



State Medical Board of Ohio

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

March 14, 2007

Arthur Richard Schramm, M.D.
11060 Wolf Creek Pike
Brookville, OH 45309

Dear Doctor Schramm:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Christopher B. McNeil, Esq., 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 Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8824
RETURN RECEIPT REQUESTED

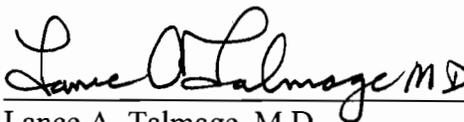
CC: Dwight D. Brannon, Todd Allim Morman and Andrea G. Ostrowski, Esqs.
CERTIFIED MAIL NO. 91 7108 2133 3933 4658 8831
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Mailed 3-16-07

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Christopher B. McNeil, 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, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Arthur Richard Schramm, M.D., as it appears in the Journal of the State Medical Board of Ohio.

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



Lance A. Talmage, M.D.

Secretary

(SEAL)

March 14, 2007

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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*

ARTHUR RICHARD SCHRAMM, M.D.

*

ENTRY OF ORDER

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

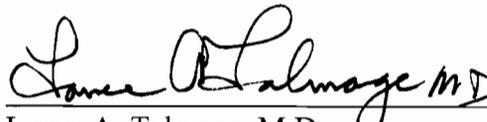
Upon the Report and Recommendation of Christopher B. McNeil, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of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

It is hereby ORDERED that:

The certificate of Arthur Richard Schramm to practice medicine and surgery in Ohio is PERMANENTLY REVOKED.

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

(SEAL)



Lance A. Talmage, M.D.
Secretary

March 14, 2007

Date

**REPORT AND RECOMMENDATION
IN THE MATTER OF ARTHUR RICHARD SCHRAMM, M.D.**

The Matter of Arthur Richard Schramm, M.D., was heard by Christopher B. McNeil, Esq., Hearing Examiner for the State Medical Board of Ohio, on November 2, 2006.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated September 13, 2006, the State Medical Board of Ohio [Board] notified the Respondent, Arthur Richard Schramm, M.D., that it proposes to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's proposed action is based on allegations concerning (1) Dr. Schramm's decision to prescribe cross-reactive controlled substances for two patients with substance abuse problems; (2) Dr. Schramm's treatment of three patients and his alleged failure to conform to minimal standards of care with those three patients; (3) Dr. Schramm's failure to accurately reflect in his medical records controlled substance prescriptions for three patients; and (4) claims that Dr. Schramm inappropriately took nude or partially-nude pictures of two patients.

Corresponding to these four sets of claims, the Board identified four independent legal bases for taking disciplinary action against Dr. Schramm:

- The Board alleged that Dr. Schramm's decision to prescribe cross-reactive controlled substances to Patients 1 and 2 constituted the "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or the failure to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.
- The Board alleged that Dr. Schramm's conduct concerning his medical and psychiatric treatment of Patients 1, 2 and 3 constituted "[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.
- The Board alleged that by his failure to accurately reflect controlled substance prescriptions for Patients 1, 2 and 3, Dr. Schramm violated "[a] provision of [R.C. Chapter 4731] or any rule promulgated by the Board," as that clause is used in Section

4731.22(B)(20), specifically referring to Rule 4731-11-02(D) (requiring that a physician shall complete and maintain accurate medical records); and

- The Board alleged that by taking nude or semi-nude photographs of Patients 1 and 2, Dr. Schramm committed a “[v]iolation of any provision of a code of ethics of the American Medical Association,” as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, referring specifically to Principles I, II, IV, and VIII of the American Medical Association’s Principles of Medical Ethics.

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

- B. On October 4, 2006, Dwight D. Brannon, Esq. and Todd A. Morman, Esq., submitted a written hearing request on behalf of Dr. Schramm. (State’s Exhibit 1T)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Steven McGann and Damion M. Clifford, Assistant Attorneys General.
- B. On behalf of the Respondent: Dwight D. Brannon, Esq., Todd A. Morman, Esq., and Andrea G. Ostrowski, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State:
 1. Arthur R. Schramm, M.D., as if on cross-examination
 2. Peter J. Geier, M.D.
 3. Gregory A. McGlaun
- B. Presented by the Respondent:

Arthur R. Schramm, M.D.

II. Exhibits Examined

- A. Presented by the State:
 1. State’s Exhibits 1A through 1KK: Procedural exhibits.

- * 2. State's Exhibit 2: Medical Records from Dr. Schramm regarding Patients 1 and 2.
- * 3. State's Exhibit 3 – 3C: Medical Records from Dr. Schramm regarding Patients 1 and 2.
- * 4. State's Exhibit 4: Medical Records from CVS/Revco regarding Patient 1.
- * 5. State's Exhibit 5: Medical Records from CVS/Revco regarding Patient 1.
- * 6. State's Exhibit 6: Medical Records from Rite Aid regarding Patient 2.
- * 7. State's Exhibit 7: Medical Records from Rite Aid regarding Patient 2.
- * 8. State's Exhibit 8: Medical Records from Dr. Schramm regarding Patient 3.
- * 9. State's Exhibit 9: Medical Records from Kroger Pharmacy regarding Patient 3.
- * 10. State's Exhibit 10: Medical Records from Kroger Pharmacy regarding Patient 3.
- 11. State's Exhibit 11: Dr. Schramm's Deposition.
- * 12. State's Exhibit 12: Photographs of Patient 1.
- * 13. State's Exhibit 13: Photographs of Patient 2.
- 14. State's Exhibit 14: Expert Report of Peter J. Geier, M.D.
- 15. State's Exhibit 15: [withdrawn]
- * 16. State's Exhibit 16: Patient Key.
- 17. State's Exhibit 17: American Medical Association Principles of Medical Ethics, June 2001.
- 18. State's Exhibit 18: CV of Dr. Geier.
- * 19. State's Exhibit 19: Videotape (Proffered).
- * 20. State's Exhibit 20: Photographs of Patient 1.
- 21. State's Exhibit 21: State's Closing Statement

B. Presented by the Respondent:

1. Respondent's Exhibit A: Expert Report of Dr. Arthur Schramm
2. Respondent's Exhibit B: Closing Argument of Dr. Schramm
3. Respondent's Exhibit C: Objections to Closing Statement

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

PROFFERED EXHIBIT

During the hearing, the State proposed to introduce a videotape of an investigative interview of Patient 1. Respondent's objection to this exhibit was sustained, and the State's request that the record be maintained as proffered evidence was granted. Accordingly, the videotape, shown as State's Exhibit 19, is in the record but was not considered in the preparation of this report.

PROCEDURAL MATTERS

The hearing record in this matter was held open until November 13, 2006, to allow the parties to submit written closing arguments. The parties submitted their arguments in a timely manner, and the documents were admitted to the record as State's Exhibit 21 and Respondent's Exhibit B. The Respondent also filed "Objections to Closing Statement," shown in the record as Respondent's Exhibit C. Those objections are without merit, and are overruled.

SUMMARY OF THE EVIDENCE

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

Dr. Schramm's Relationship with Patient 1

1. The Board has charged Dr. Schramm with failing to conform to professional standards in his treatment of three patients. The allegations concern both his professional and personal conduct, and focus on his conduct between the spring of 2004 and the fall of 2005. The charges with respect to Patient 1 require an examination into the timing of when Dr. Schramm actually began providing services as a psychiatrist to Patient 1. This examination is called for because of inconsistencies in Dr. Schramm's explanation of when his friendship with Patient 1 changed from non-professional interest in Patient 1 to the establishment of a physician-patient relationship.

2. At the time Dr. Schramm first met Patient 1, she was approximately 21 years old and was working as a dancer at The Living Room. When they first met, Dr. Schramm did not introduce himself as a doctor, and the relationship was a blend of social friendship and patronage. The Living Room offers its patrons the opportunity to meet young women, to engage them in conversation, to socialize, and if requested by the patrons, to perform “lap dances” – dances where the patron remains seated and clothed, and the dancer removes most of her clothing, save for panties and shoes, and dances both near the patron and on the lap of the patron. (Tr. at 104, 117-19)
3. For about a nine-month period starting in January 2004, Dr. Schramm had conversations with Patient 1 and occasionally hired her to perform lap dances with him. As they became better acquainted, the two met for dinner from time to time, and Dr. Schramm visited Patient 1’s home. Dr. Schramm then hired Patient 1 to perform clerical tasks, which she did both in his office and at his home. (Tr. at 105-09)
4. At the same time, starting in January 2004, Dr. Schramm conducted an evaluation of Patient 1, going to her home and taking steps preliminary to preparing a treatment plan. Dr. Schramm did not, however, tell Patient 1 that he was evaluating her home, nor did he disclose the fact that he was a psychiatrist until eight months had passed, when he hired Patient 1 to work in his office. (Tr. at 118)
5. Dr. Schramm contends his professional relationship with Patient 1 did not actually begin until September 2004. As will be examined more thoroughly below, however, the evidence concerning Dr. Schramm’s relationship with Patient 1 is at times contradictory, especially with respect to whether Dr. Schramm’s conduct was in the capacity of a friend, or was in fact service as a medical professional, during the months between January and September 2004. This becomes important because during these nine months, Dr. Schramm maintained a close personal relationship with Patient 1 and continued to hire her to dance for him when he went to the club where Patient 1 worked.

Dr. Schramm’s Relationship with Patient 2

6. Dr. Schramm met Patient 2 in much the same way as he met Patient 1. Like Patient 1, Patient 2 was a 21-year-old dancer at a club like The Living Room. Dr. Schramm established both a friendship with Patient 2 and from time to time would hire her to dance for him at the club. He said they became friends and maintained this mix of social friendship and patronage throughout the spring of 2004, and then in April 2004 he hired Patient 2 to provide clerical services in his medical office. This relationship – the mix of friendship, office work, and patronage at the club, continued between April 2004 and July 2004, when the relationship changed, and Dr. Schramm established a physician-patient relationship with Patient 2. (Tr. at 173)

7. Before Patient 2 became Dr. Schramm's patient, however, Patient 2 asked Dr. Schramm to take photographs of her, photographs that Patient 2 hoped would be useful to her if she pursued a modeling career. The photographs included pictures where Patient 2 was not fully clothed – some included topless poses and poses that were sexually suggestive. Notwithstanding this preexisting close personal relationship between Dr. Schramm and Patient 2, Dr. Schramm elected to enter into a physician-patient relationship with Patient 2 in July 2004. (Tr. at 168-73)

Nature of the Board's Charges Against Dr. Schramm

8. The Board's charges against Dr. Schramm fall into two general categories. The first category requires the application of ethical standards and focuses on Dr. Schramm's decision to provide medical services to these two young women, given the nature of his relationship with them prior to entering into a physician-patient relationship with each of them, and given the continuing personal relationship Dr. Schramm maintained with Patient 1 after he began treating her. The second category of charges examines Dr. Schramm's actual treatment of these two patients and Patient 3, to determine whether the medical treatment of the three patients failed to conform to applicable practice standards. These practice-related charges focus on Dr. Schramm's treatment decisions concerning all three of these patients, including decisions regarding the prescription of certain controlled substances under conditions that called into question whether Dr. Schramm's actions fell below minimum standards for the medical profession. (St. Ex. 1Q)

Background, Training, and Credentials of Dr. Schramm

9. The Respondent, Arthur R. Schramm, M.D., has been practicing psychiatry for over forty years. He earned his medical degree from the University of Illinois College of Medicine in 1962. After graduating, he completed a one-year internship at Presbyterian-St. Luke's Hospital in Chicago, then a two-year residency in adult or general psychiatry at the same hospital. In 1965, he commenced a two-year fellowship in child psychiatry at the same hospital, while at the same time completing psychoanalytic training at the Chicago Institute for Psychoanalysis. (Tr. at 333)
10. Dr. Schramm moved to Dayton in 1967 and fulfilled a two-year commitment to the United States Air Force, serving from 1967 to 1969 as a staff psychiatrist at Wright-Patterson Air Force Base. After this, Dr. Schramm started a private practice of child psychiatry, general psychiatry, and forensic psychiatry in Dayton. He has maintained this private practice from 1969 to the present. (Tr. at 333-34)
11. Dr. Schramm explained that he had a stroke in 2003, and had a hip replacement, and in September 2003, his wife died, and he became depressed. He testified that his depression responded to antidepressants (specifically Lexapro) early in 2006. Dr. Schramm added that he has received informal counseling for his depression from two

social workers at Kettering Hospital, as well as more formal, scheduled meetings, for about a year and a half. (Tr. at 339-40)

Dr. Schramm's Qualifications as an Expert Witness

12. Dr. Schramm prepared a report in which he advances opinions applying provisions of the Ohio Administrative Code and the American Medical Association's Principles of Medical Ethics to the circumstances of this case. (Resp. Ex. A). During the hearing, Dr. Schramm sought to be qualified as an expert in the field of applied ethics, and testified as to his credentials as an expert. (Tr. at 324-25)
13. To demonstrate his qualifications as an expert, Dr. Schramm described his professional experiences. Dr. Schramm said that starting in the 1980s, he held a number of leadership positions within the professional community. He said for twelve years he was the director of the detoxification program at St. Elizabeth Medical Center, where he worked with over 3,000 patients. He also was the developer and medical director of the adolescent in-patient psychiatry unit from 1986 to 1991. In addition, before St. Elizabeth closed, Dr. Schramm served as the chair of its Department of Psychiatry for seven years. After the Medical Center closed, Dr. Schramm moved his practice to Kettering Medical Center, when that facility was still known as Dartmouth Hospital. Once at Kettering, Dr. Schramm became the director of the Center's youth partial hospitalization program, the Center's residential treatment unit, and the director of a juvenile sexual offenders program. (Tr. at 324-35)
14. When Dr. Schramm sought to be permitted to testify as an expert witness, the State objected and was then given the opportunity to *voir dire* Dr. Schramm to question his credentials. During *voir dire* the State established that Dr. Schramm is not board certified, and currently is semi-retired. He holds no hospital staff privileges, electing to maintain a clinical office practice in which he sees about 1,400 patients a year, all on an outpatient basis. (Tr. at 336-39)
15. Upon review of the evidence, and based on his forty years of experience and relevant professional credentials, Dr. Schramm was qualified to give testimony as an expert witness in this administrative proceeding. (Tr. at 339-40)

The State's Expert – Qualifications of Peter J. Geier, M.D.

16. The State presented Peter J. Geier, M.D., as its expert witness. Like Dr. Schramm, Dr. Geier prepared a written report in which he applied administrative and ethical code provisions to a set of facts, some of which were gleaned from Dr. Schramm's patient notes and some of which were drawn from instructions given to Dr. Geier by the Board. (St. Ex. 14) Like Dr. Schramm, Dr. Geier sought to be recognized as an expert in the

field of applied ethics. In support, Dr. Geier produced his *curriculum vitae* (St. Ex. 18) and testified about his credentials to give such testimony. (Tr. at 189-92)

17. Dr. Geier has been practicing psychiatric medicine since 1984 and has been teaching psychiatric medicine since 1988. He earned a Bachelor's degree from Stanford University and graduated with a medical degree from the University of Cincinnati College of Medicine in 1984. After an internship at the University of Washington Hospitals in Seattle, he completed a psychiatry residency at the University of Cincinnati College of Medicine that included a term as Chief Resident at the University Hospital Psychiatric Inpatient Service. This was followed by a Fellowship in Child and Adolescent Psychiatry at the University of Chicago Department of Psychiatry, and a Forensic Psychiatry Fellowship at the Department of Psychiatry at Case Western Reserve University. (Tr. at 189-93, St. Ex. 18)
18. Dr. Geier has held a number of academic appointments including (most recently) service as the Director of Psychiatric Services at Rainbow Babies and Children's Hospital and Assistant Professor of Psychiatry at University Hospitals Case Medical Center, Case Western Reserve University. He has held positions as Attending Physician at a number of hospitals, including Laurelwood Hospital in Willoughby, Ohio, and University Hospitals Case Medical Center. Throughout his career, Dr. Geier has maintained a psychiatric practice, both in the private sector and in hospital and clinical staff positions, and his current practice is about 70 percent clinical. He is board certified in the areas of general psychiatry, child and adolescent psychiatry, and forensic psychiatry. His research has been presented through both poster and journal publications, and he is a member of a number of professional organizations, including the American and Ohio Psychiatric Associations, the American Academy of Psychiatry and the Law, and is the immediate past president of the Northeast Ohio Child and Adolescent Psychiatry Association. (Tr. at 189-93, St. Ex. 18)
19. When the State presented Dr. Geier as an expert witness, Dr. Schramm objected and was given the opportunity to *voir dire* Dr. Geier to question his credentials. During *voir dire* Dr. Schramm established that Dr. Geier's experience in the field of medical ethics was based primarily on hospital research proposals and was limited to ethical issues that might come up for the hospital. Dr. Geier also admitted that his knowledge of the medical profession's ethical guidelines is "the knowledge that a general practitioner in my profession would have," and he could not estimate the number of articles or papers on ethics that he might have read. (Tr. at 197-98)
20. Over Dr. Schramm's objections, Dr. Geier was qualified as an expert witness. (Tr. at 193-98)

Dr. Schramm's Medical Treatment of Patient 1: Charges Regarding the Selection of Drugs and the Course of Treatment

21. In its first allegations against Dr. Schramm regarding minimal standards, the Board considered Dr. Schramm's selection of drugs or other modalities in the course of his treatment of Patient 1. (St. Ex. 1Q)
22. In his report, Dr. Geier identified six instances where Dr. Schramm's medical treatment of Patient 1 failed to conform to minimal standards in the selection of drugs or other treatment modalities:
 - Dr. Schramm prescribed narcotic opioids to Patient 1, and narcotic opioids are cross-reactive with heroin, such that they should not be prescribed to a person with a heroin addiction;
 - Dr. Schramm prescribed Xanax, a benzodiazepine medication, which, like narcotic opioids, is cross-reactive with heroin and should not be prescribed to a person with a heroin addiction;
 - Dr. Schramm prescribed controlled stimulant medication (Adderall XR and Ritalin) to Patient 1 on four occasions, even though Patient 1 was addicted to heroin and her husband had a problem with cocaine abuse; and according to Dr. Geier it was well established in 2004 that controlled stimulant medications could be diverted to illicit use in the hands of drug abusers, and as such should not have been prescribed to Patient 1;
 - Dr. Schramm maintained no documentation for a diagnosis that would support the prescriptions for Adderall XR and Ritalin;
 - Dr. Schramm failed to timely refer Patient 1 for an evaluation of her post-traumatic lumbosacral strain, and instead treated the pain with a trial of narcotic opioids pain medications, without a documented evaluation of the patient's underlying condition; and
 - Despite the fact that Dr. Schramm diagnosed Patient 1 with bipolar disorder, there is no evidence that he attempted to treat this condition with appropriate medication. (St. Ex. 14, p. 5)

Background and Diagnosis of Patient 1

23. Responding to Dr. Geier's opinions, Dr. Schramm described the course of his treatment of Patient 1, starting in September 2004. According to Dr. Schramm, Patient 1 reported being addicted to heroin, and was afraid that if she went to the hospital to treat her

addiction she would lose custody of her eight-month-old son. She also reported that her husband was addicted to cocaine, and she reported that when she was seven years old she had been raped. Dr. Schramm said Patient 1 also reported that she had been injured three years earlier in an automobile crash in Florida. (Tr. at 132)

24. Dr. Schramm diagnosed Patient 1 as Axis I Bipolar/Mixed; Axis II – heroin addict, and Axis III – post-traumatic lumbosacral strain. (St. Ex. 3C) Based on this, he also sought to have Patient 1 examined by an orthopedist. He explained why: “I think it was apparent the first time I met her, as she was walking in a very guarded manner, and she wasn’t able to just freely put her weight from one foot to the next, and a lot of obvious pain. It was even in that first meeting she was in tears.” (Tr. at 351)
25. The record on this point, however, contains a relevant contradiction: In his description of the course of treatment of Patient 1, Dr. Schramm related that Patient 1 was in pain during “that first meeting,” but it appears he is referring to the meeting that took place in his office on September 3, 2004. (Tr. at 351; St. Ex. 3C at 2) This does not, however, appear to be the first time that Dr. Schramm met Patient 1. His testimony on this point is unequivocal: he first met Patient 1 when she was performing as a dancer at The Living Room, in January, 2004. (Tr. at 181) Accordingly, the conflict in this testimony is resolved by concluding that Patient 1 was in pain not during Dr. Schramm’s first meeting with her, but was in pain on September 3, 2004, during her first recorded visit in his office.

Dr. Schramm’s Assessment and Treatment of Patient 1 – the Prescription History

26. In reviewing the prescription history provided to him, Dr. Geier found eight instances where Dr. Schramm prescribed controlled substances for Patient 1 without making a record of those prescriptions in Patient 1’s file. These prescriptions were for stimulant medication on September 24, 2004, October 11, 2004, and October 18, 2004; narcotic medication on September 29, 2004, October 5, 2004, October 28, 2004, and November 9, 2004; and for benzodiazepine medication on November 30, 2004. (St. Ex. 14 at 3) Dr. Geier explained that this fell below the standard of care, because these prescriptions should have been noted in Patient 1’s medical records: “At least the medication, the strength, the date it was prescribed, the number administered and number of refills.” (Tr. at 216-17)
27. Confirming what was alleged in the Board’s charging document, Dr. Schramm agreed that he prescribed to Patient 1 the medications attributed to Patient 1, as shown in State’s Exhibit 1Q (the notice of opportunity for hearing). He also admitted that he prescribed this course of medication knowing that Patient 1 was a heroin addict. Specifically, he agreed that he prescribed Oxycontin 20 mg. #10 on October 5, 2004, October 28, 2004, and November 9, 2004; and that he prescribed Vicodin ES #10 on September 29, 2004, and again on October 18, 2004. He also prescribed Adderall XR 20 mg #10 on

September 27, 2004, Ritalin 10 mg #10 on October 11, 2004 and #20 on October 18, 2004, as well as Xanax 1 mg #20 on November 21, 2004. (Tr. 35-45).

28. Dr. Schramm did not deny the records were deficient, acknowledging in his closing statement that “he made a mistake by not keeping better records after his wife died.” (Closing Argument of Dr. Schramm at 4)

Prescription of Cross-Reactive Drugs

29. Dr. Geier was asked whether, in prescribing opioids to Patient 1, Dr. Schramm deviated from the standard of care:

Well, according to the State Medical Board of Ohio records, Dr. Schramm prescribed controlled narcotic opium-like substances to Patient 1, who had a diagnosis of heroin addiction, and it was well established in 2004 in the medical community that narcotic opium-like substances such as Vicodin, Oxycontin and MSContin are what are called “cross-reactive” with heroin. In other words, the substances can promote continued heroin dependence or addiction or a relapse in a person who has abstained from heroin and should not be prescribed to a person with a substance abuse problem in general or heroin addiction or dependency in particular. Similarly, according to the records, Dr. Schramm prescribed Xanax, a benzodiazepine medication . . . to Patient 1, who had a history of heroin addiction.

(Tr. at 214)

30. Contradicting Dr. Geier’s opinion, Dr. Schramm offered the expert opinion that his prescription of opioids to Patient 1 *was* consistent with the applicable standard of care, despite the fact that Patient 1 was addicted to heroin. In his expert report, Dr. Schramm explained his opinion:

Treating the symptoms of the back pain with narcotic opioids was indicated and within the accepted minimal standards for prescriptions of drugs. As part of the course of treatment for anxiety and post-traumatic stress disorder, prescription of Xanax was indicated and consistent with accepted minimal standards. In the course of treating Patient 1’s depression, various psychostimulants were prescribed and medication was adjusted to meet treatment goals. The prescription of these medications for depression is consistent with accepted minimal standards. Patient 1 was unable to obtain medical treatment for the underlying cause of her back pain, as recommended, though referred. This indicated analgesic treatment for the severe pain as part of the course of treatment.

(Resp. Ex. A, at 1)

31. Echoing what he wrote in his report, during the evidentiary hearing Dr. Schramm said that he disagreed with Dr. Geier's assessment, and stated it was "entirely appropriate" for him to prescribe Oxycontin to a patient who has admitted to heroin addiction. He agreed, however, that Oxycontin was known to be cross-reactive with heroin, and that cross-reactive drugs can promote a continued dependency on other drugs – so that prescribing Oxycontin could promote a continued dependency on heroin. (Tr. at 122)

Risks of Prescribing Controlled Stimulant Medication in Patient 1's Household

32. Dr. Geier also raised concerns about dispensing stimulants to Patient 1 based on what Dr. Schramm knew about Patient 1's home environment. Dr. Geier said it was below the standard of care to prescribe these stimulants, knowing that Patient 1's husband used cocaine. Dr. Geier explained his concerns:

[Patient 1] told Dr. Schramm that her husband had a problem with cocaine use. It was well established in medical practice in 2004 that the controlled stimulant medication could be diverted to illicit use in the hands of individuals with drug problems, such as Patient 1 and her husband. There was a high probability of abuse of these medications, and they should not have been, in my opinion, prescribed to Patient 1.

(Tr. at 215)

33. Dr. Schramm disagreed with this assessment. He said throughout the period where he was treating Patient 1, he looked for signs of prescription abuse by the patient, and found none: "She was not abusing." (Tr. 348-49)

Absence of Documentation Supporting Prescriptions for Adderall XR and Ritalin

34. Dr. Geier also noted with concern the state of Dr. Schramm's patient records regarding two prescriptions for ADHD medications for Patient 1 (Adderall XR and Ritalin): "I couldn't find any documentation of a disorder for which these medications would be indicated. And in 2004 it would have been the standard of care to document an evaluation for the diagnosis of a disorder such as Attention Deficit Hyperactivity Disorder before prescribing these medications." (Tr. at 216)
35. Dr. Schramm reported, however, that he did not prescribe the Adderall or the Ritalin for ADHD. He said he started Patient 1 on an anti-depressant, Lexapro (giving samples, so no prescription was needed). After several months with no real improvement, he augmented the anti-depressant with a psychostimulant, Adderall. He said at this point

Patient 1 noted “a dramatic improvement in focusing and concentration,” allowing him to draw the conclusion that she had some degree of an attention deficit disorder. With this knowledge, he shifted away from Adderall in favor of Ritalin, to see if this lesser medication would help, which he said it did. (Tr. at 123-24) He agreed, however, that he should have recorded the Lexapro medication he dispensed, but did not do so. He further agreed that he had never documented his evaluation of Patient 1’s ADD or ADHD anywhere in his notes. (Tr. at 129)

Dr. Schramm’s Failure to Properly Treat Patient 1’s Back Pain

36. Dr. Geier expressed concerns for the four prescriptions for narcotic medications and one prescription for benzodiazepine. According to Dr. Geier, when Dr. Schramm prescribed these medications for Patient 1, he “treated the pain associated with her condition without a thorough medical evaluation of the underlying condition” and as such engaged in a practice that was below the standard of care. Dr. Geier said the standard of care would have required Dr. Schramm to “refer the patient to an expert in the area of low back pain such as an orthopedic doctor or emergency department or urgent care facility.” (Tr. at 217-19)
37. Dr. Schramm admitted that he prescribed pain medication for Patient 1, explaining that he did so because of what he believed was post-traumatic lumbosacral strain Patient 1 sustained in an automobile accident three years earlier in Florida. He agreed that there was no documentation of the accident, nor was there any objective evidence of the injury. He said he elected not to order x-rays, but instead gave Patient 1 information about going to orthopedic surgeons or clinics in the community to address this pain. (Tr. at 131-32)
38. Dr. Schramm said he was able to personally observe Patient 1 so as to be able to diagnose the nature of her injury and determine an appropriate course of action. He said that shortly before he prescribed the pain medication, Patient 1 had “slipped and fallen and, while she was at home, was in severe back pain, called 911 and was taken to one of the hospitals” where “they gave her Motrin and sent her home in pain.” Dr. Schramm said he did an evaluation of Patient 1 by “observing [Patient 1] walk,” and defended this by stating “you can cover a lot of the elements of a neurological examination, just based on a way a person walks.” (Tr. at 135)
39. According to Dr. Schramm, Patient 1 reinjured her back in October 2004, when she slipped and fell while was working at The Living Room. Dr. Schramm said he was present when this happened, on October 24, 2004, and, because of the severe pain, Dr. Schramm prescribed Oxycontin. (Tr. at 137) At this point, Dr. Schramm also testified that he sought to have a Dayton orthopedist, Dr. Paley, examine and evaluate Patient 1. That examination, however, never took place, because Patient 1 was relying on Medicaid to cover the cost of medical services, and Dr. Paley “won’t see Medicaid” patients. (Tr. at 138)

Failure to Treat for Bipolar Disorder

40. Dr. Geier noted Dr. Schramm's diagnosis of Patient 1's bipolar disorder, which Dr. Geier said, "is a mood disorder generally constituting both components of mania, which is mood elevation or extreme irritability, along with meeting the criteria for major depression." Dr. Geier found no evidence that after making this diagnosis, Dr. Schramm attempted to treat Patient 1's bipolar disorder. This failure – either the failure to treat or the failure to document treatment – constituted a violation of the standard of care, according to Dr. Geier. (Tr. at 235-36)
41. Dr. Schramm agreed that when he started treating Patient 1 in September of 2004, he diagnosed her with bipolar disorder. (Tr. at 95) His patient records, however, show no treatment of this disorder nor is there any treatment plan addressing Patient 1's bipolar disorder from September 2004 to October 2005. (St. Ex. 3C)

Dr. Schramm's Failure to Assess and Treat Patient 1's Traumatic Experiences

42. Dr. Geier expressed concern about the fact that Dr. Schramm found that Patient 1 had been raped and had a history of conflict with her parents. He said Dr. Schramm should have referred Patient 1 for "some type of psychotherapy or support for that history of trauma." However, there was no evidence in Dr. Schramm's notes that he had done so. This, according to Dr. Geier, constituted another violation of the applicable standard of professional care. (Tr. at 236)
43. Dr. Schramm disagreed with Dr. Geier's assessment. He acknowledged that Patient 1 told him she had been raped when she was seven years old, and said that this event "and other various traumatic experiences were the primary focus of everything that we worked on in the therapy." He admitted, however, that he did not refer Patient 1 for any kind of psychotherapy for the rape, and agreed that nothing in his notes suggests any discussion about the rape incident. Similarly, his notes indicate Patient 1 reported conflicts with her mother, but there is nothing in the notes that would suggest that Dr. Schramm followed this up with any kind of treatment. (Tr. at 146-48)

Dr. Schramm's Treatment of Patient 1 – Failure to Refer Patient 1 for Drug Treatment and Failure to Report to Child Protective Services

44. Dr. Schramm agreed that in September 2004 he diagnosed Patient 1 as being addicted to heroin. He also knew Patient 1's eight-month-old son lived with her in this home environment, where the father was addicted to cocaine. He said Patient 1 had considered seeking help in other places before she met Dr. Schramm, but she was concerned that if she went to social workers they would take custody of her young son. He said he considered Patient 1's history of drug use, which was a once-a-day dosage, and he noted

that she had occasional withdrawal symptoms. As such, based on his experience in the outpatient detoxification program he directed at St. Elizabeth Medical Center, Dr. Schramm “thought [Patient 1] was a good candidate for outpatient detoxification.” (Tr. at 96-97) Dr. Schramm added that he had, by this time, “made a point of some home visits and observed [Patient 1’s] son, and he seemed to be well taken care of and in good health.” He said he had also talked with a female neighbor who babysat for the boy, and from this concluded, “there was nothing that would support a conclusion for neglect.” (Tr. at 96-97)

45. Dr. Geier explained his concerns about both the failure to refer Patient 1 to a drug treatment program and about the failure to address concerns raised by the fact that Patient 1 was a heroin-dependent mother caring for her eight-month-old son. In contrast with Dr. Schramm’s opinion, Dr. Geier stated that, based on Dr. Schramm’s diagnosis that Patient 1 was addicted to heroin, “the proper treatment would be [to] refer her to a drug treatment program, to a detoxification program and also drug treatment program.” (Tr. at 219) Concerning the child’s placement in this home, Dr. Geier said “In my opinion, this did constitute proper criteria to report to Child Protective Services that he learned a young child, an eight-month-old child, was living with a patient who told him she was addicted to heroin, and the father was using cocaine in the household.” (Tr. at 220-21)

Dr. Schramm’s Personal Relationship with Patient 1 Before and After Accepting Her as a Patient

46. The record makes clear that although his patient records show the first physician-patient meeting was conducted on September 3, 2004, the observations Dr. Schramm made concerning Patient 1’s home environment began prior to September 2004. Dr. Schramm said he “made these observations before [Patient 1] became a patient,” early in the spring of 2004. What is unclear, however, is the depth of these assessments. Dr. Schramm said when he first went to Patient 1’s house, he was able to observe her eight-month-old son in the home, but was unaware at that time that Patient 1 was addicted to heroin. Instead, it appears that when Dr. Schramm went to her home in January 2004, the focus of his visit initially was to size up Patient 1’s *husband*:

I went to the home, the first visit, because she had talked so much of problems with her husband, that I thought the intention of the visit was to talk with him and get some idea of how difficult his problems were and what might be helpful. In other words, it was a visit there for the purpose of planning – coming up with a treatment plan or something.

(Tr. at 99)

47. On cross-examination, Dr. Schramm stated that when he went to Patient 1’s home in early spring 2004, he did so with the intention of doing an evaluation for treatment. (Tr.

at 99-100) When asked how it would be possible for him to be conducting such an evaluation for someone who was not his patient and might not become his patient, Dr. Schramm explained this by saying:

This is something that, in my experience, happens very frequently, and it has to do with hearing about a person's concerns and then trying to get more information to see, you know, here is a problem. How big of a problem is it? Is it something that acutely needs attention? I do not consider having started working with her or her family as a patient prior to that September appointment because it wasn't until then that I felt that I had enough information to proceed with some things that I needed to talk with her about. In relation to my contact with the husband, I didn't see anything that would require any urgent attention.

(Tr. at 102-03)

48. When asked whether he told Patient 1 he was a psychiatrist, Dr. Schramm responded: "Eventually, but I don't think it was early in the friendship." He specifically said he did not recall informing Patient 1 that he was a psychiatrist prior to August 2004. (Tr. at 116-17))

Multiple and Conflicting Levels of Personal and Professional Relationship with Patient 1

49. Dr. Schramm's patronage of Patient 1 at The Living Room continued even after the patient-physician relationship was formally established in September. The record establishes that Dr. Schramm considered Patient 1 to be his patient – as shown in the patient records – on September 3, 2004. (St. Ex. 3C at 3) Dr. Schramm did not, however, stop seeing Patient 1 at The Living Room at this point: When asked to estimate the number of times he received lap dances from Patient 1 after September 2004, Dr. Schramm responded "three or four" times. (Tr. at 111)
50. In addition to engaging Patient 1 as a friend, and patronizing her when he visited The Living Room, in August of 2004, Dr. Schramm hired Patient 1 to work around the office, helping fill out insurance claim forms. Dr. Schramm acknowledged, however, that while she was helping with office-related work, Patient 1 also performed lap dances for him at his office. He testified that this happened between August and September, on no more than three occasions, and never happened in his office after she became his patient. (Tr. at 112)
51. Beyond this, Dr. Schramm also had Patient 1 come to his house in August 2004, where for a few months she assisted in getting things organized, a chore that Dr. Schramm's wife had previously attended to until her death in 2003. (Tr. at 116)

52. In addition to engaging in a social relationship with Patient 1, hiring her at The Living Room, and having her work in his office and at his home, Dr. Schramm agreed that at one time he possessed negatives of nude pictures of Patient 1. He explained that while he did not take these pictures, he knew they contained nude images of Patient 1. He said he received them from Patient 1, who had asked for his help in getting these pictures developed. “I just had the negatives, and Malone Camera in Dayton wouldn’t print them because of whatever the rules are about nudity.” Dr. Schramm explained that the negatives that were printed out and are shown as State’s Exhibit 12 were from the negatives Patient 1 gave him, and are not photos he took of Patient 1. (Tr. at 177)
53. Dr. Schramm testified that in April 2004, he did in fact take pictures of Patient 1, but none of those pictures was of Patient 1 when she was nude; rather, the ones he took were with her dressed the way she dressed when she worked at The Living Room. (Tr. at 177-79) The pictures that Dr. Schramm took of Patient 1, however, were not produced by the State and are not part of the record of these proceedings, although Dr. Schramm said he believes the pictures that he took of Patient 1 are in the Board’s possession. (Tr. at 178)

Testimony Regarding the Proffer of the Board’s Videotaped Interview of Patient 1

54. There was also testimony from the Board’s investigator, Gregory A. McGlaun, concerning evidence the State sought to introduce that it claimed would establish that Dr. Schramm actually did take nude pictures of Patient 1, and that he did so in November of 2004. Mr. McGlaun’s testimony apparently was premised in large part on what Patient 1 is alleged to have said during a videotaped interview conducted by the Board’s investigators on December 10, 2004. (Tr. at 288) The videotaped interview is not, however, part of the evidence in this matter, because Dr. Schramm’s objection to the introduction of the videotape was sustained.
55. Mr. McGlaun explained that Patient 1 was interviewed at the Kettering Police Department and that the videotape includes her statement that there was a “photo shoot” at some time “in the fall of 2004.” (Tr. at 292)
56. On further evaluation, and after reviewing the record of this exchange (running from Tr. at 285 to 298), I find the evidence as proffered to be of little forensic potential value. The main point being pursued here appears to be that the evidence on the videotape would bolster the State’s claim that Dr. Schramm took nude pictures of Patient 1 in November 2004, after the physician-patient relationship had clearly been established. Whether he did so or not is tangential at best: Dr. Schramm admitted he continued to seek out Patient 1 at The Living Room, and at that venue he continued to engage her in lap dances and pursued his personal friendship with her. (Tr. at 111) This course of behavior establishes the existence of a sexual relationship between the two in the course of his professional relationship with her, regardless of whether he also took pictures of her in November.

57. Whether Dr. Schramm also took pictures in the fall of 2004 may be relevant, but it would at best be cumulative. On the other hand, the State has known for more than a year that Patient 1 gave the unsworn out-of-court interview and could have, but did not, subpoena her to appear at the hearing. (Tr. at 294) Indeed, it does not appear the State took any action to have Patient 1 appear at the hearing or in some other way preserve her testimony while still affording Dr. Schramm the opportunity to test the reliability of her statements (e.g., by conducting a deposition in lieu of having Patient 1 appear at the hearing). That Patient 1 now lives in Florida does not change the fact that the State has had this case pending for more than eight months and at no time did it take meaningful efforts to preserve Patient 1's sworn testimony under conditions that would permit cross-examination of this witness. Considering the evidence as a whole, and being mindful of the obligation to preserve the due process rights of the parties, I find the line of questioning about whether Dr. Schramm took nude photographs of Patient 1 in the fall of 2004 to be of such little probative value as to warrant its exclusion from the analysis in this report.

Dr. Schramm's Treatment of Patient 2

58. The Board charged Dr. Schramm with inappropriately taking nude or semi-nude photographs of Patient 2 in the spring of 2004, and with failing to treat or document his treatment of Patient 2. It also charged Dr. Schramm with prescribing benzodiazepines despite Patient 2's history of alcohol and cannabis abuse. In his report to the Board, Dr. Geier elaborated on these two charges: first, he stated that in 2004 it was "well established" that "benzodiazepines in general and Xanax in particular were 'cross-reactive' with substances of abuse such as alcohol and marijuana and should not be administered" to a patient like Patient 2, who had diagnoses of alcohol and cannabis abuse. This, according to Dr. Geier, constituted the failure to conform to minimal standards of care and was a violation of R.C. 4731.22(B)(6).
59. Dr. Schramm acknowledged that he prescribed the medications shown in the Board's charging document. He agreed he prescribed Xanax 1 mg #15 with two refills, on December 11, 2004. (Tr. at 44-47). He also agreed that in his initial evaluation of Patient 2, he found she was "easily anxious," had "mood swings [and] feels depressed," had been raped by a roommate, abuses alcohol and marijuana, and had a diagnosis of post-traumatic stress disorder and bipolar disorder. He also noted that Patient 2 "drinks beer, smokes pot since 14, helps to sleep." He said for the Axis IV assessment he found severe stress; no Axis III physical health problems associated with an Axis I diagnosis. For the Axis V scale, he found she was "doing better today than in the last year," so he put a score of 30 on Axis V. (Tr., 161-63)
60. Dr. Schramm said his plan was to see how Patient 2 responded to Celexa and thereafter he would add Topomax, which he said is a mood stabilizer, and then eventually Clonidine or Xanax for her anxiety. In addition, he testified that at some point, when she

was ready, he would refer her to the drug program at Cadas, which is in Dayton. He explained that he did not refer Patient 2 to Cadas at the outset because “I didn’t think she was ready for any of the therapy because her drinking and her alcohol use were very intermittent. I never saw her intoxicated or under the influence until several months had passed.” (Tr. at 163-64)

61. Dr. Geier expressed the view that this course of treatment fell below professional minimal standards. He noted that Dr. Schramm had identified Patient 2’s history of alcohol and marijuana abuse. Dr. Geier then testified that in his opinion, Xanax was not an appropriate medication choice because it is “cross-reactive with substances such as alcohol and marijuana and can lead to worsened use or relapse and should not be administered to patients with these conditions.” (Tr. at 242)
62. Dr. Schramm rejected this assessment, offering the opinion that it can be appropriate to prescribe cross-reactive drugs even if the patient is abusing alcohol or marijuana, “provided there are other things added to it.” Specifically, he noted that he would limit the prescriptions to small amounts, allowing him to closely monitor the patient, checking for any signs of adverse effects or any other reasons to discontinue the medication. (Tr. at 167)
63. Dr. Schramm disagreed with the premise that “if you prescribe a medication to a person who has a drug problem, that all of them will have this kind of problem,” explaining further that “at no time with any of these patients did I see any adverse effects or any reason to discontinue the medication or any effect that looked like there was any potentiation of any drug problem.” He added that in some instances, he reported seeing some of the drug use and drinking was occurring less frequently. He said the fact that Patient 2 was able to get to sleep with only occasional marijuana use, and was thus able to keep a job without being fired, in Dr. Schramm’s view, “verifies that the use of this medication to control the anxiety, which is the most troubling part of the clinical picture, is working well, and the patient is doing well with it, and we are not creating new problems or aggravating previous problems.” (Tr. at 167-68)

The Propriety of Establishing a Physician-Patient Relationship with Patients 1 and 2

64. According to Dr. Geier, it is below the standard of care for a physician to take semi-nude photos of a current patient, “especially if the photos were of a sexualized nature.” He said doing so “would constitute a sexual relationship with the patient, which would fall below the standard of care.” (Tr. at 235) Dr. Geier explained that the American Medical Association in its Medical Ethics Statement expressly provides that “[s]exual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct.” (Tr. at 238, and AMA Principles of Medical Ethics E-8.14)

65. Dr. Geier called explained the significance of the fact that Dr. Schramm entered into the physician-patient relationship after having established a close personal and sexual relationship with her. To reach this part of his report, Dr. Geier testified that when he began his review of the matter, he received a “Summary of Allegations,” and he was told to assume that “Dr. Schramm took nude photographs of [Patient 2] in or about Spring 2004.” (St. Ex. 14 at 7)
66. In following the instructions given to him, Dr. Geier concluded (in his written report) that if Dr. Schramm took nude photos of Patient 2 in the spring of 2004, the decision to accept Patient 2 as a patient and then treat Patient 2 in July of 2004 was conduct that fell below minimum standards for the profession. He wrote in his report (without having seen any photos) that “this would fall below the standard of care in 2004 for any physician as constituting a sexual relationship with a patient. Such a relationship would be improper per se, and represent a betrayal of patient trust and confidentiality.” (St. Ex. 14 at 8)
67. To support its charges against Dr. Schramm, the State repeatedly sought to introduce evidence that Dr. Schramm took nude photographs of Patient 1 and semi-nude photographs of Patient 2 before and, in the case of Patient 1, after, they became his patients. State’s Exhibit 12 includes pictures of Patient 1 nude and in sexually suggestive poses, and the State offered them alleging that these were taken in the fall of 2004. There is, however, no reliable evidence supporting the State’s claim that Dr. Schramm took the pictures found in State’s Exhibit 12. When the State showed Dr. Schramm the pictures contained in State’s Exhibit 12, he testified that he did not take these pictures and that he has *never* taken nude pictures of Patient 1 or Patient 2. The Hearing Examiner found this testimony to be highly credible: Dr. Schramm throughout the proceedings made candid admissions against his interest, and appeared to give full, non-evasive answers to all questions put to him. Further, he admitted that before Patient 2 became his patient, he did take the pictures of Patient 2. Those pictures, shown at State’s Exhibit 13, depict Patient 2 in poses that are sexually suggestive and in some cases depict Patient 2 partially undressed. Accordingly, there is no support in the record for the proposition – contained in the “Summary of Allegations” that the Board supplied to Dr. Geier – that Dr. Schramm ever took any nude pictures of either Patient 1 or Patient 2. (Tr. at 170, 177)
68. While there is insufficient evidence in the record to support the charge that Dr. Schramm took pictures of a sexual nature of Patient 1, the record amply demonstrates he took pictures of Patient 2 three months before establishing a physician-patient relationship, and that those pictures are of a sexual nature. The pictures are in the record at State’s Exhibit 13, and Dr. Schramm’s patient records, shown at State’s Exhibit 3-A, reflect that Patient 2 first saw Dr. Schramm on July 12, 2004. Dr. Schramm testified that he took these pictures in April 2004. (Tr., at 161, 171-72)
69. Dr. Geier was incorrectly told to assume Dr. Schramm took nude photographs of Patient 2, and his report to the Board was based on that mistaken assumption. Nevertheless, the

pictures Dr. Schramm took were of a sexual nature. (St. Ex. 13 and St. Ex. 14) During the evidentiary hearing, once Dr. Geier examined the pictures Dr. Schramm took of Patient 2, he reached the same conclusion he reached during his initial assessment: These photographs are “of a partially nude person, and they’re sexual photographs because they are highlighting really sexual positions and they are sexually suggestive positions.” (Tr. at 278)

70. Dr. Geier’s analysis of Dr. Schramm’s conduct with Patient 2 is based on the premise that Dr. Schramm took these pictures three months before establishing a physician-patient relationship with Patient 2. As a result, Dr. Geier’s analysis of the charges concerning Dr. Schramm taking pictures of Patient 2 expressly takes into account the premise that the picture taking preceded the actual establishment of a physician-patient relationship. Dr. Geier wrote that such a relationship “would be improper, *per se*, and represent a betrayal of patient trust and confidentiality.” (St. Ex. 14, at 7-8)
71. Even though Patient 2 was not Dr. Schramm’s patient when Dr. Schramm took the sexually suggestive photographs, it was wrong for Dr. Schramm to establish a patient relationship shortly after taking those pictures. Timing makes a difference, according to Dr. Geier, where he noted: “The close proximity in time of Spring 2004 and July 2004, in my opinion, indicated that when Dr. Schramm took on [Patient 2] as a patient, he had, assuming he took nude photographs of [Patient 2], a concurrent sexual relationship with her, and/or at the least non-sexual contact with her that may be perceived as sexual contact.” Even though the pictures taken were, in fact, not nude, they were nevertheless sexual in nature. Applying the doctrine he set forth in his assessment of Patient 1, Dr. Geier reached the same conclusion during the hearing, this time with evidence that ultimately backed up his position: “Dr. Schramm’s assumed previous sexual relationship with [Patient 2] would be expected to negatively influence his objective judgment toward his patient, potentially exploit vulnerabilities of the patient, and detract from the goals of a physician-patient relationship.” (St. Ex. 14 at 8). Dr. Geier summarized the AMA Principles applicable here:
 - Article I, which commands the physician’s “respect for human dignity” for a patient, was violated by taking these pictures;
 - Article II, which requires the physician uphold the “standards of professionalism” was violated as well;
 - Article IV, which requires the physician to “respect the rights of patients” and which requires the physician to “safeguard patient confidences and privacy” was violated when he failed to respect Patient 2’s right to be treated in a non-sexual manner;
 - Article VIII, which requires the physician to regard patient responsibility as paramount, was violated “with this irresponsible behavior.” (St. Ex. 14 at 8-9 and Tr. at 245-47)

72. When asked about the fact that Dr. Schramm took these pictures in the spring of 2004 and did not start treating her until July 2004, Dr. Geier explained that this still constitutes conduct that falls below the standard of care, “because the taking of sexual photographs would constitute a sexual relationship, and it would be my opinion that he should not have taken on the patient to begin with.” He said this is because “there is the perception of a sexual relationship which could impair the physician’s judgment regarding his patient.” He added that the relationship also could “exploit vulnerabilities of the patient.” (Tr. at 244-45)
73. Dr. Geier explained that the same concerns arise with the evidence that Dr. Schramm went to The Living Room in October of 2004 and engaged in lap dances with Patient 1 after the start (in September 2004) of the formal physician-patient relationship with Patient 1. Engaging in lap dances with a current patient would constitute sexual contact or sexual misconduct under the Principles of Medical Ethics, and it would constitute a deviation from the standard of care – because the standard of care prohibits “a sexual relationship with the patients” so as not to “betray the patient’s confidences and vulnerabilities.” (Tr. at 247-48)
74. Given his relationships with both Patient 1 and Patient 2 during the spring and summer of 2004, Dr. Schramm attempted to explain his understanding of the ethical implications under the Board’s rules. Dr. Schramm said at the time, he felt it was appropriate to begin a patient relationship with Patient 1 in September, despite his personal relationship with her; but that now he does not think it was appropriate. He explained what he learned by going through the administrative process with the Board:

[B]eing here today, it’s much clearer to me that this introduces some things that are really hard to explain to people. I felt that I was able to keep a close eye on what was happening between me and the patient, and a few things went further than they should, I think. Until we have a rule that says psychiatrists aren’t allowed to establish friendships with people, I think this is kind of a problem that will be recurring, kind of a difficulty because you get to know people, you meet them, a friendship develops, and you get to know more things, and there are problems that need attention.

(Tr. at 148-49)

Dr. Schramm’s Treatment of Patient 3 – Failure to Timely Refer to an Expert in Medical Care

75. Dr. Schramm first saw Patient 3 in January of 2005. He said the initial diagnosis was “probably bipolar disorder, rule out post-traumatic stress because she had been so abused

and suffered severe anxiety and insomnia and had flashbacks of these traumatic events.” (Tr. at 355; St. Ex. 8) Dr. Schramm noted Patient 3 was also suffering severe pain because of physical injuries she sustained when she was beaten by someone using a baseball bat. (Resp. Ex. A, p. 2).

76. Dr. Geier expressed the opinion that Dr. Schramm’s three-month delay in referring Patient 3 to an orthopedist for proper evaluation and treatment of her physical ailments constituted a failure to conform to minimal standards. (St. Ex. 14 at 10)
77. In his report, Dr. Schramm rejected Dr. Geier’s conclusions, and wrote that the pain medications he prescribed “are consistent with accepted minimal standards” and the course of his treatment of Patient 3 “was within accepted practices and standards of care under the circumstances of her treatment.” (Resp. Ex. A at 2) He also said he agreed that Patient 3 needed an orthopedic evaluation. However, he said he assisted her, “either the day of the first appointment or before that,” by giving her “some phone numbers of possible resources” but that “she came up with nothing,” and he added that “in the Dayton area, I think that’s typical.” (Tr. at 355-56)
78. Dr. Schramm testified that as was the case with Patient 1, he recommended Patient 3 see Dr. Paley, and he went so far as to call Dr. Paley himself on Patient 3’s behalf. When Dr. Paley turn down the request (because Dr. Paley “wasn’t aware of any way to obtain a proper evaluation without insurance”), Dr. Schramm explained this to Patient 3 and continued to treat her – continuing the pain medication “to see if we could get better relief.” (Tr. at 357) He also recommended that Patient 3 contact other health care providers including the Health Department and the Combined Health District, but “they weren’t aware of any resources in the community that would provide this evaluation at no charge.” He told her to keep using crutches, and continued to prescribe the pain medication. With progress in the course of therapy, “her anxiety increased, and that’s the reason for increasing the dose of the Alprazolam and Xanax.” In his view, this course of treatment was in accordance with the minimum standards of care for Patient 3’s condition. He added that one of Dr. Paley’s sons eventually did see Patient 3 and “ended up doing arthroscopic surgery,” which Dr. Schramm personally paid for, in the amount of \$4,000.00. (Tr. at 359, 363)
79. In both his written analysis based on the records presented to him and during his testimony at the hearing, Dr. Geier found that Dr. Schramm waited three months to refer Patient 3 to an orthopedist, but should have initiated this much sooner. He wrote that “the standard of care would be to have experts in medical care, such as a primary care doctor, or urgent care or emergency department,” evaluate the patient to find the underlying cause of her pain. “The expert in medical care would then be the treating doctor for the medical problems, and would also be responsible for pain management, if warranted.” According to Dr. Geier, it was inconsistent with the standard of care for Dr.

Schramm to have instituted and maintained a trial of narcotic pain medications without also having expert evaluation and management. (St. Ex. 14 at 9-10 and Tr. at 249-50)

Dr. Schramm's Allocution to the Board

80. When given the opportunity to directly address the Board at the end of the hearing, Dr. Schramm said he felt "all along in my career that there has been opposition to what I call the adequate and proper treatment with certain people." He explained that particularly with persons suffering from post-traumatic stress syndrome, the disability "impacts on their ability to trust people, which I think is a major point." He said patient success with 12-step programs depends in part on trust in God, and the patients he has seen "haven't got the ability to trust God or anybody that much." He said this is one of the "primary reasons for treatment failures of these people who are chemically dependent because they are prejudiced against." (Tr. at 367)
81. Applying this to the case at hand, Dr. Schramm said "the post-traumatic stress category is one where I think there is some real discrimination and a lot of ineffective and inappropriate treatment because the patients are not ready upon referral to chemical dependency programs until they can start to trust somebody, which is the primary reason I didn't refer these three women initially into any drug treatment." Dr. Schramm also explained that "when you have someone who is on pain medications," whether it's heroin or other medications, there is a common belief by the public that "they shouldn't get anything to relieve that pain." Such patients' persistent pain "will enhance their depression" so that "then you have a person who is not only depressed and hurting, but is also suicidal." He said this was the case with Patient 3: "we worked all of the time for the first five months at least, in therapy to deal with her depression and her suicidal thinking. It was a matter of keeping her alive." (Tr. at 368-69)
82. In conclusion, Dr. Schramm said:
- Those are the points I wanted to make. I would like to think I serve as an example. We have a concern about risks with all these medications. And I think, as I said earlier, if these medications that we're taking a chance with are prescribed in small quantities, that makes it necessary to see them more frequently, and I think we have some way of assuring that we can monitor the patient well enough to be able to spot problems if they show up, and we can always back up if that's happening. I can write one prescription, but it doesn't mean that I have to write the second one if they are getting into trouble.

(Tr. at 369)

ANALYSIS

In his closing argument, Dr. Schramm proposes that this case turns upon beliefs – specifically about Dr. Schramm’s rejection of what he describes as the belief that “an addict should suffer in pain simply because there is a possibility of cross-reaction or of the patient abusing prescription medication.” (Respondent’s Closing Argument at 2) A more apt characterization, however, is that this case calls for the Board to exercise its authority over a physician whose course of conduct in the waning years of his professional practice has tread perilously close to threatening the safety of three patients – patients whom he clearly cares deeply for but has nonetheless exposed to real danger.

The record presents the Board with an ample basis for finding that Dr. Schramm’s selection of medication for both Patient 1 and Patient 2 fell below acceptable professional standards. Prescribing cross-reactive narcotic opioids to a heroin addict can promote continued heroin dependence. Patient 1 sought Dr. Schramm’s help in clearing her dependence, but there is nothing in the record that suggests Dr. Schramm’s prescription regimen did anything to help Patient 1 achieve this goal (or even make a start toward that goal). It is no answer to say, in effect, “I’m monitoring the patient.” Minimal standards of practice in effect in 2004 required more from the physician, including the physician’s appreciation for the counter-productive effect of prescribing these drugs for substance abusers. Dr. Schramm did not deny the cross-reactive character of the medications he prescribed for Patient 1 and Patient 2. Instead, he denied the risk attributed to the prescription regimen. In the face of the informed expert testimony now before the Board, that denial must fall.

The record further establishes a troubling pattern of a physician neglecting the needs of his patients. Patient 1 suffered from bipolar disorder, and received no treatment for it; she reported a history of childhood rape and family conflict, and again received no treatment for this. Patient 1 and Patient 2 both were candidates for drug detoxification and rehabilitation, yet received neither. When he met her, Patient 3 was still on crutches after having been beaten with a baseball bat. While the record shows Dr. Schramm did eventually recommend Patient 3 to an orthopedist, the recommendation came, in Dr. Geier’s words, “three months late.” The danger from this course of conduct was not limited to the three patients: Dr. Schramm’s knowledge that Patient 1 had a very young son living in the home should have triggered a prophylactic response, one that would enlist the assistance of child protective workers who could conduct an impartial assessment of the child’s home circumstances. Instead, Dr. Schramm’s response was to medicate the mother, leaving the child at risk.

With respect to the charges concerning the ethical implications of Dr. Schramm’s decision to accept Patient 1 and Patient 2 as patients, the record is clear: Dr. Schramm should have known that he was barred from providing professional psychiatric services to either patient in the summer and fall of 2004. This conclusion is not premised on the presence or absence of photographs: indeed, the photographs appear to have little or no forensic value here, suggesting their inclusion was designed to debase and embarrass both the doctor and his patients. The conclusion that Dr. Schramm violated the ethical standards cited by the Board is based on the fact that by the time he established professional relationships with these two patients, he was

already far too closely and intimately involved with the women to be qualified to provide the kind of services required of a psychiatrist.

Friendship based on the kind of intimacy occasioned by participation in a lap dance is, by its *nature*, sexual in nature. Beyond that, the record makes clear that Dr. Schramm cared very much about these two patients, and sought to help them by hiring them to work at his office in addition to hiring them to dance for him. If, however, there had been any question about the conflict present in his relationship with Patient 1 prior to the reported start of the physician-patient relationship, then all doubt passed once it became clear that Dr. Schramm was still patronizing The Living Room and was still hiring Patient 1 to dance for him in October, 2004, several weeks after establishing the formal physician-patient relationship. So too, Dr. Geier's point concerning Patient 2 is well taken: there was without question a sexual relationship established when Dr. Schramm took the pictures shown in State's Exhibit 13. Initiating a physician-patient relationship so soon afterwards was profoundly unprofessional, and Dr. Schramm should have known this before accepting Patient 2 as his patient.

The Board's final charge against Dr. Schramm likewise has been proved, albeit in a limited way. The record establishes that, as his counsel points out, Dr. Schramm "made a mistake by not keeping better records after his wife died." (*Id.* at 4) The grid on pages 2 and 3 of the Board's amended charges overstates the case, however, because there is insufficient evidence to establish Dr. Schramm failed to maintain prescription records for Patient 3 – certainly the State's expert, Dr. Geier, found no such failure. That point aside, however, the record is clear that Dr. Schramm's record-keeping practices in the records maintained for Patient 1 and Patient 2 fell seriously below applicable professional standards.

Collectively considered, the facts supporting these charges, and Dr. Schramm's responses to the charges, present a troubling picture of professional misconduct and neglect. These errors were not born out of ignorance or sloth – on the contrary, Dr. Schramm knew what he was doing when he accepted Patient 1 and Patient 2 as patients, and knew (or should have known) what Patient 3 needed when she sought his help. The practice errors attributed to Dr. Schramm put these three patients at risk, and warrant a disciplinary sanction that is punitive, that protects the public, and that is exemplary. Dr. Schramm is correct when he states that there is no rule against psychiatrists establishing friendships with people – but that's not what happened here. Before they became his patients, Dr. Schramm's friendships with Patient 1 and Patient 2 had matured into two sexual relationships, relationships that gave rise to the unmistakable duty to decline to treat these patients and to refer them to a provider who was not burdened with this kind of close personal tie. In the breach of this duty, Dr. Schramm turned his back on fundamental practice principles. Accordingly, Dr. Schramm's certificate to practice medicine in Ohio should be permanently revoked.

FINDINGS OF FACT

1. The Respondent, Arthur Richard Schramm, M.D., is licensed to practice medicine and surgery in Ohio. Dr. Schramm has been practicing psychiatry in Ohio for approximately

40 years. There is no evidence suggesting Dr. Schramm has ever been disciplined prior to these proceedings.

2. Between January and September 2004, Dr. Schramm had established a sexual relationship with Patient 1, by hiring Patient 1 to perform lap dances with him at The Living Room, a Dayton-area club. In this context, a lap dance is where the patron remains seated and clothed, and the dancer removes most of her clothing, save for panties and shoes, and dances both near the patron and on the lap of the patron. Between January and September 2004, Dr. Schramm maintained a close personal relationship with Patient 1. That relationship included making repeated visits to her home, meeting her eight-month-old son, hiring her to do clerical work at his office, inviting her to his home, having her perform lap dances at his office, and patronizing her when she worked as a dancer at The Living Room. On September 3, 2004, Dr. Schramm accepted Patient 1 as a patient, diagnosing her as being addicted to heroin with bipolar disorder. In September and October 2004, after diagnosing Patient 1 and while medically treating her, Dr. Schramm continued his close personal relationship with Patient 1, and continued to patronize Patient 1 at The Living Room, where she would perform lap dances for Dr. Schramm.
3. In early spring 2004, Dr. Schramm met Patient 2, a 21 year-old female whom he diagnosed as having bipolar disorder and whom he found abused marijuana and alcohol. Between April 2004 and July 2004, and prior to establishing a physician-patient relationship with Patient 2, Dr. Schramm established a sexual relationship with Patient 2, by hiring her to perform lap dances with him at a Dayton-area club. Dr. Schramm also took photographs of Patient 2 in April 2004, at Patient 2's request. Those photographs depicted Patient 2 in poses that were of a sexual nature and were sexually suggestive. In July 2004, while maintaining this relationship and developing a close personal friendship with Patient 2, Dr. Schramm established a physician-patient relationship.
4. There is no reliable and substantial evidence that Dr. Schramm ever took nude pictures of Patients 1 or 2.
5. In treating Patient 1 in September and October 2004, Dr. Schramm knew that Patient 1 was addicted to heroin, and nevertheless prescribed Schedule II and III controlled opioids (Vicodin ES, #10 on September 24, 2004, Oxycontin 20 mg #10 on October 5, 2004, Oxycontin 40 mg #10 on October 18, October 23, October 28, and November 9, 2004, and MSContin 60 mg #15 on October 29, 2004); and benzodiazepine (Xanax 1 mg #20) on two occasions (November 30, 2004 with two refills, and December 4, 2004). Opioids and benzodiazepine are cross-reactive with heroin, in that they can promote continued heroin dependence or addiction, or relapse in a person who has abstained from heroin, and should not be prescribed to a person with a substance abuse problem in general, or specifically heroin addiction or dependence.

6. Although he knew that Patient 1 was addicted to heroin, Dr. Schramm failed to refer Patient 1 to a drug treatment program.
7. In September and October 2004, although he knew Patient 1 was addicted to heroin and was living with her husband, who was abusing cocaine, and knew that Patient 1's eight-month-old son lived with them in the household, Dr. Schramm failed to report the child's circumstances to Child Protective Services.
8. Between September and December 2004 on four occasions, Dr. Schramm prescribed stimulant medications for Patient 1 (Adderall XR 20 mg #10 on September 27, 2004, Ritalin 10 mg #10 on October 11, 2004, and Ritalin 20 mg. #20 on October 18 and December 4, 2004). Dr. Schramm prescribed these stimulant medications without documenting an appropriate evaluation of Patient 1, and without documenting a diagnosis to support these prescriptions.
9. When he first examined Patient 1 in September 2004, Dr. Schramm diagnosed her as having post-traumatic lumbosacral strain. Dr. Schramm did not document making a proper evaluation of the back problems, and began a course of narcotic pain medications prior to referring her to an orthopedic doctor, urgent care facility, or emergency department.
10. When he first examined Patient 1, Dr. Schramm also diagnosed her as having bipolar disorder. From September 2004 to October 2005, Dr. Schramm failed to treat Patient 1 for this condition.
11. When Dr. Schramm first examined Patient 1, she reported that she had been raped when she was seven years old and that she had a history of conflict with her mother. Dr. Schramm failed, however, to document providing appropriate psychotherapy to address these issues.
12. In treating Patient 2 in December 2004, Dr. Schramm knew that Patient 2 was abusing alcohol and marijuana, and nevertheless prescribed a benzodiazepine (Xanax 1 mg #15 with two refills), which is cross-reactive with substance abuse generally and should not have been administered to a patient who had a diagnosis of alcohol and marijuana abuse.
13. In treating Patient 1 Dr. Schramm failed to accurately reflect in his records the following prescriptions:

Patient #	Date	Prescription
1	09/27/04	Adderall XR 20 mg #10
1	09/29/04	Vicodin ES #10
1	10/05/04	Oxycontin 20 mg #10
1	10/11/04	Ritalin 10 mg #10

1	10/18/04	Ritalin 20 mg #20
1	10/28/04	Vicodin ES #20
1	11/09/04	Oxycontin 40 mg #10
1	11/21/04	Xanax 1 mg #20
2	12/11/04	Xanax 1 mg #15 w/2 refills

14. Upon finding cause to believe grounds existed to take action with respect to his certificate to practice medicine and surgery in Ohio, the Board set forth its charges against the Respondent in a notice dated February 8, 2006. Thereafter the Board issued an amended notice, dated September 13, 2006. In a written response dated September 28, 2006, and received by the Board on October 4, 2006, the Respondent invoked his right to have an administrative review of the charge, and in a letter dated October 5, 2006, the Board acknowledged its receipt of the Respondent’s request for a hearing. The Board then set the matter for a hearing to commence on October 18, 2006, continued the hearing, appointed an administrative hearing examiner, and provided the parties with an opportunity to be heard on the charges in an evidentiary hearing conducted on November 2, 2006.

CONCLUSIONS OF LAW

1. Because he holds a certificate to practice medicine and surgery in Ohio, the Respondent, Arthur Richard Schramm, is subject to the jurisdiction of the State Medical Board of Ohio with respect to that certificate.
2. After it received evidence indicating that Dr. Schramm may have violated laws pertaining to the practice of medicine in Ohio, the Board set forth a written notice of charges in a letter dated February 8, 2006, and thereafter amended that notice in a charging document dated September 13, 2006. Upon its receipt of the Respondent’s request for a hearing, the Board set the matter for hearing in the manner provided for by R.C. 119.07 and 119.09 (the Administrative Procedure Act), and provided the Respondent with an opportunity to be heard, all in the manner provided for by law and in accordance with all statutory and constitutional protections afforded to persons possessing such a certificate.
3. When providing medical care or treatment, a physician in Ohio is required to “maintain minimal standards applicable to the selection or administration of drugs” and is required 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 (Anderson 2006).
4. When providing medical care or treatment, a physician in Ohio is also required to “conform to minimal standards of care of similar practitioners under the same or similar conditions,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code (Anderson 2006).

5. It was well established in 2004 in the medical community that narcotic opioid substances, including Vicodin, Oxycontin, and MSContin, are cross-reactive with heroin and can promote continued heroin dependence or addiction; and that they should not be prescribed to a person with heroin addiction. By at least a preponderance of the evidence, the State has proved that from September to November 2004, Dr. Schramm prescribed narcotic opioids to Patient 1, knowing that she was addicted to heroin. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the selection of drugs, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
6. It was well-established in 2004 in the medical community that benzodiazepine medication (including Xanax) is cross-reactive with heroin, and with other substances of abuse such as alcohol and marijuana; and that Xanax should not be prescribed to a person who is addicted to heroin or to a person who abuses alcohol or marijuana (or both). By at least a preponderance of the evidence, the State has proved that in November 2004, Dr. Schramm prescribed Xanax to Patient 1, knowing she was addicted to heroin, and in December 2004, Dr. Schramm prescribed Xanax to Patient 2, knowing she abused both alcohol and marijuana. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the selection of drugs, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1 and Patient 2. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
7. It was well-established in medical practice in 2004 that controlled stimulant medication, including Adderall XR and Ritalin, could be diverted to illicit use if prescribed to individuals with reported drug problems (such as cocaine abuse or heroin addiction); and that because there is a high probability of abuse, these medications should not be prescribed to such individuals. By at least a preponderance of the evidence, the State has proved that in October 2004, Dr. Schramm prescribed Adderall XR and Ritalin to Patient 1, knowing that she was addicted to heroin and knowing that her husband was living with her and was abusing cocaine. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the selection of drugs, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
8. It was well established in medical practice in 2004 that before prescribing medications, the prescribing physician was required document in the patient records the disorder for

which the medications were indicated. By at least a preponderance of the evidence, the State has proved that in September and October 2004, Dr. Schramm prescribed Adderall XR and Ritalin for Patient 1, without any documentation of a disorder for which these medications were indicated. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the selection of drugs, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).

9. It was well-established in medical practice in 2004 that upon diagnosing a patient as having post-traumatic lumbosacral strain, the physician should have an expert in back problems (such as an orthopedic doctor) evaluate the patient to determine the underlying cause of the pain; or, if the physician is such an expert, he or she should document in the patient records evidence of such an evaluation; and that this evaluation should take place before instituting and maintaining a trial of narcotic pain medications. Further, upon such an evaluation, the expert in back problems would then be the treating doctor for the back problems, and would be responsible for pain management. By at least a preponderance of the evidence, the State has proved that Dr. Schramm is not an expert in back problems, and that he nevertheless began a trial of narcotic opioids pain medications for Patient 1 without a documented evaluation of her underlying condition. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the administration of drugs and in the selection of treatment modalities, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
10. Similarly, when a psychiatrist who is not a primary care doctor is presented with a patient who has been beaten and in need of pain management, the standard of care would be to have experts in medical care, such as a primary care doctor, or urgent care or emergency department, evaluate the patient for the underlying cause of her pain; and thereafter that doctor would be the treating doctor for both the medical problems and pain management. By at least a preponderance of the evidence, the State has proved that in January 2005, Dr. Schramm diagnosed Patient 3 with having been beaten by someone using a baseball bat, and began a trial of narcotic pain medications without a documented evaluation of the patient's underlying condition. The evidence further establishes that Dr. Schramm continued in this course of treatment for three months, before referring Patient 3 to an orthopedic doctor. This evidence proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
11. The State has established, by at least a preponderance of the evidence, that on September 3, 2004, Dr. Schramm diagnosed Patient 1 with bipolar disorder, and that he met with

Patient 1 until November 3, 2005, without ever attempting to treat this condition with appropriate medication, as would have been the standard in 2004. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the selection of drugs and in the selection of treatment modalities, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).

12. The State has established, by at least a preponderance of the evidence, that on September 3, 2004, Patient 1 reported to Dr. Schramm that she had been raped when she was seven years old and had a history of conflict with her mother; and that Dr. Schramm met with Patient 1 until November 3, 2005, without ever attempting to conduct psychotherapy regarding these issues or refer the patient for individual or group psychotherapy, as would have been the standard in 2004. Upon this evidence, the State has proved Dr. Schramm failed to maintain minimal standards applicable to the selection of treatment modalities, and in this manner violated R.C. 4731.22(B)(2) in his treatment of Patient 1. The same evidence also proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
13. When presented with a patient having a diagnosis of heroin addiction, the standard of care would dictate that the patient participate in a drug treatment program concurrently with or following detoxification. The State has established, by at least a preponderance of the evidence, that Dr. Schramm diagnosed Patient 1 with heroin addiction and then failed to refer her to a drug treatment program in a timely manner. This evidence proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).
14. When presented with a patient who is addicted to heroin and is the custodial mother of an eight-month-old child who is in the household where the patient's husband is an unemployed cocaine abuser, there is evidence that the child is at risk of harm or neglect. Upon this evidence the standard of care would dictate that the physician report the child's circumstances to Child Protective Services. The State has established, by at least a preponderance of the evidence, that Dr. Schramm diagnosed Patient 1 with heroin addiction, knew from personal observation in January 2004 that Patient 1 was living in a home with her husband, an unemployed cocaine abuser, and that they were caring for Patient 1's eight-month-old son in the home; and that Dr. Schramm failed to report this to Child Protective Services, either during the time before he formally established a physician-patient relationship, or between September 3 and November 3, 2004, when he was treating Patient 1. This evidence proves Dr. Schramm failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, and in this manner violated 4731.22(B)(6).

15. A physician whose conduct violates “any provision of a code of ethics of the American Medical Association” may be disciplined pursuant to Section 4731.22(B)(18). Under the Preamble to the AMA’s “Principles of Medical Ethics (June 2001)”, as a member of the medical profession, a physician “must recognize responsibility to patient first and foremost, as well as to society, to other health professionals, and to self.” Among the relevant principles applicable to Dr. Schramm in this case is the requirement that a physician shall be “dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”
16. In its “Opinion on Practice Matters: Sexual Misconduct in the Practice of Medicine,” (E-8.14)¹ the AMA addresses the ethical implications of sexual contact that arises “concurrent with the physician-patient relationship” by noting such contact constitutes sexual misconduct. According to this Opinion, the theoretical bases for declaring such contact to be misconduct are that a sexual or romantic interaction between a physician and a patient may (1) detract from the goals of the physician-patient relationship; (2) may exploit the vulnerability of the patient, (3) may obscure the physician’s objective judgment concerning the patient’s health care; and (4) may ultimately be detrimental to the patient’s well-being.
17. Upon these theoretical bases, the AMA in its Principles of Medical Ethics prohibits sexual misconduct. The Principles supporting this prohibition are (Principle I) that a physician “shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights,” (Principle II) that a physician shall “uphold the standards of professionalism,” and (Principle IV) that a physician shall “respect the rights of all patients . . . and shall safeguard patient confidences and privacy[.]”
18. Where a psychiatrist is treating a patient for heroin addiction and bipolar disorder, the physician-patient relationship is established. During the term of that relationship, sexual contact between the psychiatrist and the patient is prohibited by the AMA in its Principles of Medical Ethics, as set forth above. During the term of that relationship, when the treating physician hires his patient to perform lap dances as described in the foregoing findings of fact, the physician has engaged in sexual misconduct. The State has established, by at least a preponderance of the evidence, that Dr. Schramm engaged in sexual misconduct with Patient 1 during the course of his treatment of Patient 1. Upon such proof, the State has established that Dr. Schramm violated “[a] provision of a code of ethics of the American Medical Association” and that he may be disciplined pursuant to Section 4731.22(B)(18).
19. Where a psychiatrist engages the services of potential patient who is a lap dancer, and thereafter establishes a close personal relationship with the potential patient, and where upon the potential patient’s request the psychiatrist takes sexually suggestive

¹ Issued December 1989; Updated March 1992 based on the report "Sexual Misconduct in the Practice of Medicine," adopted December 1990 (JAMA. 1991; 266: 2741-2745).

photographs of the potential patient, the relationship between the psychiatrist and the potential patient is a sexual relationship. Where such a relationship develops and is maintained within a period from January 2004 to July 2004, the psychiatrist is prohibited from establishing a physician-patient relationship in July 2004, and entering into such a professional relationship constitutes a violation of the AMA's Principles of Medical Ethics, as set forth above. The State has established, by at least a preponderance of the evidence, that Dr. Schramm entered into and maintained an ongoing sexual relationship with Patient 2 between January and July 2004, and then entered into a physician-patient relationship with Patient 2 on July 12, 2004. Upon such proof, the State has established that Dr. Schramm violated "[a] provision of a code of ethics of the American Medical Association" and that he may be disciplined pursuant to Section 4731.22(B)(18).

20. By Rule, a physician is required to "create and maintain accurate medical records." Rule 4731-11-02(D) (Anderson 2006). Failing to conform to such a Rule is a violation of Section 4731.22(B)(20) ("violating . . . any provision of this chapter or any rule promulgated by the Board"), and constitutes a violation of both R.C. 4731.22(B)(2) (minimal standards applicable to the selection or administration of drugs) and R.C. 4731.22(B)(6) (conforming to minimal standards of care for the profession). It was well established in medical practice in 2004 that upon prescribing controlled medications, a physician should, consistent with the minimal standard of care, document the date of the prescription, the quantities of the drugs prescribed, and the reasons for the prescription. The State has established, by at least a preponderance of the evidence, that Dr. Schramm failed to document the prescription and administration of those drugs shown above in Finding of Fact 13. This evidence proves Dr. Schramm violated Rule 4731-11-02(D), and also proves Dr. Schramm violated R.C. 4731.22(B)(2) in the administration of drugs, and failed to conform to minimal standards of care of similar practitioners under the same or similar conditions, in violation of R.C. 4731.22(B)(6).
21. Upon sufficient proof that the Respondent has violated any provision of R.C. 4731.22, as has been demonstrated by the foregoing findings of fact and conclusions of law, the Board, by an affirmative vote of not fewer than six of its members, shall to the extent permitted by law, limit, revoke or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate, all pursuant to R.C. 4731.22(B). Further, when the Board revokes an individual's certificate to practice, it may specify that the action is permanent. An individual subject to 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 the issuance of a new certificate. See R.C. 4731.22(L) (Anderson 2005).

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Arthur Richard Schramm to practice medicine and surgery in Ohio is PERMANENTLY REVOKED.

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

A handwritten signature in black ink, appearing to read "McNeil", written over a horizontal line.

Christopher B. McNeil, Esq.
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.

.....

ARTHUR RICHARD SCHRAMM, M.D.

.....

DR. DAVIDSON MOVED TO APPROVE AND CONFIRM MR. MCNEIL'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER IN THE MATTER OF ARTHUR RICHARD SCHRAMM, M.D. MR. BROWNING SECONDED THE MOTION.

.....

A vote was taken on Dr. Steinbergh's motion to approve and confirm:

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	- aye

The motion carried.



State Medical Board of Ohio

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AMENDED NOTICE OF OPPORTUNITY FOR HEARING

September 13, 2006

Arthur Richard Schramm, M.D.
11060 Wolf Creek Pike
Brookville, OH 45309

Dear Doctor Schramm:

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 after 2004 and 2005, you undertook the care of Patients 1-3, as identified on the attached Patient Key, in the course of your psychiatric practice (Patient Key confidential and to be withheld from public disclosure).
- (2) In or about the spring of 2004, you took partially nude photographs of Patient 2, and, in or about November 2004, you took partially nude and/or nude photographs of Patient 1.
- (3) In your care of Patient 1, you inappropriately treated and/or failed to appropriately treat and/or failed to document your treatment of Patient 1. Examples of such conduct include, but are not limited to, the following:
 - (a) You inappropriately prescribed Schedule II and III controlled opioids, stimulants and benzodiazepines to Patient 1 despite her advising you that she was addicted to heroin.
 - (b) You failed to refer and/or document the referral of Patient 1 to a drug treatment program despite her advising you that she was addicted to heroin.
 - (c) You failed to report and/or document the reporting of Patient 1 to Child Protection Services, despite your knowledge that Patient 1 had an eight-month-old son living in a household with Patient 1, a self-described heroin addict, and with Patient 1's husband, whom Patient 1 reported to you as abusing cocaine.

Mailed 9-14-06

- (d) You prescribed the Schedule II stimulants Adderall XR and Ritalin to Patient 1 without evaluating and/or documenting an appropriate evaluation of Patient 1, and/or without rendering a diagnosis and/or documenting a diagnosis to support the prescribing of those stimulants.
 - (e) You failed to timely refer and/or document the timely referral of Patient 1 to the proper specialist for evaluation of reported "Post-trauma lumbrosacral strain."
 - (f) Although you diagnosed Patient 1 with "Bipolar/Mixed," you failed to treat and/or document the treatment of this condition with appropriate medication.
 - (g) Although you report in your record for Patient 1 that Patient 1 described a history of rape and conflict with her parents, you failed to provide and/or document the provision of appropriate psychotherapy and/or refer and/or document the referral of Patient 1 for individual or group psychotherapy to address this issue.
- (4) In your care of Patient 3, you inappropriately treated and/or failed to treat and/or document the appropriate treatment of Patient 3. For example, you inappropriately prescribed Schedule II and III controlled opioids to Patient 3 for a period of three months and failed to timely refer Patient 3 to the proper specialist for evaluation.
- (5) In your care of Patient 2, you inappropriately treated and/or failed to treat and/or document the appropriate treatment of Patient 2. For example, you inappropriately prescribed scheduled benzodiazepines to Patient 2 despite her advising you of a history of alcohol and cannabis abuse.
- (6) You failed to accurately reflect in your medical records controlled substance prescriptions for Patients 1 through 3 as follows:

Patient number	Date	Prescription
1	09/27/04	Adderall, XR 20 mg #10
1	09/29/04	Vicodin ES #10
1	10/05/04	Oxycontin 20.mg #10
1	10/11/04	Ritalin 10 mg #10
1	10/18/04	Ritalin 20 mg #20
1	10/18/04	Vicodin ES #20
1	10/28/04	Oxycontin 40 mg #10
1	11/09/04	Oxycontin 40 mg #10
1	11/21/04	Xanax 1 mg #20
3	01/23/05	Percocet 10/650 #10
3	01/23/05	Vicodin HP #20
3	01/29/05	Valium 10 mg #15 w/ 2 refills

3	01/29/05	Percocet 5/325 #20
3	02/01/05	Valium 10 mg #10 w/ 2 refills
3	02/07/05	Valium 10 mg #20 w/ 2 refills
3	02/07/05	Percocet 5/325 #20
3	02/08/05	Percocet 5/325 #20
3	02/14/05	Diazepam 10 mg #60 w/ 1 refill
3	02/15/05	Percocet 5/325 #20
3	02/17/05	Percocet 5/325 #20
3	02/18/05	Alprazolam 1 mg #60
3	02/20/05	Vicodin ES #30
2	12/11/04	Xanax 1 mg #15 w/ 2 refills

Your acts, conduct, and/or omissions as alleged in paragraphs (3) through (5) above, individually and/or collectively, constitute “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (2) through (5) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute “[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule,” as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, to wit: Principles I, II, IV, and VIII of the American Medical Association’s Principles of Medical Ethics.

Further, your acts, conduct, and/or omissions as alleged in paragraph (6) 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 Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

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

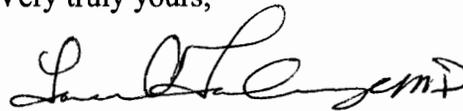
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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

In the event that there is no request for such hearing received within thirty 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."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7004 2510 0006 9801 7626
RETURN RECEIPT REQUESTED

cc: Dwight D. Brannon, Esq.
130 West Second Street
Suite 900
Dayton, OH 45402

CERTIFIED MAIL # 7004 2510 0006 9801 7619
RETURN RECEIPT REQUESTED



State Medical Board of Ohio

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

February 8, 2006

Arthur Richard Schramm, M.D.
11060 Wolf Creek Pike
Brookville, OH 45309

Dear Doctor Schramm:

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 after 2004 and 2005, you undertook the care of Patients 1-3, as identified on the attached Patient Key in the course of your psychiatric practice (Patient Key confidential and to be withheld from public disclosure).
- (2) In or about the spring of 2004, you took partially nude photographs of Patient 3, and, in or about November 2004, you took partially nude and/or nude photographs of Patient 1.
- (3) In your care of Patient 1, you inappropriately treated and/or failed to appropriately treat and/or failed to document your treatment of Patient 1. Examples of such conduct include, but are not limited to, the following:
 - (a) You inappropriately prescribed Schedule II and III controlled opioids, stimulants and benzodiazepines to Patient 1 despite her advising you that she was addicted to heroin.
 - (b) You failed to refer and/or document the referral of Patient 1 to a drug treatment program despite her advising you that she was addicted to heroin.
 - (c) You failed to report and/or document the reporting of Patient 1 to Child Protection Services, despite your knowledge that Patient 1 had an eight-month-old son living in a household with Patient 1, a self-described heroin addict, and with Patient 1's husband, whom Patient 1 reported to you as abusing cocaine.

*Second Mailing 3-14-06
Mailed 2-9-06*

- (d) You prescribed the Schedule II stimulants Adderall XR and Ritalin to Patient 1 without evaluating and/or documenting an appropriate evaluation of Patient 1, and/or without rendering a diagnosis and/or documenting a diagnosis to support the prescribing of those stimulants.
 - (e) You failed to timely refer and/or document the timely referral of Patient 1 to the proper specialist for evaluation of reported "Post-trauma lumbrosacral strain."
 - (f) Although you diagnosed Patient 1 with "Bipolar/Mixed," you failed to treat and/or document the treatment of this condition with appropriate medication.
 - (g) Although you report in your record for Patient 1 that Patient 1 described a history of rape and conflict with her parents, you failed to provide and/or document the provision of appropriate psychotherapy and/or refer and/or document the referral of Patient 1 for individual or group psychotherapy to address this issue.
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Further, your acts, conduct, and/or omissions as alleged in paragraph (6) 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 Rule 4731-11-02(F), Ohio Administrative Code,

Arthur Richard Schramm, M.D.

Page 4

violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

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

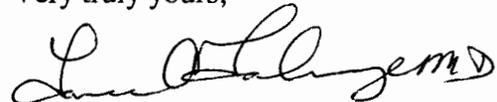
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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

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Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4330 3907
RETURN RECEIPT REQUESTED

Arthur Richard Schramm, M.D.
Page 5

Second mailing: 11060 Wolfe Creek Pike
Brookville, OH 45309
CERTIFIED MAIL NO. 7003 0500 0002 4329 8333
RETURN RECEIPT REQUESTED