The Supreme Court of Ohio

FILED

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MARCIA J. MENGEL, CLERK
SUPREME COURT OF OHIO

Leonard K. Smith, M.D., Appellant,	:	Case No. 01-1599
v.	:	E N T R Y
State Medical Board of Ohio, Appellee.	:	

Upon consideration of the jurisdictional memoranda filed in this case, the Court declines jurisdiction to hear the case and dismisses the appeal as not involving any substantial constitutional question.

COSTS:

Docket Fee, $40.00, paid by Lane, Alton & Horst.

(Franklin County Court of Appeals; No. 00AP1301)

THOMAS J. MOYER
Chief Justice

0018r112101

HEALTH & HUMAN

SEP 0 6 2001

SERVICES SECTION

IN THE SUPREME COURT OF OHIO

LEONARD K. SMITH, M.D.,	:	
	:	On Appeal from the
Appellant,	:	Franklin County Court
	:	of Appeals, Tenth
	:	Appellate District
vs.	:	
	:	
STATE MEDICAL BOARD OF OHIO,	:	Court of Appeals
	:	Case No. 00AP-1301
Appellee.	:	

NOTICE OF APPEAL
OF APPELLANT LEONARD K. SMITH, M.D.

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COUNSEL FOR APPELLEE, STATE MEDICAL BOARD OF OHIO

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NOTICE OF APPEAL OF APPELLANT LEONARD K. SMITH, M.D.

Appellant Leonard K. Smith, M.D. hereby gives notice of appeal to the Supreme Court of Ohio from the Judgment of the Franklin County Court of Appeals, Tenth Appellate District, entered in Court of Appeals Case No. 00AP-1301 on July 19, 2001.

This case raises a substantial constitutional question and is one of public or great general interest.

Respectfully submitted,

By: _____
Jeffrey J. Jurca, Counsel of Record

By: _____
Alvin E. Mathews, Jr.

COUNSEL FOR APPELLANT
LEONARD K. SMITH, M.D.

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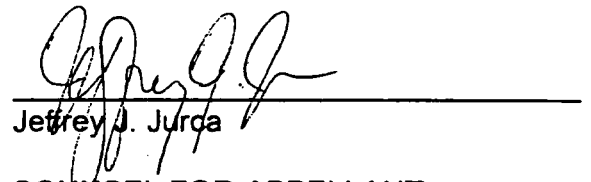
PROOF OF SERVICE

I certify that a copy of this Notice of Appeal was sent by ordinary U.S. Mail to Counsel for Appellee, Mary Kirchner Crawford, Assistant Attorney General, General Health & Human Services, 30 East Broad Street, 26th Floor, Columbus, OH 43215-3428, on September 4, 2001.



Jeffrey J. Jurca

COUNSEL FOR APPELLANT
LEONARD K. SMITH, M.D.

16

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FRANKLIN COUNTY, OHIO
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CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Leonard K. Smith, M.D.,	:	
Plaintiff-Appellant,	:	
v.	:	No. 00AP-1301
State Medical Board of Ohio,	:	(REGULAR CALENDAR)
Defendant-Appellee.	:	

JUDGMENT ENTRY

For the reasons stated in the opinion of this court rendered herein on July 19, 2001, appellant's assignments of error are overruled. Therefore, it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed.

LAZARUS, BOWMAN & BROWN, JJ.

By: Cynthia C. Lazarus
Judge Cynthia C. Lazarus

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FRANKLIN CO. OHIO

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CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Leonard K. Smith, M.D.,	:	
Plaintiff-Appellant,	:	
v.	:	No. 00AP-1301
State Medical Board of Ohio,	:	(REGULAR CALENDAR)
Defendant-Appellee.	:	

O P I N I O N

Rendered on July 19, 2001

Lane, Alton & Horst LLC, Jeffrey J. Jurca and *Alvin E. Mathews, Jr.*, for appellant.

Betty D. Montgomery, Attorney General, and *Mary K. Crawford*, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

LAZARUS, J.

Appellant, Leonard K. Smith, M.D., appeals from the judgment of the Franklin County Court of Common Pleas affirming the order of appellee, State Medical Board of Ohio ("Board"), suspending appellant's medical license for one hundred twenty days, placing him on probation, and imposing certain other conditions. For the reasons that follow, we affirm.

Appellant asserts the following assignments of error:

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ASSIGNMENT OF ERROR #1:

THE TRIAL COURT ERRED IN ITS DETERMINATION THAT THE BOARD'S ORDER IS BASED UPON RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE.

ASSIGNMENT OF ERROR #2:

THE TRIAL COURT ERRED IN ITS DETERMINATION THAT THE BOARD'S ORDER WAS ISSUED IN ACCORDANCE WITH LAW.

Appellant is a board-certified family practice physician in Hardin County and has been licensed to practice medicine in Ohio since 1973. In 1995, appellant conducted his practice out of his office in Kenton, Ohio, and at the Alger Health Clinic in Alger, Ohio. Appellant voluntarily closed the Alger Clinic as unprofitable in June of 1995 before he was aware of the Board's investigation into his practices.

Acting on a complaint that appellant had been permitting a nurse to see patients on her own at the Alger Clinic, David McCafferty, a Board investigator, posed as a patient and made an appointment at the Alger Clinic on April 4, 1995. Meanwhile, another Board investigator visited appellant's office in Kenton to make sure that appellant was in Kenton, and the nurse was working at the Alger Clinic by herself.

The nurse wrote a prescription for Adipex-P, a schedule IV controlled substance, on a prescription pad that had been pre-signed by appellant. The investigator never saw appellant that day or on a subsequent visit when he was given another prescription.

Another Board investigator, posing as a patient, made an appointment with appellant at the Alger Clinic for elbow pain. The same nurse saw this patient on April 10,

1995, and diagnosed tendonitis. She wrote a prescription for Naprosyn on a pre-signed prescription form. No physician saw the investigator.

By letter dated September 9, 1998, the Board notified appellant that they intended to take disciplinary action. In addition to the above-referenced incidents, the Board alleged that appellant had issued thirty-five post-dated prescriptions for Schedule II, III, and IV controlled substances to four different patients. The Board further alleged that appellant had treated seven patients for weight loss without determining whether the patients had previously made bona fide efforts to lose weight without the use of controlled substances. The Board also alleged that appellant had failed to obtain sufficient histories on those patients, had failed to perform a thorough examination, and continued to prescribe controlled substances even though the patients did not lose weight and showed signs of drug abuse.

The Board conducted a hearing on January 5th, 6th, February 16th, 17th, and March 17th, 1999. In a fifty-eight page report, the hearing examiner found that appellant had violated R.C. 4731.22(B)(1), (2), (3), (6), (10), (12), and (20), and Ohio Adm.Code 4731-11-02(B) and (D). The hearing examiner recommended an indefinite suspension of not less than one year along with five years probation and conditions and restrictions.

Appellant objected to the hearing examiner's report and appeared before the Board on June 9, 1999. The Board modified the report and recommendation of the hearing examiner, reducing the suspension to one hundred twenty days.

Appellant appealed to the court of common pleas. The common pleas court found that appellant had received a fair hearing and that the determination of the Board was supported by the evidence and in accordance with law. This appeal followed.

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On appeal to this court, appellant first argues that the court of common pleas erred in its determination that the Board's order is based upon reliable, probative and substantial evidence. Appellant argues that the Board did not meet its burden of providing sufficient evidence to substantiate the particular charges against him. Specifically, appellant takes issue with the finding that appellant failed to determine whether patients 1, 2, 4, 5, and 6 made efforts to lose weight without the use of controlled substances before appellant prescribed controlled substances. Appellant also disagrees with the findings of the hearing examiner and the Board that appellant continued to prescribe anorectics to patients who failed to lose weight, ignored patients' drug-seeking behavior, and post-dated prescriptions for them.

A court of common pleas is bound to uphold an order of the State Medical Board if that order is supported by reliable, probative, and substantial evidence. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621; *Hayes v. State Med. Bd. of Ohio* (2000), 138 Ohio App.3d 762, 767. A common pleas court should generally defer to administrative resolution of evidentiary conflicts. *Gen. Motors Corp. v. Joe O'Brien Chevrolet, Inc.* (1997), 118 Ohio St.3d 470, 482. Thus, as long as there is reliable, probative, and substantial evidence that supports the Board's findings, the common pleas court may not substitute its judgment as to disputed facts. *Id.* Whether any evidence supports the decision is a question of law. *Id.* at 483.

The responsibility of this court, in reviewing an administrative appeal, is limited to determining whether the trial court abused its discretion. *Roy v. Ohio State Med. Bd.* (1992), 80 Ohio App.3d 675. Our review of whether the Board's order is in

accordance with law is plenary. *Pons, supra*, at 621; *Ohio Historical Soc. v. State Emp. Relations Bd.* (1993), 66 Ohio St.3d 466, 471.

Turning to the factual determinations in this case, appellant argues that the evidence is uncontroverted that he took a medical history from patient 2 before prescribing anorectic drugs. Appellant also testified that it was his standard practice to take a history from his weight-loss patients and determine what efforts they had made in the past to lose weight. Thus, appellant claims it was error for the trial court to find that the Board's order was supported by reliable, probative, and substantial evidence.

The Board's allegations against appellant in regard to patients 1, 2, 4, 5, and 6, were that, prior to appellant's treatment of those patients with controlled substance anorectics, "[appellant] had failed to determine and/*or [his] records fail to reflect* that [he] determined that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective." (Emphasis added. State's Exh. 13, Sept. 9, 1998, Notice of Opportunity for Hearing.) In response to a direct question, appellant testified that he could not tell whether he had made specific inquiry as to patient 2's previous attempts to lose weight:

> Q. Okay. Did you make any inquiry of the patient as to whether or not the patient had attempted to lose weight previously via either caloric restrictions, nutritional counseling, behavior modification, or exercise?
>
> A. The record does not indicate, and I can't recall what conversation I might have had. The record does indicate some - - the record suggests some extent of conversation about the problems that he's having and the life that he's

> leading, and it may or may not have included that. But the record does not substantiate that.
>
> Q. So you cannot tell based upon your record whether or not you inquired regarding what specific attempts this patient had previously made to lose weight without using controlled substance anorectics; correct?
>
> A. That's right. That's right. [Tr. 432-433.]

Thus, by appellant's own admission, his records failed to reflect whether he had made such a determination.

Appellant next takes issue with the hearing officer's finding that appellant continued to prescribe controlled substance anorectics to patients who failed to lose weight. Appellant notes a comment from a Board member about a number of significant, life-saving, weight losses achieved by appellant's patients.

While it is true that over the years of their treatment, a number of appellant's patients lost significant amounts of weight, the specific charge against appellant was that he continued to prescribe weight loss drugs to patients who did not lose weight at the prescribed intervals required by law. Ohio Adm.Code 4731-11-04(B)(5), as promulgated in 1986, stated that a physician shall discontinue the use of Schedule III and IV controlled substances immediately if a patient has "failed to lose weight while under treatment with a controlled substance or controlled substances over a period of fourteen days." The report and recommendation of the hearing officer contains a chart documenting in great detail the instances when patients failed to lose weight in the previous fourteen-day period, yet the controlled substances were not discontinued.

Appellant also argues that the trial court erroneously analyzed appellant's conduct under a version of the rules that was not enacted until 1998, after the conduct

alleged in the Board's citation letter took place. While true, any such error is harmless given that there was ample evidence in the record that appellant violated the version of the rule in effect at the time the conduct was alleged to have taken place.

Appellant next argues that there is no reliable, probative, and substantial evidence that appellant's conduct in issuing post-dated prescriptions constituted a felony as the hearing examiner concluded. Appellant contends that the actual prescriptions are not part of the record and that no prosecutor in the state would consider appellant's actions to be a criminal offense.

Appellant, however, admitted that he issued post-dated prescriptions for Schedule II, III, and IV controlled substances, although he stated that he did so to insure that his patients did not receive too much medication too soon. Regardless of his intentions, the Board concluded that knowingly post-dating prescriptions constituted the making of a false statement in a drug document, a violation of R.C. 2925.23. The Board concluded that such conduct constituted "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in R.C. 4731.22(B)(10). Thus, in light of appellant's admission that he issued post-dated prescriptions, the court of common pleas did not abuse its discretion in finding that there was reliable, probative, and substantial evidence in the record that appellant engaged in criminal misconduct.

Appellant also argues that, in order to find that appellant's conduct constituted a felony, all elements of a criminal offense had to be proven beyond a reasonable doubt. This argument was rejected by this court in *Hayes, supra*. In *Hayes*, this court held that "the board is not required to prove that appellant committed the crimes

of perjury and falsification beyond a reasonable doubt. The board's action was against his podiatry license, which requires reliable, probative, and substantial evidence under R.C. Chapter 119." *Id.* at 772. See, also, *In re Eastway* (1994), 95 Ohio App.3d 516, 525 ("appellant's acts would constitute a felony in Ohio, thus violating R.C. 4731.22[B][10]. The fact appellant was not convicted of a felony is irrelevant").

The remaining allegations against appellant concerned the practice at the Alger Clinic. Appellant testified that he was on-site and may have seen and spoken briefly to patient 10, an undercover Board investigator, while the investigator waited for his appointment; however, appellant did not examine patient 10, nor did his nurse consult with him any time prior to writing out the prescription for Naprosyn. The evidence was clear that appellant was not on-site when the first undercover investigator came to the clinic, that the clinic nurse examined both patients, wrote prescriptions for them on pre-signed prescription pads, and gave the prescriptions to the patients without consulting appellant or anyone else. Accordingly, the trial court did not abuse its discretion in finding the Board's order to be supported by reliable, probative, and substantial evidence. The first assignment of error is not well-taken and overruled.

In his second assignment of error, appellant argues that the trial court erred in its determination that the Board's order was issued in accordance with law. In challenging the trial court's determination, appellant raises five different arguments. First, appellant argues that he was entrapped by the undercover investigators posing as patients. Second, he argues the charges against him are barred by the doctrine of laches. Third, he argues he was denied his right to cross-examine a Board employee. Fourth, he argues improper argument by the assistant attorney general prejudiced him.

And fifth, he argues he was denied due process as he was not given adequate notice of the charges against him, was required to defend himself against allegations that he had committed criminal acts absent being charged with a crime, and finally that he was denied access to information the Board deemed confidential. We shall address each of these arguments in turn.

Appellant has raised the affirmative defense of entrapment. In *Lakis v. Board of Liquor Control* (1963), 120 Ohio App. 163, 168, the defense of entrapment was defined as follows:

> "**** [T]he defense is available to one who is induced or lured by an officer of the law or other person for the purpose of prosecution into the commission of a crime which he otherwise had no intention of committing. ***."

Appellant argues that instead of simply telling him that there had been unconfirmed reports of the unlicensed practice of medicine occurring at the Alger Clinic, the Board sent in undercover investigators to entrap him. Failure to inform appellant of an investigation is not entrapment. Appellant has presented no evidence that the investigators induced or lured the nurse into seeing patients and prescribing medication when appellant was not present. The evidence indicates that the investigator simply sent another investigator to the Kenton office in order to be able to prove that appellant was not at the Alger Clinic while the nurse treated the first investigator. Having failed to establish the defense of entrapment, the argument is not well-taken.

Appellant next argues that the doctrine of laches bars this action on the basis that the Board's charges against appellant related to acts which allegedly occurred between 1989 and 1995. We disagree.

As a general rule, in the absence of a statute to the contrary, when the government brings a suit to enforce a public right or protect the public interest, laches is not a defense. *Ohio State Bd. of Pharmacy v. Frantz* (1990), 51 Ohio St.3d 143; *McCutcheon v. Ohio State Medical Bd.* (1989), 65 Ohio App.3d 49, 56. To the extent appellant is arguing his due process rights were violated by an unreasonable delay in prosecution, appellant must show more than mere delay occurred in bringing the action. See *McCutcheon* (three-year delay in bringing charges not unduly prejudicial). "Delay in asserting a right does not of itself constitute laches, and in order to successfully invoke the equitable doctrine of laches it must be shown that the person for whose benefit the doctrine will operate has been materially prejudiced by the delay of the person asserting his claim." *Smith v. Smith* (1959), 168 Ohio St. 447, paragraph three of the syllabus. Moreover, "the existence of laches is a question primarily addressed to discretion of trial court." *Gardner v. Panama Railroad Company* (1951), 342 U.S. 29.

Here, appellant argues the staleness of the charges resulted in material prejudice to him because he was unable to remember conversations with patients that occurred many years ago. Despite this claim, appellant was able to testify about each of his patients, in part, because he kept very thorough records. Accordingly, we find that appellant failed to demonstrate how he has been materially prejudiced by the Board's delay, and that the trial court did not abuse its discretion by rejecting the affirmative defense of laches.

Appellant next argues that Board employee David Katko's refusal to answer questions denied appellant the right to cross-examine witnesses. Appellant called, as if on cross-examination, Mr. Katko, and asked a series of questions about the Board's

investigation, including what subpoenas had been issued, what witnesses were interviewed, and what documents were obtained in the course of the investigation. Mr. Katko testified that he was unable to recall very little of the specifics of appellant's case because he had not reviewed appellant's file. In addition, Mr. Katko stated that he was not comfortable answering questions about the investigation that he deemed confidential.

While this court recognizes that appellant was understandably frustrated with Mr. Katko's lack of any specific recall of the facts of the investigation, appellant has not shown how he was prejudiced or how he was unable to defend himself in this matter. Appellant's cross-examination of Mr. Katko appeared unfruitful for the most part, but he was not denied the opportunity to question the witness. As to questions that Mr. Katko was unwilling to answer because he deemed the information confidential, former R.C. 4731.22(C)(1), now 4731.22(F)(5), provides that "[i]nformation received by the board pursuant to an investigation is confidential and not subject to discovery in any civil action." In *State Med. Bd. of Ohio v. Murray* (1993), 66 Ohio St.3d 527, 536, the Ohio Supreme Court stated that such information is to be kept confidential at all times. The hearing officer sustained a number of objections to questions concerning the confidential nature of the investigation. Other than general allegations that the Board's investigation was inadequate, appellant has not demonstrated the relevance of the questions Mr. Katko did not answer to the allegations set forth in the notice letter.

Appellant next argues that the assistant attorney general made closing remarks calculated to arouse passion or prejudice on the part of the Board. The Board's minutes reflect that the assistant attorney general stated that:

> Mr. McGovern [the AAG] stated that he did say at the conclusion of the hearing that Dr. Smith appeared to be a caring and compassionate physician. He will stand by that as to his apparent treatment of patients 1 through 8. However, regarding the two Board investigators, who were technically patients of Dr. Smith's practice, he was not a caring and compassionate physician. In fact, he had no involvement whatsoever in their care. This cuts against an impression that Dr. Smith tries to give that he is a caring and compassionate physician. Mr. McGovern stated that, to him, this is a physician who is more interested in practice volume and getting more money. The violations that occurred in relation to Ms. Myers [the clinic nurse] are egregious and appalling. [Excerpt from the minutes of June 9, 1999, at 4-5.]

The assistant attorney general was arguing one permissible inference that could be made from the evidence that appellant scheduled patients at the Alger Clinic while he was present at the Kenton office. We agree with the trial court that, although appellant desired the Board to infer that he was providing a community service by keeping the Alger Clinic open, we do not find that appellant was denied a fair hearing or prejudiced by the assistant attorney general's remarks.

Appellant next argues that he was not given adequate notice of the charges against him. Appellant contends that the charges with regard to the weight loss patients were vague, and the notice lacked precise dates.

Based on our review of the record, we agree with the trial court that the notice letter provided "very detailed and very specific" allegations against appellant. With respect to the weight loss patients, the notice letter charged that appellant had continued prescribing controlled substance anorectics to patients 1 through 7 when those patients failed to lose weight. This conduct was alleged to have violated Ohio Adm.Code 4731-11-04(B), which, at that time, provided that a physician shall discontinue the use of

Schedule III and IV controlled substances immediately if a patient has "failed to lose weight while under treatment with a controlled substance or controlled substances over a period of fourteen days." We hold that such notice was sufficient to inform appellant of the charges against him and did not present an unreasonable burden in preparing a defense. See *Johnson v. State Medical Bd. of Ohio* (Sept. 28, 1999), Franklin App. No. 98AP-1324, unreported (allegations that physician routinely prescribed controlled substances without recording objective findings substantiating the necessity of the medications did not present an unreasonable burden in preparing a defense).

Appellant's argument that he was required to defend himself against claims that he had committed criminal acts has already been addressed in connection with assignment of error one.

Appellant argues that his due process rights were violated because the hearing examiner is an employee of the Board. The presumptive validity of an administrative agency's determination means that the burden of establishing bias is upon appellant. *West Virginia v. Hazardous Waste Facility Approval Bd.* (1986), 28 Ohio St.3d 83, 86. The hearing officer submitted a detailed fifty-eight page report and recommendation meticulously reviewing the evidence. Appellant has presented no evidence of the hearing officer's bias other than the allegation that he was an employee of the Board. Such an allegation is insufficient to overcome the burden of establishing bias. See *id.* at 86 (examiner's former employment with the EPA insufficient to overcome the presumption of the integrity of the proceedings below).

Finally, appellant argues that he was denied due process because his requests for confidential information were denied. Appellant requested the Board

investigator's assessment of other subpoenaed records for which no charges were filed. Even if not confidential, as discussed previously, we fail to see the relevance of such requests.

In sum, the Board's order was in accordance with law and supported by reliable, probative, and substantial evidence, and the trial court did not abuse its discretion in so finding. The second assignment of error is not well-taken and is overruled.

Based on the foregoing, appellant's two assignments of error are overruled, and the judgment of Franklin County Court of Common Pleas is affirmed.

Judgment affirmed.

BOWMAN and BROWN, JJ., concur.

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

LEONARD K. SMITH, M.D.,	:	
Appellant,	:	
vs.	:	Case No. 99CVF-07-5481
STATE MEDICAL BOARD OF OHIO	:	Judge Watson
Appellee.	:	

NOTICE OF APPEAL

Notice is hereby given that Leonard K. Smith, M.D., Appellant, hereby appeals to the Court of Appeals for Franklin County, Ohio, Tenth Appellate District, from the Decision and Judgment Entry affirming the Order of the Ohio State Medical Board entered in this action on the 17th day of October, 2000.

Respectfully submitted,

LANE, ALTON & HORST LLC

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Attorneys for Appellant
Leonard K. Smith, M.D.

CERTIFICATE OF SERVICE

This is to certify that a true copy of the foregoing has been served by regular U.S. mail, postage prepaid, this 4th day of Nov., 2000 upon:

Mary Kirchner Crawford, Esq.
Assistant Attorney General
30 E. Broad Street, 26th Floor
Columbus, Ohio 43215-3428

Jeffrey J. Jurca
Alvin E. Mathews

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

SEP - 7 2001

LEONARD K. SMITH, M.D.,	:	
Appellant,	:	
	:	Case No. 99CVF-07-5481
vs.		
STATE MEDICAL BOARD OF OHIO	:	Judge Watson
Appellee.	:	

DECISION AND ENTRY SUSTAINING THE OCTOBER 17, 2000 MOTION OF APPELLANT FOR EXTENSION OF STAY

Appellant's Motion for Extension of Stay Pending Appeal is found to be well-taken and is hereby SUSTAINED, retroactive to October 2, 2000.

Judge Watson

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
00 OCT 19 AM 11:55
CLERK OF COURTS-CV

APPROVED BY:

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Attorneys for Appellant
Leonard K. Smith, M.D.

COPY TO:

Mary Kirchner Crawford, Esq.

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

LEONARD K. SMITH, M.D..,	]	FINAL APPEALABLE ORDER
Appellant,	]	**CASE NO. 99CVF07-5481**
	]	**JUDGE WATSON**
STATE MEDICAL BOARD, OF OHIO,	]	ENTERED NO. 18 BY KW
Appellee.	]	

DECISION AND JUDGMENT ENTRY AFFIRMING THE ORDER OF THE OHIO STATE MEDICAL BOARD

Rendered this 13th day of October, 2000.

FILED COMMON PLEAS COURT FRANKLIN COUNTY OHIO 2000 OCT 17 AM 8:18 CLERK OF COURTS

Watson, J.

This case is before the Court on a R.C. 119.12 appeal from the June 9, 1999 Order of the State Medical Board of Ohio suspending Dr. Smith's medical license for a period of 120 days and placing him on probation for at least five years with numerous conditions and restrictions on his certificate. It is from that Order that this timely appeal has been filed.

The events which led up to the Order are as follows. By letter dated September 9, 1998, Dr. Leonard K. Smith was notified that the State Medical Board (Board) intended to take disciplinary action against his Ohio medical license based on four allegations which can be summarized as follows:

- A board investigator, posing as a patient,[1] made an

HEALTH CARE SERVICES SECTION OCT 19 2000

[1] Referred to in the record as Patient 9.

appointment with Dr. Smith concerning a weight problem. He was seen on April 10, 1995 by a nurse employed by Smith. She wrote a prescription for Adipex-P, a schedule IV controlled substance on a prescription pad pre-signed by Smith. The investigator never saw the doctor that day nor on his subsequent visit on April 24, 1995 at which time he was given another prescription.

- Another board investigator, posing as a patient,[2] made an appointment with Dr. Smith for treatment of elbow pain. The same nurse saw this patient and diagnosed tendonitis. She wrote a prescription for Naprosyn on a pre-signed prescription form. No physician saw the investigator.

The Board's letter alleged that this conduct violated R.C. 4731.22(B)(1), (2), (6), (12) and (20) and OAC 4731-11-02(D) and (F).

- Dr. Smith treated Patients 1-7 (identified on patient key, but identities not revealed to protect confidentiality) for weight loss without determining whether bona fide efforts had been made to lose weight without controlled substances. Dr. Smith failed to obtain sufficient histories on these patients and failed to perform a thorough examination. He continued to prescribe the controlled substances despite the fact the patients did not lose weight and showed signs of drug abuse.

The Board alleged that these actions violated R.C. 4731.22(B)(2), (6), and 20 and OAC 4731-11-04.

- Dr. Smith issued 35 post-dated prescriptions for Schedule II, III and IV controlled substances to Patients 1, 3, 4 and 8.

The Medical Board advised that that conduct violated R.C. 4731.22(B)(10).

[2] Referred to in the record as Patient 10.

Dr. Smith was served with the notice of opportunity for hearing letter on September 11, 1999 and requested a hearing by letter from his attorney dated October 5. The hearing was held on January 5 and 6, February 16 and 17 and March 17, 1999. The record contains 968 pages of transcript, numerous exhibits and the patient records. The hearing examiner wrote a 58 page report and recommendation finding that most of the allegations were proved and recommending suspension indefinitely but for not less than one year and five years probation with conditions and restrictions. Appellant objected to the hearing examiner's report and recommendation and both he and his attorney were heard before the Board at its meeting held June 9, 1999. The Board modified the Report and Recommendation of the Hearing Examiner, reducing the suspension to 120 days. This timely appeal followed.

The facts in this case are simple and are, in large part, not disputed. It is the interpretation of those facts which is causing the problem. They can be succinctly stated as follows.

Dr. Smith is a family practice physician who has been practicing in Hardin County since 1973. His practice includes many patients who are unable to pay him, are on welfare or are receiving Worker's Compensation benefits. At the time of the hearing, he was also the Hardin County coroner. From 1994-95, Dr. Smith also had a clinic in Alger, Ohio which he eventually closed because it was not profitable. He learned of the availability of that clinic, in part, through a nurse who worked there Marilyn Myers, R.N. She is the nurse who prescribed the controlled substances for the two board investigators. Smith admitted that Myers saw patients at Alger while he was at Kenton.

She did so under "protocols" set up by Dr. Smith. They are in evidence at exhibit 24. She became a certified nurse practitioner in August, 1997, well after the Alger clinic closed.

When the Board investigator (McCafferty) referred to in allegation 1 went to Alger for his "weight loss" consultation, he sent another investigator (Saddler) to Kenton to be sure that Dr. Smith was there. He was investigating a complaint that the nurse was treating patients by herself and wanted to be able to prove that Smith was at Kenton during his appointment at Alger if the complaint was true. It was. The nurse weighed him and asked about any exercise program, but did not inquire about any past attempts to lose weight. She handed him the prescription from a pad of blank prescriptions, pre-signed by Smith, and she filled in the details. The investigator did not fill the prescription and it is in evidence. On the date of McCafferty's second appointment, Saddler returned to Kenton and found Dr. Smith's car in the parking lot. Meanwhile, McCafferty was being treated by Myers at Alger. She gave him a second prescription, exhibit 21, which had also been pre-signed by Dr. Smith. The medical records do indicate that his diet and level of exercise were discussed.

Patient 10, whose real name is Jeffrey Bradford and who is another investigator for the Board, made an appointment for right elbow pain. Dr. Smith left the Alger clinic while he was awaiting his appointment on April 26, 1995. After Dr. Smith left, the investigator was seen by Nurse Practitioner[3] Myers who diagnosed tendonitis and pulled a pre-signed prescription pad out of her pocket and wrote a prescription for Naprosyn.

[3] She wore a name tag which identified her as a nurse practitioner though she could not lawfully call herself that yet.

Myers claimed that Dr. Smith had pre-approved the use of the drugs and there were protocols which she felt allowed her to fill out the pre-signed forms.

Patients 1 through 7 were all treated with anorectics which were controlled substances. None of the records reflect that they were asked whether or not they had tried dieting without drugs. They were all given 1200 calorie diets and Adipex.

Patient 1 has a long history with Dr. Smith. Despite the fact that he was given Adipex P, the patient gained weight.[4] Dr. Smith continued to prescribe the drug for him on an irregular basis. Patient 1 was also taking Percodan and Darvocet for some legitimate health problems, but it is apparent that Dr. Smith knew he was abusing these prescription drugs because he exhibited drug seeking behavior such as claiming his medication was lost or stolen. Dr. Smith's own records reveal that he and other physicians had concerns about drug abuse early on and yet he continued to prescribe controlled substances. Many of the office notes appear to have been written by someone other than Dr. Smith because they refer to him in the third person. The treatment with controlled substances went on for five years with no real improvement.

Patient 2 lost weight dramatically when he began taking Adipex P in 1994 but then gained in mid-1995. Dr. Smith continued him on Adipex P regardless.

Patient 3's medical records show she also gained weight on Adipex although she denied it and testified on Smith's behalf. She has complicated medical problems and her obesity puts her at risk for heart disease and liver problems besides her diabetes and lung problems.

Patient 4 is the wife of Patient 1. She also was prescribed controlled substances to the point where both she and her husband were notified by the HMO that they needed to go to BioDyne for treatment. She also had a prior industrial injury. The records seem to indicate that Dr. Smith thought she might well have had a drug problem too although he denied thinking she did at the hearing.

Patient 5 also was treated with Adipex P and while he had a steady weight loss in the beginning, after a while he gained dramatically.

Patient 6 is the wife of patient 5 and was also prescribed Adipex while not losing weight.

Patient 7 is Appellant's wife. He treated her for weight loss. She too was continued on Adipex P despite failing to lose weight.

Patient 8 was a worker's compensation patient who had chronic back and neck problems from falls. He was given a number of controlled substances such as Darvocet and Tylenol 3 and the records are replete with requests for additional drugs.

Dr. Smith is accused of and admits to post dating prescriptions for Patients 1,3, 4, and 8. He urges that this kept them from abusing drugs rather than helped them do so. While they may have gotten the prescription early, he urges the date on the prescription should have kept them from being filled until the date they were due for more. He stated this was done mostly as a

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[4] As an example, the first time he was given Adipex P was in 1989. He was 5'7" tall and weighed 241 pounds on August 3, 1990. Six days later he had gained 10 pounds. Despite that, the

convenience for his patients. The problem is that Patients 1, 4 and 8 were drug seekers and Dr. Smith knew this.

The Weight Loss Treatment

Adipex P is a Schedule IV controlled substance. Dr. Smith's treatment of patients 1-7 and 9 with Adipex-P violated OAC 4301-11-04 in a number of ways:

- Dr. Smith did not determine what efforts the patients had made to lose weight before requesting the assistance of drug therapy:

  > (C)(1) Before initiating treatment utilizing a schedule III or IV controlled substance, the physician determines through review of the physician's own records of prior treatment, or through review of the records of prior treatment which another treating physician or weight-loss program has provided to the physician, that the patient has made a substantial good-faith effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, and exercise, without the utilization of controlled substances, and that said treatment has been ineffective.

- He failed to meaningfully monitor the weight loss:

  > (B) The appropriate utilization of controlled substances to assist in weight reduction requires continuing interaction between the physician and the patient to assess the patient's dedication to the treatment program, response to treatment, freedom from signs of drug or alcohol abuse, and the presence or absence of contraindications and adverse side effects. The physician shall personally meet face-to-face with the patient each time

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Adipex prescription was renewed.

> controlled substances are utilized for weight reduction, and shall record in the patient record information demonstrating the patient's continuing efforts to lose weight and the presence or absence of contraindications, adverse effects, and indicators of possible substance abuse that would necessitate cessation of treatment utilizing controlled substances.

There were clear indications of drug seeking behavior in Patient 1 and the records reflect concern in patient 4 and 8. Dr. Smith did not even see Patient 9 despite the fact that the regulation requires face to face contact between the patient and the physician. The patients all gained weight while on the Adipex at one time or another.

- Dr. Smith did not see Patient 9 and continued to prescribe for Patient 1 despite the fact that he sent him to BioDyne for treatment for drug addiction:

> (C)(3)The physician shall not utilize any schedule III or IV controlled substance when the physician knows or has reason to believe that a recognized contraindication to its use exists.

- Dr. Smith continued the treatment despite the fact that it was not working:

> (5) the physician shall not initiate or shall discontinue utilizing all schedule III or IV controlled substances . . . immediately upon ascertaining or having reason to believe:
>
> (a) That the patient has failed to lose weight while under treatment with a controlled substance or controlled substances over a

period of thirty days during the current course of treatment, which determination shall be made by weighing the patient at least every thirtieth day, except that a patient who has never before received treatment for obesity utilizing any controlled substance who fails to lose weight during the first thirty days of his first such treatment attempt may be treated for an additional thirty days; or

- Dr. Smith ignored clear drug seeking behavior and his own concerns for drug abuse in patients 1 and 8.

(6) The physician shall not initiate or shall discontinue utilizing all controlled substances for purposes of weight reduction immediately upon ascertaining or having reason to believe:

(a) That the patient has a history of or shows a propensity for alcohol or drug abuse, or has made any false or misleading statement to the physician relating to the patient's use of drugs or alcohol; or

(b) That the patient has consumed or disposed of any controlled substance other than in strict compliance with the treating physician's directions.

- Dr. Smith allowed his patients to go on and off the diet:

(7) Except as provided in paragraph (D) of this rule, the physician shall not resume utilizing a controlled substance following an interruption of treatment of more than seven days . . . unless the interruption resulted from one or more of the following:

(a) Illness of or injury to the patient justifying a temporary cessation of treatment; or

(b) Unavailability of the physician; or

> (c) Unavailability of the patient, if the patient has notified the physician of the cause of the patient's unavailability.

- He prescribed the drugs for longer than 12 weeks:

> (8) . . .the total course of treatment using that controlled substance shall not exceed twelve weeks.

The above acts are violative of the Ohio Revised Code:

> A violation of any provision of this rule, as determined by the board, shall constitute "failure to use reasonable care discrimination in the administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code; "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; and "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 division (B)(6) of section 4731.22 of the Revised Code.

A physician's license may properly be suspended for prescribing controlled substances for weight loss purposes without complying with the pertinent administrative rules. ***Stegall v. Ohio State Med. Bd. (1993), 92 Ohio App. 3d 389*** Appellant argues that these patients in fact lost weight. While this is true from time to time, there are dozens of instances in the records where Adipex P is given despite the fact that the patient not only did not lose, but gained, and the records also reflect that the doctor admonished them that this was not acceptable, but gave them the prescription anyway. There are instances

of patient 1 drinking beer with his diet medication and mixing other controlled substances with beer and Adipex. What is important here is not that the patient did this, but that the doctor, in continuing the prescription, condoned it.

The Alger Clinic

Nurse Myers was not permitted by law to dispense medication, much less controlled substances. While Appellant's so-called protocols are in evidence, he was authorizing the unlicensed practice of medicine in violation of 4731.22(B)(1), (2) and (12):

> The board, by an affirmative vote of not fewer than six 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 for one or more of the following reasons:
>
> (1) Permitting one's name or one's certificate to practice or certificate of registration to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given;
>
> (2) Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;
>
> (12) Commission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed;

Appellant and Ms. Myers attempt to justify their actions by claiming that she is a certified nurse practitioner which may arguably allow some of her conduct. However, she did not receive that license until 1997 and these acts took place in 1995. She clearly cannot prescribe controlled substances.

Post-Dated Prescriptions

Appellant wrote a total of 35 post dated prescriptions for the three patients who were the most likely drug dependent of the ten at issue—Patients 1, 4, and 8. Although Smith denies that he thought Patient 4 was drug dependent, his own records substantiate drug seeking behavior—calling and claiming her drugs were lost or accidentally put in the dishwasher. Patient 8 also exhibited drug dependency type actions—consistently calling and asking for something stronger for pain. The post-dating of prescriptions is a technical violation of R.C. 2925.23(A):

> No person shall knowingly make a false statement in any prescription, order, report, or record required by Chapter 3719. of the Revised Code.

R.C. 4731.22(B)(10) allows the Board to take action against Appellant for:

> Commission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed;

While there is no evidence of any harm which resulted from this conduct, and while the Board found that it can occasionally be justified, given the drug seeking behavior of these patients, certainly it was a dangerous practice. Coupled with the careless use of the anorectics and the handing out of blank prescriptions for use by the nurse, it was one factor in the overall discipline

warranted. Appellant is probably correct—that no prosecutor would take this case and the doctor may not be convicted if he did. Still, the statute only requires that the conduct constitute a felony, not that he be convicted of one.

Dr. Smith keeps meticulous records. While that is unusual in these type cases and commendable, the fact that they are so detailed contributed to his problems because they reflect concerns about drug seeking behavior and also reflect that he knew he could not prescribe Adipex-P without weight loss. Despite this knowledge, he continued to prescribe for these patients. The records also tend to rebut his contention that he or Ms. Myers inquired about past efforts to lose weight since those inquiries and/or responses are not within his highly detailed records.

Appellant's complaints in this case have more to do with procedure than substance. His first complaint is with the notice of opportunity letter which he claims gave him insufficient information with which to defend himself. In reality, this letter is very detailed and very specific. These are, after all, Dr. Smith's patients. He gave detailed testimony about how and why he treated them and his records are extremely thorough. In ***Johnson v. State Med. Bd. of Ohio, 1999 Ohio App. LEXIS 4487, Franklin App. No. 98AP-1324, unreported, decided September 28, 1999,*** the Court held that a party's due process rights are not violated where the Board's notice is sufficient to apprise Appellant of the precise nature of the charges to be raised against him at the disciplinary hearing and where he was afforded a full and fair opportunity to prepare and

present his defense to those charges. In this case, like ***Johnson,*** a patient key was provided and the precise three areas of concern were identified—allowing the nurse to prescribe medication with pre-signed prescription pads, improper use of diet anorectics, and back-dating prescriptions for controlled substances. The specific statutes and regulations he was charged with violating were listed in the notice letter. Appellant thoroughly cross-examined every witness and testified in his own behalf over roughly 400 pages of the transcript. Under ***Johnson,*** whose notice letter was not nearly as precise, due process was afforded Dr. Smith.

Dr. Smith further argues violations of due process in Appellee's refusal to provide him with documents it did not intend to use in the administrative hearing and the investigator's poor memory on cross-examination. Dr. Smith was not prejudiced by the hearing officer's refusal to allow him to cross-examine about sources of the information obtained during the investigation. The board's power to investigate evidence that suggests a violation of R.C. Chapter 4731 or a board rule is found in R.C. 4731.22(F):

> (1) The board shall investigate evidence that appears to show that a person has violated any provision of this chapter or any rule adopted under it.

That same section protects the confidentiality of the investigation:

> (5) Information received by the board pursuant to an investigation is confidential and not subject to discovery in any civil action.

State Med. Bd. of Ohio v. Murray (1993), 66 Ohio St. 3d 527.

It is for that reason that the investigator's testimony was not worthy of comment by the hearing examiner. His function was largely to oversee the investigation and collect the medical records, etc. The evidence itself is what resulted in Dr. Smith's brief suspension. Dr. Smith had ample opportunity, which he fully executed, to test that evidence.

Smith next argues that the Medical Board cannot accuse him of committing a crime when no prosecution has taken place. While their allegations may also amount to a crime, Dr. Smith had simply been charged with violating the Medical Practices Act. He has violated it as discussed above. R.C. 4731.22(B)(6) cited above allows the Board to take action against his license based on those violations. Allowing the unlawful prescribing of drugs and aiding and abetting the unauthorized practice of medicine may well be crimes, but in the context of these proceedings, they are violations of the Medical Practices Act and this is a civil proceeding. The State need only prove reliable, substantial and probative evidence that these acts occurred. It need not prove that felony conduct occurred beyond a reasonable doubt. For the same reason, the argument that the statute of limitations for some of the "crimes" has run is also without merit.

Appellant next argues that he was entrapped by the investigators. His theory is that if they had told him he was doing something wrong he would have stopped. That argument fails for several reasons. First, the investigator went to the Kenton office to speak to Dr. Smith in order to be able to prove

that he was not at the Alger Clinic where his partner was being treated by the nurse. This was an entirely proper investigative technique and was legitimately commenced because of complaints about a nurse treating patients on her own at the clinic. Second, there is no duty for the Board's investigators to inform Dr. Smith of his violations. Not only is he charged with knowing the law regarding his practice, but his records clearly reflect that he did know the law and expressed concern in his records about patients on Adipex not losing weight and fears that Patient 1 was addicted. Lastly, entrapment occurs where one is induced or lured by an officer or other person for the purpose of committing a crime which he otherwise had no intention of committing. Even if the investigator had provided the opportunity for the violation, which he did not, entrapment would not have been shown. ***UDF Ltd. Pshp. II v. Ohio Liquor Control Comm. 1999 Ohio App. LEXIS 5374, Franklin App. No. 98AP-1561, unreported, decided November 16, 1999.*** Here, the only thing the investigators did was fail to inform him that they were investigating him, an entirely proper and customary practice. Despite his protestations otherwise, his records reflect that he knew his conduct was violative of the medical regulations.

Next, Appellant argues that laches should prevent this prosecution since some of allegations are based on records which are nearly ten years old. However, Appellant has shown no prejudice. As stated above, he presented a lengthy defense, and thoroughly cross-examined the State's witnesses. In ***Ohio***

State Board of Pharmacy v. Frantz (1990), 51 Ohio St. 3d 153, the Supreme Court held in the syllabus, paragraphs 2 and 3:

> 2. The government cannot be estopped from its duty to protect public welfare because public officials failed to act as expeditiously as possible.
>
> 3. Laches is generally no defense to a suit by the government to enforce a public right or to protect a public interest.

Dr. Smith did not come to the attention of the Board until someone complained about Ms. Myers in 1995. While it does seem odd that the investigation took three years before the notice of opportunity for hearing was sent out in 1998, he has shown no prejudice by the delay. The cases cited by Appellant are distinguishable. In ***Cleveland Bar Assn v. Mallin, (2000)__Ohio St. 3d__***the timeframe for investigation was established by Gov. Bar R. V(4)(D). In ***Cols. Bar Assn v. Teaford (1966), 6 Ohio St 2d 253,*** the attorney was able to show prejudice since his witnesses' memories had faded.

The State's attorney's characterization of Dr. Smith's greed in her closing argument is not inflammatory. It is a reasonable inference which can be drawn from the evidence that Dr. Smith was scheduling patients at two offices while having the ability to be at only one or the other. Another reasonable inference, which Appellant would like the Court to draw, is that he was providing a valuable service to the community. Both are reasonable. Both are supported by the evidence. There is no apparent reason to assume that the hearing examiner was

impassioned or inflamed by the attorney general's comments. While this objection is typically made in criminal cases, it has been held in both criminal and civil cases that the outcome had to have been affected by the comments. It is the fairness of the trial which must be considered; not the conduct of the prosecutor. ***State v. Harris, 2000 Ohio App. LEXIS 2696, Franklin App. No. 99AP-1097, unreported, decided June 22, 2000; Syphax v. Kirkland, 2000 Ohio App. LEXIS 2169; Warren App. No. CA99-05-049, unreported, decided May 22, 2000.***

Finally, Appellant argues that the hearing examiner could not be fair based on the fact that he is an employee of the Board and therefore is inclined to find the allegations in the notice letter are true. That argument has been tried and rejected on numerous occasions. The Court must presume that the decision of an administrative board is valid and arrived at in a proper manner. ***Ohio Motor Vehicle Dealer's Bd. v. Central Cadillac Co. (1984), 14 Ohio St. 3d 64; Wheeling Steel Corp. v. Evatt (1944), 143 Ohio St. 71; Cleveland v. Budget Comm. (1977), 50 Ohio St. 2d 97.*** That presumption places upon the party contending bias to present evidence of impropriety or bias. ***Ohio Motor Vehicle Dealers Bd., supra; West Virginia v. Hazardous Waste Facility Approval Bd. (1986), 28 Ohio St. 3d 83.*** Since appellant did not present any evidence of bias of the hearing officer, the Court must presume the decision was valid and arrived at in a proper manner. ***In Re Tonti, 1993 Ohio***

App. LEXIS 3844, Franklin App. No. 92AP-1361 and 1386, unreported, decided August 3, 1993.

Appellant's characterization of the discussion by the Board members is tortured. He takes comments of one doctor and attributes them to the Board and takes them out of context and urges the Court to find that the Board did not believe his actions were inappropriate. For instance, Dr. Steinecker found that Appellant was legitimately trying to help his patients lose weight because of the myriad of other life-threatening problems some of them had. He seemed to feel that the effort should not be considered a violation because of those health problems. However, he did not justify the continued prescribing of controlled substances to people who were clearly not trying to help themselves and who were not losing weight. Everyone agreed that Dr. Smith kept good medical records and he is not charged with not keeping them. In fact, the extensiveness of his records is partly what caused the charges concerning the Adipex and the post dated prescriptions. No Board member condoned this activity other than to state that his heart was in the right place and post-dating prescriptions can occasionally be justified, but not for drug addicted patients. The Board's biggest concern was the nurse using the pre-signed prescription pads to prescribe controlled substances herself. While Dr. Smith attempted to deny that that was the purpose for which they were given to her, claiming they were for return to work releases, etc., the ALJ did not find that evidence credible. Dr. Smith argues that the Board's comments that the nurse was "doling out" prescriptions

repeatedly is unsupported by the evidence. Again, the Court finds that given the fact that she gave one to the investigators three out of three opportunities is pretty good evidence that it was a regular occurrence, especially given that they were new patients. Supposedly, Dr. Smith had a policy that he always saw his new patients himself before allowing Nurse Myers to treat them. He violated his own policy with both Patients 9 and 10.

In a R.C 119.12 appeal, the Court of Common Pleas must review the agency's record to determine whether its order is supported by reliable, substantial, and probative evidence and is in accordance with law. ***Pons v. Ohio State Med. Bd. (1993), 66 Ohio St. 3d 619; Univ. of Cincinnati v. Conrad (1980), 63 Ohio St. 2d 108.*** In reviewing the administrative order, the common pleas court generally defers to the administrative resolution of issues on which there is conflicting evidence. ***Id.*** In this case, the Hearing Examiner did a very good job of reviewing the evidence. Instead of rubber-stamping the Board's allegation in its notice letter, he meticulously reviewed the charges, the testimony, and the patient records and concluded that some charges were proved and some were not. His findings of fact and conclusions of law, which were subsequently adopted by the Board (except for a typographical correction), were adequately substantiated by the record. In fact, as previously noted, the patient records were quite harmful to Dr. Smith. The two patients Ms. Myers treated without so much as the presence of Dr. Smith on the premises

is indicative of how often that conduct probably occurred. Certainly, patients may well have been at risk.

The Board only modified the penalty and this it did because it found that Dr. Smith was a devoted physician trying to help his patients. However, there comes a time when you have to tell your patients "no" as he finally discovered with Patient 1. The problem was that he continued to prescribe controlled substances long after he should have stopped. This is only a 120-day suspension. Given the potential for serious harm to these patients and the Board's past history of revoking physicians who over-prescribed controlled substances[5], Dr. Smith was treated extremely fairly. The Board is composed primarily of experienced health professionals. The legislature and the courts have delegated comprehensive decision-making power to the Board. ***Murray, supra.*** That power includes the authority to discipline physicians for the transgressions they have committed without interference from the Court. The Board members, being physicians themselves, are uniquely qualified to determine how best to punish, and in some cases including this one, give assistance to the offending member of their own profession. The minutes of the Medical Board meeting clearly reflect a thoughtful and deliberative approach to their punishment of Dr. Smith. Because his transgressions were committed with good intentions for the most part, the Board treated him quite leniently. The

[5] The Court would grant that the revocations were on more egregious facts.(***Johnson, supra,*** for example)

Court is without authority to modify the penalty. ***Henry's Café, Inc. v. Bd. Of Liquor Control (1959), 170 Ohio St. 233.***

The evidence in this case meets the tests of R.C. 119.12. Dr. Smith was given a fair trial at the administrative level and was found by his peers to have violated the Medical Practices Act. That determination and the subsequent penalty are supported by the evidence and are in accordance with the law. The Order of the Ohio State Medical Board is **AFFIRMED.** Costs to Appellant.

MICHAEL H. WATSON, JUDGE

Appearances:

Jeffrey S. Jurca, Esq.
Attorney for Appellant

Mary K. Crawford, Esq.
Attorney for Appellee

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO

OHIO STATE MEDICAL BOARD
JUL 28 1999

Leonard K. Smith, M.D.,	:	
Plaintiff,	:	
vs.	:	Case No. 99CVF07-5481
State Medical Board of Ohio,	:	Judge Michael H. Watson
Defendant.	:	

DECISION AND ENTRY SUSTAINING THE JULY 2, 1999 MOTION OF APPELLANT FOR STAY PENDING APPEAL

Rendered this 27th day of July, 1999.

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
99 JUL 27 PM 4:22
CLERK OF COURTS

WATSON, JUDGE

Before the Court is the July 2, 1999 Motion of Appellant Leonard K. Smith, M.D. (hereinafter "Appellant") for Stay Pending Appeal. Appellee State Medical Board of Ohio (hereinafter "Appellee") filed a Memorandum in Opposition on July 16, 1999.

Appellant seeks, pursuant to O.R.C. §119.12, a stay of Appellee's June 9, 1999 Order (hereinafter "Order") suspending his medical license for one hundred and twenty (120) days. He contends an undue hardship will result if the Order is allowed to take effect. Specifically, if a stay is not permitted, Appellant argues he will serve all, or most, of his suspension, prior to this matter being fully briefed and ready for the Court's review. Accordingly, without a stay of the suspension pending review by this Court, Appellant contends he will be deprived any effective judicial review as he is unable to be compensated for the harm he may suffer during the suspension period. Finally, Appellant maintains that a stay of the Order will not threaten the health, welfare and safety of the public.

In response, Appellee argues Appellant fails to set forth the requisite element of O.R.C. §119.12. Appellee maintains Appellant has failed to demonstrate that a denial

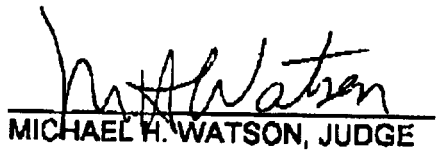
of the stay will result in an unusual hardship and that the public's health and safety will be protected if a stay of the Order is allowed.

O.R.C. §119.12 states, in relevant part:

> ... In the case of an appeal from the state medical board or chiropractic examining board, the court may grant a suspension and fix its terms if it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal and the health, safety, and welfare of the public will not be threatened by suspension of the order. This provision shall not be construed to limit the factors the court may consider in determining whether to suspend an order of any other agency pending determination of an appeal....

Upon review, the Court concludes an unusual hardship will result if a stay of Appellee's Order is not permitted. First, Appellant is the elected Coroner of Hardin County. While Appellant may eventually serve the subject suspension, the Court is of the opinion that an interruption of his service as Coroner prior to a final resolution of the appeal imposes an undue hardship upon Appellant and the citizens of Hardin County. Second, the Court was informed that Appellant's wife is currently very ill. Again, while the suspension may ultimately be served, denial of a stay may result in an unnecessary interruption of her medical treatment at a critical stage. Finally, as argued by Appellant, if a stay is not entered, he will likely complete his entire suspension prior to a review of the Order by the Court. Accordingly, the Court concludes Appellant will suffer an unusual hardship if a stay of the Order is not entered. Furthermore, public health, safety, and welfare will not be in jeopardy if a stay is granted as the practices which have resulted in Appellant's suspension have not been committed in over three (3) years.

Accordingly, the July 2, 1999 Motion of Appellant for Stay Pending Appeal is hereby **SUSTAINED**.



MICHAEL H. WATSON, JUDGE

Copies to:

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IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

LEONARD K. SMITH, M.D., **900 East Franklin Street** **Kenton, Ohio 43326**	:	
Appellant,	:	
vs.	:	**Case No.**
STATE MEDICAL BOARD OF OHIO **77 South High Street, 17th Floor** **Columbus, Ohio 43266-0315**	:	**Judge**
Appellee.	:	

STATE MEDICAL BOARD
99 JUL -2 AM 7:20

NOTICE OF APPEAL

Leonard K. Smith, M.D., hereby gives notice of his appeal, pursuant to R.C. 119.12, of the Order of the State Medical Board of Ohio, dated June 9, 1999, and mailed on June 28, 1999, a copy of which is attached hereto.

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

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Alvin E. Mathews (0038660)
175 South Third Street
Columbus, Ohio 43215
(614) 228-6885
Attorneys for Appellant
Leonard K. Smith, M.D.

CERTIFICATE OF SERVICE

This is to certify that a true copy of the foregoing has been served by regular U.S. mail, postage prepaid, this 2d day of JULY, 1999 upon:

James M. McGovern
Ohio Attorney General Health & Human Services
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428

Jeffrey J. Jurca
Alvin E. Mathews

State Medical Board of Ohio

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

June 9, 1999

Leonard K. Smith, M.D.
900 E. Franklin Street
Kenton, OH 43326

Dear Doctor Smith:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 9, 1999, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal 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.

Anand G. Garg, M.D.
Secretary

AGG:jam
Enclosures

CERTIFIED MAIL RECEIPT NO. Z 233 839 222
RETURN RECEIPT REQUESTED

cc: Jeffrey J. Jurca, Esq.
CERTIFIED MAIL RECEIPT NO. Z 233 839 223
RETURN RECEIPT REQUESTED

Mailed 6/28/99

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 9, 1999, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Leonard K. Smith, 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)

JUNE 9, 1999
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

*

LEONARD K. SMITH, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on June 9, 1999.

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

It is hereby ORDERED that:

1. The certificate of Leonard K. Smith, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of one hundred twenty (120) days.

2. Upon reinstatement, Dr. Smith's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five years:

    a. Dr. Smith shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

    b. Dr. Smith shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

    c. Dr. Smith shall appear in person for interviews before the full Board or its designated representative within three months of the date in which probation becomes effective, at three month intervals thereafter, and upon

his request for termination of the probationary period, or as otherwise requested by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Smith's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Smith shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

d. Dr. Smith shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of probation. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which probation becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

e. Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Smith shall provide acceptable documentation of successful completion of a course dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the biennial registration period(s) in which they are completed.

f. Within thirty (30) days of the reinstatement of Dr. Smith's certificate, Dr. Smith shall provide a copy of this Order to all employers or entities with which he is under contract to provide physician services or is receiving training, and the Chief of Staff at each hospital where Dr. Smith has privileges or appointments. Further, Dr. Smith shall provide a copy of this Order to all employers or entities with which he contracts to provide physician services, or applies for or receives training, and the Chief of Staff at each hospital where Dr. Smith applies for or obtains privileges or appointments.

g. Dr. Smith shall provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for licensure or reinstatement of licensure. Further, Dr. Smith shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.

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

i. If Dr. Smith violates probation in any respect, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.

j. Dr. Smith shall not prescribe, administer, dispense, order, write orders for, give verbal orders for, or possess (except as prescribed for his use by another so authorized by law), without prior Board approval, the following drugs:

a. Controlled substance anorectics

Moreover, Dr. Smith shall not seek the Board's approval for a change in this provision for a minimum of one year from the reinstatement of Dr. Smith's certificate.

k. If Dr. Smith violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

3. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Smith's certificate will be fully restored.

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

Anand G. Garg, M.D.

Anand G. Garg, M.D.
Secretary

(SEAL)

JUNE 9, 1999
Date

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REPORT AND RECOMMENDATION
IN THE MATTER OF LEONARD K. SMITH, M.D.

The Matter of Leonard K. Smith, M.D., was heard by R. Gregory Porter, Attorney Hearing Examiner for the State Medical Board of Ohio, on January 5 and 6, February 16 and 17, and March 17, 1999.

INTRODUCTION

I. Basis for Hearing

A. By letter dated September 9, 1998, the State Medical Board of Ohio [Board] notified Leonard K. Smith, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations concerning his treatment of Patients 1 through 10. (See State's Exhibit 12.) The Board alleged that the acts, conduct, and/or omissions of Dr. Smith, individually and/or collectively, constituted violations of the following statutory provisions:

- "'[p]ermitting one's name or one's certificate of registration to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given,' as that clause is used in Section 4731.22(B)(1), Ohio Revised Code";

- "'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: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate";

- "'[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice,' as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, as in effect prior to July 1, 1996, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate";

- "'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

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Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code";

- "'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 4731-11-04(B), Ohio Administrative Code"; and/or

- "'[c]ommission of an act that constitutes a felony in this state regardless of the jurisdiction in which the act was committed,' as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.23, Ohio Revised Code, Illegal processing of drug documents."

The Board further alleged that, 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. Moreover, the Board alleged that, pursuant to Rule 4731-11-04(C), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.

Finally, the Board advised Dr. Smith of his right to request a hearing in this matter. (State's Exhibit 13)

B. By letter received by the Board on October 5, 1998, Jeffrey J. Jurca, Esq., requested a hearing on behalf of Dr. Smith. (State's Exhibit 14)

II. Appearances

A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by James M. McGovern, Assistant Attorney General.

B. On behalf of the Respondent: Jeffrey J. Jurca and Alvin E. Mathews Jr., Esqs.

EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

1. David Shawn McCafferty
2. Jeffrey D. Bradford

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3. Karl Saddler
4. Leonard K. Smith, M.D., as upon cross-examination
5. Marilyn J. Myers, R.N., as upon cross-examination

B. Presented by the Respondent

1. Mary Harp
2. Larry Baker
3. Diana Smith
4. David P. Katko, as upon cross-examination
5. Leonard K. Smith, M.D.

II. Exhibits Examined

A. Presented by the State

* 1. State's Exhibits 1 through 10: Copies of medical records for Patients 1 through 10.

* 2. State's Exhibit 11: Patient record verification.

* 3. State's Exhibit 12: Patient Key.

4. State's Exhibits 13 through 18: Procedural exhibits.

5. State's Exhibit 19: Statements of services provided by Dr. Smith for Patients 9 and 10.

6. State's Exhibits 20 through 22: Prescriptions written for Patients 9 and 10.

* 7. State's Exhibit 23: Copy of Dr. Smith's patient appointment calendar.

8. State's Exhibit 24: Copy of Dr. Smith's nurse practitioner job description and protocols.

9. State's Exhibit 25: Copy of literature provided to weight-loss patients by Dr. Smith.

10. State's Exhibit 26: Copy of Marilyn J. Myers' Application for Certificate of Nurse Practitioner.

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B. Presented by the Respondent

1. Respondent's Exhibit B: Telephone records for Dr. Smith's Alger, Ohio office.

2. Respondent's Exhibit C: Example prescription written to Jim McGovern by Dr. Smith for 20 Vicodin with two refills.

3. Respondent's Exhibits D through F: Letters of support for Dr. Smith.

C. Post-Hearing Admissions to the Record

* 1. Respondent's Exhibit H: Copy of Dr. Smith's medical records for Patient 7 for events occurring after October 19, 1995.

* 2. Respondent's Exhibit I: Copy of Dr. Smith's medical records for Patient 5 for events occurring after October 19, 1995.

* 3. Respondent's Exhibit J: Copy of Dr. Smith's medical records for Patient 6 for events occurring after October 19, 1995.

* 4. Respondent's Exhibit K: Copy of Dr. Smith's medical records for Patient 3 for events occurring for events occurring after October 19, 1995.

* 5. Respondent's Exhibit L: Copy of Dr. Smith's medical records for Patient 8 for events occurring after October 19, 1995.

* 6. Respondent's Exhibit M: Copy of Dr. Smith's medical records for Patient 4 for events occurring after October 19, 1995.

7. Respondent's Exhibit N: Letter of support for Dr. Smith.

III. Proffered Evidence

The following exhibits were not admitted to the record and were not reviewed for purposes of preparing this Report and Recommendation. However, they will be held as proffered exhibits for review by the courts during any subsequent appeal.

A. Respondent's Exhibit A: Article published by the National Association of Boards of Pharmacy Foundation, Inc.

B. Respondent's Exhibit G: Collection of Formal Action Mailing List Memoranda issued by the Board.

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C. Board Exhibits A and B: Oral argument by Attorney Jurca on behalf of the Respondent on February 17, 1999, and March 17, 1999, and separated from the Hearing Transcript.

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

PROCEDURAL MATTERS

1. The hearing record was held open until March 24, 1999, at the request of the Respondent in order to give him an opportunity to supplement the records with updates of his patient records. These items were received into evidence on March 24, 1999, and the hearing record closed on that date.

2. Administrative notice is hereby taken of the following, based upon federal law:

   a. Adipex P is a Schedule IV controlled substance;
   b. Darvocet N-100 is a Schedule IV controlled substance;
   c. Diazepam 5 mg. is a Schedule IV controlled substance;
   d. Tenuate Dospan 75 mg. is a Schedule IV controlled substance;
   e. Valium 5 mg. is a Schedule IV controlled substance;
   f. Fiorinal is a Schedule III controlled substance;
   g. Tylenol No. 3 is a Schedule III controlled substance;
   h. Vicodin ES is a Schedule III controlled substance;
   i. Percocet is a Schedule II controlled substance; and
   j. Percodan is a Schedule II controlled substance.

SUMMARY OF THE EVIDENCE

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

Background Information

1. Leonard K. Smith, M.D., testified that he obtained his Doctor of Medicine degree in 1972 from the University of Miami School of Medicine. After having started his residency training in obstetrics and gynecology, Dr. Smith completed a residency in family medicine at Jackson Memorial Hospital, Miami, Florida. Dr. Smith stated that he has been board certified in family medicine since 1976. Dr. Smith further testified that he is a member of the American Academy of Family Practice, the Ohio State Medical Association, and the Hardin County Medical Society. Dr. Smith stated that he holds courtesy privileges at

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Hardin Memorial Hospital, Kenton, Ohio; and Marion General Hospital, Marion, Ohio. Moreover, Dr. Smith testified that he is currently serving his second term as Hardin County Coroner. (Hearing Transcript at pages [Tr.] 269-272, 794-798)

2. Dr. Smith testified that he was licensed to practice medicine in Ohio in October 1973. He also holds a license to practice medicine in Tennessee. Dr. Smith indicated that he has maintained a license in Tennessee because his family is from that state and he maintains ties to that state. Dr. Smith testified that he has never before faced professional disciplinary action in either state. (Tr. 793-794)

3. Dr. Smith testified that he came to practice in Ohio when an opportunity presented itself in Kenton, Ohio. He had originally viewed that opportunity to be temporary, but stated that he is still there after 25 years. Dr. Smith testified that he has a family practice in a rural community; Kenton, with approximately 10,000 residents, is the only city in Hardin County. Moreover, Dr. Smith testified that Hardin County has a population of approximately 30,000 residents, and is a medically underserved area. Dr. Smith testified that he sees patients of all ages, and that his practice includes welfare recipients and Workers' Compensation patients. Dr. Smith stated that he has about 3,000 active charts. (Tr. 796-800)

Patient 1

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 1:

   a. Prior to Dr. Smith's treatment of Patient 1 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 1 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

   b. Further, in Dr. Smith's treatment of Patient 1 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 1.

   c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 1 when Patient 1 failed to lose weight.

   d. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 1, despite Dr. Smith's suspicions that Patient 1 exhibited signs of drug abuse."

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e. Dr. Smith issued postdated prescriptions for Schedule IV controlled substances to Patient 1.

2. Dr. Smith testified that Patient 1 suffered from a serious and painful condition in his right wrist brought on by an industrial injury. Dr. Smith referred Patient 1 to a number of specialists, but the results of those referrals were unsuccessful. Dr. Smith indicated that Patient 1 was a very difficult patient to manage in that his condition required analgesic medication, and he also had a problem with drug addiction. (State's Exhibit [St. Ex.] 1; Tr. 830-837)

Dr. Smith testified that Patient 1 was also a weight-control patient. Dr. Smith indicated that he had believed that it had been important that Patient 1 lose weight because Patient 1 was significantly overweight, and had other risk factors such as smoking and high cholesterol. Dr. Smith noted that Patient 1 did not do well initially with his weight loss program, but successfully lost weight later in the program. (St. Ex. 1; Tr. 837-839)

Dr. Smith concedes that there are elements of his care and treatment of Patient 1 that are "rocky." Dr. Smith further testified that he has learned from the experience. (Tr. 839-840)

3. Dr. Smith testified that he wrote the following postdated prescriptions for Patient 1:

Prescription	Prescription Issued	Prescription Dated
Adipex, quantity unspecified	10/27/92	10/30/92
20 Darvocet N-100	2/22/93	2/23/93
20 Darvocet N-100	2/26/93	2/27/93
20 Darvocet N-100	3/23/93	3/24/93
20 Darvocet N-100	5/11/93	5/14/93
20 Darvocet N-100	8/23/93	8/24/93
14 Adipex	8/24/93	8/26/93
20 Darvocet N-100	9/13/93	9/14/93
28 Diazepam 5 mg.	3/25/94	3/27/94
28 Diazepam 5 mg.	5/27/94	5/28/94

(St. Ex. 1, pp. 13B, 14B, 15, 16, 17B, 18; Tr. 358-362)

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4. Dr. Smith issued prescriptions for Adipex P to Patient 1 on the following dates:

Date	Weight	Date	Weight
12/8/89	251	7/17/92	251
12/22/89	247.2	7/30/92	247.3
6/22/90	247	10/16/92	249.5
7/20/90	242.6	10/27/92	248.8
8/3/90	241	11/27/92	249.3
8/24/90	240.5	12/11/92	243.7
9/1/90	241	1/4/93	241.4
10/15/90	251	1/19/93	244.3
11/2/90	244	3/30/93	251.9
11/16/90	248	4/13/93	250.6
11/29/90	255	4/27/93	243
12/13/90	262.5	5/11/93	239.3
1/4/91	252.7	5/28/93	244.5
1/15/91	252	6/11/93	238.2
2/22/91	253.9	6/28/93	234.6
3/11/91	255.2	7/12/93	230.5
4/8/91	251.6	7/30/93	231.5
4/22/91	252.4	8/12/93	228.0
6/7/91	248	8/24/93	224.6
7/16/91	255	9/7/93	223.5
10/4/91	265.4	9/21/93	221
10/18/91	266.3	10/5/93	219.3
11/1/91	260	10/19/93	215.7
12/2/91	263	11/2/93	213.2
12/13/91	265	11/16/93	208.9
12/30/91	265.0	11/29/93	210.2
1/13/92	256.2	12/13/93	207.2
1/27/92	260.2	12/27/93	216.5
2/11/92	269	1/25/94	213.4
2/24/92	260	2/11/94	213.1
3/10/92	265	2/25/94	211.6
6/16/92	252.1	5/26/94	217.2
		6/9/94	210.4

(St. Ex. 1, pp. 4-19) Entries contained in these records include the following:

a. An entry dated December 27, 1993, says "Overweight with extenuating circumstances causing his weight gain." (St. Ex. 1, p. 17)

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b. On June 23, 1994, Patient 1 weighed 218.9, a gain of 8.5 pounds since the previous visit. The entry notes "[u]nacceptable weight gain." No Adipex P was prescribed. (St. Ex. 1, p. 18)

5. Evidence concerning these prescriptions included the following:

a. Dr. Smith first prescribed Adipex P, a controlled substance anorectic, to Patient 1 on December 8, 1989. Dr. Smith testified that Patient 1 "was clearly overweight, and it seemed like a logical approach to help him with his overweight problem." Dr. Smith acknowledged that his examination of Patient 1 that day was largely or exclusively related to the patient's chief complaint involving his foot. Dr. Smith further testified that he could not recall if he had inquired of Patient 1 concerning any previous efforts on Patient 1's part to lose weight via caloric restriction; however, Dr. Smith acknowledged that his medical records did not so indicate. Moreover, Dr. Smith testified that the medical records do not state whether Dr. Smith had inquired concerning whether Patient 1 had previously undergone nutritional counseling, or whether Dr. Smith offered any nutritional counseling to Patient 1. Nevertheless, Dr. Smith testified that he believes it is likely that nutritional counseling was offered at that time. Finally, Dr. Smith acknowledged that the medical records do not indicate whether Patient 1 was questioned concerning previous attempts to lose weight via exercise. In addition, the medical records do not indicate that Dr. Smith had inquired into Patient 1's previous efforts to lose weight via behavior modification. (St. Ex. 1, p. 4; Tr. 365-376)

The medical records indicate that Patient 1 was an established patient of Dr. Smith's prior to first receiving a prescription for controlled substance anorectics on December 8, 1989. Although the physical examination performed on that date was focused on Patient 1's foot pain; Dr. Smith had previously performed physical examinations on, and obtained a history from, Patient 1. (St. Ex. 1, pp. 3-4)

b. Dr. Smith testified that he could not explain the gap in weight control treatment that occurred between April 12 and June 22, 1990. Moreover, Dr. Smith indicated that Patient 1 had gained 10 pounds between those dates. Nevertheless, Dr. Smith testified that it would be reasonable to assume that Patient 1 had ceased dieting during that period. Dr. Smith restarted Adipex P therapy on June 22, 1990. (St. Ex. 1, p. 4-6B; Tr. 376-381)

c. Dr. Smith could not recall at hearing why a brief gap in Patient 1's treatment with anorectics had occurred between August 24 and September 21, 1990. Dr. Smith speculated that events may have transpired that had prevented Patient 1 from continuing with his therapy during that period. (St. Ex. 1, pp. 7-7B; Tr. 385-389)

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d. Another brief gap in treatment occurred between September 21 and October 15, 1990. Dr. Smith testified that a two-week supply had been prescribed on September 21, 1990, and that that supply would have been expected to run out by October 5, 1990. Dr. Smith could not recall why Patient 1 wasn't seen at the regular interval, but indicated that the patient had significant problems in other areas of his life that may have interfered. Dr. Smith further testified that he had continued Patient 1 on Adipex P on October 15, 1990, even though Patient 1 had gained weight since the previous visit, because Patient 1 was "considerably overweight," had co-morbid risk factors, and would have benefited from losing weight. Dr. Smith acknowledged that the situation was not ideal, but added that "sometimes life's situations are less than ideal." Dr. Smith could not recall if he had stressed to Patient 1 the importance of seeing him every two weeks while on anorectic drug therapy. (Tr. 389-393)

e. The medical records indicated that Patient 1 had been prescribed Adipex P on November 2, 1990, and that he had weighed 244 pounds at that time. Dr. Smith next prescribed Adipex P to Patient 1 on November 16, 1990, when Patient 1 weighed 248 pounds. Dr. Smith testified that he could not recall the circumstances surrounding the November 16, 1990, prescription, but stated that it had been important to Patient 1 that Patient 1 lose weight. Dr. Smith next prescribed Adipex P to Patient 1 on November 29, 1990, at which time the patient weighed 255 pounds—a gain of seven pounds since the previous visit. When asked why he had continued to prescribe Adipex P to Patient 1 when Patient 1 was failing to lose weight, Dr. Smith answered, "Good question." Dr. Smith testified that, in retrospect, he should have discontinued anorectic therapy, and could not recall why he did not. (St. Ex. 1, pp. 8-8B; Tr. 393-396)

Following the November 29, 1990, prescription, Dr. Smith next prescribed Adipex P to Patient 1 on December 13, 1990, at which time Patient 1 weighed 262.5 pounds—a gain of approximately seven pounds since his previous visit. When asked why he had again prescribed Adipex P to a patient who had failed to lose weight, Dr. Smith replied, "Touché." Dr. Smith further testified that the State's point had "been made repeatedly and is appreciated and is painful." Moreover, Dr. Smith's response was similar concerning another prescription for Adipex P issued to Patient 1 on February 22, 1992, when Patient 1 had failed to lose weight since the previous visit. Finally, Dr. Smith testified that he had "no rational explanation to explain for what occurred many, many years ago." (St. Ex. 1, pp. 8B; Tr. 396-398, 418-419)

6. Dr. Smith testified concerning his interpretation of "short term" as that phrase is used in the Physicians' Desk Reference concerning Adipex P. Dr. Smith testified that his interpretation "would be that as long as a person is successfully losing weight and is finding that the medication is helpful and adequately suppressing the individual's diet, that

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would be a short term." Dr. Smith further testified that he had applied that definition to his prescribing of Adipex P to Patient 1. Dr. Smith stated that "the patient was in fits and spurts on and off a diet, and if short-term means to initiate and use this as adjunct for those times, it was appropriate." (Tr. 403-410)

7. In the medical records, Dr. Smith noted that Patient 1 had been using Percodan "in addicting quantities." An entry dated December 2, 1991, stated that Dr. Smith had discussed his concerns about Patient 1'a use of Percodan with other physicians. On that date, Dr. Smith referred Patient 1 to BioDyne for prescription drug abuse counseling. Another entry, dated December 13, 1991, indicated that Dr. Smith and Patient 1 had discussed Patient 1's evaluation at BioDyne, and that "the [consulting specialist] realizes that [Patient 1] has a problem and he will be on the 12 week program for withdrawal." (St. Ex. 1, p. 11; Tr. 412-418)

   Subsequently, an entry dated May 11, 1993, stated that "hopefully [the Camera Center] will wean [Patient 1] off his Darvocet." Dr. Smith testified that the Camera Center "is a rehabilitation center for people with Workers' Compensation injury." The next entry in the records, dated May 20, 1993, stated that Patient 1 was "[i]n today stating his medication was stolen while he was at the rehab center." Another entry dated July 15, 1993, stated that Patient 1 wanted more Darvocet, but that Dr. Smith had said no. Dr. Smith testified that the entries of May 20 and July 15, 1993, are indicative of drug-seeking behavior. (St. Ex. 1, p. 15; Tr. 424-426)

   Dr. Smith testified that Patient 1 had had a legitimate medical problem that required these medications, and that "[i]f he was taking medication for a bonafide problem, at the specified interval, and he was having legitimate pain, that would not be an abuse of his drugs." Nevertheless, when asked if he believed that the patient at any time had abused the medications that Dr. Smith had prescribed for him, Dr. Smith replied, "At this time looking at the record with the retrospective analysis, the answer is clearly yes. At that time I don't know. I mean, I too am befuddled." (St. Ex. 1, p. 17; Tr. 426-429)

Patient 2

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 2:

   a. Prior to Dr. Smith's treatment of Patient 2 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 2 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

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b. Further, in Dr. Smith's treatment of Patient 2 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 2.

c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 2 when Patient 2 failed to lose weight.

2. Dr. Smith testified that he first saw Patient 2 on September 29, 1994, for weight loss consultation. Patient 2's eyes, heart, lungs, and abdomen were examined, and his medical history taken. Dr. Smith could not recall whether he questioned Patient 2 concerning previous attempts to lose weight via caloric restriction, behavior modification, nutritional counseling, or exercise. He acknowledged that the record does not so indicate. (St. Ex. 2; Tr. 430-433)

3. Dr. Smith disputed the Board's allegation that he had failed to obtain a thorough history and perform a thorough physical examination prior to prescribing anorectic medication: "I think the initial encounter [with Patient 2] in September 1994 indicates his social history, occupational history, background, past medical history for any serious illnesses or allergies, and does indicate an appropriate examination at that time. Laboratory work was drawn." This testimony is corroborated by the medical records. (St. Ex. 2; Tr. 844)

4. Dr. Smith prescribed anorectic medication to Patient 2 as follows:

Date	Weight	Medication	Date	Weight	Medication
9/29/94	270.4	Adipex P	5/26/95	214.1	Tenuate
10/1/3/94	253.6	Adipex P	7/7/95	216.0	Tenuate
11/15/94	247	Adipex P	7/21/95	214.4	Adipex P
11/29/94	237.7	Adipex P	8/11/95	214.9	Adipex P
4/4/95	221.6	Adipex P	8/25/95	211.6	Adipex P
4/28/95	218.3	Adipex P	9/22/95	213.6	Adipex P
5/12/95	217.7	Adipex P	10/13/95	213.8	Adipex P
			10/27/95	213	Fastin

(St. Ex. 2, pp. 2-3) Testimony concerning these prescriptions included the following:

a. From September 29 through November 29, 1994, Patient 2 lost approximately 33 pounds after a gap in his treatment. Dr. Smith next prescribed Adipex P to Patient 2 on April 4, 1995; at that time Patient 2 had lost an additional 16 pounds without the aid of medication. When asked why he had restarted Patient 2 on a regimen of anorectic medication, Dr. Smith replied that Patient 2 was ready to

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restart his diet. Patient 2 had told Dr. Smith that he had lost some weight but had slipped and begun to regain. Patient 2 wanted assistance. (St. Ex. 2; Tr. 433-434)

b. Another gap in Patient 2's treatment occurred between May 26 and July 7, 1995. Dr. Smith testified that he could offer no explanation why Patient 2 had gone off his diet, and that the reason is not contained in the medical record. Dr. Smith testified that, when one of his patients goes off the diet he "sometimes" inquires as to the reason and "[m]ay or may not" record that reason in the medical record. Dr. Smith testified that he had continued prescribing controlled substance anorectics to Patient 2 because Patient 2 had "a previously proven track record of successful weight loss." Dr. Smith further testified that it was reasonable for him to consider extenuating circumstances in Patient 2's life. (St. Ex. 2; Tr. 434-442)

5. Dr. Smith testified that he last saw Patient 2 in November 1995. Dr. Smith noted that Patient 2 had originally presented to his practice in September 1994 and was significantly overweight. Dr. Smith testified that he did very well the first time, and lost approximately 56 pounds during six months of dieting. Patient 2 subsequently returned for weight loss assistance in 1995, but was less successful than before. (St. Ex. 2; Tr. 841-843)

Patient 3

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 3:

a. Prior to Dr. Smith's treatment of Patient 3 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 3 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

b. Further, in Dr. Smith's treatment of Patient 3 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 3.

c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 3 when Patient 3 failed to lose weight.

d. Dr. Smith issued a postdated prescription for a Schedule IV controlled substance to Patient 3.

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2. Dr. Smith testified that Patient 3 is beset by a number of very difficult medical problems. Patient 3 suffers from diabetes. She also suffers from cirrhosis of the liver caused by overweight, not by alcohol abuse. Dr. Smith described the course of his treatment of Patient 3 at length, and emphasized the importance of weight reduction as an element of Patient 3's treatment regimen. (St. Ex. 3; Tr. 844-852)

3. The medical records indicate, and Dr. Smith conceded at hearing, that Dr. Smith prescribed 14 Tenuate Dospan 75 mg. to Patient 3 on April 21, 1992, but postdated the prescription to April 27, 1992. (St. Ex. 3, p. 4; Tr. 362-363)

4. Dr. Smith testified that the medical records for Patient 3 that are in the Board's possession go back only to July 8, 1992, and are not complete. Dr. Smith testified that Patient 3's earlier records had been culled and sent to a separate location sometime prior to Dr. Smith being served with a subpoena for the records. (Tr. 442-445)

5. The medical records indicate that, after January 17, 1992, Dr. Smith prescribed anorectics to Patient 3 as follows:

Date	Weight	Medication	Date	Weight	Medication
1/17/92	194.3	Tenuate	8/5/93	199.5	Adipex P
1/31/92	195.1	Tenuate	8/19/93	197.1	Adipex P
2/17/92	193.8	Tenuate	9/2/93	196.5	Adipex P
3/2/92	196.7	Tenuate	9/16/93	196.3	Adipex P
3/30/92	203.4	Tenuate	9/30/93	192.5	Adipex P
4/13/92	201.6	Tenuate	10/14/93	195.1	Adipex P
4/21/92	191	Tenuate	10/28/93	193.5	Adipex P
5/11/92	201.1	Tenuate	11/11/93	193	"continue"
7/27/92	213.4	Tenuate	11/26/93	197.2	Adipex P
8/13/92	211.4	Tenuate	12/9/93	194.6	Adipex P
9/24/92	208.3	Tenuate	12/23/93	193.4	Adipex P
10/8/92	206	Tenuate	1/20/94	194	Adipex P
10/22/92	206	Tenuate	2/3/94	194.5	Adipex P
11/5/92	208.2	Tenuate	2/17/94	193.2	Adipex P
11/20/92	207.7	Tenuate	3/3/94	192.2	Adipex P
4/8/93	219	Adipex P	3/17/94	190.8	Adipex P
4/22/93	211	Adipex P	3/31/94	189.5	Adipex P
5/10/93	211	[none ?]	4/14/94	189.5	[none ?]
5/24/93	209	Adipex P	4/28/94	193.4	Adipex P
6/10/93	208	Adipex P	5/26/94	196.3	Adipex P
6/24/93	207.3	Adipex P	6/9/94	196	Adipex P
7/8/93	201.8	Adipex P	6/23/94	190.6	Adipex P
7/22/93	199.5	Adipex P	7/7/94	198.4	Adipex P

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Date	Weight	Medication	Date	Weight	Medication
7/25/94	200.1	Adipex P	9/8/94	202.1	Adipex P
8/22/94	206	Adipex P	9/22/94	201.3	Adipex P

(St. Ex. 3, pp. 3-9) Entries contained in these records include the following:

a. A note dated March 30, 1992, indicated that Patient 3 had had foot surgery and had been unable to exercise. (St. Ex. 3, p. 3B)

b. A note dated May 11, 1992, indicated that Dr. Smith wasn't sure the weight had been correct on the previous visit. (St. Ex. 3, p. 4)

c. A note dated July 27, 1992, said that Patient 3 was back to restart her diet. (St. Ex. 3, p. 4)

d. A note dated December 4, 1992, indicated that Patient 3 had gained weight since the previous visit and wanted to stop the diet pills. (St. Ex. 3, p. 5B)

e. A note dated November 26, 1993, indicate that the weight gain was unacceptable, and that Patient 3 was "[a]dvised she better lose weight next time." (St. Ex. 3, p. 7)

f. A note dated April 28, 1994, indicated that Patient 3 wanted to restart her diet and that she hadn't taken Adipex P during the previous two weeks. (St. Ex. 3, p. 8)

6. Concerning those occasions when Dr. Smith prescribed anorectics to Patient 3 when Patient 3 had gained weight since the previous visit, Dr. Smith emphasized that he believed that weight loss was "an important part of this patient's medical management." Moreover, concerning a prescription dated October 14, 1993, Dr. Smith acknowledged that the patient had not been keeping up with her diet, and had not been actually using anorectics as an adjunct at that time. Further, Dr. Smith testified that he had prescribed anorectics, on an on-and-off fashion, to Patient 3 from January 17, 1992, when she weighed 194 pounds, until April 24, 1995, when she weighed 226 pounds. (St. Ex. 3, p. 3-9; Tr. 449-450, 455, 457-458, 460-471)

7. Mary Harp, who is identified in the confidential Patient Key as Patient 3, waived her right to patient confidentiality. (St. Ex. 12; Tr. 161)

Patient 3 testified that she has been a patient of Dr. Smith's for approximately 20 years. She first saw Dr. Smith in 1978 for hypertension and diabetes. Patient 3 testified that in 1992 she went on a diet plan, and that she had asked Dr. Smith if there was anything he could do to assist her in losing weight. She stated that Dr. Smith had told her that losing

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weight would help lower her blood pressure and help with her diabetes. She stated that Dr. Smith had always discussed her weight when she went to see him. (Tr. 162-164)

Patient 3 testified that she stayed on the diet plan for four or five months. Patient 3 further testified that "sometimes [she] would gain a pound, sometimes [she] would lose a pound" while on the diet plan. Patient 3 testified that Dr. Smith was unhappy on those occasions when she failed to lose weight, and that Dr. Smith warned her that she had to lose weight. Patient 3 stated that, while on the diet plan and taking diet pills, she was diagnosed with sarcoidosis. Her sarcoidosis was treated with Prednisone, and she was taken off the diet pills because Prednisone "defeated the purpose." (Tr. 164-166)

Patient 3 testified that Dr. Smith had recommended exercise to her, such as walking or riding a bicycle. In addition, Patient 3 testified that she had counted calories before she even began seeing Dr. Smith. She further testified that she had kept track of her calories while using diet medication prescribed by Dr. Smith. (Tr. 174-181)

Patient 3 testified that she had weighed 230 pounds when Dr. Smith began prescribing diet pills for her, and that she lost weight until she weighed 180 pounds. Nevertheless, even when told that her medical records had indicated that she weighed 194 pounds when first prescribed diet pills on January 17, 1992, and that she weighed 213 pounds on January 17, 1993, Patient 3 still insisted that she had lost weight. (Tr. 184-189)

Patient 3 testified that she had never received a prescription from Dr. Smith that had the wrong date on it. She further testified that she could not recall ever having received a prescription from Dr. Smith that was dated to be filled on some future date. (Tr. 168-169)

Patient 3 testified that she believes that Dr. Smith is a good doctor, and that she has been happy with the care that he has given her. (Tr. 166-167)

Patient 4

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 4:

   a. Prior to Dr. Smith's treatment of Patient 4 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 4 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

   b. Further, in Dr. Smith's treatment of Patient 4 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a

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thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 4.

c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 4 when Patient 4 failed to lose weight.

d. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 4, despite Dr. Smith's suspicions that Patient 4 exhibited signs of drug abuse."

e. Dr. Smith issued postdated prescriptions for Schedule II and III controlled substances to Patient 4.

2. Dr. Smith noted that Patient 4 is the wife of Patient 1. Dr. Smith testified that Patient 4 had first come to him with a chief complaint of an industrial injury to her shoulder. Dr. Smith testified that the injury was at first thought to be a simple shoulder separation, but that Patient 4 had continued to have pain and immobility. Dr. Smith testified that she had been referred to a shoulder specialist in Columbus, who diagnosed Patient 4 as suffering from a bonafide problem which included shoulder impingement syndrome, and recommended surgery. Dr. Smith testified that Patient 1 was disabled and was not able to work, and that Patient 4 had needed to continue working to support their family. Dr. Smith testified that she had required anti-inflammatory and analgesic medication in order to continue to work. (St. Ex. 4; Tr. 860-863)

Dr. Smith testified that he would be tougher on this patient today than he had been at the time. Dr. Smith testified that Patient 4 had delayed having surgery done to correct her shoulder problem. Dr. Smith stated that he "put up with it knowing that she had a bona fide problem and knowing that it—with this medication, she was kept functional." Nevertheless, Dr. Smith stated that he finally told Patient 4 that she would receive no more medication until she saw an orthopedic surgeon. She finally did so, and she continues under the care of that physician for this problem. Dr. Smith stated that he is not certain whether she ever has had the surgery done, however. Dr. Smith noted that he continues to see Patient 4 for other health problems. (Tr. 863-865)

Dr. Smith testified that there was never any indication that Patient 4 was abusing her medication. Dr. Smith stated that Patient 4 "always was given a prescription for a limited number of medications to take for her chronic severe pain. The medication was given in appropriate intervals. It was always monitored closely. She never exhibited either physical or emotional signs of drug abuse. There was never any irrational, irate, assuming behavior." (Tr. 865-866)

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3. Dr. Smith acknowledged that he had written the following postdated prescriptions for Patient 4:

Medication	Prescription Issued	Prescription Dated
64 Percodan	7/22/91	7/23/91
30 Fiorinal	11/24/92	11/25/92
64 Percocet	1/11/93	1/12/93
42 Flexeril	1/11/93	1/12/93
64 Percocet	2/23/93	2/25/93
30 Fiorinal	4/12/93	4/13/93
56 Vicodin ES	11/22/93	11/24/93

(St. Ex. 4, p. 10, 14, 14B, 15B; Tr. 363-365)

4. The medical records indicate that Dr. Smith prescribed Adipex P to Patient 4 as follows:

Date	Weight
11/12/91	146
11/26/91	143
12/10/91	139.9
12/23/91	138.2
1/6/92	137.5
1/20/92	136.9
2/3/92	136.7
2/17/92	135.2
3/2/92	136.4

(St. Ex. 4, pp. 11-12) The medical records indicate that Dr. Smith first prescribed Adipex P to Patient 4 on November 12, 1991. Dr. Smith testified that Patient 4 had recently gained some weight and was approximately 30 pounds overweight at that time. When asked if he had considered the patient's drug abuse potential prior to initiating treatment with Adipex P, Dr. Smith replied that "that's based on the premise that the patient was taking medication for drug abuse—the drug abuse potential. She was being treated for a bona fide medical condition, and now she had another one, overweight." When again asked if he had considered the patient's potential for drug abuse prior to prescribing Adipex P, Dr. Smith replied that he could not recall. Further, Dr. Smith acknowledged that the medical record is silent on that issue. Dr. Smith also acknowledged that the record does not reflect whether he inquired concerning Patient 4'a efforts to lose weight via caloric restriction, nutritional counseling, behavior modification, or exercise, but stated that it was likely that the circumstances of her weight gain had been discussed. (St. Ex. 4, p. 11; Tr. 489-491, 867)

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The medical records indicate that the physical examination performed on Patient 4 on November 12, 1991, was limited to her weight and blood pressure. Nevertheless, Patient 4 was by that time an established patient of Dr. Smith's. Dr. Smith had previously performed physical examinations of, and obtained a history from, Patient. 4. (St. Ex. 4, p. 11)

Dr. Smith testified that Patient 4 "steadily and continuously lost weight" while taking Adipex P. Dr. Smith further testified that he had prescribed no weight loss medication to Patient 4 since March 1992. (St. Ex. 4, pp. 11-12; Tr. 866-868)

5. An entry dated May 26, 1989, stated:

> Called this a.m. asking for Tylox. States she is going out of town for the weekend. We are contacted by Dr. Quenemoen's office pertaining to her medications. She was given Fiorinal #30 this a.m. by Dr. Quenemoen and RX was called to the pharmacist. Pharmacist brought this to the attention because he was concerned that she was getting too much strong medication. There is some question that she may be using another physician, Dr. Roget also to get her medications. [Patient 4] gave Dr. Quenemoen and also us the same story that she was going out of town for the weekend and would be needing the medication. We will not give her any medications today.

(St. Ex. 4, p. 4) When asked if this constituted drug-seeking behavior, Dr. Smith responded as follows:

> That—that question is based on the premise—is based on a premise, if you will, this similar analogy of when did you beat your wife. I am treating this patient for an appropriate medical condition, in suitable intervals of time. She has considerable pain. And if this individual happened to try to acquire medication from other sources for various conditions, I—that may or may not be what [Mr. McGovern] said is drug-seeking behavior, but certainly we are treating her for the medical condition which we feel is genuine and bona fide.

(Tr. 482-483)

6. An entry dated March 8, 1990, stated that Dr. Smith and Patient 4 had "discussed our concern for potential narcotic abuse after a period of time." Dr. Smith testified that the entry indicated that he had had "an open and frank discussion with this patient" about Dr. Smith's concern for potential narcotic abuse. Dr. Smith further testified that he had

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not wanted Patient 4 to take more medication than was necessary to control her pain. Nevertheless, Dr. Smith denied that he had had any reason to believe that Patient 4 was taking more than was being prescribed. (St. Ex. 4, p. 6B; Tr. 484-485)

7. An entry dated June 12, 1990, stated that Patient 4 had called and said that her Percocet had been destroyed when it fell into her dishwasher, and that she had been told that Dr. Smith would not prescribe more for her until June 21, 1990. At hearing, when asked if he had considered this to be drug-seeking behavior, Dr. Smith responded that Patient 4 had been told that she would not be prescribed additional medication until the proper time, and that if she lost her medication, it was her responsibility. Several questions later, after being repeatedly directed to give a yes or no response, Dr. Smith finally stated, "Do I consider—I'd say maybe I—I consider that yes possibly drug-seeking behavior, but events like this do happen." (St. Ex. 4, p. 7; Tr. 485-488)

8. Dr. Smith's medical records for Patient 4 indicated that on December 3, 1991, he had prescribed Tylox to Patient 4 instead of Percodan, and that they would try again to obtain a TENS unit. Dr. Smith testified that the entry indicated that he had made an effort to wean Patient 4 to a less potent medication to treat her chronic pain problem. (St. Ex. 4, p. 11; Tr. 493-495)

9. An entry dated December 5, 1991, stated, "Patient canceled appointment for 12/4/91 with BioDyne and did not reschedule another appointment. Dr. Smith says she may have more Tylox but cannot have any more Percodan." Dr. Smith testified that BioDyne provided psychological counseling services and drug and alcohol rehabilitation services. At hearing, Dr. Smith could not recall why he had referred Patient 4 to BioDyne. He testified that it may have been for a drug abuse problem or it may have been for other problems in Patient 4's life, such as marital difficulties. (St. Ex. 4, p. 11; Tr. 491-492)

Patient 5

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 5:

   a. Prior to Dr. Smith's treatment of Patient 5 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 5 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

   b. Further, in Dr. Smith's treatment of Patient 5 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a

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thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 5.

c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 5 when Patient 5 failed to lose weight.

d. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 5, despite Dr. Smith's suspicions that Patient 5 exhibited signs of drug abuse."

2. Dr. Smith testified that Patient 5 first came to his office in December 1990. Dr. Smith stated that Patient 5 suffered from hypertension and hypercholesterolemia, as well as severe pain in both ankles which was aggravated by his weight. Dr. Smith testified that Patient 5 had been an appropriate candidate for weight reduction. Moreover, Dr. Smith testified that "[d]uring the period of time that [Patient 5] was under [Dr. Smith's] supervision for weight reduction, he always lost steadily, and [Dr. Smith] would say pretty much consistently, lost weight." Dr. Smith noted that Patient 5 would leave the diet program periodically, then come back. Dr. Smith further noted that Patient 5 had had trouble keeping his weight off while he was not on the program. (St. Ex. 5; Tr. 868-870)

3. The medical records indicate that Dr. Smith performed physical examinations of Patient 5 on December 17 and 24, 1990, and on January 7, 1991, prior to prescribing Adipex P. Moreover, Dr. Smith diagnosed Patient 5 as suffering from borderline hypertension and brought that condition under control before prescribing Adipex P. (St. Ex. 5, p. 3; Tr. 497-499)

   Dr. Smith testified that he had prescribed a 1,400 calorie diet for Patient 5 on December 24, 1990. Patient 5 weighed 220.5 pounds at that time. On January 7, 1991, when the patient returned, he weighed 219 pounds; Dr. Smith testified that he had considered this to be an insignificant amount and he prescribed Adipex P to Patient 5 on that date. Dr. Smith testified that he had discussed the patient's effort to lose weight via caloric restriction, as he had been placed on a diet at the previous visit. Dr. Smith further testified that he also believes that he had discussed exercise, behavior modification, and nutritional counseling. This was not recorded in the medical records, however. (St. Ex. 5, p. 3; Tr. 499-504)

4. The medical records indicate that Dr. Smith prescribed anorectic medication to Patient 5 as follows:

Date	Weight	Medication	Date	Weight	Medication
1/7/91	219	Adipex P	2/4/91	209	Adipex P
1/21/91	212	[none ?]	2/18/91	204	Adipex P

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Date	Weight	Medication	Date	Weight	Medication
3/4/91	205	Adipex P	12/27/91	181.9	[none ?]
3/18/91	208	[none ?]	2/7/92	182.2	Adipex P
4/1/91	199	Adipex P	5/4/92	202.5	Adipex P
4/15/91	198	[none ?]	5/18/92	197.6	Adipex P
4/29/91	197.3	Adipex P	6/1/92	195.2	[none ?]
5/13/91	192.6	Adipex P	6/15/92	193.4	Adipex P
5/30/91	192.1	Adipex P	6/29/92	192	[none ?]
6/13/91	189.1	Adipex P	7/16/92	192	Adipex P
7/11/91	184.5	Adipex P	10/29/92	219	Adipex P
7/25/91	184.8	Adipex P	12/3/92	211	Adipex P
8/23/91	182	Adipex P	12/17/92	208.6	Adipex P
9/6/91	181	Adipex P	12/31/92	206.5	[none ?]
9/20/91	181.6	Adipex P	1/14/93	205.5	Adipex P
10/4/91	181	Adipex P	1/28/93	203.7	Adipex P
10/18/91	180	Adipex P	2/11/93	200.4	[none ?]
11/1/91	179.6	Adipex P	10/2/95	232.7	Adipex P
11/15/91	182	Adipex P	10/16/95	222.1	Adipex P
11/29/91	181.5	[none ?]	10/30/95	218.8	Adipex P
12/13/91	177	Adipex P			

(St. Ex. 5, pp. 3-9) Testimony concerning these prescriptions included the following:

a. Dr. Smith prescribed Adipex P to Patient 5 on March 4, 1991, after a recorded gain of one-half pound since the previous visit. Dr. Smith testified that the medical records indicated that Patient 5 had had "preoccupying problems" that may have accounted for this gain, although those problems were not specified in the record. (St. Ex. 5, p. 3B; Tr. 505-506)

b. Dr. Smith prescribed Adipex P to Patient 5 on July 25, 1991, when the patient had failed to lose weight since the previous visit. Dr. Smith testified that the medical records indicated that Patient 5 had had pain in his back, and right foot and ankle, for about a week, which had made it difficult for Patient 5 to exercise. (St. Ex. 5, p. 4B; Tr. 506-508)

c. Dr. Smith prescribed Adipex P to Patient 5 on September 20, 1991, at which time the patient's weight was recorded as 181.6 pounds—a gain of 0.6 pounds since the previous visit. Dr. Smith denied that the patient had failed to lose weight, however, because the medical records stated that the patient had been wearing more clothing that day due to cold weather. (St. Ex. 5, p. 5; Tr. 508-510)

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d. Dr. Smith prescribed Adipex P to Patient 5 on November 15, 1991, when the patient had gained approximately one and one-half pounds since the previous visit. Dr. Smith testified that the patient had reached a plateau, but had lost a good deal of weight overall. Dr. Smith further testified that Patient 5 suffered from a bona fide medical condition for which he needed to lose weight, and that the patient had expressed a desire to lose another 25 pounds. Dr. Smith testified that he discussed with the patient the need for the patient to exercise more to improve his progress. (St. Ex. 5, p. 5B; Tr. 511-512)

e. Dr. Smith testified that there was a two-month gap in prescriptions between December 13, 1991, and February 7, 1992, because, "[f]or whatever reason the individual was not on his diet, and I can't tell you now why that was." The entry dated February 7, 1992, stated that Patient 5 was "back on his weight loss program. He has lost another five pounds taking Adipex P." (St. Ex. 5, pp. 5B-6; Tr. 512-513)

f. Following the February 7, 1992, prescription, Patient 5 next received Adipex P from Dr. Smith on May 4, 1992—a gap of three months—and had gained 20 pounds during this time. (St. Ex. 5, pp. 6; Tr. 513-514)

g. An entry dated June 1, 1992, stated that Patient 5 was "admonished that he must continue to lose weight and that this will be the last time that we will help him to lose weight and that he must maintain his weight loss." Nevertheless, Dr. Smith testified that this entry had not been written by him but by a student physician assistant who had been assigned to Dr. Smith's office for a short period of time. Moreover, Dr. Smith testified that he does not know why the student had admonished Patient 5 at that time because Patient 5 had shown acceptable weight loss at that visit. (St. Ex. 5, p. 6B; Tr. 513-518)

h. Dr. Smith prescribed Adipex P to Patient 5 on July 16, 1992, at which time Patient 5 weighed 192 pounds—the same weight as the previous visit. Dr. Smith did not again prescribe Adipex P to Patient 5 until October 29, 1992, at which time Patient 5 weighed 219 pounds. Dr. Smith testified that Patient 5 had "squandered much of the progress that he had made previously, but he—during that period of time he was not taking diet pills." When asked whether Patient 5 would be held to the admonishment given him by the student physician assistant on June 1, 1992, Dr. Smith stated, "I can't imagine why this individual would have said such a thing. I don't even understand what is being said there or why it's being said." (St. Ex. 5, pp. 6B-7; Tr. 518-520)

i. Between February 11, 1993, and October 2, 1995, Dr. Smith did not prescribe Adipex P to Patient 5. Patient 5 was restarted on Adipex P on October 2, 1995, at which time he weighed 232 pounds. When asked why he had continued to restart

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Patient 5 on Adipex P after the patient had gained weight, Dr. Smith testified that Patient 5 had suffered from a medical condition that was aggravated by excessive weight. Dr. Smith further testified that it was reasonable for him to assist Patient 5 in Patient 5's efforts to lose weight when Patient 5 requested him to do so. Moreover, Dr. Smith stated that "[t]his is a less than perfect world, and sometimes people do things when they are not under medical care that one would not like, but—but during the period that this individual was seeking assistance and guidance he adhered to the rules and he successfully achieved the goals sought." (St. Ex. 5, pp. 8-9; Tr. 520-522)

5. An entry in Dr. Smith's medical records for Patient 5 dated August 12, 1991, said, "Patient wanting Darvocet today however it is noted that on dictation of 8/8/91 lumbosacral pain was completely gone. Wonder what he wants the Darvocet for. None is given today." Dr. Smith testified that he could not explain that entry, which he testified had been written by a nurse in his employ. He stated that he did not know what she was talking about. "The record indicates that he had resolving lumbosacral back pain. It also indicates that he has continued arthritic pain in his right ankle. That's a curious entry into the record. I have no—I have no plausible explanation for that. I'm sorry." (St. Ex. 5, p. 5; Tr. 529-531)

6. An entry dated September 21, 1993, stated, "Received call from Dr. Morris's office stating patient didn't keep his [appointment] with them for 9/21/93. Patient calls in now requesting Propacet. None given since his [appointment] with Dr. Morris was not kept." (St. Ex. 5, p. 8)

7. Dr. Smith disagreed with the Board's allegation that Patient 5 had exhibited signs of drug abuse. Dr. Smith testified that Patient 5 suffered from chronic severe pain, and that his condition was well documented in the medical records. Dr. Smith stated that, although initial bone scans yielded normal results, x-rays indicated "old, traumatic arthritis in at least one, if not both the ankles." Moreover, an MRI performed in 1997 showed, among other things, a "[m]ild narrowing and subchondral sclerosis of the talus and navicular surrounding the talonavicular joint," in Patient 5's right ankle. Dr. Smith testified that this MRI confirmed that Patient 5 had "had a bonafide genuine problem all along." (Respondent's Exhibit [Resp. Ex.] I; Tr. 870-873, 935-936)

Patient 6

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 6:

   a. Prior to Dr. Smith's treatment of Patient 6 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 6 had made a substantial effort to lose weight in a

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treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

b. Further, in Dr. Smith's treatment of Patient 6 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 6.

c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 6 when Patient 6 failed to lose weight.

2. Dr. Smith testified that Patient 6 is the wife of Patient 5. Dr. Smith noted that Patient 6 suffered from recurrent lower back pain that sometimes referred to her legs. Dr. Smith further testified that Patient 6 was recently diagnosed by a neurologist as suffering from L5-S1 radiculopathy. An MRI revealed a bulging disk at that level. She is currently undergoing physical therapy. (Resp. Ex. J; Tr. 873-875)

Dr. Smith stated that Patient 6 periodically gained weight which aggravated her back problem. Dr. Smith stated that, "[d]uring those periods of time, she did lose weight with a diet program supervised by us; and during those periods of time, she lost weight. Always lost weight. There was never any doubt about the downward trend on the scales." Dr. Smith testified that he last treated Patient 6 with diet medication in August 1997. (Resp. Ex. J; Tr. 875-877)

3. Dr. Smith first placed Patient 6 on a reduced calorie diet and prescribed Adipex P on July 5, 1994. The medical record state that she was approximately 30 pounds overweight. The medical records do not state whether Dr. Smith inquired concerning Patient 6's previous efforts to lose weight via exercise, caloric restriction, behavior modification, or nutritional counseling. Nevertheless, Dr. Smith testified that he may have done so, and may not have been aware of the importance of recording these discussions in the medical record. (St. Ex. 5, p. 17B; Tr. 522-524)

The medical records indicate that Patient 6 received a physical examination on July 5, 1994, although the exam appeared to be focused on her lower back, hip, and leg pain. Nevertheless, Patient 6 was by that time an established patient of Dr. Smith's, and had had previous physical examinations performed by Dr. Smith. (St. Ex. 5, pp. 16-17B)

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4. The medical records indicate that Dr. Smith prescribed anorectic medication to Patient 6 as follows:

Date	Weight	Medication	Date	Weight	Medication
7/5/94	147.8	Adipex P	10/31/94	140	Adipex P
7/18/94	145.8	Adipex P	11/15/94	139.2	Adipex P
8/1/94	145.5	Adipex P	11/29/94	138.2	Adipex P
8/15/94	143.3	Adipex P	12/30/94	136.8	Adipex P
8/29/94	139.5	Adipex P	2/3/95	136.5	Adipex P
9/12/94	140.6	Adipex P	2/16/95	137.2	Adipex P
9/26/94	140	Adipex P	3/3/95	136.8	Adipex P
10/10/94	139	Adipex P			

(St. Ex. 5, pp. 17B-18B)

5. Dr. Smith acknowledged that he had prescribed Adipex P to Patient 6 on September 12 and October 31, 1994, and February 16, 1995, although the patient had failed on each of those occasions to lose weight since the previous visit. Dr. Smith testified that Patient 6 had received additional encouragement at those times and was advised to increase her exercise levels. (St. Ex. 5, pp. 17-18B; Tr. 524-528)

Patient 7

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 7:

   a. Prior to Dr. Smith's treatment of Patient 7 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that Patient 7 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

   b. Further, in Dr. Smith's treatment of Patient 7 with controlled substance anorectics, Dr. Smith failed to obtain and/or his records fail to reflect that he had obtained a thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of Patient 7.

   c. Further, Dr. Smith continued prescribing controlled substance anorectics to Patient 7 when Patient 7 failed to lose weight.

2. Dr. Smith testified that Patient 7, Dr. Smith's wife, came to him for diet assistance in addition to the general medical care he had been providing to her. Dr. Smith testified that

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he had seen Patient 7 as he would any other patient. "[S]he would come to [Dr. Smith's] office, climb on the scales, have her weight taken, and prove that she would lose weight before [Dr. Smith] would renew any prescriptions." (Tr. 880-881)

The medical records indicate that Dr. Smith performed a physical examination of Patient 7 on March 21, 1995, the day that Dr. Smith first prescribed anorectics to Patient 7. The medical records further indicate that Patient 7 had consulted with a dietitian prior to receiving a prescription for anorectic medication. However, there is nothing in the medical record to indicate that Dr. Smith had inquired into Patient 7's previous efforts to lose weight via caloric restriction, exercise, or behavior modification. (St. Ex. 7, p. 17B)

3. Dr. Smith prescribed anorectic medication to Patient 7 as follows:

Date	Weight	Medication	Date	Weight	Medication
3/21/95	171.5	Adipex P	5/10/96	151.5	Tenuate
4/4/95	167.7	Tenuate	6/7/96	152.9	Tenuate
4/18/95	164.7	Tenuate	8/2/96	157.1	Tenuate
5/2/95	162.6	Tenuate	8/16/96	153.8	Tenuate
5/16/95	157.8	Tenuate	8/30/96	157.1	discontinued
5/30/95	158.4	Tenuate	2/21/97	172.3	Adipex P
6/13/95	155.9	Tenuate	3/7/97	166.7	Adipex P
11/24/95	159.9	Tenuate	3/20/97	164.3	Adipex P
12/14/95	153.9	Tenuate	4/4/97	161.9	Adipex P
3/22/96	158	Adipex P	4/18/97	159.2	Adipex P
4/5/96	156.5	Tenuate	5/1/97	162.1	Adipex P
4/25/96	152.8	Tenuate			

(St. Ex. 7, pp. 2, 5A-5B, 17B) Testimony concerning these prescriptions included the following:

a. Dr. Smith testified that Patient 7 had taken a break from the diet program between June 13, 1995, and November 24, 1995, and that the reason was not noted in the medical records. Dr. Smith stated that "people take breaks from their diet program for various reasons, personal reasons, and this may have been [the] situation here." Another break in Patient 7's diet program occurred from December 14, 1995, through March 22, 1996. Dr. Smith testified that he was

> not aware of anything in the standards of medical practice that it is deleterious to the patient's health to prescribe medication after that individual has had an interval, a gap, when that person has been off a diet. The benefits of reduced weight for a co-morbid medical condition has clearly been documented throughout the medical

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literature, and in the specifics of this case I think that the practice habits that we used here are consistent with standards of good medical care.

(St. Ex. 7, p. 5B; Tr. 536, 540)

b. Dr. Smith acknowledged that he had prescribed controlled substance anorectics to Patient 7 on May 30, 1995, and June 7, 1996, when the patient had failed to lose weight since the previous visit. Dr. Smith testified that, overall, Patient 7's progress was good although she may not have been sticking to her diet and exercise programs as carefully as she should have been. Dr. Smith testified that Patient 7 "had been a diligent patient and had adhered to a diet, and I think rather than kick her after what may or may not have been a significant weight loss or weight gain, the more reasonable approach might be that one should say, hey, get with it." (St. Ex. 7, p. 5B ;Tr. 534-542)

Dr. Smith testified that, during Patient 7's June 7, 1996, visit, he had admonished her to adhere more carefully to her diet and watch her caloric intake. He also told her to return in two weeks. Nevertheless, the Patient 7's next visit was on August 2, 1996. Noting that Patient 7 had been away on vacation during the interim and showed a slight weight gain, Dr. Smith stated that he nonetheless believed that Patient 7 was a complaint patient. Dr. Smith stated that "[t]here was an interval period in which the patient was not on the diet, and if that individual so chose to take a break, for whatever reason, and then come back and restart her diet, that's perfectly acceptable in my mind." (St. Ex. 7, pp. 5A-5B; Tr. 545-546)

c. Dr. Smith testified that on August 30, 1996, Patient 7 had gained weight since the previous visit and was not prescribed medication because "[s]he had not made sufficient progress." Nevertheless, Patient 7 was restarted on anorectics on February 21, 1997. At that time she weighed 172.3 pounds, which was within one pound of what she had weighed when first prescribed anorectics by Dr. Smith in March 1995. When questioned concerning this issue, Dr. Smith testified that the patient had successfully lost weight each time she received medical assistance. (St. Ex. 7, pp. 5A, 17B; Tr. 546-549)

d. On May 1, 1997, Patient 7 was prescribed Adipex P although she had gained 2.9 pounds since the previous visit. Dr. Smith testified that the entry also indicated that the patient had been having a digestive problem, but that the patient had been making good progress overall. (St. Ex. 7, p. 2; Tr. 555-556)

4. Dr. Smith's medical records contain a report from Kathleen Schnader, R.D., L.D., at Hardin Memorial Hospital, dated January 19, 1995. This report indicated that Ms. Schnader had inquired concerning Patient 7's exercise and eating habits, and that

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Patient 7 had been placed on a limited fat diet on that date. The report further stated that behavior modification had been planned. Moreover, the report indicated that Patient 7 had weighed 177.75 pounds on January 19, 1995. (St. Ex. 7, pp. 19-20A)

5. Diana Smith testified that she is the wife of Dr. Smith. Ms. Smith, who waived her right to patient confidentiality, is further identified as Patient 7 in this matter. (St. Ex. 12; Tr. 624-625)

Patient 7 testified that, prior to seeking assistance from Dr. Smith, she had tried to lose weight on her own, and with the assistance of weight loss centers. Among these, she had tried Weight Watchers and YMCA. She had also tried various diets. Patient 7 finally asked Dr. Smith for assistance in 1987. (Tr. 625-626, 631-637)

Patient 7 testified that when she consulted with Dr. Smith concerning her weight he performed a physical examination and discussed diet and exercise with her. Patient 7 stated that "it was all tied in together that it was not just a matter of being able to take these pills, but that there were other areas that definitely were important in maintaining or managing a weight loss program." Patient 7 testified that she had succeeded in losing weight while on medication. (Tr. 627-628, 645)

Patient 7 testified that, on a subsequent attempt to lose weight, there may have been "an instance or two where [she] had gone back in with a minimal weight gain." Patient 7 testified that Dr. Smith was not happy with her lack of weight loss, but gave her the benefit of the doubt on the first instance or two. Nevertheless, she was eventually told that she could not continue receiving diet medication. Patient 7 testified that she last received an prescription for diet medication from Dr. Smith sometime in 1997. (Tr. 628-630, 646-650)

Ms. Smith testified that she believes that Dr. Smith is a good physician and that he has provided, and continues to provide, a valuable service to his community. (Tr. 630)

Patient 8

1. In the September 9, 1998, notice of opportunity for hearing, the Board made the following allegations regarding Dr. Smith's treatment of Patient 4:

   a. Dr. Smith issued postdated prescriptions for Schedule III and IV controlled substances to Patient 4.

2. Dr. Smith testified that Patient 8 suffers from chronic neck and back pain which, he believes, is well documented. Dr. Smith noted that he had referred Patient 8 to a number of specialists but that Patient 8 continued to have pain. Dr. Smith further testified that Patient 8 had taken anti-inflammatory medications to the point where he can no longer

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tolerate them. Dr. Smith stated that Patient 8's treatment had been hampered by the Bureau of Workers' Compensation's refusal to pay for treatment such as a pain clinic, TENS unit, aquatic therapy, and other modalities other than medication. Dr. Smith added that, despite Patient 8's condition, Patient 8 had always been a pleasant person who is dependable and sensible. (St. Ex. 8; Tr. 882-885)

3. The medical records indicate that Dr. Smith wrote the following prescriptions for Patient 8:

Medication	Prescription Issued	Prescription Dated
60 Valium 5 mg.	6/1/92	6/12/92
30 Tylenol No. 3	7/21/92	7/22/92
60 Valium 5 mg.	1/8/93	1/22/93
60 Valium 5 mg.	7/29/93	7/31/93
30 Vicodin ES	2/17/94	2/22/94
30 Vicodin ES	1/9/95	1/10/95
30 Vicodin ES	1/23/95	1/24/95
30 Tylenol No. 3	2/27/95	3/2/95
60 Valium 5 mg.	2/27/95	3/2/95
30 Vicodin ES	5/26/95	5/30/95
30 Vicodin ES	7/6/95	7/8/95
30 Tylenol No. 3	7/6/95	7/8/95
60 Valium 5 mg.	7/6/95	7/8/95
30 Tylenol No. 3	8/3/95	8/5/95
60 Valium 5 mg.	8/3/95	8/5/95
30 Tylenol No. 3	10/5/95	10/9/95
60 Valium 5 mg.	10/5/95	10/9/95

(St. Ex. 8, pp. 8-13; Tr. 265-269) [Note: Dr. Smith also wrote a prescription for 30 Vicodin ES on January 16, 1995, and postdated it to January 17, 1995; however, this prescription was not alleged in the Board's notice of opportunity for hearing, and no violation will be found therefor. (St. Ex. 8, p. 12)]

Testimony concerning these prescriptions included the following:

a. Dr. Smith acknowledged that the prescription for Valium dated June 12, 1992, may have been given to the patient on June 1, 1992. Dr. Smith further acknowledged that June 12, 1992, would have been 30 days after Patient 8 had last received a prescription for a 30-day supply of Valium. (St. Ex. 8, pp. 8, 8B; Tr. 234-248)

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b. Dr. Smith testified that his medical records indicated that, on July 21, 1992, Patient 8 received a prescription for 30 Tylenol No. 3 that was dated July 22, 1992. Dr. Smith testified that he had no personal recollection of that prescription other than what is contained in the medical records. Nevertheless, Dr. Smith testified that he was concerned that the patient not receive his medication too early and perhaps "get ensnared in the trap of taking too much." (St. Ex. 8, p. 8; Tr. 248-249)

c. Dr. Smith testified the January 8, 1993, prescription that was dated January 22, 1993, was written so as not to inconvenience Patient 8 by having him drive back to see Dr. Smith on January 22, 1993. (St. Ex. 8, p. 9; Tr. 250-252)

4. Dr. Smith testified that he had "some misgivings" in referring to the above-referenced prescriptions as "postdated." Dr. Smith stated that "[i]f a prescription is given for one date dated the next day, there may be some extenuating circumstances for why that is done. And I'm not sure what that might have been, what that might be. The drugstore might have been closed." Nevertheless, Dr. Smith agreed that a prescription that had been issued one day, but dated to a subsequent date, could be termed a postdated prescription. (Tr. 259-265)

5. Larry Baker, who is listed as Patient 8 in the confidential Patient Key, waived his right to patient confidentiality. (St. Ex. 12; Tr. 196)

Patient 8 testified that he first began seeing Dr. Smith in March or April 1989. Patient 8 first saw Dr. Smith because Patient 8 had injured his neck at work. Six months later, Patient 8 injured himself again at work when he fell off of a ladder. Patient 8 testified that he had filed Workers' Compensation claims for both of these injuries. Patient 8 testified that he was declared permanently and totally disabled in February 1998. (Tr. 197-199)

Patient 8 testified that he had never received a postdated prescription from Dr. Smith. Patient 8 further testified that he had never been turned away by his pharmacist for having presented a prescription too early. Patient 8 indicated that he usually had his prescriptions filled on the same day he received them. Moreover, Patient 8 testified that he never asked Dr. Smith for an early refill of medication. Finally, Patient 8 testified that Dr. Smith had warned him about the dangers involved concerning his medication "[a] lot of times." (Tr. 206-208, 219-220)

The Alger Clinic

General Information

1. Dr. Smith testified that, from November 1994 until summer 1995, he had had a second office in Alger, Ohio, a town that is approximately 15 miles from Kenton. Dr. Smith

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further testified that, when he acquired the office in November 1994, the Alger Clinic was open two and one-half days per week, and that those hours were eventually reduced due to a lack of business. (Tr. 272-277)

Dr. Smith testified that he had taken over the Alger Clinic because he had thought that it was an important service to the community. Prior to Dr. Smith's taking over the Alger Clinic, it had been owned and operated by the Hardin Memorial Hospital Physician Corporation. That organization had opened a number of clinics in small communities around the county, and had staffed them with physicians and allied health care workers to serve those communities. At the Alger Clinic, the physician who had been hired to supervise the clinic had had a service obligation to the National Health Service. In 1994, when that physician left, Dr. Smith was approached by several parties including Marilyn Myers, R.N., who had worked at the clinic, and the physician corporation, and asked if he would be willing to take over the clinic. Dr. Smith testified that he agreed to do so, although "[w]ith some reservations." (Tr. 803-805)

Dr. Smith testified that he knew when he took over the Alger Clinic that he could not be in two places at the same time. After some discussion and deliberation, however, Dr. Smith determined that he would be able to spend some time at Alger and still maintain his Kenton practice. Dr. Smith testified that he personally saw patients at the Alger Clinic. In addition, Ms. Myers, a certified family nurse pratitioner, saw patients at the Alger Clinic while Dr. Smith was practicing at his Kenton office. Moreover, Dr. Smith testified that he understood that he was Ms. Myers' supervisor, and that all of her assessments and recommendations had to be approved by him. (Tr. 310-312, 805-806) Dr. Smith further testified:

> I made every effort to get over to Alger that I could. Even though it's 15 miles away from Kenton, I made a lot of commutes over there. I would get there in the morning, check to see if there were any problems, stayed as long as I was needed for problems that developed and [to see] patients that had to be seen by myself. And after completing what I felt to be my duties, I departed and went over to the Kenton Clinic. At the Kenton office I was in constant and frequent communication by phone. At all times the services in Alger were very closely monitored and supervised. And if I may say so, from what I'm told, much more closely that had been previously.

(Tr. 805-806)

2. Dr. Smith acknowledged that there were times that patients were seen by Ms. Myers at the Alger Clinic while Dr. Smith was working at the Kenton office. Dr. Smith testified

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that Ms. Myers saw patients for "a variety of common maladies as well as periodic screening of — periodic health screening physicals on well people." (Tr. 299-303)

3. Dr. Smith testified that the telephone records of the Alger Clinic for April 1995 are indicative of the close communication that existed between that office and the Kenton office. (Resp. Ex. B; Tr. 886-888)

4. Marilyn J. Myers testified that she is a Registered Nurse and that she works for Dr. Smith as a family nurse practitioner. Ms. Myers testified that she received her nursing diploma from the Grant School of Nursing, Columbus, Ohio. Subsequently, in 1976, she attended the nurse practitioner program at the Ohio State University. Ms. Myers testified that this program trained nurses "beyond their R.N. program to assist the physician similar to a physician's assistant program." (Tr. 562-564)

   Ms. Myers testified that in June 1997 she applied to the State Nursing Board for a certificate of authority to practice as a nurse practitioner. Ms. Myers testified that a change in the law enabled nurse practitioners to obtain a certificate from the State of Ohio "that actually said we could work as nurse practitioners beyond our Nursing Board license." Ms. Myers testified that she the law was changed "about two years ago, which really didn't change the way we practiced, but it gave us the permission to put CNP [behind our names] and to get third party payment." Ms. Myers stated that this certification did not expand her scope of practice in any way from what she had been permitted to do previously. (St. Ex. 26; Tr. 564-567)

   Ms. Myers testified that her job title at Dr. Smith's office is Nurse Practitioner. She further testified that she has a written job description that states, in general, that she is to assist Dr. Smith in seeing patients under his supervision, or in collaboration with him. Ms. Myers is also allowed to obtain subjective information from patients, to examine patients, and to develop an assessment and a plan of care. Moreover, Ms. Myers testified that she follows protocols that were established between her and Dr. Smith. The protocols outline the procedures that Ms. Myers is to perform when she sees patients for certain conditions. (Tr. 567-571)

5. Dr. Smith testified that his protocols were developed in order that Ms. Myers would have "a very clear and distinct understanding of what the procedures and treatment policies are in the office of Dr. Leonard K. Smith." Dr. Smith further testified that the protocols are periodically reviewed and updated as needed. (St. Ex. 24; Tr. 816-817)

6. Dr. Smith and the State stipulated that Ms. Myers received her certificate of authority as a certified nurse practitioner from the Ohio Nursing Board on August 21, 1997. (Tr. 308-309)

7. Dr. Smith testified that the Alger Clinic closed in June 1995. (Tr. 814-816)

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The Alger Clinic: Patient 9

1. David Shawn McCafferty testified that he is an investigator for the Board, and has been employed by the Board in that capacity for four years. Inv. McCafferty testified that he had been assigned to investigate a complaint that Dr. Smith had been permitting a nurse to see patients on her own at a clinic in Alger, Ohio. (Tr. at 47-49) [Note: Patient 9 is referred to hereinafter as either Inv. McCafferty or Patient McNeil, the alias used by Inv. McCafferty in the investigation.]

   Inv. McCafferty stated that he called the Alger Clinic on April 4, 1995, and said that he needed to see a physician concerning a weight loss consultation. Using a fictitious name—David Shawn McNeil—Inv. McCafferty scheduled an appointment for April 10, 1995. Prior to keeping the scheduled appointment, however, Inv. McCafferty contacted another Board investigator, Karl Saddler, and asked him to visit Dr. Smith's office in Kenton, Ohio, while Inv. McCafferty kept his appointment at the Alger Clinic. Inv. McCafferty stated that he did this to verify that Dr. Smith was in Kenton, and that the nurse was working at the Alger Clinic by herself. (Tr. 49-50)

2. Inv. McCafferty testified that on April 10, 1995, he entered the Alger Clinic a few minutes before his 2:30 appointment. Inv. McCafferty stated that there were a few people seated in the waiting room, and there was a nurse or receptionist sitting behind a desk. Inv. McCafferty registered with the receptionist and was given a questionnaire to fill out concerning his medical and family history. Subsequently, a woman escorted him back, took his weight, led him to an examination room, and took his blood pressure. She then exited the room. (St. Ex. 9, p. 5; Tr. 50-53)

   Inv. McCafferty testified that all of the personal information that he provided on the questionnaire, such as address, employment, social security number, is false with the exception of his date of birth. Inv. McCafferty further testified, however, that all of the information concerning his health history was accurate. (St. Ex. 9, p. 5; Tr. 78-80, 90-92)

   Inv. McCafferty testified that Ms. Myers entered the room a few minutes later. She reviewed his family history, asked him about his exercise program, and asked what he had weighed in high school. Inv. McCafferty testified that he had answered all these questions truthfully, except for his name. Inv. McCafferty testified that Ms. Myers did not inquire further concerning his past attempts to lose weight, past attempts at behavior modification, past nutritional counseling, or whether he had in the past used controlled substance anorectics to control his weight. (Tr. 54-58)

   Inv. McCafferty testified that Ms. Myers then gave him a collection of written materials concerning diet and weight loss. She reviewed the diet information contained therein with

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Inv. McCafferty, which included a 1,200 calorie per day diet, instruction to eat sensibly, and to exercise. (St. Ex. 25; Tr. 54-55)

Inv. McCafferty testified that Ms Myers then told him that she was going to give him a medication to assist him with weight loss. Inv. McCafferty asked Ms. Myers if it was like Dexatrim, and she told him that it was "better and safer than Dexatrim." Inv. McCafferty testified that Ms. Myers reached into a pocket of her lab coat and pulled out a prescription pad. She wrote a prescription for 14 Adipex P and gave it to Inv. McCafferty. Inv. McCafferty noted that the prescription that she had filled out bore the signature "L.K. Smith" at the bottom. Inv. McCafferty testified that he had observed that Ms. Myers did not write that signature. Moreover, Inv. McCafferty testified that the next blank on the prescription pad also bore what appeared to be the same signature. Inv. McCafferty testified that he was approximately two or three feet away from Ms. Myers when this occurred. Inv. McCafferty identified State's Exhibit 20 as the prescription that Ms. Myers had given him that day. (St. Ex. 20; Tr. 58-61)

Inv. McCafferty testified that Ms. Myers told him that he would have to schedule another appointment for 14 days later. She told Inv. McCafferty that she could legally only give him a prescription for a 14-day supply of the medication. Inv. McCafferty went to the receptionist, paid for his visit, and scheduled another appointment for April 24, 1995, at 2:30 p.m., then left. (Tr. 61)

Inv. McCafferty testified that, during the entire time of his visit with Ms. Myers, Ms. Myers did not leave the examination room, nor did she communicate with anyone else by any means. (Tr. 61-62)

3. Karl Saddler testified that he has been employed as an investigator for the Board for nine years. He further stated that he had worked for the State Highway Patrol for 29 years prior to working for the Board. Inv. Saddler testified that he had participated in an investigation of Dr. Smith in April 1995. At approximately 2:30 p.m. on April 10, 1995, Inv. Saddler visited Dr. Smith's Kenton office and spoke briefly to Dr. Smith. Subsequently, at approximately 2:30 p.m. on April 24, 1995, Inv. Saddler observed an automobile registered to Dr. Smith in the parking lot of Dr. Smith's Kenton office. (Tr. 143-146)

Inv. Saddler testified that the distance between Kenton and Alger is between 15 and 20 miles. (Tr. 147-148)

4. Inv. McCafferty testified that, on April 24, 1995, he again visited the Alger Clinic for his follow up appointment. Inv. McCafferty was escorted back and weighed by the same woman who had done so previously. Inv. McCafferty noted that he had lost six pounds from his previous visit. Inv. McCafferty was taken back to the examination room, and his blood pressure was taken. He was then left alone in the examination room. (Tr. 64-65)

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Inv. McCafferty testified that, a few minutes later, Ms. Myers entered the examination room. Ms. Myers and Inv. McCafferty discussed how Inv. McCafferty's blood pressure had decreased since the last visit. She asked Inv. McCafferty if he had experienced any heart palpitations or abnormal heartbeats and Inv. McCafferty told her that he had not. Ms. Myers then removed a prescription pad from her lab coat and wrote a prescription for 14 Adipex P. Inv. McCafferty noted that the prescription again bore the signature "L.K. Smith" as the earlier one had. Moreover, Inv. McCafferty again noted that the blank underneath the prescription that Ms. Myers gave to him also bore what appeared to be the same signature. Inv. McCafferty testified that he was again about two or three feet away from Ms. Myers as he observed this. Inv. McCafferty identified State's Exhibit 21 as the prescription that Ms. Myers gave to him during that visit. (St. Ex. 21; Tr. 65-67)

Inv. McCafferty testified that Ms. Myers told him that "we would try it for another two weeks and see how it went." He was then led to the reception area where he made another appointment, paid for the visit, and then left. (Tr. 66)

Inv. McCafferty testified that, during the entire time that Ms. Myers visited with him on April 24, 1995, she did not leave the room or communicate in any way with anyone else. Inv. McCafferty further testified that she did not consult any written material other than what Inv. McCafferty believed to be his patient chart. (Tr. 66)

5. Dr. Smith acknowledged that his initials appear twice in the chart for Patient McNeil—once for each of the two entries. Dr. Smith further testified that he "cannot guarantee that those initials were placed on the chart prior to the patient's departure from the premises." Dr. Smith added that "we try to initial the charts as soon as possible, or hopefully at the very same time that the patient is seen in the office. * * * [I]t's done just as soon after the patient has been there, is there or has been there, and I have actual physical access to the chart itself." Concerning Patient McNeil's April 10, 1995, visit, Dr. Smith testified that it was "possible, but highly doubtful," that he had seen and initialed the chart prior to the patient's departure that day. (St. Ex. 9, p. 2; Tr. 335-340)

Dr. Smith testified that he could not recall if he had been contacted by Ms. Myers concerning Patient McNeil's second visit prior to Ms. Myers' issuance of a prescription for that patient that day. Dr. Smith further testified that he initialed the entry for that visit indicating that he had reviewed and approved the therapy. Moreover, Dr. Smith testified that, although he had no specific recollection, his review of the chart entry for that date probably occurred after the prescription had been written. Finally, Dr. Smith testified that the April 24, 1995, prescription for Patient McNeil bore Dr. Smith's signature but was filled out by Ms. Myers. (St. Ex. 9, p. 2; St. Ex. 21; Tr. 342-349)

6. Ms. Myers testified that she remembered Patient McNeil. She further testified that she had had no physical contact with Dr. Smith during the times that she examined and issued

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prescriptions to that patient. Moreover, Ms. Myers testified that she did not doubt the testimony of Inv. McCafferty that she had had no telephone contact with Dr. Smith during those visits. (St. Ex. 9; Tr. 581-583)

7. Ms. Myers testified that she had not inquired concerning Patient McNeil's previous efforts to lose weight via caloric restriction, but that she had inquired concerning exercise and behavior modification. She stated, however, that Patient McNeil had told her that he had had trouble cutting back on his food intake and wanted something to help curb his appetite. Ms. Myers further testified that she had placed Patient McNeil on a 1,200 calorie diet, given him a booklet of information concerning exercise, instructed him concerning aerobic exercise, and discussed nutrition. (Tr. 606-610)

   The medical records indicate that an inquiry was made concerning Patient McNeil's exercise habits; it states that Patient McNeil worked out 2 or three times per week, and used a stepper four times per week for 20 to 30 minutes. The medical records further indicate an inquiry had been made concerning his eating habits. However, there is no confirmation in the medical records of any inquiry concerning past efforts to lose weight via behavior modification. Moreover, there is nothing in the medical records to indicate that an inquiry had been made concerning Patient McNeil's past efforts to lose weight via caloric restriction, behavior modification, or nutritional counseling. (St. Ex. 9, p. 2)

The Alger Clinic: Patient 10

1. Jeffrey D. Bradford testified that he is an investigator for the Board, and has been so employed for four years. Inv. Bradford testified that he had participated in the investigation of Dr. Smith along with Investigators Saddler and McCafferty. (Tr. 96-98) [Note: Patient 10 is referred to hereinafter as either Inv. Bradford or Patient Brown, an alias used by Inv. Bradford during the investigation.]

   Inv. Bradford testified that he had called the Alger Clinic and made an appointment for April 26, 1995, at 2:50 p.m. When he called, Inv. Bradford told the person on the phone that he had been having pain in his right elbow and wanted someone to take a look at it. Inv. Bradford used the name "Jeffrey Brown" when he set up the appointment. (Tr. 98-99)

   Inv. Bradford testified that he had arrived at the Alger Clinic at about 2:45 p.m. on April 26, 1995. The receptionist gave Inv. Bradford some papers to fill out. Inv. Bradford took a seat in the waiting room and filled out the papers. Inv. Bradford indicated that page 4 of State's Exhibit 10 was the sheet that he had filled out at that time. Inv. Bradford testified that the date of birth that he provided is correct; the rest of the information on that form is false. (St. Ex. 10, p. 4; Tr. 99-102)

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Inv. Bradford testified that he had waited for about 45 minutes in the waiting room. While waiting, he noticed a person leave the office who he identified at hearing as Dr. Smith. Subsequently, Inv. Bradford was escorted back by a woman who took his weight, led him to an examination room, and took his blood pressure. She asked Inv. Bradford how he had hurt his arm, and Inv. Bradford told her that he had injured his elbow during the course of his work as a self-employed landscaper. She then told him that nurse practitioner Marilyn Myers would be in to see him, then left and closed the door. (Tr. 102-106)

Inv. Bradford testified that approximately 10 minutes passed, when a woman entered the room and introduced herself as Marilyn. Inv. Bradford testified that she was wearing a name tag that said "Marilyn Myers, Nurse Practitioner." She examined Inv. Bradford's elbow by pressing on certain areas, and by turning and bending his arm and wrist, while asking Inv. Bradford to let her know when he felt pain. Inv. Bradford testified that this lasted approximately five minutes, and that he answered her inquiries truthfully. Ms. Myers asked how Inv. Bradford had injured his elbow, and Inv. Bradford replied that he had injured it during his work as a self-employed landscaper. (Tr. 106-107)

Inv. Bradford testified that, while he was sitting approximately one foot away from Ms. Myers, she withdrew a prescription pad from the right pocket of her lab coat. Inv. Bradford noticed that the signature line on that pad appeared to be blank. Ms. Myers looked at the prescription pad, put it back in her right pocket, and then withdrew another prescription pad from the left pocket of her lab coat. Inv. Bradford indicated that she pulled this second pad out in such a way that it flipped open part-way; Inv. Bradford noticed that there was a signature on the signature line of the prescription blank that was visible. Ms. Myers flipped the pad back to the prescription on the top of the pad, and Inv. Bradford noticed that it was blank except for a signature on the signature line. (Tr. 107-110)

Inv. Bradford testified that Ms. Myers had told him that she was going to give him a prescription for Naprosyn to help reduce inflammation. She filled out the prescription on top of the pad, tore it off, and gave it to Inv. Bradford. As she did so, Inv. Bradford noticed that the next prescription also appeared to be blank except for a signature on the signature line. Inv. Bradford testified that the signature on the prescription that he received appeared to match the signature he observed on the second prescription blank in the pad. Inv. Bradford testified that the prescription that she gave to him was signed "L.K. Smith." Inv. Bradford identified State's Exhibit 22 as the prescription that he had received from Ms. Myers. Finally, Inv. Bradford testified that he then went to the reception counter to pay for his visit, and left. (Tr. 110-113)

Inv. Bradford testified that Ms. Myers did not give him any instructions concerning the Naprosyn other than to take it for inflammation. (Tr. 112)

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Inv. Bradford testified that Ms. Myers never exited the room during her visit with him. Inv. Bradford further testified that she did not communicate with anyone but him during the visit. Moreover, Inv. Bradford testified that Ms. Myers did not review any written materials during his visit other than his patient chart. (Tr. 113)

Inv. Bradford testified that he has never spoken to Dr. Smith, either in connection with this investigation or otherwise. (Tr. 119-120)

2. In response to questions by Dr. Smith's attorney, Inv. Bradford testified that it is his responsibility to investigate complaints, obtain facts, and to report his findings to the Secretary and Supervising Member of the Board. If he is then instructed to return to a physician and tell the physician that he or she is doing something wrong, he would do that. However, Inv. Bradford testified that he does not take it upon himself to tell a physician if he or she is doing something wrong; that is the Board's decision. (Tr. 136)

3. Dr. Smith testified that the April 26, 1995, prescription for Naprosyn in the name of Jeffrey Brown had been signed by him but filled out by Ms. Myers. Dr. Smith testified, however, that he did not believe that that was a pre-signed prescription. Dr. Smith explained this as follows: "Because I was there in the clinic that day, as the witness testified having seen me, knew what the—in all likelihood, although I can't specifically recall this many years later, but would have known what the problem was, had seen him." Dr. Smith further stated that he would have checked with Ms. Myers, and, knowing what the recommended therapy would be, "very likely could have given her specific instructions what she might do prior to my departure." Dr. Smith testified that he could have known the nature of Patient Brown's complaint before Patient Brown's visit because Patient Brown had described the nature of his problem to the receptionist when he called for his appointment. (St. Ex. 10; St. Ex. 22; Tr. 349-356)

   Dr. Smith further testified that he did not believe that the April 26, 1995, prescription to Patient Brown violated his office policy concerning new patients because Dr. Smith had been in the office and knew of the problem, "and very possibly could have recommended to [Ms. Myers] what she might do prior to [Dr. Smith's] departure." (Tr. 356)

4. Later in the hearing, Dr. Smith testified that he recalls Patient 10's April 26, 1995, visit. Dr. Smith testified that that day stands out clearly in his mind because that was the day he had offered testimony in a homicide case as Hardin County Coroner. Dr. Smith stated that he had been seeing patients with Ms. Myers, and had briefly discussed Patient 10 with her. He saw the patient biographical data sheet that Patient 10 had filled out, and "felt that [Ms. Myers] was capable of handling that problem as I understood it to be." Moreover, Dr. Smith testified that he recalls seeing Patient 10 in the waiting room as Dr. Smith left the office, and had a few brief words with Patient 10 as he left. (Tr. 811-813)

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5. Ms. Myers testified that she remembers Patient Brown's visit. Ms. Myers stated, "Based on my objective findings I [came] up with the diagnosis he had tendonitis, and based on our protocols I followed through with the plan that Dr. Smith had diagnosed a tendonitis, wanted me to use Naprosyn." When asked how the protocols assisted her in her diagnosis of tendonitis, Ms. Myers replied, "Based on the objective findings that I found and are in the protocols, along with the history." (St. Ex. 10; Tr. 585-587)

   Ms. Myers testified that she could not recall if Dr. Smith had done anything to confirm a diagnosis of tendonitis prior to Ms. Myers' issuing the prescription for Naprosyn. Nevertheless, Ms. Myers testified that she did consult with Dr. Smith on some occasions prior to patient visits based upon what patients had complained of over the phone when scheduling their appointments. Ms. Myers stated, if Dr. Smith was there, he would say "oh, it sounds like they have a bursitis or tendonitis; you know, if that's what you think, go ahead and give them some Naprosyn." Ms. Myers noted that the information given by a patient when the patient calls to schedule an appointment may not have been written down, but transmitted orally; Dr. Smith could then ask the receptionist what a patient was coming in for, and could be told, for example, that Patient Brown had a complaint about his elbow. (St. Ex. 10; Tr. 587-588)

6. Ms. Myers testified that Dr. Smith had initialed the charts for Patients Brown and McNeil, which meant that Dr. Smith had reviewed them. (St. Exs. 9 and 10; Tr. 580-581, 584-585)

Additional Information

Dr. Smith's Policy Concerning New Patients

1. Dr. Smith testified that "[t]he policy of the practice of Dr. Leonard Smith, both in Kenton as well as Alger, both then as well as now, is that no new patients are to be seen without [Dr. Smith's] immediate physical presence and without [Dr. Smith's] being there." Dr. Smith further testified that he had subsequently discovered that there may have been occasions when that policy was not followed, but that he had been unaware of that at the time. (Tr. 303-304)

   The testimony is unclear regarding who had been made aware of this policy, and when. Dr. Smith testified that the first prescription issued to Patient McNeil—a patient who Dr. Smith had never seen—was filled out by Ms. Myers but bears his signature. Dr. Smith testified that he had spoken with Ms. Myers about that patient on the day the prescription was issued, but could not recall if this conversation had occurred before or after the prescription was issued. Dr. Smith further testified that he could not recall the specific conversation. Moreover, Dr. Smith testified that the issuance of this prescription was a violation of his office's policy that no new patients be seen or treated without Dr. Smith's approval. Dr. Smith further added that "[t]he policy was violated but not on the part of

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[Ms. Myers]." Rather, the policy was violated by "[t]he receptionist who allowed this gentleman to come in and be seen while [Dr. Smith] wasn't there." This testimony gave rise to the following exchange:

> Q [by Mr. McGovern]: Okay. And I'd like you to explain that for us. Why did she [the receptionist] violate the policy?
>
> A [by Dr. Smith]: Because she specifically—as well as the receptionist in Kenton, is specifically told no new patients are to be seen without Dr. Smith's presence. I can bring in the current receptionist in Kenton who has been there with me for some nine years, and she will testify to the same; that is the policy of the office of Dr. Leonard Smith.
>
> Q: So only the receptionist was aware of the policy and Ms. Myers was not aware of the policy? Is that your testimony, doctor?
>
> A: I'm afraid that to be true.
>
> * * *
>
> Q: So you had this policy—can you explain to us why Ms. Myers was not aware of this policy?
>
> A: Again, we are testifying in January 1995 as to events—
>
> Q: January 1999.
>
> A: Excuse me, in January 1999 as to events in April of 1995, and are handicapped by the large lapse in time that has occurred. It is my understanding subsequently in discussions with Marilyn [Ms. Myers] that she did not know the policy. And I believe Marilyn to be truthful in her statement. It may be that—I can conjecture only a series of possible scenarios; that, in fact, she wasn't told and should have been told, or that she was told and forgot, or a whole line of scenarios. But the point is, as I testified in April of 1996, and now in January 1999, that this was and is the policy of the office of Dr. Leonard Smith.
>
> Q: When one has a policy such as that is it fair to expect that all of one's employees would be aware of the policy?
>
> * * *

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A: No, it's not fair. It's not fair at all. People have limited functions and capabilities. Your question is that all employees—

Q: Okay. Is that your answer?

A: Yes.

Q: How about employees that would be in the best position to violate that policy, such as ones who are given pre-signed prescription blanks, doctor?

* * *

A: Yes.

Q: It would be fair to expect that type of individual should be made aware of the policy, is that your answer, yes, to that question?

A: (indicates affirmatively.)

Q: Okay. Okay.

A: That's an agonizing yes.

(Tr. 323-330)

2. Later during the hearing, Ms. Myers testified that Dr. Smith's policy was that no new patients were to be seen by her at the Alger Clinic; these patients were to be seen by Dr. Smith at the Kenton office or at the times he was present at the Alger Clinic. Ms. Myers stated that this policy had been in effect since Dr. Smith opened the Alger Clinic. Nevertheless, Ms. Myers testified that the receptionist had violated this policy and scheduled new patients out of concern that the office would close for lack of patients and she would lose her job. Ms. Myers testified that the receptionist "was desperate to get the numbers up. So she would make appointments for anyone." She stated that she learned that Patients McNeil and Brown were new patients after they had been brought back to the examination room. When asked why she had violated this policy and seen these new patients, Ms. Myers testified:

> I knew the policy, but there again, when a patient's taken time out of their day to make an appointment and be put in a room and they are sitting waiting there expecting to be seen, I am not about to go in and make the patient very mad, upset and possibly lose a patient because I took maybe two hours out of his day, and now I'm not going to even see him and make him reschedule. So because he got that far, I felt that it was my

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> professional duty to go ahead and see him and treat him according to protocols.

(Tr. 589-590)

Later in the hearing, Ms. Myers was informed of Dr. Smith's earlier testimony in which he stated that Ms. Myers had been unaware of his policy concerning new patients. Ms. Myers testified that Dr. Smith's testimony did not surprise her because Dr. Smith had not told her of this policy—Ms. Myers had learned about it from the receptionist—and Dr. Smith may therefor not have known that she had been aware of this policy. Ms. Myers further testified that she could not recall when she had learned of Dr. Smith's policy, and that she did not know if she had been aware of that policy when she saw Patients McNeil and Brown in April 1995. [Note that this statement contradicts Ms. Myers' earlier testimony as described in the preceding paragraph.] Moreover, Ms. Myers stated that, even if she had not been aware of Dr. Smith's policy regarding new patients when she saw Patients McNeil and Brown, the reason she saw them was because she did not want to inconvenience them. Pressed further and asked why, if she had been unaware of Dr. Smith's policy, she had felt a need to justify seeing those patients, Ms. Myers stated:

> I knew, and I don't recall, it's been too long ago, if it was [the receptionist] that told me that, if you want to call it a policy, okay, or if it was Dr. Smith that told me. I don't remember, but—and I don't remember when I was told that, but obviously I had a little concern about it, seeing first-time patients, even on [the day she first saw Patient McNeil].

(Tr. 589-603) When asked about this concern, Ms. Myers replied, "I knew that Dr. Smith didn't like that, okay. And I don't recall if it came from Dr. Smith or it came from [the receptionist.] I just knew that, okay." (Tr. 603)

3. Concerning any disparity between the testimony of Dr. Smith and Ms. Myers, Dr. Smith stated:

> Once again, I wasn't quite clear when I gave my testimony at that time exactly what [Ms. Myers] knew the policy to be. I did know—I do know and did know that the receptionist knew what the policy was to be. The problem now being that it is four years later and it's hard to pinpoint exactly from the employees, some of whom no longer are working for me, exactly what they did and did not know at that time.

(Tr. 810-811)

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Ms. Myers' Use of Pre-Signed Prescription Blanks

1. Dr. Smith testified that he had pre-signed prescription blanks "[m]any years ago" for Ms. Myers' use "[f]or administrative purposes such as an off work excuse, an absence from school excuse, for explanations of work restrictions or explanations that were needed." Dr. Smith acknowledged that these blanks could have been used for medication "[i]f we got caught in a pinch." Dr. Smith stated that he supplied Ms. Myers with a limited number of pre-signed prescription blanks daily by signing the top few blanks on a pad. (Tr. 317-322, 808-809)

2. Ms. Myers testified that Dr. Smith had provided her with pre-signed prescription blanks when she worked at the Alger Clinic. Ms. Myers further testified that she had asked Dr. Smith to continue the practice of the physician who had previously run that clinic. This physician had provided pre-signed prescription blanks for Ms. Myers to use for medications that could not be phoned in, such as Ritalin. Ms. Myers stated that that was the only purpose for which she had been given pre-signed prescription blanks, and that she had been given "just a very limited number" to use each day. When asked if she had been given them to use for work excuses, Ms. Myers testified, "I could use them for that, but I also could write it on a piece of paper too, you know. But it looked a little more professional coming from the doctor's office heading on it. So I would use them for that too." Ms. Myers testified that Dr. Smith provided her with a prescription pad and that he would sign the first few blanks each day. (Tr. 575-578)

   Ms. Myers testified that, as a nurse, she is allowed to call prescriptions into a pharmacy "[i]f they were prescriptions that had been approved by the physician by protocols or standing orders, written orders, as they would be like in a hospital setting." Ms. Myers testified that she believed that the protocols that were in place at Dr. Smith's office provided her with that authority even if the physician had not personally evaluated the patient himself. (Tr. 578-579)

3. On re-cross examination, Dr. Smith reiterated his testimony that the main purpose the his issuing pre-signed prescription blanks to Ms. Myers was for administrative purposes, such as work excuses. Dr. Smith stated that they were used "very rarely" by Ms. Myers to write prescriptions when she had been placed in a "compromise situation" when a new patient had been scheduled contrary to Dr. Smith's wishes. (Tr. 902-905)

4. Dr. Smith testified that his practice of making pre-signed prescription blanks available to Ms. Myers has ceased. Dr. Smith testified that under his current system, Ms. Myers now provides prescriptions to patients in one of two ways: either she can call the prescription in to a pharmacy after having discussed it with Dr. Smith, or she can fill out a prescription and present it to Dr. Smith for his signature. (Tr. 933-935)

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Post-dated Prescriptions

1. Dr. Smith testified with regard to the Board's allegation concerning post-dated prescriptions that his intent had always been to see that the patients got their medication only at the appropriate interval. Dr. Smith testified that he had never intended to commit a crime. Moreover, Dr. Smith added:

> As to why [the patients] might have gotten the prescription a day or two or three early, I can't tell you for certain; but I can tell you that frequently, we see patients in the office for perhaps another unrelated problem and that they are due for an up-coming prescription. And rather [than] inconvenience them [and] have them come back, we go ahead and give them the prescription at that time.
>
> It's not intended that they get more medication. It's not intended in any way to deceive them. Indeed, it's intended so * * * they can't get any more medication other than at the appropriately prescribed interval.

(Tr. 890-892)

Dr. Smith further testified that the process of issuing prescriptions that can later be refilled by the patient is analogous to what he was doing. Dr. Smith noted that when a physician issues a prescription with refills, the physician does not specify what date the patient is entitled to the refills. Nevertheless, it is assumed that the patient will be entitled to a refill after the patient goes through the first batch of medication. (Resp. Ex. C; Tr. 893-894)

2. Dr. Smith testified concerning his prescribing of pain medication that he has "always dealt with patients with real problems; and the pain medications were closely monitored." Dr. Smith further testified that his treatment of these patients was occasionally hampered by the refusal of the Bureau of Workers' Compensation to approve tests and treatment modalities that Dr. Smith had wanted his patients to have. (Tr. 897-898)

Prescriptions for Weight-Control Medication

1. Dr. Smith testified that "[o]verweight patients were prescribed medication for a limited period of time. They were largely limited to the patients in the practice and for limited medical purposes. As a rule, except maybe in one situation here, they lost weight. Even that one individual eventually did lose weight." (Tr. 898)

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Dr. Smith testified that weight loss patients comprise a small percentage of his total practice, approximately five percent. Of those patients, most are treated by Dr. Smith for other medical problems as well. (Tr. 822-823)

2. Dr. Smith described the protocol for treatment of a patient who comes for assistance in losing weight. Dr. Smith testified that a history and physical examination is given which includes a review of the patient's prior efforts to lose weight and whether the patient had previously taken any medication to lose weight. The patient is placed on a restricted calorie American Diabetic Association diet, and the importance of exercise and willpower is stressed. (Tr. 823-827)

   Dr. Smith testified that patients sometimes leave their diet program and come back later. Dr. Smith testified that that situation is handled in different ways depending on how long the patient was off the diet. If the patient was off for a very short time, then they pick up where they left off. If the time period was more significant then the patient is treated as though they were new to the diet program. (Tr. 827-828)

   Concerning weight rechecks, Dr. Smith testified that if a patient who had been making good progress comes in with negligible weight loss or no weight loss, the patient is given the benefit of the doubt. Dr. Smith stated, "We're not only there to prescribe medication for them, but we're also a coach and a counselor to encourage them on." (Tr. 828-829)

3. Dr. Smith testified that if the risk of carrying excess weight is greater than the risk of prescribing anorectic medication, then it is appropriate to prescribe such medication to help the patient lose weight. Nevertheless, Dr. Smith was unable to identify any specific, objective criteria that could be used in analyzing these risks. (Tr. 549-554)

General Information

1. Dr. Smith testified that what is contained in the medical records for Patients 1 through 8 accurately reflects the care that he rendered to those patients. (Tr. 290-293)

2. Dr. Smith testified that he has never been charged with any crime relating to the allegations made by the Board. (Tr. 890)

3. Dr. Smith expressed feelings of frustration and bewilderment over the Board's handling of his case. Dr. Smith testified that he believes that the Board should have approached him concerning any problems with his practice and shared its concerns. Dr. Smith testified that he had offered to cooperate with the Board when he was deposed in April 1996. Dr. Smith stated that "[t]he whole approach could have been one of cooperation rather than confrontation; and to this day, I'm still—I still stand ready and willing to cooperate in every way with the Medical Board." (Tr. 895-897)

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Dr. Smith testified that if any improper practices had been brought to his attention by the Board or its investigators, he would have corrected those practices. (Tr. 814, 820-822)

4. Dr. Smith testified that he is proud of the way he has conducted himself during his 25 years of practice. Dr. Smith believes that he has served his community well. He testified that he comes from a family of physicians, and has always tried to do well by his family and community. Dr. Smith stated that he has never done "anything intentionally or otherwise to discredit" himself or others around him. (Tr. 898-899)

5. Dr. Smith submitted letters of support written on his behalf by physician colleagues. These letters uniformly characterize Dr. Smith as a talented and dedicated physician and an ethical person. (Resp. Exs. D, E, F, and N) [Please note that the State did not have an opportunity to cross-examine the authors of these letters.]

LEGAL ISSUES

1. Dr. Smith, through his counsel, Mr. Jurca, moved that the September 9, 1998, notice of opportunity for hearing be dismissed because it gave inadequate notice of the Board's allegations against him. Mr. Jurca argued that the dates of certain allegations concerning Patients 1 through 7 had not been specified, and that the medical records did not appear to reflect the violations alleged.

   Rule 4731-13-03(E)(1), Ohio Administrative Code, states that a Hearing Examiner does not have the authority to grant motions for dismissal of charges, and Dr. Smith's motion was denied at hearing. Mr. Jurca then requested that the Hearing Examiner consider his motion when making a recommendation to the Board, and the Hearing Examiner agreed to do so.

   Upon a review of the hearing record and the arguments of counsel, the Hearing Examiner is of the opinion that the September 9, 1998, notice of opportunity for hearing gave adequate notice to Dr. Smith of the Board's allegations against him. Accordingly, the Hearing Examiner recommends that the Board not dismiss these allegations based on a lack of sufficient notice to Dr. Smith.

2. During closing argument, Mr. Jurca argued that the State had made a deliberate attempt to unfairly prejudice Dr. Smith by implying that there were other matters concerning Dr. Smith that the Board had investigated. However, upon a review of the hearing record, the Hearing Examiner was unable to discern any instance where the State had made such an implication.

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FINDINGS OF FACT

1. The evidence presented at hearing supported the following allegations regarding Patient 9 made by the Board in its September 9, 1998, notice of opportunity for hearing:

   a. On or about April 10, 1995, a State Medical Board investigator, using the name of David Shawn McNeil, initially presented himself to the office of Leonard K. Smith, M.D., in Alger, Ohio [the Alger Clinic] for a scheduled appointment to receive medical services for weight loss. Patient McNeil was seen by Marilyn Myers, a nurse in Dr. Smith's employ. Ms. Myers provided Patient McNeil with a packet of information and explained the diet he was to follow. Ms. Myers then removed a pad of prescription blanks from her pocket. Patient McNeil observed some of the prescription blanks, which were pre-signed at the bottom, but contained no other writing. Ms. Myers completed this pre-signed prescription blank for 14 Adipex P, a Schedule IV controlled substance, and gave it to Patient McNeil. This prescription bore Dr. Smith's signature. No inquiry was made of any attempts by Patient McNeil to lose weight via nutritional counseling, caloric restriction, or behavior modification, without the use of controlled substances. Neither Dr. Smith nor any other physician saw Patient McNeil. Patient McNeil paid for the office visit and made an appointment for April 24, 1995.

      Although the medical records indicate that Ms. Myers inquired concerning Patient McNeil's eating habits, such inquiry did not extend to Patient McNeil's previous efforts to lose weight via caloric restriction.

   b. On or about April 24, 1995, Patient McNeil again presented himself to the Alger Clinic for his scheduled appointment. He was again seen by Ms. Myers. Ms. Myers removed a pad of prescription blanks from her pocket. Patient McNeil observed some of the prescription blanks, which were pre-signed at the bottom, but contained no other writing. Ms. Myers completed this pre-signed prescription blank for 14 Adipex P, a Schedule IV controlled substance, and gave it to Patient McNeil. This prescription bore Dr. Smith's signature. Neither Dr. Smith nor any other physician saw Patient McNeil.

2. The evidence presented at hearing supported the following allegations regarding Patient 10 made by the Board in its September 9, 1998, notice of opportunity for hearing:

   On or about April 26, 1995, a State Medical Board investigator, using the name of Jeff Brown, initially presented himself to the Alger Clinic for a scheduled appointment to receive medical services for pain in his right elbow. Patient Brown was seen by Ms. Myers. Ms. Myers questioned Patient Brown about the pain in his elbow, she examined his elbow, and she then informed Patient Brown that he

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had tendonitis. Ms. Myers removed a pad of prescription blanks from her pocket. Patient Brown observed that this pad was blank with no writing on it. Ms. Myers replaced this prescription pad, reached into another pocket, and removed a different prescription pad. Patient Brown observed at least three prescription blanks, all of which were pre-signed at the bottom, but had no further writing on them. Ms. Myers wrote a prescription for Naprosyn on a pre-signed prescription blank and gave it to Patient Brown. This prescription bore Dr. Smith's signature. Neither Dr. Smith nor any other physician saw Patient Brown.

Testimony offered by Dr. Smith and Ms. Myers that Dr. Smith may have directed the diagnosis and treatment of Patient Brown based on discussions with the Alger Clinic receptionist is not credible.

3 The evidence presented at hearing supported the following allegations regarding Patients 1 through 7 made by the Board in its September 9, 1998, notice of opportunity for hearing:

In the routine course of Dr. Smith's practice, Dr. Smith undertook the care of Patients 1–7 with Schedule IV controlled substance anorectics for weight loss.

a. Prior to Dr. Smith's treatment of Patients 1, 2, 4, 5, and 6 with controlled substance anorectics, Dr. Smith failed to determine and/or his records fail to reflect that he had determined that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances.

Although the evidence indicated that Dr. Smith had placed Patient 5 on a restricted calorie diet approximately two weeks prior to prescribing Adipex P to Patient 5, such evidence does not support a finding that Patient 5 had made a substantial effort to lose weight via caloric restriction.

b. Dr. Smith continued to prescribe controlled substance anorectics to Patients 1 through 7 on occasions when these patients failed to lose weight.

c. Dr. Smith continued to prescribe controlled substance anorectics to Patients 1 and 4, despite Dr. Smith's suspicions that these patients exhibited signs of drug abuse.

Dr. Smith protested at hearing that he had never had any suspicions that Patient 4 exhibited signs of drug abuse. This statement is contradicted by the medical records, however. On one occasion, Dr. Smith was contacted by another physician who advised that Patient 4 had been obtaining medication from multiple sources. This occurred on the same date that

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Patient 4 called and asked for more medication because she was going out of town. On a subsequent occasion, Dr. Smith was contacted by Patient 4 who related a story about losing her medication in the dishwasher. On both of these occasions, Dr. Smith refused to prescribe the additional medication sought by Patient 4.

4. Dr. Smith issued postdated prescriptions for Schedule II, III and/or IV controlled substances to Patients 1, 3, 4, and 8, as follows:

Patient	Prescription	Prescription Issued	Prescription Dated	Schedule
1	Adipex; amount unspecified	10/27/92	10/30/92	IV
1	20 Darvocet N-100	2/22/93	2/23/93	IV
1	20 Darvocet N-100	2/26/93	2/27/93	IV
1	20 Darvocet N-100	3/23/93	3/24/93	IV
1	20 Darvocet N-100	5/11/93	5/14/93	IV
1	20 Darvocet N-100	8/23/93	8/24/93	IV
1	14 Adipex	8/24/93	8/26/93	IV
1	20 Darvocet N-100	9/13/93	9/14/93	IV
1	28 Diazepam 5 mg.	3/25/94	3/27/94	IV
1	28 Diazepam 5 mg.	5/27/94	5/28/94	IV
3	14 Tenuate	4/21/92	4/27/92	IV
4	64 Percodan	7/22/91	7/23/91	II
4	30 Fiorinal	11/24/92	11/25/92	III
4	64 Percocet	1/11/93	1/12/93	II
4	64 Percocet	2/23/93	2/25/93	II
4	30 Fiorinal	4/12/93	4/13/93	III
4	56 Vicodin ES	11/22/93	11/24/93	III
8	60 Valium 5 mg.	6/1/92	6/12/92	IV
8	30 Tylenol No. 3	7/21/92	7/22/92	III
8	60 Valium 5 mg.	1/8/93	1/22/93	IV
8	60 Valium 5 mg.	7/29/93	7/31/93	IV
8	30 Vicodin ES	2/17/94	2/22/94	III
8	30 Vicodin ES	1/9/95	1/10/95	III
8	30 Vicodin ES	1/23/95	1/24/95	III
8	30 Tylenol No. 3	2/27/95	3/2/95	III
8	60 Valium 5 mg.	2/27/95	3/2/95	IV
8	30 Vicodin ES	5/26/95	5/30/95	III
8	30 Vicodin ES	7/6/95	7/8/95	III
8	30 Tylenol No. 3	7/6/95	7/8/95	III
8	60 Valium 5 mg.	7/6/95	7/8/95	IV
8	30 Tylenol No. 3	8/3/95	8/5/95	III

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Patient	Prescription	Prescription Issued	Prescription Dated	Schedule
8	60 Valium 5 mg.	8/3/95	8/5/95	IV
8	30 Tylenol No. 3	10/5/95	10/9/95	III
8	60 Valium 5 mg.	10/5/95	10/9/95	IV

5. The evidence presented in this matter does not support the following allegations made in the Board's September 9, 1998, notice of opportunity for hearing:

   a. In paragraph (1)a of the notice of opportunity for hearing, the Board alleged that no inquiry had been made concerning Patient McNeil's [Inv. McCafferty's] previous attempts to lose weight via exercise. However, the medical records indicate that Ms. Myers inquired of Patient McNeil's exercise habits.

   b. In paragraph (3)a of the notice of opportunity for hearing, the Board alleged that, prior to Dr. Smith's treatment of Patient 3 with controlled substance anorectics, Dr. Smith had failed to determine and/or his records failed to reflect that he had determined that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances. Nevertheless, the medical records for Patient 3 presented at hearing were, by Dr. Smith's testimony, incomplete. Older records had been culled from that record and were unobtainable for the hearing. Further testimony indicated that Dr. Smith may have treated Patient 3 with anorectic medication at an earlier date than is reflected in State's Exhibit 3. Accordingly, no finding can be made concerning Dr. Smith's initial treatment of Patient 3 with controlled substance anorectics.

   c. In paragraph (3)a of the notice of opportunity for hearing, the Board alleged that, prior to Dr. Smith's treatment of Patient 7 with controlled substance anorectics, Dr. Smith had failed to determine and/or his records failed to reflect that he had determined that Patient 7 had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances. However, the evidence indicated that Patient 7 had consulted with a dietitian approximately two months prior to being prescribed controlled substance anorectics. Moreover, a report from the dietitian indicated that the dietitian had inquired concerning Patient 7's exercise and eating habits, and that she had been placed on a limited fat diet on that date. The report further stated that behavior modification would be used. Finally, Patient 7 had lost approximately six pounds between the time she consulted with the dietitian and the time that Dr. Smith started prescribing controlled substance anorectics.

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Nevertheless, no evidence was presented that this constituted a successful weight loss effort.

d. In paragraph (3)b of the notice of opportunity for hearing, the Board alleged that, in Dr. Smith's treatment of Patients 1 through 7 with controlled substance anorectics, Dr. Smith had failed to obtain and/or his records failed to reflect that he had obtained a thorough history, and further he had failed to perform and/or his records fail to reflect that he had performed a thorough physical examination of these patients. The medical records relate instances where physical examinations had not been performed, and histories had not been taken, on the date that controlled substances were first prescribed. Nevertheless, in each of these instances, the patient in question was an established patient of Dr. Smith's who had been previously examined by him, and whose history had been previously obtained.

e. Dr. Smith continued to prescribe controlled substance anorectics to Patient 5, despite Dr. Smith's suspicions that this patient exhibited signs of drug abuse. Evidence contained in the medical record is not sufficient to support such a finding, and Dr. Smith denied at hearing that he had had such suspicions concerning this patient.

f. Dr. Smith issued a prescription to Patient 4 for 30 Fiorinal, a Schedule III controlled substance, on March 25, 1994, which had been postdated to March 27, 1994. The page containing the entry describing that prescription was missing from State's Exhibit 4.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Leonard K. Smith, M.D., as set forth in Findings of Fact 1 and 2, individually and/or collectively, constitute "[p]ermitting one's name or one's certificate of registration to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given," as that clause is used in Section 4731.22(B)(1), Ohio Revised Code.

2. The acts, conduct, and/or omissions of Dr. Smith, as set forth in Findings of Fact 1 and 2, 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: Section 4731.41, Ohio Revised Code, Practice of Medicine or Surgery without Certificate.

3. The acts, conduct, and/or omissions of Dr. Smith, as set forth in Findings of Fact 1 and 2, individually and/or collectively, constitute "[c]ommission of an act that constitutes a

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misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, as in effect prior to July 1, 1996, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate.

Mr. Jurca argued that the Board lacks the authority to find that criminal activity has occurred. He further argued that if the Board is to make such a finding, it must do so based upon evidence that proves beyond a reasonable doubt that such activity had occurred, and only after following the same rules that would apply in a criminal proceeding. Moreover, Mr. Jurca argued that if such rules are followed, a violation of Section 4731.22(B)(12), Ohio Revised Code, can not be found because the statute of limitations for the underlying offense had expired. Finally, Mr. Jurca argued, based on the language of the statute, that Section 4731.22(B)(12) applies only to conduct that occurs in another state.

The Hearing Examiner rejects these arguments for the reasons argued by the State at the commencement of the hearing. Dr. Smith is not facing the penalties that a criminal defendant would face in a criminal proceeding; therefore, the rights afforded criminal defendants in such proceedings do not apply to this matter. Moreover, the plain language of Section 4731.22(B)(12) indicates that it applies to offending conduct "regardless of the jurisdiction" in which such conduct is committed. This language does not exclude conduct that occurs in Ohio.

4. The acts, conduct, and/or omissions of Dr. Smith, as set forth in Findings of Fact 1, 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.

5. The acts, conduct, and/or omissions of Dr. Smith, as set forth in Findings of Fact 1 and 3, 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 4731-11-04(B), Ohio Administrative Code.

6. The acts, conduct, and/or omissions of Dr. Smith, as set forth in Findings of Fact 1, 2, and 4, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.23, Ohio Revised Code, Illegal Processing of Drug Documents.

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The Respondent's arguments that these allegations must be proven beyond a reasonable doubt under the rules that would govern a criminal proceeding are rejected for the same reasons discussed in Conclusions of Law 3.

7. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, the violation of Rule 4731-11-02(D), Ohio Administrative Code, as addressed in Conclusions of Law 4, also constitutes violations of Sections 4731.22(B)(2) and (6), Ohio Revised Code.

8. Pursuant to Rule 4731-11-04(C), Ohio Administrative Code, the violation of Rule 4731-11-04, Ohio Administrative Code, as addressed in Conclusions of Law 5, also constitutes violations of Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.

* * * * *

The evidence presented in this matter indicated that, in April 1995, Dr. Smith allowed a nurse to see and examine new patients, assess those patients, and make diagnoses concerning those patients' conditions. In addition, Dr. Smith supplied the nurse with pre-signed prescription blanks with which she could prescribe medication to those patients. In so doing, Dr. Smith abdicated matters of clinical judgment to an individual who was incompetent under the laws of Ohio to bear this responsibility.

The evidence further indicated that Dr. Smith prescribed controlled substance anorectics to patients without first inquiring as to those patients' previous efforts to lose weight via caloric restriction, exercise, behavior modification, and/or nutritional counseling, as required by the Board's rules. In addition, Dr. Smith continued to prescribe controlled substance anorectics to patients who had failed to lose weight. Moreover, he prescribed controlled substance anorectics to two patients despite the fact that he had noted in the medical records that these patients exhibited signs of drug abuse. Further, Dr. Smith wrote postdated prescriptions for controlled substances on a number of occasions. Compounding these findings, however, is the fact that Dr. Smith sometimes appeared at the hearing to be less than forthcoming in discussing the Board's allegations against him.

On the other hand, there was also evidence that Dr. Smith kept very thorough medical records. He also appeared to be a compasionate physician who is dedicated to his patients. Moreover, for those patients who had received pain control medication, (which was not an issue in this case), Dr. Smith documented that the patients' complaints were legitimate, referred them to specialists, sought alternative modes of treatment, and kept close control over those patients' use of medications.

The violations found in this matter warrant a period of suspension practice and monitoring following reinstatement to insure that these violations are not repeated.

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PROPOSED ORDER

It is hereby ORDERED that:

1. The certificate of Leonard K. Smith, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than one year.

2. The Board shall not consider reinstatement of Dr. Smith's certificate to practice unless all of the following minimum requirements have been met:

   a. Dr. Smith shall submit an application for reinstatement, accompanied by appropriate fees.

   b. Dr. Smith shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

   c. Dr. Smith shall appear in person for interviews before the full Board or its designated representative within three months of the effective date of this Order and at three month intervals thereafter, or as otherwise requested by the Board.

      If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Smith's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in which the appearance should have occurred, Dr. Smith shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

   d. Dr. Smith shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the terms of this Order. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which this Order becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

   e. Dr. Smith shall take and pass an examination to be administered by the Board or its designee related to the content of the DEA Physician's Manual, which manual may be obtained from the offices of the Board. In the event that Dr. Smith fails this examination, he must wait at least three (3) months between re-examinations.

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Dr. Smith must pass this examination before submitting his application for reinstatement.

f. Dr. Smith shall take and pass an examination to be administered by the Board or its designee related to the content of Chapter 4731-11 of the Ohio Administrative Code. In the event that Dr. Smith fails this examination, he must wait at least three (3) months between re-examinations. Dr. Smith must pass this examination before submitting his application for reinstatement.

g. Within thirty (30) days of the effective date of this Order, Dr. Smith shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds a license to practice. Dr. Smith shall further provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for licensure or reinstatement of licensure. Further, Dr. Smith shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.

h. In the event that Dr. Smith has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

3. Upon reinstatement, Dr. Smith's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five years:

a. Dr. Smith shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

b. Dr. Smith shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.

c. Dr. Smith shall appear in person for interviews before the full Board or its designated representative within three months of the date in which probation becomes effective, at three month intervals thereafter, and upon his request for termination of the probationary period, or as otherwise requested by the Board.

If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled. Although the Board will normally give him written notification of scheduled appearances, it is Dr. Smith's responsibility to know when personal appearances will occur. If he does not receive written notification from the Board by the end of the month in

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which the appearance should have occurred, Dr. Smith shall immediately submit to the Board a written request to be notified of his next scheduled appearance.

d. Dr. Smith shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of probation. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which probation becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

e. Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Smith shall provide acceptable documentation of successful completion of a course dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the biennial registration period(s) in which they are completed.

f. Within thirty (30) days of the reinstatement of Dr. Smith's certificate, Dr. Smith shall provide a copy of this Order to all employers or entities with which he is under contract to provide physician services or is receiving training, and the Chief of Staff at each hospital where Dr. Smith has privileges or appointments. Further, Dr. Smith shall provide a copy of this Order to all employers or entities with which he contracts to provide physician services, or applies for or receives training, and the Chief of Staff at each hospital where Dr. Smith applies for or obtains privileges or appointments.

g. Dr. Smith shall provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which he applies for licensure or reinstatement of licensure. Further, Dr. Smith shall provide this Board with a copy of the return receipt as proof of notification within thirty (30) days of receiving that return receipt.

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

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i. If Dr. Smith violates probation in any respect, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.

j Dr. Smith shall not prescribe, administer, dispense, order, write orders for, give verbal orders for, or possess (except as prescribed for his use by another so authorized by law), without prior Board approval, the following drugs:

a. Controlled substance anorectics

Moreover, Dr. Smith shall not seek the Board's approval for a change in this provision for a minimum of one year from the reinstatement of Dr. Smith's certificate.

k. If Dr. Smith violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Smith's certificate will be fully restored.

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

R. Gregory Porter
Attorney Hearing Examiner

State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF JUNE 9, 1999

REPORTS AND RECOMMENDATIONS

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

Dr. Steinbergh 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 Brian W. Davies, M.D.; Phyllis L. Gresham, M.D.; Ashwin H. Shah, M.D.; Richard S. Simon, M.D.; Leonard K. Smith, M.D.; Karl E. Steinberg, M.D.; and Nicholas J. Triana, D.P.M. A roll call was taken:

ROLL CALL:

Mr. Albert	- aye
Dr. Bhati	- aye
Dr. Talmage	- aye
Dr. Somani	- aye
Dr. Egner	- aye
Mr. Browning	- aye
Ms. Noble	- aye
Dr. Stienecker	- aye
Dr. Garg	- aye
Dr. Buchan	- aye
Dr. Steinbergh	- aye

Ms. Noble stated that she did not review the hearing record in the matter of Richard S. Simon, M.D.

Dr. Steinbergh 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. Talmage	- aye
Dr. Somani	- aye
Dr. Egner	- aye
Mr. Browning	- aye
Ms. Noble	- aye
Dr. Stienecker	- aye
Dr. Garg	- aye
Dr. Buchan	- aye

Dr. Steinbergh - aye

In accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Dr. Steinbergh 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.

.....

LEONARD K. SMITH, M.D.

Dr. Steinbergh directed the Board's attention to the matter of Leonard K. Smith, M.D. She advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

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

Mr. Jurca stated that it is his privilege to appear on behalf of Dr. Leonard Smith, who has served the people of Hardin County for 25 years. Mr. Jurca stated that he and Dr. Smith respectfully object to the Report and Recommendation, and especially to the Proposed Order of suspension. This Board's disciplinary guidelines indicate that the Board will give each case individual consideration. He asked that the Board do that in this case, particularly in light of comparing Dr. Smith's case to that of Dr. Carlson and Dr. Houser, cases that recently came before the Board and are summarized at length in the objections.

Mr. Jurca stated that he will defer to Dr. Smith for the remainder of the time, but before he does he wants to make four or five points concerning the evidence before the Board. First of all, there is no evidence to indicate that Dr. Smith aided or abetted in the unlicensed practice of medicine since he closed his satellite office in the summer of 1995. Second, there is nothing in the record to indicate that Dr. Smith's patients did not have real medical problems that required treatment. Third, there is no evidence that any prosecutor in this state has considered Dr. Smith's case and concluded that any crimes were committed. Fourth, there's no evidence that Dr. Smith has engaged in any ongoing violations of the Medical Practices Act since he pledged his full cooperation to the Board in 1996. Finally, there is no explanation in the evidence as to why, when the Board investigator was face to face with Dr. Smith in April 1995, that the investigator simply didn't tell Dr. Smith that there was a problem with the satellite office. That may have put an end to

the entire matter.

Dr. Smith thanked the Board. He stated that he stands before the Board in jeopardy of license suspension. The case against him stands on three legs. First, in April 1995, in the village of Alger, pre-signed prescriptions were used by a nurse practitioner for a new patient in his absence. This was a previously existing clinic, set up to help a rural under-served area. This action was not only contrary to the Board rules, but also contrary to the office policies of Dr. Leonard Smith. This was a solitary event, but an error was made and he is responsible. Within days the status of the office was discussed and within weeks the clinic was closed, long before any knowledge of a Board investigation. The use of all pre-signed prescriptions ceased, and no evidence has ever been shown that they have been used since. Dr. Smith stated that he testified to this in the Spring of 1996, when he also said that he would be open to any suggestions and would cooperate with the Board in any way.

Dr. Smith continued that, secondly, post-dated prescriptions for pain medications, by median average of two days, were sometimes prescribed for four patients, specifically to limit these medications and to ensure their use to standard appropriate dose. Dr. Smith stated that he never knew this to be wrong. These were difficult cases, mostly Workers Compensation, where he was the physician of record, responsible for all paperwork, referrals and prescriptions. They were seen by the best available specialists, who knew and approved of these medications. In 1993, one of these patients did develop a dependency problem. As soon as this was realized, he was referred to a drug treatment center.

Third, anorexic medications were used for seven patients, all overweight, all seen regularly every two weeks. Five lost steadily and sometimes dramatically. Two did not. Dr. Smith stated that he persisted because their obesity was directly detrimental to their health. He felt that this was good clinical judgment. Eventually, they did lose weight.

Dr. Smith asked the Board to keep in mind that all of these events occurred in 1995 or earlier. Mr. McGovern's first words at the beginning of his cross examination were, "(d)octor, thank you for your excellent records." His last words were "Dr. Smith is a concerned and compassionate physician." The Hearing Examiner agreed. While these words were appreciated, he submits that he's not only concerned and compassionate, but capable and competent as well. He's not perfect, and he's not brilliant. He's made mistakes, but he feels that he's a good doctor who has served his community for 25 years and whom he believes enjoys a solid reputation. He's proud of his life, his career, his records, and the fact that he's always taken on the tough cases and the indigent cases. He's never shirked his duties. He cares about doing what is right and he's always been cooperative, honest and forthright in his dealings with the Medical Board. This action questions his integrity and his good name. He loves what he does, and because he believes the Board members to be wise and deliberative and just, he asks the Board members to reconsider this judgment against him.

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

Mr. McGovern stated that the key violations in this case relate to Dr. Smith allowing a nurse to staff a clinic unattended in some cases. Dr. Smith was caught doing this red-handed. Two Board investigators went to the clinic and were seen by the nurse as new patients and received prescriptions without any contact whatsoever between the nurse and Dr. Smith. These were pre-signed prescriptions that Dr. Smith made available for the nurse's use. Also, there are clear-cut controlled substance anorectic violations. Dr. Smith did violate the Board's rule in his treatment of these patients. These violations were clearly proven at hearing. Mr. McGovern stated that he is at a loss to understand how Dr. Smith can assert in his objections that the Board did not demonstrate that he violated the good faith provision, determining whether or not the patients had made a good faith effort to lose weight utilizing other means, and that he continued to prescribe these drugs, despite the fact that the patients failed to lose weight. When you look at the Report and Recommendation and the patient records, it's clear that there were a number of times that the patient failed to lose weight and Dr. Smith continued to prescribe these drugs. Dr. Smith's own testimony at the hearing supports these findings.

Mr. McGovern continued that another theme the Board hears today is that Dr. Smith should not be disciplined because time has passed since the violations occurred and that he has practiced appropriately since the alleged conduct. If anything, this should mitigate against the violation, but it should in no way excuse the conduct that occurred.

Mr. McGovern stated that Dr. Smith argues, more in his objections than in his statements today, about a double standard; namely, why should he be expected to remember things that happened five to seven years ago when the Board's enforcement coordinator couldn't remember things that occurred during his investigation. Mr. McGovern stated that he believes Dr. Smith is missing the point. The Board is not going to discipline him because he could not remember the specifics of how he handled his care of these patients. Instead, if the Board chooses to discipline Dr. Smith, it is going to do so because of the violations that were clearly proven. Mr. McGovern stated that he believes that Dr. Smith's inability to remember relates more to his credibility, which the Hearing Examiner did question. Mr. McGovern stated that he's at a loss to understand how in his objections Dr. Smith states that the Hearing Examiner cites to a null instance where Dr. Smith demonstrated a lack of credibility. Mr. McGovern stated that from a simple reading of the Report and Recommendation, where the Hearing Examiner summarizes the testimony of Dr. Smith and Ms. Myers regarding the pre-signed prescriptions and Dr. Smith's policy on the seeing of new patients, it's very clear that a number of different explanations were provided throughout the course of the hearing for what, in fact, went on.

Mr. McGovern stated that he did say at the conclusion of the hearing that Dr. Smith appeared to be a caring and compassionate physician. He will stand by that as to his apparent treatment of patients 1 through 8. However, regarding the two Board investigators, who were technically patients of Dr. Smith's practice, he was not a caring and compassionate physician. In fact, he had no involvement whatsoever in their care. This cuts against an impression that Dr. Smith tries to give that he is a caring and compassionate physician. Mr. McGovern stated that, to him, this is a physician who is more interested in practice volume and getting more money. The violations that occurred in relation to Ms. Myers are egregious and

appalling.

DR. SOMANI MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF LEONARD K. SMITH, M.D. DR. BHATI SECONDED THE MOTION.

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

Dr. Steinbergh stated that she would like to make an editorial correction on page 29 of the Report and Recommendation under the caption "Patient 8." In paragraph 1 and paragraph 1(a), the words "Patient 4" should read "Patient 8."

Dr. Stienecker stated that with regard to the weight loss problems, Dr. Smith was not in strict compliance with the records, but in reference to other cases the Board has seen where medications were given out time after time for people who lost no weight at all or gained weight repeatedly, this was not the case with this group of patients. One of the patients lost about 70 lb., another lost 40 lb., one lost 59 lb. from February to June of the following year. These were people with diabetes, hyperlipidemia. One hyperlipidemic patient lost 67 lb. These were probably lifesaving weight losses for these people, or at least life-lengthening weight losses. Dr. Stienecker stated that if the Board looks at the competence of the problem rather than the compliance of this weight loss program, the Board can't hold Dr. Smith remiss for these particular patients. Some of the patients were very difficult. One had diabetic cirrhosis, another had hypertension hypothyroidism. These were difficult problems, and even under the Board's present rules, for people with those kinds of co-morbid problems, this was probably good medical care.

Dr. Stienecker stated that he cannot accept Dr. Smith's contention that it was the responsibility of the investigating officer to advise him that he was doing something that was not in compliance. While that may be nice for the officers to do when it looks like it could be helpful, he does not believe that, in this circumstance, it was the investigator's job to do that. The investigator was there to investigate a problem, not to correct it. Dr. Stienecker stated that he cannot take the investigator to task because he did not tell Dr. Smith during the course of his investigation that he had a bad problem going on in his other office.

Dr. Stienecker stated that Dr. Smith's records are excellent; no doubt some of the best the Board has seen. He added that he believes Dr. Smith has given good reasons for the use of the medications. He can accept the postdating of the one and two days for the reasons that he stated. The Board has done that in the past when it has felt it was a reasonable thing to do. The only thing he cannot support him on is allowing the practice of an unlicensed person to the extent that the nurse was practicing in the clinic. At the same time, he had taken over the job of supervisor of the clinic under the auspices of the hospital, and thus is not entirely alone in being responsible for the nurse's practice.

Dr. Stienecker stated that he believes a one-year suspension is too long.

DR. STIENECKER MOVED TO AMEND THE PROPOSED ORDER IN THE MATTER OF LEONARD K. SMITH, M.D., TO CHANGE THE PERIOD OF SUSPENSION TO 60 DAYS. THE PROBATIONARY PERIOD AND CONDITIONS WOULD REMAIN THE SAME. DR. EGNER SECONDED THE MOTION.

Dr. Steinbergh asked for further discussion.

Dr. Somani stated that he thinks this is an interesting departure from the usual case where the Board does not find good records. There are good patient records in the weight cases. At the same time, there were some serious, troubling issues that emerged in the testimony and the record in this case. Concerning the issue of post-dating prescriptions, the Board has heard that occasionally it may be appropriate in unusual circumstances. It appears to him from the record that there were a number of instances when that happened. That became obvious only from the limited records to which the Board has access. Therefore, it's quite likely that it's been going on for a long time, except that, as heard today, once it became clear that it is not acceptable practice, it ceased. The fact of the matter is that it was a routine practice for prescriptions, sometimes postdated, to be given to the nurse. That's one troubling issue.

Dr. Somani continued that the second issue that is even more troubling is the unsupervised practice by a nurse in a clinic. Nurses are not supposed to see new patients because that is an "office practice." It's very obvious that the nurse should have known that the patient, in this case the investigator, was a new patient. She should have said that she could not treat the patient. There is no evidence that the nurse even made the attempt to call Dr. Smith and say that there was a new patient and to seek his instruction. Dr. Somani stated that he's not prepared to accept Dr. Smith's excuses.

Dr. Somani stated that the third thing that was a little troubling is that it appears from the testimony that the nurse had a chance to discuss the cases with the doctor in advance when reviewing the day's appointments, and that diagnoses and determinations that prescriptions were needed were made sight unseen, based upon information obtained over the telephone when the appointments were made. Dr. Somani stated that he thinks it is a dangerous practice, to diagnose a condition based upon what has been described by a patient when making the appointment. Based upon that, Dr. Somani stated that he is willing to go with the original Order.

Dr. Bhati asked whether the clinic was a private practice.

Dr. Smith stated that it was a non-profitable clinic. It was opened with the assistance of Congressman Mike Oxley and a national health service physician was brought in to serve this designated, rural, under-served area. In 1994, the physician no longer supervised the nurse practitioner. He was asked by local people, the citizens of the village of Alger, as well as people who were involved in the Hardin community to assume this responsibility. He did not do this out of greed, because the whole clinic was non-profitable.

Dr. Steinbergh asked whether the clinic was non-profitable or not for profit.

Dr. Smith stated that it was in the red. It lost money.

Dr. Steinbergh asked what the tax status was. She noted that there is a difference in saying non-profitable and not for profit.

Dr. Smith stated that it was not a non-profit clinic. It was previously owned by a private company.

Dr. Steinbergh asked whether it was expected to be profitable but was not.

Dr. Smith stated that that is correct.

Dr. Bhati asked whether the nurse working at the clinic was his employee.

Dr. Smith stated that she was his employee at the time the investigators came.

Dr. Bhati stated that to him it seems that there is a problem having signatures on prescriptions given to a nurse who is Dr. Smith's employee and is practicing medicine without a license. This went on, giving prescription after prescription, until two investigators went there and got prescriptions with Dr. Smith's signature. Dr. Bhati stated that he can't go along with a 60-day suspension. He would be willing to accept six months.

Dr. Egner stated that the advanced practice nurse has a license to see patients. She does not fall under the same rules as a physician assistant. She is allowed to see patients without the doctor being there. What she's not allowed to do is prescribe medicine. That's the problem.

Dr. Bhati stated that this happened in 1994. That wasn't the case then. She wasn't allowed to see patients then.

Dr. Egner asked what rules there were that stated that advanced practice nurses could not see patients. There are no rules by the Nursing Board. In 1994, an advanced practice nurse could actually do just about anything she wanted to because there were no rules restricting what she could not do, technically. There was no advanced practice nurse bill, but there were advanced practice nurses. She's allowed to see those patients and she was allowed to then. What she was not allowed to do was prescribe medicine, and that's what she did. Dr. Egner stated that taking this man out for a year of practice does no good. He has corrected every single problem there is. Dr. Egner stated that she wants it clear that the nurse was allowed to do what she did, she just was not allowed to prescribe.

Dr. Stienecker stated that the original nurse certification was in 1978, according to the Nursing Board. She was certified as a nurse practitioner in April 1996. The protocols that she signed with Dr. Smith were dated October 1994 and October 1995 on revision. He would presume that she was still working under her

original 1978 certification at the time this was done. He has nothing to say otherwise. The recertification in April 1996 was as an advanced practice nurse. She was able to do what she was doing with the exception of the pre-signed prescription. Her job description was not dated. Had it pre-dated this activity, and had it been accepted by the Nursing Board, it states exactly what she was doing.

Dr. Egner stated that there was no rule by the Nursing Board prior to that time to have any sort of registration with the Nursing Board. There was no such thing as a collaborative agreement.

Dr. Bhati stated that the only contention in this case is the prescription. He believes the Board agrees on that issue. He added that he believes the other members also agree that a one-year suspension is too long.

Dr. Somani stated that it boils down to the same issue: there were post-dated prescriptions, and unsupervised prescriptions being filled out by the nurse working for Dr. Smith. Those are the two major issues.

Dr. Buchan stated that he has a hard time with leniency in this case, but he defers to the disciplinary guidelines. Dr. Smith did sign prescriptions and allowed a nurse to dole them out as he or she chose. That warrants significant sanction. Dr. Buchan spoke in support of the original Order.

Dr. Steinbergh asked whether Dr. Stienecker intends his 60-day suspension to be indefinite.

Dr. Stienecker stated that he did not. It would be a flat 60-day suspension with no reinstatement conditions. He added that he did not believe changes were needed to the Findings of Fact.

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

ROLL CALL:

Mr. Albert	- abstain
Dr. Bhati	- nay
Dr. Talmage	- aye
Dr. Somani	- nay
Dr. Egner	- aye
Mr. Browning	- aye
Ms. Noble	- aye
Dr. Stienecker	- aye
Dr. Garg	- abstain
Dr. Buchan	- nay
Dr. Steinbergh	- nay

The motion carried.

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

FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF LEONARD K. SMITH, M.D. DR. STIENECKER SECONDED THE MOTION. A vote was taken:

ROLL CALL:

Mr. Albert	- abstain
Dr. Bhati	- nay
Dr. Talmage	- aye
Dr. Somani	- nay
Dr. Egner	- aye
Mr. Browning	- aye

Mr. Browning interjected that he hopes that Dr. Smith now understands that he made more than one mistake. There were serious issues here that he corrected, but they are serious. Dr. Smith needs to never forget that if he walks out of here with a 60-day suspension. The vote continued:

Ms. Noble	- aye
Dr. Stienecker	- aye
Dr. Garg	- abstain
Dr. Buchan	- nay
Dr. Steinbergh	- nay

Needing six votes to carry, the motion failed.

Dr. Egner asked what the objections are to the amendment.

A number of members indicated that they would want a longer suspension.

DR. BHATI MOVED TO AMEND THE AMENDED ORDER BY CHANGING THE SUSPENSION PERIOD TO 120 DAYS. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

ROLL CALL:

Mr. Albert	- abstain
Dr. Bhati	- aye
Dr. Talmage	- aye
Dr. Somani	- aye
Dr. Egner	- aye
Mr. Browning	- aye
Ms. Noble	- aye
Dr. Stienecker	- aye
Dr. Garg	- abstain
Dr. Buchan	- aye
Dr. Steinbergh	- aye

The motion carried.

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

ROLL CALL:

Mr. Albert	- abstain
Dr. Bhati	- aye
Dr. Talmage	- aye
Dr. Somani	- aye
Dr. Egner	- aye
Mr. Browning	- aye
Ms. Noble	- aye
Dr. Stienecker	- aye
Dr. Garg	- abstain
Dr. Buchan	- aye
Dr. Steinbergh	- aye

The motion carried.

State Medical Board of Ohio

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

September 9, 1998

Leonard K. Smith, M.D.
900 East Franklin Street
Kenton, OH 43326

Dear Doctor Smith:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, 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) a. On or about April 10, 1995, a State Medical Board investigator, using the name of David Shawn McNeil, initially presented himself to your office in Alger, Ohio (the Alger Health Services Clinic) for a scheduled appointment to receive medical services for weight loss. Mr. McNeil was seen by Marilyn Myers, a nurse in your employ. Ms. Myers provided Mr. McNeil with a packet of information and explained the diet he was to follow. Ms. Myers then removed a pad of prescription blanks from her pocket. Mr. McNeil observed some of the prescription blanks, which were presigned at the bottom, but contained no other writing. Ms. Myers completed this pre-signed prescription blank for fourteen (14) Adipex-P, a schedule IV controlled substance, and gave it to Mr. McNeil. This prescription bore your signature. No inquiry was made of any attempts by Mr. McNeil to lose weight by caloric restriction, nutritional counseling, behavior modification or exercise, without the use of controlled substances. Neither you nor any other physician saw Mr. McNeil. Mr. McNeil paid $32.00 for the office visit and made an appointment for April 24, 1995.

b. On or about April 24, 1995, Mr. McNeil again presented himself to your office in Alger, Ohio, for his scheduled appointment. He was again seen by Ms. Myers, a nurse in your employ. Ms. Myers removed a pad of prescription blanks from her pocket. Mr. McNeil observed some of the prescription blanks, which were presigned at the bottom, but contained no other writing. Ms. Myers completed this pre-signed prescription blank for fourteen (14) Adipex-P, a schedule IV controlled substance, and gave it to Mr. McNeil. This prescription bore your signature. Neither you nor any

Mailed 9/10/98

other physician saw Mr. McNeil. Mr. McNeil paid $20.00 for this office visit.

(2) On or about April 26, 1995, a State Medical Board investigator, using the name of Jeff Brown, initially presented himself to your office in Alger, Ohio (the Alger Health Services Clinic) for a scheduled appointment to receive medical services for pain in his right elbow. Mr. Brown was seen by Marilyn Myers, a nurse in your employ. Ms. Myers questioned Mr. Brown about the pain in his elbow, she examined his elbow, and she then informed Mr. Brown that he had tendonitis. Ms. Myers removed a pad of prescription blanks from her pocket. Mr. Brown observed that this pad was blank with no writing on it. Ms. Myers replaced this prescription pad, reached into another pocket, and removed a different prescription pad. Mr. Brown observed at least three prescription blanks, all of which were presigned at the bottom, but had no further writing on them. Ms. Myers wrote a prescription for Naprosyn on a pre-signed prescription blank and gave it to Mr. Brown. This prescription bore your signature. Neither you nor any other physician saw Mr. Brown. Mr. Brown paid $32.00 for the office visit.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[p]ermitting one's name or one's certificate of registration to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given," as that clause is used in Section 4731.22(B)(1), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) 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: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, as in effect prior to July 1, 1996, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in

Section 4731.22(B)(20), Ohio Revised Code, to wit: Section 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.

(3) In the routine course of your practice, you undertook the care of Patients 1 - 7 (as identified on the attached Patient Key - Key confidential and not subject to public disclosure) with Schedule IV controlled substance anorectics for weight loss.

a. Prior to your treatment of Patients 1-7 with controlled substance anorectics, you failed to determine and/or your records fail to reflect that you determined that the patients had made a substantial effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, behavior modification, or exercise, without the use of controlled substances, and that said treatment had been ineffective.

b. Further, in your treatment of Patients 1-7 with controlled substance anorectics, you failed to obtain and/or your records fail to reflect that you obtained a thorough history, and further you failed to perform and/or your records fail to reflect that you performed a thorough physical examination of these patients.

c. Further, you continued prescribing controlled substance anorectics to Patients 1 - 7 when these patients failed to lose weight.

d. Further, you continued prescribing controlled substance anorectics to Patients 1, 4 and 5, despite your suspicions that these patients exhibited signs of drug abuse.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (3) 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: Section 4731-11-04(B), Ohio Administrative Code. Pursuant to Rule 4731-11-04(C), Ohio Administrative Code, violation of Rule 4731-11-04, Ohio Administrative Code, also violates Sections 4731.22(B)(2), (3) and (6), Ohio Revised Code.

(4) You issued postdated prescriptions for Schedule II, III and/or IV controlled substances to Patients 1, 3, 4, and 8 as follows:

Patient	Date Issued	Prescription Dated	Drug	Amount	Schedule
1	10/27/92	10/30/92	Adipex P	14	IV
1	02/22/93	02/23/93	Darvocet N 100	20	IV
1	02/26/93	02/27/93	Darvocet N 100	20	IV
1	03/23/93	03/24/93	Darvocet N 100	20	IV
1	05/11/93	05/14/93	Darvocet N 100	20	IV
1	08/23/93	08/24/93	Darvocet N 100	20	IV
1	08/24/93	08/26/93	Adipex P	14	IV
1	09/13/93	09/14/93	Darvocet N 100	20	IV
1	03/25/94	03/27/94	Diazepam 5 mg.	28	IV
1	05/27/94	05/28/94	Diazepam 5 mg.	28	IV
3	04/21/92	04/27/92	Tenuate 75 mg.	14	IV
4	07/22/91	07/23/91	Percodan	64	II
4	11/24/92	11/25/92	Fiorinal	30	III
4	01/11/93	01/12/93	Percocet	unknown	II
4	02/23/93	02/25/93	Percocet	64	II
4	04/12/93	04/13/93	Fiorinal	30	III
4	11/22/93	11/24/93	Vicodin ES	56	III
4	03/25/94	03/27/94	Fiorinal	30	III
8	06/01/92	06/12/92	Valium 5 mg.	60	IV
8	07/21/92	07/22/92	Tylenol #3	unknown	III
8	01/08/93	01/22/93	Valium 5 mg.	60	IV
8	07/29/93	07/31/93	Valium 5 mg.	60	IV
8	02/17/94	02/22/94	Vicodin ES	30	III
8	01/09/95	01/10/95	Vicodin ES	30	III
8	01/23/95	01/24/95	Vicodin ES	30	III
8	02/27/95	03/02/95	Tylenol #3	30	III
8	02/27/95	03/02/95	Valium 5 mg.	60	IV
8	05/26/95	05/30/95	Vicodin ES	30	III
8	07/06/95	07/08/95	Vicodin ES	30	III
8	07/06/95	07/08/95	Tylenol #3	30	III
8	07/06/95	07/08/95	Valium 5 mg.	60	IV
8	08/03/95	08/05/95	Tylenol #3	30	III
8	08/03/95	08/05/95	Valium 5 mg.	60	IV
8	10/05/95	10/09/95	Tylenol #3	30	III
8	10/05/95	10/09/95	Valium 5 mg.	60	IV

Your acts, conduct, and/or omissions as alleged in paragraphs (1), (2), and (4) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.23, Ohio Revised Code, Illegal processing of drug documents.

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,

Anand G. Garg, M.D.
Secretary

AGG/bjs
Enclosures

CERTIFIED MAIL #Z 395 591 293
RETURN RECEIPT REQUESTED

cc: Jeffrey J. Jurca, Esq
CERTIFIED MAIL #395 591 107
RETURN RECEIPT REQUESTED

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