records. Certainly, no subsequent treatment provider would get any use out of these records.

Mr. Wilcox stated that the most disturbing fact regarding Dr. Reed's care of these patients is her cavalier attitude towards scheduled narcotic medications. Many times during the hearing Dr. Reed said that her patients want drugs like Xanax because they are "popular drugs." She said that her patients want Xanax for their nerve problems. They used to all want Valium. Mr. Wilcox commented that Dr. Reed's attitude seems to be that, as long as her patients ask for a Schedule IV drug, or lower, and not Schedule II drugs, that it is okay for her to give them out in large quantities. Additionally, Dr. Reed's records indicate that many patients were showing signs of obvious drug-seeking behavior, including asking for drugs specifically by name. Dr. Reed did not stem the flow of her prescriptions.

Mr. Wilcox stated that, in summary, this record reflects a physician who routinely prescribes narcotics to multiple patients, rarely documenting the reasons or diagnoses for these prescriptions. She often prescribed refills when none were needed or indicated. She often over-prescribed strong antibiotics and rarely, if ever, recommended alternative treatments or testing.

Mr. Wilcox stated that, sadly, the record in this case clearly indicates that Dr. Reed can no longer safely practice medicine within the minimal standard of care, and her license should be permanently revoked.

DR. BHATI MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF BARBARA A. REED, M.D. DR. STEINBERGH SECONDED THE MOTION.

Dr. Davidson stated that she would now entertain discussion in the above matter.

Dr. Kumar stated that this is a minimal standards case in more ways than one. This is a physician who graduated from medical school in 1949 or earlier, and has been practicing for approximately five decades. Dr. Kumar stated that, if he reads the record correctly, Dr. Reed does not take Medicare, Welfare or any insurance, and she only sees two or three patients a day at her home office. Dr. Kumar stated that he got a little confused when he saw Dr. Reed's objections, because she lists another physician and address.

Dr. Kumar stated that it appears that she has continued practicing in the mode of the 1950s, and that she has never really kept up with the changes in medicine.

Dr. Kumar thanked Mr. Porter and Mr. Wilcox for their professionalism in the hearing process. He said that, if the entire transcript is reviewed, it becomes apparent how difficult it probably was for them to go through this process.

Dr. Kumar stated that, concerning Dr. Reed's recordkeeping, in the 1940s and 1950s, medical students

were taught to keep medical records on small index cards. He stated that he has had in his community physicians who have been practicing for five or six decades, and when you get a release of records from them, the information will come on small cards that only say, "diagnosis this and that", and essentially, they will keep the diagnosis at the bottom of the card. This is what Dr. Reed was taught, this is what she's kept doing all of her life. Dr. Reed doesn't even know what a SOAP (subjective complaint, objective findings, assessment and plan) format is. It appears that time has been passing her by and she has never looked at changing things.

Dr. Kumar commented that he thinks time must be passing by the Board's expert witness and Mr. Wilcox as well, because even though SOAP is the accepted way of documenting, over the last five years there have been further changes under the CMS and AMA guidelines for the documentation system. Ten or fifteen years from now, SOAP will probably also be below minimal standards of care.

Dr. Kumar stated that Dr. Reed's recordkeeping does not come close to today's standards. In the past they were taught that if patients got dizzy, just write "asthma." That's what Dr. Reed wrote in her medical records. That's how she was trained and she never saw the need to change. Concerning ordering of tests, in the '40s and '50s, most physicians made diagnoses from simple physical observation and minor physical examination. CTs and MRIs didn't even exist. Dr. Kumar stated that if you go through the hearing transcript, it appears that Dr. Reed has never even seen a CT or MRI done. It has become very difficult or time consuming for such physicians to accept the CT and MRI. Clinical observations and examinations have actually become secondary. Now when people go the ER, the first thing they do is get a CT and so forth. Dr. Kumar stated that many times Dr. Reed treated people with upper respiratory infections after just looking at the throat. She didn't do cultures and so forth, and, as a matter of fact, she doesn't even know what a Quick Strep test really is.

Dr. Kumar continued, discussing Dr. Reed's use of antibiotics. He noted that Dr. Reed is the product of a time when penicillin was given for everything. There was a great push to give large quantities of antibiotics. If you go back and look at the old PDRs, Dr. Reed is correct. It does not even address the issue of excessive dosing.

Dr. Kumar stated that, to Dr. Reed's credit, she did not prescribe Oxycontin or Vicodin, etc., even though her documentation is lacking. However, five decades have passed by Dr. Reed, and she obviously doesn't have the knowledge or skill to comply with minimal standards. Dr. Kumar stated that he cannot support her continued practice of medicine; however, he doesn't have the heart to essentially impose a permanent revocation. He would have preferred a better way to take her out of the system. Dr. Kumar stated that he would like to give Dr. Reed the option of suspending her license indefinitely, with a provision that if she can complete some courses in medical recordkeeping and narcotic and antibiotic prescribing, she could get her license back.

Dr. Egner stated that she's not going to go through all of the deficiencies because she thinks that Dr. Kumar has done a very good job of listing the serious deficiencies of Dr. Reed's practice. Dr. Egner stated that no one can look at Dr. Reed today and not have their heart go out to her. She graduated from

medical school at a time when she doubts that there were many women in Dr. Reed's class. Dr. Egner stated that she believes that Dr. Reed has probably served the medical community and her own community very well; but, this is just so unfortunate. Dr. Egner stated that she has to believe that Dr. Reed was probably offered the opportunity to voluntarily surrender her license and she chose not to do that. Dr. Egner noted that, even when Dr. Reed spoke to the Board today, it is clear that she does not have a full grasp of what the deficiencies are and what the Board would consider adequate practice. It's not just prescribing things differently.

Dr. Egner stated that she appreciates Dr. Reed's coming to the meeting today, and added that it makes her very sad to take Dr. Reed's license away, but she doesn't think that the Board has any other choice but to do that.

Dr. Reed stated that her patients are doing very well.

Dr. Steinbergh thanked Dr. Reed for coming today. She stated that each physician on the Board and the Board's consumer members know the years of service that she has given to her patients. Dr. Steinbergh stated that when the Board assesses Dr. Reed's medical records, it finds many deficiencies indicating that Dr. Reed has not kept up with medical practice of the day, and that it's undoubtedly time for her to retire her license.

Dr. Steinbergh stated that Dr. Reed does have a medical degree, and she will always have that. The Board cannot take that from her, and she will always be able to go to her class reunions. However, under the Board's assessment, it is not safe for Dr. Reed to practice any longer.

Dr. Reed asked whether this is just because she doesn't keep records like the Board expects people to do.

Dr. Steinbergh stated that it's for not keeping medical records up to date, for not examining and assessing patients in a way that is consistent with contemporary medical care, for prescribing in a way...

Dr. Reed interrupted, stating that she doesn't write down all those things because she saw no necessity for it because nobody looks at her records.

Dr. Steinbergh stated that she understands, but added that the development of a medical record for all physicians is to allow that, if Dr. Reed were gone from the practice tomorrow, and her patients relied on another physician to come in, that that physician would be able to see the kinds of concerns that Dr. Reed had, and what her assessments have been in the past.

Dr. Reed stated that she has her diagnosis there.

Dr. Steinbergh stated that that would help the physician make diagnoses today. Nevertheless, Dr. Reed's prescribing of antibiotics and controlled substances has been inappropriate for quite a period of time. She advised that the Medical Board is charged with protecting the public. All physicians have to meet the same

standard, and if the Board finds, as it has in this case, that the medical records and the prescribing has been inappropriate, the Board is charged with making a decision as to whether or not a physician has the ability to appropriately practice in this day and age. Dr. Steinbergh stated that the Board doesn't feel that Dr. Reed can practice any longer. Dr. Steinbergh added that it's very difficult for the Board to make that decision because it does respect the past medical care that Dr. Reed has given her patients.

Dr. Reed stated that she thinks that the Board is overlooking the fact that her patients are doing well. She stated that that's a factor. She added that she's also not able to get all of the medical tests that they like to have now because they've closed half the hospitals in the state, and there's only one hospital left in the city (Mansfield).

Dr. Steinbergh advised that the Board has reviewed the record, and it does appreciate her opinion on all of this.

Dr. Bhati asked that the Board allow one of its staff members to talk with Dr. Reed to see if she would be willing to consider voluntarily surrendering her license instead.

Dr. Egner stated that Dr. Reed is not going to do that. Even today, as Dr. Steinbergh is talking to her, Dr. Reed is justifying her actions.

Dr. Steinbergh stated that, initially, she agreed with Dr. Kumar; that a suspension of Dr. Reed's license and an opportunity to become re-educated would be appropriate. Dr. Steinbergh stated that she doesn't think that's possible anymore.

Dr. Kumar stated that the Board can indefinitely suspend Dr. Reed's license and require certain things for reinstatement. He added that that probably won't happen. In essence, the Board would be revoking her, but still give her the option for retraining.

DR. KUMAR MOVED TO AMEND THE PROPOSED ORDER TO SUBSTITUTE AN ORDER OF INDEFINITE SUSPENSION WITH CONDITIONS FOR REINSTATEMENT. The motion died for lack of a second.

Dr. Egner stated that the problem here is that Dr. Reed is elderly, she's a woman, and she's sweet, and it's really hard to revoke her license. If the Board looked at Dr. Reed's practice of medicine, no matter the age, the Board would say that this is well below minimal standards. If Dr. Reed would surrender her license permanently, the Board members would all feel better. Dr. Egner stated that it's always difficult for the Board to permanently revoke a license, but Dr. Reed deserves the same consideration that the Board gives all of its licensees. The Board should be giving all of its licensees the same consideration that it is giving Dr. Reed. Dr. Egner stated that the Board wouldn't offer a permanent suspension to a 40-year-old physician with this kind of practice. The Board only has two choices: Dr. Reed permanently surrenders, or, if she doesn't, the Board must permanently revoke.

Dr. Bhati suggested taking a short break. He noted that he believes that Dr. Reed is considering her options.

Dr. Davidson at this time stated that the Board would take a brief break. When the meeting reconvened, all members were present.

**DR. KUMAR MOVED TO REMOVE THE MATTER OF DR. REED FROM THE TABLE.
DR. BHATI SECONDED THE MOTION. A vote was taken:**

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Dr. Davidson	- aye

The motion carried.

Dr. Bhati stated that he understands that people have tried to achieve what he has tried to achieve during the break. He stated that he couldn't, and apologized to the Board for the time spent.

Dr. Steinbergh stated that Dr. Reed simply doesn't understand. Her feeling is that she has patients to take care of and she doesn't understand any of this.

Dr. Bhati stated that he doesn't believe that the Board is left with any option other than revocation.

Dr. Talmage suggested that the Board, if it desired, could revoke a physician's license but allow a few days for the physician to voluntarily surrender instead, and to wind down his or her practice.

Dr. Steinbergh stated that she does want to give Dr. Reed 30 days' time to wind down her practice if she surrenders.

DR. BHATI MOVED TO AMEND THE PROPOSED ORDER TO MAKE THE PERMANENT REVOCATION EFFECTIVE TWO WEEKS FROM THE DATE OF MAILING OF THE ORDER, ABSENT THE BOARD'S RECEIPT OF DR. REED'S PERMANENT SURRENDER WITHIN TWO WEEKS OF THIS MEETING.

Dr. Bhati stated that if Dr. Reed agrees to voluntarily surrender her license on a permanent basis within the

next two weeks, he would be inclined to have the board accept that surrender, at which time she would be allowed 30 days to wind down her practice.

Board members voiced their agreement.

DR. STEINBERGH SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Dr. Davidson	- aye

The motion carried.

DR. BHATI MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF BARBARA A. REED, M.D. MR. BROWNING SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Dr. Davidson	- aye

The motion carried.



State Medical Board of Ohio

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

September 10, 2003

Barbara A. Reed, M.D.
177 Park Ave W
Mansfield, Ohio 44902

Dear Doctor Reed:

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, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

In the routine course of your practice, you undertook the treatment of Patients 1 to 11, as identified on the attached confidential Patient Key. (The Patient Key is to be withheld from public disclosure).

- (1) As demonstrated in your patient records, you excessively and/or otherwise inappropriately prescribed controlled substances and dangerous drugs to Patients 1 to 11 without performing appropriate histories and physical examinations, without utilizing diagnostic testing or other methods of evaluating the validity of the patients' complaints or the nature or severity of the patients' reported pain, without devising treatment plans, without periodically reassessing the effectiveness of the treatment, and/or without appropriately documenting the above actions. In addition, at times, such prescribing occurred despite your knowledge that the patients were abusing controlled substances or exhibiting drug-seeking behavior. Further, you failed to provide and/or document the rationale for prescribing prolonged courses of antibiotics, placing the patients at great risk for developing bacterial infections resistant to commonly used antibiotics, and/or you prescribed potent broad spectrum antibiotics that should be reserved for select clinical circumstances in order to maintain their overall use in the population and impede the emergence of resistant bacterial strains.

Examples of such prescribing and/or conduct include, but are not limited to, the following:

- (a) In your care of Patient 1 since 1994, you frequently treated Patient 1 for a sore throat, however you failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis that warranted fifteen days of uninterrupted treatment with amoxicillin as opposed to the PDR recommended ten days.

Mailed 9-11-03

You prescribed amoxicillin on February 21, 1995, Cipro on March 8, 1999, and Keflex on August 14, 2000, all of which in manners that were inappropriate treatment plans for true streptococcal pharyngitis. Placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics, you often prescribed prolonged courses of antibiotics, however you failed to document the use and the diagnosis. Additionally, without documenting the justification, you inappropriately prescribed amoxicillin at a dosing schedule of four times a day as opposed to the PDR recommended three times a day. You also failed to document the patient's body temperature, and the presence or absence of lymphadenopathy or pharyngeal exudate. Instead of prescribing penicillin or amoxicillin, you inappropriately prescribed ciprofloxacin and azithromycin, to Patient 1 without any documentation of the rationale or basis for utilizing these potent broad spectrum antibiotics that should be reserved for select clinical circumstances to maintain their overall use in the population and avert the emergence of resistant bacterial strains.

Your treatment of Patient 1 included inappropriately prescribing frequent doses of meprobamate for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Further, you failed to document any concern regarding the potential of this patient becoming addicted to and physiologically tolerant of meprobamate.

You appropriately diagnosed Patient 1 as having hyperlipidemia, however you failed to counsel and/or failed to document that you counseled the patient on a low-lipid diet as part of the treatment plan.

- (b) In your care of Patient 2 since 1988, you treated Patient 2 for a sore throat, however you failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis that warranted antibiotic treatment. You further failed to document the patient's body temperature, and the presence or absence of lymphadenopathy or pharyngeal exudate.

In 1999, you treated Patient 2 for acute cystitis, despite that the urinalysis only demonstrated trace protein rather than signs of inflammation or infection such as positive nitrite, positive leukocytes, or positive blood. Further, you failed to perform and/or document a suprapubic or flank abdominal examination or a pelvic exam to discern the reason for the patient's presenting complaint of dysuria.

- (c) In your care of Patient 3 since 1988, you frequently and inappropriately treated Patient 3 for severe arthritis, however you often failed to document instances of the delineation of the patient's joint symptomatology such as,

which joints, their range of motion, and the localization of back discomfort. Further, you failed to perform and/or document musculoskeletal evaluations to support the diagnosis and the prescribing of Tylenol with codeine over multiple years. You failed to perform and/or document any vigilance for issues surrounding the potential of this patient becoming addicted to and physiologically tolerant of the meprobamate also utilized in this setting. Further, despite that Patient 3 had an odor of alcohol on his breath on one occasion, you inappropriately prescribed Tylenol with codeine to Patient 3.

On July 24, 2000, you diagnosed Patient 3 with asthma, however you failed to perform and/or document a physical assessment to substantiate this diagnosis.

On multiple occasions, you prescribed to Patient 3 prolonged courses of amoxicillin, however you failed to perform and/or document objective findings to substantiate the rationale for its use, placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics. You also prescribed amoxicillin at a dosing schedule of four times a day as opposed to the PDR recommended three times a day.

- (d) In your care of Patient 4 since 1993, you treated Patient 4 for a sore throat on many occasions, however you failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis. Although this patient was noted as being allergic to penicillin, you inappropriately prescribed ciprofloxacin and azithromycin, to Patient 4 without any documentation of the rationale or basis for utilizing these potent broad spectrum antibiotics that should be reserved for select clinical circumstances to maintain their overall use in the population and avert the emergence of resistant bacterial strains. You also failed to document the patient's body temperature, and the presence or absence of lymphadenopathy or pharyngeal exudate.

You frequently treated Patient 4 for cystitis, however you failed perform and/or document an appropriate evaluation and assessment of the patient's symptoms to conclude that the patient had cystitis of bacterial origin.

You prescribed to Patient 4 a steady regimen of Librax over multiple years. On the first instance that you prescribed this medication, the only reason you listed was simply, "She likes Librax." Despite that Librax is generally prescribed for the treatment of irritable bowel syndrome, you failed to perform and/or document an appropriate evaluation, diagnosis, and/or assessment of the patient's symptoms.

- (e) In your care of Patient 5 since 1999, your treatment of Patient 5 included inappropriately prescribing frequent doses of analgesic controlled substances

for the diagnosis of back pain and Xanax for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Similarly, you frequently inappropriately prescribed Darvocet without adequate documentation of an evaluation and assessment of the patient's medical conditions, the response to treatment or any consideration about the appropriateness of the amount of Darvocet being prescribed. During the course of your treatment, even though Patient 5 had displayed the following drug-seeking behavior, you continued to inappropriately prescribe controlled substances:

- On May 28, 1999, you documented that Patient 5 expressed a preference for Vicodin.
- On August 4, 1999, you inappropriately prescribed to Patient 5 Darvocet and Soma, and on August 5, 1999, Patient 5 was treated in the emergency department for an apparent overdose of these drugs.
- On June 20, 2000, you noted in the patient record that Patient 5 was very "rude & mad" in her effort to obtain more "pain pills."

- (f) In your care of Patient 6 since 1988, your treatment of Patient 6 included inappropriately prescribing frequent doses of analgesic controlled substances, Xanax, sedative-hypnotics and antidepressants for the corresponding diagnoses of back pain, anxiety, sleep and depression disorders without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Further, on August 23, 2000, despite your documenting, "she is so depressed today she can hardly stand it," you failed to perform and/or document an assessment of the complaint and determine if Patient 6 was in fact suicidal.

The patient was treated on many occasions for sore throat, however you failed to perform and/or document a throat culture to substantiate the diagnosis of bacterial-based acute pharyngitis.

You inappropriately prescribed Restoril and Prosom for periods far greater than short term as recommended by the PDR. Further, without clear indication for medical necessity, you inappropriately prescribed to Patient 6 the following hazardous combinations of drugs relative to their combined effect on the sensorium:

- Meprobamate and Dalmane;
- Lorazepam, Restoril and Soma;
- Lorazepam and Prosom.

Although you often prescribed courses of antibiotics, you failed to perform and/or document an appropriate evaluation, diagnosis, assessment of her symptoms, and the rationale for their use, thus placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics.

- (g) In your care of Patient 7 since 1990, your treatment of Patient 7 included inappropriately prescribing frequent doses of Xanax for the diagnosis of back pain and Tranzene for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. In 1997, a lumbar spine x-ray revealed possible lumbar facet degenerative disease, but subsequent x-rays appeared to be normal. Despite that Patient 7 continued to complain of severe back pain, you failed to order more advanced radiological studies of the back and continued to inappropriately prescribe analgesic controlled substances. Further, you failed to document any concern about this patient becoming addicted to and physiologically tolerant of the controlled substances prescribed by you in this setting.

Placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics, your treatment of Patient 7 included inappropriately and frequently prescribing antibiotics: amoxicillin on October 14, 1994, February 3, 1996, December 4, 1996, October 1, 1997, January 20, 1998, December 29, 1999, February 27, 2001, September 26, 2001, and Ciprofloxacin on April 17, 1998. Additionally, you failed to perform and/or document an appropriate evaluation, diagnosis, and/or assessment of the patient's symptoms.

- (h) In your care of Patient 8 since 1988, your treatment of Patient 8 included inappropriately prescribing frequent doses of Xanax for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. On multiple occasions you prescribed to Patient 8 a hazardous combination of Restoril and Xanax, however you failed to document the rationale for this combination or the use for either drug alone.

Your treatment of Patient 8 included inappropriately prescribing frequent doses of analgesic controlled substances for headaches of unknown etiology for multiple years. However, you failed to perform and/or document any form of diagnostics, and you failed to undertake any additional pertinent studies to ensure that the headaches were of benign nature.

During the course of your treatment, even though Patient 8 had displayed the following drug-seeking behavior and/or signs of drug abuse, you continued to inappropriately prescribe controlled substances:

- On October 21, 1991, the patient requested Valium, and, although this request was refused, you prescribed Serax.
 - On May 12, 2000, the patient was noted as indicating a preference for Percocet.
 - On May 31, 2001, an emergency department encounter revealed that the patient had a history of substance abuse.
- (i) In your care of Patient 9 since 1999, you documented that Patient 9 suffers from pain and discomfort however you failed to perform and/or document a corresponding physical examination. Additionally, you treated Patient 9 for neck pain by frequently prescribing analgesic controlled substances for more than two years, however you failed to order a radiological evaluation of Patient 9's neck to dismiss the possibility of an anatomical pathological lesion and help further discern the nature of the problem.

Your treatment of Patient 9 included inappropriately prescribing frequent doses of sedative-hypnotics for the diagnosis of anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Further, you prescribed to Patient 9 a steady regimen of Xanax during 2001, however you failed to document a diagnosis or a treatment plan. Additionally, on several occasions you prescribed Restoril for 30-day periods, which is longer than that indicated in the setting of temporary relief of sleep disorders.

During the course of your treatment, even though Patient 9 had displayed the following drug-seeking behavior, you continued to inappropriately prescribe controlled substances:

- On April 7, 2000, you documented that the patient, "Thinks he would like to try Codeine." You denied this request, however you instead prescribed Darvocet.
 - On June 28, 1999, you documented that Patient 9 had slurred speech on the phone and requested Darvocet, claiming that he lost his bottle that had a refill. However, you also documented that the patient reported later in the conversation that he in fact got a refill.
- (j) In your care of Patient 10 since 1996, your treatment of Patient 10 included inappropriately prescribing frequent doses of controlled substances and sedative-hypnotics for the corresponding diagnoses of back pain and anxiety without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Further, you failed to document the localization of back discomfort, the range of motion and any neurological

findings associated with the back pain, such as sciatica from nerve root irritation. You also failed to undertake any additional pertinent studies.

Without a clear indication of medical necessity, you frequently prescribed to Patient 10 the following hazardous combination of drugs that are prone to abuse: Fioricet, Darvocet, Soma, and Ativan. During the course of your treatment, even though Patient 10 had displayed the following drug-seeking behavior, you continued to inappropriately prescribe controlled substances:

- On May 1, 1999, although you documented that the patient verbally expressed a preference for Fioricet instead of Darvocet and that, "Her husband likes this (Fioricet) too," you inappropriately prescribed Fioricet to Patient 10.
- Despite documenting that Patient 10 was allergic to ASA, you inappropriately prescribed Darvon Compound 65 after Patient 10 said that she was no longer allergic to ASA and requested Darvon Compound 65.

(k) In your care of Patient 11 since 1993, you treated Patient 11 for a sore throat on many occasions, however you failed to perform and/or document an appropriate evaluation and/or a throat culture to substantiate a diagnosis of bacterial-based acute pharyngitis to such an extent that it warranted fifteen days of uninterrupted treatment with amoxicillin as opposed to the PDR recommended ten days, which is an inappropriate treatment plan for true streptococcal pharyngitis. Further, you failed to document the patient's body temperature or the presence or absence of lymphadenopathy or pharyngeal exudate. Placing the patient at great risk for developing bacterial infections resistant to commonly used antibiotics, you often prescribed prolonged courses of antibiotics, generally amoxicillin, once at the patient's request, however you failed to document the use and the diagnosis. Additionally, without documenting the justification, you inappropriately prescribed amoxicillin at a dosing schedule of four times a day as opposed to the PDR recommended three times a day.

(2) Additionally, when treating Patients 1 and 3 through 7, on multiple instances, you gave the patients injections of vitamin B12. You failed to document in the medical records support of the diagnoses of a B12 deficiency, particularly one that requires parenteral administration of this vitamin as opposed to the oral route.

(3) Additionally, when treating Patients 1 through 11, you failed to document and/or demonstrate an active clinical thought process that involved and integrated the following: the collection of subjective findings from the patient; followed by the collection of objective findings by the physician;

then establishing differential diagnoses; challenging these differential diagnoses with a regimen of trial medications or the furtherance of diagnostic testing to hone in on the true diagnoses; and, finally performing follow-up care with accompanying medical record documentation relative to the progress of the patient along the continuum of medical care.

- (4) Additionally, when treating Patients 1 through 11, you routinely failed to maintain records which accurately reflected your evaluation, examination, and the utilization of controlled substances in the treatment of those patients, and the diagnoses and purposes for which the controlled substances were being utilized.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above that occurred before March 9, 1999, individually and/or collectively, constitute “[f]ailure to use reasonable care discrimination in the 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, as in effect before March 9, 1999.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above that occurred on or after March 9, 1999, 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) through (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, 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, as in effect from November 17, 1986 through August 31, 2000 and since September 1, 2000. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

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 (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, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, 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/blt
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5140 3686
RETURN RECEIPT REQUESTED



STATE MEDICAL BOARD OF OHIO

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

August 16, 1996

Barbara A. Reed, M.D.
177 Park Avenue West
Mansfield, Ohio 44902

Dear Doctor Reed:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Esq., Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 14, 1996, including Motions approving and confirming the Findings of Fact, and the Conclusions of Law 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 may be taken to the Franklin County Court of Common Pleas only.

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

THE STATE MEDICAL BOARD OF OHIO

Thomas E. Gretter, M.D.
Secretary

TEG:em
Enclosures

CERTIFIED MAIL RECEIPT NO. P 152 983 634
RETURN RECEIPT REQUESTED

Mailed 8-27-96



STATE MEDICAL BOARD OF OHIO

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

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Sharon W. Murphy, Esq., Attorney Hearing Examiner, State Medical Board; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 14, 1996, including Motions approving and confirming the Findings of Fact, and the Conclusions of Law 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 Barbara A. Reed, M.D., as it appears in the Journal of the State Medical Board of Ohio.

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

A handwritten signature in black ink, appearing to read "T. E. Gretter, M.D.", written over a horizontal line.

Thomas E. Gretter, M.D.
Secretary

(SEAL)

8/19/96

Date



STATE MEDICAL BOARD OF OHIO

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

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

BARBARA A. REED, M.D.

*

ENTRY OF ORDER

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

Upon the Report and Recommendation of Sharon W. Murphy, Hearing Examiner, Medical Board, in this matter designated pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the 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:

Barbara A. Reed, M.D., is hereby REPRIMANDED.

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

Thomas E. Gretter, M.D.

Secretary

(SEAL)

8/19/96

Date

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**REPORT AND RECOMMENDATION
IN THE MATTER OF BARBARA A. REED, M.D.**

The Matter of Barbara A. Reed, M.D., was heard by Sharon W. Murphy, Attorney Hearing Examiner for the State Medical Board of Ohio, on June 27, 1996.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated April 17, 1996, the State Medical Board of Ohio [Board] notified Barbara A. Reed, M.D., that it proposed to take disciplinary action against her certificate to practice medicine and surgery in Ohio based on one or more of the following allegations:

On or about June 9, 1992, Dr. Reed signed an application for renewal of her Ohio certificate to practice medicine and surgery. On the application, Dr. Reed certified that the information contained therein was true and correct. The application asked the question, "At any time since signing your last application for renewal of your certificate have you . . . 4) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?" Dr. Reed answered "No," despite the fact that, on or about March 18, 1992, the Peoples Hospital in Mansfield, Ohio, had imposed a co-admitting requirement upon her clinical privileges. The hospital cited quality of care issues as the basis of its actions.

The Board asserted that Dr. Reed's conduct constitutes "fraud, misrepresentation, or deception in applying for or securing any license or certificate issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code, [and] 'publishing a false, fraudulent, deceptive, or misleading statement,' as that clause is used in Section 4731.22(B)(5), Ohio Revised Code." In addition, the Board alleged that Dr. Reed's conduct constitutes "[t]he 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."

In addition, the Board advised Dr. Reed of her right to request a hearing in this matter. (State's Exhibit 1).

- B. On May 15, 1996, Dr. Reed filed a written hearing request. (State's Exhibit 2).

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Patrick W. Beatty, Assistant Attorney General.
- B. On behalf of Respondent: Dr. Reed, having been apprised of her right to be represented by counsel, appeared on her own behalf.

EVIDENCE EXAMINED

I. Testimony Heard

Presented by Respondent: Barbara A. Reed, M.D.

II. Exhibits Presented

In addition to State's Exhibits 1 and 2, noted above, the following exhibits were identified and admitted into evidence:

A. Presented by the State:

1. State's Exhibit 3: Copy of a May 21, 1996, letter to Dr. Reed from the Board, notifying her that a hearing had been scheduled for May 29, 1996, but further advising that the hearing had been postponed pursuant to Section 119.09, Ohio Revised Code.
2. State's Exhibit 4: Copy of a May 22, 1996, letter to Dr. Reed from the Board scheduling the hearing for June 27, 1996. (2 pp.)
3. State's Exhibit 5: Copy of Dr. Reed's application for renewal of her certificate to practice medicine and surgery in Ohio, signed by Dr. Reed on June 9, 1992.
4. State's Exhibit 6: Certified copies of letters sent to Dr. Reed [and another physician] from Peoples Hospital on December 24, 1991, and March 18, 1992. (7 pp.)

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B. Presented by Respondent:

1. Respondent's Exhibit A: Copy of a May 18, 1992, letter to Elizabeth Reed, M.D., from the Department of Health and Human Services, advising Dr. Elizabeth Reed that the department had rejected allegations made against her by the Peer Review Systems, Inc.
2. Respondent's Exhibit B: Copy of a June 19, 1996, letter to the Assistant Attorney General from Dr. Barbara Reed advising that Dr. Barbara Reed had received a letter from the Department of Health and Human Services which was "virtually identical" to the letter sent to Dr. Elizabeth Reed. [See Respondent's Exhibit A].
3. Respondent's Exhibit C: Copy of a June 19, 1996, letter to the Board from Philip R. Dever, Chief Executive Officer of Peoples Hospital, written in support of Dr. Reed. (2 pp.)
4. Respondent's Exhibit D: Copy of a Physician's Order sheet from Peoples Hospital dated October 15, 1991, purported to be taken from the medical records of Dr. Reed's late husband, ordering that no orders shall be taken from Dr. Reed.
5. Respondent's Exhibit E: Copy of a page purported to be from the medical records of Dr. Reed's late husband, where Dr. Reed notes that the patient is in a coma, with shock and severe dehydration.

C. Admitted at hearing on the Attorney Hearing Examiner's own motion:

Board Exhibit A: Copies of the following documents:

1. A November 23, 1992, letter written to Dr. Reed from Peoples Hospital, Inc., responding to Dr. Reed's request for restoration of full admitting privileges;
2. A March 18, 1992, letter to Dr. Reed from Peoples Hospital, Inc., advising that co-admitting limitations had been placed on her hospital privileges; and
3. A certified mail envelope addressed to the Board from Dr. Reed dated June 18, 1996.

SUMMARY OF THE EVIDENCE

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

1. Barbara A. Reed, M.D., is a solo practitioner. Dr. Reed stated that she is "board eligible" in Internal Medicine, but has never taken the certifying examination. Dr. Reed maintains a private practice and sees "a few patients" during her afternoon office hours. Dr. Reed testified that her patients are generally elderly people she has known all her life who like to visit her office. Dr. Reed does not admit patients to any hospital at this time. (Transcript [Tr.] at 32-34; State's Exhibit [St. Ex.] 2).
2. By letter dated December 24, 1991, Joseph Damoff, President, People's Hospital, Inc., in Mansfield, Ohio, advised Dr. Reed that the Medical Staff of Peoples Hospital had suspended her full admitting privileges. The decision was made "upon a belief that summary suspension [was] in the best interest of patient care in the Hospital," due to "quality of care issues." Nevertheless, the hospital did allow Dr. Reed to co-admit patients with another physician on the active medical staff of Peoples Hospital. Dr. Reed personally signed the certified mail receipt on December 27, 1991. (St. Ex. 6 at 5-6).

Subsequently, by letter dated March 18, 1992, Joseph Damoff advised Dr. Reed that the Board of Trustees had accepted the recommendation of the Medical Staff Executive Committee that Dr. Reed be restricted to co-admitting privileges only. The letter further advised that because Dr. Reed had failed to request a hearing in the matter, the Board of Trustee's decision was final and the matter would be reported to the National Practitioner Data Bank. (St. Ex. 6 at 7).

Thereafter, Dr. Reed requested that the hospital review the decision to limit her admitting privileges. By letter dated November 23, 1992, the Department of Medicine informed Dr. Reed that the committee had recommended that her "co-admission status be maintained for six months and then re-evaluated." (Board Exhibit A).

3. On June 9, 1992, Dr. Reed signed an application for renewal of her certificate to practice medicine and surgery in Ohio. On the application, Dr. Reed certified that the information contained therein was true and correct. Nevertheless, Dr. Reed responded negatively to the question:

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At any time since signing your last application for renewal of your certificate have you . . .

- 4) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

(St. Ex. 5).

4. At hearing, Dr. Reed raised diverse arguments in her defense. First, Dr. Reed testified that, at the time Peoples Hospital limited her privileges, she did not consider it a disagreeable development. For the first time in her life, she did not have to take night call or emergency room call. Dr. Reed stated that she thought it was a privilege or benefit which came with age. (Tr. at 8, 30-31; St. Ex. 2). Nevertheless, Dr. Reed admitted that she was aware that the restriction had been placed on her admitting privileges. Moreover, she admitted that she had requested that Peoples Hospital reconsider the restriction. She also explained that the hospital had informed her in November 1992 that they would reconsider the matter in six months. However, when she did not hear anything after six months, she assumed that the restriction had been terminated. Dr. Reed implied that, since she believed the restriction was a privilege rather than a burden and since it had been only temporary, she had not been required to report it on her renewal application. (Tr. at 26-31).

Dr. Reed further argued that Mr. Damoff had instituted the restriction on her admitting privileges to prevent Dr. Reed from suing the hospital over the care received by her husband, a Moslem, while he was a patient in that hospital. Dr. Reed testified the Mr. Damoff came to Peoples Hospital from Yugoslavia. Dr. Reed further testified that she had asked Mr. Damoff to tell her why people in Yugoslavia were killing each other, but Mr. Damoff wouldn't tell her; he only gave her an evasive answer. She stated that she only found out later that the problems in Yugoslavia were based on religious hatred. Dr. Reed explained that she had not been aware of the religious hatred when she admitted her husband to Peoples Hospital in 1991. Nevertheless, Dr. Reed believed that the religious hatred between Yugoslavians caused Mr. Damoff to tell the nurses to accept orders only from "immigrant doctors," and not from Dr. Reed. Dr. Reed concluded that Mr. Damoff contributed to her husband's death because "the immigrant doctors were not treating him properly." In addition, a nurse at the hospital "poured syrup into his lungs and stomach," and the hospital staff gave her husband a contaminated blood transfusion and an overdose of medication. Finally, her husband suffered shock and severe

dehydration and was mistreated by the attending physician. Dr. Reed transferred her husband to another institution where he eventually died. Dr. Reed testified that Mr. Damoff feared that Dr. Reed would sue the hospital because of the mistakes made in the care of her husband. Therefore, in order to prevent a lawsuit, Mr. Damoff ordered that her privileges be limited. (Tr. at 18-23, 34, 38-39; Respondent's Exhibits [Resp. Exs.] D and E).

Dr. Reed also argued that the original letters sent to her from Peoples Hospital, on December 24, 1991, and March 18, 1992, informing her that her privileges had been limited, differed from those presented at hearing. Dr. Reed alleged that the letters had been changed or amended when put into the hospital files. Although Dr. Reed did not retain her copies of the letters, she alleged that the file copies referenced an additional two patients. She further testified that Mr. Damoff had altered the letters in the file, which he can do because he owns the hospital. (Tr. at 10, 16-18, 23; St. Ex. 2). Dr. Reed denied having seen the file copies of the letters from the file prior to the hearing. (Tr. at 23-24). On cross-examination, however, Dr. Reed admitted that she had sent a copy of the March 18, 1992, letter to the Board on June 18, 1996. (Tr. at 29-30; Board Exhibit A).

Dr. Reed raised a fourth defense, but her argument is not relevant to the matters at issue. In addition, the evidence upon which her argument is based is a letter sent to Dr. Reed's sister, Elizabeth Reed, M.D. (Resp. Ex. A). Dr. Reed claimed that she had received an identical letter from the Department of Health and Human Services [DHHS], but that she was unable to locate her own letter. (Resp. Ex. B). Nevertheless, based on the letter which had allegedly been sent to her, Dr. Reed objected to the admission of the December 1991 and March 1992 letters from Peoples Hospital. She reasoned that the suspension was based on charges alleged against her by the Peer Review Systems, Inc., [PRO]. The PRO recommended to DHHS that Dr. Barbara Reed be excluded from participation in Medicare and Medicaid programs because she had "violated [her] obligation to provide care of a quality that meets professionally recognized standards of health care" in the care of one patient. Dr. Reed concluded, however, that after reviewing PRO's claims, DHHS determined that the evidence did not support the PRO's findings, and the case against Dr. Barbara Reed was dismissed with prejudice. Therefore, Dr. Reed implied that because DHHS had exonerated her, she had not been responsible to inform the Board of the limitation on her admitting privileges at Peoples Hospital. (Tr. at 13-15; Resp. Ex. A).

5. On June 19, 1996, Philip R. Dever, Chief Executive Officer, Peoples Hospital, wrote to the Board in support of Dr. Reed. (Resp. Ex. C).

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FINDINGS OF FACT

1. On or about June 9, 1992, Dr. Reed signed an application for renewal of her Ohio certificate to practice medicine and surgery. On the application, she certified that the information contained therein was true and correct.

The application asked the question, "At any time since signing your last application for renewal of your certificate have you . . . 4) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?" Dr. Reed answered "No."

2. At the time of completing her application for renewal, Dr. Reed was aware that the Peoples Hospital, Inc., in Mansfield, Ohio, had imposed a co-admitting requirement upon her clinical privileges based on quality of care issues.
3. Although Dr. Reed admitted that she had been aware of the limitations on her admitting privileges to Peoples Hospital, it is not clear that she fully understood the implications of those limitations when completing her application for renewal. Her testimony regarding these issues was inconsistent, inappropriate, and confused.
4. No allegations were made, nor evidence presented, regarding the quality of care provided by Dr. Reed.

CONCLUSIONS

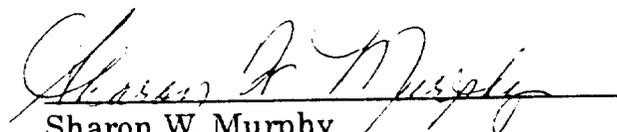
1. Dr. Reed's conduct, as described in Findings of Fact 1 and 2, constitutes "misrepresentation or deception in applying for or securing any license or certificate issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code.
2. In addition, Dr. Reed's conduct, as set forth in Findings of Fact 1 and 2, constitutes "publishing a false, deceptive, [and] misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.
3. Finally, due to the confusing testimony provided by Dr. Reed, the evidence is insufficient to support a conclusion that Dr. Reed's conduct constitutes "[t]he 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.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Barbara A. Reed, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of sixty (60) days.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio. In the thirty (30) day interim, Dr. Reed shall not undertake the care of any patient not already under her care.


Sharon W. Murphy
Attorney Hearing Examiner



EXCERPT FROM THE DRAFT MINUTES OF AUGUST 14, 1996

REPORTS AND RECOMMENDATIONS

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

Dr. Stienecker asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Robert L. Abdalla, M.T.; Matthew A. Polito, D.P.M.; Barbara A. Reed, M.D.; Esther Elizabeth Reed, M.D.; Joseph E. Rich, M.D.; and Anthony D. Zucco, D.O.

A roll call was taken:

ROLL CALL:	Mr. Albert	- nay
	Dr. Bhati	- aye
	Dr. Heidt	- aye
	Dr. Gretter	- aye
	Dr. Egner	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Dr. Stienecker	- aye

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

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

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

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

.....
REPORT AND RECOMMENDATION IN THE MATTER OF BARBARA A REED, M.D.

Dr. Stienecker stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and order in the above matter. No objections were voiced by Board members present.

Dr. Stienecker advised that a request to address the Board has been timely filed on behalf of Dr. Reed. Dr. Reed would be allotted approximately five minutes for her address.

Dr. Reed indicated that she had no objection to the absence of a court reporter, and understands that the Board's minutes are the official record of the Board.

Dr. Reed indicated that she was quite concerned by the accusations against her because there are several errors in the paper the Board sent her. One was the fact that the attorney had a copy of a letter from Mr. Damoff, the superintendent of People's Hospital, and the attorney said that she had received a copy of this letter. That was an error. She never received a copy of that letter. The letter that she had was a copy that was given to her by a secretary at People's Hospital. That's the first time she had ever seen that letter. Dr. Reed stated that that letter was totally different from the letter Mr. Damoff had sent her. This letter had obviously been written by an attorney and is not the letter she received from him. Dr. Reed continued that the State's attorney stated that she had received this letter, and that is not correct. It was given to her by a secretary at People's Hospital a couple of months ago. That was the first time she had seen the letter at all. She believes this is a definite error. Dr. Reed repeated that the first time she saw the letter was a couple of months ago. Connie West, a nurse at People's Hospital, sent a copy of this letter to the Medical Board.

Dr. Reed stated that she had received a letter from the Inspector General saying that all of the previous accusations had been dispensed with and, as far as she was concerned, she thought all of her privileges had been restored when she received the letter from the Department of Health and Human Services (D.H.H.S.) and from Eileen T. Boyd, the Assistant Inspector General from the D.H.H.S. in Washington. In her letter Ms. Boyd said that she also had sent a favorable report to the Ohio State Medical Board. Dr. Reed indicated that, based on this, when she filled out her renewal application, she felt that everything was

settled and taken care of. She thought she had a temporary request to have another physician for co-admitting.

Dr. Reed stated that it was quite a shock to see a letter totally different from the letter she had received.

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

Mr. Beatty stated that the issue is whether or not at the time Dr. Reed completed her 1992 renewal application she was aware of the fact that her privileges at People's Hospital had been suspended. The evidence contained in the record, as produced to the Hearing Examiner, demonstrated that she was, in fact, aware that her hospital privileges had been limited. Dr. Reed denied this on her application. On that basis it was found that her denial constituted a misrepresentation of the fact. Dr. Reed has denied receiving correspondence from People's Hospital informing her that her admitting hospital privileges would be limited. Mr. Beatty referred the Board to State's "Exhibit #6." Pages five and six of that exhibit indicate that she did receive correspondence and signed a return receipt card for that correspondence from People's Hospital.

Dr. Reed indicated that that was for a Christmas card.

Mr. Beatty stated that Dr. Reed has acknowledged that she was aware of the restrictions, and those acknowledgments were contained in the hearing transcript. Dr. Reed argued that she assumed the restrictions had been terminated due to correspondence from the Inspector General's office. That correspondence had nothing to do with her admitting privileges at People's Hospital.

Mr. Beatty submitted the matter for the Board's consideration, adding that the facts are clear.

DR. GARG MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF BARBARA A. REED, M.D. DR. AGRESTA SECONDED THE MOTION.

Dr. Stienecker asked whether there were any questions concerning the proposed findings of fact, conclusions and order in the above matter.

DR. GARG MOVED TO AMEND THE PROPOSED ORDER TO REPRIMAND DR. REED, AND TO RESTRICT HER D.E.A. FOR SCHEDULED DRUGS.

Dr. Garg stated that, after reading the hearing record, he questioned the reasoning for the proposed 60-day suspension. Is it simply punitive? Dr. Garg stated that there were enough mitigating circumstances, in his judgment, with no suggestion of fraud or convincing deception. D.H.H.S. did not support the P.R.O. findings, so there might have been confusion there. These are mitigating circumstances.

DR. AGRESTA SECONDED DR. GARG'S MOTION.

Dr. Egner stated that she supports the proposed reprimand, adding that a suspension in this case would not serve a purpose. She does not agree with the proposed D.E.A. restriction. The problem in this case is the manner in which Dr. Reed completed her renewal application. This case had nothing to do with prescribing or use of a D.E.A. certificate.

Dr. Garg stated that he would agree to make a separate motion for D.E.A. He added that he only suggested the restriction because Dr. Reed testified at hearing that she wishes to keep her license in order to allow her to prescribe.

Dr. Gretter left the meeting during the previous discussion.

DR. GARG WITHDREW HIS MOTION. DR. AGRESTA, AS SECOND, AGREED.

DR. GARG MOVED TO AMEND THE PROPOSED ORDER IN THE MATTER OF BARBARA A. REED, M.D., BY SUBSTITUTING THE FOLLOWING:

It is hereby ORDERED that Barbara A. Reed, M.D., be and is hereby REPRIMANDED.

DR. BUCHAN SECONDED THE MOTION. A vote was taken:

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

The motion carried.

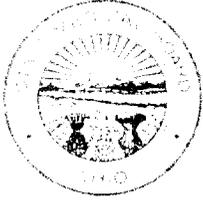
DR. GARG MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF BARBARA A. REED, M.D. DR. BHATI SECONDED THE MOTION. A vote was taken:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- aye
	Dr. Heidt	- aye

EXCERPT FROM THE DRAFT MINUTES OF AUGUST 14, 1996
IN THE MATTER OF BARBARA A. REED, M.D.

Dr. Egner	- aye
Dr. Agresta	- aye
Dr. Buchan	- aye
Mr. Sinnott	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.



STATE MEDICAL BOARD OF OHIO

33766-0315 • (614)466-3034

April 17, 1996

Barbara A. Reed, M.D.
177 Park Avenue, West
Mansfield, OH 44902

Dear Doctor Reed:

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 medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- 1) On or about June 9, 1992, you signed the application for renewal of your Ohio certificate to practice medicine and surgery, certifying that the information provided on the application was true and correct in every respect. In response to the question, "At any time since signing your last application for renewal of your certificate have you . . . 4) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?" you responded, "No."

In fact, on or about March 18, 1992, Peoples Hospital, Inc., in Mansfield, Ohio, imposed a co-admitting requirement upon your clinical privileges based on quality of care issues.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "fraud, misrepresentation, or deception in applying for or securing any license or certificate issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code.

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

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "(t)he 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.

Mailed 4/18/96

April 17, 1996

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

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

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 medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read 'T. E. Gretter, M.D.', written in a cursive style.

Thomas E. Gretter, M.D.
Secretary

TEG/bjm
Enclosures

CERTIFIED MAIL # P 152 983 363
RETURN RECEIPT REQUESTED

rev.2/15/95