verified/es

IN THE COMMON PLEAS COURT OF FRANKLIN COUNTY, OHIO

Nader Afrooz, M.D.,	:	
Appellant,	:	
vs.	:	Case No.: 98CVF03 2411
State Medical Board of Ohio,	:	Judge Bessey
Appellee.	:	

NOTICE OF VOLUNTARY DISMISSAL OF APPEAL

Appellant Nader Afrooz, M.D. hereby voluntarily dismisses his appeal from the Order of the State Medical Board of Ohio, which was filed on March 25, 1998 with this Court. Appellant also withdraws his Motion for Stay filed with this Court on March 25, 1998.

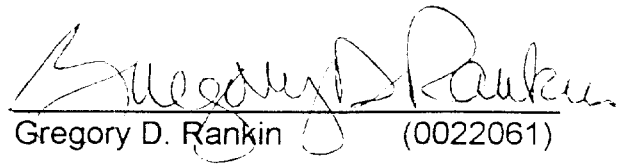
Respectfully submitted,

LANE, ALTON & HORST

Gregory D. Rankin (0022061)
Laura A. Carpenter (0068123)
175 South Third Street
Columbus, Ohio 43215
(614) 228-6885
Attorneys for Appellant Nader Afrooz, M.D.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing was served upon Larry Pratt and James M. McGovern, Assistant Attorneys General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, OH 43215-3428, by ordinary U.S. mail this ~~20th~~ 21st day of April, 1998.



Gregory D. Rankin (0022061)

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BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF: :

Nader Afrooz, M.D. :

NOTICE OF APPEAL

Pursuant to Ohio Revised Code Section 119.12, Nader Afrooz, M.D., hereby gives notice of his appeal from the Order of the State Medical Board of Ohio, dated March 11, 1998 and mailed on March 13, 1998. Accordingly, Appellant requests that the Board transmit a complete copy of the record to the Franklin County Court of Common Pleas.

Appellant states that the Board's Order is not based on reliable, probative, and substantial evidence and was not issued in accordance with law.

Respectfully submitted,

LANE, ALTON & HORST

Laura A. Carpenter

Gregory D. Rankin (0022061)
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(614) 233-4763
Attorneys for Appellant Nader Afrooz, M.D.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing was served upon Larry Pratt and James M. McGovern, Assistant Attorneys General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, OH 43215-3428, by ordinary U.S. mail this 24TH day of March, 1998.

Laura A. Carpenter

Laura A. Carpenter (0068123)

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State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43266-0315 • (614) 466-3934 • Website: www.state.oh.us/med/

March 11, 1998

Nader Afrooz, M.D.
1220 Belmont Drive, Suite 1
Youngstown, OH 44504

Dear Doctor Afrooz:

Please find enclosed certified copies of the Entry of Order; the Report of *Goldman* Hearing and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 11, 1998, including motions approving and confirming the Report of *Goldman* Hearing 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 may be taken to the Franklin County Court of Common Pleas only.

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

THE STATE MEDICAL BOARD OF OHIO

Anand G. Garg, M.D.
Secretary

AGG:jam
Enclosures

CERTIFIED MAIL RECEIPT NO. Z 233 895 273
RETURN RECEIPT REQUESTED

cc: Terri-Lynne B. Smiles, Esq.
CERTIFIED MAIL RECEIPT NO. Z 233 895 274
RETURN RECEIPT REQUESTED

Mailed 3/13/98

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report of *Goldman* Hearing and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 11, 1998, 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 Nader Afrooz, 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.

Anand G. Garg, M.D.
Secretary

(SEAL)

3/11/98
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*
	*
NADER AFROOZ, M.D.	*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on March 11, 1998.

Upon the Report of *Goldman* Hearing and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report of *Goldman* Hearing 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 Nader Afrooz, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

Anand G. Garg, M.D.
Secretary

(SEAL)

3/11/98
Date

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REPORT AND RECOMMENDATION UPON THE STATE'S PRESENTATION OF EVIDENCE IN THE MATTER OF NADER AFROOZ, M.D.

The matter of Nader Afrooz, M.D., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on October 27, 1997.

INTRODUCTION

I. Basis for Hearing

A. By letter dated March 12, 1997 (State's Exhibit 48), the State Medical Board of Ohio [Board] notified Nader Afrooz, M.D., that it proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio, based upon his care and treatment of 39 specified patients (identified in a Patient Key [State's Exhibit 41] to be withheld from public disclosure).

The Board alleged that Dr. Afrooz's acts, conduct, and/or omissions, individually and/or collectively, 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."

Dr. Afrooz was advised of his right to request a hearing in this Matter.

B. By letter received by the Board on April 10, 1997, John T. Dellick and Brad Gessner, Esqs., requested a hearing on behalf of Dr. Afrooz. (State's Exhibit 49) Pursuant to that request, a hearing was scheduled. (State's Exhibits 51 and 56) However, by letter dated October 23, 1997, Dr. Afrooz withdrew his request for a hearing. (State's Exhibit 60) Subsequently, on October 27, 1997, the State filed a motion to conduct a *Goldman*-type hearing at which the State would present evidence in this matter.[1] (State's Exhibit 61)

[1] See *Goldman v. State Medical Board of Ohio* (1996), Ohio App.3d 124.

II. Appearances

On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by James M. McGovern and Lawrence D. Pratt, Assistant Attorneys General.

EVIDENCE EXAMINED

I. Testimony Heard

Howard D. Shapiro, M.D.

II. Exhibits Examined

In addition to State's Exhibits 41, 48, 49, 51, 56, 60, and 61, noted above, the following exhibits were identified by the State and admitted into evidence:

A. State's Exhibits 1 through 40: Copies of Dr. Afrooz's medical records for Patients 1 through 40, respectively. (Note: One of the patients had two charts, and is listed as both Patient 7 and Patient 8. There are actually 39 patients involved.) (Also note: These exhibits have been sealed to protect patient confidentiality.) (Further note: The pages of these exhibits were numbered prior to the hearing. However, only the front side of the pages were numbered, and many of the pages had printing on both sides. In the Summary of Evidence, below, a reference to these page numbers constitutes a reference to both sides of the page.)

B. State's Exhibit 42: Copy of January 4, 1993, subpoena duces tecum. (3 pp.) (Note: This exhibit has been sealed to protect patient confidentiality.)

C. State's Exhibits 43 and 44: Copies of Patient Record Verifications. (Note: These exhibits have been sealed to protect patient confidentiality.)

D. State's Exhibit 45: Certified copy of the MDMAST database information as it appeared on October 27, 1997, in Board records concerning Dr. Afrooz. (3 pp.)

E. State's Exhibit 46: Curriculum vitae of Howard D. Shapiro, M.D. (5 pp.)

F. State's Exhibits 47, 47A, and 47B: These exhibits were originally admitted to the record collectively as State's Exhibit 47. The Hearing

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Examiner subsequently separated and renumbered these documents as follows:

1. State's Exhibit 47: Copy of Dr. Shapiro's expert report concerning Dr. Afrooz. (9 pp.)

2. State's Exhibit 47A: Copy of Dr. Shapiro's October 1, 1996, record review concerning Dr. Afrooz, with patient names redacted. (41 pp.)

3. State's Exhibit 47B: Copy of Dr. Shapiro's October 1, 1996, record review concerning Dr. Afrooz. (41 pp.) (Note: This exhibit has been sealed to protect patient confidentiality.)

G. State's Exhibit 50: Copy of an April 14, 1997, letter to Brad Gessner and John T. Dellick, Esqs., from the Board advising that a hearing had been scheduled for April 22, 1997, but further advising that the hearing had been postponed pursuant to Section 119.09, Ohio Revised Code; a copy of the certified mail receipts is attached.

H. State's Exhibit 52: Copy of a June 7, 1997, cover letter from Lawrence D. Pratt, Assistant Attorney General, to Dr. Afrooz, transmitting a copy of Dr. Shapiro's expert report to Dr. Afrooz.

I. State's Exhibit 53: Copy of a June 7, 1997, cover letter from Assistant Attorney General Pratt to Dr. Afrooz, transmitting a copy of the April 30, 1997, Entry; a copy of that Entry is attached. (3 pp.)

J. State's Exhibit 54: Copy of the State's August 29, 1997, Motion for a Continuance. (2 pp.)

K. State's Exhibit 55: September 2, 1997, Entry scheduling a teleconference to discuss the State's Motion for a Continuance.

L. State's Exhibit 57: Copy of the Respondent's September 5, 1997, Motion for Extension of Expert Witness Deadline. (3 pp.)

M. State's Exhibit 58: September 9, 1997, Entry granting in part the Respondent's Motion for Extension of Expert Witness Deadline.

N. State's Exhibit 59: Copy of the State's September 30, 1997, request for lists of witnesses and documents.

SUMMARY OF THE EVIDENCE

All transcripts of testimony and exhibits, whether or not specifically referenced hereinafter, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background Information

1. Howard D. Shapiro, M.D., testified as an expert for the State. Dr. Shapiro obtained his Doctor of Medicine degree from Albany Medical College, Albany, New York, in 1970. Dr. Shapiro interned at the Cleveland Clinic Foundation from 1970 to 1971, and completed a residency in neurology at that institution from 1971 to 1974. Dr. Shapiro testified that he was board certified in neurology and psychiatry in 1977, and in electroencephalography in 1979. Dr. Shapiro's curriculum vitae was admitted to the record as State's Exhibit [St. Ex.] 46. (Transcript at pages [Tr.] 24-27)

   Dr. Shapiro testified that he has been engaged in the private practice of neurology since 1974, and practices in Akron, Ohio. Until 1988, he practiced with a neurological and neurosurgical group. In 1988, he left that group and began a solo practice. Since 1994, Dr. Shapiro has practiced in a two-physician partnership. Dr. Shapiro testified that he and his partner see approximately 2,500 patients per year, ages 16 and up. (St. Ex. 46; Tr. 25, 27)

   Dr. Shapiro testified that, in addition to his private medical practice, he teaches at Akron General Medical Center [Akron General] and at Barberton's Citizen's Hospital. Dr. Shapiro stated that he has been Director of the neurology and neurovascular laboratories at Akron General since 1976, and is also the Director of the Sleep Disorder Center at Akron General. Moreover, Dr. Shapiro is an Associate Professor of Clinical Internal Medicine at the Northeastern Ohio Universities College of Medicine. Finally, Dr. Shapiro testified that he is actively involved in a number of professional associations and committees. (St. Ex. 46; Tr. 25-29)

2. Dr. Shapiro testified concerning the standard of care for a neurological examination for a patient's first visit. Dr. Shapiro stated that "the examination begins with a comprehensive history of the problem of the patient." This history should include "a complete family history, a record of medications with adverse reactions, as well as a record of all medications, treatments that have been done in the past." Dr. Shapiro stated that an adequate history is of paramount importance for any medical specialty, but

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perhaps even more so for neurology. Dr. Shapiro stated that neurologists rely heavily on the patient's history. (Tr. 32-34)

Dr. Shapiro testified that the next step is to perform a thorough physical examination. Dr. Shapiro stated that this examination should include the following elements:

- An examination of the cranial nerves, which are those that involve the head and the scalp and serve such senses as sight, hearing, smell, and taste. Dr. Shapiro stated that this examination provides details concerning total brain function.

- Testing of reflexes, which evaluates the muscles and their connections with the spinal cord.

- A detailed motor examination, during which the neurologist observes the patient's ability to walk and make other movements, and tests the individual muscles in the extremities.

- A sensory examination, that "generally includes modalities of pin prick, light touching, vibration, and position sense[.]" Dr. Shapiro noted that the sensory information elicited from each of these modalities travels through different columns of the spinal cord to be interpreted by different areas of the brain.

- An examination of the cerebellum, which is the balance mechanism of the brain, as well as the patient's mental status, circulation, pulses, and blood pressure.

(Tr. 33-34) Dr. Shapiro further testified that failure to perform an adequate examination may result in an incorrect diagnosis. The neurologist could miss something or reach an erroneous conclusion. (Tr. 34-35)

3. Dr. Shapiro testified that follow-up neurological examinations should be more focused than the initial examination. Dr. Shapiro stated that follow-up examinations usually become necessary for one of two reasons: either the patient has developed a new problem, or the old problem has not been treated satisfactorily. Either way, Dr. Shapiro stated, the background information gathered during the initial visit can be updated. (Tr. 35)

   Dr. Shapiro testified that, after the background information has been updated, the follow-up examination focuses on the patient's immediate problem.

Dr. Shapiro stated that, if it is an old problem that has not improved, the neurologist may want to reexamine that part of the patient to be certain that nothing was missed previously. Dr. Shapiro further stated that, if it is a new problem, it is addressed with the knowledge that the information gathered during the initial examination probably has not changed very much. (Tr. 35-36)

4. Concerning the standard of care of medical record keeping for neurologists, Dr. Shapiro testified that "[w]e are under the adage which has been pounded into us by our teachers and, in case we forget, by the government as well, if it is not written, it never happened[.]" Dr. Shapiro further testified that any important information must be recorded, and anything the neurologist does must also be recorded. In addition, Dr. Shapiro stated that the medical record must be legible. (Tr. 36-37)

   Dr. Shapiro testified that good medical records are necessary because the physician may be asked to give a report concerning a patient many years after the patient contact occurred. Moreover, Dr. Shapiro stated that the physician "may have a patient return ten years after the first visit and [the physician may] be expected to take up from where [the physician] left off." (Tr. 36-37)

5. Dr. Shapiro testified that, in his opinion, "Dr. Afrooz departed from and failed to conform to minimal standards of care of similar practitioners in that he failed to conduct appropriate and adequate neurological examinations and/or he failed to adequately document neurological examinations in Patients 1 through 40." (Tr. 37)

Electromyography

1. Dr. Shapiro testified that electromyography [EMG] is a test that is performed to determine whether there is muscle disease or nerve damage; if the nerve is damaged, the EMG can locate the damage, whether it is at the root level or further down the nerve's pathway. Dr. Shapiro further testified that the EMG test involves inserting a needle into muscle tissue, and that this must be repeated several times for each limb because "it's mandatory that you have to examine muscles from each of the nerves that leaves the spinal cord and goes to that particular limb; so it necessitates examination of multiple muscles in the same limb." Consequently, Dr. Shapiro testified, EMG testing is painful and uncomfortable for the patient. Dr. Shapiro noted that an EMG test takes approximately 20 minutes per limb. (Tr. 38-39, 43)

   Dr. Shapiro testified that, before performing an EMG, the physician should have seen something in the examination that would lead him or her to suspect

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that nerve damage is present. Dr. Shapiro stated that the nerves tested by EMG carry information bi-directionally—motor function is sent downstream from the spine to the muscle, and sensory function is sent upstream to the spine and ultimately to the brain. Dr. Shapiro testified that, consequently, the possibility of nerve damage should first be demonstrated by "an abnormal examination consisting of a sensory deficit, a motor deficit, and a reflex deficit; they should all be consistent." (Tr. 39-41)

Dr. Shapiro testified that if an EMG indicates that nerve damage is present, another EMG examination must then be performed along the paraspinal muscles to confirm whether the damage is at the root level—where the nerve branches from the spine—or farther down. An abnormal result from the test of the paraspinal muscles would indicate that damage exists at the root level. (Tr. 41-42)

2. Dr. Shapiro testified that EMGs are rarely repeated, and there is no indication to repeat an EMG unless a new problem develops. Dr. Shapiro stated that an EMG "is a definitive test. Once it's done, it's done and either it is positive or it's negative. Damage is present or damage is not present. Damage does not come and go." (Tr. 42-43)

   Dr. Shapiro testified that there are good medical reasons for not repeating EMGs. An initial EMG causes damage to the muscle. This damage can then be read as a false positive on a subsequent EMG. (Tr. 46)

3. Dr. Shapiro testified that the physician should never perform an EMG on all four limbs because a muscle that has been subjected to an EMG test cannot then be biopsied; such muscle "will show findings consistent with polymyositis or inflammatory disease of muscle just by having an EMG done to it[.]" If the EMG indicates a primary disease of muscle, the physician would then need a biopsy to determine which muscle disease is at issue. (Tr. 46)

   Dr. Shapiro testified that physicians "[v]irtually never" perform an EMG on an asymptomatic limb. Dr. Shapiro further testified that "it's not really possible to have an asymptomatic limb that has nerve damage in it." (Tr. 48)

4. Dr. Shapiro testified that Dr. Afrooz failed to conform to the minimal standard of care in his utilization of EMGs:

   - Dr. Shapiro testified that Dr. Afrooz's treatment of Patients 2, 5, 13, 14, 15, 17, 20, 23, 24, 25, 27, 30, 31, 34, 35, 36, and 40 fell below the minimal standard of care in that he performed or ordered EMGs on these patients

"without appropriate indications and/or justifications substantiated by the medical records."

Dr. Shapiro testified that only the limb or limbs that are suspected of being damaged should be tested by EMG, and that there is no medical justification in examining an asymptomatic limb. Nevertheless, Dr. Shapiro testified that Dr. Afrooz almost always examined both upper and lower extremities every time an EMG was performed, even if the patient did not have symptoms in all of the extremities. Dr. Shapiro further testified that, in spite of that, Dr. Afrooz almost never examined the paraspinal muscles.

- Further, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by repeating EMGs "over and over again[]" on Patients 2, 5, 13, 14, 15, 20, 23, 25, and 31, "even though the initial EMG was not indicated, the initial EMG was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the examinations."

- Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by repeating EMGs on Patients 1, 10, 16, 18, 26, 29, and 33. Dr. Shapiro noted that the initial EMG examination on these patients "may have been partially indicated," however, the results of the initial EMGs were normal and Dr. Afrooz's medical records failed to justify repeating the EMGs.

- In addition, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by repeating EMGs on Patients 3, 4, 6, 7, 9, 11, 12, 19, 21, 22, 28, 32, 37, 38, and 39. Dr. Shapiro noted that the initial EMG examination on these patients "may have been partially indicated," however, Dr. Afrooz's medical records failed to justify repeating the EMGs.

- Finally, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care "in that he failed to examine the paraspinal muscles in Patients 1, 2, 3, 4, 6, 7, 9, 10, 12, 16, 17, 18, 22, 24, 26, 28, 29, 30, 33, 37, 38, and 40, whom Dr. Afrooz documented to have one or more signs or symptoms of radiculopathy or of a compressed nerve at the root level, even though the examination of the paraspinal muscles * * * was mandatory in order to properly diagnosis a radiculopathy or a compressed nerve at the root level."

(Tr. 43-47)

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5. Dr. Shapiro testified that "EMGs are billed per limb." If one arm is examined, the physician bills for one limb, if both arms are done, the physician bills for two limbs, and so on. (Tr. 48)

6. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz performed 21 EMGs on Patient 5; 28 EMGs on Patient 7; 16 EMGs on Patient 10; 29 EMGs on Patient 12; 23 EMGs on Patient 22; and 4 EMGs on Patient 33. (St. Ex. 47A, pp. 5-10, 17-18, and 26)

Nerve Conduction Studies

1. Dr. Shapiro testified that a nerve conduction study involves applying an electrical impulse to a nerve and measuring its ability to travel along the nerve. Dr. Shapiro noted that the normal values for the speed and amplitude of the impulse are known. Dr. Shapiro stated that, if the nerve has been damaged, the speed and amplitude of the response will be less than normal. (Tr. 50)

   Dr. Shapiro testified that nerve conduction studies often accompany an EMG, as each tests a different function of a nerve, although either test can be performed alone. Dr. Shapiro testified that a nerve conduction study is a far more sensitive test than an EMG for evaluating a pinched nerve in an elbow or wrist; therefore, a nerve conduction study alone may be used in cases of suspected carpal tunnel syndrome. Moreover, Dr. Shapiro testified that nerve conduction studies are useful in diagnosing polyneuropathy, which is damage to the sensory fibers at the ends of nerves. Dr. Shapiro said that nerve conduction studies can reveal such damage, whereas an EMG is only useful when there is enough damage to affect muscle strength. (Tr. 51-52)

2. Dr. Shapiro testified that Dr. Afrooz departed from or failed to conform to the minimal standard of care in his use of nerve conduction studies as follows:

   - Dr. Afrooz used nerve conduction studies without appropriate indications or justification on Patients 2, 5, 13, 14, 15, 17, 20, 23, 24, 25, 27, 30, 31, 34, 35, 36, and 40.

   - Dr. Afrooz repeated nerve conduction studies on Patients 2, 5, 13, 14, 15, 20, 23, 25, and 31, despite the fact that the initial study was not indicated, and the findings of the initial study were normal or only minimally abnormal. Dr. Afrooz's medical records did not substantiate any justification for repeating the study.

- Dr. Afrooz repeated nerve conduction studies on Patients 1, 10, 16, 18, 26, 29, and 33. The initial study on each of these patients "may have been partially indicated," but the findings were normal. Dr. Afrooz's medical records "failed to substantiate any justification for repeating the examination."

- Dr. Afrooz repeated nerve conduction studies on Patients 3, 4, 6, 7, 9, 11, 12, 19, 21, 22, 28, 32, 37, 38, and 39. The initial study on each of these patients "may have been partially indicated, but the medical records failed to substantiate any justification for repeating the study."

(Tr. 53-54)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz had performed 21 nerve conduction studies on Patient 5; 28 nerve conduction studies on Patient 7; 16 nerve conduction studies on Patient 10; 29 nerve conduction studies on Patient 12; 23 nerve conduction studies on Patient 22; and 4 nerve conduction studies on Patient 33. (St. Ex. 47A, pp. 5-10, 17-18, and 26)

Somatosensory Evoked Response Testing

1. Dr. Shapiro testified that somatosensory evoked response testing [SER] involves the application of electrical stimulation to an arm or leg and measuring the response in the spinal cord or brain. Dr. Shapiro further testified that the test may be indicated if, following a neurological evaluation, the patient appears to have an abnormality. (Tr. 55)

   Dr. Shapiro stated that the test is performed by applying multiple electrical stimulations to a limb over the nerve being evaluated. The responses are then recorded at various points along the spinal cord and over the cortex of the brain. Dr. Shapiro testified that "the study determines whether or not the impulse that you are giving out in the limb travels in an appropriate speed and fashion through the spinal cord and up to the opposite side of the brain." (Tr. 55-56)

   Dr. Shapiro testified that SER is very crude, has "too much artifact[,]" and has limited applications. Dr. Shapiro testified that its most frequent use during the last ten years has been during spine surgery to verify that the spine is still intact. Moreover, Dr. Shapiro testified that "[t]he amount of stimulation you have to give to evoke a response that you can see in the brain is appreciable, so

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it's not a particularly comfortable test to do as well." Finally, Dr. Shapiro testified that SER is done very infrequently "and appropriately so, because until spine surgery came along, it simply did not give much in the way of information at all." (Tr. 56-57)

Dr. Shapiro testified that he knows of no indication for repeating an SER. (Tr. 57, 59)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in his care and treatment of the following patients for the following reasons:

   - Dr. Afrooz performed or ordered SER testing without appropriate indication on Patients 1 through 7, 9, 10, 12 through 17, 19, 22, 23, and 25 through 40.

   - Dr. Afrooz performed or ordered repeat SER tests on Patients 4 through 7, 9, 10, 12 through 16, 18, 22, 23, 25, 26, 28, 30 through 34, and 37 through 39 "even though the initial [SER] was not indicated, the initial [SER] was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating these examinations."

   (Tr. 58-59) Dr. Shapiro added that Dr. Afrooz generally performed or ordered SER testing on both upper and lower limbs when such testing was performed. (Tr. 59)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz performed 19 SERs on Patient 4; 22 SERs on Patient 5; 19 SERs on Patient 7; and 16 SERs on Patient 22. (St. Ex. 47A, pp. 3-7 and 17-18)

Brainstem Auditory Evoked Response Testing

1. Dr. Shapiro testified that brainstem auditory evoked response testing [BAER] is used to evaluate the auditory pathway from the inner ear to the brainstem. He further testified that it is performed by placing earphones on the patient and measuring, through electrodes placed on the scalp, the patient's response to a series of rhythmical clicks. Further, Dr. Shapiro testified that BAER can reveal damage to the lower part of the brain resulting from a stroke or tumor. In addition, Dr. Shapiro testified that, in cases of severe dizziness, the test can be used to determine if a problem lies in the inner ear or in the bottom part of the brain. Moreover, Dr. Shapiro testified that BAER was used as a screening test for multiple sclerosis. Nevertheless, Dr. Shapiro testified that BAER is

not as accurate as other tests that are available today. Dr. Shapiro testified that MRI scanning, which became available in the late 1980s, is better at detecting the sorts of abnormalities that BAER was developed to evaluate. (Tr. 60-61)

Dr. Shapiro testified that he is aware of no indication for repeating a BAER test. (Tr. 63)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in that he performed or ordered BAER tests without indication on Patients 2 through 10, 12 through 18, 22, 23, 25 through 31, 33, and 37 through 39. Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by performing repeat BAER tests on Patients 3 through 10, 12 through 16, 18, 22, 23, 25, 26, 28, 30, 38, and 39, when the initial test had not been indicated and returned normal or minimally abnormal results. (Tr. 63-64)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz performed 21 BAERs on Patient 5; 10 BAERs on Patient 9; and 10 BAERs on Patient 22. (St. Ex. 47A, pp. 5, 8, and 17-18)

Visual Evoked Response Testing

1. Dr. Shapiro testified that visual evoked response testing [VER] is used to check the optic nerve, and to a much lesser degree, the optic pathways through the brain. The patient views a television screen showing a checkerboard pattern that shifts between black and white, and the responses are measured. Dr. Shapiro further testified that it is useful in diagnosing damage to the optic nerve that results from multiple sclerosis, optic neuritis, and optic tumors. (Tr. 64-65)

   Dr. Shapiro noted that VER has the highest rate of positive correlation among the evoked response tests in diagnosing multiple sclerosis; nevertheless, it is still a crude test. Dr. Shapiro testified that results are affected if the patient does not concentrate on the center of the television screen during the test. It can be difficult for the physician to tell if the results of the test have been so affected. (Tr. 65-66)

   Dr. Shapiro testified that the only indication for repeating a VER would be the appearance of new symptoms. (Tr. 67)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by performing an initial VER on Patients 1 through 10, 12 through 18, 22 through

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35, and 37 through 39 without appropriate indication. Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by performing repeat VERs on Patients 1, 3 through 10, 12 through 16, 18, 22, 23, 25, 26, 28, 30, 34, and 37 through 39 even though the initial test was not indicated and yielded results that were normal or minimally abnormal. (Tr. 67-68)

3. Dr. Shapiro testified that, when Dr. Afrooz performed SER, BAER, and VER, he usually performed all three tests on the same date. Dr. Shapiro testified that this was true even though only one of the 39 patients under review was suspected of having multiple sclerosis, which Dr. Shapiro testified would be the only reason to perform all three tests on a patient. Moreover, Dr. Shapiro testified that when Dr. Afrooz repeated these tests he usually repeated all three. Dr. Shapiro testified that this was inappropriate. (Tr. 68-69)

4. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz had performed 21 VERs on Patient 5, and 17 VERs on Patient 7. (St. Ex. 47A, pp. 5 and 6-7)

Electronystagmography

1. Dr. Shapiro testified that electronystagmography [ENG] is "a complicated series of tests designed to evaluate the vestibular or balance mechanism of the brain. It's usually performed in speech and auditory centers by trained audiologists. Its primary purpose has been in evaluating patients with chief complaints of vertigo or dizziness, but it's seldom used routinely for evaluating such complaints. * * * It's virtually never done in an asymptomatic patient. It's not a fun test to do." Dr. Shapiro testified that it is a lengthy test, taking approximately one and one-half hours, and involves evoking significant dizziness in the patient. Dr. Shapiro further testified that it is most frequently ordered by otolarynologists who are unable to otherwise determine the cause of dizziness or vertigo in a patient. Finally, Dr. Shapiro testified that "there are virtually no indications for repeating the study." (Tr. 70-71)

   Dr. Shapiro testified that it is usually possible to determine the cause of dizziness in a patient without resorting to this test. Dr. Shapiro stated that, consequently, it is infrequently used. (Tr. 71-72)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in that Dr. Afrooz performed ENGs on Patients 3 through 7, 10, 14, 17, 18, 22, 23, 25, and 34 without appropriate indication. Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by performing repeat ENGs on Patients 5, 10, 14, 23, 25, and 34 "even though the initial ENG was

not indicated, the initial ENG was normal and the medical records failed to substantiate any justification for repeating the examination." (Tr. 72-73)

Dr. Shapiro stated that in his review of Dr. Afrooz's medical records "if a patient mentioned the word 'dizzy' as recorded by him, the patient received the test." (Tr. 73)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz had performed 5 ENGs on Patient 5; 2 ENGs on Patient 10; and 2 ENGs on Patient 23. (St. Ex. 47A, pp. 5, 8-9, and 18-19)

Carotid Ultrasound

1. Dr. Shapiro testified that a carotid ultrasound test is performed to detect atherosclerotic disease or blockage in the carotid arteries via ultrasound technique. Dr. Shapiro testified that it can be used to determine the extent of the blockage present. In addition, Dr. Shapiro testified that these tests may be appropriate to detect blockage resulting from trauma to the neck. Dr. Shapiro further testified that these studies do not have to be repeated often—if a blockage is there it will be detected; if there is no blockage, it will not suddenly appear later. Moreover, Dr. Shapiro noted that Medicare will not pay for a repeat study within 12 months of a previous study. (Tr. 74-76)

   Dr. Shapiro further testified that, "[b]y far, the most common reason for doing the study is a patient who has a stroke or has symptoms that are strongly suggestive of an impending stroke and you're trying to find a reason" for the patient's problem. (Tr. 76-77)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in that Dr. Afrooz performed carotid ultrasound studies on Patients 3 through 17, 21, 23, 25 through 30, 32 through 35, 38, and 39 without appropriate indication. Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in that Dr. Afrooz repeated carotid ultrasound studies on Patients 3 through 10, 12 through 16, 18, 22, 23, 25, 26, 28, 30, 38, and 39 despite the fact that the initial studies were not indicated, and despite the fact that the initial studies yielded results that were essentially normal. (Tr. 77-78)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz had performed 11 carotid ultrasound studies on Patient 4, and 21 carotid ultrasound studies on Patient 5. (St. Ex. 47A, pp. 3-5)

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Echoencephalography

1. Dr. Shapiro testified that echoencephalography was a very crude form of ultrasound test that had been developed to detect midline shifts in brain tissue. Such shifts could be indicative of a brain tumor or a massive stroke. Dr. Shapiro testified that the test was rendered "completely obsolete" when the CT scan became available in 1976 or 1977. Moreover, Dr. Shapiro testified that echoencephalography is no longer even mentioned in neurology textbooks. (Tr. 78-79)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in that Dr. Afrooz used echoencephalography on Patients 1, 3 through 10, 12 through 18, 22, 23, 25, 26, 28, 30, 31 through 33, 35, and 37 through 39. Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by repeating echoencephalography on Patients 3, 5 through 10, 12 through 15, 22, 23, 25, 26, 28, 30, 31, 38, and 39 despite normal results on the initial studies. (Tr. 80)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz had performed 26 echoencephalographies on Patient 5, and 16 echoencephalographies on Patient 10. (St. Ex. 47A, pp. 5, 8-9)

Electroencephalography

1. Dr. Shapiro testified that electroencephalography [EEG] is a study that measures the electrical activity of the brain. Dr. Shapiro further testified that it is used to determine if there is any seizure activity, "to evaluate changes in level of consciousness[,] or to confirm the presence of diffuse disease which is affecting brain function." (Tr. 83)

   Dr. Shapiro testified that repeat EEGs are indicated in cases of suspected epilepsy and in patients who are experiencing changing clinical states of consciousness. (Tr. 84-85)

   Dr. Shapiro testified that EEG is not an appropriate test to diagnosis the cause of headaches. Dr. Shapiro further testified that the American Academy of Neurology has issued a practice statement to that effect. (Tr. 85-87)

2. Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care in that Dr. Afrooz "inappropriately used EEG as a screening tool on Patients 1, 2, 3, 10, 11, 16 through 18, 21, 22, 24 through 27, 30, 31, 34, 35, 37, 38, and 39 who had complaints of headache and/or had no suggestion of seizure activity

and/or had no change in their level of consciousness." Moreover, Dr. Shapiro testified that Dr. Afrooz fell below the minimal standard of care by performing repeat EEGs on Patients 1, 2, 5, 7, 10, 13, 14, 16, 18, 25, 30, 37, and 39 despite a normal initial study and without appropriate indication. (Tr. 87-88)

3. In his written review of the patient records, Dr. Shapiro noted that Dr. Afrooz performed 10 EEGs on Patient 5. (St. Ex. 47A, p. 5)

Advanced Imaging Techniques

1. Dr. Shapiro testified that, in his review of Dr. Afrooz's medical records, he rarely encountered references to advanced imaging techniques, such as CT scans and MRIs. Dr. Shapiro stated that visualization allows the physician to see what is causing a problem, and is an important part of a neurological evaluation. (Tr. 80-81)

2. Dr. Shapiro testified that CT scans became available in Youngstown, Ohio, where Dr. Afrooz practices, in 1976. Dr. Shapiro expressed concern that "[f]or all the thousands of studies that [Dr. Afrooz] performed, there are only a handful of visualization[s.]" Dr. Shapiro noted that Dr. Afrooz performed function testing repeatedly, over and over, "but [he] never took a look to see what was going on, if anything, and that discrepancy bothered [Dr. Shapiro] very much." Dr. Shapiro stated that he could not understand why there were not numerous CT scans in the medical records as well, but noted that there were only "a handful of CT scans that were done." (Tr. 81)

Individual Patients

Dr. Shapiro testified that he selected six individual patient charts, from among the 40 presented, that he believes to be representative of Dr. Afrooz's practice. He further testified, however, that "[y]ou could pick any six charts out of this group of 40 charts and I would be saying virtually the same thing about every single one of them." (Tr. 88-89, 130)

Patient 13

1. Dr. Shapiro testified that Patient 13, female, first saw Dr. Afrooz in October 1982 when she was 7 years old. She continued seeing Dr. Afrooz for nine years, until January 1992. Patient 13's chief complaints were episodes of passing out and headaches. Dr. Shapiro noted that her episodes of passing out had followed a head injury that she had suffered while playing. Concerning these episodes, Dr. Shapiro testified that Patient 13's parents had reported

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that Patient 13 would first have double vision, then her speech would become abnormal, and then she would pass out momentarily. (Tr. 106-108)

Dr. Shapiro testified that Patient 13's symptoms may have been consistent with an epileptogenic disorder or with an intracranial problem such as a blood clot or malformation. Dr. Shapiro further testified that an EEG would have been appropriate, as well as a CT scan to rule out an intracranial abnormality. If these studies were negative, they should have been followed by a repeat EEG or a 24-hour EEG. (Tr. 108)

Dr. Shapiro noted that a CT scan was performed in April 1983 that showed a dense, calcified opacity in the back of the brain. Dr. Shapiro further testified that it could have resulted from a subdural hematoma that Patient 13 may have suffered as a result of her head injury. (Tr. 111)

2. Dr. Shapiro testified that during the course of Dr. Afrooz's treatment of Patient 13, Dr. Afrooz performed 16 EMGs and nerve conduction studies that usually involved all four extremities, 21 VERs, 21 BAERs, 19 SERs, 21 carotid ultrasounds, 29 echoencephalograms, and 15 EEGs. Dr. Shapiro further testified that all of these studies yielded normal results. Moreover, Dr. Shapiro testified that Dr. Afrooz provided no rationale in the medical records for these tests. (Tr. 112)

   Dr. Shapiro testified that Dr. Afrooz treated Patient 13 with anti-seizure medication. Dr. Shapiro further testified that Patient 13 was probably suffering from seizures resulting from her subdural hematoma. (Tr. 112)

3. Dr. Shapiro testified that Dr. Afrooz's care and treatment of Patient 13 was inappropriate and substandard to the practice of neurology. (Tr. 114)

Patient 14

1. Dr. Shapiro testified that Patient 14, female, was first seen by Dr. Afrooz in July 1986 when she was 12 years old. She continued to see Dr. Afrooz for the next four years. Dr. Shapiro testified that her chief complaints were headaches accompanied by nausea and occasional vomiting, as well as some brief episodes of loss of consciousness. Dr. Shapiro noted that Dr. Afrooz treated Patient 14's headaches with Tylenol. (Tr. 115)

   Dr. Shapiro testified that, when Patient 14 was 13 or 14 years of age, she complained to Dr. Afrooz of generalized aches and chest pain. Dr. Afrooz referred her to a cardiologist with a diagnosis of angina pectoris, which

Dr. Shapiro stated is heart pain resulting from coronary artery disease. Dr. Shapiro testified that if such a diagnosis had been confirmed in a patient this age "it would have made medical history." Dr. Shapiro further testified, however, that the cardiologist returned a diagnosis of musculoskeletal chest pain rather than angina. (Tr. 115)

Dr. Shapiro noted that Dr. Afrooz documented very little concerning Patient 14's symptoms. He further testified that headaches are common in patients this age because of the traumatic physical changes that are taking place, nevertheless it was possible the patient suffered from migraines. Dr. Shapiro added, however, that "[t]here are no tests for migraine." Consequently, Dr. Shapiro testified, the key to a diagnosis is history. Dr. Shapiro noted that there was no history documented by Dr. Afrooz, which Dr. Shapiro characterized as "entirely inappropriate." (Tr. 116-118)

2. Dr. Shapiro testified that during Patient 14's course of treatment, Dr. Afrooz performed 15 EMGs and nerve conduction studies of all four extremities, 2 ENGs, 16 VERs, 16 BAERs, 14 SERs of all four extremities, 17 carotid ultrasounds, 16 echoencephalograms, 3 EEGs, 3 audiometry examinations, and 2 visual field studies. Dr. Shapiro further testified that the results of all of these tests were normal. Dr. Shapiro testified that none of these tests were appropriate. (Tr. 118-121)

3. Dr. Shapiro testified that Dr. Afrooz's care and treatment of Patient 14 fell below the minimal standard of care. (Tr. 121)

Patient 15

1. Dr. Shapiro testified that Patient 15, male, was 50 years old when he first presented to Dr. Afrooz in December 1987. His chief complaints were headaches and light-headedness that had lasted for several months. Dr. Shapiro noted that there was nothing significant recorded in the medical history, and, as far as Dr. Shapiro could determine from the records, the initial examination was normal. Dr. Shapiro stated that Dr. Afrooz later found Patient 15 to have high blood pressure which he subsequently treated with medication. (Tr. 121-122)

   Dr. Shapiro testified that the only time Patient 15 developed problems while being treated by Dr. Afrooz was when his blood pressure medication was discontinued. Dr. Shapiro stated that, when that happened, Patient 15's blood pressure became very high and he began having headaches and light-headedness, which were his presenting symptoms. Dr. Shapiro further stated that Dr. Afrooz ordered numerous blood tests, all of which were normal.

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Dr. Shapiro concluded from the records that Patient 15's symptoms had been secondary to his high blood pressure, and that there was no evidence of a neurological problem. Dr. Shapiro indicated that he would have turned the patient over to an internist because there was no neurological problem. (Tr. 122-123)

2. Dr. Shapiro testified that over the 22-month course of Dr. Afrooz's treatment of Patient 15, Dr. Afrooz performed or ordered 9 EMGs and nerve conduction studies of all four extremities, 10 VERs, 10 BAERs, 10 SERs of all four extremities, 10 carotid ultrasounds, and 10 echoencephalograms. Dr. Shapiro further testified that the results of all of these studies were normal. Moreover, Dr. Shapiro testified that none of these studies was medically indicated. (Tr. 124-125)

3. Dr. Shapiro testified that Dr. Afrooz's care and treatment of Patient 15 fell below the minimal standard of care. (Tr. 125)

Patient 16

1. Dr. Shapiro testified that Patient 16, female, age 43, first presented to Dr. Afrooz in November 1983. She had a history of headaches, dizziness, and numbness in her upper and lower extremities. Dr. Shapiro testified that, for Patient 16's initial visit, Dr. Afrooz recorded only a brief description of the patient's history and a note that the neurological examination was normal. (Tr. 125-127)

   Dr. Shapiro further testified that in 1983 Dr. Shapiro performed or ordered a number of studies, such as a cervical spine x-ray, a carotid ultrasound, an EEG, ENG, VER, BAER, and an SER of all four extremities. Dr. Shapiro stated that the results of all of these tests were normal. Dr. Shapiro further testified that, based on the history and examination, none of these tests was indicated. (Tr. 127-128)

2. Dr. Shapiro testified that Patient 16 did not return to see Dr. Afrooz until 1989, when she presented again with similar complaints. Dr. Shapiro noted that Patient 16 visited Dr. Afrooz four times during that period, and each time she underwent an EMG and nerve conduction study of all four extremities, a VER, a BAER, an SER of all four extremities, carotid ultrasound studies, and an echoencephalogram. Dr. Shapiro testified that each study yielded normal results. Dr. Shapiro further testified that there was no explanation in the medical record "why the studies were repeated each time when the symptoms and findings were completely unchanged and there was no change in the

patient's clinical status and all the previous studies had been normal[.]" (Tr. 128-129)

3. Dr. Shapiro testified that Dr. Afrooz's care and treatment of Patient 16 fell below the minimal standard of care. (Tr. 129-130)

Patient 25

1. Dr. Shapiro testified that Patient 25 was first seen by Dr. Afrooz in 1984. She was 37 years old at that time. She was suspected of suffering from myasthenia gravis, which is an autoimmune disease that effects neurotransmitters and the neuromuscular junction. Her symptoms included fatigue and difficulty swallowing. Dr. Shapiro testified that such symptoms could be indicative of myasthenia gravis. (Tr. 90)

   Dr. Shapiro testified that the first step a neurologist should take in a case of suspected myasthenia gravis would be to take a history. Dr. Shapiro stated that a history consistent with a diagnosis of myasthenia gravis would include symptoms of motor weakness in the arms and legs, swallowing, chewing and/or talking. Dr. Shapiro also noted that the history would not include sensory symptoms such as numbness or tingling, or problems with bowel or bladder function, because these do not utilize the neurotransmitters that are affected by the disease. (Tr. 90-91)

   Dr. Shapiro testified that, if the history is appropriate for myasthenia gravis, there are three tests that are performed to confirm the diagnosis:

   - The first is the tinselon test, whereby the patient is injected with the neurotransmitter that the disease interferes with. Dr. Shapiro said that any improvement in muscle strength is then objectively measured. Dr. Shapiro further noted that, in a patient suffering from myasthenia gravis, there will be an increase in strength provided by the added neurotransmitters.

   - The second test is to check the patient's blood for the antibodies that are specific to the disease. Dr. Shapiro stated that patients suffering from active myasthenia will have high levels of these antibodies.

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- The third test is called a "repetitive nerve stimulation test." He further testified that:

> this test is based on the fact that there [are] inadequate neurotransmitters being passed from the nerve to the muscle. So by stimulating the muscle repeatedly, you develop what's considered a decremental response, less of a response each time you stimulate it because there's not enough transmitter there for a full response. And the decremental response that is seen on repetitive nerve stimulation tests is considered diagnostic of myasthenia.

(Tr. 91-92) Dr. Shapiro further testified that "[t]hese three studies and only these three studies would be considered appropriate studies for the diagnosis of myasthenia gravis." (Tr. 92)

2. Dr. Shapiro testified that, in his review of Dr. Afrooz's medical record for Patient 25, he found no record of a tinselon test having been performed. Dr. Afrooz further testified that Dr. Afrooz performed a number of repetitive nerve stimulation tests; however, all of the positive tests were reported with the same answer: "up to a 20 percent decrement in response." Dr. Shapiro testified that it is very odd to see the same result each time such a test is performed. Finally, Dr. Shapiro testified that an antibody test was performed which failed to show the presence of antibodies. In his written record review, Dr. Shapiro had indicated that such a result "would argue against an active problem of Myasthenia Gravis." (St. Ex. 47A, p. 20; Tr. 92-93)

3. Dr. Shapiro further testified that Dr. Afrooz performed many other tests on Patient 25 which were not appropriate for a case of suspected myasthenia gravis. For example, Dr. Shapiro testified that, at the first visit, Dr. Afrooz performed ENG, SER, BAER, and VER, in addition to EMG and nerve conduction studies of all four extremities. Moreover, Dr. Shapiro noted that, from April 1985 through January 1990, Dr. Afrooz repeated these studies numerous times, to wit: 39 EMGs and nerve conduction studies of all four extremities, 9 ENGs, 27 VERs, 29 BAERs, 30 SERs, 28 carotid ultrasound studies, 36 echoencephalograms, 13 EEGs, and four visual field studies. (St. Ex. 47A, p. 20; Tr. 93-94, 99-100)

4. Dr. Shapiro further testified that, although Patient 25 was first seen by Dr. Afrooz in March 1984, Dr. Afrooz did not perform the antibody test until the following December. Dr. Shapiro stated that the antibody test and the

repetitive nerve stimulation tests should have been performed at the first visit. (Tr. 93-95)

5. Dr. Shapiro testified that, after receiving a negative antibody test, Dr. Afrooz should have considered other diagnoses or referred her to a specialist for a second opinion. However, Dr. Shapiro testified that Dr. Afrooz did not pursue these avenues until years later. (Tr. 95)

   Dr. Shapiro testified that, in 1988, Dr. Afrooz referred Patient 25 to Dr. Levin at the Cleveland Clinic Foundation. Dr. Shapiro testified that Dr. Levin noted that the patient had been seen at that facility in 1979 by Dr. Hanson, and that Dr. Hanson had rendered a diagnosis of "conversion reaction or hysteria." Dr. Shapiro further testified that Dr. Levin evaluated the patient and reported that the patient's history and antibody serum study were inconsistent with a diagnosis of myasthenia gravis. Moreover, Dr. Shapiro testified that Dr. Levin reported that he did not believe that Patient 25 suffered from myasthenia gravis or any other neurological condition, but opined that there may have been "psychological factors" involved. (Tr. 95-98)

   Dr. Shapiro further testified that, in 1989, Patient 25 was seen by Dr. Katershy at University Hospitals in Cleveland, Ohio. Dr. Shapiro's testimony indicated that Dr. Katershy reached essentially the same conclusion as Dr. Levin: Patient 25 did not suffer from myasthenia gravis and should be evaluated by a psychiatrist. Dr. Shapiro further testified that Patient 25 was subsequently seen by a third neurologist in Pittsburgh whose opinion was consistent with those of Dr. Levin and Dr. Katershy. (Tr. 98)

   Dr. Shapiro noted that the three neurologists to whom Dr. Afrooz referred Patient 25 all reached their conclusions after having performed antibody tests and repetitive nerve stimulation tests, which are the appropriate tests for diagnosing myasthenia gravis. (Tr. 98)

6. Dr. Shapiro testified that one of Dr. Afrooz's progress notes stated that Dr. Afrooz had thought that Patient 25 may not actually suffer from myasthenia gravis, but that the patient had insisted that the medication was helping her, and Dr. Afrooz did not know how to stop it. Dr. Shapiro testified that this was not an appropriate response by Dr. Afrooz. Dr. Shapiro stated that continuing Patient 25's medication and ordering more tests only served to reinforce her psychiatric problem, and probably did more harm than good. (Tr. 98-100)

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7. Dr. Shapiro testified that Dr. Afrooz's care and treatment of Patient 25 "was inappropriate and severely fell below any standard of any physician that would have been taking care of this patient." (Tr. 100)

Patient 26

1. Dr. Shapiro testified that Patient 26 was a 39-year-old male who first presented to Dr. Afrooz in September 1986. Patient 26's chief complaints were headaches, light-headedness, neck and lower back pain, numbness in his right arm, and feelings of impending syncope. (Tr. 101-102)

   Dr. Shapiro testified that the initial neurological examination was poor, although Dr. Afrooz reached the conclusion "there are no focal neurological deficits." Dr. Shapiro testified that such a statement would imply that Dr. Afrooz had performed a complete neurological examination, but that the record does not bear this out "without making a great number of assumptions." (Tr. 102)

   Dr. Shapiro stated that there was not enough information in the records concerning the patient's history and examination. For example, Dr. Shapiro noted that the complaints of neck pain and numbness in the right arm could suggest radiculopathy. Dr. Shapiro said that to confirm that one would need to find weakness, reflex changes, and a sensory deficit in the arm. Nevertheless, Dr. Shapiro stated that Dr. Afrooz only recorded that there were "no focal neurological deficits." Dr. Shapiro testified that such a statement is essentially meaningless in the context it was given. (Tr. 102-103)

2. Dr. Shapiro testified concerning the testing procedures performed by Dr. Afrooz:

   - Dr. Afrooz performed echoencephalography, which Dr. Shapiro characterized as "a hundred percent antiquated, useless, and should not be done."

   - The carotid ultrasound study may have been indicated given the patient's feeling of impending syncope. Such a symptom may result from obstructive carotid artery disease. Nevertheless, Dr. Shapiro testified that he would have expected to find more definitive symptoms, such as a bruit in the neck.

   - Dr. Shapiro stated that an EMG and nerve conduction study of the right arm may have been indicated if radiculopathy was suspected.

Nevertheless, Dr. Shapiro testified that such tests on the left arm and both legs, which were asymptomatic, were not justified.

- Dr. Shapiro testified that it was not appropriate to perform an EEG because there was no suggestion of either a seizure disorder or of changes in levels of consciousness.

- Dr. Shapiro testified that he could see no reason for Dr. Afrooz to perform SER, VER, and BAER studies on Patient 26. Dr. Shapiro added that the SER was performed on all four extremities.

(Tr. 103-104) Dr. Shapiro noted that the results of all of these studies were normal. (Tr. 104)

3. Dr. Shapiro testified that, despite the fact that all of the initial studies yielded normal results, Dr. Afrooz performed repeat studies. Dr. Shapiro stated that, between September 1986 and January 1990, Dr. Afrooz performed 11 EMGs and nerve conduction studies of both upper and lower extremities, 8 VERs, 8 BAERs, 10 SERs of both upper and lower extremities, 7 noninvasive carotid Doppler studies, 7 echoencephalograms, and 1 EEG. Dr. Shapiro further testified that the results of all of these studies were normal. (Tr. 104-105)

4. Dr. Shapiro testified that Dr. Afrooz's care and treatment of Patient 26 fell "substantially" below the minimal standard of care. (Tr. 105-106)

FINDINGS OF FACT

The evidence presented in this matter is sufficient to support the following Findings:

1. In the routine course of practice as a neurologist, Nader Afrooz, M.D., failed to conduct appropriate and adequate neurological examinations and/or failed to adequately document neurological examinations in Patients 1-40.

2. In the routine course of Dr. Afrooz's practice, Dr. Afrooz performed an initial needle electromyography [EEG] and nerve conduction study on Patients 2, 5, 13, 14, 15, 17, 20, 23, 24, 25, 27, 30, 31, 34, 35, 36, and 40 without appropriate indication and/or justification substantiated by their medical records.

   Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz performed repeat EMGs and nerve conduction studies on Patients 2, 5, 13, 14, 15, 20, 23, 25, and 31, even though the initial EMG and nerve conduction study was not

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indicated, the initial EMG and nerve conduction study was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exams. Such acts included performing at least: nine EMGs and nerve conduction studies on Patient 15; sixteen EMGs and nerve conduction studies on Patient 13; twenty-one EMGs and nerve conduction studies on Patient 5; and thirty-nine EMGs and nerve conduction studies on Patient 25.

Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz performed repeat EMGs and nerve conduction studies on Patients 1, 10, 16, 18, 26, 29, and 33 whose initial EMG and nerve conduction study may have been partially indicated, even though the results of the initial EMG and nerve conduction study were in fact normal, and the medical records failed to substantiate any justification for repeating the exams. Such acts include, but are not limited to, performing at least: four EMGs and nerve conduction studies on Patients 16 and 33; eleven EMGs and nerve conduction studies on Patient 26; and thirteen EMGs and nerve conduction studies on Patient 10.

3. Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz performed repeat EMGs and nerve conduction studies on Patients 3, 4, 6, 7, 9, 11, 12, 19, 21, 22, 28, 32, 37, 38, and 39 whose initial EMG and nerve conduction study may have been partially indicated, but the medical records failed to substantiate any justification for repeating the exams. Such acts include, but are not limited to, performing at least: twenty-two EMGs and nerve conduction studies on Patient 12; twenty-three EMGs on Patient 22; and twenty-eight EMGs and nerve conduction studies on Patient 7.

   Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz failed to examine the paraspinal muscles of Patients 1, 2, 3, 4, 6, 7, 9, 10, 12, 16, 17, 18, 22, 24, 26, 28, 29, 30, 33, 37, 38, and 40, whom Dr. Afrooz documented to have had one or more signs or symptoms of radiculopathy or a compressed nerve at the root level, even though examination of the paraspinal muscles is mandatory in order to properly diagnose a radiculopathy or a compressed nerve at the root level.

4. In the routine course of Dr. Afrooz's practice, Dr. Afrooz performed an initial somatosensory evoked response study [SER] on Patients 1-7, 9, 10, 12-17, 19, 22, 23, and 25-40 without appropriate indication and/or justification substantiated by their medical records.

   Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz performed repeat SERs on Patients 4-7, 9, 10, 12-16, 18, 22, 23, 25, 26, 28, 30-34, and 37-39, even though the initial SER was not indicated, the initial SER was normal

or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exam. Such acts include, but are not limited to, performing at least: fifteen SERs on Patient 13; fourteen SERs on Patient 14; sixteen SERs on Patient 22; nineteen SERs on Patient 4; nineteen SERs on Patient 7; twenty-two SERs on Patient 5; and thirty SERs on Patient 25.

5. In the routine course of Dr. Afrooz's practice, Dr. Afrooz performed an initial brainstem auditory evoked response study [BAER] on Patients 2-10, 12-18, 22, 23, 25-31, 33, and 37-39 without appropriate indication and/or justification substantiated by their medical records.

   Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz performed repeat BAERs on Patients 3-10, 12-16,18, 22, 23, 25, 26, 28, 30, 38, and 39 even though the initial BAER was not indicated, the initial BAER was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exam. Such acts include, but are not limited to, performing at least: ten BAERs on Patients 15 and 22; ten BAERs on Patient 9; sixteen BAERs on Patient 14; twenty-one BAERs on Patient 5; twenty-one BAERs on Patient 13; and twenty-nine BAERs on Patient 25.

6. In the routine course of Dr. Afrooz's practice, Dr. Afrooz performed an initial visual evoked response study [VER] on Patients 1-10, 12-18, 22-35, and 37-39 without appropriate indication and/or justification substantiated by their medical records.

   Further, in the routine course of Dr. Afrooz's practice, Dr. Afrooz performed repeat VERs on Patients 1, 3-10, 12-16, 18, 22, 23, 25, 26, 28, 30, 34, and 37-39, even though the initial VER was not indicated, the initial VER was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exam. Such acts include, but are not limited to, performing at least: sixteen VERs on Patient 14; seventeen VERs on Patient 7; twenty VERs on Patient 13; twenty-one VERs on Patient 5; and twenty-seven VERs on Patient 25.

7. In the routine course of Dr. Afrooz's practice, Dr. Afrooz performed an initial electronystagmography study [ENG] on Patients 3-7, 10, 14, 17, 18, 22, 23, 25, and 34 without appropriate indication and/or justification substantiated by their medical records.

   Further, Dr. Afrooz performed repeat ENGs on Patients 5, 10, 14, 23, 25, and 34, even though the initial ENG was not indicated, the initial ENG was normal, and the medical records failed to substantiate any justification for

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repeating the exam. Such acts include, but are not limited to, performing at least: two ENGs on Patients 10, 14 and 23; five ENGs on Patient 5; and nine ENGs on Patient 25.

8. In the routine course of Dr. Afrooz's practice, Dr. Afrooz inappropriately used electroencephalography [EEG] as a screening tool on Patients 1, 2, 3, 10, 11, 16-18, 21, 22, 24-27, 30, 31, 34, 35, 37, 38, and 39, who had complaints of headaches, and/or had no suggestion of seizure activity, and/or had no changes in their level of consciousness.

   Further, Dr. Afrooz repeated the EEG studies on Patients 1, 2, 5, 7, 10, 13, 14, 16, 18, 25, 30, 37, and 39 despite the previous study being normal and without any appropriate indication and/or justification for repeating the exam substantiated by their medical records. Such acts include, but are not limited to, performing at least: ten EEGs on Patient 5; thirteen EEGs on Patient 13; and fifteen EEGs on Patient 25.

9. In the routine course of Dr. Afrooz's practice, Dr. Afrooz performed carotid ultrasound studies on Patients 3-17, 21-23, 25-30, 32-35, 38, and 39 without appropriate indication and/or justification substantiated by their medical records.

   Further, Dr. Afrooz repeated the carotid ultrasound studies on Patients 3-10, 12-16, 18, 22, 23, 25, 26, 28, 30, 38, and 39, even though the initial studies were not indicated, the initial studies were essentially normal, and the medical records failed to substantiate justification for repeating the studies. Examples of such acts include, but are not limited to, performing: ten carotid ultrasounds on Patient 4; fifteen Carotid Ultrasounds on Patient 14; twenty carotid ultrasounds on Patient 13; twenty-one carotid ultrasounds on Patient 5; and twenty-eight carotid ultrasounds on Patient 25. Moreover, Patient 13 was seven years old and Patient 14 was twelve years old when initially seen.

10. In the routine course of Dr. Afrooz's practice, between the years 1982 through at least 1991, Dr. Afrooz utilized echoencephalography on Patients 1, 3-10, 12-18, 22, 23, 25, 26, 28, 30-33, 35, 37, 38, and 39, despite the fact that, since approximately 1975, echoencephalography has been rendered obsolete by the advent of computerized tomography and was, during the time period under consideration, considered a valueless test.

    Further, Dr. Afrooz repeated echoencephalographies despite the reported normal results, on Patients 3, 5-10, 12-15, 22, 23, 25, 26, 28, 30, 31, 38, and 39.

Examples of such acts include, but are not limited to, performing at least: sixteen echoencephalographies on Patients 10 and 14; twenty-six echoencephalographies on Patient 5; twenty-nine echoencephalographies on Patient 13; and thirty-six echoencephalographies on Patient 25.

CONCLUSIONS OF LAW

The acts, conduct, and/or omissions of Nader Afrooz, M.D., individually and/or collectively, as set forth in the Findings of Fact, above, 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.

PROPOSED ORDER

It is hereby ORDERED that the certificate of Nader Afrooz, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

R. Gregory Porter
Attorney Hearing Examiner

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43266-0315 • (614) 466-3934 • Website: www.state.oh.us/med/

EXCERPT FROM THE DRAFT MINUTES OF MARCH 11, 1998

REPORTS AND RECOMMENDATIONS

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

Dr. Buchan asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Abel P. Borromeo, M.D.; Cardiac Surgeons for Northwest, Ohio, Inc.; Cardiothoracic & Vascular Surgeons, Inc.; Marion Ob/Gyn, Inc.; Paul E. Pancoast, M.D.; John M. Speca, M.D.; Tina Thomas-McCauley, M.D.; Dorian M. Vidu, M.D.; and Report of the State's Presentation of Evidence in the Matter of Nader Afrooz, M.D. A roll call was taken:

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

Mr. Sinnott advised that he has an attorney/client relationship with one of the cardiothoracic physicians and recused himself from consideration in the matter of Cardiothoracic & Vascular Surgeons, Inc.

Dr. Stienecker indicated that Cardiothoracic & Vascular Surgeons, Inc., works at his hospital, and he will also recuse himself from consideration of the case.

Dr. Garg indicated that he would recuse himself in the matter of Nader Afrooz, M.D. He indicated that he has knowledge of the physician's practice.

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

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye

Dr. Gretter	- aye
Mr. Sinnott	- aye
Dr. Stienecker	- aye
Dr. Agresta	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Dr. Buchan	- aye

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

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

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

.....

Dr. Buchan asked Dr. Egner whether she had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Cardiothoracic & Vascular Surgeons, Inc.; Marion Ob/Gyn, Inc.; Paul E. Pancoast, M.D.; John M. Speca, M.D.; Tina Thomas-McCauley, M.D.; Dorian M. Vidu, M.D.; and Report of the State's Presentation of Evidence in the Matter of Nader Afrooz, M.D.

Dr. Egner indicated that she had.

Dr. Buchan asked Dr. Egner whether she 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.

Dr. Egner stated that she does understand.

.....

NADER AFROOZ, M.D.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED

FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF NADER AFROOZ, M.D. MR. SINNOTT SECONDED THE MOTION.

.....

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

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

The motion carried.

STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

March 12, 1997

Nader Afrooz, M.D.
1220 Belmont Avenue
Suite 1
Youngstown, Ohio 44504

Dear Doctor Afrooz:

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

(1) In the routine course of practice as a neurologist you failed to conduct appropriate and adequate neurological examinations and/or failed to adequately document neurological examinations in Patients 1-40, as identified on the attached Patient Key (Key confidential - to be withheld from public disclosure).

(2)(A) In the routine course of your practice, you performed an initial needle Electromyography and Nerve Conduction Study (hereinafter, EMG) on Patients 2, 5, 13, 14, 15, 17, 20, 23, 24, 25, 27, 30, 31, 34, 35, 36, and 40 without appropriate indication and/or justification substantiated by their medical records.

(2)(B) Further, in the routine course of your practice, you performed repeat EMG's on Patients 2, 5, 13, 14, 15, 20, 23, 25, and 31, even though the initial EMG was not indicated, the initial EMG was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exams. Such acts include, but are not limited to, performing at least: nine EMG's on Patient 15; seventeen EMG's on Patient 13; twenty-three EMG's on Patient 5; and forty-eight EMG's on Patient 25.

(2)(C) Further, in the routine course of your practice, you performed repeat EMG's on Patients 1, 10, 16, 18, 26, 29, and 33 whose initial EMG may have been partially indicated, even though the results of the initial EMG were in fact normal, and the medical records failed to substantiate any justification for repeating the exams. Such acts include, but are not

limited to, performing at least: four EMG's on Patients 16 and 33; eleven EMG's on Patient 26; and thirteen EMG's on Patient 10.

(2)(D) Further, in the routine course of your practice, you performed repeat EMG's on Patients 3, 4, 6, 7, 9, 11, 12, 19, 21, 22, 28, 32, 37, 38, and 39 whose initial EMG may have been partially indicated, but the medical records failed to substantiate any justification for repeating the exams. Such acts include, but are not limited to, performing at least: twenty-one EMG's on Patient 6; twenty-two EMG's on Patient 12; twenty-four EMG's on Patient 22; and thirty-three EMG's on Patient 7.

(3) Further, in the routine course of your practice, you failed to examine the paraspinal muscles of Patients 1, 2, 3, 4, 6, 7, 9, 10, 12, 16, 17, 18, 22, 24, 26, 28, 29, 30, 33, 37, 38, and 40, whom you documented to have had one or more sign(s) or symptom(s) of radiculopathy or a compressed nerve at the root level, even though examination of the paraspinal muscles is mandatory in order to properly diagnose a radiculopathy or a compressed nerve at the root level;

(4)(A) In the routine course of your practice, you performed an initial Somatosensory Evoked Response study (S.E.R.) on Patients 1-7, 9, 10, 12-17, 19, 22, 23, and 25-40 without appropriate indication and/or justification substantiated by their medical records.

(4)(B) Further, in the routine course of your practice, you performed repeat S.E.R.'s on Patients 4-7, 9, 10, 12-16, 18, 22, 23, 25, 26, 28, 30-34, and 37-39, even though the initial S.E.R. was not indicated, the initial S.E.R. was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exam. Such acts include, but are not limited to, performing at least: fifteen S.E.R.'s on Patients 13 and 14; seventeen S.E.R.'s on Patient 22; nineteen S.E.R.'s on Patient 4; twenty-one S.E.R.'s on Patient 6; twenty-three S.E.R.'s on patient 7; twenty-five S.E.R.'s on Patient 5; and thirty-three S.E.R.'s on Patient 25.

(5)(A) In the routine course of your practice, you performed an initial Brainstem Auditory Evoked Response study (B.A.E.R.) on Patients 2-10, 12-18, 22, 23, 25-31, 33, and 37-39 without appropriate indication and/or justification substantiated by their medical records.

(5)(B) Further, in the routine course of your practice, you performed repeat B.A.E.R.'s on Patients 3-10, 12-16,18, 22, 23, 25, 26, 28, 30, 38, and 39 even though the initial B.A.E.R.was not indicated, the initial B.A.E.R. was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exam.

Such acts include, but are not limited to, performing at least: ten B.A.E.R.'s on Patients 15 and 22; eleven B.A.E.R.'s on Patient 9; fourteen B.A.E.R.'s on Patient 6; sixteen B.A.E.R.'s on Patient 14; twenty-one B.A.E.R.'s on Patient 5; twenty-two B.A.E.R.'s on Patient 13; and thirty-two B.A.E.R.'s on Patient 25.

(6)(A) In the routine course of your practice, you performed an initial Visual Evoked Response study (V.E.R.) on Patients 1-10, 12-18, 22-35, and 37-39 without appropriate indication and/or justification substantiated by their medical records.

(6)(B) Further, in the routine course of your practice, you performed repeat V.E.R.'s on Patients 1, 3-10, 12-16, 18, 22, 23, 25, 26, 28, 30, 34, and 37-39, even though the initial V.E.R. was not indicated, the initial V.E.R was normal or displayed only minimal abnormal findings, and the medical records failed to substantiate any justification for repeating the exam. Such acts include, but are not limited to, performing at least: sixteen V.E.R.'s on Patient 14; seventeen V.E.R.'s on Patient 7; twenty V.E.R.'s on Patient 13; twenty-three V.E.R.'s on Patient 5; and thirty V.E.R.'s on Patient 25.

(7)(A) In the routine course of your practice, you performed an initial Electronystagmography study (ENG) on Patients 3-7, 10, 14, 17, 18, 22, 23, 25, and 34 without appropriate indication and/or justification substantiated by their medical records.

(7)(B) In the routine course of your practice, you performed repeat ENG's on Patients 5, 10, 14, 23, 25, and 34, even though the initial ENG was not indicated, the initial ENG was normal, and the medical records failed to substantiate any justification for repeating the exam. Such acts include, but are not limited to, performing at least: two ENG's on Patients 10, 14 and 23; five ENG's on Patient 5; and twelve ENG's on Patient 25.

(8)(A) In the routine course of your practice, you inappropriately used Electroencephalography (EEG) as a screening tool on Patients 1, 2, 3, 10, 11, 16 -18, 21, 22, 24-27, 30, 31, 34, 35, 37, 38, and 39, who had complaints of headaches, and/or had no suggestion of seizure activity, and/or had no changes in their level of consciousness.

(8)(B) Further, you repeated the EEG studies on Patients 1, 2, 5, 7, 10, 13, 14, 16, 18, 25, 30, 37, and 39 despite the previous study being normal and without any appropriate indication and/or justification for repeating the exam substantiated by their medical records. Such acts include, but are not limited to, performing at least: eleven EEG's on Patient 5; and sixteen EEG's on Patients 13 and 25.

(9)(A) In the routine course of your practice, you performed Carotid Ultrasound studies on Patients 3-17, 21-23, 25-30, 32-35, 38, and 39 without appropriate indication and/or justification substantiated by their medical records.

(9)(B) Further, you repeated the Carotid Ultrasound studies on Patients 3-10, 12-16, 18, 22, 23, 25, 26, 28, 30, 38, and 39, even though the initial studies were not indicated, the initial studies were essentially normal, and the medical records failed to substantiate justification for repeating the studies. Examples of such acts include, but are not limited to, performing: ten Carotid Ultrasounds on Patient 4; fifteen Carotid Ultrasounds on Patient's 6 and 14; twenty Carotid Ultrasounds on Patient 13; twenty-two Carotid Ultrasounds on Patient 5; and thirty-one Carotid Ultrasounds on Patient 25, all of whom were under the age of 40 when initially seen. In fact, Patient 13 was seven years old and Patient 14 was twelve years old when initially seen.

(10)(A)In the routine course of your practice, between the years 1982 through at least 1991, you utilized Echoencephalography on Patients 1, 3-10, 12-18, 22, 23, 25, 26, 28, 30-33, 35, 37, 38, and 39, despite the fact that since approximately 1975 Echoencephalography has been rendered obsolete by the advent of computerized tomography and considered a valueless test.

(10)(B)Further, you repeated the valueless Echoencephalographies despite the reported normal results, on Patients 3, 5-10, 12-15, 22, 23, 25, 26, 28, 30, 31, 38, and 39. Examples of such acts include, but are not limited to, performing at least: sixteen Echoencephalographies on Patients 10 and 14; seventeen Echoencephalographies on Patient 6; twenty-six Echoencephalographies on Patient 5; twenty-nine Echoencephalographies on Patient 13; and thirty-six Echoencephalographies on Patient 25.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (10) above, individually and/or collectively, constitute "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

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

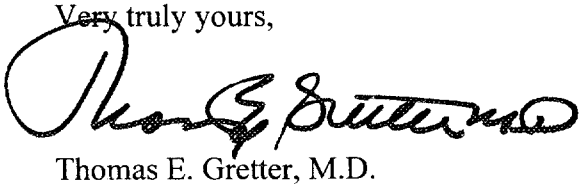
You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this

agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty (30) days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Thomas E. Gretter, M.D.
Secretary

TEG/bjs
Enclosures

CERTIFIED MAIL #P 152 983 023
RETURN RECEIPT REQUESTED

rev. 2/15/95