



State Medical Board of Ohio

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March 14, 2007

Albert W. Smith, III, M.D.
515 Brownwood Court
Bowling Green, OH 43402

Dear Doctor Smith:

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 March 14, 2007, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

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

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

THE STATE MEDICAL BOARD OF OHIO

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

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8541
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8558
RETURN RECEIPT REQUESTED

Mailed 4-11-07

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 14, 2007, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Albert W. Smith, III, 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
Lance A. Talmage, M.D. RW
Secretary

(SEAL)

March 14, 2007
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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ALBERT W. SMITH, III, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on March 14, 2007.

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

It is hereby ORDERED that:

- A. PERMANENT REVOCATION, STAYED; SUSPENSION: The certificate of Albert W. Smith, III, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. Smith's certificate shall be SUSPENDED for an indefinite period of time, but not less than two years.
- B. CONDITIONS FOR REINSTATEMENT OR RESTORATION: The Board shall not consider reinstatement or restoration of Dr. Smith's certificate to practice medicine and surgery until all of the following conditions have been met:
 1. Application for Reinstatement or Restoration: Dr. Smith shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
 2. Medical Records Course: At the time he submits his application for reinstatement or restoration, Dr. Smith shall provide acceptable

documentation of satisfactory completion of a course or courses on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any course or courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Smith submits the documentation of successful completion of the course or courses on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course or courses, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

3. Post-Licensure Assessment Program: At the time he submits his application for reinstatement, Dr. Smith shall submit a Learning Plan developed for Dr. Smith by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. The Learning Plan shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Smith by the PLAS.
 - a. Prior to the initial assessment by the PLAS, Dr. Smith shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that assessment.
 - b. Should the PLAS request patient records maintained by Dr. Smith, Dr. Smith shall include in that submission copies of the patient records at issue in this matter. Furthermore, Dr. Smith shall ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.
 - c. Dr. Smith shall assure that, within ten days of its completion, the written Assessment Report compiled by the PLAS is submitted to the Board. Moreover, Dr. Smith shall ensure that the written Assessment Report includes the following:
 - A detailed plan of recommended practice limitations, if any;
 - Any recommended education;
 - Any recommended mentorship or preceptorship;

- Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.
- d. Dr. Smith shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

Upon successful completion of the educational activities, including any assessment or evaluation recommended by PLAS, Dr. Smith shall provide the Board with satisfactory documentation from PLAS indicating that Dr. Smith has successfully completed the recommended educational activities.

- e. Dr. Smith's participation in the PLAS shall be at his own expense.
4. Additional Evidence of Fitness To Resume Practice: In the event that Dr. Smith has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.
- C. **PROBATION**: Upon reinstatement or restoration, Dr. Smith's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
1. Obey the Law: Dr. Smith shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
 2. Declarations of Compliance: Dr. Smith shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Smith's certificate is reinstated or restored. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
 3. Personal Appearances: Dr. Smith shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Smith's certificate is reinstated or restored, or as otherwise directed by the Board. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing

appearances shall be scheduled based on the appearance date as originally scheduled.

4. Post-Licensure Assessment Program: Dr. Smith shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Smith shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Smith's continued compliance with the Learning Plan.

Dr. Smith shall obtain the Board's prior approval for any deviation from the Learning Plan.

If, without permission from the Board, Dr. Smith fails to comply with the Learning Plan, Dr. Smith shall cease practicing medicine and surgery beginning the day following Dr. Smith's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Smith has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered unlicensed practice in violation of Section 4731.41, Ohio Revised Code.

5. Monitoring Physician: Within thirty days of the date of Dr. Smith's reinstatement or restoration and prior to Dr. Smith's commencement of practice in Ohio, or as otherwise determined by the Board, he shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Smith and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Smith and his medical practice, and shall review Dr. Smith's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Smith and his medical practice, and on the review of Dr. Smith's patient charts. Dr. Smith shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Smith's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Smith must immediately so notify the Board in writing. In addition, Dr. Smith shall make arrangements acceptable

to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Smith shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

6. Absence from Ohio: In the event that Dr. Smith should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Smith must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
- D. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Smith's certificate will be fully restored.
 - E. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Smith violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
 - F. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS**: Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Smith shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Smith shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Smith receives from the Board written notification of his successful completion of probation.
 - G. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES**: Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Smith shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Smith shall also provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration or restoration of any professional license. Further, Dr. Smith shall provide this Board with a copy of the

return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board. This requirement shall continue until Dr. Smith receives from the Board written notification of his successful completion of probation.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)

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

March 14, 2007
Date

**REPORT AND RECOMMENDATION
IN THE MATTER OF ALBERT W. SMITH, III, M.D.**

The Matter of Albert W. Smith, III, M.D., was heard by R. Gregory Porter, Hearing Examiner for the State Medical Board of Ohio, on November 28 and 30, 2006.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated March 8, 2006, the State Medical Board of Ohio [Board] notified Albert W. Smith, III, M.D., that it had proposed taking disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations concerning Dr. Smith's treatment of one patient identified in a confidential Patient Key.

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

- “‘A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,’ as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.”
- With regard to conduct alleged to have occurred prior to March 9, 1999, “[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 prior to March 9, 1999.”
- With regard to conduct alleged to have occurred on or after March 9, 1999, “[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.”
- With regard to conduct alleged to have occurred on or after November 17, 1986, and on or before March 16, 1987, “‘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)(16), Ohio Revised Code, as in effect at that time, to wit: Rule 4731-11-02(D), Ohio Administrative Code.”

- With regard to conduct alleged to have occurred on or after March 17, 1987, “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code.

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

- B. By document received by the Board on March 31, 2006, Dr. Smith requested a hearing. (State’s Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Barbara J. Pfeiffer, Assistant Attorney General.
- B. On behalf of the Respondent: Eric J. Plinke, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Albert W. Smith, III, M.D., as upon cross examination
 - 2. Thomas P. Hubbell, M.D.
- B. Presented by the Respondent
 - 1. Albert W. Smith, III, M.D.
 - 2. William E. Feeman, Jr., M.D.

II. Exhibits Examined

- A. Presented by the State
 - 1. State’s Exhibits 1A through 1M: Procedural exhibits. (Note that some of these exhibits were marked and admitted post hearing. See Procedural Matters 1, below.)
 - * 2. State’s Exhibit 1H: Patient Key.

3. State's Exhibit 2: Certified copies of documents maintained by the Board concerning the Board's December 3, 1980, action against Dr. Smith.
4. State's Exhibit 3: Copy of March 5, 2006, report of Thomas P. Hubbell, M.D.
5. State's Exhibit 3A: Copy of Dr. Hubbell's curriculum vitae.
- * 6. State's Exhibit 4: Copy of Dr. Smith's medical record for Patient 1.
- * 7. State's Exhibit 4A: Copy of excerpt from Dr. Smith's medical record for Patient 1, consisting of Dr. Smith's progress notes arranged in chronological order.
- * 8. State's Exhibit 5: Copy of medical records concerning Patient 1 maintained by Wood County Hospital in Bowling Green, Ohio.
9. State's Exhibit 6: Withdrawn and not admitted.
- * 10. State's Exhibit 7: Copy of laboratory results concerning Patient 1 maintained by Wood County Hospital.

B. Presented by the Respondent

1. Respondent's Exhibit A: Curriculum Vitae of William E. Feeman, Jr., M.D.
2. Respondent's Exhibit B: Copy of Dr. Feeman's report. Note that a patient name was redacted from this exhibit. See Procedural Matters 2, below.

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

PROCEDURAL MATTERS

1. With the agreement of the parties, additional procedural exhibits were marked by the Hearing Examiner and admitted to the hearing record following the close of the hearing. (See Hearing Transcript at page 227.)
2. On the first page of the written report of Dr. Smith's expert witness, William E. Feeman, Jr., M.D., a patient name appears. On February 13, 2007, a telephone conference was held among the Hearing Examiner and counsel for each party. With the agreement of both parties, the Hearing Examiner redacted the patient's name and substituted "Patient 1."

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

Albert W. Smith, III, M.D.

1. Albert W. Smith, III, M.D., testified that he had obtained his medical degree from the University of Cincinnati in 1968. From 1968 through 1969, Dr. Smith participated in an internship at Kaiser Permanente in Oakland, California. After finishing his internship, Dr. Smith enlisted in the United States Army, and was subsequently discharged in or about 1972. Following his discharge, Dr. Smith worked for several months at Kaiser Permanente in Cleveland, Ohio, and then accepted a friend's invitation to relocate to Bowling Green, Ohio, to work in an emergency room and to start a practice. (Tr. at 228-231)

Dr. Smith testified that, shortly after he relocated to Bowling Green, he discovered that his friend had a substance abuse problem, and his friend moved away from the area. Dr. Smith remained in Bowling Green, worked in an emergency room there, and started an office practice. Dr. Smith practiced general medicine and treated patients of all ages. Dr. Smith also assisted in surgeries on a regular basis. He remained in that practice until he closed it in January 2006 for financial reasons. (Tr. at 232-236)

Dr. Smith testified that, since closing his practice, he had tried to find locum tenens work with the VA hospital system, without success. Dr. Smith noted that his years of experience placed him at the top of the pay schedule, and that the VA system prefers to hire doctors who can start a lower pay level. In addition, Dr. Smith testified that he had attempted to find locum tenens work in the private sector, but that he has had some malpractice cases in the past, which he believes hindered that effort. However, Dr. Smith testified that, a short time prior to the hearing, he had finally found work in an urgent care center in Perrysburg, Ohio. (Tr. at 236-237)

2. Dr. Smith testified that he is a fellow and a diplomate of the American Board of Family Practice. (Tr. at 253-254)

Thomas P. Hubbell, M.D.

3. Thomas Park Hubbell, M.D., testified as an expert witness on behalf of the State. Dr. Hubbell obtained his medical degree from the University of Missouri – Kansas City, School of Medicine in 1975. In 1978, Dr. Hubbell completed a three-year residency in family practice at Baptist Memorial Hospital in Kansas City, Missouri. Dr. Hubbell moved to Ohio in 1978, three months after completing his residency training, and has practiced family medicine in Delaware, Ohio, since that time. Dr. Hubbell testified that his practice is a “birth-to-death comprehensive practice,” and that he shares an office with his wife, who is

also a family physician. Finally, approximately eleven years ago, Dr. Hubbell and other physicians merged their practices to become American Health Network, which now includes 200 physicians, 80 or 90 of whom are in Ohio. (St. Ex. 3A; Tr. at 121-124, 177-178)

Dr. Hubbell testified that he currently serves as the chief of the medical staff at Grady Memorial Hospital in Delaware. Dr. Hubbell further testified that the responsibilities of that position include being “the chief quality officer for the hospital, which involves peer review, supervising or conducting peer review, and leading programs to improve the quality of care, * * *” and includes reviewing patient records. Dr. Hubbell testified that during the previous year about 600 patient records were reviewed as part of that process, although he did not review every one himself. (St. Ex. 3A; Tr. at 125-127)

Dr. Hubbell was certified by the American Board of Family Medicine in 1978, and has been recertified every six years since then, most recently in 2002. He has been licensed in Ohio since 1978. (St. Ex. 3A; Tr. at 122-124)

4. Dr. Hubbell testified that, prior to preparing his report to the Board, he had reviewed Dr. Smith’s medical records for Patient 1, medical records from Wood County Hospital concerning Patient 1, excerpts from a deposition of Dr. Smith, and exhibits from that deposition. (Tr. at 129)

William E. Feeman, Jr., M.D.

5. William E. Feeman Jr., M.D., testified as an expert witness on behalf of Dr. Smith. Dr. Feeman obtained his medical degree in 1970 from the Ohio State University College of Medicine. In 1971, Dr. Feeman completed a rotating internship at the United States Air Force Medical Center/Wright-Patterson Air Force Base in Dayton, Ohio. From 1971 through 1974, Dr. Feeman served as a General Medical Officer in the United States Air Force. In 1974, Dr. Feeman opened a solo private practice in Bowling Green, where he has practiced family medicine ever since. He holds hospital privileges at Wood County Hospital in Bowling Green. Dr. Feeman testified that he is not board-certified. (Resp. Ex. A; Tr. at 339-342)
6. Dr. Feeman testified that, in preparing for his testimony in this case, he had reviewed the Board’s March 8, 2006, notice of opportunity for hearing [notice], Dr. Hubbell’s written report, Dr. Smith’s medical records for Patient 1, and records from Patient 1’s emergency room visits and 2004 hospitalization. (Tr. at 343-344)
7. Dr. Feeman testified that he knows Dr. Smith professionally, but that he does not socialize with Dr. Smith and does not know him on a personal basis. (Tr. at 344-345)
8. Dr. Smith testified that he has known Dr. Feeman professionally for many years. Dr. Smith further testified that he does not socialize with Dr. Feeman. (Tr. at 115-116)

Prior Action by the Board

9. On December 9, 1980, the Board took administrative action against Dr. Smith based upon the following violations:
- “failure to use reasonable care discrimination in the administration of drugs,” in violation of Section 4731.22(B)(2), Ohio Revised Code, as in effect at that time;
 - “a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances,” in violation of Section 4731.22(B)(6), Ohio Revised Code, as in effect at that time;
 - “knowingly maintaining a professional connection or association with the person who is in violation of this chapter or rules of the Board,” in violation of Section 4731.22(B)(8), Ohio Revised Code, as in effect at that time;¹
 - “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, were conspiring to violate any provisions of this chapter or any rule promulgated by the board,” in violation of Section 4731.22(B)(17), Ohio Revised Code, as in effect at that time. Note that the specific statute or rule violated was not specified.

(St. Ex. 2)

Based upon those violations, the Board ordered that Dr. Smith’s medical license be suspended for one year, with all but 60 days stayed subject to certain conditions. (St. Ex. 2)

Overview of the Issues Addressed in this Matter

10. In this administrative action, the Board set forth allegations concerning various aspects of Dr. Smith’s treatment of Patient 1, including medical recordkeeping; obtaining and/or documenting appropriate medical histories; performing and/or documenting appropriate examinations; performing and/or documenting the performance of appropriate tests and/or studies; referring and/or documenting referral of the patient for appropriate consultations; establishing and/or documenting the establishment of a treatment plan for his prescribing; appropriately establishing and/or documenting the appropriate establishment of specific diagnoses; and appropriately informing and/or appropriately documenting the informing of risks associated with certain treatment. The Board further alleged acts, conduct, and/or omissions relating to matters including the following: hormone replacement therapy, anti-anxiety medication, steroid medication, antihypertensive medication, breast examination, and mammograms. (St. Ex. 1A)

¹ This statutory language has no counterpart in the current Medical Practices Act.

Dr. Smith's Care and Treatment of Patient 1 – Excerpts from Dr. Smith's Medical Records

11. Patient 1 first visited Dr. Smith's office on September 18, 1973, and again on November 22, 1974. Several years later, starting on June 9, 1981, Patient 1 began seeing Dr. Smith on a fairly regular basis. (St. Ex. 4 at 39-44; St. Ex. 4A²)
12. The following are excerpts from Dr. Smith's medical records for Patient 1, accompanied by explanatory testimony from Dr. Smith, and in a few instances by commentary from the expert witnesses. A few excerpts were electronically reproduced directly from Dr. Smith's progress notes.

June 9, 1981, Visit

13. Dr. Smith's progress note for Patient 1's June 9, 1981, states as follows:

6/9/81 170/110 PMH // Tubal lig '80 GIX PII ± HBP. ± RF, SF, JH, IM. ± Allergic
± Meds. BCP x 10yrs. LMP 6/7/81. Reg. ± UTI. PI // ± HBP (Wesland ± Surg.)
Rt NLR ± @ ± Edema bruits.
Rx: SMA II 181 1/2

(St. Ex. 4A at 1)

14. Dr. Smith testified that the above note states that on June 9, 1981, Patient 1 had had a blood pressure of 170/110, and a past medical history of: tubal ligation in 1980; gravida 4, para 4; without previous hypertension; without rheumatic fever, scarlet fever, infectious hepatitis, or infectious mononucleosis; without allergies; not currently taking any medications; birth control pills for ten years; last menstrual period June 7, 1981; regular periods; without urinary tract infection. Dr. Smith testified that her present illness had been “the blood pressure.” Dr. Smith believes that Patient 1 had been experiencing “symptoms related to high blood pressure. It says here her husband had surgery, and she must have been upset at that time.” (Tr. at 27-30)

Dr. Smith further testified that his notations in the third line labeled “PE” [physical examination] mean that Patient 1 “had a normal heart without murmur. No edema; no bruits.” (Tr. at 30)

Finally, Dr. Smith testified that the last line labeled “RX,” which stands for “treatment,” indicates that he had ordered an SMA II, which he testified is a complete laboratory workup of the patient's blood. However, no results for that lab work appear in Dr. Smith's medical record for Patient 1. (St. Ex. 4; St. Ex. 4A at 1; Tr. at 24, 31)

² State's Exhibit 4 is Dr. Smith's complete medical record for Patient 1, including his progress notes, which appear on pages 39 through 44 of that exhibit. State's Exhibit 4A consists of Dr. Smith's progress notes arranged in chronological order. In this report, references to Dr. Smith's progress notes are to State's Exhibit 4A.

June 11, 1981, Visit

15. Dr. Smith's progress note for Patient 1's June 11, 1981, visit states: "200/100 Post Argument." (St. Ex. 4A at 1)
16. Dr. Smith testified that, because some patients without hypertension experience high blood pressure when visiting the doctor, which Dr. Smith referred to as "white coat blood pressure," he had had Patient 1 return for a second blood pressure reading to see if it was still elevated. However, he stated that when Patient 1 returned to his office on June 11, 1981, she advised that she had had an argument with someone. Dr. Smith was concerned that her emotional state had been responsible for her elevated blood pressure reading that visit; therefore, he had her return for another reading prior to initiating treatment for hypertension. (Tr. at 32-33)

June 19, 1981, Visit

17. Dr. Smith's progress note for Patient 1's June 19, 1981, visit states as follows:

6/19/81 170/110 *Diuril 500, q am & OS

(St. Ex. 4A at 1)

18. Dr. Smith testified that when Patient 1 presented on June 19, 1981, her blood pressure was still elevated, and he placed her on "Diuril, 500 mg every morning with orange juice." (Tr. at 33)

June 30, 1981, Visit

19. Dr. Smith's progress note for Patient 1's June 30, 1981, visit states, in its entirety: "190/110 Centrax 10, R/O Early Menopause." (St. Ex. 4A at 1)
20. Dr. Smith testified that Centrax is an anti-anxiety medication. Dr. Smith explained: "[S]he was anxious and pretty—it was this way or that way. She was a little bit argumentative, and at that time she was starting to have—thought to have some early menopause symptoms." When asked whether he had diagnosed Patient 1 with anxiety, Dr. Smith replied: "Well, it says 'Rule out early menopause,' which would put it into a category with anxiety starting. I'm sure it was part of my thought." (Tr. at 33-34)

When asked what symptoms Patient 1 had been exhibiting, Dr. Smith testified that she had exhibited "[i]rritability, hot flashes, [and] vaginal dryness." When asked if he had documented that information, Dr. Smith replied: "No. It says "rule out early menopause," and that would include all of those things." (Tr. at 35-36)

July 3, 1981, Visit

21. Dr. Smith's progress note for Patient 1's July 3, 1981, visit states:

7/3/81 170/70 Hot flashes LMP 6/25
PB. Tension ↓ NSE sl. tach.
Rx Ag/Depo Est/B12 2cc IM.

(St. Ex. 4A at 1)

22. Dr. Smith testified that his July 3, 1981, note stated that Patient 1 had been experiencing hot flashes, that her last menstrual period had been June 25, her tension had decreased, her sinus rhythm had been normal, and her heart rate had been slightly tachycardic. Dr. Smith gave Patient 1 injections of Agous, Depo Estrogen, and vitamin B12. Dr. Smith testified that Agous is fast-acting form of estrogen, and that Depo Estrogen is longer-acting. He further testified that he had given the hormone injections to Patient 1 “[t]o see if it would relieve the symptoms of the menopause.” (Tr. at 36)
23. Dr. Hubbell testified that he does not understand why Dr. Smith had administered hormone replacement therapy to Patient 1 on July 3, 1981. Dr. Smith's medical record indicates that Patient 1 had had a menstrual period on June 7, 1981. Subsequently, on July 3, 1981, Dr. Smith documented “Hot flashes” and that Patient 1 had had another menstrual period on June 25, 1981, three weeks after the last one. Dr. Hubbell testified that, because Patient 1 was having regular periods, it appears that her estrogen and progesterone had been working. Therefore, it is “exceedingly unlikely that her hot flashes are hormonally driven hot flashes.” Dr. Hubbell suggested that her hot flashes may have been caused by hypertension, but in any case, hormone replacement therapy had not been necessary. (St. Ex. 4A at 1; Tr. at 165-166)
24. When asked whether Patient 1's hypertension could have been responsible for her hot flashes, Dr. Smith replied that it is possible, but unlikely. Dr. Smith testified that he has never found hypertension to be the source of hot flashes. (Tr. at 37, 291)

August 13, 1981, Visit

25. Dr. Smith's progress note for Patient 1's August 13, 1981, visit states: “170/120 Emotional seems better. BP 160/60 @ Hosp. Hot Flashes. PE – [without] Edema, Bruits. 191# RX - Ag/Depo Est /B12. 10# loss.” (St. Ex. 4A at 1)
26. Dr. Smith noted that, on August 13, 1981, Patient 1 had continued to report hot flashes, which Dr. Smith regarded to be a hormonal symptom. When asked to describe the frequency and severity of Patient 1's hot flashes, Dr. Smith testified that Patient 1 “was

relatively uncomfortable, and she was irritable, and emotional lability was so-so.”³
(Tr. at 40-41)

Dr. Smith further testified that his physical examination of Patient 1 had revealed no edema, by which he had meant “[w]ithout fluid retention” in her body overall. Dr. Smith further testified that he had found no bruits in Patient 1’s carotid arteries and abdomen.
(Tr. at 41-42)

27. Dr. Smith testified that he had administered injections of Agous and Depo-Estrogen, 1 cc of each. He testified that he had arrived at this dosage “[p]retty much empirically.”
Dr. Smith continued:

I learned that that dose was effective from a surgeon that was in his mid-60s that had the office next to mine and did a ton of hysterectomies. And when his patients would come in, that was a standard treatment that they would get for hormone replacement therapy.

(Tr. at 42-43) Dr. Smith added that the surgeon would give the injections to his patients “about once every two weeks.” (Tr. at 43)

October 27, 1981, Centrax Refill

28. On October 27, 1981, Patient 1 called Dr. Smith’s office and received a refill of Centrax 10 mg #60. (St. Ex. 4A at 1; Tr. at 43)
29. Dr. Smith testified that he had been aware on October 27, 1981, that Patient 1 was experiencing anxiety symptoms, because that had been an ongoing problem for her throughout his years of treating her. (Tr. at 44)

July 8, 1982, Visit

30. Dr. Smith’s medical record for Patient 1’s July 8, 1982, visit states: “188# 180/100 Well. Early Menopausal Synd. BP @ work 160/70. Reg. Menses.” Under “PE,” he recorded “NSR [normal sinus rhythm] fundi WNL.” Under “RX:” Dr. Smith recorded “*Aldactazide, Aldomet 250 TID, *Premarin .625 q AM x 21,” and that Patient 1 was to return for another visit in one week. (St. Ex. 4A at 1)
31. Dr. Smith testified with regard to the note concerning his fundoscopic examination, “I looked at the back of the eye, the fundus, which can show changes of hypertension if it’s chronic or getting more severe, and the back of her fundi were within normal limits.”
(Tr. at 47)

³ Note that Dr. Smith did not document in his progress note Patient 1’s level of comfort, irritability, and/or emotional lability. (St. Ex. 4A at 1)

32. At the July 8, 1982, visit, Dr. Smith first prescribed oral hormone replacement therapy to Patient 1. He prescribed Premarin 0.625 mg, to be taken in the morning. Dr. Smith testified that he had instructed her to take this dose of Premarin⁴ in the morning “for a 21-day period off and then to restart it again after 10 days.” Dr. Smith testified that he had determined the dosage of Premarin “empirically.” He explained that, “at that time there were three different doses, I think, of the Premarin, and I picked one that was in the middle, thinking that that would be the one that would do the best.” Dr. Smith added, “She was still having some periods, and I was afraid if I gave her a higher dose it would start heavier menstrual bleeding.” (Tr. at 47-48)
33. Dr. Smith testified that, from July 8, 1982, through 2004, he had continued to prescribe Premarin to Patient 1 on a regular basis. (Tr. at 48)

July 15, 1982, Visit

34. Dr. Smith’s progress note for Patient 1’s July 15, 1982, visit states, among other things, that he had increased Patient 1’s dosage of Premarin to 1.25 mg. The only notes regarding Patient 1’s condition are her weight, blood pressure readings from each arm, the word “Better,” and normal sinus rhythm. (St. Ex. 4A at 1)
35. Dr. Smith testified that he is certain that the reason he had increased Patient 1’s dosage of Premarin had been “to see if the higher dose would work better for her tension and perhaps with the high blood pressure.” He added that “the blood pressure was 50 percent tension and probably 50 percent physiological.” Finally, Dr. Smith testified that he had explained to Patient 1 that he was increasing her dosage of Premarin. (Tr. at 49)

March 15, 1983, Visit

36. Dr. Smith’s progress note for Patient 1’s March 15, 1983, visit states that she had weighed 178 pounds, and had blood pressure of 190/100 in her left arm and 160/90 in her right arm. Dr. Smith documented that his physical examination revealed “fundi – WNL/ ↑ fullness/optic cup.” Under “RX,” Dr. Smith recorded, among other things, “Carotid Scan (Bruit Neck).” (St. Ex. 4A at 1)
37. Dr. Smith testified that increased fullness of the optic cup reflected Patient 1’s high blood pressure. (Tr. at 50)

Dr. Smith further testified that a subsequent progress note dated March 22, 1983, indicates that the results of Patient 1’s carotid scan had been negative. (St. Ex. 4A at 2; Tr. at 51)

⁴ An excerpt from the Physicians Task Reference that is included in Dr. Smith’s medical record for Patient 1 indicates that Premarin consists of conjugated estrogen. (St. Ex. 4 at 13)

April 26, 1983, Visit

38. In his April 26, 1983, progress note, Dr. Smith stated, among other things, "Cont. Meds." (St. Ex. 4A at 2)
39. Dr. Smith testified that the notation "Cont. Meds." means that he had continued Patient 1's routine medications, including Premarin. (Tr. at 70-72)

May 26, 1983, Visit

40. Dr. Smith's progress note for Patient 1's May 26, 1983, visit states, among other things, "PEB II WNL." (St. Ex. 4A at 2)
41. Dr. Smith testified that he had ordered a PEB II blood test because Patient 1 "was getting menopausal, and it was time to get a series of blood tests to see where things were." Dr. Smith further testified that he had ordered the lab tests at that visit and, after receiving the results at a later time, had gone back to the May 26, 1983, entry to note that the test results had been within normal limits (WNL). (St. Ex. 4 at 243, 247-251; Tr. at 53-54)

July 25, 1983, Visit

42. Dr. Smith's progress note for Patient 1's July 25, 1983, visit indicates that Patient 1 had complained of acute anxiety in crowds and while driving. He also noted that she had had regular menses with decreased flow, and he wrote "Early Menopausal Synd[rome]." The note further indicates that the physical examination revealed normal sinus rhythm. Dr. Smith also recorded that he had given Patient 1 an injection of "Ag/DepoEst 2cc IM." Nothing is recorded concerning Patient 1's use or nonuse of Premarin. (St. Ex. 4A at 2)
43. Dr. Smith testified with reference to the July 25, 1983, visit that he does not know if Patient 1 had stopped taking her Premarin as prescribed, and added that she had not always been compliant with her medication. When asked if he would have documented it if Patient 1 had told him that she had stopped taking Premarin, Dr. Smith replied, "I might have, or I would have just jumped ahead and given her the shot of the estrogen." (Tr. at 56-57)

August 23, 1983, Visit

44. Dr. Smith's progress note for Patient 1's August 23, 1983, visit states that she had decreased anxiety with estrogen, and was without menses. He administered an injection of "Ag/DepoEst ½ cc IM." (St. Ex. 4A at 2)
45. Dr. Smith testified that, at Patient 1's previous visit, he had given her an injection of estrogen and she had improved. Dr. Smith testified that, accordingly, he gave her another injection of half the amount previously administered. (Tr. at 57)

January 26, 1984, Visit

46. Dr. Smith testified that his notation of Premarin 0.625 mg, as recorded in his progress note for Patient 1's January 26, 1984, visit, indicates that Patient 1 had been "restarted" on Premarin at that visit. Dr. Smith testified that he had also given her an injection of Agous and Depo Estrogen. (St. Ex. 4A at 2; Tr. at 58)

February 24, 1984, Visit

47. On February 24, 1984, Patient 1 visited Dr. Smith with a complaint of upper respiratory infection. In addition to continuing her usual medications, Dr. Smith prescribed Ampicillin and gave her an intramuscular injection of Depo-Medrol. (St. Ex. 4A at 2)
48. Dr. Smith testified that Depo-Medrol is a long-lasting cortisone that he had administered to treat Patient 1's upper respiratory infection. He stated, "The allergists would use it for people with chronic sinusitis, and it was very effective." (Tr. at 59)

June 19, 1984, Visit

49. Dr. Smith's progress note for June 19, 1984, states, "Premarin [with] ↓ Tremor." The physical examination revealed possible edema. Dr. Smith stated, under treatment, "↓ Premarin .625 q AM" and "Ag/Depo 2cc IM." (St. Ex. 4A at 2)
50. Dr. Smith testified that his progress note indicates that he had probably increased her dose of Premarin to twice a day, and then took it back down to once a day. Dr. Smith acknowledged that a prior increase in Premarin is not documented in his progress notes. (Tr. at 60-61)

August 16, 1984, Visit

51. Dr. Smith's progress note for August 16, 1984, states only, "Ag/Depo Est." (St. Ex. 4A at 2)
52. Dr. Smith testified that the purpose of Patient 1's August 16, 1984, visit had been "[m]enopausal symptoms." When asked how he knows the purpose of that visit, Dr. Smith replied, "That's the only reason I would have given [that injection] to her." (Tr. at 62)

February 7, 1985, Visit

53. Dr. Smith's progress note for February 7, 1985, states, among other things, that he had ordered pulmonary function studies. No results of the studies were documented in the progress notes. (St. Ex. 4A at 2)
54. Dr. Smith testified that the results of the pulmonary function studies would be on a separate document. (Tr. at 63) However, the Hearing Examiner could find no reference in

Dr. Smith's medical record concerning pulmonary function studies being performed on Patient 1 in 1985. (St. Ex. 4)

February 5, 1987, Visit

55. Dr. Smith's progress note for February 5, 1987, states, among other things, "PAP/Dr. M WNL." (St. Ex. 4A at 3)

56. Dr. Smith testified that Patient 1 had seen an OB/GYN in Bowling Green named Dr. Miller. (Tr. at 20)

When asked how he had known that Dr. Miller had performed a Pap test and that it had been within normal limits, Dr. Smith replied, "I asked and [Patient 1] told me." Dr. Smith added: "[S]he had told me that after she had her children she [had been seeing] Dr. Miller, and it was in conversation. I knew I wasn't doing it." When asked why the subject had come up during that particular visit, Dr. Smith replied that it was "[p]robably just a routine question." Dr. Smith acknowledged that he had never asked Patient 1 that question previously, but testified that, by February 5, 1987, Patient 1 had been "getting older." (Tr. at 64-66)

57. Dr. Smith testified that he had never asked Patient 1, and that Patient 1 had never advised him, whether Dr. Miller had been performing breast examinations or ordering mammograms. Dr. Smith added that Patient 1 had refused mammograms. (Tr. at 66-67)

When asked if he had ever spoken directly to Dr. Miller, Dr. Smith replied, "As a matter of fact, I called Dr. Miller when this citation came." However, Dr. Smith testified that he had not previously spoken with or requested records from Dr. Miller. (Tr. at 67)

58. Dr. Feeman testified that Dr. Miller had been in OB/GYN in Bowling Green, and that he had retired about 10 or 15 years ago. Dr. Feeman further testified that, in Dr. Feeman's experience, Dr. Miller had been cooperative in providing information and reports concerning mutual patients. However, Dr. Feeman stated that that had happened in cases where he had referred patients to Dr. Miller for consultation. Dr. Feeman testified that Dr. Miller had not provided him with routine records, such as Pap test results on patients who went directly to Dr. Miller without a referral. Nevertheless, Dr. Feeman believes that Dr. Miller would have provided those results if Dr. Feeman had asked for them. (Tr. at 397-398, 401-403)

March 17, 1987, Visit

59. In his progress note for Patient 1's March 17, 1987, visit, Dr. Smith noted, among other things, "URI better" and "2+ Sinusitis." Patient 1's treatment included an intramuscular injection of Depo-Medrol and "Cont. Meds." (St. Ex. 4A at 3)

60. Dr. Smith testified that he had given Patient 1 Depo-Medrol for her sinusitis and continued her routine medications. (Tr. at 68)

September 24, 1987, Visit

61. In his progress note for Patient 1's visit on September 24, 1987,⁵ Dr. Smith recorded among other things, "ō [without] SOB, DOE." (St. Ex. 4A at 3)

Dr. Smith testified that the above note means "ō [without] shortness of breath or dyspnea on exertion." Dr. Smith added that dyspnea on exertion would mean "[s]hortness of breath when walking." (Tr. at 71)

February 23, 1988, Visit

62. In his progress note for Patient 1's February 23, 1988, visit, Dr. Smith documented that he had ordered "PEB II – TSH, FSH" and a pulmonary function test. (St. Ex. 4A at 3)

The only documentation in Dr. Smith's medical record concerning the tests that he ordered is a March 4, 1988, report that states that the FSH and TSH "specimen was not suitable for [the] test ordered" and that the sample had been received in one "lavender top tube." (St. Ex. 4 at 253)

63. Dr. Hubbell testified that the blood sample had not been suitable for the test ordered because blood draws to be used for TSH and FSH tests goes in a tube with a red top. A tube with a lavender top is used for blood counts. (Tr. at 203-204)

July 24, 1995, Visit

64. In his progress note for Patient 1's July 24, 1995, visit, Dr. Smith recorded, among other things, "PAP 4/95 WNL." He also recorded, "Sister [with] CVA 52." (St. Ex. 4A at 4)
65. Dr. Smith testified that his note concerning the Pap results had been based upon what Patient 1 had told him, and that he had not received any Pap smear results from the administering physician. (Tr. at 74)

Dr. Smith testified that the note concerning Patient 1's sister indicates that the sister had had a stroke at the age of 52 years. (Tr. at 74)

January 9, 2001, Visit

66. In his progress note for Patient 1's January 9, 2001, visit, Dr. Smith recorded, among other things, that he had suspected that Patient 1 had chronic obstructive airway disease [COAD], and also documented "Breast self exam." In addition, Dr. Smith noted that he had

⁵ This date was mistakenly referenced at hearing as April 24, 1987. The number 9 in "9-24-87" as it appears on the exhibit is easily mistaken as the number 4. (St. Ex. 4A at 3)

prescribed or continued Patient 1 on Premarin 0.625 mg, Xanax 0.25 mg #100 with three refills, and Tenoretic 50/25.⁶ (St. Ex. 4A at 5)

67. Dr. Smith testified that COAD, or chronic obstructive airway disease, is the same thing as COPD, and that both are synonymous with emphysema. Dr. Smith testified that he had documented COAD as a note to himself that Patient 1 may have been developing emphysema. (Tr. at 78, 263)

Further, with regard to the note concerning breast self examinations, Dr. Smith testified, “She claimed that every time she took a shower or certain times of the month she would check the breasts for any masses.” He stated that that had been a note to himself “that she’s doing it.” (Tr. at 78)

68. When asked if he had instructed Patient 1 on how to conduct a self breast exam, Dr. Smith replied, “Probably verbally but not physically.” (Tr. at 299)

September 26, 2001, and July 9, 2002, Visits

69. Dr. Smith’s September 26, 2001, progress note states, in its entirety,

Xanax 0.25 x 5 / 120 ct.
Xanax 0.5 (cut in half #360⁷)

(St. Ex. 4A at 5)

70. Dr. Smith’s next progress note, dated July 9, 1002, states, among other things, “Xanax 0.5 #360 RF [refill] X 3.” (St. Ex. 4A at 5)

71. When asked if he had increased Patient 1’s Xanax dose from 0.25 mg to 0.5 mg, Dr. Smith testified that he had not. To save Patient 1 money, he had prescribed a higher dose and instructed her to cut them in half. (Tr. at 79)

The Fifth Page of Dr. Smith’s Progress Notes, Containing Notes Dated November 21, 1995, through July 9, 2002

72. The fifth page of Dr. Smith’s progress notes for Patient 1 contains his progress notes from November 11, 1995, through and including July 9, 2002. At the top of the page, Dr. Smith recorded:

ō [without] Ca Colon
ō [without] Breast

⁶ Dr. Smith testified that Tenoretic is a beta blocker with a diuretic used to treat hypertension. (Tr. at 79)

⁷ The closing parentheses is missing from the original. (St. Ex. 4A at 5)

(St. Ex. 4A at 5) The information quoted above was not dated. (St. Ex. 4A at 5)

73. When Dr. Smith was asked to explain those notations, the following exchange took place:

A. [By Dr. Smith] On all my patients and all my charts, about that time—I think it actually started when Katie Couric’s husband got cancer of the colon, and it became very apparent there was a familial concept. Colonoscopies were being done frequently. So I started asking people if they had a family history of cancer of the colon, and she said no. And then I also knew that breast cancer was hereditary, and I rechecked, and she said there was no breast cancer.

Q. [By Ms. Pfeiffer] Now, you learned later on that, in fact, her [Patient 1’s] mother did have breast cancer; correct?

A. Apparently. I never was aware of it.

Q. Do you know when you made this inquiry about the history of colon or breast cancer?

A. I did, I’m sure, back about the time we started talking about menopause, but I just didn’t write it down until it became a public thing and I thought it would be wise to document it.

Q. My question is, when did you document those two notations at the top of that page without—

A. It was on this page. Okay?

Q. I understand that, but do you know when you made that entry?

A. Oh. No.

Q. Why would it not have been next to a particular date the way you have done all the others?

A. I have done all of them this way in my chart.

Q. Meaning you just put it at the top of a page?

A. Right. Again, it’s a reminder to me.

Q. A reminder to do what?

A. Again, check for mammograms if there’s a history or check for colonoscopy if there’s a history.

(Tr. at 79-81)

January 21, 2003, Visit

74. In his January 21, 2003, progress note, Dr. Smith recorded, among other things, that Patient 1 had stopped smoking for 21 days, and that she had an upper respiratory infection with shortness of breath and dyspnea on exertion. Dr. Smith ordered a chest x-ray, prescribed an antibiotic and Medrol Dos Pak, and gave Patient 1 injections of Solu-Medrol 40 mg and Decadron 8 mg. (St. Ex. 4A at 6)
75. Dr. Smith testified that he had decided on the dosages of Solu-Medrol and Decadron “[e]mpirically.” (Tr. at 82-83)

January 24, 2003, Visit

76. Dr. Smith’s January 24, 2003, progress note indicates, among other things, that a chest x-ray had been negative but had shown COAD, and that Patient 1 was continuing to experience shortness of breath and dyspnea on exertion. Dr. Smith recorded that he had given Patient 1 injections of Solu-Medrol 40 mg and Decadron 8 mg. (St. Ex. 4A at 6)
77. Dr. Smith testified that Decadron would “dramatically make the breathing easier.” (Tr. at 83)

February 2, 2004, Visit

78. On February 2, 2004, Dr. Smith noted, among other things, that Patient 1 had influenza, and that he had given her an injection of Decadron 8 mg. (St. Ex. 4A at 6)
79. Dr. Smith testified that he had administered the Decadron injection to help with Patient 1’s respiration because she had had the flu. (Tr. at 84-85)

Patient 1’s February 4, 2003 Hospitalization at Wood County Hospital

80. On February 4, 2003, Dr. Smith admitted Patient 1 to Wood County Hospital for viral pneumonia. Dr. Smith’s History and Physical Report includes a physical examination of Patient 1, including a breast examination wherein Dr. Smith stated, “Examination of the breasts shows no masses.” The report also includes a description of Patient 1’s chief complaint and history of present illness and medical history. The report did not include a family history or a social/personal history. Under the heading, “Admitting Diagnosis,” Dr. Smith wrote, among other things, “Hormone replacement therapy with advisement, stable.” (St. Ex. 4 at 223-225)

May 24, 2004, Visit

81. Dr. Smith's May 24, 2004, progress note states:

524-04 176 # 130/80 RKA
↓ Meniscus ↓ROM.
PE ↓ effusion ⊕ ↓ROM.
R. Decadron 8.M x 2
ASA x 2 TID

(St. Ex. 4A at 6)

82. Dr. Smith testified that the notation "(R) leg ± Meniscus ↓ROM" means "Right leg with a questionable meniscus injury to the right knee with a decreased range of motion." Dr. Smith further testified that he believes that Patient 1 had complained of twisting her knee. He treated Patient 1 with two injections of Decadron 8 mg and instructed to her to take two aspirin three times per day. (St. Ex. 4A at 6; Tr. at 85-86)

Dr. Smith stated that he had determined the dose of Decadron "[e]mpirically." (Tr. at 86)

Patient 1's June 5, 2004, Emergency Room Visit

83. Dr. Smith's medical record for Patient 1 includes a copy of an emergency room report from Wood County Hospital for Patient 1's emergency room visit on June 5, 2004. That report states that Patient 1's chief complaint had been pain in her right thigh. In the section entitled History of Present Illness, the report states:

A 63-year-old female comes in complaining of right thigh pain. Patient states that two to three weeks ago she had some right knee [sic] and had some injections and felt better. Patient states yesterday she was out grocery shopping and then she had some pain in the medial aspect of the right thigh. There has been no swelling, no recent trauma. Patient did take aspirin with intermittent relief. The aspirin did make her feel a little better.

(St. Ex. 4 at 141) The report further states, "All the systems are reviewed and are negative." (St. Ex. 4 at 141)

In addition, under the heading, "ED Course," the report stated:

We do offer an ultrasound of the right leg. Although, she has no tenderness occurring in the knee whatsoever and there is no swelling appreciated, the patient refuses. We state no trauma and no other injuries reported, then ultrasound would be the best way to proceed. Daughters are present and they

also try to convince her to get an ultrasound. Patient again refuses. Patient states that she would prefer just to try some muscle relaxants since she believes that this is all muscular. We will follow up with her family doctor on Monday. For a third time again, I offered ultrasound and the patient still refuses. Patient states that she will use some pain medicines if she prefers again to simply follow up with her family doctor on Monday and if he feels it is warranted at that point, she will go ahead and proceed with whatever he would prefer.

(St. Ex. 4 at 143)

June 8, 2004, Visit

84. Dr. Smith's June 8, 2004, progress note states:

6-8-04 130/80 ⊕ leg Rx ER Rx
Flexeril / Darvocet Spasm Quad ⊕
PE: 6/10 ⊕ Quadrap
Rx: ASA x 2 QID
Decadron 8 mg x 2

(St. Ex. 4A at 6)

Patient 1's treatment that day again included 2 injections of Decadron 8 mg. (St. Ex. 4A at 6)

85. Dr. Smith testified that his June 8, 2004, note indicates that Patient 1 had been seen in an emergency room for her right leg and had received Flexeril, a muscle relaxant, and Darvocet, an analgesic. When asked if he could tell from his notes whether those medications had been having any effect, he replied, "No, they weren't, because that's why she came back to see me, because the shots worked." (Tr. at 86-87)

June 10, 2004, Visit

86. Two days later, on June 10, 2004, Patient 1 returned to Dr. Smith's office. His progress note for that visit states:

6-10-04 Re-injured ⊕ leg
PE 6/10 ⊕ Quad
Rx: Decadron 8 mg x 2
Methyl Dac Patch

(St. Ex. 4A at 6)

Dr. Smith treated Patient 1 with 2 injections of Decadron 8 mg and a prescription for Medrol Dos Pak. (St. Ex. 4A at 6)

87. When asked if he knew how Patient 1 had reinjured her leg, Dr. Smith testified, "I think she told me she was trying to do some gardening, and she was down on her knees and tried to get up and reinjured it again." (Tr. at 86)

Dr. Smith testified that Medrol Dos Pak is a steroid medication that is ingested orally. He further testified that they come in a pack that is taken over a period of six days, for an effect that lasts for seven days. (Tr. at 87, 89-90)

Dr. Smith testified that he would expect two injections of Decadron 8 mg to have an effect lasting ten days to two weeks.

When asked if he had been concerned about administering two additional injections of Decadron only two days following treatment with two injections of Decadron, Dr. Smith replied: "Not really. I have done it before. If it works and there's successful results, fine. If not, then you have to go and find more definitive diagnostic procedures to see what's going on." (Tr. at 88)

June 17, 2004, Visit

88. On June 17, 2004, one week after her last visit to Dr. Smith, Patient 1 returned to Dr. Smith's office with a chief complaint of lower back pain. Dr. Smith's progress note for that visit states:

6-17-04 LBP/RM Spasm. ↓OP
fx. LS Vert.
PE: Tendr ~ L2-3 ⊕ > ⊖
Rx: Decad 8. IM x 2
Medl Dos Pack
Cont. Home L25/Vit D

(St. Ex. 4A at 6)

89. Dr. Smith testified that his progress note states, in part, that Patient 1 had been suffering from lower back pain and paravertebral muscle spasms. Dr. Smith testified that he had documented questionable osteoporosis "and/or possible fracture of a lumbosacral vertebral body." Dr. Smith further testified that he had based these suspicions on Patient 1's pain complaint. When asked if Patient 1 had advised him of anything that may have caused the

pain, Dr. Smith replied that she had been outside, trying to be active, “and it was not getting better.” (Tr. at 88-89)

Dr. Smith further testified that he had diagnosed back pain after having palpated Patient 1’s back. Moreover, Dr. Smith testified that, based upon that examination, he had found that she had been “[t]ender over the vertebral body L2-3, more on the right than on the left.” (Tr. at 270-271)

Dr. Smith testified that he had given Patient 1 two more injections of Decadron 8 mg and prescribed another Medrol Dos Pak. (Tr. at 89)

June 22, 2004, Visit

90. Five days later, on June 22, 2004, Patient 1 again visited Dr. Smith because of continuing pain. His progress note for that visit states:

6-22-04 Pain & relief
Rx: & Change.
Rx: Bone Scan:
DEXA Scan
Decadron 8. IM x 2

(St. Ex. 4A at 6)

91. Dr. Smith testified that his treatment for Patient 1 had been to order a bone scan and a DEXA scan, and to give Patient 1 two more injections of Decadron 8 mg. (Tr. at 90)

Patient 1’s June 2004 Hospitalization - Dr. Smith’s June 25, 2004, History and Physical Report

92. On June 25, 2004, Patient 1 was admitted to Wood County Hospital. Dr. Smith prepared a History and Physical Report in which he provided the following information under the heading Chief Complaint/History of Present Illness:

Patient is a 63 year old female who was seen by me in the office approximately one week prior to admission and at that time she was having some pain in the right thigh, probably from a pulled muscle. The patient was treated with Corticosteroids and the thigh pain disappeared and she was back within the next few days, this time complaining of some back pain. The patient has been a heavy smoker for a number of years and recently quit about one year ago and chest x-ray at that time was negative. The patient was thought to have osteoporosis and possibly a lumbar vertebral compression fracture. As currently the onset was just during some outside gardening. The patient otherwise had been feeling well and apparently relates the onset of this

pain complex to a fall in March but apparently was not severe and I had not seen her except in May and that time she was complaining of the right leg. With a right knee injury with an effusion. Treated again with corticosteroids and good results. * * *

(St. Ex. 4 at 219)

93. At hearing, Dr. Smith was questioned concerning his statement that Patient 1 had been seen in his office “one week prior to admission” complaining of pain in the right thigh. When Dr. Smith was asked which office visit he had been referring to in that statement, the following exchange followed:

A. [By Dr. Smith] The first—5/24/04.

Q. [By Ms. Pfeiffer] Which would have been really about a month before the admission, not a week. Is that what you’re referring to?

A. No, no, because I was referring to the low back pain of 6/17/04.

Q. I’m a little confused. So would the June 10, ’04, be the pulled muscle, right thigh?

A. Yes, but it also mentions down there the patient was thought to have osteoporosis and possibly a lumbar vertebral compression fracture, which would possibly cause sciatica of the right leg.

Q. Continuing on there, “The patient otherwise had been feeling well and apparently relates the onset of this pain”—is that complex?

A. Pain complex. By this time I was thinking, “No. Wait. I have got two things here. I’ve got a knee; I’ve got a leg. I’ve got maybe a sciatic nerve, and I have got maybe a back fracture.” So that’s the complex that I’m mentioning.

Q. But that sentence, “The patient otherwise had been feeling well, and the patient relates the onset of this pain complex to a fall in March but apparently was not severe. And I had not seen her except in May, and at that time she was complaining of the right leg”?

A. Right.

Q. So when you saw her in May and she was complaining about the right leg, did she ever mention this fall in March?

A. No. I don’t think so. It was mentioned later down, probably at about the 6/17/04 visit.

(Tr. at 91-93) The Hearing Examiner notes that Dr. Smith did not document in his progress notes any information concerning a March 2004 fall. (St. Ex. 4A at 6)

94. In addition, Dr. Smith stated in the June 25, 2004, History and Physical Report that he had not performed a breast examination at that time. (St. Ex. 4 at 221)
95. When asked why he did not perform a breast examination on June 25, 2004, Dr. Smith replied that he had been more concerned at that time with Patient 1's general physical condition, getting tests done, and ruling out metastatic bone disease. (Tr. at 94-95)

However, in an earlier History and Physical Report dictated by Dr. Smith for Patient 1's February 4, 2003, hospital admission for pneumonia, Dr. Smith had noted that an examination of Patient 1's breasts had shown no masses. When asked why he had performed a breast examination in 2003 but not in 2004, Dr. Smith replied that he had been "taking more time" in 2003, and had been more concerned in 2004 with Patient 1's condition than he had been in 2003. Dr. Smith added that he did not perform breast examinations on all patients admitted to the hospital. (St. Ex. 4 at 225; Tr. at 94-95)

When asked if the breast examination that he had performed on Patient 1 in February 2003 had been the only breast examination he had ever conducted on Patient 1, Dr. Smith replied that he had previously performed breast examinations "[p]robably once or twice." (Tr. at 95-96)

96. Further, in his June 25, 2004, History and Physical Report, Dr. Smith provided no information in the spaces labeled Family History and Social/Personal History. (St. Ex. 4 at 219)

When asked why he did not provide any information concerning family history or social and personal history, Dr. Smith replied: "I generally didn't put that in the hospital charts. It wasn't required until just recently. I forget how long ago they put it in, but I would only put these things in if I thought they were pertinent." (Tr. at 94)

Patient 1's June 2004 Hospitalization - Dr. Smith's July 2, 2004, Discharge Summary

97. Dr. Smith's July 2, 2004, Discharge Summary states, in part, as follows:

The patient is a 63 year-old female who over the past at least 3-4 months has had some various pains and some in the back and some in the leg. Apparently none too serious. She did not come to see me about any of them until about the last week prior to the admission. At that time the pain was in the right thigh and then treated with some corticosteroids and improved. She was back the following three days with back pain and this was treated in the same manner thinking it was possibly an osteoporotic fracture of the vertebral column. There was no relief. She then had a DEXA scan and a bone scan

ordered. The bone scan was suspicious for metastatic carcinoma and the DEXA scan showed severe osteopenia. The patient then had a workup including an MRI and CT scan of the brain, abdomen and chest. Initial thought was that it was lung cancer from her long years of smoking but it indeed appears that it was an occult carcinoma of the breast. Apparently in a skin fold where she did not notice it and it had metastasized to the spine and probably to the liver. There appears to be no metastasis to the brain. The patient's pain now has been treated with radiation therapy. Palliative and will be done as needed. The biopsy was done under local and has not returned yet but is presumed breast cancer. * * *

(St. Ex. 4A at 217)

98. With regard to Dr. Smith's statement that Patient 1 had not seen him until the last week prior to her hospital admission, the following exchange took place

Q. [By Ms. Pfeiffer] Your summary indicates that she did not come to see you about any of the pains until about the last week prior to the admission, which was June 25, '04; correct?

A. Okay.

Q. Would you agree that's not quite correct, that she actually came to you about a month before that on May 24?

A. Again, we are talking about different pains.

Q. Some in the back and some in the leg?

A. Correct.

Q. Which ones were you talking about?

A. Let's do leg first. Well, knee, leg—reinjured right leg and then low back pain on 6/17/04. Questionable osteoporotic fracture; so it didn't start to fall into place until 6/17.

Q. So when you state in your discharge summary "She did not come to see me about any of them," are you referring to the June 14—I'm sorry—the June 17 visit?

A. No. That counts as the low back pain.

Q. So in your statement “She did not come to see me about any of them up until about the last week prior to admission,” which office visit are you referring to?

A. 6/17. Well, let’s see. She came in 6/25. It would have been 6/22.

Q. She had right thigh pain and lower back pain prior to 6/22/04; correct?

A. Correct, but it didn’t—like I said, it didn’t fall into a low back pain, vertebral sciatic nerve, possible knee damage until 6/17.

Q. But she was experiencing the pain prior to 6/17?

A. Right, but not in the back.

(Tr. at 97-99)

Patient 1’s June 2004 Hospitalization - Oncologist’s June 29, 2004, Consultation Report

99. A June 29, 2004, Consultation Report by an oncologist at Wood County Hospital states, under Family History: “**Remarkable for her mother having a diagnosis of breast cancer in her late 50s.** * * * Her daughter has received radiation therapy to her foot for cancer eight years ago, the type of which is unknown to [Patient 1].” (St. Ex. 4 at 197) (Emphasis added.)

100. Dr. Smith testified that he has “no idea” why Patient 1 would have told him that she had no family history of breast cancer. (Tr. at 109)

101. In the June 29, 2004, Consultation Report, under the heading Review of Systems, the oncologist stated, among other things: “She reports having regular pelvic exams and Pap smears, the last occurring approximately one year ago. By her report, she last underwent mammography 30 years ago, having started such exams at an early age due to having first pregnancy at age 17.” (St. Ex. 4 at 197)

102. Dr. Smith testified that he has no reason to dispute that statement. (Tr. at 110)

Medical Records Maintained by Wood County Hospital concerning Patient 1

103. Medical Records maintained by Wood County Hospital include an August 2004 Discharge Summary authored by a physician at the hospital. The Discharge Summary states that Patient 1 had been on “DNR-CC only status.” The summary further states, in part:

She became more congested, she developed congestive heart failure, she was assisted adequately with oxygen and Lasix and she eventually expired [in August 2004]. In my opinion the cause of death is respiratory failure

secondary to congestive heart failure which is secondary to debilitation from carcinoma of the left breast with metastases to the liver, the brain, the bones and mediastinum.

(St. Ex. 5 at 279)

Expert Opinion concerning Dr. Smith's Medical Recordkeeping - In General

Testimony of Dr. Hubble

104. In his written report, Dr. Hubbell noted that Dr. Smith's progress notes concerning his care and treatment of Patient 1 for period of time exceeding 20 years consists of six sides of 8.5" x 11" paper. Approximately 80 visits are included on those six sides of paper. Dr. Hubbell opined: "This severely abbreviated record represents a practice of medicine below the minimal standard. Documentation of the medical encounter is an important element in the practice of medicine." (St. Ex. 3 at 2)
105. At hearing, Dr. Hubbell testified that, in the past, medical records were frequently very brief. However, during the 1970s, the concept of creating "problem oriented medical record[s]" had arisen. Dr. Hubbell testified that the idea developed that medical records should document four elements, "subjective, objective, assessment, and plan, or SOAP." Dr. Hubbell further testified that, around that same time, "the mantra was born * * * that if it wasn't documented, it didn't happen." However, Dr. Hubbell acknowledged that it is difficult to identify the point in time when more comprehensive medical recordkeeping became the standard of care. (Tr. at 185)

Dr. Hubbell noted that Dr. Smith's progress notes would have been deemed acceptable through the 1960s. However, Dr. Hubbell testified that Dr. Smith's medical record for Patient 1 is inadequate "by the 1970s standard or the 1980s standard and absolutely, positively by the 1990s and the 2000 standard." Finally, Dr. Hubbell stated in his 2006 report that "a more detailed record has been necessary for at least 25 years." (Tr. at 133-134, 169)

Testimony of Dr. Feeman

106. In his written report, Dr. Feeman stated that the standard of care for medical recordkeeping in Ohio is variable across the state. Dr. Feeman further stated that, because Dr. Hubbell does not practice medicine in northwest Ohio, he "has no real idea" concerning the standard of care for medical recordkeeping as it exists in northwest Ohio. (Resp. Ex. B at 1)

Dr. Feeman stated in his written report:

Whilst the matter of records keeping practiced by Dr. Smith is not what I would accept, I have seen medical records of other physicians practicing in Wood County (one covering their patients while the physicians were on

vacation, etc.) and I can state that Dr. Smith's recordkeeping does not differ substantially from the manner in which other doctors keep their medical records. Therefore, I do not find that his recordkeeping falls below minimal standards.

(Resp. Ex. B at 1)

Testimony of Dr. Smith

107. Dr. Smith testified as follows concerning his approach to medical recordkeeping:

My attitude at the beginning and really through the whole 35, 36 years, the notes were my notes, and they were to me. And, again, I admitted some things I didn't want to put in the notes because the insurance companies would request the records, and some people were changing jobs or their employer changed insurance companies. So I was reluctant to put down much that would give concern, such as heavy smoking or heavy drinking, as long as these people were not in jail or they were working and responsible.

(Tr. at 238-239)

Dr. Smith further testified, "[I]f you start writing everything down, you're not talking to the patient, and the essence of the office exam was to talk to the patient to find out what was wrong and then make a note in the chart about what you felt was pertinent." (Tr. at 242)

Finally, Dr. Smith stated that, as a result of patients transferring to his practice from other physicians, he has seen numerous medical records kept by other physicians in the Bowling Green area. Dr. Smith testified that those records are very similar to his, are very brief, and most of the time not very legible. (Tr. at 242-243)

108. Dr. Smith indicated that recordkeeping for a solo practitioner is different from recordkeeping in a group practice because in a group practice multiple physicians see the patients. More information must be documented because different physicians may see the same patient. However, a physician in a solo practice is the only one seeing the patient, which to Dr. Smith means that information in the chart does not have to be repeated over and over. (Tr. at 323-324)

109. Dr. Smith testified that, during his medical training, he had received no guidance concerning a standard for recordkeeping. However, Dr. Smith testified that, as a medical student, he had obtained complete histories and physical examinations on patients, had documented as much as he possibly could, and afterward a resident had taken over. Nevertheless, Dr. Smith testified that "for the most part, the recordkeeping was for educational purposes, and no mention was made of what to do with the recordkeeping after you went into practice." (Tr. at 243)

110. With regard to the SOAP format of medical recordkeeping, Dr. Smith stated that he had tried using it but had found that it interfered with his discussions with patients. Further, Dr. Smith stated that there had been only one physician in the hospital where Dr. Smith practiced who had used the SOAP format, and that physician had been a professor at the Medical College of Ohio. Moreover, Dr. Smith testified, "I was writing too many things down." (Tr. at 243-244)

Dr. Smith disagreed with Dr. Hubbell's testimony that the SOAP format of recordkeeping has become the standard of care. Dr. Smith testified, "It couldn't have been because, like I said, there was only one doctor at the hospital I know that actually used it, and we had 230 on staff." Moreover, Dr. Smith testified that he is a fellow and diplomate of the American Board of Family Practice [ABFP], and that, over a 35 year period, he has not seen any CME offered, or any CME booklet published, by the ABFP concerning recordkeeping. (Tr. at 253-254)

Expert Opinion concerning Dr. Smith's Medical Recordkeeping - Documentation of Patient 1's Medical History, Family Medical History, and Social History

Testimony and Written Report of Dr. Hubble

111. In his written report, Dr. Hubbell stated that each of Dr. Smith's progress notes is deficient concerning documentation of the patient's history. Dr. Smith's record of "patient complaints and symptoms is invariably limited to a few words, often one or two words." Dr. Hubbell observed that Dr. Smith had obtained Patient 1's personal medical history on one occasion, June 9, 1981, and that history was not reviewed or updated until Patient 1 was hospitalized in February 2003. Moreover, Dr. Hubbell found no documentation of family history except one entry dated July 24, 1995, indicating that Patient 1's sister had had a stroke. Furthermore, Dr. Hubbell wrote:

This lack of documentation of history is profound. The record lacks sufficient statements of the patient's complaints, a comprehensive history that includes (personal) medical history, family medical history, social history, and interval history elements. Such deficiency represents a practice of medicine below the minimal standard. Physicians are expected to record the patient's complaints at each visit, to obtain and record a comprehensive medical history once, and to update this comprehensive history at reasonable intervals as needed.

(St. Ex. 3 at 2) In addition, Dr. Hubbell stated that "[o]btaining and documenting the history is an important element in making a diagnosis and planning treatment including the selection of medications." (St. Ex. 3 at 2)

112. At hearing, Dr. Hubbell testified that it is not necessary for a physician to obtain a complete history at every patient visit, but that a complete history should be obtained some time during the patient's first few visits. Further, "[i]t is imperative that at each visit the history of the current problem is detailed, and it requires more than one word. It requires some

description of severity, frequency, location, and so on.” It should also include the cause of the complaint, if any, such as a fall. Dr. Hubbell stated that he did not find that information in any of Dr. Smith’s notes concerning Patient 1. (Tr. at 130-132)

113. Dr. Hubbell testified that Dr. Smith had obtained and documented minimally adequate histories during Patient 1’s hospitalizations in February 2003 and in June 2004. However, even on those occasions, Dr. Smith did not record a family or social history. (St. Ex. 3 at 2)

Testimony of Dr. Feeman

114. In his written report and testimony, Dr. Feeman opined that the standard of care does not require a physician to obtain a complete history at every visit. (Resp. Ex. B at 2; Tr. at 349-353) However, Dr. Feeman testified that the standard of care requires that a pertinent history that relates to the patient’s complaint should be obtained at each visit, and that he records a patient’s family history when the patient comes in for the first time. (Tr. at 353)

Testimony of Dr. Smith

115. Dr. Smith testified that, in his opinion, he had taken a complete history from Patient 1 on June 9, 1981. He stated that he had included Patient 1’s complete past medical history as well as a history of her present illness. Furthermore, he testified that he obtained and documented physical findings. He further stated that he had obtained, but did not document, her family history. Moreover, Dr. Smith testified that he had obtained, but did not document, a review of systems. (Tr. at 265-266)
116. Dr. Smith testified that, subsequent to the medical history that Patient 1 had given him on June 9, 1981, he had updated her history only when Patient 1 had been in the hospital. (Tr. at 116-117)

Later in the hearing, Dr. Smith testified that, throughout the course of his treatment of Patient 1, he had asked her for an update of her medical history. However, he stated that if there was no change he did not write it down. (Tr. at 266-267)

Expert Opinion concerning Dr. Smith’s Medical Record for Patient 1 - Documentation of Performance of Physical Examinations

Testimony and Written Report of Dr. Hubbell

117. In his written report, Dr. Hubbell stated that obtaining and documenting physical examinations “is an important element in making a diagnosis and planning treatment including the selection of medications.” Dr. Hubbell further stated that it is “a “cardinal rule that a current examination of the system affected” must occur prior to treating a condition with medication or some other modality. Nevertheless, Dr. Hubbell found that Dr. Smith

had prescribed medication to Patient 1 “for several conditions with little or no documentation of relevant system examinations,” and that his documentation of a physical examination had been deficient at each visit. (St. Ex. 3 at 3)

In addition, Dr. Hubbell stated that Dr. Smith did not document performance of a complete physical examination except during Patient 1’s hospitalizations. Finally, Dr. Hubbell stated that, in Dr. Smith’s progress notes, he had failed to sufficiently document appropriate but more limited physical examinations; thus it appears that such examinations were never performed at any of Patient 1’s visits to Dr. Smith’s office. (St. Ex. 3 at 3)

Testimony and Written Report of Dr. Feeman

118. In his written report and testimony, Dr. Feeman opined that the standard of care does not require that a physician perform a complete physical examination at every visit. (Resp. Ex. B at 2; Tr. at 349-353) However, Dr. Feeman testified that the standard of care requires that a physician perform at each visit a pertinent physical examination that relates to the patient’s complaint. (Tr. at 349-350)

119. With regard to pertinent physical examinations, Dr. Feeman testified that the physical examination that Dr. Smith had documented on June 9, 1981, did not just meet the minimal standard of care, it *was* the standard of care. Dr. Feeman testified that the visit had concerned possible hypertension, and Dr. Smith had documented the patient’s blood pressure, had listened to her heart and to the arteries in her neck and in the abdomen, and had ordered a blood test. (Tr. at 349-351)

Testimony of Dr. Smith

120. Dr. Smith testified: “My practice was one where people would get sick and come and see me for a specific thing. * * * I would do physical exams on truck drivers or sports physicals, that kind of stuff, but it was mostly symptomatic treatment.” (Tr. at 116-117)

121. Dr. Smith disagreed with Dr. Hubbell’s testimony that his physical examinations of Patient 1 had been deficient at each visit. Dr. Smith testified that he simply did not document findings that were normal. Nevertheless, Dr. Smith acknowledged that he had often documented “NSR” [normal sinus rhythm], even though that finding had been normal. (Tr. at 267-269)

Dr. Smith testified that his documentation of normal sinus rhythm was evidence that he had also listened to Patient 1’s breath sounds. Dr. Smith testified that, if he listened to Patient 1’s heart, he would also have listened to her chest. (Tr. at 269-270)

Expert Opinion concerning Dr. Smith's Medical Record for Patient 1 - Documentation of Diagnoses and/or Assessments

Testimony of Dr. Hubbell

122. Dr. Hubbell testified that Dr. Smith had failed to document diagnoses in his progress notes for Patient 1. Dr. Hubbell further testified that "it's absolutely essential to any treatment decision that there be a diagnosis." Dr. Hubbell acknowledged that diagnoses can sometimes be inferred from other progress notes, "but the notes never or rarely spell out what the diagnosis actually was that was identified and [was] being treated. (Tr. at 139-140)
123. Dr. Hubbell acknowledged that he considers menopause to be a diagnosis. Dr. Hubbell further acknowledged that menopause is documented in Dr. Smith's progress notes. (Tr. at 140, 183)

Expert Opinion concerning Dr. Smith's Medical Record for Patient 1 - Documentation of Laboratory Data

Testimony of Dr. Hubbell

124. Dr. Hubbell testified that very little laboratory data is recorded in Dr. Smith's medical record for Patient 1. Dr. Hubbell indicated that Dr. Smith's progress notes reflect that there were a number of instances when lab tests had been ordered but no results were ever received or documented. (Tr. at 141)
125. Dr. Hubbell testified that, because Patient 1 had hypertension, Dr. Smith had needed to do an EKG to assess her heart and check for signs of an enlarged heart. However, no EKGs were documented. (Tr. at 145)

Testimony of Dr. Feeman

126. Dr. Feeman testified that it is not necessary to routinely run an EKG on a patient who suffers from simple high blood pressure. It would be a waste of time and money. (Tr. at 430-431)

Testimony of Dr. Smith

127. Dr. Smith testified that Patient 1 had sometimes refused to comply with his orders for diagnostic tests. However, he acknowledged that he had not documented such refusals in the medical record. In addition, Dr. Smith's testimony indicates that he had often approached the issue of diagnostic testing by asking Patient 1 if she wanted a test, rather than directing her to obtain the test. For example, Dr. Smith testified concerning the episode when Patient 1 had complied with his direction to have a blood draw, but the blood draw had been placed in the wrong tube. When asked if he had ever advised Patient 1 to go back and get another blood draw, Dr. Smith replied that he had told her that he did not need

the test, “but she could have it done if she wanted to. And she, again, was not one that was actively seeking tests * * * so she decided not to.” (Tr. at 303-304)

Nevertheless, Dr. Smith testified that, “[f]or the most part,” when he had actually *told* Patient 1 that it was necessary that the test be done, Patient 1 had complied with his orders. However, when he simply advised her that she could have a test if she wanted it, she oftentimes would not get the test. (Tr. at 306-307)

128. With regard to this issue, Dr. Smith testified that Patient 1 had refused to have mammograms performed. However, when Dr. Smith was asked if he had *directed* Patient 1 to get a mammogram or had merely *asked* her if she wanted a mammogram, Dr. Smith indicated that he had asked Patient 1 if she wanted to have a mammogram. (Tr. at 67, 297) [The issue of Dr. Smith’s failure to obtain documentation of mammograms is discussed more fully below.]

Further Testimony of Dr. Feeman

129. Dr. Feeman noted that he would have documented a patient’s refusal to have examinations performed. (Tr. at 380-381)

Expert Opinion concerning Dr. Smith’s Prescribing of Estrogen Prior to August 2002

Testimony and Written Report of Dr. Hubbell

130. With regard to Dr. Smith’s prescribing of hormone replacement therapy to Patient 1 prior to August 2002, Dr. Hubbell stated in his written report that such prescribing would not have been unreasonable had Dr. Smith documented adequate performance of “periodic history, examination, and periodic mammograms.” If that had occurred, Dr. Smith’s utilization and prescribing of hormone replacement therapy would have been within the standard of care. However, Dr. Hubbell stated that Dr. Smith’s record contains “almost no documentation” to support such prescribing. (St. Ex. 3 at 4)
131. Dr. Hubbell testified that it has been customary throughout Dr. Hubbell’s career to include in a patient’s medical record documentation from other physicians who provide services to the patient. Dr. Hubbell further testified that it is “especially troublesome” in Patient 1’s case that Dr. Smith did not document pelvic and breast examinations that may have been performed by another physician. (Tr. at 134-135)

Moreover, Dr. Hubbell testified that there is a medical principle that a physician should treat only the problems for which the physician is providing complete monitoring, including a history and physical examination for that problem. The only exception to that principle is when a physician has “crystal-clear documentation” from another physician who is providing that monitoring. (Tr. at 135-136)

In addition, Dr. Hubbell testified that, even if a patient is receiving regular pelvic and breast examinations, he would not prescribe hormone replacement therapy unless the patient was also getting periodic mammograms. Dr. Hubbell testified: “You can’t find everything on a physical exam. You have got to do the mammogram as a complementary process to be sure about a lack of tumors.” (Tr. at 147-148)

Furthermore, Dr. Hubbell testified that he would not rely upon a patient’s statement that she had been conducting her own breast self-examinations. Dr. Hubbell testified that, although it is helpful to the patient if she does her own self-examinations, a physician must still perform periodic breast examinations. (Tr. at 148-149)

Finally, Dr. Hubbell testified that pelvic examinations, breast examinations, and periodic mammography had been required elements for prescribing estrogen even before the Women’s Health Initiative published a report in August 2002 that placed additional requirements on hormone replacement therapy. (Tr. at 150)

132. Dr. Hubbell acknowledged that, until a law was passed in the 1990s, some insurance companies had refused to pay for routine mammograms. Dr. Hubbell acknowledged that, prior to the change in law, patients sometimes avoided doing tests that were not covered by insurance. (Tr. at 205-206)

Testimony of Dr. Feeman

133. Dr. Feeman testified that he disagrees with the allegation in paragraph 2(a) of the Board’s notice that Dr. Smith had violated the minimal standard of care by prescribing estrogen while failing to establish or document a diagnosis. Dr. Feeman stated that a physician always makes a diagnosis, even if the diagnosis is not written down. Further, Dr. Feeman testified, “You can’t treat people without having at least a mental diagnosis of what’s going on.” Moreover, Dr. Feeman testified that menopause is a diagnosis, and that menopause had been documented in the medical record. (Tr. at 368-369)
134. Dr. Feeman testified that some types of breast cancer are estrogen-dependent, and that continued prescribing of estrogen could fuel the growth of the cancer. Dr. Feeman stated that, accordingly, a patient receiving estrogen should have regular breast examinations and mammograms. (Tr. at 394-395)

Nevertheless, Dr. Feeman also testified that he disagrees with the allegation that Dr. Smith had failed to perform or document appropriate tests or studies, including periodic Pap smears, breast examinations, and mammograms. Dr. Feeman further testified that, “in ideal circumstances,” the prescribing physician should receive written confirmation concerning the tests performed by another physician. However, Dr. Feeman testified that it has been his experience that it is often difficult to obtain such documentation from the Wood County Women’s Center, which is currently the only OB/GYN clinic in Wood County. (Tr. at 370-373)

Dr. Feeman later testified that if no other physician had done breast or pelvic examinations on Patient 1, and if Dr. Smith had not done them himself, it would have been below the minimal standard of care for Dr. Smith to continue to prescribe Premarin. When asked how a physician can determine if someone else is doing examinations, Dr. Feeman replied that “[y]ou take a patient’s word for it, basically,” because it is difficult to get information from the Wood County Women’s Center. (Tr. at 399-401) The Hearing Examiner notes, however, that the evidence indicates that Patient 1 did not go to the Wood County Women’s Center; she went to Dr. Miller. Dr. Feeman acknowledged that, if Patient 1 had seen Dr. Miller, she would not have been going to the Women’s Center. (Tr. at 397)

Testimony of Dr. Smith

135. Dr. Smith testified that he does not agree with Dr. Hubbell’s statement that a physician should be required to obtain a breast exam and/or mammography on a patient prior to initiating Premarin. Dr. Smith further testified that when he had first started utilizing estrogen, mammography had not been available. He stated that it had not been until sometime in the 1980s when mammography became available and became a standard of care. (Tr. at 258-259)
136. Dr. Smith testified that he had not actually recommended mammograms to patients, but instead had advised them that a mammogram was available, “unless they had lumps or something I could feel.” Dr. Smith testified that he did not alter his approach, even after the law in Ohio was changed to require insurance companies to pay for mammograms. (Tr. at 336-337)

Expert Opinion concerning Dr. Smith’s Prescribing of Estrogen after August 2002

Premarin Package Insert

137. Dr. Smith’s medical records for Patient 1 include a copy of the package insert for Premarin, revised July 16, 2003. The document includes a boxed warning that states, in part, as follows:

Estrogens with or without progestins should not be used for the prevention of cardiovascular disease.

The Women’s Health Initiative (WHI) study reported increased risks of myocardial infarction, stroke, invasive breast cancer, pulmonary emboli, and deep vein thrombosis in postmenopausal women during 5 years of treatment with conjugated equine estrogens (0.625 mg) combined with medroxyprogesterone acetate (2.5 mg) relative to placebo* * *. Other doses of conjugated estrogens and medroxyprogesterone acetate, and other combinations of estrogens and progestins were not studied in the WHI and, in the absence of comparable data, these risks should be assumed to be similar. Because of these risks, estrogens with or without progestins should be

prescribed at the lowest effective dose is in for the shortest duration consistent with treatment goals and risks for the individual woman.

(St. Ex. 4 at 13)

138. In addition, the patient information section of the package insert for Premarin lists some questions and answers. In answer to the question, “What can I do to lower my chances of getting a serious side effect with Premarin?” one of the bulleted answers states as follows:

Have a breast exam and mammogram (breast x-ray) every year unless your healthcare provider tells you something else. If members of your family have had breast cancer or if you have ever had breast lumps or an abnormal mammogram, you may need to have breast exams more often.

(St. Ex. 4 at 14)

Testimony of Dr. Hubbell

139. Dr. Hubbell testified that, following publication of the WHI study, physicians were required to inform patients receiving hormone replacement therapy of the results of that study. If a patient had been obtaining breast examinations, mammographies, and Pap smears, then the patient could choose whether to continue using hormone replacement therapy. Nevertheless, “there needed to be a crystal-clear discussion of this issue and a choice by the patient whether or not to continue.”⁸ (Tr. at 151-153)

Dr. Hubbell testified concerning an entry in Dr. Smith’s February 4, 2003, History and Physical Report for Patient 1’s February 2003 hospitalization that states, “Hormone replacement therapy with advisement, stable.” Dr. Hubbell indicated that that statement is “marginally adequate” documentation of the necessary disclosure, “and seems kind of too late.” Dr. Hubbell further testified that documentation of the necessary disclosure following the WHI study should have been in Dr. Smith’s progress notes immediately following publication of the WHI study in the summer of 2002. However, Dr. Hubbell acknowledged that Patient 1’s first visit to Dr. Smith following August 2002 had occurred on January 21, 2003. Finally, Dr. Hubbell acknowledged that Patient 1’s hospitalization, and Dr. Smith’s documentation of “advisement,” had occurred within two weeks of that visit. (St. Ex. 4 at 225; Tr. at 154-155)

⁸ Dr. Hubbell noted that the results of the WHI study are more clear-cut for women taking a combination of estrogen and progesterone, and he acknowledged that Patient 1 had received only estrogen. However, Dr. Hubbell testified that he believes, and other physicians upon whom he has relied for information concerning this issue believe, “that this was a significant enough issue that required a disclosure even if [the patient was] only taking estrogen.” (Tr. at 153)

Testimony of Dr. Feeman

140. Dr. Feeman indicated that he does not believe that the 2002 WHI study had imposed any additional duty on a physician who prescribes estrogen. Dr. Feeman testified that the WHI study was one study among many, and a physician must determine how it fits in with all the other studies that have been done. Further, with regard to the “estrogen only” part of the study, Dr. Feeman testified that he believes that they had found an increased risk of stroke and dementia, but that the study is an outlier. Dr. Feeman stated that no previous study had documented increased risk of stroke and dementia, and that all the other studies that he is familiar with had indicated that estrogen should preserve brain function. (Tr. at 374-377)

Further, Dr. Feeman testified that Dr. Smith documented, “Hormone replacement therapy with advisement, stable,” in a February 4, 2003, History and Physical Report. Dr. Feeman testified that that indicates that Dr. Smith had discussed the WHI study with Patient 1. (St. Ex. 4 at 223; Tr. at 376-377)

Testimony of Dr. Smith

141. Dr. Smith testified that he had discussed with Patient 1 the risks associated with taking Premarin around the same time that she began having menopausal symptoms. However, Dr. Smith acknowledged that he did not have any further discussion with Patient 1 after the WHI study came out in 2002. (Tr. at 104-105)

Dr. Smith subsequently testified that he had discussed the WHI study with Patient 1. Dr. Smith further testified that this discussion had been documented on his February 4, 2003, History and Physical Report. (Tr. at 258)

142. Dr. Smith acknowledged that, on the date that he recorded that Patient 1 had been taking hormone replacement therapy with advisement, Patient 1 had been in the hospital suffering from viral pneumonia, and had been very ill. When asked why he would have advised her at that time, when she was very sick, Dr. Smith first replied that that had been the time that he made the note, and that the hormone replacement therapy advisement had been ongoing prior to her pneumonia. Subsequently, Dr. Smith acknowledged that he had advised Patient 1 concerning hormone replacement therapy while she was in hospital. (Tr. at 312-315)

Expert Opinion concerning Dr. Smith’s Steroid Prescribing prior to May 2004

Testimony of Dr. Hubbell

143. In his written report, Dr. Hubbell stated that he cannot determine from the medical record the diagnosis for which Dr. Smith prescribed steroids between February 24, 1984, and May 24, 2004. (St. Ex. 3 at 6)

144. Dr. Hubbell testified that prescribing steroids for a complaint documented as an upper respiratory infection is problematic because “upper respiratory infection” is not a diagnosis. Dr. Hubbell further testified that prescribing steroids would be acceptable for a patient who has asthma or suffers from very inflamed sinuses. However, in the case of Dr. Smith’s medical record for Patient 1, there is no diagnosis that warrants the utilization of steroids. (Tr. at 156-158)

Dr. Hubbell later acknowledged that steroids can be utilized for the treatment of COAD. However, Dr. Hubbell further testified that “[h]ardly anybody does it long-term as injections. It’s almost always oral and in small doses.” (Tr. at 192-193)

Testimony of Dr. Feeman

145. Dr. Feeman testified that he does not agree with the Board’s allegation in paragraph 2(c) of its notice concerning Dr. Smith’s utilization of steroids without an appropriate diagnosis. Dr. Feeman testified:

My response would be that every patient receives a diagnosis, whether or not it’s written down. You can’t treat a patient properly if you don’t know what the diagnosis is. Do you always write it down? No, not always. Should you read it down? Perhaps. These records, for example, are the individual doctor’s records of what is going on. The doctor knows what’s going on with his patient.

(Tr. at 361)

146. With regard to Dr. Smith’s prescribing of steroids prior to May 2004, Dr. Feeman testified that it is appropriate to use steroids in the treatment of COAD. He noted that Dr. Smith had documented COAD in his progress note dated May 19, 1987. [The note actually uses Dr. Smith’s symbol for questionable or possible COAD.] (St. Ex. 4A at 3; Tr. at 362-363)
147. With regard to Dr. Smith’s prescribing steroids for COAD, Dr. Feeman noted that “[s]teroids do not heal anything. What they do is they fix inflammation that leads to bronchospasms,” and are used to treat patients symptomatically. However, Dr. Feeman acknowledged that there is no notation of bronchospasms in Dr. Smith’s medical record for Patient 1. When asked whether he therefore cannot know why Dr. Smith had administered steroids to her in the mid-1980s, Dr. Feeman replied, “I can make an assumption, but I cannot state for certain.” (Tr. at 404-405)

Dr. Feeman testified that he is uncertain how a physician would determine the dose of steroids to give intramuscularly for COAD. Dr. Feeman further stated that he does not use injectable steroids to treat that condition. (Tr. at 405-407)

Testimony of Dr. Smith

148. Dr. Smith testified that COAD, or chronic obstructive airway disease, is the same thing as COPD, and that both are synonymous with emphysema. (Tr. at 263)

Dr. Smith testified that steroids are very effective for treating COAD. Dr. Smith further testified that steroids effectively eliminate symptoms such as shortness of breath and dyspnea on exertion, and patients feel as though they do not have the disease. Moreover, Dr. Smith testified that Patient 1 had had intermittent episodes of shortness of breath and wheezing, and the steroids had relieved her symptoms. Finally, Dr. Smith testified that his use of steroids to treat Patient 1's COAD had been within the standard of care. (Tr. at 263-265)

Expert Opinion concerning Dr. Smith's Prescribing of Steroids in May and June 2004

Testimony of Dr. Hubbell

149. Dr. Hubbell stated in his written report that Dr. Smith had used steroids to treat Patient 1 on five occasions between May 24 and June 22, 2004. Dr. Hubbell further stated it is unacceptable that the progress note for each visit had "a cryptic notation suggesting the patient had leg pain, yet there was no diagnosis and no testing until her [hospital] admission in late June." Moreover, he stated that the minimal standard of care required an x-ray or consultation at the June 8, 2004, visit, while perhaps continuing symptomatic treatment. (St. Ex. 3 at 6)
150. Dr. Hubbell testified that, in his opinion, two injections of Decadron 8 mg in a single visit is a "really big dose." He further testified: "These days the range for Decadron is up to 12 milligrams a day, and that is for really serious things like brain swelling. So to me this is stretching the limits of reason on the dose, and we don't really have a diagnosis. Perhaps there is a swollen knee. Okay. It just doesn't seem like it's in proportion." (Tr. at 160-161)

In addition, Dr. Hubbell testified that steroids are the most powerful form of anti-inflammatory medication that exists, and would be expected to relieve the symptoms "providing the problem is inflammatory." Moreover, Dr. Hubbell testified that he would expect the anti-inflammatory effect of an injection of Decadron to last approximately one month. (Tr. at 161-162)

Furthermore, with regard to Dr. Smith's repeated utilization of steroids during May and June 2004, Dr. Hubbell testified:

I fully recognize that at the first visit a serious problem masquerading as one symptom in one part of the body—lots of people would miss that. But if you got a second visit or a third visit, it's time to start thinking of other explanations and getting some tests. And I think it's questionable at best, the

dose on 6/8, which was two weeks after the first dose. To me it's completely beyond reason at 6/10, just two days later, to give additional Decadron plus the Medrol Dos Pak. So we are getting IM as well as oral steroids in pretty big doses.

* * *

So to keep doing that at 6/8, 6/10, 6/17 without pressing for, [sic] we have to have a reason. You're going to get an x-ray. You're going to do something. That's where I'm really disturbed that the ball has been dropped.

(Tr. at 162-163) When asked what more should have been done, Dr. Hubbell testified,

Well, it's hard to say. I don't know exactly because I clearly don't have the history to go on and I don't have much of the physical findings, but it seems like it's time certainly for x-rays.

(Tr. at 164)

Testimony of Dr. Feeman

151. When asked about the appropriateness of Dr. Smith's utilization of steroids from May 24, 2004, through June 2004, Dr. Feeman testified:

I first have to understand what the steroids would be prescribed for, and Dr. Smith would know what they were being prescribed for because he gave the steroids. It is not clear to me why [she] got the steroids. If [she] got the steroids for COPD, then that's within the standard of care. But I can't answer the question because I'm not sure why [she] got the steroids * * *.

(Tr. at 364-365)

152. Dr. Feeman testified that he agrees that, by June 10, 2004, something more extensive should have been done to determine the cause of Patient 1's pain, such as an x-ray. (Tr. at 411)

153. Dr. Feeman testified that he does not use Decadron in his practice, and cannot opine concerning the appropriateness of the dosages of Decadron that Dr. Smith had given to Patient 1, or the duration of its effects. (Tr. at 409-410)

Testimony of Dr. Smith

154. Dr. Smith testified that he does not agree with Dr. Hubble's opinion that he should have done something more for Patient 1 on June 8, 2004. Dr. Smith further testified: "I had said the first time she came in with the leg that we could get an x-ray, but it probably wouldn't

show anything. She said that was fine. She didn't want to have the x-ray done.”⁹
(Tr. at 271)

Dr. Smith testified that Patient 1 had been very reluctant to have diagnostic tests done. Moreover, Dr. Smith testified that, on June 22, 2004, her last visit to his office, he had documented “Bone scan” and “DEXA scan” but that she had refused those tests. Dr. Smith acknowledged that he did not document her refusal. Dr. Smith stated, “Throughout the whole course, until she was in the hospital, she refused any diagnostic treatment.”
(Tr. at 272-273)

155. Dr. Smith testified concerning Dr. Hubbell’s criticism of his use of steroids, stating that he had learned the use of Decadron and Depo-Medrol from orthopedic physicians to whom he had sent patients. Dr. Smith further testified that the orthopedic physicians, as well as allergists, would give their patients “fairly large doses of the Depo-Medrol and the Decadron and the Medrol Dos Pak.” Finally, Dr. Smith testified that his treatment of Patient 1 with steroids during June 2004 had been consistent with the minimal standards of care because it had given her relief and, at that time, he had thought that her pain had resulted from an injury. (Tr. at 279-281)

Expert Opinion concerning Dr. Smith’s Prescribing of Anti-Anxiety Medication

Testimony of Dr. Hubbell

156. Dr. Hubbell criticized Dr. Smith because there was no history and examination documented to support his prescribing of anti-anxiety medication to Patient 1. However, Dr. Hubbell stated that, if the documentation had been there, Dr. Smith’s management of the patient’s anxiety would have been “perfectly okay.” (Tr. at 149)

Dr. Hubbell explained that, prior to prescribing anti-anxiety medication, Dr. Smith should have documented such things as whether Patient 1’s thyroid had been enlarged, whether she had had headaches, and whether she had had problems with sleep. Without such information, one cannot tell, for example, whether the patient’s problem had been depression rather than anxiety. (Tr. at 149)

157. Dr. Hubbell testified that, if Dr. Smith had prescribed a larger dose of Xanax to Patient 1 and instructed her to cut the pills in half, that would be acceptable as long as the medical record reflected what the actual dose had been. (Tr. at 155-156)

Testimony of Dr. Feeman

158. Dr. Feeman testified that he does not agree with the Board’s allegation in paragraph 2(d) of its notice that Dr. Smith had prescribed antianxiety medication to Patient 1 without

⁹ Note that the offer of x-rays and subsequent refusal were not documented in Dr. Smith’s May 24, 2004, progress note. (St. Ex. 4A at 6)

documenting an appropriate diagnosis, taking or documenting appropriate histories, and/or failing to perform or document appropriate physical examinations. Dr. Feeman further testified that a patient will advise a physician, if given the chance, of what is going on psychiatrically. Moreover, Dr. Feeman testified that there is no physical examination that a physician can do for anxiety. Therefore, the physician has to rely on what the patient says. (Tr. at 357-359)

Dr. Feeman testified that one exception would be hyperthyroid, which can cause a patient to become nervous and hypertensive, which Patient 1 had been. However, Dr. Feeman testified that Patient 1 lacked other symptoms of hyperthyroid such as fast heartbeat, tremor, and sweating. (Tr. at 357-359)

Finally, Dr. Feeman testified that Dr. Smith had recorded a diagnosis of anxiety in a 1983 progress note. Dr. Smith's progress note for July 25, 1983, states that Patient 1 had had possible acute anxiety in crowds and while driving; and another note dated August 23, 1983, states that Patient 1 had decreased anxiety with estrogen. (St. Ex. 4A at 2; Tr. at 359-360)

159. Dr. Feeman acknowledged that if, on June 30, 1981, Dr. Smith had prescribed Centrax to treat anxiety, then he had done so without recording a diagnosis of anxiety. (St. Ex. 4A at 1; Tr. at 427-428)

Testimony of Dr. Smith

160. With regard to his treatment of Patient 1's anxiety, Dr. Smith testified that, after it becomes apparent that there is "no visible goiter and/or other symptoms, it's anxiety." He further stated that anxiety is not something that a physician can put his hands on or diagnose with a blood test. Moreover, Dr. Smith testified that he had checked Patient 1's TSH function to ascertain that her anxiety did not result from a thyroid condition. Finally, Dr. Smith testified that he had found nothing that would dispel an indication to prescribe Xanax to Patient 1. (Tr. at 277-278)
161. Dr. Smith testified that he had prescribed Xanax to Patient 1 and instructed her to cut the pills in half. He further testified that he had done this to save money for Patient 1. (Tr. at 278)

Expert Opinion concerning Dr. Smith's Prescribing of Antihypertensive Medication

Testimony of Dr. Feeman

162. Dr. Feeman testified that he does not agree with the Board's allegation in paragraph 2(e) of its notice that Dr. Smith failed to document the performance of a satisfactory medical history and/or physical examination with regard to his prescribing of antihypertensive medication to Patient 1. Dr. Feeman further testified that, in a family practice setting, it makes little sense to do a physical examination every time the person comes in for a blood pressure check. Moreover, Dr. Feeman testified that performing a physical exam every

third month would be fine. However, waiting as long as every six months would be inappropriate. (Tr. at 354-355)

Dr. Feeman testified that an appropriate follow-up physical examination for hypertension would consist of listening for gallops in the heart, and for bruits in the neck and abdomen. Dr. Feeman testified that he does not believe it had been appropriate for Dr. Smith to wait as long as he had to recheck Patient 1 for such conditions. (Tr. at 355-356)

Testimony of Dr. Smith

163. Dr. Smith testified that, following the June 9, 1981, visit, he had had Patient 1 come back to his office several times over the next month so that he could verify that she truly did suffer from high blood pressure. Dr. Smith testified that he had been concerned that she may have had “white-coat hypertension” rather than actual hypertension. (Tr. at 275-276)

Additional Information

164. Dr. Feeman acknowledged that he had discussed this case with Dr. Smith prior to the hearing. Dr. Feeman testified that on one occasion, he had asked Dr. Smith why no breast, pelvic, or rectal examination had been performed, and that Dr. Smith advised that Patient 1 had refused those examinations. (Tr. at 380)
165. In his written report, Dr. Feeman stated, in part, “In summary, the matter that I have reviewed involves the care of a patient who declined the usual examinations and, by extension, laboratory testing attendant to proper medical care.” (Resp. Ex. B)

Dr. Feeman testified that he had based that statement in part upon his conversation with Dr. Smith that Patient 1 had refused breast examinations. Dr. Feeman further testified that he had also based that statement upon the medical record, indicating that he had seen orders for tests but did not see the results for those tests. (Tr. at 438-441)

Dr. Hubbell’s Conclusion

166. Dr. Hubbell testified that, in his opinion, Dr. Smith’s care and treatment of Patient 1 prior to March 9, 1999, constituted a failure to use reasonable care discrimination in the administration of drugs or a failure to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 170-171)

Dr. Hubbell further testified that, in his opinion, Dr. Smith’s care and treatment of Patient 1 on or after March 9, 1999, constituted a 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. (Tr. at 171-172)

Finally, Dr. Hubbell testified that, in his opinion, Dr. Smith’s care and treatment of Patient 1 constituted a departure from or failure to conform to minimal standards of care of

similar practitioners under the same or similar circumstances, whether or not actual injury to Patient 1 occurred. (Tr. at 172)

Dr. Feeman's Conclusion

167. Dr. Feeman testified that, in his opinion, Dr. Smith's care and treatment of Patient 1 had met the minimal standard of care. (Tr. at 346-347)

Dr. Feeman further testified that, in his opinion, Dr. Smith's care and treatment of Patient 1 had been consistent with the use of reasonable care discrimination in the administration of drugs, and had been consistent with acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. (Tr. at 377-379)

Dr. Smith's Conclusions

168. Dr. Smith testified that he does not agree with any of the allegations concerning his care and treatment of Patient 1 that are contained in the Board's notice. Further, Dr. Smith testified that his care and treatment of Patient 1 did not violate the minimal standard care. (Tr. at 284-287)

Moreover, Dr. Smith testified that he does not believe that his care and treatment of Patient 1 constituted 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. (Tr. at 285-286)

Finally, Dr. Smith testified that he does not believe that his care and treatment of Patient 1 constituted 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. (Tr. at 286)

169. Dr. Smith testified concerning the allegations against him as follows:

I think that being a solo practitioner for a long period of time, as opposed to a doctor who's in a large group, as Dr. Hubbell was, that the standards of care in those situations are different. And his opinion was, again, probably more reflective of the large group care.

(Tr. at 287-288)

FINDINGS OF FACT

1. In or about September 1973, in the routine course of his medical practice, Albert W. Smith III, M.D., undertook the treatment of Patient 1. Dr. Smith continued to treat

Patient 1 until in or about June 2004. In June 2004, Patient 1 was hospitalized for metastatic carcinoma of the breast, which resulted in her death in August 2004.

2. In his medical care of Patient 1, Dr. Smith failed to obtain and/or document appropriate medical histories; failed to perform and/or document the performance of appropriate physical examinations; failed to perform and/or document the performance of appropriate tests and/or studies; failed to refer and/or document referrals for appropriate consultations; failed to establish and/or document the establishment of a treatment plan for his prescribing; and failed to appropriately establish and/or document the appropriate establishment of specific diagnoses.

Examples of such conduct include the following:

- (a) Although Dr. Smith prescribed estrogen to Patient 1 from July 1981 through June 2004, he failed to establish and/or record a diagnosis supporting such prescribing until July 8, 1982, when he documented early menopausal syndrome. Further, Dr. Smith failed to perform and/or document the performance of appropriate physical examinations, including breast examinations; and failed to perform and/or document the performance of appropriate tests and/or studies, including periodic Pap smears and mammograms.
- (b) Although Dr. Smith intermittently prescribed steroids to Patient 1 from February 1984 through June 2004, he failed to establish and/or failed to appropriately document the diagnosis supporting such prescribing. Further, he prescribed steroids to Patient 1 five times between May 24, 2004, and June 22, 2004, without providing and/or documenting a diagnosis, without ordering and/or documenting the ordering of x-rays, and without ordering and/or documenting the ordering of consultations.
- (c) Although Dr. Smith prescribed anti-anxiety medication, including Xanax, to Patient 1, he failed to appropriately establish and/or document an appropriate diagnosis supporting the prescribing of such medication; failed to take and/or record appropriate histories, and failed to perform and/or record the performance of appropriate physical examinations.

The evidence includes two progress notes that mention anxiety—one dated July 25, 1983, and one dated August 23, 1983. The first note states that Dr. Smith had considered anxiety as a possibility, and the second states that Patient 1 had had decreased anxiety while taking estrogen. Neither of these constitutes documentation of a diagnosis of anxiety.

- (d) Although Dr. Smith prescribed antihypertensive medication for Patient 1, he failed to perform and/or document the performance of a satisfactory medical history and/or physical examination related to such prescribing.

- 3 The evidence is insufficient to support a finding that, although Dr. Smith continued to prescribe estrogen to Patient 1 after August 2002, he failed to properly inform and/or appropriately document informing Patient 1 of the risks associated with hormone replacement therapy, and/or failed to obtain and/or appropriately document the obtaining of Patient 1's acceptance of the risks associated with hormone replacement therapy.

In a History and Physical Report dated February 4, 2003, Dr. Smith stated that Patient 1 had been taking hormone replacement therapy "with advisement." The opinion of the State's expert witness that was offered at hearing indicated that such documentation was "marginally adequate." Documentation that is marginally adequate is still adequate.

Nevertheless, the Board was substantially justified in bringing this allegation. In his written prehearing report, the State's expert opined that Dr. Smith's documentation of the disclosure required following publication of the WHI study in August 2002, and Patient 1's acceptance of the risks of continuing hormone replacement therapy, was not sufficient. However, during hearing, additional evidence regarding the disclosure and acceptance of risk was developed, and the State's expert acknowledged at hearing that Dr. Smith's documentation was marginally adequate.

CONCLUSIONS OF LAW

1. The conduct of Albert W. Smith, III, M.D., that occurred before March 9, 1999, as set forth in Findings of Fact 2, 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 that language is used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.
2. The conduct of Dr. Smith that occurred on or after March 9, 1999, as set forth in Findings of Fact 2 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 that language is used in Section 4731.22(B)(2), Ohio Revised Code.
3. The conduct of Dr. Smith as set forth in Findings of Fact 2 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 language is used in Section 4731.22(B)(6), Ohio Revised Code.
4. The conduct of Dr. Smith that occurred on or after November 17, 1986, and on or before March 16, 1987, as set forth in Findings of Fact 2(c) 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 language is used in Section 4731.22(B)(16), Ohio Revised Code, as in effect at that time, to wit: Rule 4731-11-02(D), Ohio Administrative Code.

5. The conduct of Dr. Smith that occurred on or after March 17, 1987, as set forth in Findings of Fact 2(c) 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 language is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code.

* * * * *

It is clear from the evidence presented in this matter that Dr. Smith’s care and treatment of Patient 1 was inadequate and is totally unacceptable. Dr. Smith failed to document, and perhaps failed to even perform or obtain, such necessary elements as appropriate medical histories, physical examinations, tests, and diagnoses. Dr. Smith offered testimony that he had obtained histories, performed examinations, and made diagnoses that he did not document in the medical record. However, Dr. Smith’s credibility is suspect; for example, a comparison of his May and June 2004 progress notes to statements he made in a June 25, 2004, History and Physical Report, and a July 2, 2004, Discharge Summary demonstrates a number of contradictions.

At a minimum, Dr. Smith's medical license should be suspended and he should be required to undergo an assessment of his medical knowledge and skills and complete any necessary remedial education. He may then be given an opportunity to return to practice provided that appropriate monitoring is taking place.

PROPOSED ORDER

It is hereby ORDERED that:

- A. **PERMANENT REVOCATION, STAYED; SUSPENSION:** The certificate of Albert W. Smith, III, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. Smith’s certificate shall be SUSPENDED for an indefinite period of time, but not less than one year.
- B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Smith’s certificate to practice medicine and surgery until all of the following conditions have been met:
 1. **Application for Reinstatement or Restoration:** Dr. Smith shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
 2. **Medical Records Course:** At the time he submits his application for reinstatement or restoration, Dr. Smith shall provide acceptable documentation of satisfactory completion of a course or courses on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any

course or courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Smith submits the documentation of successful completion of the course or courses on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course or courses, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

3. **Post-Licensure Assessment Program**: At the time he submits his application for reinstatement, Dr. Smith shall submit a Learning Plan developed for Dr. Smith by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. The Learning Plan shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Smith by the PLAS.
 - a. Prior to the initial assessment by the PLAS, Dr. Smith shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that assessment.
 - b. Should the PLAS request patient records maintained by Dr. Smith, Dr. Smith shall include in that submission copies of the patient records at issue in this matter. Furthermore, Dr. Smith shall ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.
 - c. Dr. Smith shall assure that, within ten days of its completion, the written Assessment Report compiled by the PLAS is submitted to the Board. Moreover, Dr. Smith shall ensure that the written Assessment Report includes the following:
 - A detailed plan of recommended practice limitations, if any;
 - Any recommended education;
 - Any recommended mentorship or preceptorship;
 - Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.
 - d. Dr. Smith shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

Upon successful completion of the educational activities, including any assessment or evaluation recommended by PLAS, Dr. Smith shall provide the Board with satisfactory documentation from PLAS indicating that Dr. Smith has successfully completed the recommended educational activities.

- e. Dr. Smith's participation in the PLAS shall be at his own expense.
4. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Smith has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.
- C. **PROBATION**: Upon reinstatement or restoration, Dr. Smith's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
1. **Obey the Law**: Dr. Smith shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
 2. **Declarations of Compliance**: Dr. Smith shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Smith's certificate is reinstated or restored. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
 3. **Personal Appearances**: Dr. Smith shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Smith's certificate is reinstated or restored, or as otherwise directed by the Board. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
 4. **Post-Licensure Assessment Program**: Dr. Smith shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Smith shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Smith's continued compliance with the Learning Plan.

Dr. Smith shall obtain the Board's prior approval for any deviation from the Learning Plan.

If, without permission from the Board, Dr. Smith fails to comply with the Learning Plan, Dr. Smith shall cease practicing medicine and surgery beginning the day following Dr. Smith's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Smith has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered unlicensed practice in violation of Section 4731.41, Ohio Revised Code.

5. **Monitoring Physician:** Within thirty days of the date of Dr. Smith's reinstatement or restoration and prior to Dr. Smith's commencement of practice in Ohio, or as otherwise determined by the Board, he shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Smith and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Smith and his medical practice, and shall review Dr. Smith's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Smith and his medical practice, and on the review of Dr. Smith's patient charts. Dr. Smith shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Smith's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Smith must immediately so notify the Board in writing. In addition, Dr. Smith shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Smith shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

6. **Absence from Ohio:** In the event that Dr. Smith should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Smith must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

- D. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Smith's certificate will be fully restored.

- E. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. Smith violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
- F. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Smith shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Smith shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Smith receives from the Board written notification of his successful completion of probation.
- G. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Smith shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Smith shall also provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Smith shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board. This requirement shall continue until Dr. Smith receives from the Board written notification of his successful completion of probation.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of notification of approval by the Board.


R. Gregory Porter
Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF MARCH 14, 2007

REPORTS AND RECOMMENDATIONS

Dr. Kumar announced that the Board would now consider the Reports and Recommendations appearing on its agenda. He asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Paula Clark Adkins, M.D.; Thomas Leon Gemmer, P.A.; Jeffrey Michael Halter, M.D.; Jeffrey Vaughn Meyer, M.D.; Alan J. Parks, M.D.; Arthur Richard Schramm, M.D.; Philip L. Creps, D.O.; Mark Allen Davis, M.T.; Basma Ricaurte, M.D.; Albert W. Smith, III, M.D.; and Lovsho Phen, M.D. A roll call was taken:

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

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

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye

Dr. Robbins - aye
Dr. Steinbergh - aye
Dr. Kumar - aye

Dr. Kumar noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. They may, however, participate in the matters of Dr. Halter and Dr. Ricaurte, as those cases are not disciplinary in nature and concern only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

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

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ALBERT W. SMITH, III, M.D.

Dr. Kumar directed the Board's attention to the matter of Albert W. Smith, III, M.D. He advised that objections were filed by both the State and Dr. Smith to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

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

Dr. Smith was accompanied by his attorney, Eric J. Plinke.

Mr. Plinke stated that he's here on behalf of Dr. Smith. They did file objections in this matter, and he knows that the Board has reviewed them. There was one patient involved in this case for treatment going back to the 1970s. The primary focus of the Hearing Examiner's findings is dedicated to the contents of Dr. Smith's medical records for Patient 1, the documentation of certain treatment. There were certain findings that the Hearing Examiner made against Dr. Smith that they objected to. There were certain findings that he believes were dismissed, although he admitted that he could be confusing this with another case he has before the Board today. Mr. Plinke at this time stated that Dr. Smith would address the Board regarding those concerns.

Dr. Smith stated that the concern of the medical records began in 1973, when he started in practice. At that time, he had just been discharged from the army, and he used the form that the army used for taking a history and physical: chief complaint, past medical history, family history, and physical findings and treatment. He used that format throughout his career. They, again, reflect his office notes. Dr. Smith stated that he's in a solo practice, not a group practice. Usually, when a patient came in, he would put down what the complaint was, the observation and then the treatment. It was standard with all of the

patients he took care of during all of this period of time.

Dr. Smith stated that, regarding Patient 1, he knew her well. She was a nice lady, but she was somewhat stubborn. She came to him at the end of May 2004 and complained of some pain in her leg and knee from a fall. He treated her with some cortisone and it got better. She was back in about ten days with a recurrent complaint of pain, and he treated her again with some cortisone, and it got better. She then went to the emergency room on a weekend, when he wasn't in the office, because of some of the pain. When she was there, she elected not to have any diagnostic studies done, as she had done with him. She was just a lady who didn't like to have mammograms and didn't like to have things done because she didn't like to have tests. Consequently, the pain returned and, at the end of June, he finally managed to get a bone scan and a DEXA scan because he thought she had osteoarthritis, some osteoporosis of the back, and some sciatica on the right. The bone scan was consistent with metastatic carcinoma type class four of the breast. Apparently she had a breast lump and never said anything about it, although she claimed that she checked her breasts routinely. Dr. Smith stated that he sort of thinks that it may have been painless.

Dr. Kumar advised Dr. Smith that he had one more minute for his address.

Dr. Smith stated that he thinks that the Patient didn't think that there was anything wrong, other than arthritis, and that's what he treated her for.

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

Ms. Pfeiffer stated that she wants to focus her comments on two areas. The first will relate to the objections that she filed. The other relates to the standard of care issue, which related to hormone replacement therapy. Ms. Pfeiffer indicated that she would focus her response on the second issue because, to her, that's the crux of this case.

Ms. Pfeiffer stated that this is a physician who started prescribing hormone replacement therapy for Patient 1 when she was in her early 40s. He continued, starting in 1981, and continuing in 1982, 1983, 1984, 1985, basically up until the time she was hospitalized and subsequently died in 2004. He continuously prescribed hormone replacement therapy (HRT), the primary drug of choice being Premarin, and at times even increased the dosage. Ms. Pfeiffer stated that the State's expert testified that, before prescribing HRT, you examine the systems affected: the breast and the pelvis. Before you start HRT, you want to look for abnormal masses and problems in those areas, to make sure everything looks good. Then, you regularly examine those areas. With the exception of one hospitalization in February 2003, Dr. Smith never did a breast examine of Patient 1. He never obtained any documentation that any breast exams were done by a physician. He did not order her to obtain a mammogram. Ms. Pfeiffer noted that Dr. Smith characterizes this patient as being stubborn, but the testimony is pretty clear. He would, at times, offer her tests; he told her that, if she were interested, she could have this done, and she would decline. Ms. Pfeiffer stated that Dr. Smith never told Patient 1 that she had to get a mammogram.

At this time, Ms. Pfeiffer read portions of the transcript relating to Dr. Smith's responses to her questions

during the hearing regarding mammograms and other diagnostic tests for Patient 1. As previously indicated, Board members had the opportunity to read the entire hearing transcript, including the portions read by Ms. Pfeiffer.

Ms. Pfeiffer commented that Dr. Smith's concept of "refusal" is not really refusal. He makes suggestions that tests should be done. Ms. Pfeiffer indicated that it is different from the doctor stressing that the patient needs to have the tests performed. In such cases, she would think that most patients would have the tests. She asked that the Board keep that in mind.

Ms. Pfeiffer stated that this is a standard-of-care case that resulted in significant patient harm. Because of the complete failure, with one exception in 2003, to examine Patient 1's breasts, to ever order a mammogram, to find out if another physician was doing these tests and getting the results, and prescribing HRT year after year, starting at age 41, the patient subsequently died of metastatic breast cancer. Ms. Pfeiffer stated that she's not saying that Dr. Smith caused the breast cancer, nor is she saying that the HRT caused the cancer. What she is saying is that, because of Dr. Smith's complete failure over this time period to do the proper diagnostic and assessment tests, this cancer could have been detected much earlier and there could have been a significantly different outcome. There could have been a patient who was cured, treated and went on to live a long, healthy life; or you could have had a patient whose life was extended well past her early 60s. It was at the last minute of her hospitalization back in 2004 when the cancer was detected, and two months later Patient 1 was dead. Ms. Pfeiffer stated that Dr. Smith relies upon his patients to do self exams. She stated that self-examination is a good thing, and it is encouraged, but a physician also needs to do those exams.

Ms. Pfeiffer stated that, when Patient 1 was admitted to the hospital in February 2003, a number of lab tests were done. Ms. Pfeiffer referred to State's Exhibit 7, the lab results from the blood work done when she was in the hospital. Ms. Pfeiffer stated that, without exception, almost all of the liver tests were significantly elevated. They continued to rise during her hospitalization. One in particular that the expert opined on was the GGT test. Her level on February 7 was 83. Her level the next day was 86. Her level the day she was discharged was 104. The average range is 3 to 27. Dr. Smith never did any follow-up tests on these. Could they have been as a result of the metastases of the cancer? It could have been, but he never, ever followed up on it. In his previous testimony regarding an earlier lab test in the late 1980s, he got an abnormally high result on a liver function test. He admitted that his records indicate that it was within the normal limits. Ms. Pfeiffer commented that Dr. Smith has a 30-year history of patient records condensed into six pages.

Ms. Pfeiffer stated that what is overriding this case is the overall standard of care on the HRT.

Ms. Pfeiffer stated that she would like to address the State's objections in this case. This relates to one of the allegations in the notice of opportunity for hearing.

Dr. Kumar asked Ms. Pfeiffer to conclude her statement.

Ms. Pfeiffer stated that the Hearing Examiner basically found that Dr. Smith did adequately document that he had advised the patient of the Women's Health Initiative study in 2002. She stated that she won't dispute that. However, the allegation is that Dr. Smith failed to properly inform, as well as failed to properly obtain and document her acceptance of the risk. There was no crystal clear discussion at all of that, or clear indication that Patient 1 understood the risk of that. Ms. Pfeiffer stated that she strongly recommends that the Board amend the Findings of Fact and Conclusions of Law with respect to that particular allegation.

Ms. Pfeiffer stated that she would like to conclude with a statement by Dr. Smith. When she asked him a particular question about getting a patient history on Patient 1, Dr. Smith responded, "My practice was one where people would get sick and come and see me for a specific thing. It was very little – I would do physical exams on truck drivers or sports physicals, that kind of stuff, but it was mostly symptomatic treatment." All Patient 1 got in this case was symptomatic treatment that resulted in her ultimate death.

Dr. Kumar noted that Ms. Pfeiffer spoke for longer than five minutes, and he offered Dr. Smith the opportunity to address the Board again.

Mr. Plinke indicated that he appreciates the offer, and asked Dr. Smith whether he had anything further to say.

Dr. Smith stated that he did not.

DR. EGNER MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER IN THE MATTER OF ALBERT W. SMITH, III, M.D. DR. STEINBERGH SECONDED THE MOTION.

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

Dr. Steinbergh pointed out that, in 1980, this Board took action against Dr. Smith's license for, among other issues, departure or failure to conform to minimal standards of care. She stated that she really read through this case, and as a primary care physician herself, she has a lot of thoughts. Dr. Steinbergh stated that she felt that this case is one of the most egregious minimal standards cases she's seen in a long time. From 1980, the time when the Board first disciplined Dr. Smith, until 2004, this physician never changed his approach to medical care. Over all the years he saw Patient 1, he never changed his approach to her medical care, even though medical knowledge was growing tremendously over those years. He ignored the most basic skills a physician is expected to have: that is, appropriate history taking, appropriate physical assessment as it relates to the history, and the documentation of both. His assessments were rarely documented.

Dr. Steinbergh stated that she felt that Dr. Smith was indiscriminate in his prescribing of estrogens and steroids in this patient. This is a patient with essential hypertension. He never appropriately treated her hypertension, and yet he continued to prescribe estrogens, never questioning whether or not estrogen may

be affecting her blood pressure. Dr. Steinbergh noted Dr. Smith's inappropriate prescribing of estrogens, injections, oral estrogens, combinations of both, never doing his own breast exams until once in 2003, never doing her pelvic exams, never having a pap test on the record, and added that, in her mind, if Dr. Smith was not doing Patient 1's gynecologic care, he had no right to prescribe her estrogen therapy. That belongs in the hands of the physician who was doing her gynecologic care and breast care.

Dr. Steinbergh stated that, concerning Dr. Smith's use of steroids, she felt that it was indiscriminate, and ongoing, without justification. Patient 1 may have had a diagnosis of chronic lung disease, but not once does he ever document any wheezing. No prior trials of non-steroidal anti-inflammatories for any joint complaints, except for occasional aspirin use. He just prescribed steroids, never considering that this is dangerous, can and does cause bone mass loss. The patient ultimately had osteopenia on the bone density test. Dr. Steinbergh indicated that that was not surprising, and added that even that was too late to treat as the patient was now dying of breast cancer.

Dr. Steinbergh stated that there was never any preventive care for this patient, and she felt there was a gross misuse of medication. She found no evidence in the record that Dr. Smith was aware of what he did wrong. There was no acknowledgment that medical knowledge had passed him by. Dr. Steinbergh stated that she finds nothing remedial in this case.

DR. STEINBERGH MOVED TO AMEND THE PROPOSED ORDER BY SUBSTITUTING AN ORDER OF PERMANENT REVOCATION.

Dr. Steinbergh indicated that she feels that Patient 1's death was, in her mind, an effect of, if not caused by, Dr. Smith's years of negligence.

DR. MADIA SECONDED DR. STEINBERGH'S MOTION.

Dr. Kumar asked for discussion on the motion to amend.

Dr. Madia stated that he agrees with Dr. Steinbergh. This death could have been prevented, or the cancer could have been diagnosed early. The progress notes indicate practice much below the minimal standards of practice.

Dr. Egner stated that she doesn't agree with permanent revocation in this case. There are certain questions that need to be addressed about the medical care given by Dr. Smith. The first question is whether the standard of care is different in northwestern Ohio than in other areas of the state, or for that matter, discussing any areas of the state or the country. This was brought up in Dr. Smith's hearing. There may be some minor differences reflective of an area or region, but the standard of care regarding medical recordkeeping, documentation, performing history and physical exams, diagnosing and implementing a plan of care do have standards, no matter where you live in Ohio.

Dr. Egner stated that the second question that came up is the role of the medical record. The medical

record has multiple functions. First, for the treating physician, it helps the doctor remember what the previous visits were for and what was done. It protects the doctor when he or she needs to defend what they've done. Second, it is also for the patient, so that they have an accurate record of their medical care. Third, it is also for other physicians who may become involved in the care and treatment of the patient, to have a reliable and clear understanding of the patient's presentation, workup and the treatment that has been given.

Dr. Egner stated that the crucial question is whether the care of Patient 1 reflects a care that Dr. Smith gave to the majority of his patients, or could it be an outlier. It is always difficult for the Board, on a minimal standards case, to have a one-patient case. Dr. Smith throughout his testimony stated reasons why he had done or not done certain things. This was always couched in his standard of practice. He never stated that he, for example, ordered mammograms for all of his female patients over 40, and Patient 1 was unusual in not having them. By his own testimony, the Board can draw the conclusion that the care of Patient 1 reflects the care that Dr. Smith provided in his daily practice to all of his patients. Dr. Egner stated that, unfortunately, Dr. Smith defends everything that he did throughout his hearing testimony. She stated that she has serious doubts that he is able to change as he did not give any reflection on the expert testimony given or entertain the possibility that his ways may be outdated and not in the best interest of the patient. Dr. Egner stated that, for this reason, she can understand the amendment to permanently revoke Dr. Smith's license.

Dr. Egner continued, however, that she thinks that he still deserves some assessment, and, perhaps, he can change. She added that she doubts that he will change, but the possibility still exists.

Concerning Patient 1, Dr. Egner stated that the Board can't conclude that Patient 1's developing breast cancer, her late diagnosis, and ultimate demise were from the dose and the way she received her estrogen. Although it was old school and not the standard approach to hormone replacement, the Board cannot say that she would not have gotten the breast cancer were it not for the unconventional estrogen replacement. Dr. Egner stated that her personal opinion is that the patient would have gotten breast cancer unrelated to the estrogen replacement, as she had been on it for over twenty years. Generally speaking, she probably would have developed it sooner if it were related to the estrogen replacement. Patient 1's medical care was deficient in a number of areas, and that should be addressed. Dr. Egner noted the treatment of Patient 1's hypertension, the lack of preventive measures and diagnostic testing, and Dr. Smith's allowing the patient to decide which test to have without an explanation to her for the rationale of such testing.

Dr. Egner stated that, looking over Dr. Smith's medical records over the course of 23 years is very revealing. There is no change in the way Dr. Smith kept his medical records, the way he made a diagnosis, or the way he treated patients. He saw the patient for the problem they came in for that day. He tried to keep his care and evaluation as simple as possible. Dr. Egner stated that he probably had an excellent rapport with his patients, and they saw him as a caring physician, something they may not find in the same way that Dr. Smith feels that doctors in group practices practice.

Dr. Egner commented that patients are often reflective of the doctors they choose. The patient who wants

simple, uncomplicated care, finds the doctor who provides that. Patients who want more up-to-date and thorough care, find those doctors. They're not satisfied with Dr. Smith's type of practice. However, even a patient wanting a simpler approach and a personal, caring physician deserves to have medical care that meets the minimal standards. Dr. Smith's care did not meet minimal standards. Dr. Egner stated that she would agree with the Proposed Order in the Report and Recommendation, and not with the amended order for permanent revocation.

Dr. Buchan stated that he is in favor of the Report and Recommendation. He does believe that this is the tip of the iceberg. Dr. Buchan commented that he questioned before today whether that was the case, but his feeling today after hearing Dr. Smith is that this is his practice "M.O."; this is what he does and it's far below the standards. Dr. Buchan stated that the standard is the same in Pomeroy as it is in Columbus, as it is in Cleveland. There's no difference in his mind. Dr. Smith is just wholly below the standard. Dr. Buchan added, however, that he is willing to give Dr. Smith an opportunity to be retrained. He stated that he respects Dr. Steinbergh's position, but he came here preparing that the burden would be on Dr. Smith. The Board should take him out of practice, let him remediate, and if he can rise to the level that the Board feels is acceptable, then so be it. Dr. Buchan commented that that's a bar that he's not sure that Dr. Smith can attain.

Dr. Steinbergh stated that she wouldn't disagree with Dr. Egner's assessment of the estrogen, as it relates to breast cancer because we don't have that answer. She does really believe that this physician is absolutely not remedial. His care of this patient was so bad, and she'll assume that Patient 1 is not the only one. This is abhorrent. Everyone has the right to better medical care than this. Dr. Steinbergh stated that she doesn't think that there's anything that will ever change this physician. In her mind, he absolutely harmed this patient. This indiscriminate steroid use over all these years robbed her of bone mass. This is just such old treatment that she can't picture this man practicing on anybody. Dr. Steinbergh stated that she could guarantee that not one person in this room would want a family member to go to this physician.

Dr. Egner stated that she doesn't disagree with that at all.

Dr. Steinbergh stated that the Board should do as it does with other practitioners who are simply not practicing up to appropriate standards, and given the point he is at in his practice career, after the Board disciplined him in 1980, he didn't learn anything from that, in all these years, he is not capable of changing. Dr. Steinbergh stated that she absolutely believes that Dr. Smith's license needs to be permanently revoked. She reminded the Board that its mission is public protection. Taking Dr. Smith out of practice is a means of protecting the public.

Ms. Sloan stated that she agrees with Dr. Steinbergh that Dr. Smith needs to be taken out of practice. She added that she was waiting to hear something today from Dr. Smith that would change her mind, but she didn't. It is old school. Ms. Sloan referred to paragraph #108, under the Summary of Evidence, which states: "Dr. Smith indicated that recordkeeping for a solo practitioner is different from recordkeeping in a group practice...." Ms. Sloan stated that that's not necessarily so. She stated that a solo practitioner's recordkeeping needs to be up to par because patients may be referred to other physicians who would have

to see the records, and the other physicians would need to know what care has been given the patient in order to establish other care that may need to be given. Ms. Sloan stated that she doesn't see, at this point, that Dr. Smith would be able to be educated on how to treat these patients. Ms. Sloan stated that she thinks that the Board has seen this over the years. Dr. Smith has been before the Board before, years ago, and nothing has changed. It's still old school. Ms. Sloan stated that she doesn't think courses and classes will work.

Dr. Davidson stated that she agrees with Dr. Steinbergh and Ms. Sloan. She stated that the Board looked at Dr. Smith 20 years ago, finding a violation of minimal standards. Here the Board sits again and the same punishment is being proposed – a one-year suspension. Dr. Davidson noted that the Proposed Order also requires that Dr. Smith be assessed, but she doesn't know that the Board has a lot of experience with the Post Licensure Assessment System (PLAS). As she reads the Proposed Order, she's not sure that it includes language that would facilitate the Board at the end of the assessment in determining whether the Board achieved its goal of remediation. The Order just says that the Board is going to give it a good try, and he'll complete any final assessment or evaluation, but she thinks that the Board will be right back where it started from.

Dr. Steinbergh stated that she would like to pick up on the comment about education. She referred to paragraph #109 of the Summary, which states:

Dr. Smith testified that, during his medical training, he had received no guidance concerning a standard for recordkeeping. However, Dr. Smith testified that, as a medical student, he had obtained complete histories and physical examinations on patients, had documented as much as he possibly could, and afterward a resident had taken over. Nevertheless, Dr. Smith testified that “for the most part, the recordkeeping was for educational purposes, and no mention was made of what to do with the recordkeeping after you went into practice.”

Dr. Steinbergh stated that, at that point, Dr. Smith's education was lost. He did not recognize it for what it was. They taught him, they set an example of proper documentation, and you take that with you for years into your practice. It's not something you question as to whether you're supposed to do it or not.

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

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- nay
	Dr. Talmage	- abstain
	Dr. Buchan	- nay
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye

Dr. Robbins - nay
Dr. Steinbergh - aye

The motion carried.

MR. BROWNING MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF ALBERT W. SMITH, III, M.D. DR. STEINBERGH SECONDED THE MOTION.

Dr. Kumar asked for further discussion on the amended Order.

Dr. Buchan stated that, as he processes this, he agrees that, as a family practitioner, Dr. Smith fails in every way. To revoke his license permanently would suggest that he fails as a physician in any other capacity in which he might work from now until his career is over. Dr. Buchan noted that there is a big hurdle for Dr. Smith to get back into practice or to maintain any license. Dr. Buchan stated that he's not sure that he's ready to pass sentence on that license permanently. There may be something out there for Dr. Smith to do in the world of medicine. Dr. Buchan commented that he doesn't think that Dr. Smith's heart is inappropriately placed, but he thinks that his skill-set is abhorrent.

Dr. Robbins agreed, stating that, as abhorrent as this case is, he hates to give this physician the death sentence. Laying out what is laid out in the originally Proposed Order and having Dr. Smith go through the PLAS program – for him to want to do this will be a major hurdle. Dr. Robbins stated that he doesn't think that Dr. Smith can do it, but he'd like to give Dr. Smith the chance to try. If Dr. Smith comes back from the PLAS program with a good report, Dr. Robbins indicated that he would certainly feel more comfortable about Dr. Smith's potential to fit in; but Dr. Smith will have to change everything he does and his whole concept of practice. At the stage he is in his life, and the way he's been practicing all these years, it's a hurdle that Dr. Smith will probably not be able to do. Dr. Robbins again stated that he'd rather give Dr. Smith the chance.

Dr. Steinbergh stated that the Board can't measure what's in the heart of most of the physicians who come before it, but she can say that Dr. Smith has no skill-set. If he's harmed this patient, which she believes he did, he's harmed a lot of others. Dr. Steinbergh stated that the Board has permanently revoked licenses for minimal standards before, and this is an egregious case. No one will ever take his medical degree from him. That's something he will always have. It is a privilege to practice in this state, and he has, in her mind, lost that privilege.

Dr. Egner stated that by no means does she want to defend the care that Dr. Smith gave to Patient 1. She also thinks that he gave that same poor care to the majority of his patients. The Board sees physicians practice below minimal standards for multiple reasons. When they do it for greed, it's so easy to punish them because they gave poor care, they caused harm, and they did it for very selfish reasons. She stated that she thinks that that's part of the problem here. There is no greed involved. It was not an excessive ego involved. Dr. Egner stated that she believes that Dr. Smith has been a dedicated physician to his patients,

how he defined it. She agreed that she wouldn't want to go to him, nor would she want her family to go to him. She thinks that his baseline knowledge is poor and has not improved over the years.

Dr. Steinbergh stated that it's pure negligence.

Dr. Egner stated that she agrees with Dr. Robbins. Does she think that Dr. Smith can do what needs to be done to come back to practice? Dr. Egner stated that she really doesn't; however if he did, if he learned, if he could prove that he has current knowledge, he can keep a medical record, he can keep patients appropriately and he will be monitored, could the Board let him practice? Dr. Egner stated that for her, today, she would say that the answer is "yes." However, she doesn't think that that's going to come to pass.

Mr. Browning stated that, to pick up on that point, he couldn't vote for a year out. He'd have to at least vote for two years, which would require the SPEX, an even higher mountain to climb, which, in all likelihood would not happen. Mr. Browning stated that he doesn't think that anyone around the table thinks that that will happen. Then the question is, "Why are we doing this?" Why is the Board creating something that won't happen? It's the same result as permanent revocation, but by another means. Mr. Browning added that, at this point in his career, if Dr. Smith is taken out of practice for two years, it would require an examination and everything that goes with that, the odds of his getting his license back are very, very low. Mr. Browning stated that he feels that, in some ways, it's more honest to just say that his pattern of practice is so bad – it's benign in some ways in the sense that he's probably a good guy who's trying to do a good job, and it's 30 some years later and he fell apart and didn't realize it. Then there's a death. Dr. Smith didn't intend to do that. He didn't intend to hurt anyone. He got up every day to help people, but it did not happen. It was almost by design – you couldn't have come up with a better design to end up hurting somebody, at least indirectly. Mr. Browning stated that he just thinks it's over and the Board should revoke.

Dr. Robbins stated that Mr. Browning is making a good point, but being a physician is the greatest thing in life. As physicians go along and get older, the thing that gnaws on all physicians is the fact that they are physicians. How do you retire from being a physician? You can't. This is the physician's fiber, it's what he does. Dr. Robbins stated that his hope would be that that feeling would be so strong in Dr. Smith, that Dr. Smith would go through any hurdle to get it. He added that he would not be opposed to a two-year suspension, adding that more hurdles in this situation are fine. To require the SPEX is fine. Dr. Robbins stated that his hope would be that that feeling and that importance of being a physician is so strong that there isn't any hurdle Dr. Smith wouldn't go through to maintain being a physician. He added that he doesn't think that Dr. Smith will do it, but he would still like to give him the chance to do it.

A vote was taken on Mr. Browning's motion to approve and confirm as amended:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- nay
	Dr. Talmage	- abstain

Dr. Buchan	- nay
Dr. Madia	- aye
Mr. Browning	- aye
Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Robbins	- nay
Dr. Steinbergh	- aye
Dr. Kumar	- nay

Needing six aye votes to carry, the motion failed.

MR. BROWNING MOVED TO AMEND THE PROPOSED ORDER BY SUBSTITUTING THE PROPOSED ORDER ORIGINALLY DRAFTED BY THE HEARING EXAMINER, AND BY INCREASING THE SUSPENSION PERIOD IN PARAGRAPH A OF MR. PORTER'S PROPOSED ORDER TO AN INDEFINITE PERIOD OF TIME, BUT NOT LESS THAN TWO YEARS, AND BY REQUIRING DR. SMITH TO PASS THE SPEX PRIOR TO REINSTATEMENT. DR. ROBBINS SECONDED THE MOTION.

Dr. Kumar asked whether there was any further discussion. There was not.

A vote was taken on Mr. Browning's motion:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Steinbergh	- nay

The motion carried.

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

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain

Dr. Buchan	- aye
Dr. Madia	- aye
Mr. Browning	- aye
Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Steinbergh	- nay

The motion carried.

At this time Dr. Kumar recognized, for the record, the presence of family members of Patient 1. He added that he hopes that they were able to hear the Board's deliberations in this matter.



State Medical Board of Ohio

100 North High Street, Columbus, OH 43260-3970 • Telephone: 614-466-3970 • Website: www.smb.ohio.gov

March 8, 2006

Albert W. Smith, III, M.D.
515 Brownwood Court
Bowling Green, Ohio 43402

Dear Doctor Smith:

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

- (1) In or about September 1973, in the routine course of your medical practice, you undertook the treatment of Patient 1, identified in the attached Patient Key. (The Patient Key is confidential and shall be withheld from public disclosure.) You continued to treat Patient 1 until in or about June 2004. In or about June 2004, Patient 1 was hospitalized for metastatic carcinoma of the breast, which resulted in her death in or about August 2004.
- (2) In your medical care of Patient 1, you failed to obtain and/or document appropriate medical histories; failed to perform and/or document the performance of appropriate physicals; failed to perform and/or document the performance of appropriate tests; failed to perform and/or document the performance of appropriate studies; failed to refer and/or document referrals for appropriate consultations; failed to establish and/or document the establishment of a treatment plan for your prescribing; failed to appropriately establish and/or document the appropriate establishment of specific diagnoses; and/or failed to appropriately inform and/or failed to appropriately document the informing of risks associated with certain treatment.

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

- (a) Although you prescribed estrogen to Patient 1 from in or about July 1981 through in or about June 2004, you failed to establish and/or record a diagnosis supporting such prescribing; failed to perform and/or document the performance of appropriate physicals, including breast examinations; and/or failed to perform and/or document the performance of appropriate tests and/or studies, including periodic Pap smears and mammograms.

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- (b) Further, although you continued to prescribe estrogen to Patient 1 after August 2002, you failed to properly inform and/or appropriately document informing Patient 1 of the risks associated with hormone replacement therapy, and/or failed to obtain and/or appropriately document the obtaining of Patient 1's acceptance of the risks associated with hormone replacement therapy.
- (c) Although you intermittently prescribed steroids to Patient 1 from in or about February 1984 through in or about June 2004, you failed to establish and/or failed to appropriately document the diagnosis supporting such prescribing. Further, you prescribed steroids to Patient 1 five times between in or about May 2004 and June 2004 without providing and/or documenting a diagnosis, without ordering and/or documenting the ordering of x-rays, and/or without ordering and/or documenting the ordering of consultations.
- (d) Although you prescribed anti-anxiety medication to Patient 1, you failed to appropriately establish and/or document an appropriate diagnosis supporting the prescribing of such medication, failed to take and/or record appropriate histories, and/or failed to perform and/or record the performance of appropriate physical examinations.
- (e) Although you prescribed antihypertensive medication for Patient 1, you failed to perform and/or document the performance of a satisfactory medical history and/or physical examination related to such prescribing.

Your acts, conduct, and/or omissions that occurred before March 9, 1999, as alleged in paragraph (2) above, 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 prior to March 9, 1999.

Further, your acts, conduct, and/or omissions that occurred on or after March 9, 1999, as alleged in paragraph (2) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar

circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after November 17, 1986, and on or before March 16, 1987, as alleged in paragraph (2)(d) 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)(16), Ohio Revised Code, as in effect at that time, to wit: Rule 4731-11-02(D), Ohio Administrative Code.

Further, your acts, conduct, and/or omissions that occurred on or after March 17, 1987, as alleged in paragraph (2)(d) 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: Rule 4731-11-02(D), Ohio Administrative Code.

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

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

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

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

Albert W. Smith, III, M.D.

Page 4

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage MD". The signature is fluid and cursive, with the "MD" at the end being more distinct.

Lance A. Talmage, M.D.

Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4330 3983
RETURN RECEIPT REQUESTED

cc: Michael J. Malone, Esq.
Oxley, Malone, Hollister, O'Malley & Warren
301 East Main Cross Street
Findlay, Ohio 45839

CERTIFIED MAIL # 7003 0500 0002 4330 3976
RETURN RECEIPT REQUESTED

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

Exhibit "A"

December 9, 1980

Albert W. Smith, M.D.
640 S. Wintergarden Rd.,
Bowling Green, OH. 43402

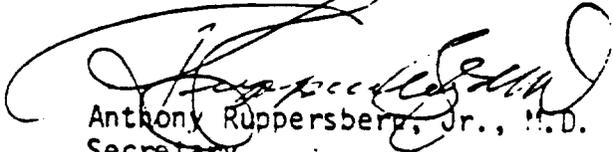
Dear Doctor Smith:

Please find enclosed a certified copy of the Findings and Order as they have been entered in the Journal of the State Medical Board of Ohio and a certified copy of the Motion by the Medical Board, meeting in regular session on December 3, 1980, approving and confirming the Findings and Order.

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

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

THE STATE MEDICAL BOARD


Anthony Ruppertsberg, Jr., M.D.
Secretary

AR:em

Encl.

CERTIFIED MAIL NO. P30 5190874
RETURN RECEIPT REQUESTED

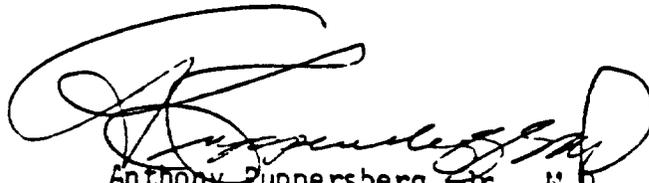
cc: Mr. Jack R. Alton, Esq.

CERTIFIED MAIL NO. P30 5190877
RETURN RECEIPT REQUESTED

STATE OF OHIO
THE STATE MEDICAL BOARD

CERTIFICATION

I hereby certify that the attached copy of the Findings and Order of the State Medical Board of Ohio, in the matter of Albert W. Smith, M.D., is a true and complete copy of the Findings and Order as they appear in the Journal of the State Medical Board; and that the attached copy of the Motion approved by the Medical Board, meeting in regular session on December 3, 1980, is a true and complete copy as it appears in the Journal of the State Medical Board.



Anthony Ruppertsberg, Dr., M.D.
Secretary

9th day of December, 1980

STATE OF OHIO
THE STATE MEDICAL BOARD
REPORT AND RECOMMENDATION
IN THE MATTER OF ALBERT W. SMITH, M.D.

The matter of Albert W. Smith, M.D., came before me, Joseph P. Yut, M.D., Member of the State Medical Board of Ohio on April 9, 1980.

INTRODUCTION AND SUMMARY OF EVIDENCE

1. Albert W. Smith, M.D. was forwarded and did receive a letter of citation (State's Exhibit #1) dated September 13, 1979, alleging violations of Section 4731.22 (B) (2), (B) (6), (B) (8), and (B) (17) of the Ohio Revised Code.
2. On October 22, 1979, Mr. James Pohlman, the attorney of Dr. Smith, (Mr. Pohlman later withdrew from the case) acknowledged receipt of the citation letter and indicated a desire for a hearing in this matter on behalf of his client. (State's Exhibit #2)
3. The hearing took place on April 9, 1980. The State's case was presented by Jeffrey Jurca, Assistant Attorney General. Dr. Smith was represented by Mr. Jack Alton.
4. Mr. Jurca, in his opening statement, summarized the allegations against Dr. Smith:
 - A. While Dr. Smith was on vacation, his office was open, patients were seen by unlicensed personnel, and prescriptions were written in his absence pursuant to his instructions.
 - B. Paragraph two of the citation letter alleges that Dr. Smith's prescribing practices as set forth constitute a violation of the various sections of the Medical Practice Act. (Transcript at 5).
5. Mr. Alton on behalf of Dr. Smith, summarized the defense:
 - A. In answering the complaint in the first paragraph of the citation letter, Dr. Smith conformed to the standards of practice of similar practitioners in Bowling Green, Ohio and that these standards have to be considered as applied to this small town.
 - B. As to Dr. Smith's prescribing practices, each of these prescriptions was proper for the particular patient, one cannot look at the list of medications and make a judgment without reference to the individual patient. (Transcript at 7)

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6. The first witness for the State Medical Board was Martha Palmer, a patient of Dr. Smith's. Her testimony revealed the following:
 - A. On July 31, 1979, Mrs. Palmer visited Dr. Smith's office to obtain a prescription. She did not see Dr. Smith that day and was not given an examination by anyone there. Mrs. Palmer did receive two or three prescriptions for diet, poor circulation, and high blood pressure. (Transcript at 11) She identified one of the prescriptions when shown to her. (State's Exhibit #8) Mrs. Palmer stated that Jan, Dr. Smith's nurse, wrote the prescription out for her. Mrs. Palmer was shown State Exhibit #9 and identified it as another prescription she received that day. State Exhibit #9 was a prescription for her grandson who was not with her. Jan also wrote the prescription saying that Dr. Smith was on vacation.
 - B. Mrs. Palmer didn't know how long she had been taking Preludin, but she has never had any adverse effects. She further stated that she has been satisfied with Dr. Smith's care of her.

7. Robert Palmer was put on the stand by the State Medical Board. His testimony revealed the following:
 - A. State's Exhibit #9 was a prescription written for him. Mr. Palmer guessed he got it from Dr. Smith's office on July 31, 1979 because this was the date stamped on it. (Transcript at 17) Mr. Palmer admitted that he received the prescription from his grandmother.
 - B. Mr. Palmer had previously taken this same medication as prescribed by Dr. Smith. Mr. Palmer said he has never had any adverse effects from taking the pills and he is satisfied with the medical treatment he has received from Dr. Smith. (Transcript at 18)

8. Mr. David Saunders, a pharmacist, in Bowling Green, Ohio was called to testify by the State Medical Board. The following information was revealed:
 - A. Mr. Saunders has processed various prescriptions from Dr. Smith. State's Exhibit #8 was a prescription Mr. Saunders filled. It was given to him by Mrs. Palmer. Mr. Saunders asked Mrs. Palmer if a nurse wrote this prescription because he knew Dr. Smith was on vacation. Mrs. Palmer replied "yes". Mr. Saunders then called Dr. Smith's office to talk to Jan, his nurse. He asked Jan if she was writing prescriptions. She said, "Yes, Dr. Smith had left a pad of blank signed prescriptions and she was writing them." (Transcript at 21, 22)

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- B. Mr. Saunders did not know of any physicians covering Dr. Smith's office while he was on vacation. (Transcript at 23)
 - C. Mr. Saunders stated he would definitely recognize Dr. Smith's signature and that the signature on State Exhibits #8 and #9 was a facsimile, but he didn't believe it was the doctor's signature. (Transcript at 36)
 - D. Mr. Saunders filled Dr. Smith's prescriptions when he knew the doctor was out of town because Jan, the nurse, told him that they were still valid and he considered her to be a spokesman for the office. Mr. Saunders was aware of the Revised Code, Section 3719.06 which pertains to the requirement for doctors making prescriptions. However, he felt that the Palmers wouldn't be harmed because they had been on these drugs before. He was bothered by the fact that he felt that the signature on the prescriptions was forged and that Dr. Smith wasn't in his office, but he filled them anyway. He admitted he was at fault for filling the Preludin prescription because that is a Schedule 2 drug. (Transcript at 40) Mr. Saunders felt, based on his experience as a pharmacist in Bowling Green, Ohio, it is customary to fill prescriptions under the circumstances just described. (Transcript at 39, 41).
9. Jan Dunlap, Dr. Smith's nurse, was called to testify by the Medical Board. Her testimony revealed the following:
- A. Jan Dunlap confirmed that she was in Dr. Smith's office on July 31, 1979, when he was on vacation. The office was not open to see patients for office visits. The patients that came in were weighed and had their blood pressure checked. Dr. Smith had left probably less than ten (10) prescribed prescriptions so that "routine medications" that patients had to have for continuing medical care could be refilled. Mrs. Dunlap checked with Dr. Hess to see if a doctor's written prescription was needed. (Transcript at 43)
 - B. Mrs. Dunlap admitted she used her judgment in making the determination as to what was routine medication. (Transcript at 44)
 - C. Mrs. Dunlap said she gave Mrs. Palmer two prescriptions on July 31, 1979. One was for Preludin and, she thought, the other was for her grandson and was for Digoxin. Mrs. Palmer was not given any physical examination. Mrs. Dunlap wrote the prescriptions and used some of Dr. Smith's signed scripts. (Transcript at 45) Dr. Smith's signature, not a duplication, was on both of these prescriptions.

- D. Mrs. Dunlap said she did not sign Dr. Smith's name to a prescription blank, but there was a possibility she may have signed Dr. Smith's name to a work slip. Later, Mrs. Dunlap said there was a possibility she may have signed Dr. Smith's name on a "prescription pad". (Transcript at 49)
- E. Of the less than ten signed prescriptions that Dr. Smith left with Mrs. Dunlap when he went on a vacation, some were used as work slips. Mrs. Dunlap knew that Dr. Smith had told these people that they could go back to work. (Transcript at 183)
- F. Dr. Smith has never authorized Mrs. Dunlap to sign his name. (Transcript at 50)
- G. Mrs. Dunlap has been Dr. Smith's nurse since 1971. She testified that she worked close enough with Dr. Smith to become aware of what the patient's problems are and what he is attempting to do for the patients.
- H. Mrs. Dunlap said when she checked with Dr. Hess (when Dr. Smith was on vacation) about a patient's prescription sometimes she walked down to his office and other times she called him, it depended on the situation. Dr. Hess never saw any of these patients personally unless Mrs. Dunlap made an appointment with him. Other patients were seen by a urologist in town and a couple were seen by general practitioners. When Mrs. Dunlap simply checked with Dr. Hess, it was to find out whether the patient could have a prescription refill or had to wait until Dr. Smith got back.
- I. Of the (about) seven presigned prescriptions utilized as prescriptions, Mrs. Dunlap indicated that she was relatively certain that she checked with Dr. Hess on every one she made up. (Transcript at 188) She could not, for a fact, say she checked with Dr. Hess about the prescriptions written for Martha and Robert Palmer.
- J. Presigned prescriptions were only for refills where the patient had an appointment to see the doctor after he got back. (Transcript at 186-187) Mrs. Dunlap said she didn't order any medication for any patient. There was no charge to these people who came to Dr. Smith's office while he was gone.
- K. There were other situations that arose in Dr. Smith's absence that didn't require a signed prescription because of the class of the drug. In those cases, Mrs. Dunlap would just phone the pharmacy and ask the pharmacist to refill the prescription as per implied arrangement between Dr. Smith and Mrs. Dunlap. Not all of these actions were discussed with Dr. Hess. Mrs. Dunlap did not order anything like antibiotics. (Transcript at 189)

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- L. Mrs. Dunlap was asked about a Demerol prescription written for patient H. Dr. Smith had stated that it is a prescription Mrs. Dunlap signed per his initials and the prescription was for a Class 2 controlled narcotic substance. Mrs. Dunlap stated that it was her signature and his initials. She couldn't remember how the situation came to be. Referring to the same prescription, Mrs. Dunlap said the number 60 on it was something Dr. Smith wrote. (Transcript at 191)
10. Dr. Smith was called to the stand by the State, his testimony revealed the following:
- A. Dr. Smith sees about 35-40 patients a day. About 15% have obesity problems. (Transcript at 52)
 - B. Dr. Smith said his general course of treatment for obese people depends on the patient, but that he finds amphetamines useful for short-term treatment of obesity. Short-term use would be about six months. (Transcript at 53) Dr. Smith said a person who wants to lose weight will come into his office and a prescription will be written for him without making any sort of examination or record of the patient's weight because it is a busy office. (Transcript at 78) Dr. Smith was guided by a pragmatic approach. If the patient lost weight and the blood pressure came down, he felt he was doing him some good. Dr. Smith felt the patients mentioned in the hearing achieved about a 70 % weight loss on a short-term basis.
 - C. Dr. Smith has prescribed amphetamines for some patients, off and on, for longer than six months for weight loss purposes. When the patient stops losing weight they are taken off the amphetamines, they may be put on them again three, six, or nine months later. (Transcript at 54)
 - D. Dr. Smith has also found amphetamines useful as a potentiator of pain medication. Amphetamines allow the patient to function without the sedating effects of the pain medication. There are about four or five cases of this in his entire practice. (Transcript at 54).
 - E. According to Dr. Smith, amphetamines have another use. A couple of patients who have had migraine-type headaches have received benefits from amphetamines.
 - F. Patient C was given Dexamyl and Biphettamine for a period of 4 years off and on and lost a total of 50 pounds. From June 1978 to March 1979, weight loss was about ten pounds. (Transcript at 57). He was taken off amphetamines after March of 1979, but was put back on them December 29, 1979.
 - G. Two prescriptions for Biphettamine that are part of State Group Exhibit #10 were shown to Dr. Smith. Dr. Smith was asked if they were both written on the same date. He replied that he didn't date them even though it is a requirement of the State Pharmacy Law.

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MEDICAL BOARD

He indicated that this may have been a situation where he was leaving and knew he wouldn't be back so he gave the patient a prescription for the following month. Dr. Smith said he didn't write a prescription for 80 capsules because he could only give the patient one supply at a time. Dr. Smith then said he apparently did give the patient two prescriptions because he didn't see him again until after the 1st of the year. (Transcript at 58)

- H. Patient D received a prescription for Seconal, a Schedule 2 drug which is not refillable. Dr. Smith marked the prescription with three refills because he was hoping it would be refilled. Dr. Smith wasn't sure if it was refillable. Dr. Smith said there was no direct way of checking to see if it was a Schedule 2 drug. Dr. Smith did not know if his copy of the Physician's Desk Reference told what schedule a drug is because he didn't use the book for that purpose. (Transcript at 61) Patient D was kept on Preludin from September 1978 to January 1979. Some of her prescriptions weren't recorded on a chart because they were given when the patient came in with her daughter who was a patient. Patient D was not examined on the two occasions this happened. (Transcript at 62). She lost 14 pounds over this nine month period. She was not on the diet medication the entire nine months.
- I. Patient E was essentially bedridden, overweight, and suffering from chronic neck pain. She is now, according to Dr. Smith, up and active. She didn't want a neck operation and just wanted pain medication. Patient E also received thyroid medication for a thyroid insufficiency. In response to questioning about testing to determine the extent of her hypothyroidism, Dr. Smith said that in her case he did "T4's" and they have been normal, so the thyroid medication has been continued. (Transcript at 65)
- J. Patient G was given a combination of Percodan and Dexedrine for moderately severe dysmenorrhea. She also had migraine headaches. Dr. Smith said no one knows if amphetamines help headache problems. In response to question about approval of such a use by the Food and Drug Administration Dr. Smith said he doubted if the PDR lists amphetamines for that sort of thing. (Transcript at 66). The patient took the medication four times a day. The amount increased because the patient's husband broke his shoulder and he started taking it, too. (Transcript at 93)
- K. Dr. Smith was shown a prescription for Demerol that Mrs. Dunlap had admitted writing for Patient H along with a refill. Dr. Smith stated it would not be refilled because he depends on the pharmacist to know which drug is Class 2 and not refillable. (Transcript at 67-68) Patient H would take four to six Demerol a day when her condition was bad. Dr. Smith was shown

two prescriptions from Exhibit #10 for 100 tablets each dated March 2, 1979, and March 6, 1979. Patient H would have to have taken 20 a day to warrant another prescription on the 6th. Dr. Smith said he doubted Patient H took 20 tablets a day and perhaps her husband picked the prescription up because she was in bed. Dr. Smith was going on vacation and they were planning ahead. (Transcript at 69) Patient H got additional prescriptions on March 12, 1979 and March 16, 1979. She was taking two tablets every four hours, so that would be 12 tablets a day. In a 14-day period, she got 316 tablets Dr. Smith stated. When Patient H was seen at the medical college, they made notes there that she seemed to enjoy taking the medication. She stopped taking it and then started again. (Transcript at 97)

- L. Patient I was an obese lady. Over a seven month period she was taking Dexamyl and Biphetamines and gained weight.
- M. Patient J was on Dexedrine when Dr. Smith first saw him. Dr. Smith felt that this patient may have been dealing in drugs. Mr. Jurca stated that the patient could have been taking 20 pills a day. Dr. Smith said the patient was only taking six a day. When the letter came from the licensing board, Patient J moved to Maine. Dr. Smith admitted that this patient may have been "conning" him because he would write a prescription and not make a note of it. The patient convinced Dr. Smith that the Dexedrine was good for his headaches. (Transcript at 72-74) Dr. Smith did an EEG on Patient J and felt that this "man had brain damage from taking so much of this stuff". (Transcript at 81) The patient was kept on amphetamines for about a year and a half after the report was given back to Dr. Smith. The Cleveland Clinic had no solution for this problem. When Dr. Smith was later asked about his statement concerning the alleged abnormal EEG of Patient J, he stated that he did an EEG on Patient J and it came back normal. Dr. Smith got the idea of telling the patient his EEG was abnormal to try to get him to reduce his medication intake. Dr. Smith stated, "In all honesty, I started believing it was abnormal myself." (Transcript at 196)
- N. Patient M was on Dexamyl, probably on and off again, for a period of two years.
- O. Patient N received more than a month's supply of medication because she was going on a vacation to Florida.
- P. Patient O was put on Dexamyl for a number of months and switched to Biphetamine in an effort to lose weight. There is a warning in the PDR which states, "Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect; rather the drug should be discontinued". Dr. Smith is familiar with this statement, but he doesn't believe it to be true. He has not been strictly guided by FDA standards, (Transcript at 84-85) but there are some standards that he has to follow.

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- Q. Dr. Smith didn't feel patients abusing medication is a problem in Bowling Green, Ohio even though it's a college town. The college students "get their stuff from other places". (Transcript at 87)
- R. When a patient comes into Dr. Smith's office other than at their regular time or discusses another patient who is a family member, the doctor might give a prescription to the other family member or to the patient and not record the prescription in the office records. (Transcript at 88) Dr. Smith was asked how he kept track of the amounts of medication he has dispensed. He replied mostly it is written on the patient's chart, but if they come in without an appointment it is not. (Transcript at 89)
- S. Dr. Smith was asked if he would be able to recognize the signs of addiction or habituation in his patients to either amphetamines or Demerol. Dr. Smith felt that he never had any problems with withdrawal symptoms or habituation in his patients except for "the fellow with the headaches who got habituated before he ever saw him." (Transcript at 201)
- T. Dr. Smith discussed the Wood County Medical Society report. (Petitioner's Exhibit B) In this report his colleagues and peers reviewed his charts. There are three doctors named in the report. These doctors wrote a letter to the State Medical Board. Dr. Smith felt the report was rough on him. The report stated that they did not condone the use of presigned scripts. (Transcript at 215)
- II. Dr. Richard Fertel was called to the stand by the State. His testimony revealed the following:
 - A. Dr. Fertel is a pharmacologist at the Ohio State University School of Medicine. As part of his duties he teaches pharmacy to the students in the College of Medicine.
 - B. Dr. Fertel stated that there are a number of side effects involved in the use of amphetamines for obesity. The major problem is with loss of sleep and if that is extended over a period of time it could cause psychological changes. There are cardiovascular effects. There are certain drugs that can't be used while amphetamines are being given, and there is a distinct possibility, depending on the individual, that the person may become strongly habituated to the amphetamines. (Transcript at 101-102) The longer the amphetamines are used in general, the greater the possibility that the person will become habituated to their use.

STATE OF OHIO
MEDICAL BOARD

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MEDICAL BOARD

- C. In response to questioning as to whether or not amphetamines have any use in facilitating the effect of pain medication for a patient, Dr. Fertel answered that there has been one reported case of an amphetamine used in conjunction with pain anesthesia and pain medication. Generally, there is no indication that amphetamines will enhance the effect of opiates or narcotics.
 - D. Dr. Fertel did not feel amphetamines were found to be effective in the treatment of vascular headaches.
 - E. When asked if all of his knowledge of the drugs which he has been testifying about comes from books and the chemistry laboratory, Dr. Fertel replied that his knowledge was not entirely from books, he has come into contact with drug abusers. He does have an idea of what kind of behavioral effects might ultimately result from the use of some types of drugs (amphetamines and opiates). (Transcript at 111)
 - F. Dr. Fertel, when asked, based on his experience, whether he believed that a physician who regularly sees a patient (every month or two) would be able to recognize the symptoms of being habituated on amphetamines, He replied, "Yes". If a person were taking amphetamines and mixing them with another drug, and then shooting or injecting them, Dr. Fertel felt that it would be possible for a physician to determine this. (Transcript at 114-115)
 - G. Dr. Fertel agreed that it is conceivable that there might be a beneficial use by using Percodan and Dexedrine together even though no one has written an article about this. However, Dr. Fertel felt that if there were a clear therapeutic advantage to a given combination of drugs, the drug companies would have made an attempt to market it. He agreed that a doctor in his office treating people would be in a position to see and determine whether the use of two drugs together was helpful to the patient. (Transcript at 116)
 - H. Dr. Fertel stated that there is no question there are medical uses for drugs which have not been officially sanctioned by the FDA and that physicians who are in practice may find drugs that are helpful for one disease, or another.
12. Dr. John J. Wunsch was called to testify by the State Medical Board. His testimony revealed the following:
- A. He has a family practice in Newark, Ohio.
 - B. Dr. Wunsch was familiar with amphetamines. He felt that amphetamines originally were used a great deal for weight control, but safer drugs have been developed

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for that purpose. Amphetamine's major usefulness is in treating narcolepsy, a sleeping disease, and minimal brain dysfunction and hyperactivity in children. The use of amphetamines is somewhat controversial. (Transcript at 123)

- C. Dr. Winsch was not familiar with the concept that amphetamines might be useful in the treatment of headaches.
- D. Dr. Winsch felt that there are dangers in using amphetamines for obese patients, chief among those is that they are psychologically and physically addicting; and if they are used for longer than a period of one month to six weeks tachyphylaxis occurs, the body becomes used to the medication. There is a desire to proceed to higher doses to obtain an euphoric effect which can be dangerous because the amphetamines have vascular side effects which can be dangerous or deadly. Dr. Winsch felt that the use of amphetamines for a period greater than one month to six weeks for weight loss would constitute failure to conform to minimal standards of care. (Transcript at 124)
- E. Regarding Patient O, Dr. Winsch felt that where a patient is placed on Dexamyl for weight loss over a lengthy period and the weight loss is insufficient or nonexistent, discontinuing the use of Dexamyl and placing the patient on Biphphetamine is not a viable alternative. This would expose the patient to the risk of addiction and habituation. (Transcript at 126)
- F. Dr. Winsch felt Dr. Smith's prescribing practices pertaining to Patient E constituted a violation of minimal standards of care. The utilization of Demerol in this case is not an acceptable practice. He was asked if his answer would be any different if a patient refuses surgery and insists upon maintaining herself on pain medication. Dr. Winsch replied that it does not help the patient to compound their medical problem by giving them a secondary problem with addiction to a potent narcotic and analgesic. (Transcript at 150)
- G. Dr. Winsch, when asked if he was familiar with the use of Percodan and Dexedrine in combination to treat patient G for Raymond's phenomena and dysmenorrhea, replied, "No". Therefore, Dr. Winsch did not feel he could judge if this treatment constituted a failure to conform to minimal standards of care. Because of the use of the Dexedrine for six months, Dr. Winsch felt there was a risk of habituation and addiction to the medication. (Transcript at 128) The Percodan caused another problem. It is closely related to Codeine, and is, itself, habituating. Most physicians would be extremely cautious and anxious about subjecting a patient to that combined risk. (Transcript at 129)

H. Dr. Winsch felt that Dr. Smith's prescribing practices as pertains to Patient H constitute a failure to conform to minimal standards of care. As few as four days passed between prescriptions of 100 tablets of Demerol. This implies that the patient is consuming an "extraordinary amount of this medication" and is very likely addicted to the medication. The patient should be hospitalized for appropriate care and diagnosis.

I. Dr. Smith's prescribing practices as to Patient I constitute a failure to conform to minimal standards of care, according to Dr. Winsch. In this case it seems unreasonable to continue the use of an amphetamine or an amphetamine-like agent in the face of weight gain.

J. Dr. Winsch felt that the treatment of Patient J constituted a failure to conform to minimal standards of care. Doses of amphetamines in the range this patient received have a potential to do great harm to the patient. The patient was exhibiting exactly the problem that is feared. Brain damage is a potential result of amphetamine usage. (Transcript at 132-133) To Dr. Winsch it seemed unconscionable that a physician could cause brain damage to a patient.

K. Dr. Winsch does not agree with the statement, "short of making a patient an addict to amphetamines or an addict to any drugs, you can prescribe just about anything for a migraine".

L. Dr. Winsch felt that prescribing practices of Dr. Smith as pertains to patients C through Q would constitute a failure of care in the administration of drugs.

M. He had strong feelings against the use of presigned prescription blanks in a physician's office with an R.N. filling in the prescription (Transcript at 141-142), and a patient coming into a doctor's office without an appointment and receiving a prescription without any sort of an examination taking place. Both, he felt, constituted a "failure to conform to minimum standards of care".

N. Dr. Winsch was asked to read a report of an ad hoc committee of the Wood County Medical Board concerning the prescribing practices of Dr. Smith. Dr. Winsch was asked if he agreed with the conclusions of the committee which are:

(1) The dosages of the anorexics are usually within the recommended dosages of the manufacturers.

Dr. Winsch disagreed.

WOOD COUNTY MEDICAL BOARD

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(2) Dosages of analgesics are, in general, within acceptable limits. Exceptions: Prescriptions for Patient A and Patient J were deemed excessive.

Dr. Winsch did not agree that the dosages, in general, were within acceptable limits. He agreed that the prescriptions for Patient A and J were quite unacceptable.

(3) Signing of the blank prescriptions is not an acceptable practice.

Dr. Winsch agreed. (Transcript at 145-146)

O. Dr. Winsch found it hard to believe that none of Dr. Smith's patients were addicted to the medication that was prescribed. (Transcript at 150)

P. Dr. Winsch indicated that management of obesity first requires modification in the patient's eating and exercise habits. Dr. Winsch favored the American Diabetic Association diet even if the patient isn't a diabetic. He does not believe that there is any safe, effective and desirable pharmacologic agent to aid in weight reduction and he doesn't use any except on a rare occasion he might use Tepanil or Ionamin. In the last two or three years he may have written three such prescriptions.

13. Dr. Douglas Hess was called to the stand by Mr. Alton. His testimony was as follows:

A. Dr. Hess explained how the medical practices at University Hospital differed from those at Bowling Green, Ohio. He felt the biggest problem of practicing in a small town is that you are the last doctor, the one who has to take the patient. After the patient has been sent to all the other cities and his problem still isn't solved, you are the one who has to deal with it." (Transcript at 160)

B. Dr. Hess stated that Dr. Smith did make arrangements with him as to what assistance he would provide while Dr. Smith was on vacation. Dr. Hess would cover for whatever problems might develop in the office. If the nurse had questions, she would call or come down. On occasion Dr. Hess would actually see patients. All Dr. Smith's patients were not referred to him. Dr. Hess denied that Dr. Smith's nurse was running and taking care of the office while Dr. Smith was gone. Dr. Hess could not recall any specific patients Mrs. Durlap called him about. Dr. Hess was asked his opinion of a doctor who writes a prescription for a patient who is not present; a situation where a grandmother comes in for medication for herself and while she is there she gets a prescription for her grandson. Dr. Hess said there isn't a physician who doesn't do that every once in awhile, especially if it is a simple thing.

C. Dr. Hess was asked if he felt Dr. Smith's practice of leaving signed blank prescriptions with his nurse and having her check with him for advice and assistance conforms to the standards

of care of doctors in Bowling Green, Ohio.

Dr. Hess said, "Yes". (Transcript at 164)

- D. Dr. Hess was familiar with Robert Palmer. He felt that Mr. Palmer's condition has improved since being under Dr. Smith's care and treatment.
- E. As regards the prescribed medication of Patient H, Dr. Hess testified that he agreed with Dr. Smith's method of treatment. He said "you would probably have a hard time doing much different with her. She is improved and doing better". (Transcript at 166) Dr. Hess was asked if he felt the amount of medication this patient received was reasonable. He said he didn't know how much pain or what kind of trouble this patient had, but that it was a terrific problem and that the medication prescribed for her could very well be all right. (Transcript at 176)
- F. Dr. Hess, when asked if it was his practice to write in his records or charts each prescription for medication for every patient, replied, "No, it depends on whether he has a chart with him. He writes the prescription down 90% of the time".
- G. Dr. Hess feels Dr. Smith is a qualified and competent doctor. The size of his practice shows this. (Transcript at 168)
- H. Dr. Hess doubts that there is any doctor in Bowling Green, Ohio who is willing or equipped to take over the entire practice of another doctor while he is out of town. When a doctor goes out of town, he may ask two or three different doctors to look after things. (Transcript at 172)
- I. Dr. Hess said that occasionally his office personnel do write prescriptions, but under his direct order. They might write it and co-sign it with his name. If it involves any kind of narcotic, he has to sign it himself. They call in prescriptions only under his direction. (Transcript at 177) Dr. Hess does not presign prescriptions. In his absence no patient gets medication. (Transcript at 178)

After considering all of the testimony and evidence presented at the hearing and after having read the transcript and all exhibits introduced, I make the following findings:

FINDINGS OF FACT

Based on the testimony and evidence, I find:

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STATE MEDICAL BOARD

1. On or about July 31, 1979, when Dr. Smith was on vacation, Mrs. Dunlap, an employee of Dr. Smith's, did prescribe for Patient A thirty tablets (seventy-five (75) milligram) of Preludin, a Schedule 2 controlled substance.
2. On or about July 31, 1979, when Dr. Smith was on vacation, Patient A attended his office for treatment. On this occasion Mrs. Dunlap did prescribe for Patient A's grandson, Patient B, thirty (30) capsules of thirty (30) milligram Ionamin, a Schedule 4 controlled substance, and thirty (30) tablets of five (5) milligram Valium, a Schedule 4 controlled substance.
3. Mrs. Dunlap, an employee of Dr. Smith's who is not licensed by the State Medical Board of Ohio, did admit to David Saunders, R.Ph. that she was writing prescriptions for patients in Dr. Smith's absence on forms presigned by him.
4. Dr. Smith prescribed or caused to be prescribed drugs to Patients C through Patient Q as listed on page two through page 8, paragraph two of Board Exhibit #1 (citation letter).

CONCLUSIONS

1. Dr. Smith's actions constitute a "failure to use reasonable care discrimination in the administration of drugs" in violation of Section 4731.22 (B) (2), Ohio Revised Code.
2. Dr. Smith's actions constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances in violation of Section 4731.22 (B) (6), Ohio Revised Code.
3. Such acts of Dr. Smith constitute "knowingly maintaining a professional connection or association with a person who is in violation of this chapter or rules of the board" as is used in Section 4731.22 (B) (8), Ohio Revised Code.
4. Such acts of Dr. Smith 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) (17), Ohio Revised Code.

PROPOSED ORDER

It is hereby ordered that the license to practice medicine of Albert W. Smith, M.D. be suspended for one year and all but sixty (60) days are stayed, provided that:

December 3, 1980

REPORT AND RECOMMENDATION IN THE MATTER OF
ALBERT W. SMITH, M.D.

Dr. Ferritto left the meeting at this time. Mr. Wenger, Mr. Falleur and Mr. Jurca remained out of the room.

Dr. Cover asked the Board if it had read the transcript and the objections to the Report and Recommendation filed in the above matter. A roll call was taken:

ROLL CALL:	Dr. Lancione	- aye
	Dr. Cramblett	- aye
	Dr. Clarke	- aye
	Dr. Yut	- aye
	Dr. Lovshin	- aye
	Dr. Oxley	- aye
	Mr. Paulo	- aye
	Dr. Ferritto	- aye
	Dr. Ruppertsberg	- aye

Dr. Lovshin moved to approve and confirm Dr. Yut's Report and Recommendation in the matter of Albert W. Smith, M.D. Dr. Cramblett seconded the motion. A roll call vote was taken:

Dr. Ferritto returned to the meeting at this time.

ROLL CALL VOTE:	Dr. Lancione	- aye
	Dr. Cramblett	- aye
	Dr. Clarke	- aye
	Dr. Yut	- abstain
	Dr. Lovshin	- aye
	Dr. Oxley	- aye
	Mr. Paulo	- aye
	Dr. Ferritto	- abstain
	Dr. Ruppertsberg	- aye

The motion carried.

Dr. Cramblett moved that an effective date of February 1, 1981 be placed on the Order. Dr. Clarke seconded the motion. A roll call vote was taken:

ROLL CALL VOTE:	Dr. Lancione	- aye
	Dr. Cramblett	- aye
	Dr. Clarke	- aye
	Dr. Yut	- abstain
	Dr. Lovshin	- aye
	Dr. Oxley	- aye
	Mr. Paulo	- aye
	Dr. Ferritto	- aye
	Dr. Ruppertsberg	- aye

The motion carried.

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 1006
180 East Broad Street
Columbus, Ohio 43215

September 13, 1979

Albert W. Smith, M.D.
640 South Wintergarden Road
Bowling Green, Ohio 43402

Dear Doctor Smith:

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

1. A. On or about July 31, 1979, during a period when you were on vacation, one Patient A attended your medical office for treatment. On this occasion, Jan Dunlap, R.N., an employee of yours who is not licensed by the State Medical Board of Ohio, did prescribe for Patient A thirty (30) tablets of seventy-five (75) milligram Preludin, a Schedule II controlled substance.
- B. On or about July 31, 1979, during a period when you were on vacation, one Patient A attended your medical office for treatment. On this occasion, Jan Dunlap, R.N., an employee of yours who is not licensed by the State Medical Board of Ohio, did prescribe for Patient A's grandson, one Patient B, thirty (30) capsules of thirty (30) milligram Ionamin, a Schedule IV controlled substance, and thirty (30) tablets of five (5) milligram Valium, a Schedule IV controlled substance.
- C. On or about July 31, 1979, Jan Dunlap, R.N., an employee of yours who is not licensed by the State Medical Board of Ohio, did admit to David Saunders, R. Ph., that she was writing prescriptions for patients in your absence on forms previously signed by you.

Such acts in Paragraph 1 above, individually and/or collectively, constitute a "failure to use reasonable care discrimination in the administration of drugs" as that clause is used in Section 4731.22(B)(2), Revised Code.

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 2

Further, such acts in Paragraph 1 above, individually and/or collectively, constitute "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances" as that clause is used in Section 4731.22 (B)(6), Revised Code.

Further, such acts in Paragraph 1 above, individually and/or collectively, constitute "knowingly maintaining a professional connection or association with a person who is in violation of this chapter or rules of the board" as that clause is used in Section 4731.22(B)(8), Revised Code.

Further, such acts in Paragraph 1 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)(17), Revised Code, to wit: Sections 4731.34, 4731.41, and/or other related sections of the Ohio Revised Code.

2. On or about the following dates, you prescribed or caused to be prescribed the following drugs to the patients listed below, who are named in the attached key (to be withheld from public disclosure), in the amounts as indicated below:

Patient C

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
06/17/78	Dexamy1 # 2	30
08/28/78	Dexamy1 # 2	60
10/30/78	Biphetamine 20	30
11/30/78	Biphetamine 20	30
11/30/78	Biphetamine 20	30
02/01/79	Biphetamine 20	30
03/31/79 or 03/31/78	Biphetamine 20	60

Patient D

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
03/22/78	Seconal 100 mg.	60
06/04/78	Seconal 100 mg.	30
07/05/78	Seconal 100 mg.	30 (3 refills)
10/07/78	Preludin 25 mg.	100
12/01/78	Preludin 25 mg.	100 (5 refills)
01/16/79	Preludin 25 mg.	100
02/13/79	Preludin 25 mg.	90
03/07/79	Preludin 25 mg.	100
07/16/79	Preludin 75 mg.	30

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 3

Patient E

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
06/16/78	Demerol 50 mg.	100
07/10/78	Demerol 50 mg.	100
07/10/78	Dexaryl 15 mg.	60
09/21/78	Demerol 50 mg.	100
09/21/78	Dexaryl #2	30
10/16/78	Demerol 50 mg.	60
11/20/78	Demerol 50 mg.	100
12/07/78	Dexaryl #2	30
12/11/78	Demerol 50 mg.	100
12/11/78	Thyroid 1 grain	100
01/06/79	Dexaryl #2	30
01/06/79	Lasix 20 mg.	60 (3 refills)
01/15/79	Demerol 50 mg.	80
01/31/79	Demerol 50 mg.	100
02/03/79	Dexaryl #2	30
02/20/79	Demerol 50 mg.	100
03/03/79	Dexaryl #2	30
03/03/79	Motrin 400 mg.	100 (6 refills)
03/08/79	Demerol 50 mg.	100
03/27/79	Demerol 50 mg.	100
04/13/79	Demerol 50 mg.	100
04/27/79	Demerol 50 mg.	100
05/17/79	Dexaryl #2	30
05/17/79	Demerol 50 mg.	100
05/27/79	Dexaryl #2	30
06/01/79	Demerol 50 mg.	100
06/15/79	Demerol 50 mg.	100
07/23/79	Dexaryl #2	30

Patient F

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
08/31/78	Preludin 25 mg.	100
10/02/78	Dexaryl #2	30
11/04/78	Dexaryl #2	30

Patient G

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
12/05/78	Percodan	60
12/05/78	Dexedrine 5 mg.	60
01/25/79	Percodan	60
01/25/79	Dexedrine 5 mg.	60
03/22/79	Percodan	60
03/22/79	Dexedrine 5 mg.	60
06/12/79	Percodan	40
06/12/79	Dexedrine 5 mg.	40

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 4

Patient H

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
11/10/78	Demerol 50 mg.	60
12/18/78	Demerol 50 mg.	60 (2 refills)
01/15/79	Demerol 50 mg.	60
01/15/79	Valium 5 mg.	100
01/22/79	Demerol 50 mg.	100
02/08/79	Demerol 50 mg.	100
02/12/79	Demerol 50 mg.	60
02/15/79	Demerol 50 mg.	100
02/20/79	Demerol 50 mg.	100
02/26/79	Demerol 50 mg.	100
03/02/79	Demerol 50 mg.	100
03/06/79	Demerol 50 mg.	100
03/12/79	Demerol 50 mg.	60
03/16/79	Demerol 50 mg.	100
04/03/79	Demerol 50 mg.	100
04/09/79	Demerol 50 mg.	60
04/20/79	Demerol 50 mg.	100
04/30/79	Demerol 50 mg.	100

Patient I

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
11/07/78	Dexamyl #2	30
11/07/78	Lasix 40 mg.	60
11/28/78	Dexamyl #2	20
12/07/78	Dexamyl #2	60
02/17/79	Dexamyl #2	30
03/18/79	Biphedamine 20	30
04/14/79	Biphedamine 20	30
04/14/79	Lasix 40 mg.	60
05/05/79	Biphedamine 20	30
06/18/79	Biphedamine 20	30
undated	Biphedamine 20	20

Patient J

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
01/19/78	Dexedrine 15 mg.	100
01/23/78	Dexedrine 15 mg.	100
01/23/78	Dalmane 30 mg.	100
02/07/78	Dexedrine 15 mg.	100
02/22/78	Dexedrine 15 mg.	100
03/09/78	Dexedrine 15 mg.	100
03/20/78	Dexedrine 15 mg.	100

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 5

Patient J

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
03/20/78	Fiorinal caps.	60
04/03/78	Dexedrine 15 mg.	100
04/03/78	Dalmane 30 mg.	60
04/17/78	Dexedrine 15 mg.	100
04/28/78	Dexedrine 15 mg.	100
05/10/78	Dexedrine 15 mg.	100
05/10/78	Fiorinal tabs	100
05/20/78	Dexedrine 15 mg.	100
05/27/78	Dexedrine 15 mg.	100
05/27/78	Fiorinal tabs	100
06/08/78	Dexedrine 15 mg.	100
06/08/78	Fiorinal tabs	100
06/19/78	Dexedrine 15 mg.	100
06/19/78	Dalmane 30 mg.	60
06/29/78	Dexedrine 15 mg.	100
06/29/78	Dalmane 30 mg.	60
07/10/78	Dexedrine 15 mg.	100
07/10/78	Benadryl 25 mg.	60
07/20/78	Dexedrine 15 mg.	100
07/31/78	Dexedrine 15 mg.	100
07/31/78	Fiorinal tabs	100
08/08/78	Dexedrine 15 mg.	100
08/08/78	Fiorinal tabs	100
08/31/78	Fiorinal tabs	100
08/31/78	Dexedrine 15 mg.	100
09/11/78	Dexedrine 15 mg.	100
10/24/78	Dexedrine 15 mg.	100
11/09/78	Dexedrine 15 mg.	100
12/23/78	Dexedrine 15 mg.	100
01/23/79	Dexedrine 15 mg.	200
01/23/79	Fiorinal tabs	200
01/23/79	Butazolidin 100 mg.	40
02/26/79	Dexedrine 15 mg.	100
03/01/79	Dexedrine 15 mg.	100
03/06/79	Dexedrine 15 mg.	100
03/30/79	Dexedrine 15 mg.	100
04/09/79	Dexedrine 15 mg.	100
04/23/79	Dexedrine 15 mg.	100
04/27/79	Dexedrine 15 mg.	100
05/10/79 or	Fiorinal tabs	100
05/10/78		
05/10/79 or	Dexedrine 15 mg.	100
05/10/78		
05/18/79 or	Dalmane 30 mg.	60
05/18/78		
05/18/79 or	Dexedrine 15 mg.	100

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 6

Patient J

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
05/18/78		
06/01/79	Dexedrine 5 mg.	100
06/01/79	Dexedrine 15 mg.	100
06/11/79	Dexedrine 15 mg.	100
06/11/79	Fiorinal tabs	100
07/10/79	Dexedrine 15 mg.	100
07/10/79	Fiorinal tabs	100

Patient K

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
11/02/78	Quaalude 300	60
12/13/78	Quaalude 300	30
02/01/79	Quaalude 300	30
02/20/79	Quaalude 300	30
04/02/79	Quaalude 300	30
04/25/79	Quaalude 300	30
05/25/79	Quaalude 300	30
06/21/79	Quaalude 300	30

Patient L

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
11/11/78	Preludin 25 mg.	100
12/11/78	Preludin 25 mg.	100
12/22/78	Preludin 25 mg.	100
02/12/79	Preludin 25 mg.	100
03/22/79	Preludin 25 mg.	100
04/28/79	Preludin 25 mg.	100
05/05/79	Preludin 25 mg.	100

Patient M

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
12/01/78	Dexamyl #2	60
01/20/79	Dexamyl #2	60
01/20/79	Diuril 500	100
02/27/79	Dexamyl #2	30
03/20/79	Dexamyl #2	60
03/20/79	Diuril 500	100
04/20/79	Dexamyl #2	60
07/11/79	Dexamyl #2	100
07/11/79	Diuril 500	100

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 7

Patient N

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
11/06/78	Valium 5 mg.	100
11/06/78	Seconal 100 mg.	20
01/22/79	Preludin 50 mg.	60
03/02/79	Preludin 25 mg.	200
06/19/79	Dexamyl #2	30

Patient O

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
05/15/78	Dexamyl #2	30
05/15/78	Lasix 20 mg.	60
07/22/78	Dexamyl #2	60
10/07/78	Dexamyl #2	30
11/07/78	Dexamyl #2	60
01/06/79	Dexamyl #2	30
02/02/79	Dexamyl #2	30
02/27/79	Biphetamine 20	60
04/27/79	Biphetamine 20	30
05/25/79	Biphetamine 20	30

Patient P

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
11/07/78	Dexamyl #2	40
12/16/78	Dexamyl #2	30
01/12/79	Dexamyl #2	30
02/27/79	Dexamyl #2	60
04/27/79	Dexamyl #2	30
05/25/79	Dexamyl #2	30

Patient Q

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
02/25/78	Percodan	100
04/07/78	Percodan	100
04/28/78	Percodan	100
05/19/78	Percodan	100
05/19/78	Seconal 100 mg.	30
06/10/78	Percodan	100
07/03/78	Percodan	100
08/17/78	Percodan	100
10/13/78	Percodan	100
11/11/78	Percodan	100

STATE OF OHIO
THE STATE MEDICAL BOARD

September 13, 1979

Albert W. Smith, M.D.

Page 8

Patient Q

<u>DATE</u>	<u>DRUG</u>	<u>AMOUNT</u>
02/12/79	Percodan	100
03/09/79	Percodan	100
03/26/79	Percodan	100
04/12/79	Percodan	100
04/28/79	Percodan	100
05/17/79	Percodan	100
06/22/79	Percodan	100

Such acts, in Paragraph 2 above, individually and/or collectively, constitute "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" as that clause is used in Section 4731.22 (B)(2), Ohio Revised Code.

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

In order to best assure protection of any privileges which may exist, the names of the above-mentioned patients are enclosed on a separate form, included with this letter.

You are advised that you are entitled to a hearing in this matter if you request such hearing within thirty (30) days of the time of mailing of this notice.

You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or you may present your positions, 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 made 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, reprimand, revoke, suspend, place on probation, refuse to register or reinstate your certificate to practice medicine and surgery.

STATE OF OHIO
THE STATE MEDICAL BOARD

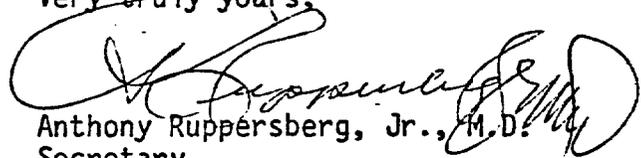
September 13, 1979

Albert W. Smith, M.D.

Page 9

A copy of the Medical Practice Act is enclosed for your examination.

Very truly yours,



Anthony Ruppertsberg, Jr., M.D.
Secretary

AR:es

Enclosure

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